Patient Experience, Quality and Safety Committee

Tuesday 4 August 2026, 09:30 - 13:15

Microsoft Teams

Agenda

09:30 - 09:30
0 min

1. PRELIMINARY MATTERS

PEQS_Agenda_04Aug26 FINAL.pdf (3 pages)

1.1. Welcome and Apologies

1.2. Declarations of Interest

PEQS_1.2_July 2026_Board Members Declaration Of Interests summary 2026-27.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.

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.

09:30 - 09:30
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3. ESCALATED ITEMS

3.1. Children's Neurodiversity Services

PEQS_3.1_CYP ND PEQs 4 August 2026.pdf (9 pages)

09:30 - 09:30
0 min

4. ITEMS FOR APPROVAL / RATIFICATION / ASSURANCE

4.1. Minutes of the previous meeting: 30 April 2026

PEQS_4.1_Minutes 2026-04-30 PEQS unconfirmed.pdf (12 pages)

4.2. Committee Action Log

PEQS_4.2_Action Log Aug26.pdf (1 pages)

4.3. Duty of Quality Annual Report 2025/26

PEQS_4.3_Duty of Quality cover paper.pdf (3 pages)
PEQS_4.3a_PTHB Annual Duty of Quality Report 2025-2026.pdf (43 pages)

Patterson,Liz
03/08/2026 09:24:59

4.4. Safeguarding Annual Report 2025/26

PEQS_4.4_PTHB Safeguarding Annual Report 2025-26.pdf (5 pages)
PEQS_4.4a_PTHB Safeguarding Annual Report 2025-26.pdf (76 pages)

4.5. Infection, Prevention and Control Annual Report

- PEQS_4.5_IPC annual report cover paper.pdf (3 pages)
- PEQS_4.5a_IPC Annual Report 2025-26.pdf (23 pages)

4.6. Integrated Quality Report

- PEQS_4.6_Integrated Quality Report Q1 July 2026 V2.pdf (26 pages)

4.7. People Experience Framework

- PEQS_4.7_Peoples Experience Framework.pdf (4 pages)
- PEQS_4.7a_peoples-experience-framework-2025.pdf (35 pages)

4.8. Maternity Services

- PEQS_4.8_Maternity Services Report - Reg 28 response - June 2026.pdf (13 pages)

4.9. Transition of Care update

- PEQS_4.9_Transition of Care Progress Update July 2026.pdf (7 pages)

4.10. Six-monthly update on Antimicrobial stewardship

- PEQS_4.10_Anti-Microbial Stewardship report Jul26.pdf (6 pages)

4.11. Nurse Staffing Levels

- PEQS_4.11_In-patient ward Establishment review 2025-2026 PEQS.pdf (23 pages)

4.12. Quality Management System

- PEQS_4.12_QMS Position.pdf (8 pages)

09:30 - 09:30
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5. ITEMS FOR DISCUSSION

There are no items for discussion

09:30 - 09:30
0 min

6. CONSENT AGENDA

6.1. Internal Audit Reports:

6.1.1. Internal Audit: Mattresses (Follow-Up)

- PEQS_6.1a_Mattresses Follow-up Final Internal Audit report.pdf (8 pages)

6.1.2. Internal Audit: Mortality Review (Reasonable Assurance)

- PEQS_6.1b_Mortality Reviews Query.pdf (2 pages)
- PEQS_6.1bi_Mortality Reviews Final Internal Audit Report.pdf (12 pages)

6.1.3. Audit Wales: Quality Governance (follow up)

- PEQS_6.1c_Powys THB Quality Governance Follow-up Review.pdf (28 pages)

Patterson,Liz
03/08/2026 09:34:55

6.2. Joint Commissioning Committee highlight report from the Quality, Safety and Outcomes Sub-Committee 27 April and 29 June 2026

- PEQS_6.2a_QSOC Highlight Report 27 April 2026 Final.pdf (14 pages)
- PEQS_6.2b_QSOC Highlight Report 29 June 2026 Final.pdf (12 pages)

6.3. Committee Governance Action Plan

PEQS_6.3_Governance Development Plan 2025-27_Cover paper.pdf (2 pages)
PEQS_6.3a_Committee Effectiveness Continuous Development Plan 2026-27.pdf (2 pages)

6.4. Board Out and About Programme

PEQS_6.4_Board Out and About Programme 2025-26.pdf (5 pages)

6.5. ePMA update

PEQS_6.5_ePMA Assurance Update July 2026.pdf (9 pages)

6.6. Committee Risk Register

PEQS_6.6_Committee Risk Register.pdf (2 pages)

6.7. Work Programme

PEQS_6.7_PEQS Work Programme Jul26.pdf (1 pages)

6.8. Glossary

PEQS_6.8_Powys Teaching Health Board Glossary.pdf (6 pages)

09:30 - 09:30
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7. OTHER MATTERS

7.1. Any Other Urgent Business

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

7.3. Committee reflections

7.4. Date of the Next Meeting: 15 October 2026

7.5. Confidential Items

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

7.6. Welcome and Apologies

7.7. Declarations of Interest

7.8. Minutes of the In-Committee meeting held on 30 April 2026

Patterson,Liz
03/08/2026 09:04:55

POWYS TEACHING HEALTH BOARD
PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE
TUESDAY 04 AUGUST 2026
09:30 – 13:15
VIA MICROSOFT TEAMS

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

AGENDA				
Time	**Item**	**Title**	**Attached/Oral**	**Presenter**
	1	**PRELIMINARY MATTERS**		
09.30	1.1	Welcome and apologies	Verbal	Chair
	1.2	Declarations of interest	Verbal	All
09.35 10 mins	1.3	Patient Story	Presentation	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	**ESCALATED ITEMS**		
09.45 10 mins	3.1	Children's Neurodiversity Services **Purpose**: Assurance	Attached	Executive Director of Planning, Performance and Commissioning
	4	**ITEMS FOR APPROVAL / RATIFICATION / ASSURANCE**		
09.55	4.1	Minutes of previous meeting: • 30 April 2026 **Purpose**: Approval	Attached	Chair
	4.2	Committee Action Log **Purpose**: Approval	Attached	Chair
10.00 15 mins	4.3	Duty of Quality Annual Report 2025/26 **Purpose**: Approval	Attached	Executive Director of Nursing, Quality, Women and Family Health
10.15 15 mins	4.4	Safeguarding Annual Report 2025/26 **Purpose**: Approval	Attached	Executive Director of Nursing, Quality, Women and Family Health
10.30 15 mins	4.5	Infection, Prevention and Control Annual Report **Purpose**: Assurance	Attached	Executive Director of Nursing, Quality, Women and Family Health
10.45 25 mins	4.6	Integrated Quality Report **Purpose**: Assurance	Attached	Executive Director of Nursing, Quality, Women and Family Health
11.10	**COMFORT BREAK (15 minutes)**			
10.25 20 mins	4.7	Peoples Experience Framework **Purpose**: Assurance/Approval	Attached	Executive Director of Nursing, Quality, Women and Family Health
11.45 20 mins	4.8	Maternity Services **Purpose**: Assurance	Attached	Executive Director of Nursing, Quality, Women and Family Health

Patterson,Liz 03/08/2026 09:04:55

12.05 20 mins	4.9	Transition of Care update **Purpose**: Assurance	Attached	Executive Director of Nursing, Quality, Women and Family Health
12.25 10 mins	4.10	Six-monthly update on Antimicrobial stewardship **Purpose**: Assurance	Attached	Executive Medical Director
12.35 20 mins	4.11	Nurse Staffing Levels **Purpose**: Assurance	Attached	Executive Director of Nursing, Quality, Women and Family Health
12.55 10 mins	4.12	Quality Management System **Purpose**: Assurance	Attached	Executive Director of Nursing, Quality, Women and Family Health
	5	**ITEMS FOR DISCUSSION**		
		There are no items for discussion		
	6	**CONSENT AGENDA**		
	6.1	Audit Reports: Internal Audit: • Mattresses (Follow-up) • Mortality Reviews (Reasonable Assurance) Audit Wales: • Quality Governance (Follow-up) **Purpose**: Information	Attached	Director of Corporate Governance
	6.2	Joint Commissioning Committee highlight report from the Quality, Safety and Outcomes Sub-Committee • 27 April 2026 • 29 June 2026 **Purpose:** Assurance	Attached	Executive Director of Nursing, Quality, Women and Family Health
	6.3	Committee Governance Action Plan **Purpose**: Assurance	Attached	Director of Corporate Governance
	6.4	Board Out and About Programme **Purpose**: Information	Attached	Director of Corporate Governance
	6.5	ePMA update **Purpose**: Assurance	Attached	Executive Medical Director
	6.6	Committee Risk Register **Purpose**: Assurance	Attached	Director of Corporate Governance
	6.7	Work programme **Purpose**: Information	Attached	Director of Corporate Governance
	6.8	Glossary **Purpose**: Information	Attached	Director of Corporate Governance
	7	**OTHER MATTERS**		
13.05	7.1	Any Other Urgent Business	Verbal	Chair

Patterson,Liz
03/08/2026 09:04:55

	7.2	Items to be brought to the attention of the Board and/or other Committees	Verbal	Chair
	7.3	Committee Reflections	Verbal	Chair
	7.4	Date of the next meeting: 15 October 2026		

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

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"

13.10	7.6	Welcome and Apologies	Verbal	Chair
	7.7	Declaration of Interest	Verbal	Chair
	7.8	Minutes of the In-Committee meeting held on the 30 April 2026 **Purpose**: Approval	Attached	Chair
13.15	Close			

Powys Teaching Health Board is committed to openness and transparency and conducts as much of its business as possible in a session that members of the public are normally welcome to attend and observe.

Meetings are currently held virtually, should you wish to observe a virtual meeting of a committee, please contact the Director of Corporate Governance at PowysDirectorate.CorporateGovernance@wales.nhs.uk at least 24 hours in advance of the meeting in order that your request can be considered on an individual basis.

Papers for the meeting are made available on the website in advance and a copy of the minutes are uploaded to the website once agreed at the following meeting.

Whilst Committee meetings are not public meetings, questions are invited and welcome from members of the public – pleased submit these at least 48 hours in advance of the meeting so a response can either be incorporated into the Board meeting or be provided directly to the requester. Please submit any questions to PowysDirectorate.CorporateGovernance@wales.nhs.uk.

Patterson,Liz
03/08/2026 09:04:55

POWYS TEACHING HEALTH BOARD - REGISTER OF DECLARATION OF INTERESTS 2026-27

Updated: July 2026

Position	Name	Interest Category	Interest Situation	Relevant Dates from	Relevant Dates to	Description of Declaration	Comment
INDEPENDENT MEMBERS							
PTHB Chair	**Carl Cooper**	Indirect Interests	Loyalty Interests	2018	Ongoing	Sole Trader, Mandy Williams, Consulting	Nil
		Indirect Interests	Loyalty Interests	2025	Ongoing	Family member is an employee of Cardiff & Value University Health Board (non Director).	Nil
Vice Chair	**Rhiannon Beaumont-Wood**	Non Financial professional interests	Outside Employment	Jun-23	Ongoing	Director and Owner of RBW Executive and Professional Coaching	Salaried Employment
		Non Finanical personal interests	Loyalty Interests	Jun-24	31/03/2027	Registrant Council Member - Nursing and Midwifery Countil (NMC)	Renumerated as per Registrant Council Member Terms and Conditions
Independent Member (General)	**Rhobert Lewis**	Non Financial professional interests	Outside Employment	Nov-21	Current	Chair NPTC Group of Colleges	NIL
		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
Independent Member (finance)	**Stephen Elliot**	Non Financial professional interests	Loyalty Interests	17 April 2024	Current	Honorary Fellow and Lifetime Member of Healthcare Financial Management Association	NIL
		Non Financial professional interests	Outside Employment	04 February 2024	Current	Spouse Directorship of Oshi's World Private Limited Company and a Trustee of Oshi's World Charity	NIL
Independent Member (General)	**Ronnie Alexander**	Indirect Interests	Outside Employment	2012	Current	Partner Director of RA and CJ Consulting Limited	Dividend Payment only
		Indirect Interests	Outside Employment	Mar-21	Current to Dec-27	Independent Monitoring Authority (IMA) – Non Executive Director	Remunerated
		Indirect Interests	Shareholdings and other ownership interests	2012	Current	Director of RA and CJ Consulting Limited	Dividend Payment only
Independent Member (University)	**Simon Wright**	Non Financial professional interests	Loyalty Interests	23 January 2026	Current	Personal: Senior Professional Fellow, Cardiff University- Various Healthcare Programmes	Honoury Role
		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
		Non Financial professional interests	Loyalty Interests	02 January 2020	Ongoing	Labour Party member	NIL
		Financial Interests	Outside Employment	09-Feb-26	Current	Head of Partner Engagement for JS Group working with HE sector	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
		Non Financial professional interests	Loyalty Interests	01 September 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
		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
		Financial Interests	Shareholdings and other ownership interests		Ongoing	Sole Trader/Owner of Celebratory Gifts Heraldic Names Sole Trader/Owner:CTW Genealogy Research and Owner:Property in the County of Powys	NIL

Patterson Liz
03/08/2026 09:04:55

Independent Member (Local Authority)	**Christopher Walsh**	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 •Member of the Community Speed Watch Group	NIL
		Non Financial professional interests	Loyalty Interests		Ongoing	•Member of Royal College of Nursing •Registered Member of Nursing and Midwifery Council	NIL
		Non Financial professional interests	Loyalty Interests		Ongoing	Labour Party member	NIL
Independent Member (Capital)	**Michael Giannasi**	Indirect Interests	Loyalty Interests	2019	Jul-26	Chair of the Board of Social Care Wales (Welsh Government Sponsored Body).	Remunerated
Independent Member	**Ian Thomas**	Non Financial professional interests	Loyalty Interests	Jun-26	2029	Trustee of a UK Charity - Family Fund that provides financial support to families with disabled and seriously ill children	NIL
		Non Financial professional interests	Loyalty Interests		Sep-26	Sit as an NED on the charity's subsidiary company - Family Fund Business Services.	NIL
EXECUTIVE MEMBERS							
Chief Executive Officer	**Hayley Thomas**	NIL	NIL	NIL	NIL	NIL	NIL
Executive Director of Finance, Capital and Support Services	**Pete Hopgood**	Non Financial Interests	Loyalty Interests	18 June 2018	Ongoing	Partner is Finance Manager working in SBUHB	Not Relevant
Executive Director of Allied Health Professions, Health Science and Digital	**Claire Madsen**	Financial Interests	Outside Employment	07 January 2019	01-Apr-28	Occasional Lecturer for University of West of England.	Hourly rate
		Non Financial professional interests	Loyalty Interests	01 April 2026	01-Mar-28	Member of the The Chartered Society of Physiotherapy	NIL
Executive Medical Director	**Kate Wright**	NIL	NIL	NIL	NIL	NIL	NIL
Executive Director of People and Culture and Transformation	**Debra Wood Lawson**	Indirect Interests	Outside Employment	01 November 2024	01-Nov-27	Non Executive Board Director - Cadarn Housing Group Limited (Powys is a zonal partner)	Remunerated
			Outside Employment	01 September 2025	Current	Relative employee and training in Aneurin Bevan Univeristy Health Board (non Director)	NIL
Executive Director of Public Health	**Mererid Bowley**	Non-Finanical professional Interest	Loyalty Interest	NIL	NIL	Member of Faculty of Public Health	Previously declared on annual Declaration of Interest form issued by corporate team since commencement of role. (Transferring recording of declaration on to ESR from this date).
		Financial Interest	Shareholdings and other Ownership interests	NIL	NIL	Husband works for Mitie Engineering who hold contracts/work with some NHS bodies/organisations. Shares held by husband and myself and Mitie Company	Previously annually since start of employment through completion of declarations of interest form issued by corporate team annually.
Director of Corporate Governance/ Board Secretary	**Helen Bushell**	Non-Finanical professional Interest	Outside Employment	Nov-21	Current	Self - School Governor – Langynwyd primary school (Bridgend)	Not remunerated
		Indirect Interests	Outside Employment	Aug-16	Current	Partner is the Chair of a Housing Association who provide social housing across a large geographical area (including Powys).	Remunerated part time role, 2-4 days per month
		Indirect Interests	Outside Employment	Jul-24	Oct-24	Partner is listed on the Bank for PTHB - working occasionally for the organisation by dual agreement.	Paid per hour/day of work
		Indirect Interests	Outside Employment	May-25	Current	Partner - Associate for Practice Solutions	

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Executive Director of Planning, Performance & Commissioning	**Nicola Johnson**	Nil	Nil	Nil	Nil	Nil	Nil
Executive Director of Primary, Community Care and Mental Health	**Elaine Lorton**	Financial Interests	Outside Employment	Apr-24	Current	Independent Member – ateb - housing Association	Remunerated
		Non Financial professional interests	Outside Employment	Nov-19	Current	Chair of the Board - West 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	15-May-26	Family Member employee of Aneurin Bevan Univeristy Health Board (non Director)	Nil
Executive Director of Nursing, Quality, Women and Family Health	**Paul Hooton**	Non Financial Professional Interests	Outside Employment	2018	Current	Member of the Royal College of Nursing	25/10/2025 Started with PTHB October 2025

Patterson Liz
03/08/2026 09:04:55

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.1

Patient Experience, Quality and Safety Committee	**04 August 2026**
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:	Deputy Director of Performance Commissioning Executive Director for Nursing, Quality, Women and Family Health Director of Midwifery, Women and Family Health Head of Children Public Health Nursing and Paediatric Services
Other Committees and meetings considered at:	Executive Committee 02 October 2024; 13 November 2024; 11 December 2024; 5 February 2025; 19 March 2025 and 23 April 2025; 23 July 2025; 15 October 2025; 04 February 2026; 15 April 2026, 17 June 2026. Patient Experience, Quality and Safety Committee 07 Nov 2024, 11 Feb 2025; 29 April 2025; 31 July 2025, 23 October 2025; 05 February 2026, 30 April 2026

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 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. Take **ASSURANCE** from the ongoing monitoring and evaluation mechanisms in place as part of IQPF.

Patterson Liz 03/08/2026 09:00:35

3. **NOTE** a recommendation will be made to a future meeting of the Executive Committee about the escalation status of the service and reported to this Committee at its next meeting in October 2026.

Approve/Take Assurance	Discuss	Note
Y	Y	N

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

EXECUTIVE SUMMARY

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

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

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

DETAILED BACKGROUND AND ASSESSMENT

Background

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

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

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

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

Level 3 (Escalation)	• Serious concerns on quality and governance. • Continued and consistent failure to meet agreed performance improvements and trajectories across a number of objectives. • Clear articulation of reasons for escalation and criteria for escalation. **This can include:** • Where a performance matter (exception) does not meet target and hits criteria for higher level of resolution, decision making or further action. • Any measure that continues to fail a health board submitted trajectory as part of the Ministerial Priority measures. • Performance recovery is failing to improve or maintain performance. • Any significant failure of quality standard. • Where IQPG deems that a service or measured outcome requires escalation resulting from identified challenge or significant concern.

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

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

As per the IQPF, an Escalation Oversight Group (EOG) for CYP Neurodevelopmental Services was established with the first meeting held on 29 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.

Patterson, Liz 03/08/2026 09:00:35

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

Progress to date

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

- Address assessment backlogs prioritising longest waits initially; Meeting RTT waits and reduce breaches (Waiting list recovery project).
- Establishing a parents and carers group focussed on 0-5- and 5–11-year-olds and address IG requirements to co-produce a padlet as a shared platform for centrally approved resources.
- Meet increased and sustained demand through a robust and sustainable workforce plan for PTHB and consider partnership roles with Powys County Council where appropriate.
- Provide a pre and post diagnostic service as set out in Welsh Government Standards and respective NICE guidance.

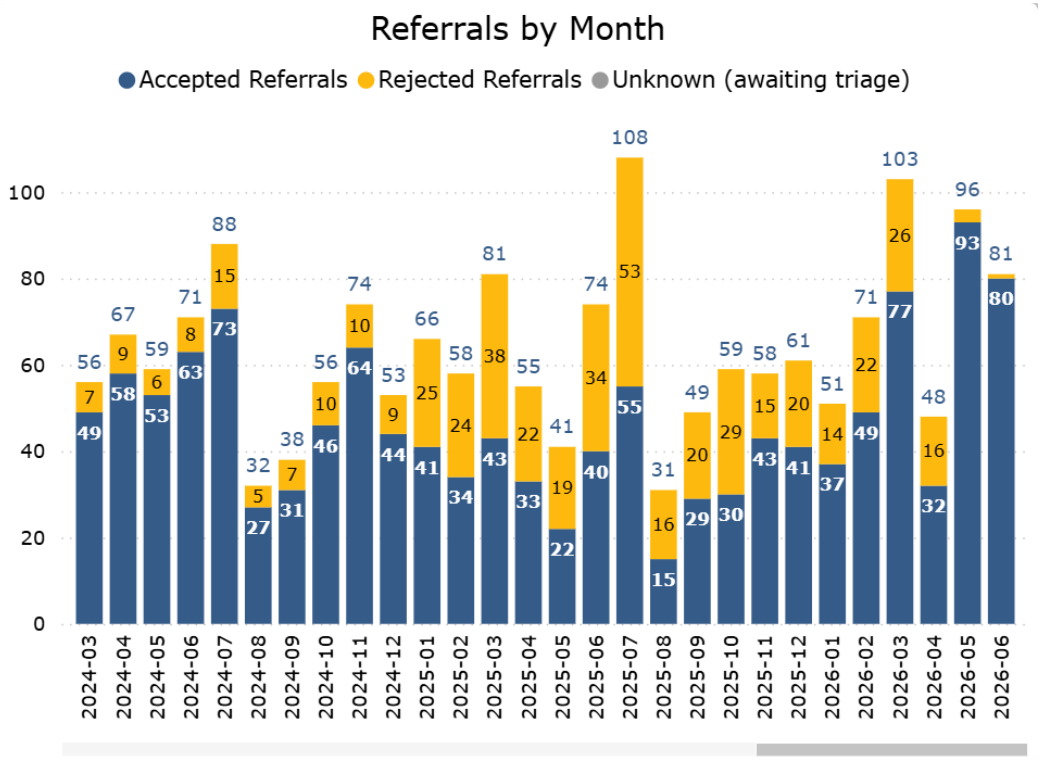
The service undertook an assessment of progress against the performance escalation triggers, noting that considerable progress had been made with the continued delivery of the implementation plan. Consequently, at the meeting held on the 23 July 2025, the Executive Committee agreed the recommendation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

Level 2a (Exception)	• Failure to achieve / maintain delivery in more than 1 key deliverable / area of performance. • Sustained deterioration on 1 or more domain. **This can include:** • Failure to deliver on an NHS Performance Framework target or local target trajectory. • A deviation or departure from the normal or expected course of action signifying specific condition or event that requires attention or further action to address the deviation. • Failure of quality standard. • Where SPC methodology notes variance of concern.

The most recent meeting of the CYP Neurodevelopmental Service EOG was held on the 28 July 2026. Work has continued outside of the formal EOG meetings between the service and the performance team with the current progress noted:

- Performance
  - Waiting List - Total of 861 CYP waiting for a first appointment on 23 July 2026. Noted that there had been 5 breaches > 104 weeks (1 x movement from out of area, 3 x agree to back date to original referral date following new information, 1 x DNA).
  - Referrals – Noted that data quality has improved with unknowns now rectified:

Patterson,Liz 03/08/2026 09:00:35



- Open pathways – 535 patients who have had their first assessment and remain in the diagnostic/clinical element at the 23 July 2026. The number of open pathways had increased since December 2025. There is significant validation work being undertaken in relation to open pathways:
  - Data anomalies (including duplicate open pathways) now understood and being rectified, e.g. re-opening a previous referral for the same child due to more information – currently creates 2 x referrals on the system and if one is open all are open.
  - A local system oversight that when a member of staff has finished and removed their name from WCCIS as the case holder, the system has defaulted back to the "ND Team" as key worker – reflecting the waiting list label - this needs to be actively over-ridden and case re-assigned to another practitioner
  - Historic cases within this number that can be closed and have not been – currently being expedited through ND Panel to support the governance of closure
  - All require actions and will take some time to complete – anticipating significant reduction in this number within the coming weeks.

- Taking current clinical demand (active caseload – open pathways) with the waiting demand for assessment, the current demand is detailed below. The capacity within the service to manage total

Patterson,Liz
03/08/2026 09:00:35

demand was noted with the increased referral acceptance and increase in open pathways having the potential to destabilise service provision within current capacity and therefore adversely impact the performance recovery trajectory:

Snapshot date	Caseload	RTA (waiting demand)	Total demand
June 2026	574	854	1428

  - The service have identified the following focused actions:
    - Recruitment as a priority has been commenced – however, this will require training and time to embed new workforce.
    - Wider actions to enhance assessments by the CAMHs team – this can be increased to 22 clinics per month.
    - Performance management of individual staff members with targeted support.
    - Director to review Paediatric workload (prioritisation) with a view to increase panels as paediatrician is core panel member.
    - Commissioned additional 36 pathways with external provider – local service providing oversight.
    - Review of impending funding under NDIP with a spend plan.
    - Detailed review of demand/capacity to ensure 'internal waiting list' is not building up.
    - New substantive Team Leader has commenced in role, with a further secondment of a Band 8a Senior Nurse role supporting across ND and Community Paediatrics.
    - NDIP monies have been secured for 26/27 and the bid included support for a temporary fixed term Clinical Psychologist which the service are currently expediting. There is also some funds for additional commissioned pathways both of which will advance our current position.

- Risks identified:
  - Some turnover from fixed term and secondment roles, with the recruitment for substantive establishment (as per the agreed business case) almost complete, there is some ongoing training requirements.
  - Required increase in diagnostician oversight of diagnostic outcomes. 1.0wte clinical psychologist remains an outstanding requirement for the service.
  - Cost pressure with implementation of Validated tools (£23k–included within Business Case).
  - Referral demand may reduce in the long term: review of service to ensure that post diagnostic support instigated when demand reduction allows and identified of excess resource managed through organisational change.

Patterson,Liz 03/08/2026 09:04:35

- Integrated Quality and Performance Assessment Framework (IQPAF)
  As part of the EOG process, an IQPAF self-assessment tool has been developed to be used for a self-assessment of service maturity, seeking to answer three key questions:
  a. How safe and effective are services?
  b. How person centred are services?
  c. How well led and effectively managed are services?

  The service has previously completed a baseline assessment in November 2024, with subsequent assessments in March 2025, February 2026 and March 2026 all of which have been presented to and considered by the EOG, Executive Committee and PEQs.

  An updated assessment was presented to the EOG meeting on the 28 July June 2026 where the following was noted:

Proposed Assessment (June 2026)	Basic Level	Early Progress	Results	Maturity	Exemplar
Safe and Effective Care					
Quality of Patient and Family Experience					
Quality of Leadership and Management					

  a. Safe and Effective Care – Proposed move from amber/green to green maturity on basis of implementation of redesigned whole system pathway, strengthened MDT diagnostic delivery, referral and triage processes which have resulted in achieving 0>104 weeks. Quality assurance mechanisms strengthened. Completeness and reliability of diagnostic coding and reporting improved. Ongoing assurance through continued workforce training, supervision and standardisation of evidence based assessment practice, implementation of SPOA and SPACE model, recurrent workforce arrangements.

  b. Quality of Patient and Family Experience – Proposed move from amber to amber/green maturity with evidence detailed to support this assessment. Aim to move to green in Q2 with proposed actions outlined.

  c. Quality of Leadership and Management – Proposed move from amber/green to green maturity on the basis of strategic approach to workforce planning and evidence of well-established plans to meet clinical requirements in the future, well-developed in house training programmes, NDIP report evidences that leadership and management arrangements have supported both operational recovery and wider service transformation, governance has been strengthened through escalation arrangements, redesigned clinical model has enabled a more

Patterson,Liz 03/08/2026 09:03:35

flexible and needs led approach to appointment sequencing and clinician deployment.

- A Conditions for Sustainability self-assessment tool has also been developed as part of the EOG process, designed to be used for self-assessment of the service against a number of domains identified as essential for a sustainable service.

  The service has previously undertaken an assessment review in April 2025 which was presented to PEQs. A further assessment review has been undertaken by the service and presented to EOG on the 01 April 2026 and subsequently to the Executive Committee and PEQs. An updated assessment was presented to the EOG meeting on the 28 July 2026 where the following was noted:
  - The service has transitioned from recovery to a more stable, quality-led model.
  - Governance arrangements are now well established, with clear escalation and reporting routes.
  - The approved business case (February 2026) supports a recurrent workforce model, with recruitment ongoing to strengthen capacity.
  - The service demonstrates alignment with Welsh Government standards and NICE guidance, with MDT-based assessment and decision-making embedded.
  - Key areas for continued development include data quality, reporting consistency, triage data capture, and post-diagnostic support.

NEXT STEPS:

At the EOG meeting of the 28 July 2026, the significant progress and sustained improvement was acknowledged. A recommendation about the future escalation status will be made to Executive Committee and communicated to this Committee at its next meeting in October 2026.

IMPACT ASSESSMENT

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

QUALITY:

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

EQUALITY:

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

RISK ASSESSMENT:

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

Patterson,Liz
03/08/2026 09:04:35

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE

UNCONFIRMED MINUTES OF THE MEETING HELD ON 30 APRIL 2026 at 09:30 VIA MICROSOFT TEAMS

MEMBERS		
Rhiannon Beaumont Wood	RBW	PTHB Vice-Chair (Chair)
Mick Giannasi	MG	Independent Member (General)
Jennifer Owen Adams	JOA	Independent Member (Third Sector) (from 09.45)
Ian Thomas	IA	Independent Member (General) (09.45)
Simon Wright	SW	Independent Member
IN ATTENDANCE		
Mererid Bowley	MB	Executive Director Public Health
Helen Bushell	HB	Director of Corporate Governance / Board Secretary
Carl Cooper	CC	Chair of PTHB Board (observing)
Hayley Hughes	HH	Corporate Business Manager (observing)
Matthew King	MK	Deputy Director Therapies and Health Sciences (observing)
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
Chris Moss	CMo	Assistant Director Performance and Commissioning (10.05 – 10.35)
Paul Hooton	PHo	Executive Director of Nursing, Quality, Women and Family Health
Liz Patterson	LP	Head of Corporate Governance
Aime Symes	AS	Director of Midwifery, Women and Family Health
Hayley Thomas	HT	Chief Executive
Kate Wright	KW	Executive Medical Director
APOLOGIES FOR ABSENCE:		
Nicola Johnson	NJ	Executive Director Planning, Performance and Commissioning
Chris Walsh	CW	Independent Member (Local Authority)

1. PRELIMINARY MATTERS

1.1 WELCOME AND APOLOGIES (PEQS/26/01)

The Chair welcomed everyone to the meeting. Apologies for absence were received as recorded above. Thanks were expressed to SW for chairing the Committee between PTHB Vice-Chair appointments

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1.2 DECLARATIONS OF INTEREST (PEQS/26/02)

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

2. CONSENT AGENDA BUSINESS

RBW asked Members if they wished to bring forward any items from the Consent agenda to the main agenda.

No items were requested to be brought forward from the Consent to the main agenda.

3. ITEMS FOR APPROVAL / DECISION / RATIFICATION

3.1 MINUTES OF PREVIOUS MEETING (PEQS/26/03)

The minutes of the meeting held on 05 February 2026 were **CONFIRMED** as an accurate record.

3.2 COMMITTEE ACTION LOG (PEQS/26/04)

HB presented the action log noting the following updates:

- PEQS/25/88 (a trajectory of improvement relating to incident closure be provided in the Integrated Quality Report) – a date change request to the August 2026 meeting was proposed
- Three actions were not due
- Ten actions were proposed as complete and recommended for closure
- One action had been transferred for monitoring under the Board escalation arrangements

Independent Members asked the following questions for assurance:
The action log and some of the responses to the actions were circulated only two days before the meeting, and in the case of the provision of the Patient Experience Framework implementation plan, this was provided as a background paper rather than brought to the meeting. Does the action log that is presented have sufficient controls to ensure that the actions marked as complete have addressed the original action?
HB advised that this action log had an unusually large number of actions and collating responses had coincided with staffing pressures in some areas and annual leave. The team would reflect on the comments and consider how best to ensure the response correctly addresses the action set out.

PH confirmed there had been staffing pressures within the Quality & Safety Team, however, the area was now in recovery and was making good progress. Some actions related to items later on the agenda for example the Patient Experience Framework Implementation Plan and perhaps consideration of closure of an action would be more appropriately timed to when an individual matter had been considered.

Should the change of date noted for PEQS/25/85 be more accurately recorded as a request for a date change rather than 'on track'?
HB concurred that this should be shown as RAG status red with a requested date change to October 2026.

In relation to PEQS/25/63 (reporting arrangements for dental services) the response details that the matter would be considered at the Chair's Forum. A recent Chair's Forum did not consider this matter.

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03/08/2026 09:04:55

HB advised that the Chair's Forum had considered and looked across all the Committee work programmes which had included dental services, and therefore this action had been viewed as complete. However, reporting arrangements for dental services will be clarified in the next iteration of the action log (PEQS/25/63 to remain open).

The Committee:

- **APPROVED** the date change request for PEQS/25/88 and PEQS/25/85, and
- **REOPENED** PEQS/25/66 dental services for a more detailed response to be included in the next action log.
- **CLOSED** the following actions: PEQS/25/62b, PEQS/25/63, PEQS/25/65a, PEQS/25/65b, PEQS/25/86, PEQS/25/87a, PEQS/25/87b and PEQS/25/94, and
- **TRANSFERRED** the following action PEQS/25/90 to the Board escalation process.

3.3 COMMITTEE ANNUAL WORK PROGRAMME 2026/27 (PEQS/26/05)

HB presented the draft work programme explaining it was informed by the terms of reference, risk register and profiles and considered by the Chair and Lead Executive Member before being brought to the Committee for approval. It is a plan for the year which remains flexible if in year changes are needed to respond to relevant or urgent matters.

Independent Members asked the following questions for assurance:
Is there sufficient capacity to deliver the programme and how is it prioritised?
HB advised that capacity remains challenging and is closely monitored across the Executive team. The programme is designed to be proportionate while meeting statutory and regulatory assurance requirements. Prioritisation is based on professional judgement, informed by risk, urgency, external factors, audit and regulatory requirements, and consultation with committee and Board Chairs. Items may be moved, deferred, escalated, or redirected to remain agile.

Should commissioned services have greater visibility within the work programme?
PH confirmed commissioned services require clearer visibility which may be achieved through a standalone focus or clearer identification within existing reports. Work is underway to strengthen quality, safety, and patient experience oversight for commissioned services, including development of a dedicated dashboard, to support assurance through the integrated quality report.

How will assurance be provided on 'listening to people' and the new complaints process?
HB advised this would be provided within the revised Integrated Quality Report.

May an item on Mortality Reviews be added to the work programme?
KW confirmed that whilst mortality reviews are briefly referenced within the Integrated Quality Report it would be appropriate to have an annual report on this item.

Patterson, Liz
03/08/2026 09:04:55

The Committee **APPROVED** and **RECOMMENDED** the PEQS Annual Work Programme 2026/27 to Board.

3.4 COMMITTEE ANNUAL REPORT 2025/26 (PEQS/26/06)

HB presented the Patient Experience, Quality and Safety Committee Annual Report for 2025/26 which outlined the roles and responsibilities of the Committee, membership and attendance along with activity during the period.

Committee Members observed the report would benefit from inclusion of key areas of focus, impact and added value, and change it to a more reflective document that identified where challenge had been applied and what changes had resulted.

HB noted the benefit of extending the annual report in this way and wished to reflect on the capacity of the team to produce such a document across all Health Board Committees.

The Committee :

- **CONSIDERED** the Patient Experience, Quality and Safety Committee Annual Report for 2025/26 summarising the key areas of business activity undertaken;
- **RECOMMENDED** the report to the Board for the 20 May 2026 meeting.

4. ESCALATED ITEMS

4.1 CHILDREN'S NEURODIVERSITY SERVICES (PEQS/26/07)

CMo joined 10.00

CMo presented the report and drew attention to the following matters:

- The Executive Oversight Group had reviewed updated Integrated Quality and Performance (IQP) and Conditions for Sustainability assessments.
- For safe and effective care, an amber/green maturity rating was accepted; the service were asked to provide actions and timescales to achieve full green status.
- For patient and family experience, green (results) and amber (maturity) were accepted; with further actions and timelines requested to secure full maturity.
- For leadership and management, insufficient evidence was provided; further detail was requested before a maturity rating could be agreed.
- The updated Conditions for Sustainability assessment recognised significant work but required additional information before formal acceptance.
- Latest performance shows 807 patients waiting for first appointment (as at 24 April 2026), an improvement, with no waits over 104 weeks.
- Referrals are increasing (73 in February rising to 105 in March), with acceptance rates above planned levels, impacting recovery trajectory (now extending to 28–29 weeks).
- Open pathway numbers are rising (528 patients), with issues identified in the under-5 pathway and proposals to move some cases to community paediatrics "watch and wait".
- Service reviewing capacity and workforce requirements, including increased MDT panels and potential clinical psychology input; overall demand continues to rise (c.1,336 in April, with ~40% open caseload).

Independent Members asked the following questions for assurance:
What assurance could be provided regarding rising referral rates and the extended recovery timeline?

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Referral rates were recently higher than expected and were under review to determine whether this was a sustained trend or temporary variation. Analysis was underway, with partnership discussions ongoing to support demand management.

What was the position regarding the diagnostic psychology role and mitigation?
Diagnosis currently relied on paediatricians due to limited psychology input. Work was progressing to explore alternative roles and a business case to improve capacity and efficiency.

What did 'substantive workforce structure alignment' mean and how was partnership working progressing?
Changes within the local authority were supporting new partnership arrangements via the Regional Partnership Board (RPB), strengthening collaboration with education partners to improve early support, referral pathways and ongoing care, with expected benefits for demand management.

Does the maturity matrix accurately reflect the position of the service, particularly given ongoing staffing gaps, pathway pressures, and increasing demand, and can assurance be provided on the rigour of the assessment and sustainability of improvement?
The service is close to meeting the Integrated Quality (IQ) Path criteria for maturity against the original escalation triggers, reflecting strong progress. However, it is not yet meeting the criteria for sustainability. Current assessments highlight concerns regarding the service's ability to sustain improvements, particularly given workforce gaps and demand pressures. Further work is underway to strengthen the sustainability assessment and provide assurance that improvements can be maintained over time.

Are increasing referral numbers and demand pressures unique to the service?
The rise in referrals and associated demand is being observed at a national level. Further mapping and analysis of these trends is ongoing to support future planning and understanding of demand.

How confident is the team that the actions identified to address capacity issues will enable the service to achieve a 'green' position?
Assurance cannot yet be provided. Further work is required through the IQ Path and sustainability assessment to test whether the identified and additional actions will sufficiently address capacity and sustainability concerns. An updated assessment will be brought to the next meeting for committee scrutiny and assurance.

Would presenting Statistical Process Control (SPC) type data support better understanding of variation in demand, such as increases in referrals?
Yes. Incorporating SPC-style data is being explored, with work underway between performance and information teams to develop this and present it through escalation oversight and future committee reporting to aid interpretation of variation.

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03/08/2026 09:04:13

PH advised that progress had been recognised, but assurance on sustainability depends on strengthening workforce capacity and developing a robust sustainability plan to be brought back for committee scrutiny.

HT noted that the report provides assurance against the original escalation triggers through a moderated self-assessment approach; however, further reflection is required on the purpose, scope and positioning of the maturity matrix within the wider assurance framework, particularly to avoid conflating escalation criteria with broader service sustainability in the context of inherently fragile services.

The Committee:

1. Took **ASSURANCE** that the implementation of the IQPF Escalation Oversight mechanism is providing robust oversight of the quality improvement and risk mitigation work being undertaken within Neurodevelopmental Services.
2. Took **ASSURANCE** from the ongoing monitoring and evaluation mechanisms in place as part of IQPF.

CMo left 10.40

4.2 PEOPLE'S EXPERIENCE FRAMEWORK UPDATE (PEQS/26/08)

PH introduced the report which provided an update on the implementation of the Peoples Experience Framework (PEF) including work completed to date, ongoing activity and the associated action plan aiming for delivery by September. The report also addressed the previously escalated Civica issue outlining the assurance provided and seeking agreement to de-escalate this issue.

Independent Members asked the following questions for assurance:
Can the framework, strategy and action plan be clarified?
AS advised that two frameworks operate: the statutory Listening to People framework (complaints) and a non-statutory patient experience framework (feedback and learning), with this paper relating to the latter. The strategy sets out local delivery, and the action plan details implementation.

Is Civica being used effectively, and how is data being strengthened (including by triangulation)?
AS advised system capacity and access are increasing, though limitations remain (e.g. cross-border and anonymised data). Triangulation with external intelligence (including Llais) will be developed through integrated quality reporting, this is currently at an early stage.

Does the self-assessment provide a whole-system view, including primary care, commissioned services and partners?
The current position largely reflects internal services. Primary care data is reported separately but is being aligned; commissioned services and partner contributions are not yet fully reflected and require further development and confirmation.

How will assurance and a comprehensive patient experience view be strengthened across commissioned services?
Assurance will be progressed through commissioning arrangements, including use of self-assessments from other providers and further work with English partners. Integration of additional data sources is planned to provide a more complete system-wide view.

What was the original reason for escalating the Civica issue and has it been addressed?

Paterson, Lisa (23/08/2026 08:04:55

The escalation related primarily to a lack of capacity to implement Civica. This has been addressed through investment in staffing, and the original issue is now considered actioned.

The Committee observed that whilst progress had been made on capacity and structures, assurance on system effectiveness and impact remains a developing matter, with ongoing concerns about functionality and maturity. Civica would remain within routine committee business, with regular updates on effectiveness and impact requested, and the ability to re-escalate through established governance mechanisms if concerns arose.

The Committee:

- **RECEIVED** the report and took **ASSURANCE** that People's Experience is appropriately monitored and reported and that continued actions are in place to further develop People's Experience implementation, monitoring, and reporting.
- **APPROVED** the recommendation to de-escalate CIVICA from Board within Patient Experience, Quality and Safety Committee.

5.ITEMS FOR ASSURANCE

5.1 INTEGRATED QUALITY REPORT (PEQS/26/09)

PH advised that the Integrated Quality Report had been refreshed following Audit Wales recommendations, with a stronger focus on data triangulation, thematic analysis, and action planning. This first iteration provided assurance and highlighted key issues, while inviting ongoing feedback, with further work planned to strengthen analysis and develop actions in future reports. AS provided an overview of the report.

Independent Members welcomed the refreshed report observing a more thoughtful analysis with an aim to further improve the report. A move to dashboard reporting would further strengthen the current narrative focussed style, along with a greater focus on commissioned services.

Independent Members asked the following questions for assurance:
Why are a significant proportion of incidents not fully harm graded, and when will this be resolved?
AS advised, this related to the Datix system and internal processes. Harm grading is completed at initial entry but was not always updated at the conclusion of investigations. Improvements are underway, with incremental progress expected monthly and more noticeable improvement anticipated by the next quarterly report. This has been prioritised for resolution.

How will dashboard reporting be developed and what will it include?
AS advised that further work was required to determine the key metrics and focus areas. National guidance had recently been published to support metric development, which will inform local implementation.

Independent Members requested that the purpose and role of patient stories as a mechanism for capturing lived experience at Board and this Committee be discussed at Board Development.
Action: Executive Director of Nursing, Quality, Women and Family Health

Page 7 of 12 09/10/2026 09:04:55

The Committee:

- **NOTED** the introduction of a revised Integrated Quality Report structure and provide feedback to support further refinement and development over the coming period.
- **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 NATIONAL ASSURANCE ASSESSMENT OF MATERNITY AND NEONATAL SERVICES IN WALES (PEQS/26/10)

PH introduced the report and AS drew attention to the following areas:

- The assessment confirmed that Powys Maternity Services are operating without immediate safety concerns.
- A structured Improvement Programme is in place, focusing on key domains including safety, escalation (including commissioning), and clinical governance.
- Further strengthening of escalation processes is required, particularly with cross-border partners in England.
- Ongoing development of clinical governance dashboards and alignment with national work, avoiding duplication through shared approaches across Wales is taking place.
- Progress is underway to improve workforce capability, including safe integration of newly qualified midwives.
- There have been significant achievements in data and digital systems (notably BadgerNet implementation) which is supported by multi-team collaboration.
- There has been a focus on strengthening care pathway assurance, particularly managing risks at service interfaces between organisations.
- There is a recognition of the complexity of the Powys midwifery model, with cross-boundary pathways presenting inherent risks.
- Work is in progress to improve consistency, coordination, and cultural capability within maternity services.

Independent Members asked the following questions for assurance:
What issues led to the strengthening of escalation arrangements, and how are escalation processes being improved?
Observations identified that the maternity manager on-call arrangements were not as robust as they could be, primarily due to variability in practice and the absence of a clear, standardised step-by-step process. The escalation policy required further development, and the rota included more junior roles than is typical in comparable services. Processes have been standardised through the introduction of clear operating procedures, revision of escalation tiers to include more senior oversight, and strengthened communication and contingency planning. In addition, improvements to data capture and incident reporting are being implemented to enhance oversight, learning, and staff confidence. These actions were undertaken as proactive improvements rather than in response to identified harm.

Paterson, Liz 05/08/2026 09:04:55

How are cross-border governance arrangements working, and what improvements are being made?

Cross-border relationships were described as positive, with established networks and strong engagement from partner organisations. However, opportunities for improvement were identified in the consistency and standardisation of information shared. Work is underway to strengthen governance arrangements by agreeing more consistent reporting requirements, enabling better comparability of data, improving the identification of safety indicators and early warning signals, and supporting more effective oversight across partner organisations.

What assurance is available regarding the experience, safety and quality of care for Powys women receiving services outside the Health Board, and when will a complete picture be available?
AS acknowledged a gap in assurance, however, cross-border arrangements (particularly with England) provide some quality information. National work in Wales is ongoing to strengthen data and assurance systems, with local mechanisms in place for intelligence sharing and contract levers available. Further development of standardised cross-border processes is underway, with a fully mature assurance position anticipated in approximately 12 months.

PH added that maternity services provide strong commissioning practices that can be applied more widely, with work underway to strengthen integrated commissioning, improve engagement, and secure better data to support assurance on care quality and safety.

What assurance can be provided on support for inexperienced midwives to build competence and confidence despite limited opportunities for experience?
AS advised that robust preceptorship, supervision and workforce planning arrangements were in place, including pairing with experienced staff. It was acknowledged that there is constrained exposure to some skills but a cautious approach to workforce mix, meant that services remained safe and effective while competencies were developed.

The Committee:

- **RECEIVED** the All-Wales Maternity and Neonatal Assurance Assessment (February 2026) and the Health Board's response, confirming maternity services are safe and effective, with a structured improvement plan in place.
- Took **ASSURANCE** that a relevant Action Plan (Appendix 1) in place, including priority areas for improvement, progress to date, delivery timelines, and alignment with national expectations.

5.3 BOARD OUT AND ABOUT PROGRAMME (PEQS/26/11)

This item was deferred due to time pressures.

5.4 ANNUAL CLINICAL AUDIT PROGRAMME 2026/27 (PEQS/26/12)

KW presented the report noting that the clinical audit plan continued to be strengthened, focusing on areas of concern, incident learning, key actions, and evaluation of new services. Service groups provided annual plans, which remained lengthy despite efforts to streamline them. Some elements were identified as potentially more suitable for future dashboards, although they currently required inclusion within the plan, which remained under ongoing review.

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Independent Members asked the following questions for assurance:

Does the organisation have sufficient capacity to complete the programme, particularly given there are a number of nationally driven reviews?
KW advised that the national audit plans tend to be relatively stable year-on-year. These are reviewed annually, with initial scrutiny undertaken by the Quality Improvement Manager, noting that not all audits are applicable to Powys and many are filtered out as not relevant.

Is the organisation consistent and effective at stopping repeat audits where the risk is low and learning has been demonstrated?
KW confirmed that this challenge had been raised with service groups. While many audits remained in place, the position was that continued scrutiny was necessary to ensure resources were being used appropriately and to test whether repeat audits were still justified.

How are audit outcomes fed into the Board and sub-committee structure, and how is learning shared across audits?
HB advised that clinical audit reports were rarely presented in full to committees; instead, learning was embedded operationally within service and improvement plans. Assurance was provided through forward plans and consolidated summary reports outlining key themes and learning, rather than individual audit reports.

Is there sufficient assurance that clinical audit coverage is appropriate across service areas, and that there is capacity to support and develop effective audit activity?
KW advised assurance was provided through Director-led ownership of audit plans, with organisational oversight to identify gaps. While no dedicated central resource existed, capacity and support were available through senior clinical leadership and the Quality Improvement function.

CM added Clinical Directors collectively reviewed and contributed to audit plans, using intelligence from complaints and incidents to shape activity. Each Director took ownership of approval within their service area, with coordination provided centrally, reflecting a shared, team-based approach.

The Committee **APPROVED** the 2026-27 Clinical Audit Programme.

5.5 MONITORING REPORT OF MENTAL HEALTH SERVICE POST ESCALATION (PEQS/26/13)

This item was deferred due to time pressures.

5.6 QUALITY STATEMENT INFECTION PREVENTION AND CONTROL (IPC) (PEQS/26/14)

GT joined 12.02

PH introduced the report and GT drew attention to the following areas:

- Mapping against the 52 IPC quality attributes confirmed a strong organisational baseline, with clear strengths, risks and improvement actions identified.
- Assurance was provided through recent audits (2024–2025) and a two-year improvement plan aligned to Welsh Government standards.
- Key strengths included robust governance, effective surveillance (38% reduction in C. diff), established operational groups, a comprehensive audit programme, and high training compliance.

Patterson, Lisa
03/08/2026 09:09:55

- Reporting arrangements have been strengthened to improve board-to-ward assurance.
- Ongoing work includes national collaboration, including embedding patient experience in IPC.
- Overall, the Health Board is well aligned with the Welsh Government IPC quality statement, supported by a structured improvement programme.

Independent Members asked the following questions for assurance:
How is the organisation engaging with primary care to ensure confidence in IPC, particularly regarding equipment and arrangements?
GT advised work was ongoing with primary care as part of an improvement project, including engagement with GP virtual ward rounds to embed IPC. A primary care lead was in place, links with GP practices were strengthening, practices were increasingly seeking advice on decontamination and IPC, and work with the commissioning team was underway to strengthen processes.

What arrangements are in place to ensure resilience and succession planning within the IPC function?
GT confirmed a strong and robust team was in place, including an antimicrobial stewardship pharmacist as part of the improvement plan. The team was well connected across the Health Board, supporting resilience and sustainability.

The Committee:

1. **NOTED** the Welsh Government IPC Quality Statement, its expectations for NHS organisations and the key findings of the Health Boards initial analysis
2. **NOTED** the strengthened governance and reporting structure, whereby operational groups provide assurance reporting into the IPC Quality domains of Safe, Effective, Timely, Workforce, Quality and Experience.
3. Took **ASSURANCE** of the Health Boards compliance with the required standards **NOTING** the planned next steps including further data analysis.

GT left 12.12
MB joined 12.12

5.7 PUBLIC HEALTH WALES TEST AND POST SEXUAL HEALTH SERVICE INCIDENT (PEQS/26/15)

MB advised that the Public Health Wales had identified issues within the Test and Post Sexual Health Service which were being dealt with by the organisation as an enhanced incident. A report is included in the Patient Experience, Quality and Safety In-Committee meeting.

5.6 COMMITTEE RISK REGISTER (PEQS/26/16)

HB presented the report noting a review of strategic risks was underway following approval of the Board supported Annual Plan and therefore future iterations of the register may change.

Independent Members asked the following questions for assurance:
Should escalated issues held at Directorate level be included on the corporate risk register?
HB was confirmed that escalated issues would sit on the organisational (corporate) risk register. Further work is underway, informed by Audit Wales feedback, to clarify whether risks reported to committees should be strategic, operational, or both, as part of the updated Risk Management Framework.

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The Committee

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

6. ITEMS FOR DISCUSSION

There were no items for discussion

7. CONSENT AGENDA (PEQS/26/17)

The below reports were taken under the Consent Agenda and recommendations supported:

- **FOR INFORMATION:** Internal Audit Reports on:
  - Clinical Supervision (Reasonable Assurance)
  - Deprivation of Liberty Standards follow-up audit (all actions implemented)
- **FOR ASSURANCE:** Joint Commissioning Committee highlight report from the Quality, Safety and Outcomes Sub-Committee 15 December 2025

8. OTHER MATTERS

8.1 ANY OTHER URGENT BUSINESS (PEQS/26/18)

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/26/19)

It was noted that the Chair would provide updates on those items escalated to Board, together with the actions taken to address the backlog in incident closure.

In particular, Board would be advised that the Civica matter would now be de-escalated from Board and monitored as business as usual.

8.3 COMMITTEE REFLECTION (PEQS/26/20)

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

- RBW noted it had been a full agenda and challenging to balance sufficient time for discussion
- SW commended the Chair for handling the demanding agenda and recognising the flexibility of deferring items where necessary
- JOA praised the quality of papers and reflected that whilst assurance had been provided there had been lesser time to scrutinise any underlying implications. (HB confirmed a scrutiny and assurance training session was scheduled for Board Development in May)
- MG highlighted effective chairing, flexibility and an improved balance between succinct officer presentations enabling more time for discussion, which had worked better than in previous meetings.

8.4 DATE OF NEXT MEETING (PEQS/26/21)

The date of the next meeting is scheduled on 04 August 2026 via Microsoft Teams.

Meeting closed 12.20.

8.5. CONFIDENTIAL MATTERS

The following motion was passed:

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

03/08/2026 04:55

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 (04 August 2026)

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								
30-Apr-25	PEQS/25/12	Executive Medical Director	Clinical Audit Programme	The Annual Clinical Audit Report to include detail on assurance routes for reporting	**Update 31.07.2025** Clinical Audit is rapidly evolving and this action will be addressed in more detail in the July 2026 Plan **Update 04.08.2026:** The clinical audit programme was approved by this Committee in April 2026. Information was not included in relation to assurance routes. A mid-year report is proposed which will include an overview of reporting arrangements. **Date change requested.**	Jul-25	Oct-26	At risk
26/02/2026	F&P/25/118b	DPP&C / Executive Director of Nursing, Quality, Women and Family Health	IQPR	To clarify the data inclusion issue related to national reportable incidents and provide increased harm-review information for commissioned services to the Patient Experience, Quality and Safety Committee (PEQS).	**Update 30.04.2026:** Item will be included in the July 2026 PEQS meeting **Update 04.08.2026:** Item not included in August 2026 agenda due to agenda prioritisation. Commissioned services framework also in development in relation to patient experience. Date change requested to Nov 2026 to allow evolving framework to be developed and adequate time on agenda for Committee. **Date change requested.**	Aug-26	Oct-26	At risk
OPEN ACTIONS - IN PROGRESS BUT NOT YET DUE OR ARE ONGOING - (04 August 2026)								
05-Feb-26	PEQS/25/85	Director of Corporate Governance / Executive Director Primary, Community Care and Mental Health	Action Log	Update requested on quality assuring/dip sampling Power of Discharge Group decisions	**Update 30.04.2026:** Collaborative work is underway to review the governance of the Hospital Manager work, including decisions made at the Power of Discharge Committee. Further recruitment is also planned. It is expected that a review and paper will be presented in Q3. **Update 04.08.26** - actions are on track to report back to the Committee in October and the Board in November 2026.	Apr-26	Oct-26	On track
25-Oct-25	PEQS/25/66	Director of Corporate Governance	Patient Experience - Dental Quality	The Chair's Forum to reflect on the most appropriate reporting approach for dental service monitoring	**Update 05.02.2026:** Action will be considered by the Chair's Forum when committee work programmes are reviewed in April/May 2026. It is not inetended to report back to PEQS separately on this action but will be clarified through the committee work programme. This action was re-opened for reporting arrangements for dental services to be clarified. **Update 04.08.2026:** The Chair's Forum next meets in September and will be discussed within that forum. In the meantime, the F&P Committee work programme includes dental performance.	Feb-26	Aug-26	On track
30-Apr-26	PEQS/26/09	Executive Director of Nursing, Quality, Women and Family Health and Director of Corporate Governance	Integrated Quality Report	A request for purpose and role of patient stories as a mechanism for capturing lived experience be discussed at Board Development	**Update 04.08.2026:** Items added to the September 2026 Board Development session, an update will be provided to the October PEQS Committee.	Oct-26		On track
ACTIONS RECOMMENDED FOR CLOSURE (MEETING 04 August 2026)								
05-Feb-26	PEQS/25/88	Executive Director of Nursing, Quality, Women and Family Health	Integrated Performance Report	A trajectory of improvement relating to incident closure be provided	**Update 30.04.2026:** Revised Intergrated Quaity Report provided for April meeting, improvement trajectory to now be developed and reported to next meeting. Date changed requested to July 2026. **Update 04.08.2026:** Update inbcluded in the Integrated Quality Report and summarised here - *The Health Board has established an improvement trajectory to address the remaining backlog of open incidents whilst maintaining timely management of newly reported events. During Quarter 1, 175 (over 55%) of open historic incidents from 2024 and 2025 were closed, demonstrating progress in reducing the backlog. During Quarter 2, the focus will be on eliminating all remaining 2024 incidents, reducing the number of open 2025 incidents by at least 50%, and preventing backlog growth through strengthened service-level accountability, routine monitoring and enhanced quality assurance arrangements. Progress against this trajectory will be reported through the Health Board's governance structure and future Integrated Quality Reports.*	Apr-26	Aug-26	Completed

Patterson,Liz
03/08/2026 09:04:55

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 4.3

PATIENT EXPERIENCE QUALITY AND SAFETY	**04 AUGUST 2026**
Subject:	**Duty of Quality Annual Report 2025-2026**
Approved and presented by:	Paul Hooton, Executive Director of Nursing, Quality, Women and Family Health
Prepared by:	Director of Midwifery, Women & Family Health, Quality & Safety
Other Committees and meetings considered at:	Executive Committee - 22 July 2026 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:

- **RECOMMEND** to the Board the APPROVAL of the Duty of Quality Annual Report which evidences progress and areas for improvement for 2025-2026.
- Take **ASSURANCE** from the evidence presented regarding delivery of the Duty of Quality during 2025/26 and the arrangements in place to support continued improvement during 2026/27.

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	

Paterson,Liz 03/08/2026 09:04:55

EXECUTIVE SUMMARY:

The Duty of Quality, established through the Health and Social Care (Quality and Engagement) (Wales) Act 2020, requires NHS organisations to continuously improve the quality of services and outcomes for people, ensuring that quality is considered in all aspects of service planning, delivery, monitoring and improvement.

This report provides an overview of how Powys Teaching Health Board has delivered the Duty of Quality during 2025/26. It describes the governance arrangements, quality intelligence, organisational learning, patient and public engagement activities, quality improvement programmes and assurance processes that support the Health Board's commitment to delivering safe, timely, effective, efficient, equitable and person-centred care.

The report demonstrates progress made during the year across a number of areas including quality governance, learning from experience, patient experience, bereavement care, Duty of Candour, safeguarding, service improvement and the development of quality intelligence and assurance arrangements. It also summarises how the Health Board has responded to local and national learning, undertaken service improvement activities and continued to strengthen its approach to quality management.

Recognising that quality improvement is an ongoing journey, the report also identifies future priorities for 2026/27, including continued development of a comprehensive Quality Management System, implementation of the NHS Wales Listening to People Framework, strengthening organisational learning arrangements, enhancing assurance of commissioned services and supporting continued engagement and co-production through programmes such as Better Together.

The report demonstrates the Health Board's ongoing commitment to ensuring that quality remains central to decision-making, service delivery and improvement activity for the people of Powys.

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 third report provides an overview of the Health Board’s development and progression within the quality sphere and alignment of a quality management system during 2025/26.

NEXT STEPS:

APPROVE of the Duty of Quality Annual Report.

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IMPACT ASSESSMENT
Not required.

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03/08/2026 09:04:55

Annual Duty of Quality Report 2025-2026

GIG CYMRU NHS WALES

Bwrdd Iechyd Addysgu Powys

Powys Teaching Health Board

Patterson,Liz
03/08/2026 09:04:55

Contents

1.0 Foreword 3
2.0 Introduction 4
3.0 Quality Governance 5
3.1 Health and Care Standards 7
4.0 Using Quality Intelligence to Understand Quality, Safety and Experience 8
4.1 Learning from Experience and Taking Action 9
4.2 Engagement and Consultation 10
5.0 Bereavement Care and Medical Examiner Service 14
6.0 Duty of Candour 17
7.0 Putting Things Right (PTR) – Concerns Management 18
8.0 Nationally Reportable Incidents (NRIs) 19
9.0 Peoples experience 20
10.0 Service Spotlights – Delivering Quality in Practice 23
10.1 Dementia Services 23
10.2 Mental Health Services 26
10.3 Maternity and Women's Health Services 27
10.4 Children's Neurodevelopmental Services 30
11.0 Safeguarding 31
12.0 Recommendations from External Reviews and Inspection 32
13.0 Assuring Quality in Commissioned Services 34
14.0 Future Developments 40
15.0 Looking Forward Quality Priorities 2026/2027 42
16.0 Conclusion 43

Paterson Liz 03/08/2026 08:04:55

1.0 Foreword

I am pleased to introduce Powys Teaching Health Board's Annual Duty of Quality Report for 2025/26.

For me, the Duty of Quality is more than a statutory requirement. It is a reminder of our responsibility to ensure that quality is visible in the decisions we make, the services we provide and the way we listen, learn and improve.

During 2025–2026, there has been much to recognise and build upon. Across the Health Board, teams have worked with commitment and professionalism to strengthen quality arrangements, respond to feedback and continue improving the care and experience of people across Powys.

This year has also reinforced the importance of listening carefully to what people tell us, whether through patient experience, concerns, compliments, incidents, reviews or lived experience. These insights help us understand what matters most and where we need to focus our improvement efforts.

We recognise that delivering high-quality care across a large rural county is not without challenge. However, I am encouraged by the continued dedication of staff and partners, and by the openness shown in identifying learning and making improvements.

I would like to thank our staff, volunteers, partners, patient representatives and communities for their continued contribution. Their compassion, professionalism and willingness to work together are central to delivering safe, effective and person-centred care for the people of Powys.

As we look ahead, this report provides an opportunity to reflect on our progress, acknowledge where more needs to be done and continue our journey towards becoming a more learning-focused, quality-driven organisation.

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Paul Hooton, Executive Director of Nursing, Quality, Women and Family Health

2.0 Introduction

The statutory Duty of Quality applies across the Health Board's functions, including directly provided services, commissioned services and the decisions that shape the planning, design and delivery of care.

Quality is defined through the six domains of healthcare quality: care that is safe, timely, effective, efficient, equitable and person-centred. These domains are supported by the Health and Care Quality Standards for Wales, which provide a common framework for understanding, measuring and improving quality across the healthcare system.

This Annual Duty of Quality Report provides assurance to the Patient Experience, Quality and Safety Committee, the Board and the public on the arrangements in place to monitor, maintain and improve quality.

The report brings together evidence from across the organisation, including:

- Quality governance and assurance arrangements
- Patient and public engagement activity
- People's experience and feedback
- Learning from incidents, concerns, complaints and claims
- Duty of Candour implementation
- Nationally Reportable Incidents and organisational learning
- Bereavement care and the Medical Examiner Service
- Safeguarding activity
- External reviews, inspections and commissioned services
- Quality improvement initiatives and future priorities

During 2025–2026, the Health Board continued to develop its Integrated Quality and Performance Framework so that quality is considered alongside safety, patient experience, workforce, performance, finance and value. During the year, the Health Board also experienced changes in executive and professional leadership across Nursing, Quality, Midwifery, Women and Family Health. These changes have provided an opportunity to build on existing strengths, maintain organisational focus on quality and support the next phase of development and improvement.

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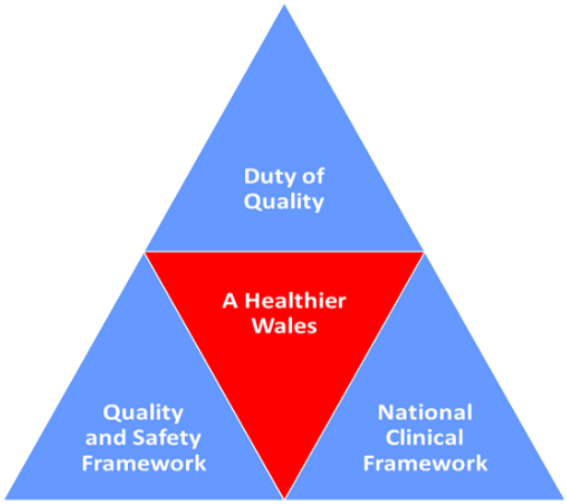
The report brings together evidence of achievements, areas for improvement and the arrangements that support transparency, accountability and continuous improvement across Powys.

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 Board's commitment to continuous improvement and organisational learning is underpinned by these guiding frameworks. During 2025/26, the Health Board continued to embed the requirements of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 through its established 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.

Patterson,Liz
03/08/2026 09:04:55

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 & escalation pathways involving bodies such as Healthcare Inspectorate Wales and Welsh Risk Pool.

Maintaining Focus on Quality in 2025/2026

During 2025/26, the Health Board continued to strengthen the foundations that support the delivery of the Duty of Quality and its ambition to become a more integrated, learning-focused organisation. Whilst further development of a comprehensive Quality Management System remains a key priority for 2026/27, significant progress has been made in strengthening governance arrangements, improving oversight and enhancing the use of quality intelligence to support decision-making.

Focus on quality has been maintained through a number of targeted activities including:

- Continued development of the Integrated Quality and Performance Framework (IQPF), supporting greater integration of quality, safety, patient experience, workforce, performance and financial information.
- Ongoing implementation and refinement of local escalation and assurance arrangements to support the identification, management and oversight of quality and performance risks.
- Continued oversight of the Medical Examiner Service and the learning arising from mortality reviews.
- Progress in embedding the NHS Wales People's Experience Framework, supporting a more structured approach to understanding and responding to people's experiences of care.
- Preparation for implementation of the Listening to People Framework and the transition from Putting Things Right arrangements from April 2026.
- Continued engagement with national reviews, audits, inspections and quality improvement programmes to identify opportunities for learning and improvement across both directly provided and commissioned services.

The Health Board's governance arrangements continue to provide oversight of quality, safety, patient experience and organisational learning. Through established committee structures, reporting mechanisms and assurance processes, the Health Board is able to monitor performance, identify emerging risks and support continuous improvement across both directly provided and commissioned services.

Item 3.1 on the 03/07/2026 09:04:55

3.1 Health and Care Standards

The Health and Care Quality Standards provide the framework for delivering the Duty of Quality across NHS Wales. They describe what good quality care should look like and support organisations to plan, deliver, measure and improve services in a consistent way.

The standards are underpinned by the six domains of quality: care that is **safe, timely, effective, efficient, equitable and person-centred**.

Together, these domains help ensure that quality is considered in every aspect of service design, delivery, monitoring and improvement.

For Powys Teaching Health Board, the standards provide a shared language for quality and support a consistent approach to assurance, learning and improvement across directly provided and commissioned services. During 2025/26 the principles of the Standards have continued to inform governance arrangements, quality reporting, service improvement activity, patient experience work, incident learning, audit programmes, commissioning oversight and decision-making processes across the Health Board.

Agenda Item 4.1 Liz 28/05/2026 09:47:56

While further development of the Health Board's Quality Management System remains a priority for 2026/27, the Standards have provided the foundation for strengthening quality governance arrangements and supporting the continued integration of quality, safety, patient experience, workforce, performance and improvement activities.

4.0 Using Quality Intelligence to Understand Quality, Safety and Experience

During 2025/26, Powys Teaching Health Board continued to strengthen how it brings together information about quality, safety, patient experience, performance, workforce, risk and outcomes. This approach supports the Health Board to understand where care is working well, where improvement is needed, and where emerging risks require further scrutiny or escalation.

The Health Board recognises that no single source of information can provide a complete picture of quality. Quality intelligence is therefore drawn from a range of sources, including incidents, concerns, Duty of Candour events, Nationally Reportable Incidents, patient feedback, compliments, patient stories, Medical Examiner themes, mortality reviews, safeguarding information, clinical audit, inspection findings, external reviews, risk registers, performance data and commissioned service assurance arrangements.

This intelligence is reviewed through established governance arrangements, including Integrated Quality and Performance reporting, directorate quality and performance discussions, Executive Committee, Patient Experience, Quality and Safety Committee, and relevant specialist groups. These arrangements support the Health Board to triangulate data, identify themes, monitor improvement actions and provide assurance to the Board on the quality and safety of services provided and commissioned for the people of Powys.

The Integrated Quality and Performance approach has continued to support a more rounded understanding of quality by bringing together quantitative measures and qualitative narrative. Extending and maturing the focus beyond regulatory compliance, this enables the Health Board to look beyond individual indicators and consider the wider context, including patient experience, workforce pressures, service sustainability, delivery against plans, inequalities, access, and outcomes.

During 2025/26, particular focus has been given to strengthening the use of intelligence in the following areas:

- Preparing for implementation of the NHS Wales Listening to People Framework
- Continuing implementation of the People's Experience Framework and supporting services to make greater use of patient feedback and experience data
- Continuing quality and performance review arrangements for commissioned services whilst developing a more comprehensive assurance framework
- Responding to learning identified through audits, inspections, external reviews and national recommendations
- Continuing to develop the links between risk management, escalation processes, improvement planning and committee assurance arrangements

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During 2025/26, the Health Board continued to build on existing quality governance and assurance arrangements, whilst recognising that further work is required to develop a more comprehensive Commissioned Services Assurance Framework and a separate Quality Management System in future years.

These developments include continued refinement of reporting arrangements, ongoing review of escalation processes, further development of quality metrics, increasing use of patient experience information and greater emphasis on bringing together learning from multiple sources to inform improvement activity.

4.1 Learning from Experience and Taking Action

Learning from experience remains a key element of the Health Board's approach to improving quality, safety and people's experience. Throughout 2025/26, learning continued to emerge from a range of activities including incidents, concerns, Duty of Candour events, Nationally Reportable Incidents, Medical Examiner reviews, patient feedback, patient stories, safeguarding activity, audits, inspections and external reviews.

The Health Board has continued to encourage services to move beyond identifying learning and focus on demonstrating how learning has informed changes to practice, policy, processes and service delivery. Whilst progress continues to be made, there remains further opportunity to strengthen how learning is consistently embedded and evidenced across all services.

Several recurring themes were identified during 2025/26, including:

- The importance of timely and effective communication with patients, families and carers
- Maintaining accurate, complete and contemporaneous clinical documentation
- Consistent application of policies, procedures and clinical pathways
- Effective assessment, escalation and risk management
- The importance of involving people in decisions about their care and experience
- Ensuring learning from incidents, concerns and reviews is shared across teams and services

Patterson
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Learning identified through reviews, audits and assurance activities has informed a range of local and organisational improvements during the year. Examples include updates to standard operating procedures, strengthening of induction and training arrangements, improvements to documentation standards, refinements to incident review processes and actions to enhance patient and family engagement following concerns or adverse events.

The Health Board recognises that becoming a truly learning organisation requires learning to be systematically captured, shared, implemented and evaluated. Building on the foundations established during 2025/26, further work will continue during 2026/27 to strengthen thematic learning, organisational oversight and the evaluation of improvement actions to ensure learning results in positive and sustainable change.

4.2 Engagement and Consultation

Meaningful engagement with people, communities, staff, partners and stakeholders remains fundamental to the Health Board's approach to quality and continuous improvement. Understanding what matters most to the people of Powys helps ensure that services are planned, delivered and improved with the needs, experiences and priorities of local communities at their centre.

During 2025/26, the Health Board continued to engage with residents, patients, carers, community groups, representative organisations and partner agencies through a range of formal and informal engagement activities. These arrangements support the Health Board's commitment to listening, learning and responding to the views of those who use, deliver and support health services across Powys.

The Health Board worked closely with Llais, Powys Association of Voluntary Organisations (PAVO), local communities and partner organisations to gather feedback, understand priorities and inform service planning and decision making. Engagement activity during the year included work associated with the Better Together programme, temporary service changes, service improvement initiatives and wider strategic planning activities.

Patterson,Liz
03/08/2026 09:04:55

What We Heard

Engagement activity undertaken during 2025/26 identified several recurring themes which were consistently raised by individuals, communities and stakeholders. These included:

- Access to health services and timely care
- The importance of maintaining local services wherever possible
- Clear communication and involvement in decisions affecting services
- Coordination of care across organisational and geographical boundaries
- Prevention, early intervention and community-based support
- The impact of travel and rurality on accessing healthcare services

Insights from Llais

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

Llais is an independent national body set up by Welsh Government in 2023 to give the people of Wales, a stronger voice in health and social care services.

Llais ensures patient views and experiences are used by decision-makers to plan and deliver better health and care services. Llais works with local NHS bodies, social care, and third-sector care providers to ensure patient voices are heard locally, regionally and nationally.

The Llais body for the Powys Region provides regular insights and reports, formally and informally to the health board, to assist with horizon scanning, early responses to concerns or issues and intelligence gathering to support decision making.

During the past 12 months, Powys Llais have engaged with the public through community groups, coffee mornings and targeted events in the local areas such as farmers markets and food banks. Events have taken place across the county including Newtown, Llanfyllin, Ystradgynlais, Crickhowell and Llanfair Caereinion.

Patient and resident engagement has been focused on targeted, high-impact engagement to respond to national priorities and emerging community issues. Llais have also visited NHS and social care services to talk to patients, residents and carers.

The following common themes have been gathered at local engagement events (The boxes on the right show the alignment to areas of delivery in the Plan).

- Children and young people — Focus on Wellbeing Strategic Priority 3
- Access to GP services
- NHS dental care
- The role of carers and carers support
- Awareness of available support services
- Feedback on the importance of local services and concerns about reductions in community based services — Early Help and Support Strategic Priority 4 & 5
- Mental health wellbeing and support — Tackling the Big Four Strategic Priority 8
- Hospital access, follow up and transport
- Hospital discharge and dignity
- Cross border care — Joined Up Care Strategic Priority 9
- Digital communications — Enabling Plans Digital First

This intelligence is a valuable contribution, alongside other engagement, to the health board's understanding of the views and lived experiences of patients, carers and communities.

16

These themes have provided valuable insight into the experiences, expectations and priorities of Powys residents and have informed ongoing planning and service development activity.

Engagement in Action

A significant focus during 2025/26 was continued engagement associated with the Better Together programme. Feedback gathered through surveys, focus groups, community events, discussions with partners and engagement with groups representing protected characteristics contributed to the ongoing development of proposals and service planning activity.

The Health Board also continued to seek feedback regarding temporary service changes introduced during late 2024 and

Pack Page 42 of 406
03/09/2026 09:04:55

maintained ongoing dialogue with communities and stakeholders to understand the impact of these arrangements.

Temporary Service Changes

In December 2024, following a series of events involving engagement with staff, and consultation with stakeholders and the public, the following temporary changes were implemented:

- Temporary changes to Minor Injury Unit Services in Brecon and Llandrindod Wells were made 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 six-month period has been extended and views sought on a continual basis ahead of launching a formal public consultation on the future of Urgent Care as part of the Better Together Programme in the Autumn 2026.

Strengthening Co-production and Community Insight

The Health Board remains an active participant within the Powys Engagement and Insight Network, working alongside public sector and third-sector partners to strengthen engagement, insight and co-production across Powys. During the year, work continued to develop and promote shared approaches to co-production and community involvement, supporting organisations to better understand and respond to the needs of local communities.

The network continues to produce Community Insight Reports which bring together engagement findings from partner organisations across Powys. These reports support shared understanding of community priorities and help inform decision making across partner agencies.

How Engagement Influenced Decision Making

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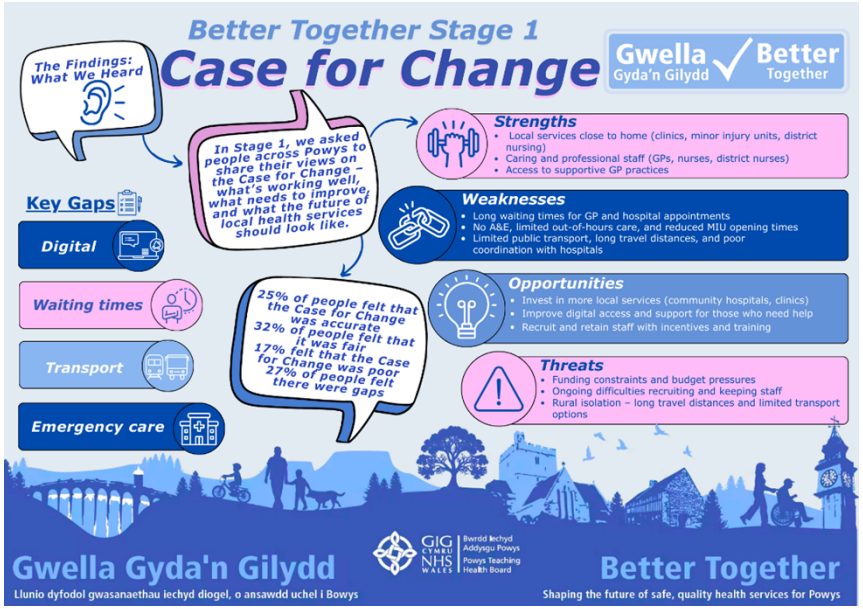
Information gathered through engagement and consultation activity was considered through established planning and governance arrangements and contributed to:

- Development of the Better Together programme
- Monitoring and evaluation of temporary service changes

- Ongoing service planning and redesign activity
- Future engagement and consultation programmes
- Continued development of co-production approaches across the Health Board

The Health Board remains committed to ensuring that feedback received from communities is not only heard but considered alongside other sources of intelligence to support decision making, service improvement and future development.



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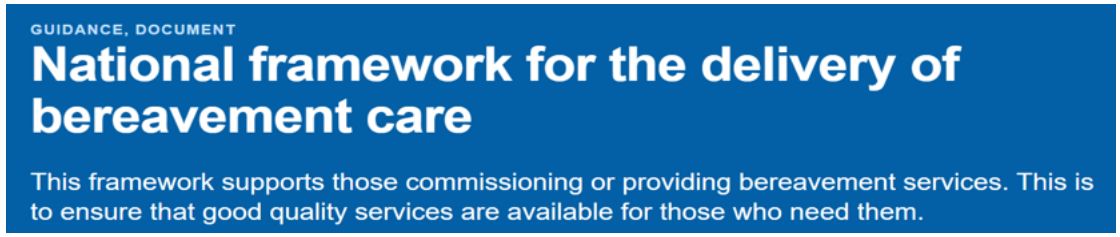
5.0 Bereavement Care and Medical Examiner Service

Bereavement care and mortality review arrangements provide important opportunities to understand the experiences of patients and families, learn from care provided and identify opportunities for improvement. Together, bereavement services and the Medical Examiner Service support the Health Board's commitment to openness, learning and person-centred care, ensuring that the voices of bereaved families contribute to ongoing quality improvement.

5.1 Bereavement Care



During 2025/26, Powys Teaching Health Board continued to develop bereavement services in line with the National Framework for the Delivery of Bereavement Care in Wales. The focus has been on establishing the foundations for a compassionate, consistent and person-centred approach to bereavement support across Powys.

The Bereavement Service has continued to develop collaborative working across health, third sector and community organisations to improve awareness of available support and strengthen bereavement pathways throughout Powys. Work has included the development of Bereavement packs, out-of-hours information leaflets and a signposting booklet for patients, families and staff, delivery of bereavement education and training, engagement with partner organisations, and the ongoing review of local Bereavement provision to ensure service remain responsive to the needs of our population.

Recognising the diverse needs of our communities, work is also underway to improve access to Bereavement support for individuals with protected characteristics. This includes engaging with community organisations and stakeholders to better understand potential barriers to accessing support and to identify opportunities to develop more inclusive, culturally appropriate and equitable Bereavement Services. This work will continue throughout the coming year and will inform future service development.

Whilst workforce and capacity challenges impacted the pace of delivery during the latter part of the year, important foundations have been established to support continued implementation of the National Framework. During 2026/27, the Health Board will focus on strengthening governance arrangements, rebuilding programme capacity and progressing priority actions to further improve the experience of bereaved individuals and families.

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Key Achievements

- Introduced bereavement information packs and out-of-hours support resources.

- Engaged with bereaved people, staff and community partners to inform service development.
- Developed initial bereavement care pathways, including within maternity services.
- Increased awareness of bereavement support across communities in Powys.
- Established foundations for implementation of the National Framework for the Delivery of Bereavement Care in Wales.

Key Message

- **Listening to bereaved people to shape compassionate, person-centred support.**
- **Strengthening bereavement pathways and information resources across Powys.**
- **Embedding the National Bereavement Framework to support a consistent and equitable service.**

5.2 Medical Examiner Service

The Medical Examiner Service provides independent scrutiny of deaths to support high standards of care, strengthen organisational learning, and ensure bereaved families have an opportunity to raise questions or concerns about the care provided.

During 2025/26, the service maintained stable delivery, with consistent referral volumes and effective mortality review processes in place. Strong partnership working continued with General Practitioners, Registration Services, the Coroner's Office and the National Medical Examiner Service, providing assurance that statutory and governance processes were operating effectively. Timeliness of records provided to the Medical Examiner Service improved during the year and was consistent with the Wales average.

Review of cases identified recurring themes relating to assessment, diagnosis and investigation, communication and clinical record keeping, and aspects of death verification and DNACPR documentation. These themes were shared through established governance arrangements and used to support learning and service improvement.

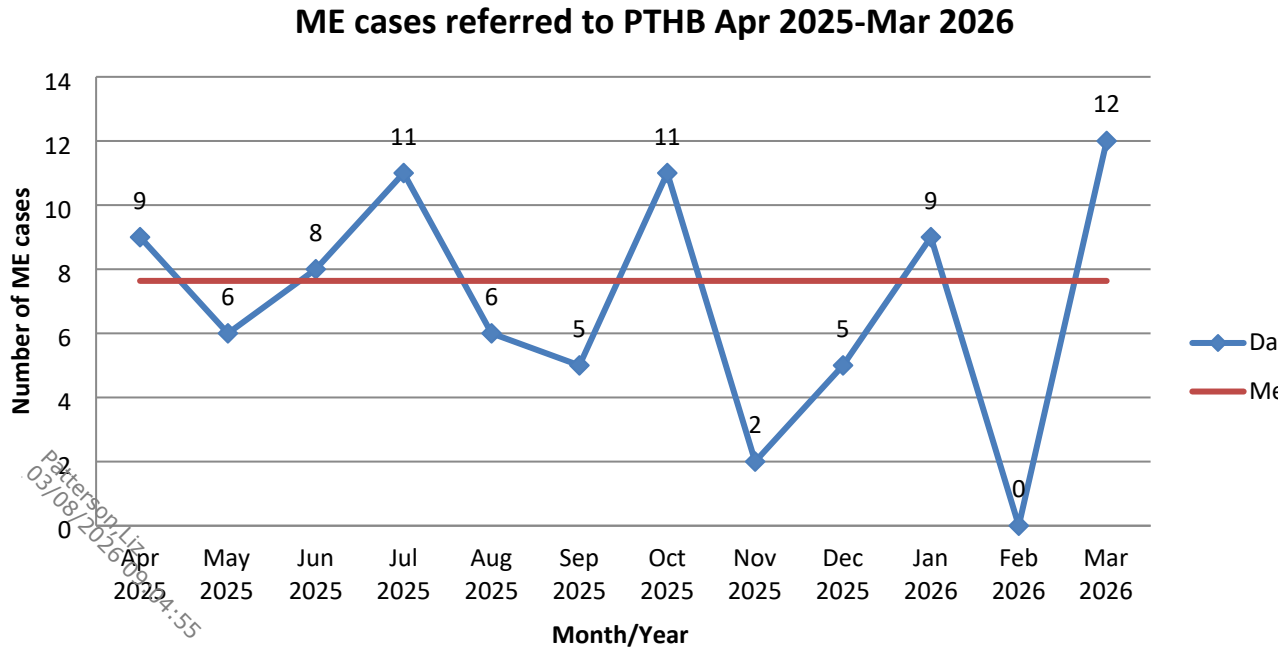
During the year, the service identified a higher-than-expected number of Medical Certificate of Cause of Death (MCCD) amendments. In response, targeted learning and support were provided to General Practitioners to strengthen the quality and accuracy of death certification.

The Health Board continues to review and refine Medical Examiner processes to maintain quality, consistency and compliance, while supporting continuous improvement across the organisation. The 2025/26 Internal Audit of Mortality Reviews undertaken by the

NHS Wales Shared Services Partnership concluded Reasonable Assurance, confirming that the Health Board has effective processes in place to support mortality reviews and engagement with the Medical Examiner Service. The audit identified areas for improvement relating to governance, documentation, recording processes and the management of Medical Examiner scrutiny summaries. An action plan is in place to strengthen oversight, improve the recording and tracking of learning, and ensure timely review and dissemination of learning across the organisation.

To promote shared learning across the organisation, the Bereavement Service produces a regular staff newsletter circulated throughout the Health Board. The newsletter provides updates on Medical Examiner activity and performance data, highlights themes and trends identified through the scrutiny process, shares examples of learning, and promotes best practice. Recent editions have identified opportunities to strengthen communication between GP practices and bereaved families, enforcing the importance of timely, compassionate and consistent communication following a patient's death. Learning identified through the Medical Examiner process is shared with relevant teams to support continuous quality improvement and improve the experience of patients and their families.

The Medical Examiner Service continues to play an important role in promoting openness, learning and continuous improvement, contributing to the Health Board's commitment to delivering safe, effective and person-centred care.



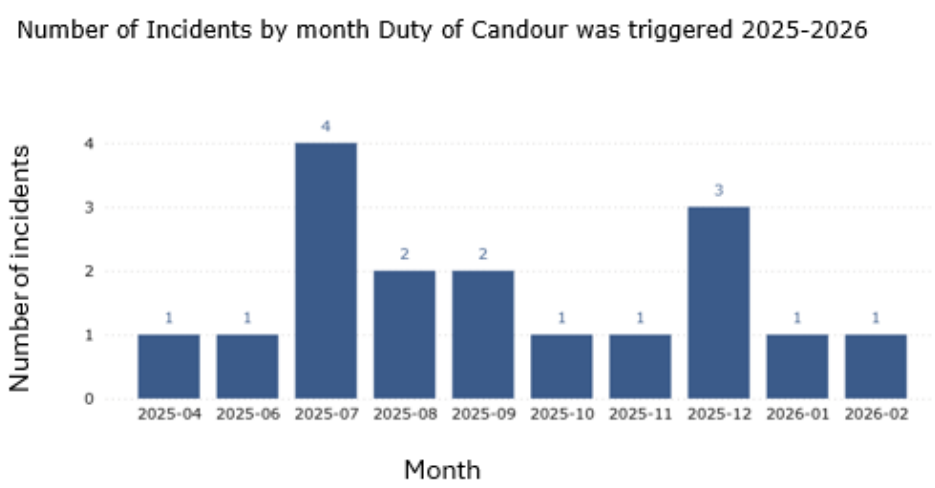
Key Message

- **Scrutiny:** independent review of deaths maintained
- **Learning:** themes identified and shared through governance
- **Improvement:** GP support provided
- on death certification
- **Assurance:** processes remain stable, compliant and improving

6.0 Duty of Candour

The Duty of Candour is a statutory requirement for NHS bodies in Wales under the Health and Social Care (Quality and Engagement) (Wales) Act 2020, in force from 1 April 2023. It requires NHS organisations to be open, honest and transparent with service users, families and carers when care has caused, or may have caused, moderate or severe harm or death.

Powys Teaching Health Board remains committed to embedding the Duty of Candour as part of its wider quality, safety and learning culture. Where the Duty applies, the Health Board will ensure that those affected are contacted promptly, receive a meaningful apology, are offered support, and are provided with clear information about what will happen next.
This approach supports the Health Board's ambition to be a listening and learning organisation, strengthening trust with patients, families and communities and ensuring that learning from incidents is used to improve care and reduce the risk of recurrence.



In 2025–26, Powys Teaching Health Board recorded 17 Duty of Candour incidents, with fewer open cases by year-end.

Themes included falls, pressure damage, vaccination errors and unexpected deaths, highlighting opportunities to strengthen risk assessment, equipment management and clinical processes.

Learning has informed improvements in documentation, standard operating procedures, induction and training. Further focus is needed on timely responses, consistent documentation and embedded learning.

During 2026/27, the Health Board will continue to strengthen thematic analysis, organisational learning and oversight of Duty of Candour cases, aligning learning with wider quality improvement and Listening to People arrangements.

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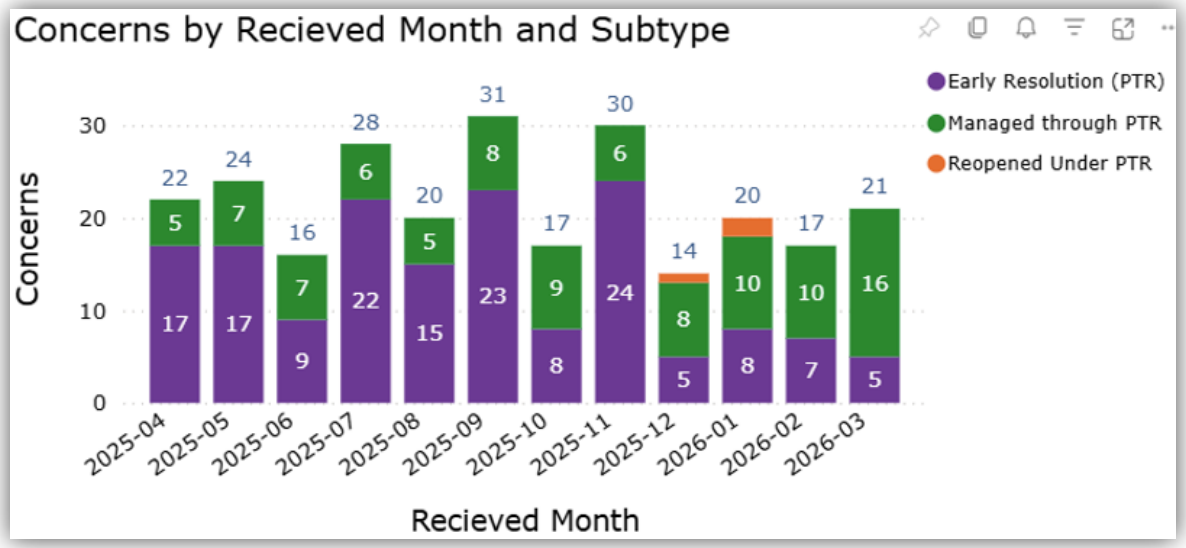
Key Message

- **Oversight focus will continue and strengthen during 2025–26**
- **Learning has improved safety, documentation and training**
- **Priorities remain timeliness, consistency and sustained improvement**

7.0 Putting Things Right (PTR) – Concerns Management

Putting Things Right was the NHS Wales process for managing concerns, complaints and incidents where someone may have experienced harm or poor experience. From 1 April 2026, it has been replaced by the Listening to People framework.

During 2025–26, learning from concerns informed improvements in communication, clinical processes and service responsiveness across a number of services. The Health Board maintained a strong focus on early resolution and timely responses, supporting improved experience for patients, families and carers. Feedback continued to provide valuable insight into quality, safety and patient experience, informing service improvement and learning. Progress was made in managing caseloads and supporting the timely resolution of concerns.



The transition to the **Listening to People framework** from April 2026 will support further improvement in response quality, timeliness and organisational learning.

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Key Message

- **162 enquiries and 101 formal concerns were received**
- **Key themes: clinical care and communication.**
- **Performance remained strong: 89.9% early resolution and 79.7% PTR responses within 30 working days**
- **Listening to People will replace PTR from April 2026 and strengthen feedback and learning**

8.0 Nationally Reportable Incidents (NRIs)

Serious incidents are reported to NHS Performance and Improvement, previously NHS Executive, where they meet the national reporting criteria for Nationally Reportable Incidents. This process provides external visibility of incidents with significant learning potential and supports consistent oversight, investigation and improvement across NHS Wales.

During 2025–26, Powys Teaching Health Board reported 10 Nationally Reportable Incidents (NRIs). Progress was made in reducing the number of open cases and in continuing to develop oversight and proportionate investigation arrangements. This has helped focus capacity and resources on incidents with the greatest learning potential, while supporting more timely review, clearer governance and improved organisational assurance.

Learning from investigations has supported improvements in incident management, governance and cross-service sharing. There has also been increased emphasis on ensuring actions are clearly evidenced within teams, so that learning can be tracked from identification through to implementation and assurance.

Review of incidents identified an emerging theme relating to patient and service user deaths. This highlights the importance of continued focus on mortality-related learning, the quality and timeliness of investigations, and the early identification of risks or themes that may require wider organisational action.

Priorities for 2026–27 are to implement the revised Incident Management Framework, improve investigation timeliness, strengthen learning dissemination and support timely case closure. This will help ensure that learning from serious incidents is translated into practical improvement, shared across relevant services and used to reduce the risk of recurrence.

Key Message

- **Oversight improved, with fewer open cases**
- **Proportionate investigations focused resources on key learning**
- **Cross-service learning and action evidence were strengthened**
- **Mortality-related learning remains a 2026–27 priority**

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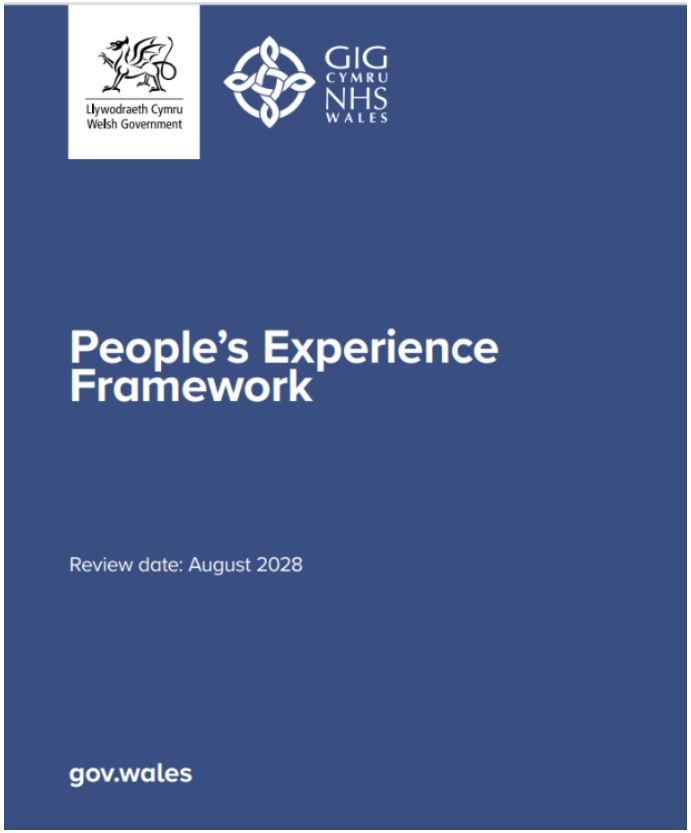
9.0 Peoples experience

The NHS Wales People's Experience Framework, released in April 2025, provides a consistent approach to understanding, measuring and improving how people experience NHS services, recognising that experience is shaped by every interaction with staff, services and organisational culture. It promotes using feedback, surveys, stories, compliments, complaints and lived experiences to drive quality improvement, ensuring that services are person-centred, responsive and aligned with the Duty of Quality and Value-Based Health Care principles.



In the first year of implementation, focus has been on how we capture people's experience and provide patients, carers and relatives the mechanism to share their thoughts through our survey system, Civica.

During 2025–26, Powys Teaching Health Board continued to strengthen how it listens to and learns from the experiences of patients, families and carers. Patient stories reflecting care received through Cardiac Rehabilitation services and at Newtown Hospital were shared to provide valuable insight into people's experiences and support quality improvement.

The Health Board reviewed and enhanced its patient feedback arrangements through the Civica platform, introducing improvements to support more effective reporting and use of feedback. New surveys were also developed and implemented to increase opportunities for people to share their experiences across a wider range of services.

Feedback activity remained strong throughout the year, with more than **45,000 responses** received through surveys and SMS feedback channels. In addition, over **890 compliments** were submitted, recognising the care, kindness and professionalism demonstrated by staff and teams across the organisation.

The themes most frequently reflected in feedback highlighted positive experiences of care, with words such as ***excellent***, ***supportive***, ***friendly***, ***reassuring***, ***welcoming***, ***kind***, and ***compassionate*** commonly used by patients and families. The People's Choice Award was also promoted across the Health Board, providing an opportunity for patients, relatives and carers to recognise and celebrate exceptional care and service.

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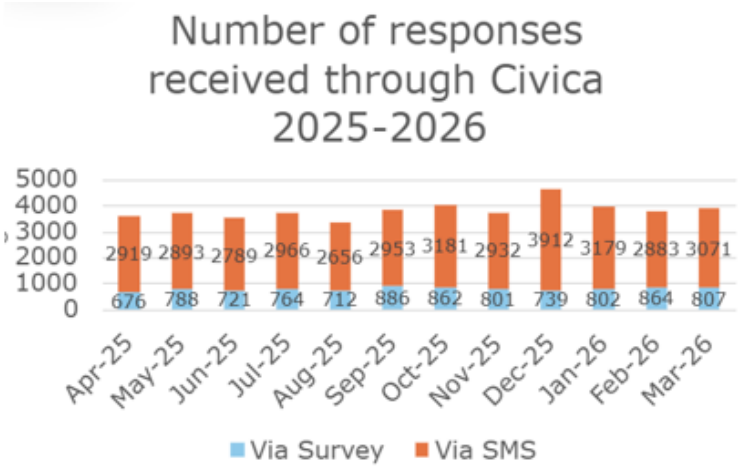

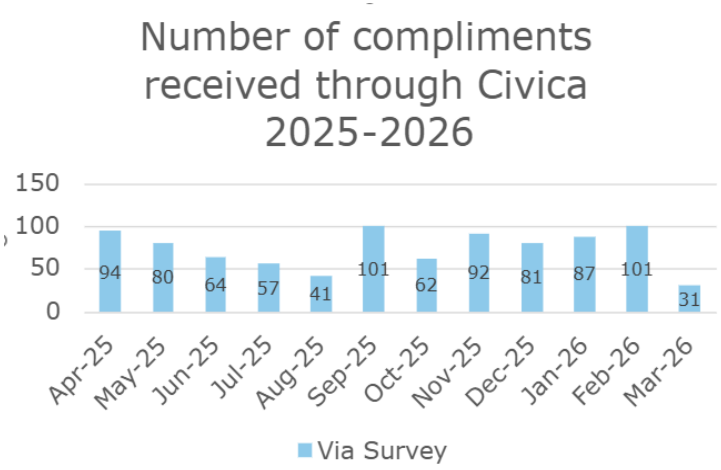

Priorities for 2026–27

Key priorities for the coming year include:

- Strengthening the governance, reporting and oversight arrangements for People's Experience, including implementation of the Patient Experience Framework.
- Increasing the capture and use of compliments and positive feedback at service level to support learning and improvement.
- Improving accessibility of patient feedback mechanisms and national surveys, including the provision of additional language options and British Sign Language (BSL) resources.

Key Message:

- **Expanded opportunities for people to provide feedback across services.**
- **Consistently high levels of engagement through surveys, SMS feedback and compliments.**
- **Overwhelmingly positive themes reflecting compassionate, person-centred care.**

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9.1 Patient Stories

A digital patient story is a recorded account of a patient's experience of care, usually shared through video, audio, or multimedia and supports both quality improvement and quality assurance.

Digital patient stories continue to play an important role in helping the Health Board understand care through the eyes of patients, families and carers. They provide valuable insight into the experiences that sit behind performance measures and support both quality improvement and organisational assurance.

During 2025/26, patient stories reflecting experiences of cardiac rehabilitation services, post-stroke rehabilitation, breast-feeding support and peri-natal mental health services were shared through Board and Patient Experience, Quality and Safety Committee arrangements. These stories provided valuable opportunities to recognise good practice, identify areas for improvement and understand what matters most to people using our services.

Patient stories have continued to support:

- understanding of patient and family experiences
- identification of quality improvement opportunities
- consideration of equality, accessibility and communication issues
- assurance regarding person-centred care
- organisational learning and reflection

Digital patient stories are presented to every Board and People's Experience, Quality and Safety Committee. The Health Board remains committed to ensuring that patient voices influence decision making and service improvement, supporting delivery of safe, effective and person-centred care.

Priorities for 2026–27

Key priorities for the coming year include:

Patterson Liz 03/12/2026 09:04:16

- Incorporate patient stories into governance and assurance processes to provide qualitative evidence alongside performance data
- Use patient feedback to identify risks, highlight areas of concern, and monitor the impact of actions taken
- Use digital patient stories to identify improvement opportunities and shape service redesign
- Share digital patient stories across teams to promote reflection, learning, and continuous improvement

- Strengthen organisational focus on what matters most to those who use our services

Key Message:

Digital patient stories continue to strengthen quality improvement and assurance by bringing patient experiences into decision-making, helping us identify opportunities for improvement, provide assurance on the quality of care, and keep the voices of patients and families at the centre of everything we do.

10.0 Service Spotlights – Delivering Quality in Practice

The Duty of Quality applies across all services provided and commissioned by Powys Teaching Health Board. Throughout this report, we have described the governance arrangements, quality intelligence, learning systems and engagement activity that support continuous improvement across the organisation.

The following service spotlights provide examples of how the principles of the Duty of Quality have been translated into practice during 2025/26. They demonstrate how services have used quality improvement, partnership working, patient and community feedback, workforce development, innovation and organisational learning to improve care and outcomes for the people of Powys.

The examples presented are not intended to represent all improvement activity undertaken during the year. Instead, they illustrate a range of programmes and services that have demonstrated progress in delivering safe, timely, effective, efficient, equitable and person-centred care, whilst responding to local needs, national priorities and areas requiring improvement.

Together, these examples demonstrate the Health Board's ongoing commitment to learning, improvement and the delivery of high-quality services for the people of Powys.

10.1 Dementia Services

Dementia services have continued to be a significant area of focus for Powys Teaching Health Board, reflecting both the changing needs of the local population and the Health Board's commitment to delivering high-quality, person-centred care for people living with dementia and those who support them.

Dementia remains the leading cause of death in the UK and presents a significant and growing challenge for Powys due to an ageing population. Powys has a higher proportion of older residents than the national average, with

substantial projected increases in people aged 65+ and 80+. In response, Powys Teaching Health Board continues to prioritise dementia as a core area of quality improvement.

Strategic Context

Powys Teaching Health Board works in partnership with the local authority and third-sector organisations to deliver care aligned to the All-Wales Dementia Care Pathway of Standards (all-wales-dementia-care-pathway-of-standards). Progress during 2025/26 has been delivered through four integrated workstreams focused on community engagement, memory services, hospital care, and workforce development.

Key Achievements 2025/26

- **Community Engagement**
  - Local engagement informed the development of brain health and dementia risk-reduction messaging
  - Roll-out planned for 2026 to support prevention and earlier help-seeking

- **Memory Services and Learning Disabilities**
  - Dementia diagnostic rates improved to 49.7%
  - Enhanced post-diagnostic support through carer education, psychology input, and cognitive stimulation therapy
  - Dementia Navigators established across all Powys localities
  - Dementia screening for people aged 30+ with Down's Syndrome is embedded in the Learning Disabilities Dementia Strategy

- **Dementia Friendly Hospital Charter**
  - Dementia-friendly environmental improvements are ongoing as part of a planned schedule of works for wards, and outpatient areas
  - Dementia training compliance reached 86% on wards, compared to 55% organisationally
  - Dementia Link Nurses and RITA Champions embedded across wards
  - Dementia Home Treatment Team supported 102 of 119 referrals at home, avoiding hospital admission and receiving positive family feedback

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- **Workforce and Organisational Development**

- Dementia *Informed* level of training added to the mandatory training matrix, achieving a 12% increase in staff completion to 55%
- A skilled-level dementia e-book developed with local authority partners, with positive feedback and national interest

Quality Monitoring and Assurance

Data collection continues to monitor diagnostic rates, waiting times, hospital length of stay, and patient experience. Hospital audits demonstrate improving compliance and staff engagement, supported by a developing dataset aligned to the Dementia Friendly Hospital Charter.

Priorities and Next Steps

Powys Teaching Health Board's vision is to ensure people in Powys are informed, supported to seek timely diagnosis, and cared for by a skilled and confident workforce. Ongoing priorities include strengthening early intervention, sustaining workforce capability, and responding to increasing demand. Feedback from the Dementia Strategy consultation (closed April 2026) will inform the refreshed strategy due for finalisation in 2026–27.

Key Message:

Dementia services have continued to strengthen community support, improve workforce capability and develop dementia-friendly care environments, supporting better experiences and outcomes for people living with dementia across Powys.

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10.2 Mental Health Services

Mental Health Services continued to be a significant area of focus during 2025/26. Building on improvement work initiated during the previous year, the service has continued to strengthen quality, safety and performance arrangements whilst maintaining a focus on delivering safe, effective and person-centred care.

In March 2024, Mental Health Services were placed into internal escalation in response to a number of identified areas requiring improvement. During 2025/26, work continued to embed improvements across the service, supported by an established improvement plan, strengthened governance arrangements and ongoing oversight through the Health Board's quality and performance framework. Following progress against priority improvement areas, internal escalation was removed in October 2024. Throughout 2025/26, the service continued to focus on strengthening governance, workforce sustainability, quality assurance arrangements and service delivery. Improvement work has been supported through regular monitoring, performance review and engagement with staff, service users and partners.

Key areas of focus included:

- Maintaining robust governance and quality oversight arrangements
- Supporting workforce stability and service sustainability
- Strengthening performance monitoring and quality assurance
- Embedding learning and continuous improvement across services
- Improving the experience of people accessing mental health support and care

The service has continued to demonstrate a commitment to organisational learning and improvement, using quality intelligence, feedback and assurance activity to identify priorities and monitor progress. The improvement journey has reinforced the importance of strong governance, clear accountability and a culture which supports learning and continuous improvement.

As the service moves forward, focus will continue on sustaining improvements achieved, maintaining effective oversight arrangements and ensuring that people accessing mental health services receive safe, timely and person-centred care.

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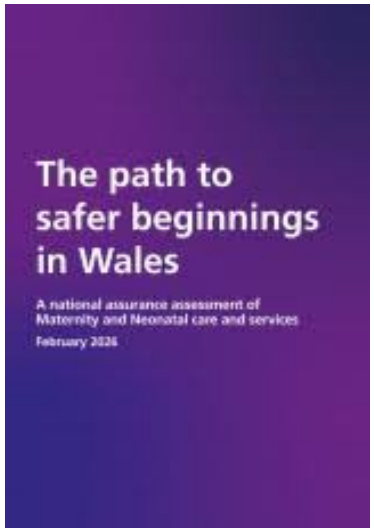
Key Message:

Sustained improvement demonstrated during 2025/26, building on improvement work initiated under escalation arrangements and maintaining focus on governance, quality, safety and service improvement following de-escalation the previous year.

10.3 Maternity and Women's Health Services



Maternity and Women's Health Services continued to be a significant area of focus during 2025/26. Improvement activity throughout the year has been informed by the principles of the Duty of Quality, with a particular focus on safety, patient experience, digital transformation, workforce development, organisational learning and partnership working. Together, these programmes demonstrate how quality is embedded into planning, service delivery and continuous improvement across Maternity, Women's and Family Services.

Nationally, maternity and neonatal services remained subject to considerable scrutiny, with an increased emphasis on quality, safety, learning and assurance across NHS Wales. In Powys, this provided an opportunity to reflect on local arrangements, strengthen oversight and continue to improve services for women, babies and families.

During the year, NHS Wales completed the National Maternity and Neonatal Assessment, which informed the publication of *The Path to Safer Beginnings*. Powys Teaching Health Board fully participated in the review, supporting an evidential and experiential based assessment. Following this, a detailed gap analysis against the assessment findings has supported development of a comprehensive improvement plan to strengthen existing arrangements and support delivery against national expectations. Progress against identified actions continues to be monitored through established governance and assurance arrangements.

The Health Board continued to actively participate in the national Maternity and Neonatal Safety Support Programme (MatNeoSSP), maintaining momentum across quality improvement, safety, workforce and service development initiatives. Continued national investment has enabled progress to be sustained and supports ongoing improvement work across maternity services.

Significant progress was also made in the digital transformation of maternity services through the continued implementation and development of BadgerNet electronic maternity records. The introduction of digital records has improved access to information, supported more integrated care and strengthened opportunities for real-time data collection, quality monitoring and service improvement.

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Recognising the importance of continuous improvement and organisational learning, a Quality Improvement Forum was established across Women's and Children's Services. The Forum supports the review of quality intelligence, identification of improvement priorities, sharing of learning and coordinated improvement activity across services.

During 2025/26, a review of maternity on-call arrangements was undertaken in response to feedback from staff. Feedback highlighted concerns relating to on-call working patterns, the potential impact of fatigue on wellbeing and the importance of ensuring sustainable staffing arrangements. The review resulted in the development of a revised operating model which aligns more closely with All-Wales on-call arrangements, supports safer and more sustainable ways of working and provides a more efficient workforce model whilst maintaining service resilience. The review also delivered some financial benefit, supporting the prudent use of resources while placing quality, safety and workforce wellbeing at the centre of decision making.

The Health Board recognises that further work is required during 2026/27 to build on these foundations. Future priorities include continued delivery of actions against emerging reports and recommendations, actions outstanding from the *Path to Safer Beginnings* action plan, implementation of MatNeo priorities, further development of quality improvement arrangements and continued engagement with staff, women and families to support service development and sustainability. These activities will continue to support the delivery of care that is safe, timely, effective, efficient, equitable and person-centred whilst ensuring the voices of women, families and staff remain central to service development.

Key Message:

Maternity services have continued to strengthen quality, safety and learning through delivery of national improvement programmes, implementation of digital maternity records, development of quality improvement arrangements and actions arising from the National Maternity and Neonatal Assessment.

Women's Health Services

Women's Health services continued to develop throughout 2025/26 in support of the Welsh Government Women's Health Plan for Wales and the Health Board's ambition to improve access to information, advice and support for women across Powys.

A key area of focus has been the successful development and launch of a virtual Women's Health Hub, providing women and healthcare professionals with improved access to information, self-referral opportunities, advice, guidance and signposting across different stages of the women's health pathway. The service has continued to expand and evolve, improving accessibility and helping women access support closer to home.

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Celebrating the Women's Health Hub Launch, March 2026.

Engagement and co-production have been central to the development of Women's Health services. Working in partnership with Powys Association of Voluntary Organisations (PAVO), the Health Board undertook engagement activity to better understand the experiences, needs and priorities of women across Powys. Feedback received has informed service development and helped ensure that future priorities reflect the needs of local communities and service users.

Particular attention has also been given to safeguarding and the wider determinants of health. Women's Health pathways have sought to strengthen links between health, wellbeing and safeguarding, recognising the importance of identifying vulnerability, promoting early intervention and ensuring women receive holistic, person-centred care and support.

As Women's Health services move into the next phase of development, priorities for 2026/27 include further expansion of the virtual offer, increasing awareness and utilisation of self-referral pathways, strengthening engagement with harder-to-reach communities. The continued development of Women's Health services demonstrates the Health Board's commitment to improving access, reducing inequalities, strengthening prevention and ensuring that women are able to influence and shape services through meaningful engagement and co-production.

Key Message:

Women's Health services have continued to improve access, strengthen engagement and develop innovative approaches that place women's voices, experiences and needs at the centre of service development, whilst building foundations for greater co-production and participation in future years.

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10.4 Children's Neurodevelopmental Services

Children's Neurodevelopmental Services continued to be a significant area of focus during 2025/26, reflecting increasing demand for assessment and support services and the Health Board's commitment to improving access, quality and experience for children, young people and families. The developments described below demonstrate the application of the Duty of Quality through service redesign, organisational learning, engagement and continuous improvement.

In October 2024, the Health Board placed Children and Young People's Neurodevelopmental Services into an escalated position within the Integrated Quality and Performance Framework. This reflected recognised challenges within the service and the need for focused improvement activity, strengthened oversight and delivery of a structured improvement plan. Throughout 2025/26, progress continued against identified actions, supported through established governance, quality and performance review arrangements.

A key area of focus during the year has been the development of a sustainable service model capable of responding to increasing demand whilst maintaining quality and safety. Work has continued to progress the Children's Neurodevelopmental Service business case, supporting longer-term service sustainability and future development. Alongside this, the service has continued to review pathways, strengthen governance arrangements and improve oversight through the Health Board's escalation and assurance framework.

Recognising the importance of listening to children, young people and families, co-production has remained central to the service's improvement journey. Regular engagement sessions with families and staff have continued throughout the year, alongside the development of parental co-production arrangements, ensuring that service improvement activity remains informed by lived experience.

The service has also focused on improving the quality and reliability of information available to support decision making. Through strengthened monitoring, quality oversight and risk management arrangements, the Health Board has continued to improve its understanding of service pressures, priorities and areas requiring further action. This has supported more informed planning and enabled progress to be monitored through established governance arrangements.

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While work remains ongoing, the progress made during 2025/26 demonstrates the Health Board's commitment to learning, improvement and partnership working. Priorities for 2026/27 include continued delivery of the improvement programme, implementation of the approved service model, further pathway development and continued engagement with children, young

people and families to ensure services remain responsive, safe and person-centred. De-escalating the service in a safe and timely manner remains a key focus.

Key Achievements

- Continued delivery of a structured improvement programme through established escalation and oversight arrangements
- Ongoing development of a sustainable Children's Neurodevelopmental Service model and supporting business case
- Continued engagement with families and staff through co-production and service improvement activity
- Strengthened governance, quality monitoring and assurance arrangements
- Improved visibility of service pressures, risks and improvement priorities through quality and performance reporting

Key Message:

Children's Neurodevelopmental Services have continued to make progress through structured improvement, strengthened governance, service redesign and meaningful engagement with children, young people and families, supporting delivery of more sustainable and person-centred services.

11.0 Safeguarding

Safeguarding remains a fundamental part of Powys Teaching Health Board's core business and organisational values. The Health Board is committed to being a trusted and safe organisation where children and adults at risk of harm, abuse or neglect are protected, and where staff feel empowered, valued and supported to act promptly and appropriately to safeguard patients, families and communities.

Safeguarding is recognised as a complex and shared responsibility. All employees and commissioned services are expected to have the appropriate skills, knowledge and competencies to safeguard effectively. PTHB promotes a culture where safeguarding concerns are identified early, shared quickly and managed appropriately, with a strong emphasis on learning and continuous improvement when things go wrong.

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The Health Board works collaboratively with partner agencies, supporting the strategic priorities of the Mid and West Wales Safeguarding Board, the Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) Board, and the National Safeguarding Network. Strong multi-agency working remains essential to achieving positive outcomes for people who live, work and visit Powys.

Throughout the year, PTHB reviews its safeguarding performance against the Safeguarding Maturity Matrix Standards. Both qualitative and quantitative data are used to understand effectiveness, identify risks, and support informed discussion around the delivery of safe, timely, effective, efficient, equitable and person-centred care, underpinned by a learning culture.

Listening to and engaging with children and adults is central to safeguarding practice and to delivering care at the heart of the community. The Health Board continues to support people's rights to live in safety, free from abuse, neglect, discrimination, exploitation and avoidable harm, while balancing protection with empowerment.

PTHB's demonstrates ongoing commitment to strengthening safeguarding arrangements, embedding safeguarding into everyday practice, and continually improving the quality of care and outcomes for the people of Powys.

Key Message:

Safeguarding remains fundamental to the delivery of safe, person-centred care across Powys. Through strong partnership working, workforce development, safeguarding governance and continuous learning, the Health Board continues to strengthen arrangements to protect children and adults at risk whilst promoting wellbeing, independence and positive outcomes.

12.0 Recommendations from External Reviews and Inspection

External reviews, inspections, audits and assurance processes provide an important source of independent scrutiny and support the Health Board's commitment to learning and continuous improvement. During 2025/26, the Health Board continued to engage with external regulators, inspectors and assurance bodies, using findings and recommendations to inform service development, strengthen governance and support quality improvement activity.

The Health Board recognises that external review processes provide valuable opportunities to validate good practice, identify areas requiring further development and support ongoing improvement across both directly provided and commissioned services. Furthermore, the Health Board has clear and established reporting routes through appropriate committees relating to reviews and inspections, providing both assurance and oversight. The integration of outcomes and findings from reviews and inspections into the wider thematic analysis has been commenced to ensure the organisation can identify the appropriate learning priorities throughout the course of the year.

Page 63 of 406 - 03/07/2026 09:04:16

12.1 Health Inspectorate Wales

Healthcare Inspectorate Wales (HIW) provides independent scrutiny and assurance regarding the quality, safety and experience of healthcare services across Wales. Inspection activity supports delivery of the Duty of Quality by providing external assessment of services, identifying areas of good practice and highlighting opportunities for improvement.

During 2025/26, Powys Teaching Health Board participated in a number of announced and unannounced HIW inspections across inpatient, community and urgent care services. These inspections provided opportunities for external review of clinical environments, governance arrangements, patient experience, workforce issues and the quality and safety of care provided.

Inspection Activity During 2025/26:

Service	Inspection Type
Felindre Ward	Unannounced Inspection
Community Mental Health Team, Ystradgynlais	Inspection
Dyfi Valley Health Centre	Inspection
Llanidloes Minor Injury Unit	Unannounced Inspection
Maldwyn Ward, Welshpool Hospital	Inspection
Tywyn Ward, Machynlleth Hospital	Inspection

At the time of preparation of this report, a number of inspection reports and associated improvement actions remained subject to ongoing review and monitoring. Detailed findings and recommendations arising from individual inspections continue to be considered through established governance arrangements and relevant committee structures.

The Health Board remains committed to responding positively to external scrutiny and ensuring that learning arising from inspection activity is incorporated into service improvement, governance arrangements and organisational learning processes. Inspection findings are considered alongside other sources of quality intelligence, including incidents, concerns, patient feedback, safeguarding activity, audits and external reviews, helping to support a comprehensive understanding of quality and safety across services.

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What Next?

As inspection reports are completed and recommendations implemented, the Health Board will continue to monitor progress through established assurance arrangements, ensuring that identified learning translates into measurable improvements in care, experience and outcomes for the people of Powys.

12.2 Welsh Risk Pool

The Welsh Risk Pool provides an important source of external assurance for NHS Wales organisations, supporting effective risk management, claims handling, reimbursement and organisational learning. For Powys Teaching Health Board, the assessment process helps to demonstrate how learning from concerns, incidents, claims, redress and inquests is used to strengthen the quality and safety of care for the people of Powys.

Welsh Risk Pool

Gwella Diogelwch Cleifion Trwy Ddysgu
Improving Patient Safety Through Learning

During 2024–25, the Health Board participated in the Welsh Risk Pool assessment programme. The review considered compliance with relevant national requirements, including the Welsh Risk Pool Reimbursement Procedures, the NHS Concerns, Complaints and Redress Arrangements Regulations, and the Health and Social Care (Quality and Engagement) (Wales) Act 2020. The assessment provided assurance on arrangements for managing incidents, complaints and enquiries, redress, claims, inquests and coronial inquiries, organisational learning and the reimbursement process.

The 2024–25 assessment identified areas for further improvement, particularly the timely closure of Nationally Reportable Incidents and Duty of Candour incidents. It also recognised positive progress, including improved quality of outcomes, evidence of sustained changes in practice and areas of strong practice within the Corporate Quality and Safety Team.

During 2025–26, work has continued to build on the recommendations and learning from the 2024–25 review. This has included strengthening oversight of improvement actions, supporting timely progression and closure of incidents, and ensuring that learning from concerns, claims and inquests informs wider quality and safety improvement.

Actions arising from the assessment, alongside any outstanding actions from previous reviews, continue to be monitored through the Health Board's quality and safety improvement action plan. This provides a mechanism to track progress, strengthen assurance to Board and support the continued embedding of learning across services.

13.0 Assuring Quality in Commissioned Services

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A significant proportion of healthcare provided to people living in Powys is delivered through commissioned arrangements with NHS Wales organisations, NHS England providers and other partner organisations. Whilst care may be delivered by another provider, the Health Board remains responsible for assuring itself that commissioned services are safe, effective, high-quality and responsive to the needs of the population it serves.

During 2025/26, the Health Board continued to strengthen arrangements for monitoring quality, safety, patient experience, performance and outcomes within commissioned services. This work has been supported through established governance structures, Contract Quality Performance Review Meetings (CQPRMs), quality intelligence, service reviews and the continued development of the Integrated Quality and Performance Framework (IQPF).

Recognising the complexity and scale of commissioned healthcare arrangements, the Health Board has also identified opportunities to further strengthen assurance processes. Development of a more comprehensive Commissioned Services Assurance Framework will continue during 2026/27, supporting greater consistency, visibility and triangulation of quality information across commissioned services.

13.1 Integrated Quality & Performance Framework (IQPF)

Powys THB is responsible for planning, providing and commissioning healthcare services to improve the health and wellbeing of the people of Powys. The purpose of the Integrated Quality and Performance Framework (IQPF) is to ensure that information is available to enable the Board and key decision-makers to understand, monitor and assess organisational performance, identify risks and support continuous improvement in service delivery.

The IQPF applies across all responsibilities of the Health Board, including services provided directly by Powys Teaching Health Board and those commissioned from partner organisations both within Wales and across the border.

The framework supports assurance across the following key domains:

- Access to Care and Timeliness
- Quality, Safety and Patient Experience
- Finance and Value
- Workforce and Culture

Through these domains, the Health Board seeks assurance that services are safe, timely, effective, efficient, equitable and person-centred, whilst also ensuring resources are used effectively and services remain sustainable. 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.

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Domains	Description
Access to Care and Timeliness	Assurance on timely and appropriate access to health care services to achieve the best health outcomes within agreed targets.
Quality, Safety and Patient Experience	Assurance against national and locally set quality and safety measures of care ensuring services are: • Safe • Timely • Effective • Efficient • Equitable • Person Centred 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). Work within the principles of the Health Board Quality Management System.
Finance & Value	Assurance that services are improving efficiency and productivity and financial plans are being delivered. Prudent or Value-Based health care approach.
Workforce and Culture	Assurance that the organisation has a motivated and sustainable workforce that is well-trained and the capacity and capability to provide quality services.

13.2 Quality Management and Assurance

Page 60 Liz
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The IQPF provides a structured approach to quality management, quality control, quality planning and continuous improvement. It supports:

- Identification and management of risk
- Monitoring of quality, safety and patient experience

- Performance management and improvement
- Integration of qualitative and quantitative intelligence
- Escalation and assurance processes
- Benchmarking and organisational learning

Performance information is considered through a range of governance arrangements, ensuring that areas of concern can be identified, escalated and addressed in a timely manner.

The PTHB Quality Management System has four elements as detailed below:

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

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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. Through the development of our Quality Management System, we aim to:

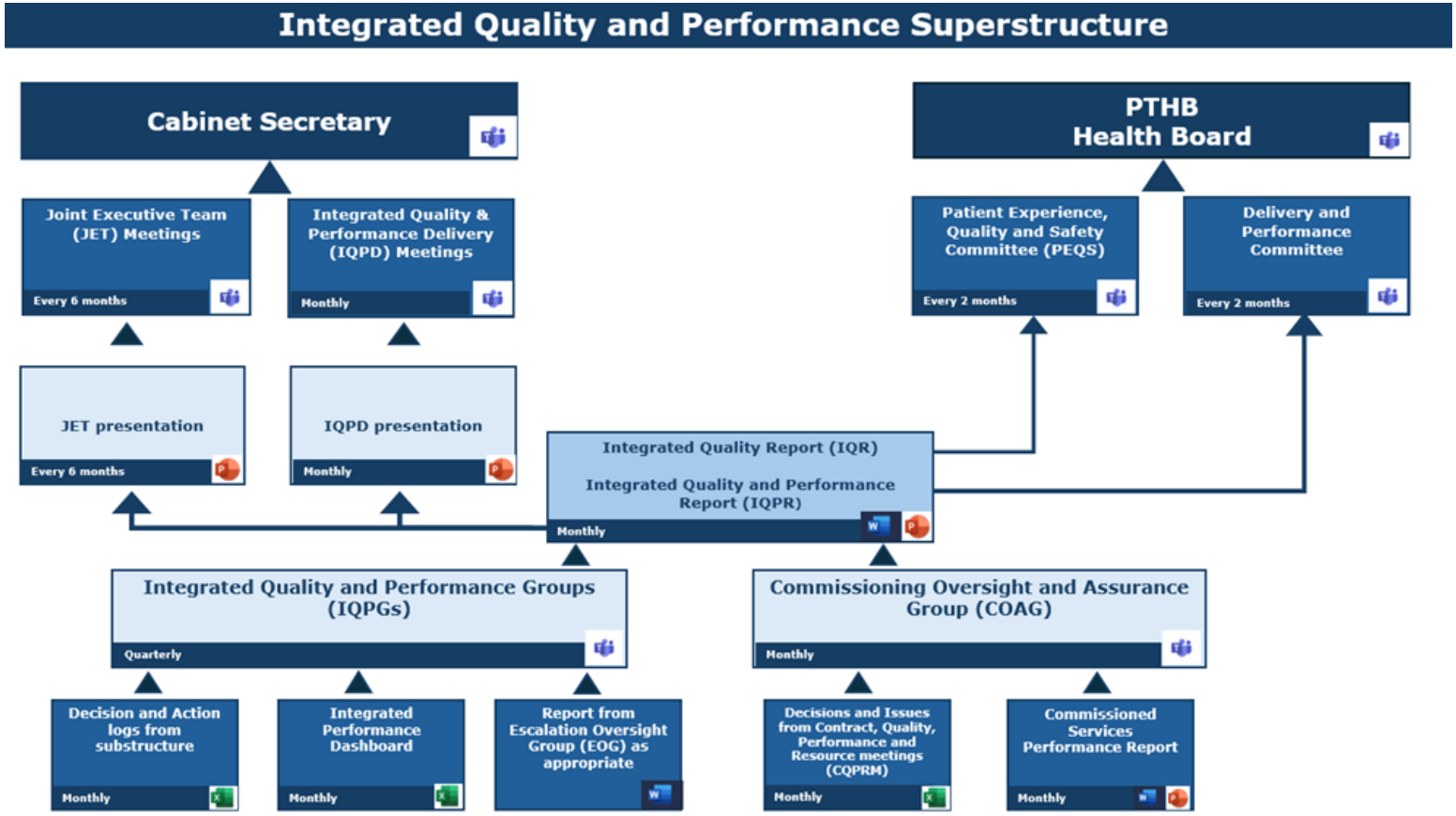
- Enable a positive, psychologically safe and just quality culture through the provision of compassionate leadership
- Enable a shared responsibility and voice for quality to ensure the provision of safe, timely, effective, efficient, equitable and person-centred care
- Embed Quality Driven Decision Making at all levels of the Health Board
- Demonstrate a quality approach based upon learning and continuous improvement

Integrated Quality and Performance Report (IQPR)

The IQPR is a key part of the IQPF designed to drive improvement in health board performance and health outcomes for those patients that Powys is responsible for.

The IQPR uses key annual NHS Performance Framework measures which include Ministerial priorities and other timely local measures to provide robust assessment of the health boards performance as both a provider and commissioner of care focusing on key challenge and success.

This process utilises both quantitative and qualitative measurements which are backed by statistical process, business rules, and narrative provided by leads of the service area.



Integrated Quality and Performance Group

The IQPF applies to the whole organisation with Integrated Quality and Performance Group Meetings being held on a Quarterly and Six-Monthly basis to review directorate performance.

- Quarterly: Focused on a subset of key quality, performance and financial metrics as required by the health board plan; this will be done by exception. Should separate, more detailed finance (or other) discussions be required, these will be agreed through the assurance review process using the escalation options. These reviews will also include specific consideration of the highest rated risks along with mitigating actions to manage these.
- Six-monthly: Focused on key performance indicators with deep dives into key areas of challenged quality, performance and finance where required. Also consider specific progress against plan and consideration of highest risks and mitigating actions.

13.3 Commissioned Services Assurance

For services commissioned from external providers, CQPRMs remain a key mechanism through which the Health Board seeks assurance regarding quality, safety, performance and patient experience.

These arrangements support the Health Board to:

- Monitor provider performance against agreed quality and performance measures
- Review patient experience and safety information
- Identify emerging risks and areas requiring escalation
- Monitor outcomes and improvement actions
- Share learning across organisations and services

The Health Board continues to work with commissioned providers to strengthen quality oversight and improve the consistency of quality intelligence and reporting. During 2025/26, this has included work to further develop quality measures, improve triangulation of information and enhance the visibility of risks and improvement priorities across commissioned services.

Looking Forward

Paterson Jane 03/08/2026 09:04:43

While established governance arrangements continue to provide oversight of commissioned services, the Health Board recognises that further development is required to support a more comprehensive and mature approach to commissioned service assurance. During 2026/27, priorities will include:

- Development of a Commissioned Services Assurance Framework
- Strengthening quality intelligence and triangulation arrangements
- Further integration with the Integrated Quality and Performance Framework
- Development of more meaningful quality and patient experience measures
- Improved visibility of risks, outcomes and improvement activity across commissioned services

14.0 Future Developments

During 2026/27, Powys Teaching Health Board will continue to build on the progress made during the year and further strengthen arrangements that support delivery of the Duty of Quality. Whilst significant foundations have been established, the Health Board recognises that continuous improvement requires ongoing development of quality systems, governance arrangements, engagement approaches and organisational learning.

A key priority will be the continued development of a comprehensive Quality Management System, bringing greater consistency and integration to the way quality is planned, monitored, assured and improved across the organisation. Building on existing governance and quality intelligence arrangements, this work will support a more systematic approach to embedding quality within everyday decision-making and service delivery.

The implementation of the NHS Wales Listening to People Framework will provide an opportunity to further strengthen how feedback, concerns, patient experience, compliments and lived experience are brought together to inform learning and improvement. The Health Board will continue to focus on ensuring that the voices of patients, service users, families, carers and communities remain central to service improvement activity.

Further work will continue to strengthen the use of quality intelligence and organisational learning. Building on developments during 2025/26, the Health Board will seek to improve the triangulation of information from incidents, concerns, patient experience, safeguarding activity, audits, external reviews and commissioned services to support earlier identification of emerging themes, risks and opportunities for improvement.

Recognising the significant role commissioned services play in the delivery of healthcare for Powys residents, development of a more comprehensive Commissioned Services Assurance Framework will continue during 2026/27. This work will focus on strengthening oversight, improving visibility of quality information and supporting a more consistent approach to assurance across commissioned services.

Page 40 of 43 - 30/01/2026 09:04:39

The Better Together programme will continue to play a central role in shaping future services and responding to the opportunities and challenges facing healthcare delivery across Powys. Continued engagement with patients, staff, communities and partners will

be essential in ensuring future service models are informed by local needs, experience and evidence. The Health Board remains committed to ensuring that quality, safety and patient experience are central considerations within future service planning and transformation activity.

The Health Board will also continue to strengthen co-production, engagement and participation arrangements, building on relationships with Llais, PAVO, community groups and partner organisations. Particular emphasis will be placed on ensuring that seldom-heard communities, vulnerable groups and those affected by health inequalities are able to influence service development and improvement activity.

Quality improvement capability will continue to be developed across services through leadership development, workforce engagement, digital innovation and the sharing of learning. Particular focus will be placed on evaluating improvement activity, identifying sustainable change and strengthening the connection between learning and measurable improvement in outcomes and experience.

The continued development of digital systems and information infrastructure will remain a priority. Building on progress already achieved through initiatives such as BadgerNet, enhanced patient feedback systems and integrated quality reporting arrangements, further opportunities will be explored to improve the quality, accessibility and use of information to support safer, more effective and person-centred care.

Finally, the Health Board recognises the need to remain responsive to a changing health and care environment. Horizon scanning, continuous learning and engagement with national policy developments, emerging evidence, inspection findings and wider NHS Wales priorities will support the Health Board in identifying future risks, opportunities and areas requiring improvement. This approach will help ensure that quality remains at the heart of decision-making as services continue to evolve to meet the needs of the population of Powys.

Key Message:

During 2026/27, the Health Board will continue to strengthen quality systems, organisational learning, engagement, co-production and commissioned services assurance, whilst remaining responsive to emerging risks, opportunities and national priorities. Through these developments, the Health Board will continue to embed the principles of the Duty of Quality across all aspects of service planning, delivery and improvement.

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15.0 Looking Forward Quality Priorities 2026/2027

As the Health Board continues its journey to embed the Duty of Quality, a number of priority areas have been identified for 2026/27. These priorities build on the progress made during the year and reflect local learning, national development, service user feedback, external scrutiny and emerging risks and opportunities.

Priority 1 – Develop a Comprehensive Quality Management System
Continue development of a more mature and integrated Quality Management System to strengthen quality planning, assurance, improvement and organisational learning across all Health Board functions.

Priority 2 – Implement the NHS Wales Listening to People Framework
Embed the Listening to People Framework, ensuring feedback, compliments, concerns, lived experience and patient stories are used consistently to support improvement, learning and decision-making.

Priority 3 – Strengthen Quality Intelligence and Organisational Learning
Further develop arrangements for bringing together information from incidents, patient experience, safeguarding, audits, external reviews, mortality reviews and commissioned services to support earlier identification of themes, risks and opportunities for improvement.

Priority 4 – Enhance Assurance of Commissioned Services
Develop a Commissioned Services Assurance Framework to support greater consistency, visibility and oversight of quality, safety, patient experience and outcomes across commissioned healthcare services.

Priority 5 – Strengthen Engagement, Co-production and the Better Together Programme
Continue to strengthen engagement and co-production with patients, communities, staff and partners through delivery of the Better Together programme and wider service transformation activity. Particular focus will be placed on involving seldom-heard groups, reducing inequalities and ensuring people can influence decisions about future services.

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Priority 6 – Remain Responsive to Emerging Risks, Opportunities and National Priorities
Maintain a focus on horizon scanning, innovation and continuous improvement to ensure the Health Board is well placed to respond to emerging quality issues, new evidence, changing population needs, regulatory developments and future NHS Wales priorities.

16.0 Conclusion

The Duty of Quality places a responsibility on the Health Board to continuously improve the quality of services, outcomes and experiences for the people of Powys. Throughout this report, we have demonstrated how quality has continued to inform decision-making, service development, governance arrangements and improvement activity across both directly provided and commissioned services.

During 2025/26, the Health Board has continued to strengthen its approach to quality through the development of quality intelligence arrangements, organisational learning processes, patient and public engagement, service improvement programmes and assurance frameworks. Progress has been made in a number of areas, including patient experience, organisational learning, maternity and women's health, dementia services, neurodevelopmental services, safeguarding, bereavement care and mortality review processes. These developments highlight the commitment of staff, partners, patients, carers and communities to improving services and outcomes across Powys.

The report has also identified areas where further work is required. Development of a comprehensive Quality Management System, strengthening commissioned services assurance, embedding the Listening to People Framework and continuing to mature organisational learning arrangements will remain important priorities during 2026/27. The Health Board recognises that improving quality is an ongoing journey and that sustaining improvement requires continued focus, collaboration and openness to learning.
The Health Board remains committed to ensuring that quality is not viewed as a separate activity, but as a fundamental part of everything it does. By listening to people, learning from experience, responding to evidence and working collaboratively with staff, partners and communities, we will continue to strengthen the delivery of safe, timely, effective, efficient, equitable and person-centred care for the people of Powys.

As we look ahead, we recognise that healthcare will continue to evolve in response to changing population needs, emerging evidence, national priorities and future challenges. Through continued engagement, horizon scanning, innovation and improvement, the Health Board will seek to ensure that quality remains at the heart of decision-making and service delivery, supporting better outcomes and experiences for current and future generations across Powys.

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Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 4.4

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE	**29 JULY 2026**
Subject:	**Powys Teaching Health Board Safeguarding Annual Report 2025-2026**
Approved and presented by:	Paul Hooton Executive Director of Nursing, Quality, Womens and Family Health
Prepared by:	Jayne Wheeler Sexton, Assistant Director of Nursing
Other Committees and meetings considered at:	Executive Committee 22 July 2026

PURPOSE:

To provide the Committee with assurance regarding the effectiveness of Powys Teaching Health Board's safeguarding arrangements during 2025–26 and to highlight key achievements, risks, learning and priorities for 2026–27.

RECOMMENDATION(S):

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

- **RECEIVE** the Annual Report and take **ASSURANCE** from the progress made during 2025–2026, whilst noting the key priorities and areas of focus for 2026–2027.
- **RECOMMEND** the approval of the report to the Board.

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 2025/26
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	

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EXECUTIVE SUMMARY:

The Safeguarding Annual Report provides assurance that safeguarding arrangements within Powys Teaching Health Board remain effective and continue to mature. Safeguarding is firmly embedded within the organisation which is supported by clear governance arrangements, effective partnership working and an established culture of continuous learning and improvement.

During 2025–2026, the Health Board has continued to strengthen its safeguarding arrangements through the delivery of key strategic priorities, participation in national safeguarding improvement programmes, enhanced quality assurance activity and further development of workforce support mechanisms. Significant progress has also been made in areas including Mental Capacity Act and Deprivation of Liberty Safeguards governance, Corporate Parenting responsibilities, multi-agency safeguarding supervision and implementation of safeguarding reforms at a regional and national level.

Safeguarding activity remains high across both children's and adult services. This is considered to reflect increasing staff awareness, confidence in safeguarding processes and improved access to specialist advice and support through the Safeguarding Hub. The continued growth in demand for safeguarding advice and supervision demonstrates the value of the service and the positive safeguarding culture that has developed across the organisation.

A comprehensive programme of audits, reviews and quality assurance activity undertaken throughout the year has provided assurance that safeguarding concerns are generally being recognised, reported and managed appropriately. Learning from internal audits, national reviews and regional safeguarding activity continues to inform improvements in policy, practice, training and governance arrangements.

The Health Board has maintained strong engagement with statutory safeguarding partnerships, including the Mid and West Wales Safeguarding Board, NHS Wales National Safeguarding Service and regional Violence Against Women, Domestic Abuse and Sexual Violence partnerships. This collaborative approach continues to support shared learning, consistent practice and improved outcomes for children and adults.

While the report demonstrates substantial progress, several areas remain a focus for improvement. These include strengthening compliance with Level 3 safeguarding training, embedding emerging national safeguarding frameworks and ensuring continued organisational resilience in response to increasing safeguarding demand and complexity.

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Overall, the report concludes that Powys Teaching Health Board continues to have effective safeguarding arrangements and governance in place and is well positioned to respond to future safeguarding challenges.

Key Achievements

Strengthened Governance and Assurance

- Continued implementation of recommendations arising from the Welsh Government *Strengthening Safeguarding in Health Review*.
- Active contribution to the development of the new NHS Wales Safeguarding Framework.
- Further enhancement of the PTHB Safeguarding Management Application, improving reporting, audit capability, data quality and organisational assurance.
- All actions arising from the NHS Wales Internal Audit of MCA/DoLS were completed, resulting in significant improvements in governance, compliance and oversight.

Workforce Development and Support

- Safeguarding Hub activity increased to 1,389 contacts, representing a 107% increase since its introduction and demonstrating growing staff confidence in accessing safeguarding advice and supervision.
- Delivery of safeguarding, Ask and Act, Childhood Injury and MCA training to staff across the organisation.
- Successful implementation of a Multi-Agency Safeguarding Supervision Model with statutory partners, receiving positive feedback from practitioners.
- Mandatory safeguarding compliance remains strong at Levels 1 and 2, although Level 3 compliance remains below target and continues to require focussed improvement.

Safeguarding Children

- 439 child safeguarding reports were made during the year, more than doubling over the last five years, reflecting increased awareness, improved reporting mechanisms and enhanced safeguarding support.
- Child protection activity remained stable with 127 children on the Child Protection Register and 35 child protection medicals undertaken.
- Continued delivery of high-quality services for Children Looked After, including:
    - 309 statutory health assessments completed.
    - Introduction of the innovative *Care Bag* initiative.

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    - Development of multilingual sexual health resources for unaccompanied asylum-seeking children.
    - Launch of the national Looked After Children feedback survey.
- Significant progress made in implementing the Corporate Parenting Charter and developing PTHB's Corporate Parenting Promises.

Safeguarding Adults

- **237 adult safeguarding reports** were submitted during 2025-2026, continuing an upward trend in safeguarding identification and reporting.
- Improvements delivered within Mental Capacity Act and Deprivation of Liberty Safeguards arrangements, including enhanced workforce capacity, governance structures, supervision and quality assurance.
- MCA training compliance remains strong, with compliance exceeding 90% at Levels 1 and 2.

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

- Successful transition to the new Daily MARAC model, improving responsiveness to high-risk domestic abuse cases.
- Preparations completed for the implementation of MATAC and DRIVE, strengthening the management of perpetrators and improving victim safety.
- Significant progress made in developing the Women's Health Hub and co-produced survivor-informed safeguarding resources.

Learning, Quality Improvement and Audit

A strong learning culture continues across the Health Board. Multiple audits and reviews provided positive assurance regarding safeguarding practice, including:

- Child Protection Conferences Audit.
- Multi-Agency Strategy Discussions Audit.
- Child's Lived Experience Audit.
- MCA/DoLS Internal Audit follow-up.
- Was Not Brought Policy Audit.

Learning from safeguarding reviews, including the North Wales Child Practice Review *"Our Bravery Brought Justice"*, has been embedded through training, policy updates and briefings.

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Areas Requiring Continued Focus

Whilst significant progress has been achieved, several areas require ongoing attention:

- Improving Adult and Children's Level 3 safeguarding training compliance.
- Strengthening assurance and audit engagement within adult services relating to the Was Not Brought Policy.
- Increasing participation rates in Children Looked After and Carer feedback surveys.
- Further embedding MCA and DoLS improvements.
- Evaluating the impact of safeguarding learning and quality improvement initiatives.
- Managing increasing demand and complexity across safeguarding services.

Key Priorities for 2026-2027

- Implementing Year 2 of the NHS Wales Safeguarding Framework.
- Delivering the Corporate Parenting Improvement Plan.
- Improving Level 3 safeguarding training compliance.
- Continue strengthening MCA and DoLS improvements.
- Progressing safeguarding and VAWDASV priorities within the Women's Health Plan.
- Implementing the RL Datix Safeguarding Reporting Module.
- Supporting national and regional safeguarding reviews and assurance activity.

In Summary, the report provides assurance that safeguarding arrangements within Powys Teaching Health Board are effective, continue to mature, and are supported by robust governance, a committed workforce and effective partnership working. The Health Board has demonstrated continued improvement across all safeguarding domains whilst maintaining a clear focus on the protection, wellbeing and voice of children, adults and families across Powys.

IMPACT ASSESSMENT – NOT REQUIRED

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Powys Teaching Health Board Safeguarding Annual Report 2025 - 2026

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Powys Teaching Health Board

Contents

	Page
Foreword	3
Introduction – Safeguarding across our County	4
Powys Teaching Health Board Safeguarding Priorities 2025-2026	5
NHS Wales Safeguarding Maturity Matrix & Standards	6
➢ Well Lead, Effective Leadership & Governance	7
➢ Confident and Competent Workforce	22
➢ Person Centred	31
➢ Learning Culture	62
➢ Multi Agency Working	67
➢ Responsive, Resilient and Purposeful	75
Powys Teaching Health Board Safeguarding Priorities 2026-2027	76

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Foreword

I am pleased to present the Powys Teaching Health Board Safeguarding Annual Report for 2025–2026.

Safeguarding is everyone's responsibility and remains fundamental to the delivery of safe, effective and person-centred care. This report highlights the commitment of our staff, partners and communities to ensuring that children, young people and adults at risk are protected from harm, abuse, neglect and exploitation, and that safeguarding continues to be embedded within everything we do.

Throughout the year, we have continued to strengthen our safeguarding arrangements, guided by the NHS Wales Safeguarding Maturity Matrix and informed by learning, reflection and quality improvement. The report demonstrates progress across all safeguarding standards, including the development of our workforce, enhanced governance and assurance processes, strengthened multi-agency partnerships, and a continued focus on listening to the voices of children, adults and families.

During 2025–2026 we have also contributed to important national developments, including the implementation of recommendations arising from the Strengthening Safeguarding in Health Review and the development of the NHS Wales Safeguarding Framework. Locally, we have continued to innovate through initiatives such as multi-agency safeguarding supervision, our Corporate Parenting Promises, improvements in Mental Capacity Act and Deprivation of Liberty Safeguards arrangements, and the ongoing development of the Women's Health Hub.

The increasing complexity of safeguarding across health and social care highlights the importance of maintaining a knowledgeable, confident and compassionate workforce. I am proud of the dedication shown by staff across Powys Teaching Health Board, who continue to demonstrate professional curiosity, kindness and determination in supporting some of the most vulnerable members of our communities.

I would like to extend my sincere thanks to our safeguarding team, colleagues across the Health Board, partner agencies, members of the Board and the many individuals with lived experience who have helped shape and improve our services. Their collective efforts ensure that safeguarding remains at the heart of our organisation.

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While much has been achieved, we recognise that safeguarding is a continuous journey. We remain committed to learning, improving and working in partnership to ensure that Powys Teaching Health Board continues to be a trusted, safe and responsive organisation for the people we serve.

Paul Hooton
Executive Director of Nursing, Quality, Women & Family Health

Safeguarding across our County

Safeguarding is a fundamental part of Powys Teaching Health Board's core business. The Health Board is committed to being a trusted and safe organisation where children and adults at risk of harm, abuse or neglect are protected, and where staff feel empowered, valued and supported to act promptly and appropriately to safeguard patients, families and communities.

Safeguarding is recognised as a complex and shared responsibility. All employees and commissioned services are expected to have the appropriate skills, knowledge and competencies to safeguard effectively. PTHB promotes a culture where safeguarding concerns are identified early, shared quickly and managed appropriately, with a strong emphasis on learning and continuous improvement when things go wrong.

The Health Board works collaboratively with partner agencies, supporting the strategic priorities of the Mid and West Wales Safeguarding Board, the Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) Board, and the National Safeguarding Network. Strong multi-agency working remains essential to achieving positive outcomes for people who live, work and visit Powys.

Throughout the year, PTHB reviews its safeguarding performance against the Safeguarding Maturity Matrix Standards. Both qualitative and quantitative data are used to understand effectiveness, identify risks, and support informed discussion around the delivery of safe, timely, effective, efficient, equitable and person-centred care, underpinned by a learning culture.

Listening to and engaging with children and adults is central to safeguarding practice and to delivering care at the heart of the community. The Health Board continues to support people's rights to live in safety, free from abuse, neglect, discrimination, exploitation and avoidable harm, while balancing protection with empowerment.

Overall, this annual report demonstrates PTHB's ongoing commitment to strengthening safeguarding arrangements, embedding safeguarding into everyday practice, and continually improving the quality of care and outcomes for the people of Powys.

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Powys Teaching Health Board Safeguarding Priorities for 2025-2026

- Engage in the National Strengthening Safeguarding Review Implementation Programme and all 4 subgroups (commissioned by CNO & WG)
- Implement the updated PREVENT Guidance and mandatory Training
- 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
- Improve Level 3 Safeguarding Training Compliance
- Develop a set of Promises to Care Experienced Children which align with the principles of the Corporate Parenting Charter
- Extend the reach of the safeguarding service using Podcasts
- Deliver the National Childrens Looked After and Carers Surveys via CIVICA
- Implement the MCA audit assurance management plan
- Deliver the Womens Health Plan year 1 deliverables of Priority 7 (Safeguarding)

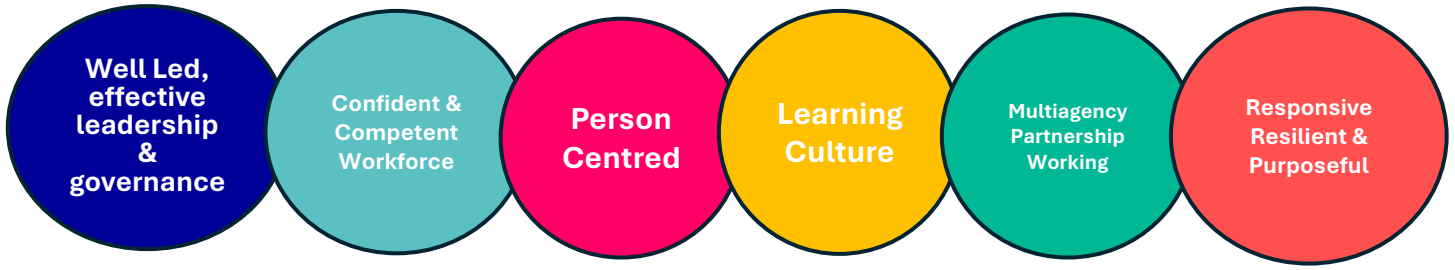
NHS Wales Safeguarding Maturity Matrix

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 **structured self assessment tool used in NHS Wales** to assess, measure, and improve how well an organisation delivers its safeguarding responsibilities.

The SMM helps organisations understand how "mature" their safeguarding systems are, where gaps or risks exist, what actions are needed to improve and provides a consistent way to evaluate safeguarding practice across organisations and services.

There are 6 Standards within the SMM assessment tool;



The SMM;

- Benchmarks safeguarding performance
- Supports continuous improvement
- Provides assurance to boards and regulators
- Drives a learning culture
- Aligns safeguarding with leadership, governance, and workforce capability

Powys Teaching Health Board's SMM self-assessment & improvement plan is completed annually, good practice, learning and improvements are shared with safeguarding peers across Wales at an Annual Peer Review hosted by the National Safeguarding Service. The review provides a safe environment for peer-to-peer reflection and contributes to the work of the National Safeguarding Networks forward workplan.

Powys Teaching Health Board's 2025-2026 Safeguarding Maturity Matrix self assessment supported the development of PTHB Safeguarding Priorities., which are reported on quarterly into PTHB Safeguarding Strategic Group. All priorities are monitored until completed.

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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 Legislation and Strategic Drivers

Safeguarding Quality Assurance

Inspections and Audits

North Wales Child Practice Review

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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 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.

PTHB Governance Reporting Structure

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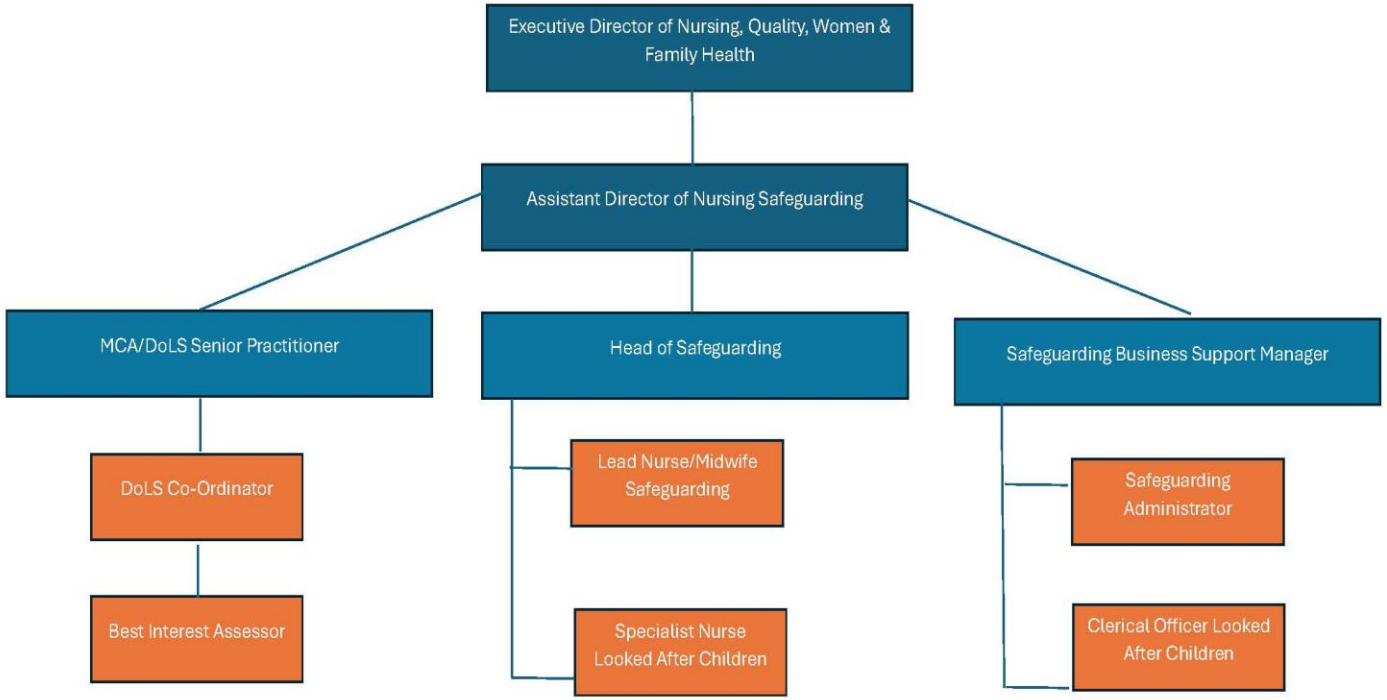
Powys Teaching Health Board Safeguarding Team Structure

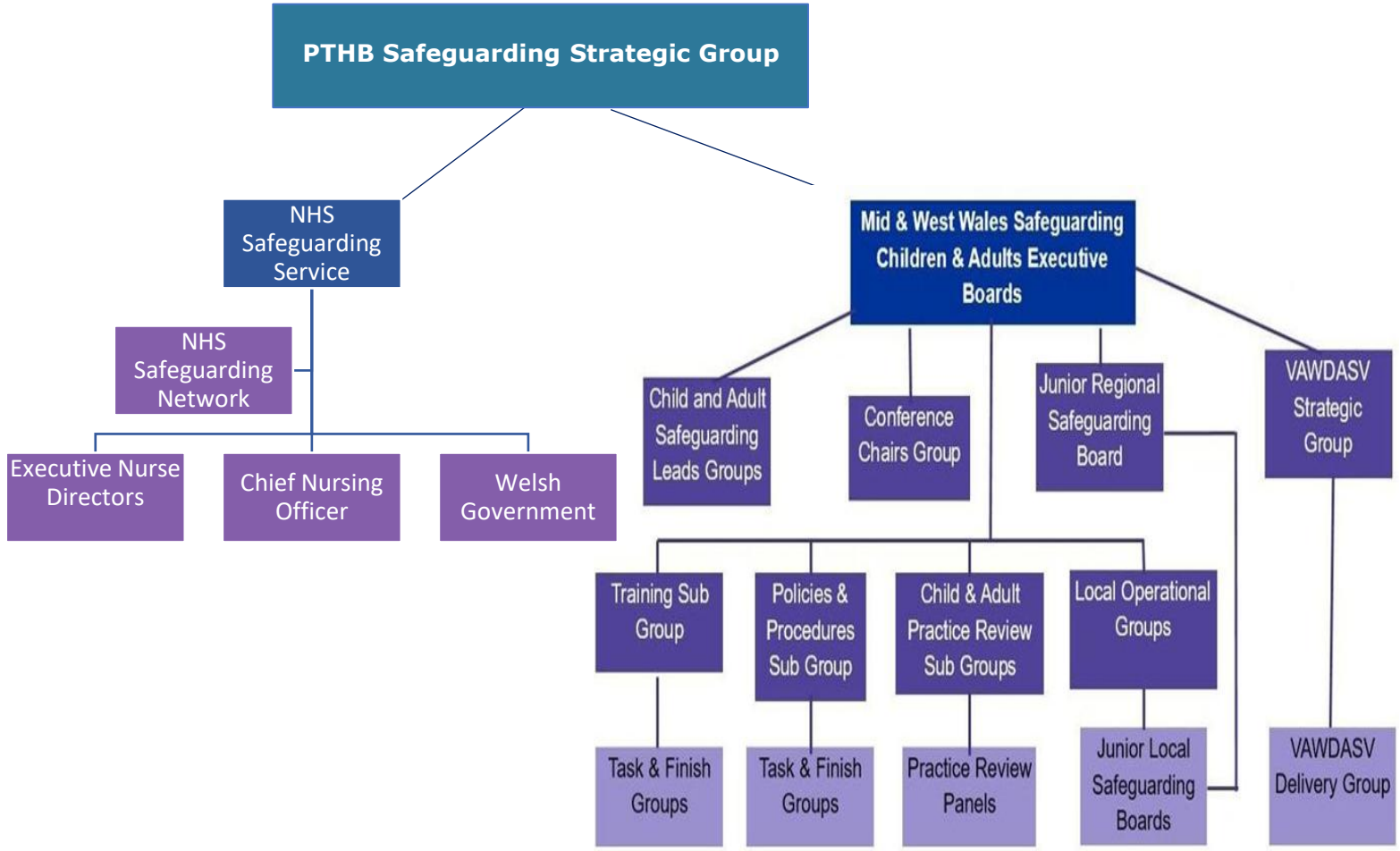


Powys Teaching Health Board Safeguarding Strategic Group

The Safeguarding Strategic Group continued to meet quarterly throughout 2025-2026.

The 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

The Safeguarding Strategic Group is chaired by the Executive Director of Nursing, Quality, Women and Family Health and attended by Heads of Services from across PTHB, the group also has in attendance a designated member of NHS Wales National Safeguarding Service



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Safeguarding Legislation and Strategic Drivers

Safeguarding legislation is designed to ensure that individuals are **protected from harm and abuse**, while promoting their safety and wellbeing. It underpins a rights-based approach to care and support, with a strong emphasis on preventing future harm. Furthermore, it establishes the **legal framework** for appropriate intervention and clearly defines **accountability,** ensuring that **organisations take responsibility** for both the prevention of harm and the effective management of safeguarding concerns.

- Children Act 1989 & 2004
- United Nations Convention on the Rights of the Child UNCRC
- Wales Safeguarding Procedures 2019
- Working Together to Safeguard Children 2018
- Protecting Children & Young People, GMC 2012
- Safeguarding Children & Young People Intercollegiate Document: Roles & Responsibilities for Health Care Staff 2025
- Adult Safeguarding: Roles and Competencies for Health Care Staff 2024
- Social Services & Well-being (Wales) Act 2014
- The Well Being of Future Generations (Wales) Act 2015
- PREVENT Duty 2023
- FGM Act 2003
- Domestic Abuse Act 2021
- WG National Strategy on VAWDASV 2022-26
- Disclosure & Barring Service Code of Practice
- Modern Slavery Act 2025
- Violence Against Women Domestic Abuse & Sexual Violence Act 201talHealth Act 2007
- Duty of Quality 2023
- Human Rights Act 1998
- Mental Health Act 2007 /2025
- Counter Terrorism and Security Act 2015
- Children Wales Act 2020
- Mental Capacity Act 2005
- Deprivation of Liberty Safeguards 2009
- Serious Violence Duty 2022
- PRUDiC 2023

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Powys Teaching Health Board Policies, Guidance and Standard Operating Procedures align with the legislative frameworks which support safeguarding processes across the Health Board

PTHB Safeguarding Policies and Guidance

Safeguarding Quality Assurance: **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 Reviews final report was received in January 2025

Background: With the establishment of the NHS Executive (now P&I) and the enactment of the Health Social Care (Quality and Engagement) (Wales) Act 2020, it was considered 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 Review acknowledged 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. 4 Actions were accepted by WG. NHS Wales P&I was given the mandate to progress the recommendations. A Steering Group was established in May 2025 to take forward the **recommendations;**

Safeguarding Quality & Safety/Learning Framework:
Establish a robust system for continuous learning and improvement in safeguarding arrangements in health

Safeguarding Quality, Assurance & Accountability Framework:
Ensure that safeguarding practices are effectively implemented, 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 into National Assurance arrangements

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.

NHS Wales Safeguarding Framework

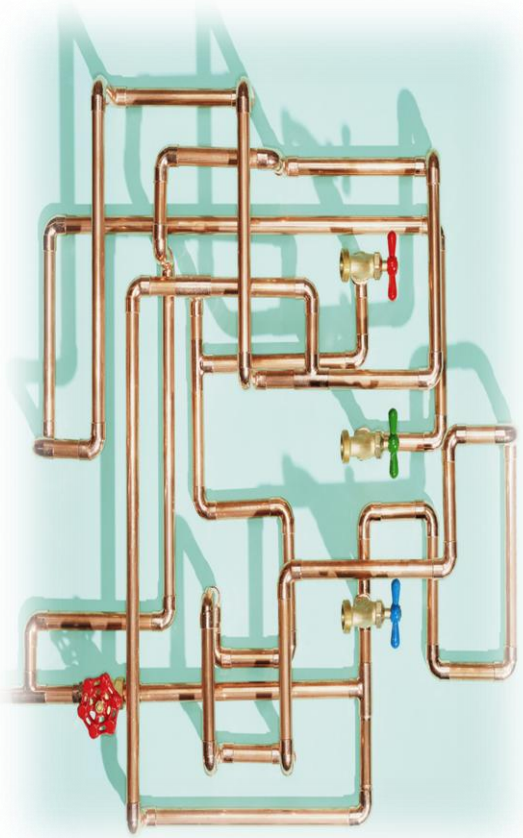
To progress the recommendations from the Strengthening Safeguarding in Health Review, a National Safeguarding in Health Delivery Group was established. PTHB Safeguarding Team represented the Health Board at the delivery group & workstreams throughout 2025-2026.
During March 2026, the final draft of the **NHS Wales Safeguarding Framework (2026)** was delivered to the CNO for final ratification. The Framework is expected to be launched during early/mid 2026-2027

Year 1 has delivered a significant step forward through the development of a consolidated NHS Wales Safeguarding Framework, bringing together assurance, learning, quality and intelligence into a single, coherent national approach. This addresses previous fragmentation and establishes clearer lines of accountability and visibility from frontline practice through to Board level. The outputs from year 1, focusing on the NHS Wales Safeguarding Framework addresses 8 original recommendations of the Strengthening Safeguarding in Health review.

Year 2 represents a critical shift from development to implementation and demonstrable assurance in practice. The focus will be on embedding the Framework consistently across NHS Wales and ensuring that safeguarding intelligence is actively used to inform decision-making, prioritisation, escalation and improvement.

Four priority areas are proposed for Year 2:

- Implementation of the Safeguarding Framework as the central vehicle for strengthening safeguarding governance and assurance
- Digital enablement to support consistent data capture, triangulation and system-wide visibility without increasing reporting burden
- Strengthening safeguarding in Primary Care, with clearer expectations, improved oversight and a stronger role for clusters in coordinating local intelligence and response
- Embedding Equity, Diversity and Inclusion (EDI) as a core safeguarding assurance domain, improving visibility of inequalities and strengthening consistency of approach



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Safeguarding Quality Assurance: PTHB Safeguarding Management Application

The implementation of the Safeguarding Management App in 2024-2025 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

The App continues to evolve with increased data, audit functionality and automation of functions within Safeguarding, Looked After Children and MCA DoLS. Continued monitoring and refinement will ensure that these measures remain effective and can be further enhanced to meet our evolving organisational needs.

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:

- **Increased Capacity:** With less time spent on manual processes, the team can allocate more resources to complex or high-priority work.
- **Improved Accuracy:** Automation reduces the likelihood of errors, enhancing the quality and reliability of outputs.
- **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.

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Inspections and Audits: Multi Agency Audit of Initial Child Protection Conferences across Mid & West Wales

A multi-agency audit of initial child protection conferences was undertaken to review compliance with statutory safeguarding standards, assess the extent of engagement with children and families, and highlight opportunities to strengthen safeguarding practice across Mid and West Wales.

Audit Purpose

- Review practitioner engagement and participation
- Review process and compliance with statutory procedures
- Review the quality of information provided to case conference
- Review the decisions, actions and outcomes of case conference

Outcome

The audit provided positive results for both PTHB and PCC. It was noted returning Case Conferences to face to face meetings was enabling improved engagement. Most conferences reviewed within the audit complied with statutory meeting timeframes. Gaps were identified in the quality of information received from GPs and Police.

Recommendations

- Explore ways to strengthen primary care engagement in the child protection (CP) process, including the timely provision of reports for conferences.
- Promote the practice of health professionals sharing reports with families in advance of conferences, with a clear rationale documented where this is not achievable.
- Identify approaches to reinforce health professionals' understanding of the importance of their contribution to child protection plans, ensuring reports are comprehensive and robust.

All recommendations have been taken forward via the Health Boards Safeguarding Practice Improvement Group

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Inspections and Audits: **Multi-Agency Strategy Discussions Audit**

This audit undertook a reflective review of five randomly selected multi-agency strategy discussions, focusing on statutory compliance, the quality of recording, the effectiveness of multi-agency engagement, and the safeguarding outcomes achieved. The audit was conducted through structured reflective sessions, using a standardised tool to assess each case against statutory requirements and best practice expectations. Evidence was drawn from official minutes, agency records, and the professional reflections of those involved in the discussions.

Key Findings: The audit found that strategy discussions were generally effective in safeguarding children and managing risk:

- Immediate safeguarding actions were implemented in all five cases, resulting in improved safety for children.
- Most discussions were convened within statutory timescales (4 out of 5 cases).
- Multi-agency collaboration was generally strong, with good information sharing and contingency planning.
- Children were seen by professionals in every case and risk assessments informed decision-making.
- Minutes were usually produced and circulated promptly

However, several recurring areas for improvement were identified:

- Inconsistent inclusion of health and education safeguarding hubs.
- Variable quality of recording and minute-taking.
- Actions often lacked clear ownership, timescales, and measurable outcomes.
- Professional challenge and rationale for decisions were not always documented.
- Weaknesses in cross-border communication and feedback arrangements.
- Contextual safeguarding risks were not consistently explored or recorded

Recommendations include;

- **Improve Recording Standards**
- **Strengthen Action Planning**
- **Enhance Multi-Agency Participation**
- **Improve Cross-Border Working**
- **Strengthen Contextual Safeguarding**
- **Monitor Timeliness and Compliance**
- **Training and Quality Assurance**

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Overall Conclusion: The audit provides assurance that children were safeguarded effectively and that multi-agency partners responded appropriately to risk. The main improvement requirements relate to documentation quality, consistency of agency involvement, SMART action planning, and strengthened governance arrangements.

All recommendations have been taken forward via the Powys Local Operational Safeguarding Group

Inspections and Audits: NWSSP follow up NHS Internal Audit of MCA DoLS

In January 2025 PTHB received the NHS Wales Internal Audit of MCA DoLS which gave overall limited assurance. The audit recommended three high and three medium priority actions. In January 2026, a follow up audit to review the status of the recommendations concluded all actions were implemented. While it is pleasing the audit confirmed the progress made, work will continue to consolidate and build up the improvements already achieved.

Priority Actions included:

- 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. The audit along with a previous MCA DoLS gap analysis undertaken in 2024, supported the development of a business case to develop a Supervisory Body. The business case was approved in May 2025 enabling the improvement work to commence in June 2026.

Key Improvements Achieved:

- Appointment of DoLS Lead and additional Best Interest Assessor (BIA) resources stabilised workforce capacity.
- Improvement priorities focused on Supervisory Body Assurance and with the workforce in place this has moved forward including implementation of streamlined and robust processes, accurate data, and reliable reporting to enable effective scrutiny and quality assurance embedded into application and the sign-off process.
- Strengthened joint working with Local Authority for DoLS Administration including streamlining of processes, reduce duplication, strengthen compliance and development of a Service Level Agreement.
- Updated PTHB DoLS guidance published, with further review aligned to Supervisory Body SOPs and the PTHB Managing Authority process flow.
- Development of BIA Supervision and peer reflective practice.

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Inspections and Audits: PTHB Audit of a Childs Lived Experience.

A PTHB audit was undertaken in response to the Care Inspectorate Wales (CIW) Rapid Review of Child Protection Arrangements in Wales (2024). The CIW review identified variation in practice across Wales regarding the extent to which a Childs lived experiences are considered when making decisions about their safety. It also highlighted that children's rights to participate in childcare and protection assessments and interventions require further strengthening, to ensure they aligned with the Wales Safeguarding Procedures.

Audit Purpose

- Provide assurance that children are seen and seen alone to provide them with the opportunity to share their views
- Practitioners explore what daily life is like for a child.
- Children's voices, wishes and feelings are appropriately shared by Health professionals.
- Consider the individual voice of a child when they were part of a large sibling group.

Outcome

Overall, this review demonstrated good practice. PTHB staff take the opportunity to speak to children alone when appropriate, capture their voice whenever possible and document the information in their records**.**

Recommendations

- Consider how to improve engagement from children looked after via the CIVICA survey
- Consider how to capture the voice of younger children
- Consider how to capture the voice of children using virtual appointments

All recommendations have been taken forward via the Health Boards Safeguarding Practice Improvement Group

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Inspections and Audits: **PTHB Audit of Was not Brought compliance**

Purpose; to provide assurance regarding the implementation and monitoring of the Powys Teaching Health Board (PTHB) *Policy for Children, Vulnerable Adults and Adults at Risk Who Were Not Brought to Health Appointments*
Policy for Children & Vulnerable Adults & Adults at Risk, who "Was Not Brought" to health appointments

Background: The WNB Policy, previously referred to as the Did Not Attend (DNA) Policy and incorporating No Access Visits (NAV), has been in place since 2013. A substantial revision and relaunch in November 2021 strengthened safeguarding accountability by:

- Clarifying that responsibility for action following a missed appointment rests with the practitioner whose appointment was missed.
- Introducing a risk assessment process to support staff in determining the potential impact of a missed appointment on a child, vulnerable adult, or adult at risk.
- Reinforcing safeguarding responsibilities and documentation requirements through the accompanying Significant Events Chronology Standard Operating Procedure (SOP).

The policy requires Heads of Service and Operational Managers to undertake regular audits of WNB and No Access Visits and provide assurance that monitoring processes are in place and effective.

Audit Approach: Service leads were asked to provide evidence of local audit processes, demonstrate compliance with the WNB Policy, and identify any learning, themes, or improvement actions arising from their findings.

Key Findings: *Children's Services – Positive Progress with Areas for Improvement*

The audit provides **assurance that the WNB Policy is embedded within Children's Services**. Fourteen of eighteen service areas reported undertaking WNB audits and provided evidence of compliance monitoring and associated quality improvement activity.

Importantly, application of the WNB process directly contributed to the identification of five children at potential safeguarding risk, resulting in safeguarding report of an MDT. This demonstrates the value of the policy as a mechanism for identifying children who may be vulnerable to neglect or unmet health needs.

However, the audit highlighted variability in compliance and recording practices. Some services identified gaps in practitioner recognition of WNB episodes, incomplete documentation, failures to notify GPs or referrers, and instances where children were discharged following missed appointments without appropriate follow-up. Services that undertook enhanced reviews of DNA records identified additional safeguarding concerns that may otherwise have been missed

Key Findings: *Adult Services – Lack of responses impacted the audit, demonstrating the need for improvement*

Of 22 services invited, only five responded, and only one service reported undertaking WNB audits. Four responding services confirmed that no formal WNB audit activity was taking place.

Low engagement and limited audit activity mean there is currently insufficient data to audit that vulnerable adults and adults at risk are consistently managed in line with the policy.
Responses also suggested that some services do not recognise the relevance of the WNB Policy within their area of practice, indicating a need for greater awareness and understanding of safeguarding responsibilities for adults who may be dependent on others to access healthcare.

Overall Conclusion

The audit demonstrates that the WNB policy is largely embedded within Children's Services, with evidence of positive safeguarding outcomes. However, further work is required to improve the consistency of WNB identification and recording. Assurance within Adult Services remains limited due to low audit participation and inconsistent application of the policy.

Key Actions

- Strengthen assurance processes to identify appointments that should have been recorded as WNB.
- Introduce an annual deep-dive audit to test the accuracy of WNB recording and compliance.
- Engage non-responding services to provide assurance and improve compliance.
- Share learning through safeguarding governance structures and professional forums.
- Review implementation arrangements across Adult Services to ensure consistent application of the policy for vulnerable adults and adults at risk.
- Increase staff awareness and training, particularly within Adult Services.

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North Wales Child Practice Review: 'Our Bravery Brought Justice' (Published November 2025)

The Child Practice Review, *'Our Bravery Brought Justice'* was undertaken by the North Wales Safeguarding Board following the conviction of former headteacher, Neil Foden, for sexual offences against children.
In November 2025 following the reviews publication, the Cabinet Secretary for Education wrote to all Health Boards in Wales to request a review of the learning and provide written assurance back to WG along with any actions identified.

Due to the courage and bravery of the children who spoke out to the police, Foden was found guilty following a criminal trial and sentenced to 17 years in prison. The Child Practice Review timeline spanned 6 years and identified over **50** missed opportunities or red flags for professionals to intervene and stop Foden.

The review set out 27 recommendations across 6 learning themes:

- The Voice of the Child
- The Management of Allegations and Concerns about Adults Working with Children – Multi-Agency Response
- The Need for Training: Thinking the 'Unthinkable' and Understanding 'It Could Happen Here'
- The Governance of Schools in Wales
- Restricted practice and use of force
- Recommendations for Safeguarding Partners

Specific learning for points for Health Boards focused on;

- Consideration of the sharing of anonymised CAMHS data with Local Authorities to identify hotspots and thematic concerns
- Health professionals should seek safeguarding advice when a child presents at an appointment accompanied by a third party without parental consent

The learning from the review was developed into a PTHB Action Plan which included:

Developing of a Briefing too share across services within PTHB, Primary Care and with English Health Boards which boarder PTHB

PTHB Safeguarding Team to discuss the briefing at all service group team meetings in the next 6-month cycle

Review and Update PTHB Safeguarding Policy and Training Packs

Update learning page on PTHB Safeguarding Intranet page

All Actions are completed

The Mid & West Wales Safeguarding Board have also developed a **Regional Action Plan**

CIW plan to undertake a **Multi-agency Persons in a Position of Trust Audit** in autumn/winter of 2026

Key Messages from the Practice Review: 'Our Bravery Brought Justice'

The key message for health professionals from the review

The Child Practice Review highlights the inappropriateness of professionals accompanying children and young people to health appointments without the knowledge of, or permission from their parent or the person who has parental responsibility for them.

In March 2019, Foden accompanied one of his victims to a General Practitioner appointment without the knowledge or permission of the child's parent. Later that same month, he also accompanied the same victim to the Sexual Assault Referral Centre (SARC).

On 4 April 2019, Foden took the child to a hospital gynaecological appointment, again without parental knowledge, and in May 2019, he accompanied her to a second gynaecological appointment, with the medical outcome letter sent to Foden at the school address.

These events underline the importance of ensuring that children are not accompanied to health appointments by professionals without parental consent, and that any such occurrence should trigger immediate safeguarding consideration.

It is crucial that health professionals are clear in their statutory responsibility under the Social Services and Well-being (Wales) Act 2014 to safeguard and promote the welfare of children.

This includes recognising, reporting and sharing concerns about persons who work in a position of trust. There were in total over 50 missed opportunities to intervene and stop Foden's abuse of children. Health Practitioners must familiarise themselves with the process to take/who to speak with if they have concerns about a person working with children and/or vulnerable adults.

Safeguarding advice and supervision can be accessed via PTHB Safeguarding Hub:

Telephone: 01686 252806

Email: PowysTHB.safeguarding@wales.nhs.uk

Consistent themes from this and other Safeguarding Practice Reviews in Wales tell us that practitioners should speak to each other, speak to children, share information, be professionally curious and think the unthinkable.

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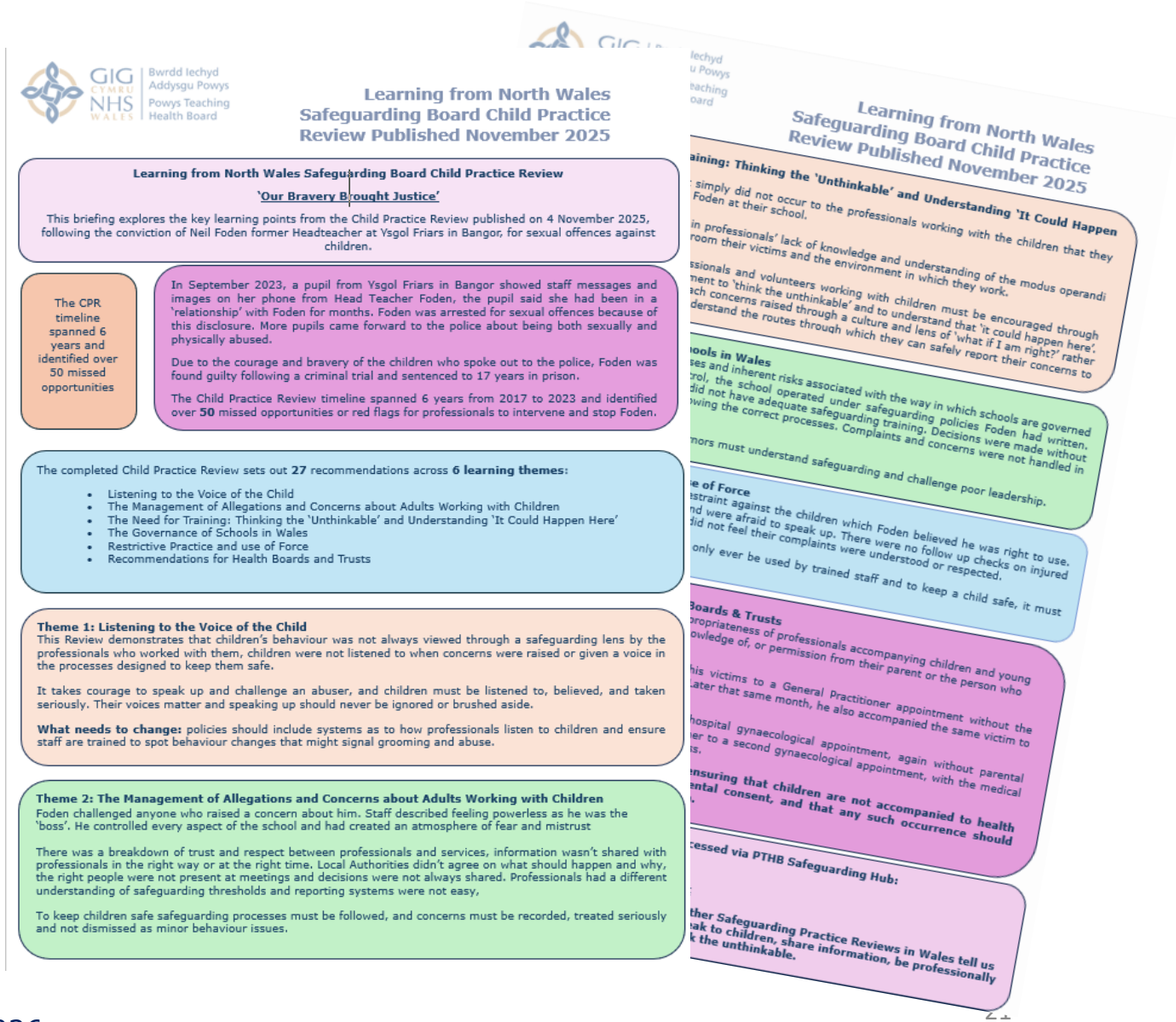

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Learning from North Wales Safeguarding Board Child Practice Review Published November 2025

Learning from North Wales Safeguarding Board Child Practice Review

'Our Bravery Brought Justice'

This briefing explores the key learning points from the Child Practice Review published on 4 November 2025, following the conviction of Neil Foden former Headteacher at Ysgol Friars in Bangor, for sexual offences against children.

The CPR timeline spanned 6 years and identified over 50 missed opportunities

In September 2023, a pupil from Ysgol Friars in Bangor showed staff messages and images on her phone from Head Teacher Foden, the pupil said she had been in a 'relationship' with Foden for months. Foden was arrested for sexual offences because of this disclosure. More pupils came forward to the police about being both sexually and physically abused.

Due to the courage and bravery of the children who spoke out to the police, Foden was found guilty following a criminal trial and sentenced to 17 years in prison.

The Child Practice Review timeline spanned 6 years from 2017 to 2023 and identified over **50** missed opportunities or red flags for professionals to intervene and stop Foden.

The completed Child Practice Review sets out **27** recommendations across **6 learning themes**:

- Listening to the Voice of the Child
- The Management of Allegations and Concerns about Adults Working with Children
- The Need for Training: Thinking the 'Unthinkable' and Understanding 'It Could Happen Here'
- The Governance of Schools in Wales
- Restrictive Practice and use of Force
- Recommendations for Health Boards and Trusts

Theme 1: Listening to the Voice of the Child
This Review demonstrates that children's behaviour was not always viewed through a safeguarding lens by the professionals who worked with them, children were not listened to when concerns were raised or given a voice in the processes designed to keep them safe.

It takes courage to speak up and challenge an abuser, and children must be listened to, believed, and taken seriously. Their voices matter and speaking up should never be ignored or brushed aside.

What needs to change: policies should include systems as to how professionals listen to children and ensure staff are trained to spot behaviour changes that might signal grooming and abuse.

Theme 2: The Management of Allegations and Concerns about Adults Working with Children
Foden challenged anyone who raised a concern about him. Staff described feeling powerless as he was the 'boss'. He controlled every aspect of the school and had created an atmosphere of fear and mistrust

There was a breakdown of trust and respect between professionals and services, information wasn't shared with professionals in the right way or at the right time. Local Authorities didn't agree on what should happen and why, the right people were not present at meetings and decisions were not always shared. Professionals had a different understanding of safeguarding thresholds and reporting systems were not easy,

To keep children safe safeguarding processes must be followed, and concerns must be recorded, treated seriously and not dismissed as minor behaviour issues.

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

Safeguarding Training and Development

Safeguarding Processes

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Safeguarding Supervision, Advice & Support

Safeguarding concerns involving a child or adult are rarely straightforward and often require professionals to assess complex, incomplete, and sometimes conflicting information. Managing risk and uncertainty demands not only practical skills and reflective practice but also the ability to navigate the emotional challenges associated with safeguarding work.
Effective safeguarding supervision and support are fundamental to delivering high-quality services that are safe, effective, person-centred, timely, efficient, and equitable, while fostering a culture of continuous learning. Staff should feel confident in raising concerns and be supported in fulfilling their safeguarding responsibilities. Robust safeguarding supervision promotes high standards of practice, enhances professional competence and confidence, and provides a constructive environment in which practitioners can reflect on and challenge practice appropriately.

The Intercollegiate Document for Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff 2025 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 appropriate to their 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;

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

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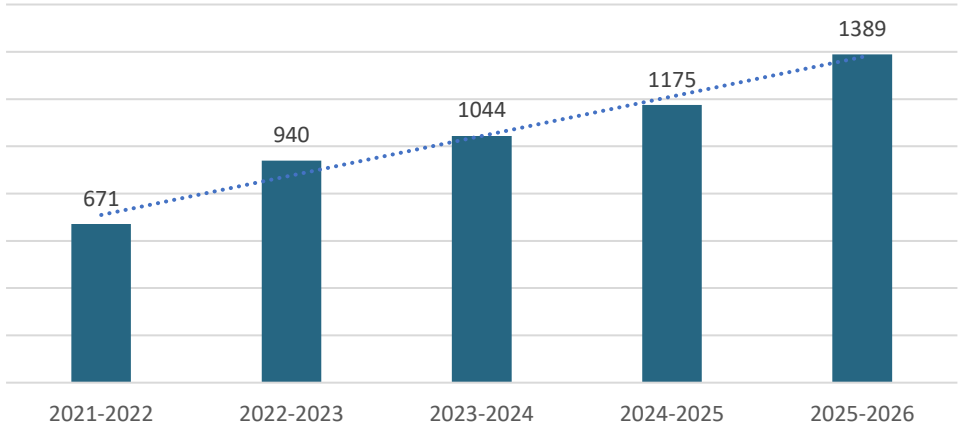
Safeguarding Supervision, Advice & Support: **Safeguarding HUB**

PTHB Safeguarding Hub is available to give supervision, advice, support and guidance Monday to Friday 9am to 5pm.
During 2025-26, **1,389** calls were received into the Safeguarding HUB, this is around a **107% increase** since the HUB was introduced in 2021.
The success of the HUB has grown year and has become firmly embedded within the Health Board

Calls to PTHB Safeguarding Hub



The increase in calls to the HUB reflects its growing prominence, accessibility, and the confidence staff have in the service.
Calls were received from staff across all services, with the highest volumes originating from Mental Health, CAMHS, and Health Visiting teams.
The most common call themes included: Domestic Abuse, Was Not Brought, Neglect and Self-Neglect

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Team feedback generally collection via our QR code:

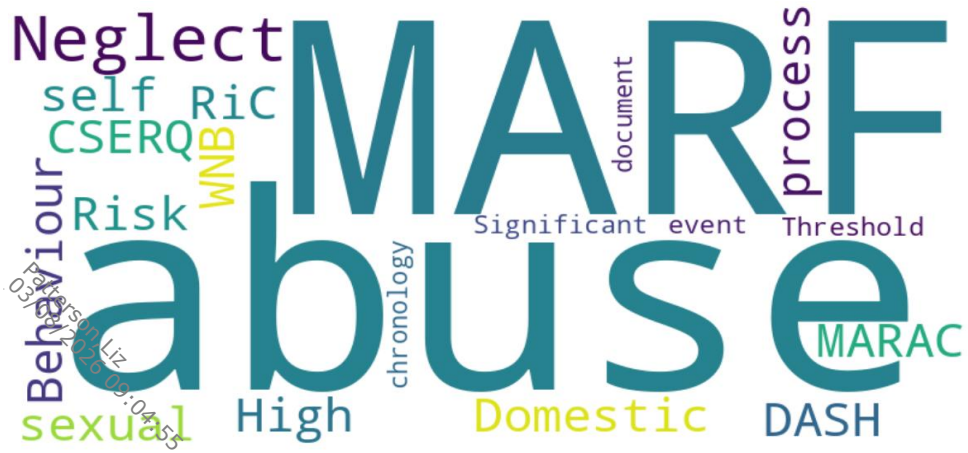
- Feedback is **overwhelmingly positive**
- The service is viewed as **responsive, supportive, and highly reliable**
- Improvements suggested are **minor and focused on enhancement**, not performance issues
- The Safeguarding Hub is clearly valued as a **trusted and essential support service**

Safeguarding Supervision, Advice & Support: **Safeguarding Supervision**

PTHB Safeguarding Hub is available to give supervision, advice, support and guidance Monday to Friday 9am to 5pm.
During 2025-26, **1,389** calls were received into the Safeguarding HUB, this is around a **107% increase** since the HUB was introduced in 2021.
The success of the HUB has grown year and has become firmly embedded within the Health Board

Safeguarding Practitioners delivered **48** Safeguarding Group Supervision sessions to **267** practitioners & attended **23** team meetings during 2025-26

Themes raised and discussed include;



An audit of 1:1 supervision reviewed; following a 1:1 supervision session practitioners:

- Added to significant event chronology
- Updated the Case note
- Document uploaded to WCCIS.
- Actions documented and completed

Summary of Findings

Staff are appropriately requesting 1:1 safeguarding supervision through the Hub. Supervision sessions are being documented, and the majority of staff are completing the agreed actions, which is a positive finding. Most staff are also attaching the completed supervision documentation to the patient's record. However, there are areas requiring improvement. Staff are not consistently recording a separate case note to confirm when agreed actions have been completed. In addition, safeguarding supervision is not routinely being recorded as a significant event in line with expected processes.
Improvements are being progressed through the appropriate channels.

Safeguarding Supervision, Advice & Support: Multi Agency Supervision

In March 2025 PTHB Safeguarding Team, Powys County Council Children Services and Education colleagues launched the new Multi Agency Supervision process. Partners worked together to design and develop a process to enable facilitated multi agency supervision sessions with practitioners who are working with children at risk of harm and on Powys Children Services Child Protection Register

Purpose of Multi-Agency Supervision

This guidance provides a framework for reflective practice using the Multi-Agency Supervision model.

Its purpose is to promote collaborative reflection across agencies, strengthen professional relationships, improve the effectiveness of plans, and achieve better outcomes for children.

The process provides practitioners with dedicated time and space to review a case, evaluate the current plan, and consider alternative approaches that may help progress outcomes. This includes identifying strengths, exploring barriers, and ensuring risks are recognised and addressed.

Multi-Agency Supervision is available only where cases meet the agreed criteria. It supports professional decision-making and strengthens collaborative working with children and families to address identified needs and risks.

Sessions are facilitated by lead practitioners from Children's Services, Powys Teaching Health Board (PTHB), and Education.

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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

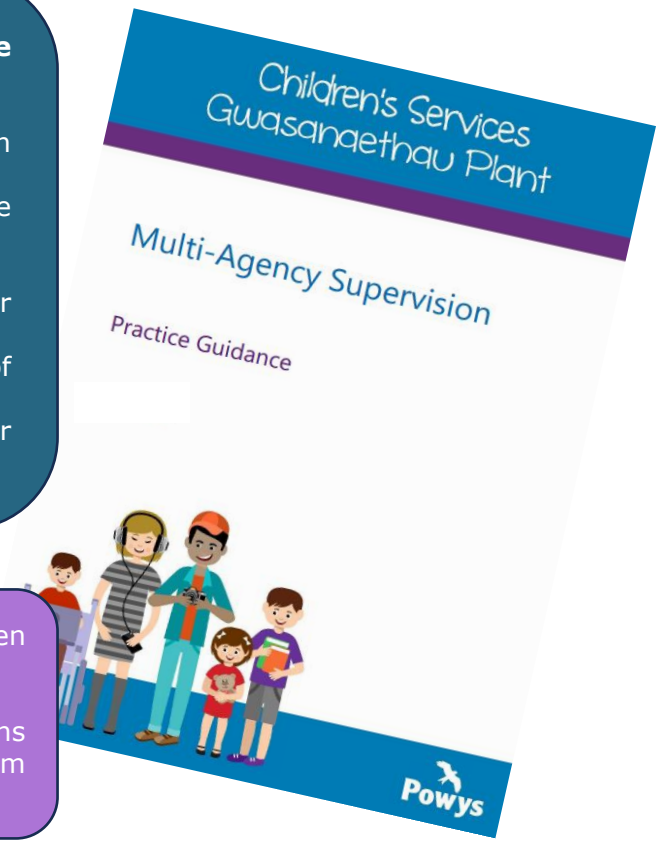
Cases where Child Protection planning is not coming together and practitioners feel 'stuck' as how best to proceed

The child has been subject to an extended period of registration more than 18 months

Cases where there is evidence of disguised compliance or challenges engaging the family.

During 2025-26 the Multi Agency Supervision model has been implemented successfully

PTHB Safeguarding Leads facilitated supervision sessions successfully. The model has received positive feedback from professionals



Safeguarding Training & Development

A skilled and knowledgeable workforce is fundamental to effective safeguarding practice within Powys Teaching Health Board. The Health Board ensures staff are equipped to identify, respond to, and appropriately escalate safeguarding concerns in accordance with local and national requirements. Throughout 2025–2026, the Safeguarding Team delivered training, promoted multi-agency learning opportunities through Training Tuesday, and maintained a comprehensive range of resources on the Safeguarding & Public Protection SharePoint site: **Safeguarding & Public Protection - Home (sharepoint.com)**

Training Delivered & Feedback Themes

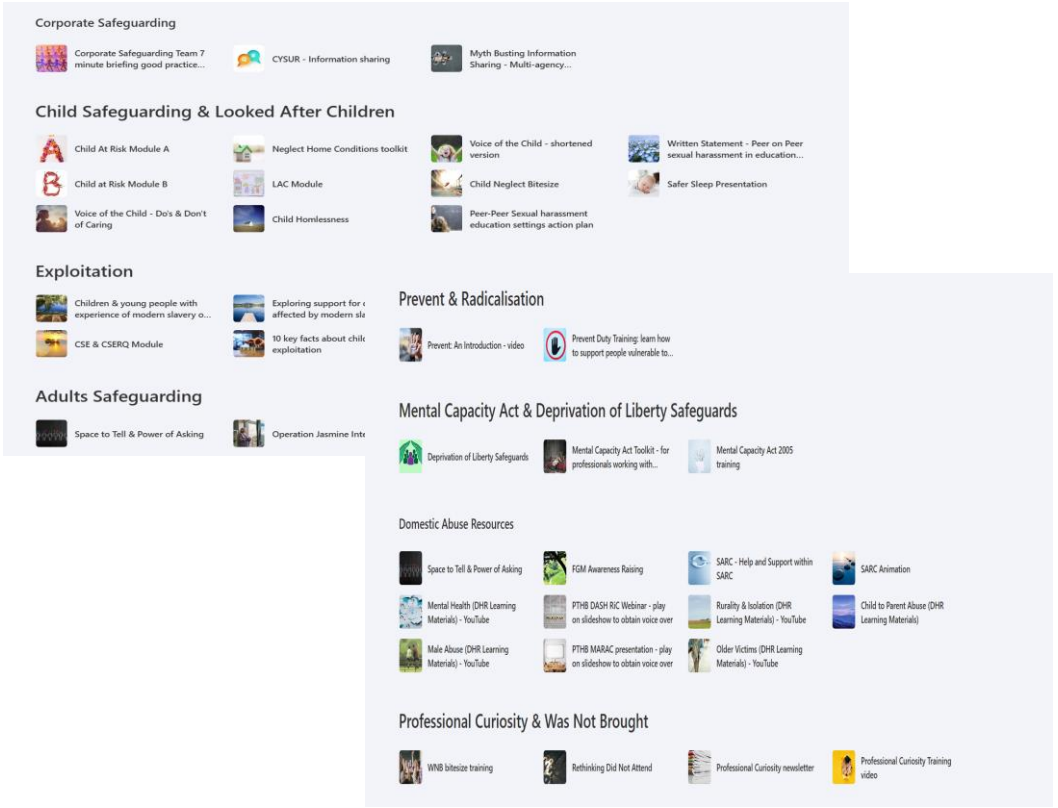
12 Level 3 training to 238 staff

12 Ask & Act training to 487 staff

2 Childhood Injury training to 38 staff

7 Mental Capacity Act Level 3 to 66 staff

The Safeguarding team have introduced an additional learning platform called **Modular Learning Safeguarding & Public Protection - Home (sharepoint.com)**



Safeguarding Training & Development: Safeguarding Training Compliance

Safeguarding training compliance continues to be monitored through Strategic and Operational Safeguarding Groups. Over the past 18 months, significant work has strengthened compliance processes, including reviewing training packages and competency passports, realigning ESR records, and introducing automated reminders and escalation processes for non-compliance.

Compliance remains strong across most mandatory safeguarding and Mental Capacity Act (MCA) training programmes, with Adult and Children's Levels 1 and 2 consistently achieving or exceeding the Health Boards target of 85%.

Progress has been made in Children's Level 3 safeguarding training; however, compliance remains below target at 76%. Adult Level 3 compliance remains the most significant challenge, although performance has improved from 48% to 56% during the year. Factors affecting Levels 3 and 4 compliance include:

- Online delivery competing with clinical service pressures.
- The requirement to complete a competency passport before compliance can be recorded.
- Experiential learning requirements for Level 4 training, which typically take 12–18 months to achieve.

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Heads of Service continue to support improvement through regular compliance monitoring and targeted action to address gaps. Senior managers receive monthly reports identifying staff who remain non-compliant with Adult and Children's Level 3 safeguarding training.

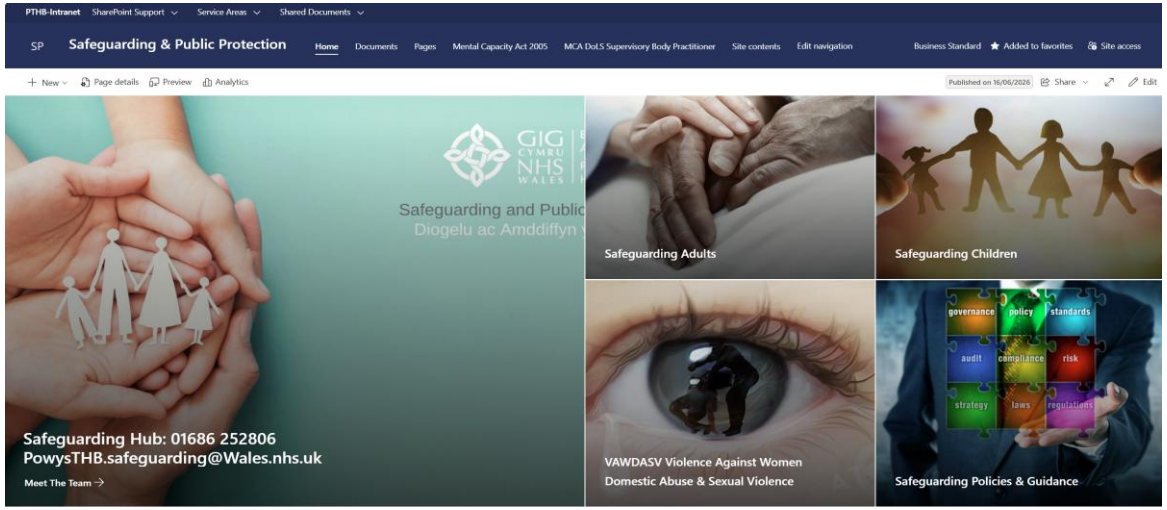
Further measures to support staff and management within service groups, include;

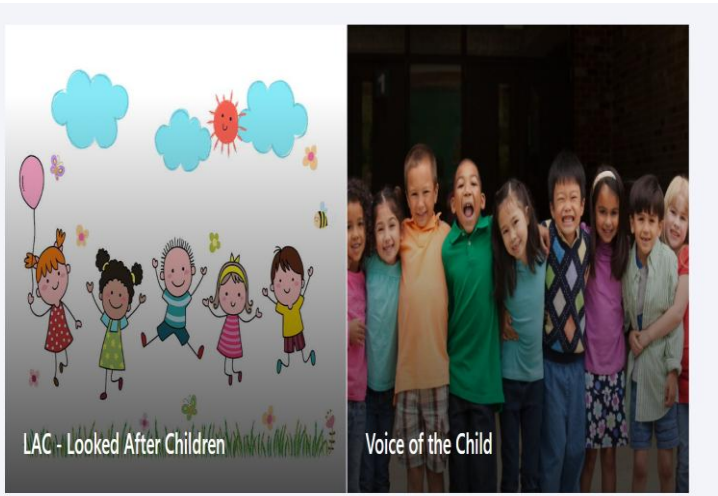
1. **Integration of passports within the safeguarding app:** key passport fields will be auto populated. The passport, training pack and evaluation form, will then be automatically emailed to the staff member.
2. **Automated reminders:** to both the staff member and their supervisor three months before the passport due date.
3. **Strengthen reporting and accountability** from Service Groups into Strategic Safeguarding Group with escalation to Executive Lead

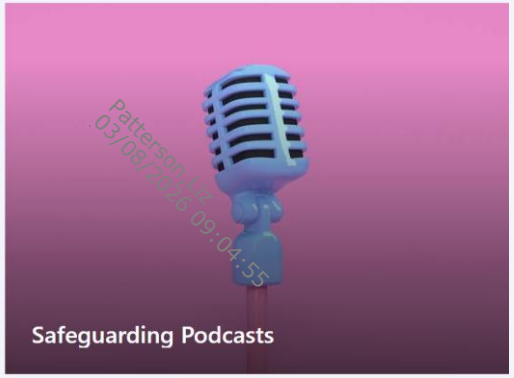
Safeguarding Training Compliance Target 85%	Q1	Q2	Q3	Q4
Adults Level 1	93	92	87	92
Adults Level 2	92	92	93	91
Adults Level 3	49	48	48	56
Children Level 1	93	92	88	92
Children Level 2	92	91	93	90
Children Level 3	76	75	79	76
VAWDASV G1	89	89	88	87
VAWDASV G2	75	74	74	72
MCA 1	93	92	90	94
MCA 2	93	92	92	93

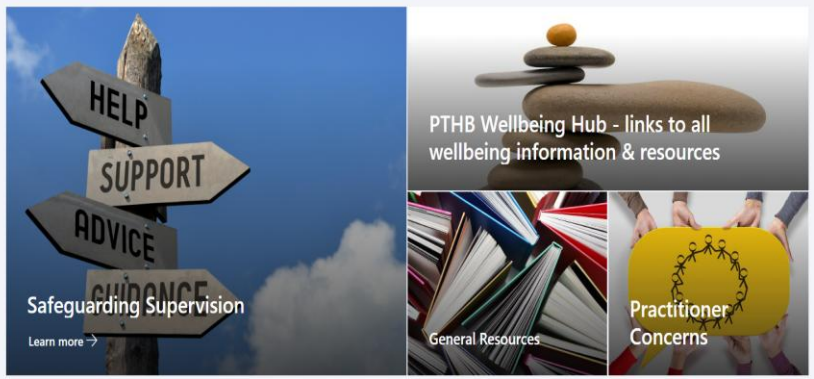
Safeguarding Training & Development: Safeguarding Intranet Pages

The **Safeguarding Intranet** is an internal staff resource that provides information, guidance, policies, and tools to help employees fulfil their safeguarding responsibilities for children, young people, and adults at risk.









Safeguarding Process

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

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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 V6 Review Date August 2028

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. Multi-agency Protocol of Professional Differences

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 has n place a Falls Scrutiny Panel.

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

Person Centred

Within this section;

Safeguarding Children

Child Protection Register

Child Protection Medicals

Child Exploitation

Children Looked After

PRUDiC (Procedural Response to Unexpected Death in Childhood)

Safeguarding Adults

Mental Capacity Act 2005

Deprivation of Liberty Safeguards

Hospital acquired Pressure Ulcers

Inpatient Falls review Huddles

Immediate Rapid Response

Public Protection and Offender Management

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

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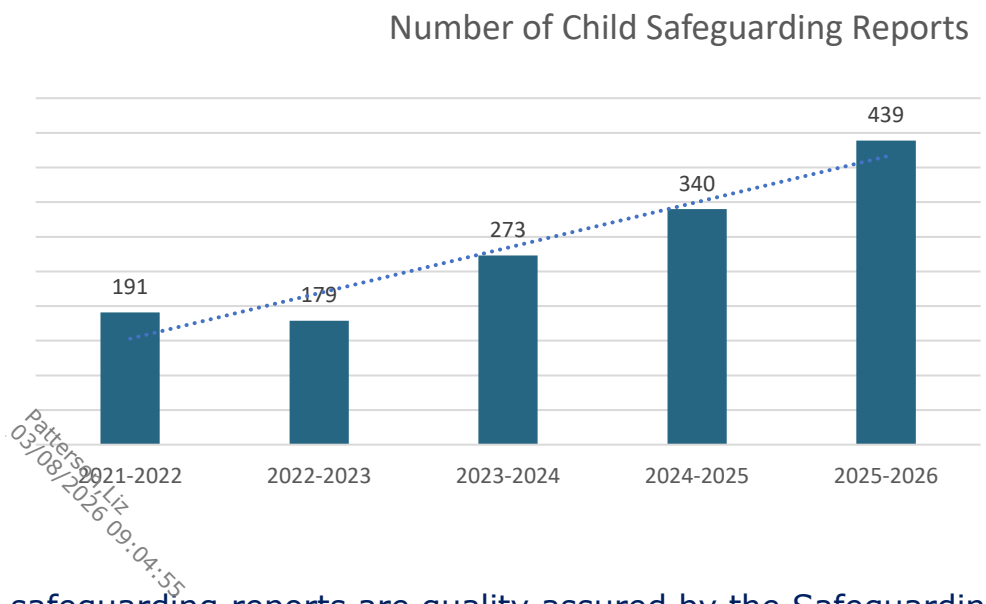
Safeguarding Children

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 .

439 Safeguarding reports were made by PTHB staff in 2025-26. 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

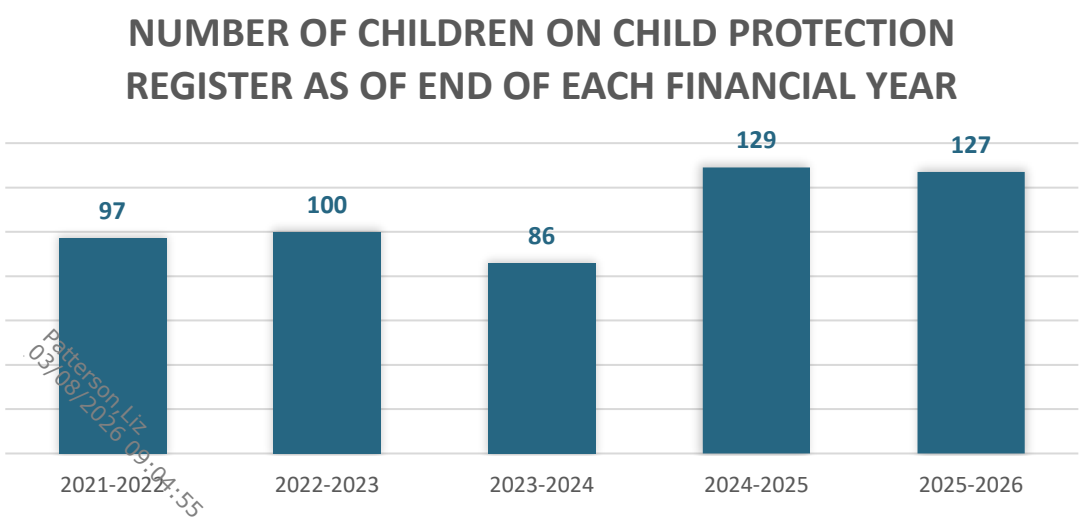
Living a life that is free from harm and abuse is a basic right for every child within Wales

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 127 as of 31.03.26. 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 31.03.26 was Emotional or Psychological Abuse

Child Protection Medicals

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

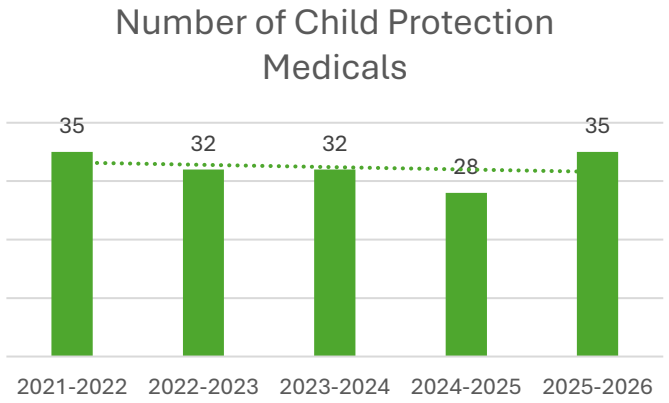
PTHB have a Child Protection Medical Pathway in place and commission medicals dependent on where the child resides and the type of medical required

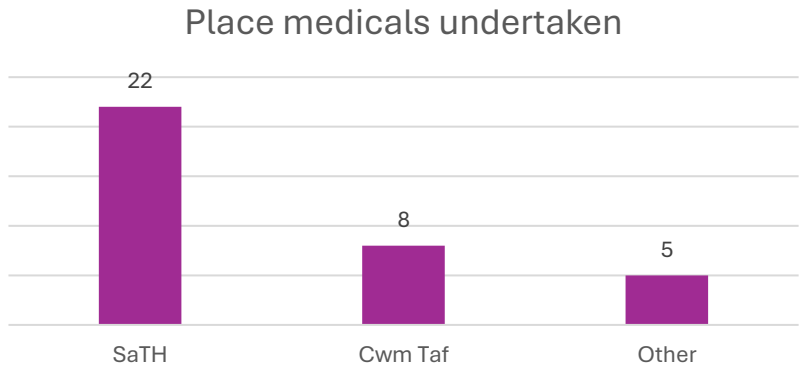
Throughout 2024-2025 there were 28 Child

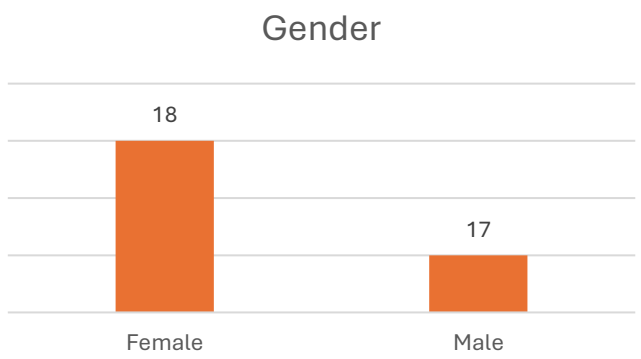
Throughout 2025-26 there were 35 Child Protection Medicals undertaken on Powys Children. This is comparable to the numbers undertaken each year since 2020. 17 were male and 18 female. 18 were under 5 years of age and 17 aged between 5 and 17 years. 27 of the 35 medicals undertaken were due to concerns regarding physical abuse

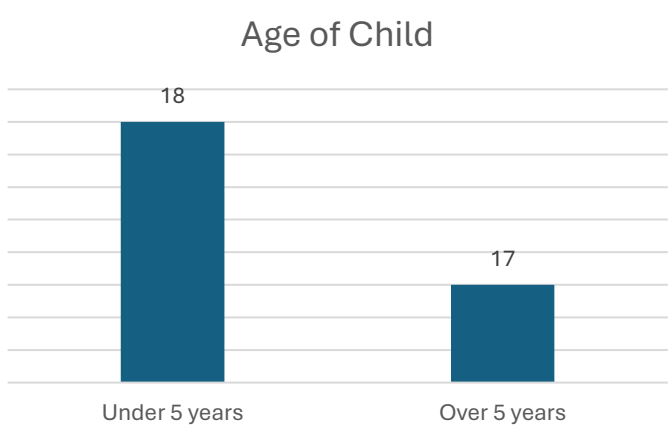
PTHB Named Doctor for Child Protection attends Child Protection Peer Review

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









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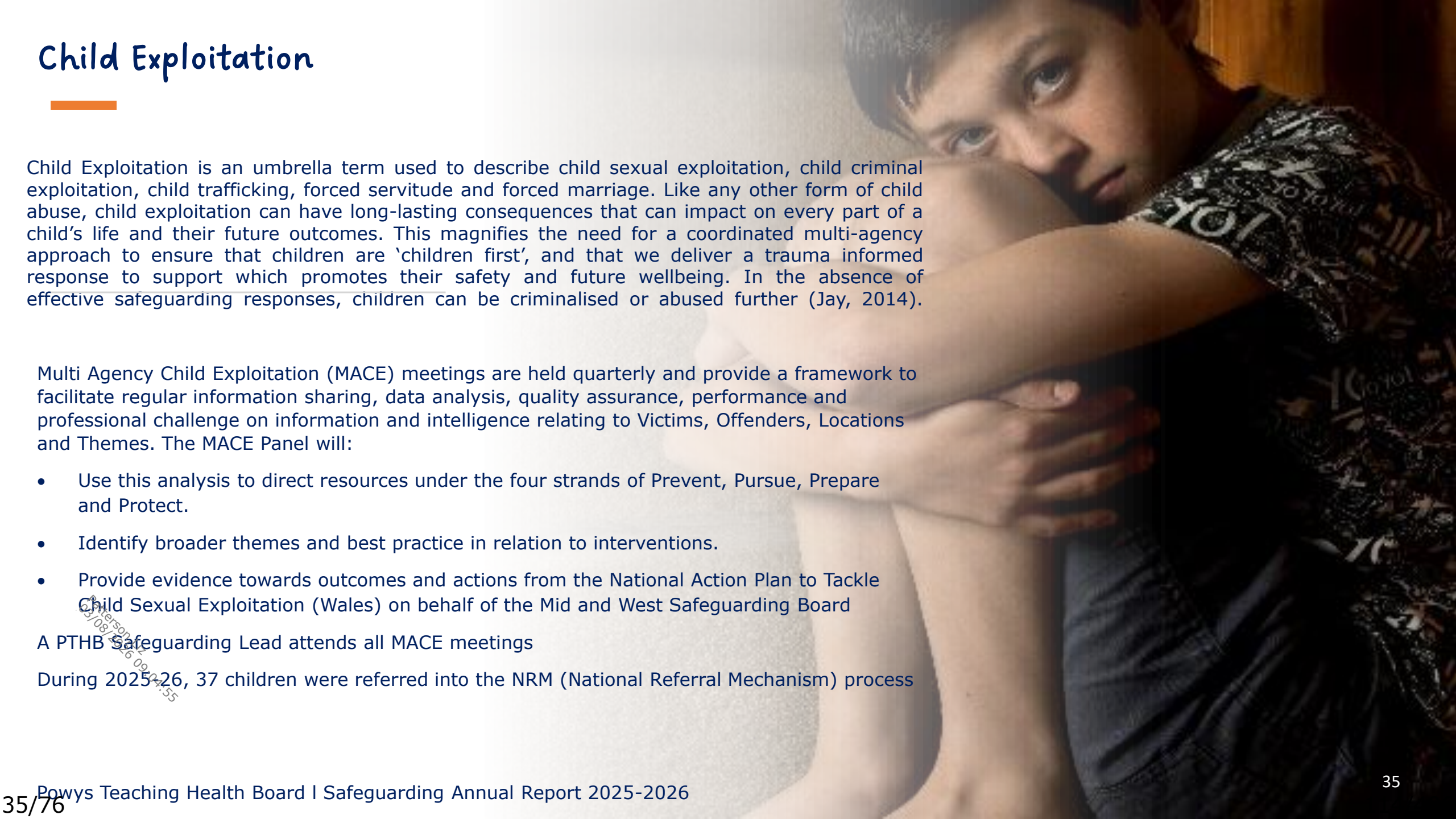
Child Exploitation



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 2025-26, 37 children were referred into the NRM (National Referral Mechanism) process

Powys Teaching Health Board
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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 2025-2026 PTHB Clinical Nurse Specialist for Children Looked After and Health Visitors continued to work flexibly around the needs of children, offering individual advice and support to children, foster carers and professionals. This includes completing a specialist health assessments, attending Children Looked After reviews, pathway planning for 16+children and strategy meetings. The views of the children are captured during their health assessment and help to shape the child's Health Plan

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Children Looked After: **Health Assessment**

The purpose of a Children Looked After (CLA) Health Assessment is to ensure that every child or young person who is looked after by a local authority has their health and wellbeing needs identified, monitored, and addressed through a planned approach.

Key aims are to:

- Identify unmet health needs such as physical, emotional, developmental, mental health, dental, vision, hearing, and lifestyle issues.
- Establish a baseline of health when a child enters care through an Initial Health Assessment.
- Develop a Health Plan that sets out actions, treatments, referrals, and support required to improve the child's health and wellbeing.
- Promote continuity of care by ensuring immunisations, screening, specialist appointments, and routine healthcare are maintained despite changes in placement.
- Support the child's overall wellbeing, recognising that children in care often have experienced trauma, neglect, adversity, or disrupted access to healthcare.
- Contribute to care planning and review processes, ensuring health needs are considered alongside education, safeguarding, and social care needs.

The NHS Wales Health Assessment Framework states that the assessment process aims to provide a consistent, high-quality approach across Wales and improve the quality of health assessments and reports for looked-after children and young people.

In practice, the assessment is not simply a medical check-up; it is a holistic review of the child's health and wellbeing that informs a personalised health plan and helps fulfil the corporate parenting responsibilities of the local authority and health board.

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Children Looked After: **Performance Data**

Children Looked After (CLA) Health Assessments are completed at set intervals:
Initial Health Assessment (IHA): as soon as possible after a child becomes looked after, to establish their health needs and create a health plan. **Review Health Assessments (RHA): Every 6 months** for children under 5 years old. **Annually** for children aged 5 years and over.

309 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.

73% were completed within statutory timescales, delays mainly due to accommodating the needs of the children and Foster carers.

There has been a significant improvement in receiving timely consent for Powys Local Authority

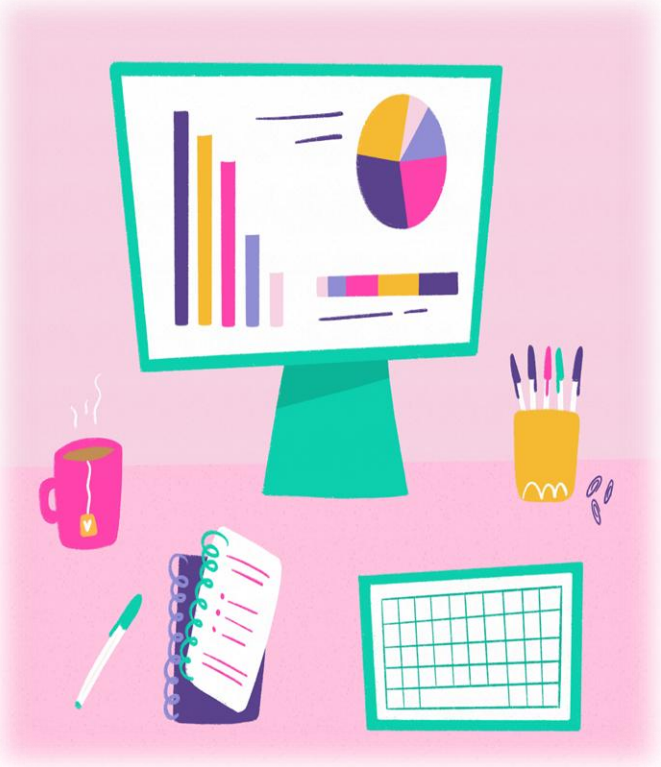
200 Health Assessments were with children from Powys

109 Health Assessments were with children from other Local Authorities placed in Powys

63 were completed by another Health Boards Child Looked After Team

100% of children were registered with a GP prior to the CLA health assessment

24 Unaccompanied Asylum Seeker Children (UASC) are being supported by PTHB CLA Team.



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Children Looked After: New Initiative: Introducing the Care Bag

The Care Bags have been designed and developed by the teams Children Looked After Nurse Specialists. They contain age-appropriate items which are given to every child when they become looked after. This initiative has been shared with the National Safeguarding Service

Transitions into care can be distressing, research consistently highlights the importance of emotional containment and predictable, nurturing responses. The care bags are a small but meaningful intervention, providing a sense of belonging and comfort at a key moment.

From a trauma-informed perspective, offering something personal and chosen with care can help reduce anxiety and support emotional regulation. It also models respectful and compassionate care, reinforcing the message that children are valued.

Overall, the care bags are a positive and worthwhile initiative and highlighted how small gestures can make a significant difference.

Feedback from the children is positive and they especially like the teddies

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Children Looked After: **New Initiative: UASC Sexual Health Leaflet**

The development of the Sexual Health leaflets was prompted by concerns identified when working with Unaccompanied Asylum-Seeking Children (UASCs), many of whom have received little or no Relationships and Sex Education (RSE) or Personal, Social, Health and Economic (PSHE) education prior to arriving in the UK.

As a result, some young people may have a limited understanding of UK laws relating to consent, healthy relationships and appropriate boundaries. Existing resources, such as the "Tea and Consent" video, have also proved difficult to use effectively due to language barriers, reducing the accessibility of standard educational approaches. In addition, incidents involving sexualised behaviours highlighted the need for more accessible and culturally appropriate resources. The leaflets were therefore developed to provide clear, easy-to-understand information that supports young people in developing an awareness of consent, healthy relationships and behavioural expectations within the UK.

The Sexual Health Leaflets provide information on Contraception, Sexually Transmitted Infections, Sex and the Law and Consent

The leaflets are available in English, Welsh, Arabic, Pashto and Turkish

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Sexual Health Leaflet.pdf

Children Looked After: Listening for Change. Launch of the National Feedback Survey

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.

The Survey Launched in April 2025

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

The surveys have been promoted by sharing cards with QR codes, by using I Pads and embedding the codes into the health assessment paperwork.

PTHB have received limited responses and will continue to promote their use. The Feedback received to date has been positive.

Children 11 plus years
the health assessment was 'alright'
LAC nurse is professional and arrives with a smile on her face
Overall good

Foster Carers
All positive
Noted the health assessment to be child centred, informative and professional and overall experience was very good

Gatherson Ltd
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Children Looked After: Corporate Parenting Promises. The Journey so Far

Powys Teaching Health Board has made progress in embedding its Corporate Parenting responsibilities following the signing of the Welsh Government Corporate Parenting Charter in 2025. The Charter promotes a collective responsibility across public bodies to improve the life chances, wellbeing and outcomes of care-experienced children and young people. As part of this commitment, PTHB has developed and gained Executive approval for its Corporate Parenting Promises, shared these with Welsh Government, and completed a self-assessment against the promises. The next phase of work will focus on implementing improvement actions, strengthening co-production with care-experienced children, and monitoring the impact of these changes

The analysis was informed by responses from six service groups and feedback gathered directly from children and young people through engagement activity with Powys County Council. The findings highlighted a range of positive practice already in place, including prioritised access to services for looked after children, routine opportunities for children to share their views, multi-agency working, trauma-informed approaches, and support for health, wellbeing and future aspirations. However, the assessment also identified several areas where consistency could be improved, particularly in relation to follow-up arrangements, capturing the voice of the child, transition planning, workforce awareness of corporate parenting responsibilities, and the tracking of outcomes for care-experienced children

A key theme emerging from the review is the importance of listening to and acting upon the views of children and young people. While a variety of mechanisms currently exist to gather feedback, the analysis identified opportunities to strengthen co-production, develop more accessible methods of communication, and provide clearer feedback on how children's views have influenced service improvement. The findings also emphasise the need to ensure children understand their rights, can access advocacy when needed, and experience care that is respectful, compassionate and responsive to their individual circumstances

The review further recognises that effective corporate parenting depends on strong partnership working across agencies and a workforce that understands the impact of trauma and adversity on children in care. Proposed improvements include enhancing links with Looked After Children Nurses, increasing awareness and training on corporate parenting across the organisation, improving transition arrangements into adulthood, and developing opportunities that support care-experienced young people to achieve their aspirations. These actions will contribute to a more coordinated, outcomes-focused approach that places the needs and experiences of children and young people at the centre of service delivery.
Overall, the analysis provides a strong foundation for the development of a detailed improvement plan and action tracker. It demonstrates PTHB's commitment to fulfilling its role as a Corporate Parent and ensuring that care-experienced children and young people are healthy, heard, safe, supported and optimistic about their future.

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The proposed actions will drive forward and support continuous improvement in 2026-2027 and provide assurance that the organisation is actively working towards delivering the commitments set out within the Corporate Parenting Promises.

Children Looked After: PTHB Corporate Parenting Promises

PTHB's Pledge is a set of **7 Promises** to Care Experienced Children about how we will take care for them. These Promises help PTHB fulfil its responsibilities under the Corporate Parenting Principles. The Promises are built upon the principle of ***Nothing about you, without you*** and the ***Vision for every child and young person who has experienced care to feel:*** **Healthy** – feeling good in body and mind, **Heard** – because what they say matters, **Safe** – in their home and community, **Supported** – by people who care about them and **Excited** – about their future

Your Health and Well-being

- We will help you see a doctor, dentist, or nurse when you need to.
- You will be offered a regular health check to talk about how you feel physically and emotionally.
- You can have private chats with a nurse or health visitor about anything on your mind.
- We will help you learn how to stay healthy and feel safe in your home.
- If you need extra support for your feeling and emotional wellbeing, we will refer you to the most appropriate service.

Listening to You

- We will always listen to what you have to say and ensure your voice is heard
- You can tell us what's going well and what could be better.
- You will have chances to share your thoughts through surveys or meetings.
- If you speak another language, we'll use an interpreter to help you share your views.
- If you use aids such as braille or loops to have your say, we will ensure you are supported to share your views
- We will tell you how your feedback has helped improve our services

Your Rights

- We will help you understand your rights and make sure they are respected.
- You will have access to an advocacy service, so your voice is heard.
- We will always be open, honest, and fair with you.

Our Promise as Corporate Parents

- Everyone in PTHB has a role in caring for you as a Corporate Parent.
- We will keep learning and working together so we can support you better
- We promise to be to take responsibility as an organisation and always try to do our best for you.

Working Together

- We will team up with local authorities, schools, and community groups to ensure you have joined-up support.
- We will plan together and set goals to make sure things keep improving.

Your Opportunities and Future

- We will support you to reach your goals and follow your dreams.
- We will make sure you know about fun and positive activities you can join.
- If you're over 16, we'll support you to plan for adulthood.

Belonging and Care

- We will make sure you feel welcome and cared for.
- We will be on time, keep our promises, and let you know if plans change.
- We will always treat you with respect, kindness, and fairness.
- We will celebrate your individuality and support all aspects of your identity, including culture, religion and gender

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Children Looked After: Corporate Parenting Promises. The Journey so far and Next Steps

In 2025, Powys Teaching Health Board signed the Corporate parenting charter

- The concept of corporate parenting is founded on the principle that when a child is in care, the local authority and all its partners **should act as a responsible parent would for their own child**.
- It is a shared responsibility to help children in care thrive and overcome any disadvantages they face.
- This approach is guided by the principles that focus on improving the well-being of care-experienced children.
- The Corporate Parenting role extends from across all levels of the Health Board

Autumn/winter 2025 PTHB Progress to embed the Charter

- Developed a set of Promises to Care experienced Children on how PTHB will be the best corporate parents we can - **Completed**
- Gain approval from Execs on the Promises **(approved 07.01.26)- Completed**
- Share promises with WG – **Completed**
- undertake an assessment against the Promises **- Completed**

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Next Steps into 2026-2027

- develop and implement an improvement plan and monitor and evaluate impact
- Work with established groups to enable coproduction with care experienced children
- Report on progress embedding the Promises and their impact to PTHB Strategic Safeguarding Group

Procedural Response to Unexpected Death in Childhood (PRUDiC)

https://phw.nhs.wales/reports/procedural-response-to-unexpected-deaths-in-childhood-prudic-2023/

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 2025-26, 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

REF25461-CDR-A5-Leaflets-Digital-Families-ENG-STP

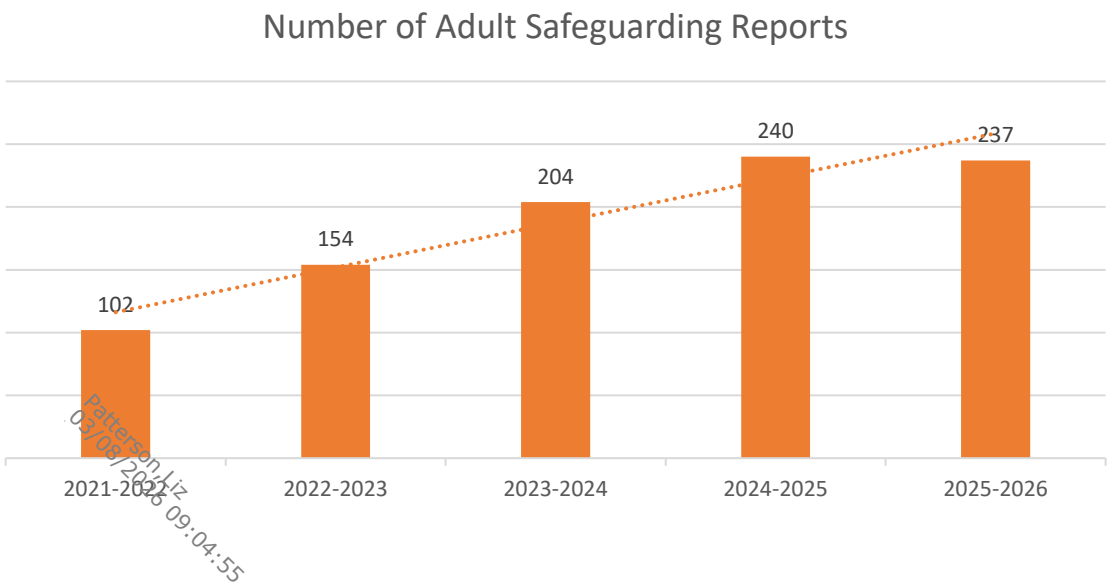
REF25461-CDR-A5-Leaflets-Digital-Professionals-ENG-STP

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.

237 Safeguarding reports were made by PTHB staff in 2025-2026. This has increased year on year 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.

30% of reports were for concerns about Neglect followed by 10% for concerns relating to domestic abuse



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

All safeguarding reports are quality assured by the Safeguarding Team

Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)

The Mental Capacity Act (MCA) 2005 provides the statutory framework for safeguarding and supporting individuals aged 16 and over who may lack the capacity to make specific decisions at the time they are required. It is underpinned by five key principles, which include the presumption of capacity and the requirement to take all practicable steps to support individuals to make their own decisions.

The Act places the individual at the centre of all decision-making processes and establishes a clear legal test for capacity, alongside a structured framework for determining best interests where capacity is lacking. In line with the principles of the MCA, individuals with capacity are entitled to make decisions that others may consider unwise, including the refusal of treatment.

The Deprivation of Liberty Safeguards (DoLS), introduced under the MCA, provide a legal process to authorise arrangements that amount to a deprivation of liberty within care homes and hospital settings. These safeguards apply to individuals who lack the capacity to consent to their care and accommodation arrangements and where such arrangements are necessary and proportionate to prevent harm, and in their best interests.

The application of DoLS ensures compliance with the Human Rights Act 1998, in particular Article 5 (the right to liberty and security), by providing a lawful mechanism to identify, assess, and authorise any deprivation of liberty. Health Boards, as managing authorities, have a responsibility to ensure that appropriate referrals are made, authorisations are in place, and that individuals' rights are upheld and regularly reviewed.

The Mental Capacity (Amendment) Act 2019, which introduces the Liberty Protection Safeguards (LPS) as the intended replacement for DoLS, has not been implemented, there hasn't been any further discussions during 2025/26, all preparatory activity at a national level remains paused. Consequently, DoLS remains the current legal framework in operation across NHS Wales and partner organisations

MCA DoLS Governance: MCA Operational and Practice Improvement Group & MCA Risk Register

Key Achievements

- Following a Limited Assurance rating in the January 2025 Internal NHS Audit of DoLS, all Key Matters Arising have been addressed and formally signed agreed in January 2026.
- The appointment of a DoLS Lead, additional Best Interests Assessor (BIA) capacity has increased workforce resilience and supported service development.
- Significant progress has been made in strengthening Supervisory Body assurance through improved processes, data quality, reporting, quality assurance, and the introduction of BIA supervision and reflective peer group practice.
- A review of all Form 1 applications submitted by PTHB Managing Authorities is underway to improve consistency and understanding of DoLS requirements and supports engagement with wards.
- Managing Authorities have incorporated DoLS audit activity into the Monitoring and Evaluation Group (MEG) framework.
- Supervisory Body scrutiny and authorisation processes have been strengthened, with enhanced quality assurance embedded throughout.
- Updated PTHB DoLS guidance has been published, supported by a review of Supervisory Body SOPs and Managing Authority process flows.
- Applications to Supervisory Body are now completed online by Managing Authority.

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Deprivation of Liberty Safeguards Data: **Performance and Activity**

PTHB Deprivation of Liberty data Activity 2025-2026

2025 - 2026	Q1	Q2	Q3	Q4
Number of Referrals for the period	69	91	112	121
Number of Urgent Referrals for the period	63	84	94	114
Number of Standard/Renewal Referrals for the period	6	7	18	7
Number Allocated to Internal BIAs	20	23	41	56
Number Allocated to External BIAs	10	24	22	40
Number sent to Signatory	28	24	46	42
Application identifies that P is objecting to their accommodation or treatment	16	22	43	54
Total Outstanding Applications	24	29	33	27
Total Outstanding Applications - pending only	21	13	27	12

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- Referrals requiring Urgent Authorisations continue to be received by the PTHB Supervisory Body through the established referral process.
- The PTHB DoLS Lead commenced a review of all DoLS applications received from November 2025 onwards. Examples of good practice and any issues identified will be shared with Managing Authorities across PTHB, with an emphasis on proactive support and service improvement.
- BIAs were deployed from Quarter 4, including the use of one bank BIA following a staff resignation. Additional assessment capacity was secured through agency provision during Q4. Despite high levels of staff absence during the quarter, the service demonstrated resilience and maintained assessment capacity, resulting in no overall reduction in throughput.
- The impact of interim measures introduced over the previous five quarters to maximise assessment completion rates can be seen in the Q4 performance data. From Q4 onwards, these measures should become standard practice rather than interim arrangements, contributing to a reduction in cases awaiting allocation, an increase in assessments completed by internal BIAs, and a sustained increase in the number of assessments progressing to signatory approval.
- Significantly increased numbers of patients are being identified by Managing Authorities as objecting to their accommodation, care and/or treatment. This is considered a positive outcome of the training provided and the quality assurance processes implemented for Form 1 completion.

Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) Training and Development

During the reporting period, significant progress has been made in strengthening MCA and DoLS knowledge and application across Powys Teaching Health Board (PTHB).

Programme Development and Workforce Engagement

A range of additional learning and development activities have been implemented to support staff across services:

- A six-month pilot of MCA and Safeguarding update sessions was delivered across PTHB wards via MS Teams. These sessions focused on Managing Authority responsibilities and reinforced the importance of timely and effective review within DoLS processes. Following positive engagement, a revised rolling programme will be implemented for all ward staff with Managing Authority responsibilities.
- Quarterly joint update sessions continue to be delivered in collaboration with Safeguarding teams for Therapy staff, supporting continued professional development and multidisciplinary learning.
- A tailored, one-off question-and-answer session, supported by a formal presentation, was delivered to the Immunisation Team to address specific service needs.
- MCA and DoLS awareness sessions are embedded within the PTHB Preceptorship Programme and International Nurse Induction, ensuring early exposure and consistent understanding among newly appointed staff.

Specialist and Legal Training

PTHB staff have attended annual Court of Protection training delivered by NHS Wales Legal & Risk over the past two years. Supporting materials and resources are available via the PTHB Intranet to enable ongoing access to specialist guidance.

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Learning Resources and Accessibility

The PTHB Intranet hosts a comprehensive and regularly updated MCA and DoLS resource hub. Dedicated resource support has been allocated to ensure materials remain current and accessible, promoting continuous learning across the organisation.

Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) Training and Development

Safeguarding & Public Protection - Home (sharepoint.com)

Level 3 Training Delivery

Seven Level 3 training sessions were delivered, reaching 66 attendees. These sessions focused on enhancing advanced knowledge and supporting practitioners in applying legislation in complex cases. To further strengthen practical application, delivery will transition to an enhanced face-to-face model from Quarter 1 (Q1) 2026.

Training Compliance

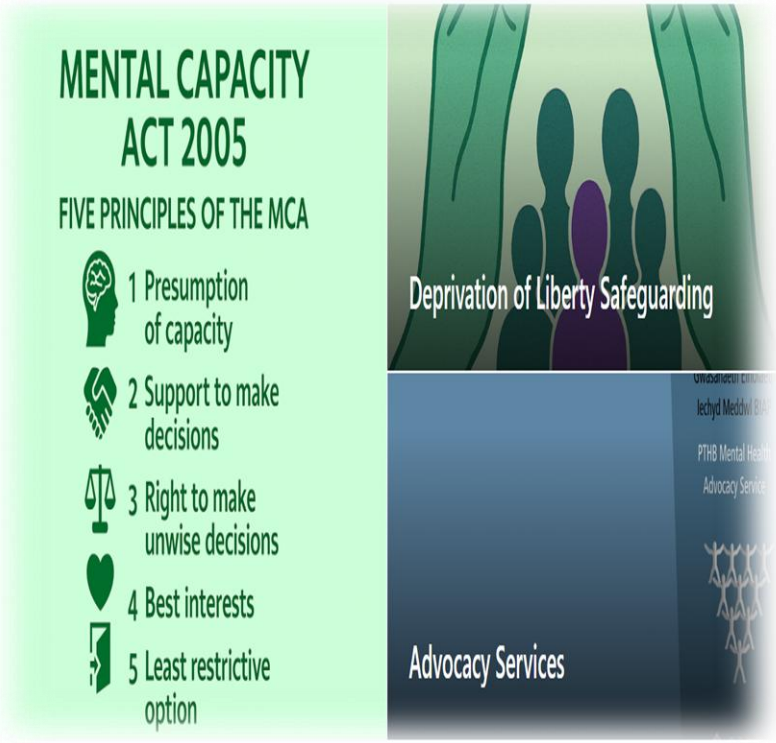
Compliance with mandatory MCA training remains high:

- Level 1: 94%
- Level 2: 93%

This compliance reflects sustained organisational commitment to ensuring staff are equipped with the knowledge required to uphold legal responsibilities and safeguard individuals' rights.

Forward Focus

The continued development of blended learning approaches, alongside targeted workforce engagement, will further strengthen the consistent application of MCA and DoLS principles in practice across PTHB



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NHS Wales Safeguarding Network MCA Improvement Group

PTHB continue to be an active member of the Network. The group continues to be meet quarterly and progress an agreed workplan, examples of the work include;

- Shared learning opportunities from across Wales, including the learning from Supreme Court Judgement impacting MCA DoLS
- Policy development and the advice regarding the recording of restrictive practice on Datix.
- MCA training updated including ESR Level 1 and Level 2 training packages to ensure legal accuracy.
- Development of a standardised MCA Training Framework (Levels 3–6) is advancing; A draft All-Wales MCA Training Framework is currently being developed.
- Updated joint DoLS Forms 1 and 1a have been piloted. Initial feedback from both Supervisory Bodies and hospital wards has been positive. Once all evaluation feedback has been collated, Welsh Government will be approached for its views.
- Agreement has been reached on developing a standardised capacity assessment process to support a range of national projects and systems, including the WAST proforma, Community Health Pathways, and the Welsh Nursing Care Record. This aims to establish a consistent All-Wales approach to MCA capacity assessments and best interest decision-making.
- Work continues on reviewing DoLS processes. A presentation entitled *"DoLS – Developing a Unified Approach for Wales"* has been prepared for presentation to EDoNs
- Feedback has been provided to HIW and CIW regarding data reporting requirements. Concerns raised about duplication within reporting requests; however, no solution has yet been identified.

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Hospital-Acquired Pressure Ulcer

Pressure Ulcer Learning Panels are held fortnightly and include representation from safeguarding. 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 ulcers are deemed as moderate harm, then they are managed via the Duty of Candour/Nationally Reportable Incident (NRI) process.

During 2025-2026 there were 2 moderate harm avoidable pressure ulcers which triggered the Duty of Candour process. No pressure damage has been reported as a National Reportable Incident.

Recurring Learning Themes

- Documentation and record keeping – ensuring care plans updated, assessments completed and recording all changes to wounds.
- Datix reporting and wound photography – Prompt datix reporting, ensuring photographs are attached.
- Pressure Ulcer prevention and assessment
- Pressure relieving equipment – consider early use of equipment.
- Communication and handover – ensure clear communication during transfers, within the multidisciplinary team and external teams.
- Patient and carer education – Ensuring information leaflets given and all advice documented.
- Completing timely referrals.
- Staff training and governance - reinforce Purpose T and pressure ulcer grading training.

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In Patient Falls Review Huddles

From October 2024, the process of reviewing all inpatient falls commenced via a huddle for each fall. These continue to be investigated through the incident reporting system to ensure learning, oversight, and the implementation of preventative measures.
Six of the nine inpatient wards have consistently demonstrated high-quality and timely investigations and now undertake local falls reviews without requiring a formal falls huddle in every case. Exceptions include incidents resulting in moderate harm, injury, or where wider organisational learning is identified. In these cases, or where required, a multidisciplinary falls huddle is held. Where no huddle takes place, the Governance Lead maintains oversight, with learning themes recorded and monitored centrally.
The gold standard remains for falls huddles to be completed within 72 hours. Although this is not consistently achieved due to limited staff capacity, all incidents continue to receive appropriate review, with learning identified and actions monitored to support improvements in patient safety.

Between April 2025 to March 2026, 350 falls were reported and reviewed. 4 falls were deemed as avoidable, but no injuries were sustained from these falls. 12 injuries were sustained from in-patient falls that were deemed as unavoidable, no omissions in care were identified.

Themes from reviews and learning

- Avoidable falls were linked to equipment and process issues, including incorrectly fitted toilet frames, chair brakes not being applied, falls mats not being reactivated after care, and unsecured pressure cushions.
- A recurring theme throughout the year has been ensuring falls risk assessments are updated following a fall, with targeted improvement work showing positive progress.
- Since Quarter 2, the National Audit of Inpatient Falls (NAIF) post-fall debrief has been implemented. Completion rates continue to improve, although timely completion before the end of the shift remains an ongoing area for development.

Good practice

- The introduction of lying and standing blood pressure recording within the Welsh Nursing Care Record risk assessment has significantly improved compliance.
- Strengthened governance arrangements for inpatient falls have supported more timely reviews and enabled learning to be shared more effectively across the Clinical Service Group.

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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 of the Immediate 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 2025-26, 28 suspected suicides have been managed using the Immediate 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.

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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 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

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The main involvement from a safeguarding 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

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

Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) has a profound impact on the physical, mental and emotional wellbeing of individuals, families and communities across Wales. Recognising the need for a coordinated response, the Welsh Government introduced the Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015, the first legislation in the UK to specifically address violence against women while also strengthening responses to domestic abuse and sexual violence. The Act promotes early intervention, prevention, safeguarding and multi-agency working, with health services playing a crucial role in identifying those at risk, providing support, and improving outcomes for victims and survivors.

The statistics highlight the importance of early intervention, trauma-informed practice, safeguarding, and multi-agency working across health, social care and partner organisations in Wales.

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Welsh Government continues to identify VAWDASV as a national priority through the **VAWDASV National Strategy 2022–2026** and the VAWDASV Blueprint programme

- Around **1 in 3 women** and **1 in 6 men** experience domestic abuse during their lifetime.
- The Crime Survey for England and Wales estimates that **9.1% of women** experienced domestic abuse in the year ending March 2025.
- Approximately **25.8% of adults** have experienced domestic abuse since the age of 16.
- Women account for approximately **72.5% of victims of domestic abuse-related crimes** recorded by police.
- Around **65.4% of domestic homicide victims are female**.
- Modern Slavery is the illegal exploitation of people for personal or commercial gain, it affects over 16,000 people in the UK a 33% increase since 2021.
- Men, women and children may be forced into slavery which includes forced prostitution, child trafficking, criminal & sexual exploitation, domestic servitude, forced labour and organ harvesting
- Female genital mutilation (FGM) is a procedure where the female genitals are deliberately cut or injured or changed for no medical reason.

VAWDASV: Multi Agency Response - **Moving to a Daily MARAC Model**

In summer 2025, the process changed from Daily Discussion (DD) meetings with escalation to MARAC, to a *Daily MARAC (DM) model*. This change was introduced to improve responsiveness to high-risk domestic abuse cases, strengthen multi-agency information sharing, and enable more timely risk assessment, decision-making, and safety planning.

Benefits and Impact

- Reduced administrative burden and duplication by replacing the previous two-stage process (DD followed by MARAC) with a single Daily MARAC discussion.
- Faster assessment and management of risk, supporting earlier intervention and safety planning.
- Improved victim engagement through earlier contact and support from Independent Domestic Violence Advisors (IDVAs).
- Enhanced multi-agency collaboration, enabling information to be shared and actions agreed more promptly.
- Streamlined decision-making, ensuring high-risk cases are reviewed and acted upon without unnecessary delay.

Challenges

- Moving from a two-stage process to a single discussion reduces opportunities for additional information gathering between meetings, increasing the importance of comprehensive and up-to-date clinical records.
- Daily MARACs require significant preparation, with Safeguarding Leads undertaking detailed searches of health systems to gather relevant information.
- Effective multi-agency risk assessment is increasingly dependent on the quality, accuracy, and timeliness of documentation completed by health practitioners.
- The transition has removed the routine opportunity to obtain and present information from Powys GP practices prior to discussion, potentially limiting the availability of primary care information and affecting the completeness of risk assessments and intervention planning.
- The timing of Powys Daily MARAC meetings (breaktime) can create operational pressures for the Safeguarding Team Leads and raise staff wellbeing considerations, particularly when meetings overrun.

Overall Assessment

The introduction of the Daily MARAC model has created a more streamlined, responsive, and efficient process for managing high-risk domestic abuse cases. It has strengthened multi-agency working and enabled earlier intervention and safety planning. However, realising the full benefits of the model depends on timely, high-quality information sharing, robust clinical record keeping, and sufficient capacity within safeguarding teams to support daily attendance and case preparation.

Paper No: 2026/0084: 5.1

VAWDASV: Multi Agency Response - **Planning for the Introduction of MATAC & DRIVE**

Since December 2025, planning has been underway to prepare for the introduction in spring 20206 of **MATAC** (**Multi-Agency Tasking and Coordination)** and the **DRIVE programme.** PTHB has contributed to the development of an information sharing a agreement, terms of reference and operating processes to support consistent practice, strengthen governance arrangements, and provide greater clarity regarding agency roles, responsibilities, and operational processes. PTHB Safeguarding Leads have also attended training to enable full participation in the meetings.

The **Multi-Agency Tasking and Coordination (MATAC)** process will support a coordinated multi-agency approach to managing serial and repeat perpetrators of domestic abuse across Powys. Monthly MATAC meetings will manage multi agency discussions, risk assessing and intelligence sharing, of the highest risk, complex perpetrators of domestic abuse, with the aim of developing actions aimed at disrupting harmful behaviour and reducing the risk of further abuse.

The preparation and information-gathering processes for MATAC is similar to those undertaken for Daily MARACs, with Safeguarding Leads reviewing relevant health records and contributing health information to support robust risk assessment and decision-making. The MATAC process will be overseen through the same governance and steering arrangements as the Daily MARAC, ensuring a coordinated and consistent approach to both victim safeguarding and perpetrator management.

The **DRIVE programme** will complement the work of MATAC by providing intensive case management and targeted interventions for perpetrators who are accepted into DRIVE through the MATAC process. Through intensive case management and multi-agency support, DRIVE seeks to increase perpetrator accountability, promote behaviour change, and reduce repeat offending.

Together, MATAC and DRIVE strengthen the focus on perpetrator management within the domestic abuse pathway, contributing to improved victim safety, reduced repeat victimisation, and better outcomes for individuals and families affected by domestic abuse.

The introduction of MATAC will create an additional demand on Safeguarding Team Leads, who are responsible for preparing and presenting health information to inform multi-agency discussions. Similar to the Daily MARAC process, this requires dedicated time to review records, gather relevant information, attend meetings, and complete any follow-up actions. As a developing process, MATAC represents an additional commitment for the safeguarding team alongside their existing operational and safeguarding responsibilities, once fully operationalised a review of the impact will be undertaken.

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Powys Teaching Health Board Womens Health Hub

Project Overview

Powys Teaching Health Board is developing a Virtual Women's Health Hub to support delivery of the NHS Wales Women's Health Plan (2025–2035). The hub will provide access to local and national health pathways, self-referral routes, information resources, training materials, videos, toolkits and signposting services. Developed through a life-course approach and informed by a local Women's Health Needs Assessment, the hub aims to improve access to equitable, person-centred healthcare and address health inequalities experienced by women across Powys.

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VAWDASV and a Co-production Approach

A key element of the Women's Health Hub is the inclusion of Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) content. Powys Teaching Health Board has adopted a co-production approach, recognising victims and survivors of all forms of abuse as experts by experience. Survivor engagement has been central to the design and development of both the VAWDASV hub content and associated staff training resources, ensuring that materials reflect lived experience and support a trauma-informed approach to healthcare services.

Womens Health Hub Project Overview

Progress Update

Engagement with the survivor panel and Cowshed, a media company commissioned to support the project has now concluded. PTHB are in receipt of the final assets which include a suite of resources, a professionally developed animation for the public, voiceovers and facilitator training materials.

A final viewing of the animation has taken place between PTHB's safeguarding staff who managed the project, the survivor panel and Cowshed. Work is now progressing on updates to the Safeguarding and Public Protection webpages to strengthen links between the Women's Health Hub and VAWDASV information, ensuring a more user-friendly and accessible digital offer.

Once this is completed the public assets will go live

Impact of Survivor Feedback

Feedback received from the survivor panel has directly influenced the development of the hub. Changes implemented include the creation of separate Safeguarding and VAWDASV webpages, improved links between resources and escalation of issues requiring wider organisational consideration. The feedback highlighted the importance of improving information relating to stalking, grooming, technology-facilitated abuse, healthy relationships, neurodivergent victims and access to support services. Survivors also identified opportunities to enhance patient experience through improved appointment information, routine offers of chaperones and consideration of mechanisms to reduce the need for individuals to repeatedly disclose traumatic experiences.

Current Position and Next Steps

Powys Teaching Health Board already has several measures in place to support delivery of VAWDASV priorities, including dedicated safeguarding services, mandatory training programmes, domestic abuse routine enquiry processes, partnership working through MARAC and MAPPA forums, and a range of supporting policies and staff resources. The next phase of work will focus on reviewing and implementing the co-produced training package, developing a delivery programme that complements existing Ask and Act training, considering improvements to patient-facing information and appointment processes, and developing an action plan to assess the feasibility of the recommendations made by survivors.

Key Achievement

The project has demonstrated meaningful engagement with victims and survivors throughout the design process, ensuring that the developing Women's Health Hub reflects the needs of those affected by violence, abuse and trauma. The collaborative work undertaken to date provides a strong foundation for delivering accessible, informed and trauma-aware resources that support both healthcare staff and the public.

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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;

Management of Learning from Safeguarding Reviews

Single Unified Safeguarding Review (SUSR)

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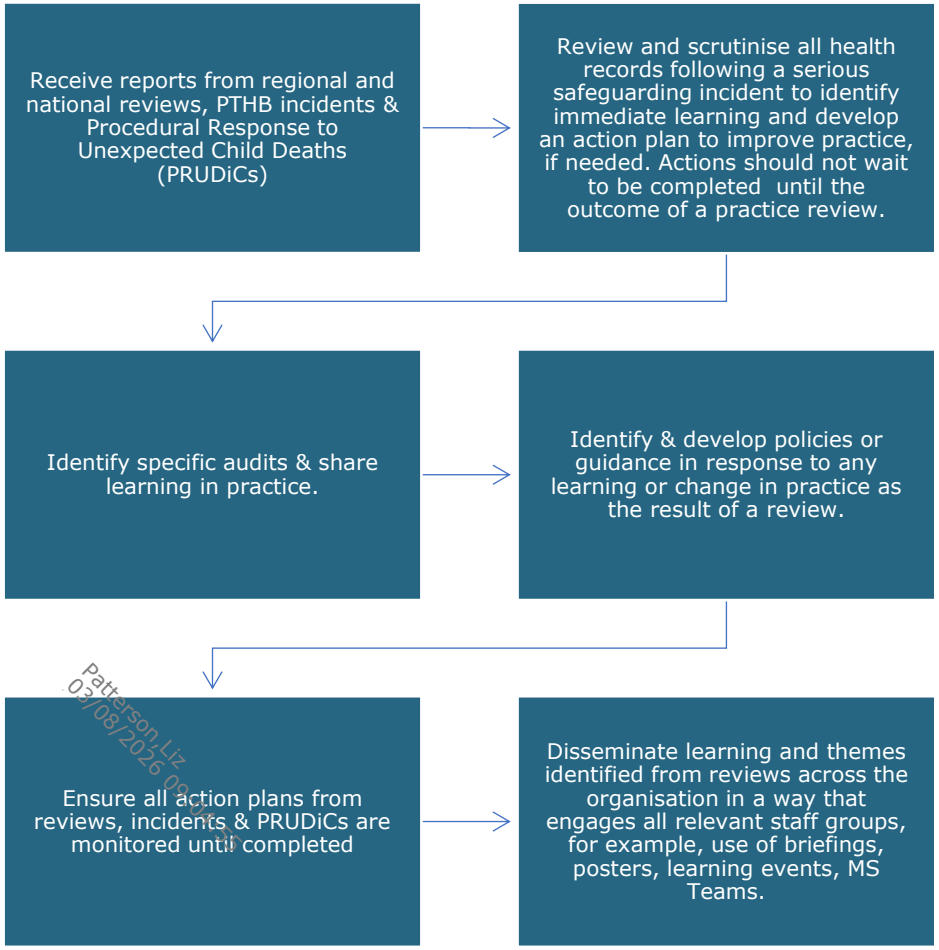
Management of Learning from Safeguarding Reviews

Learning from safeguarding reviews (SUSR'S), incidents & PRUDiC's are managed within PTHB's Safeguarding Practice Improvement Group. The group is attended by Senior Managers from across the organisation and reports to the PTHB Strategic Safeguarding Group.

The objectives of the group are;

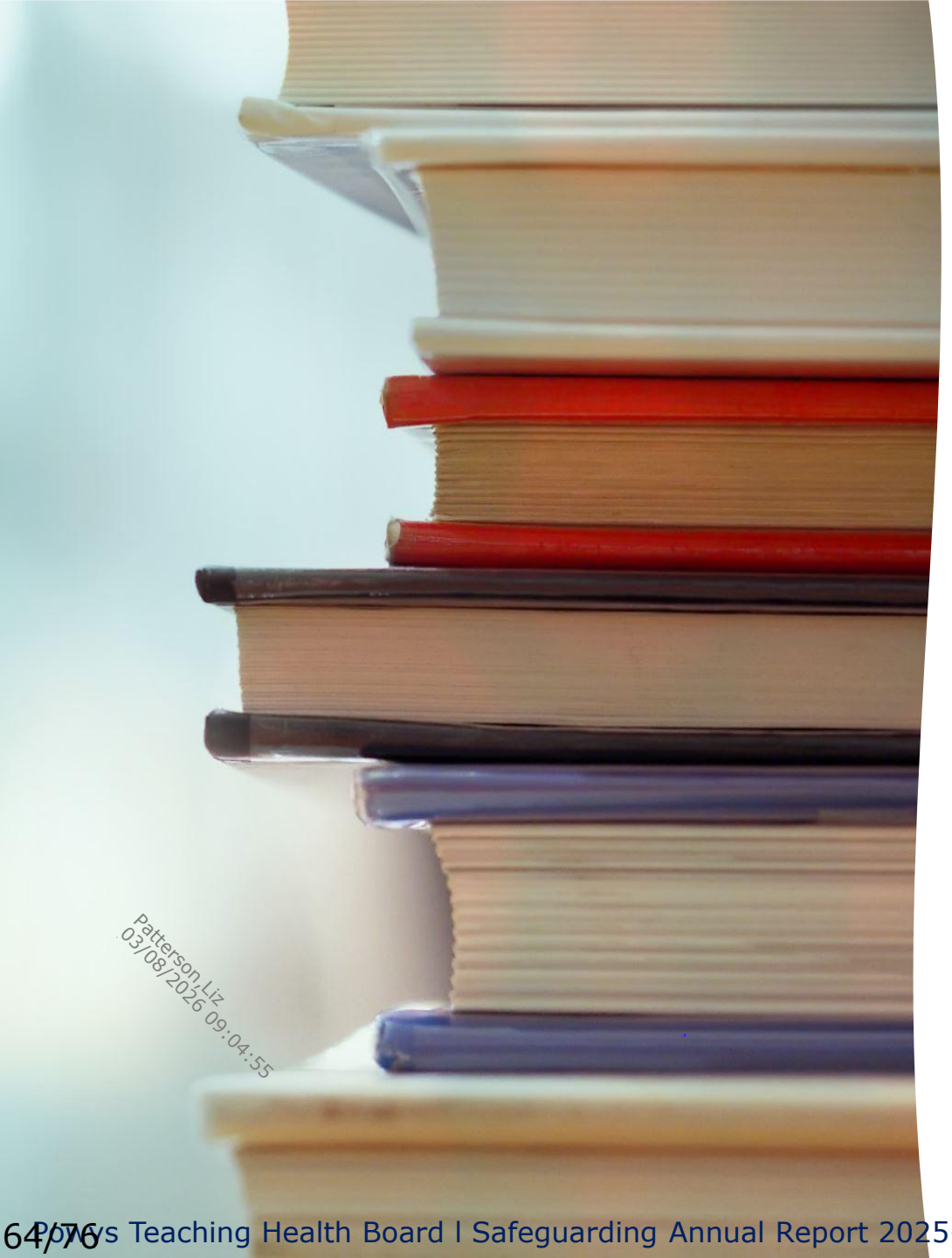


Safeguarding Practice Reviews for Powys managed by M&WWSB

Type of Review	Q1	Q2	Q3	Q4
APR underway (PTHB)	0	0	0	0
CPR underway (PTHB)	0	0	0	0
DHR underway (PTHB)	2	2	2	2
MAPF's (PTHB)	3	3	3	3
M&WW Published Reviews (Regional)	1	1	0	0

Open Safeguarding Improvement Plans managed in Practice Improvement Group

	Q1	Q2	Q3	Q4
Number of Improvement Plans (PTHB & M&WWSB)	4	8	6	5
Number of Open Actions	5	12	10	10
Challenges escalated in completing the actions	None	None	None	None



Themes and Learning from Regional Reviews

- Managing Was Not Brought
- Documenting Significant Events
- Information Sharing, Communication, Record Keeping
- Flagging Children at Risk of Harm in General Practice and Out of Hours
- Transition
- Multi-Disciplinary Team Process
- Professional Curiosity
- Listening to the Voice of the Child
- Seeing and hearing from Electively Home Educated Children
- The Management of Allegations and Concerns about Adults Working with Children
- Managing prisoner release and re entry
- Safeguarding Supervision
- Recognising and managing male victim of domestic abuse
- Routine Enquiry in MH Services

How the Themes and Learning are shared

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

These themes consistently feature across practice reviews in Wales. Challenges remain regarding how agencies measure and evaluate the impact of lessons learnt.

For PTHB the themes inform audits and work plans.

Management of Learning from Safeguarding Reviews: **Public Health Wales Test and Post**

Public Health Wales (PHW) identified a series of significant issues within the national Test and Post STI service between November 2025 and March 2026. PTHB Safeguarding Team, Sexual Health Service and Public Health Team worked with Public Health Wales to support their internal review and look back exercise

Key Risks

- Safeguarding and protection of vulnerable young people
- Weak governance and assurance processes within PHW
- Delayed escalation and communication to Health Boards
- Data protection and information governance risks
- Reputational risk across NHS Wales

PHW Actions

- National **look-back exercise** for safeguarding cases
- All known test result errors reviewed and addressed
- Data incidents reported to ICO; mitigations in place
- Testing protocols updated

PTHB Response

- **Task & Finish Group established** for oversight
- Full participation in national assurance processes
- Safeguarding and sexual health procedures reviewed

Next Steps

- Agree and implement updated **Data Protection Impact Assessment (DPIA)** and PHW SOP
- Revise **PTHB Standard Operating Procedures**
- Continue to support PHW investigation and national response
- Maintain ongoing Board oversight of safeguarding assurance

Aassurance Position

- No evidence of significant harm identified within PTHB to date
- Appropriate action taken where information was shared
- National work ongoing to provide full assurance and strengthen systems

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SUSR: Single Unified Safeguarding Review

In October 2024, Welsh Government published statutory guidance which implemented the Single Unified Safeguarding Review (SUSR) model across Wales. The model incorporates multiple review processes into one unified model, eliminating the need for families to take part in multiple processes and allowing services to identify learning sooner. The SUSR model incorporates the following processes into one cohesive process: Adult Practice Reviews, Child Practice Reviews, Domestic Homicide Reviews, Mental Health Homicide Reviews

The SUSR Model

A core principle of the model is to learn from the experiences and perspectives of the individuals connected to the incident. This means engaging with victims and families, as well as with multi-agency practitioners across the services who supported them, to consider what actions can be taken to support improvements to future practice and service provision.

The new SUSR model is also supported by the development of the Wales Safeguarding Repository, which will host published reviews within an innovative, searchable platform. This provides a mechanism for the learning that flows from completed reviews to be more easily accessed by professionals, and for this learning to be captured and considered in future reviews undertaken, thus promoting the ongoing development of learning across Wales.

SUSRs are not investigations or inquiries, nor do they seek to appoint blame or culpability. Instead, the principle of learning is at the heart of the model, supporting those involved in the review to reflect together to identify actions that can lead to improvements to practice and therefore, better outcomes for children, adults at risk and victims of domestic abuse.

Launch of Safeguarding Repository Wales Safeguarding Repository.

The Wales Safeguarding Repository (WSR) is a secure, searchable digital database that brings together safeguarding review reports from across Wales into one place. It help professionals learn from serious safeguarding incidents and improve practice. Only relevant professionals now can access the repository

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Launch of Resources to Support Continued Role out of the Model

All links and resources available to staff on the safeguarding intranet page

Awareness for All	**Video Link**
Learning Events in SUSR	**Video link**
An Introduction to SUSR for Senior Leaders	**Video Link**

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;

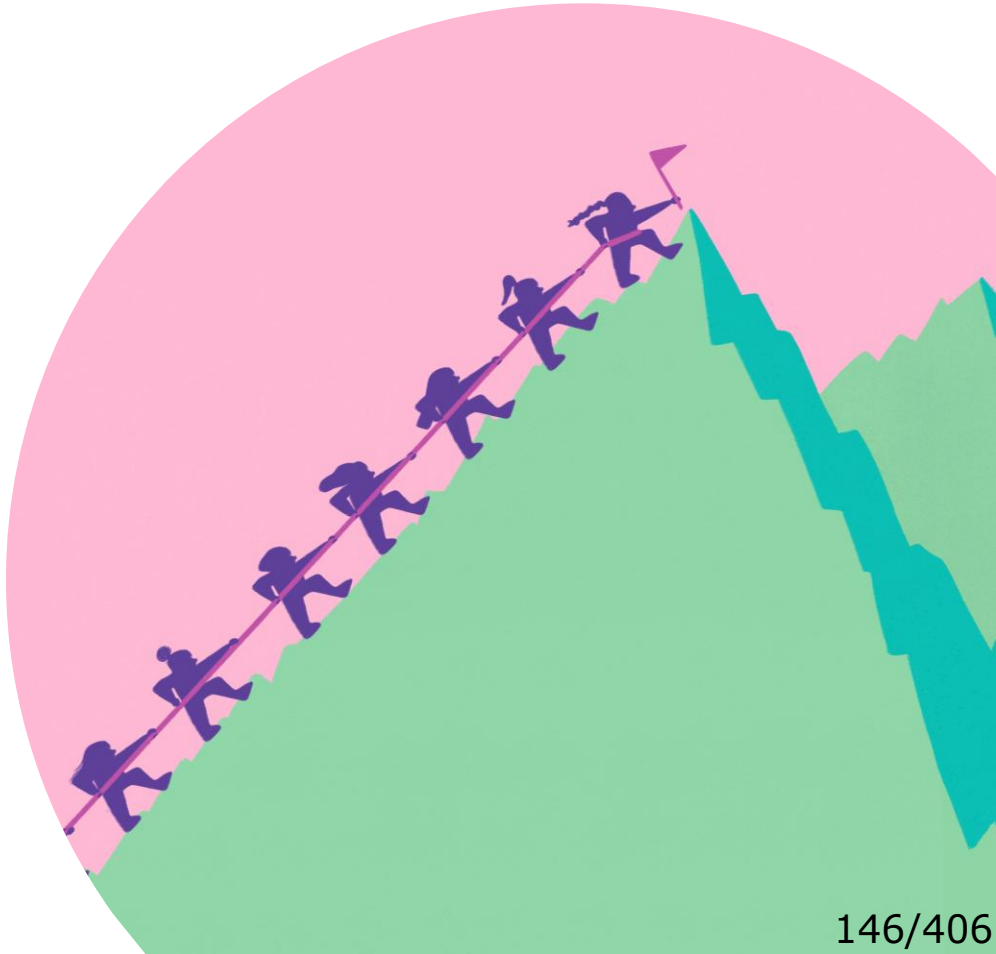
Mid and West Wales Safeguarding Board

VAWDASV Board

NHS Wales National Safeguarding Service & Network

National Safeguarding Week

Multi Agency Partnership working



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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), the Board 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 safeguarding practice across the region. Powys Teaching Health Board is represented and fully engages at across all areas of the Board

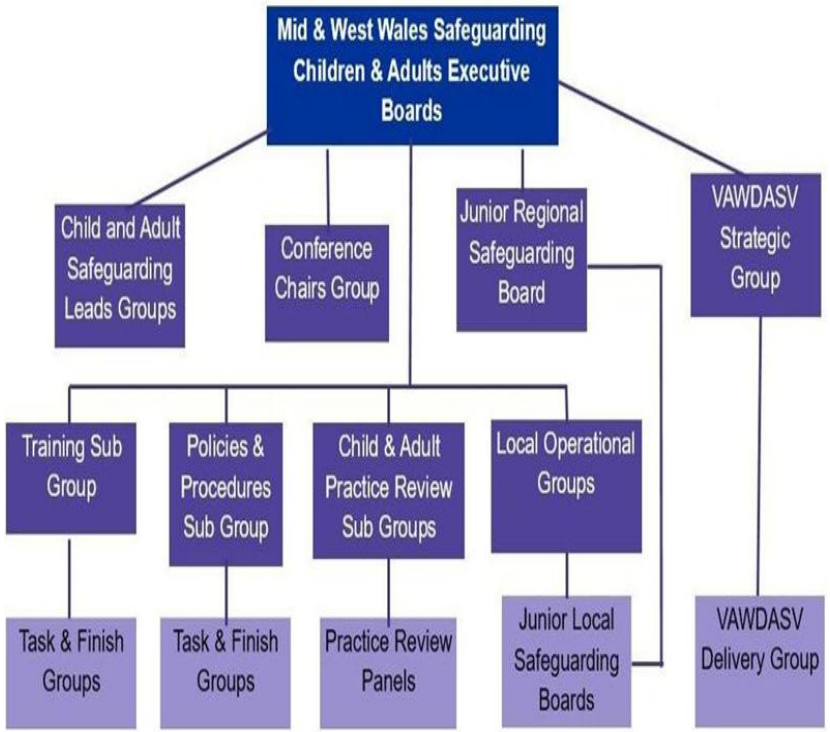
The Executive Board consists of senior managers from key statutory agencies. The Executive Boards' aim is to provide leadership and guidance to all its constituent agencies through the delivery of a series of strategic priorities for safeguarding activity and practice.

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 & Audit 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.



Mid & West Wales Safeguarding Board (M&WWSB): The Boards Vision & Priorities

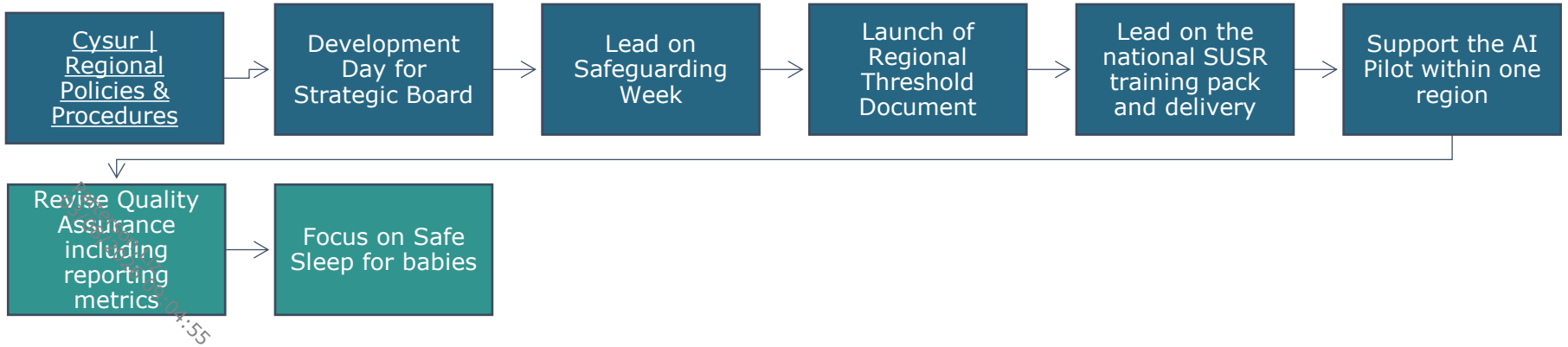
The vision of the Mid & West Wales Safeguarding Board is that all people in the region live their lives free from violence, abuse, neglect and exploitation and that their rights are protected. All safeguarding work is sensitive to and firmly rooted in respect for differences in race, ethnicity, culture, ability, faith and sexual orientation. Engaging with and being responsive to the needs of all stakeholders, including children, young people, adults at risk, their families, carers, service providers and the wider community, is essential to promote the Board's vision.

At a **Safeguarding Board development day** in January 2025, strategic partners worked together to set the Boards **Strategic Priorities** for 2025-2026;

1. Develop a culture of collaboration and innovation across the partnership, which promotes a safe, skilled and resilient workforce
2. 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
3. Undertake systemic analysis of organisational performance and change to better understand its impact on children and adults at risk
4. Continue to influence and contribute to the national strategic agenda to support improvements in safeguarding legislation, guidance and policy.

The **Priorities** informed the **M&WWSB Annual Plan 2025-2026** Annual Plan Link

Achievements in 2025-2026 include;



The **M&WWSB Annual Report 2025-2026** showcases the Boards activity throughout 2025-2026 ADD LINK

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

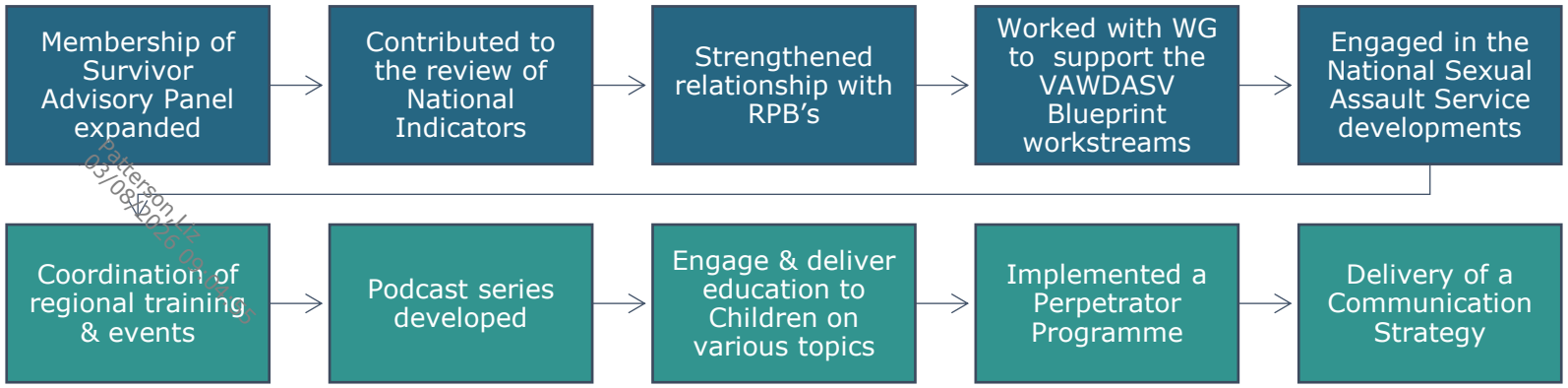
The VAWDASV Board is a multiagency meeting that drives forward the requirements of the VAWDASV Act, including the delivery of the Mid and West Wales Violence Against Women, Domestic Abuse and Sexual Violence Strategy 2023-2027 **MWWStrategicPlanV2 3**

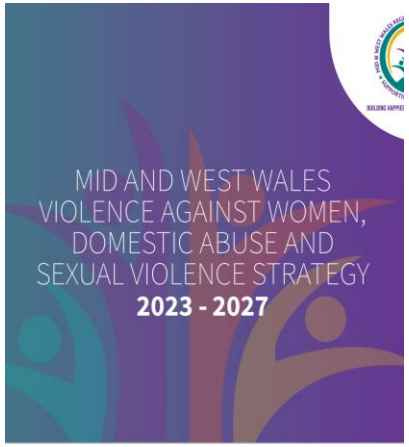
The strategy sets out the integrated regional approach that will deliver a collective vision to stop violence against women, domestic abuse and sexual violence, to improve the health and well-being of individuals and families affected by abuse and hold to account those who perpetrate such abuse.

The 2023-2027 Strategy sets out 6 Priorities:

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.

Achievements in 2025-2026 include;





NHS Wales National Safeguarding Service & Network

The NHS Wales Nationall 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 which 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.

The NHS **Safeguarding Service Priorities** for 2025-2026 include;

- Leadership, Governance & Assurance
- Safeguarding Quality Assurance
- Voice of the child and adult at risk
- Assessment & Professional Curiosity
- Safeguarding Learning
- Hierarchy of Knowledge

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 and its subgroups. **Achievements in 2025-2026 include;**

- Managing Safeguarding Allegations Guidance
- Strengthening Safeguarding in the Medical Appraisal System
- NHS Wales Safeguarding Framework & Safeguarding Quality Statement and Metrics
- Assurance Template to support Prevent Duty
- Learning from Reviews Dissemination
- National Child Protection Principles
- Looked After Children Survey – Feedback Review
- Launch of Drama-Based Safeguarding Scenario Videos
- Strengthening Adults Safeguarding Round Table
- Trusted to Safeguard Conference

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GIG CYMRU NHS WALES DIOGELU RHWYDWAITH SAFEGUARDING NETWORK

The **NSS Annual Report 2025-2026** showcases activity throughout the year [NHS-Wales-safeguarding-network-annual-report-2025-to-2026-.pdf]

National Safeguarding Week: 10 to 14 November 2025

National Safeguarding Week took place this year from 10 to 14 November 2025, with the theme of "**Positive Safeguarding Practice**". 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, all events sought to raise awareness and highlight issues that currently affect children and adults at risk.

The agenda included;

- Revisiting key elements of the Mental Capacity Act 2005 and how these should be applied in safeguarding practice in a variety of situations, contexts and scenarios.
- Sharing the findings from the 2025 thematic review of adult practice reviews in Wales
- Highlighting a free service for safeguarding vulnerable people with dementia who are at heightened risk of going missing (the Herbert Protocol). Alongside these events, there was input from third sector and independent groups, including sessions from New Pathways, Lucy Faithful Foundation Wales, NSPCC Cymru, and Llanelli Mind.

The highlight of the week was a conference for multi-agency practitioners. This included presentations and workshops from keynote speakers and featured the outcome and findings of the review undertaken on the events that took place in Southport in July 2024, information on the Most Significant Change model of practice, vulnerability in neurodiversity, and using AI to support information sharing, alongside input from service users and those with lived experience.

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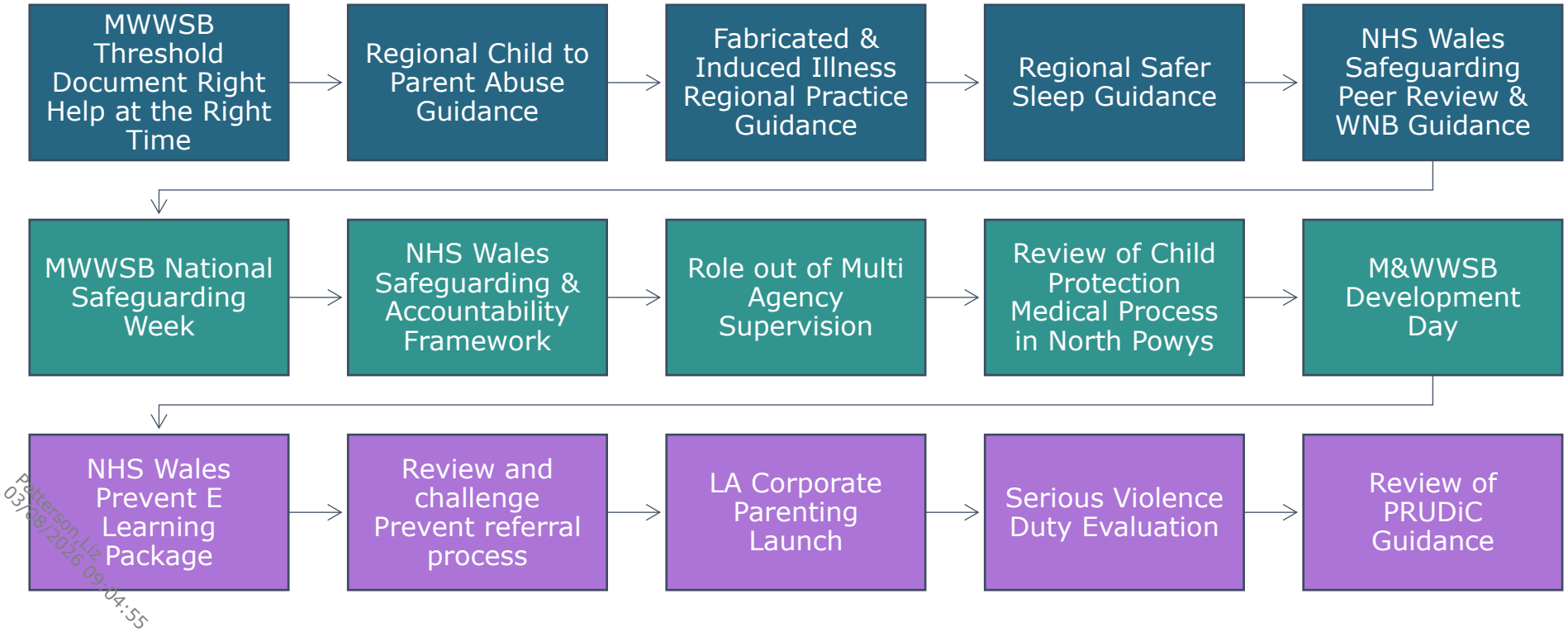
By using the link below you can explore the conference photo gallery, watch recordings of keynote presentations, and access resources from the week's online events:

Cysur | National Safeguarding Week 2025

Multi Agency Partnership working: Working in Collaboration

Effective safeguarding partnerships rely on all agencies having aligned policies, agreed referral pathways, and shared expectations for communication, information sharing, and decision-making, all of which must align with the Wales Safeguarding Procedures (2019).
During 2025/26 **PTHB Safeguarding Team** have worked with our safeguarding partners both regionally and at a national level to influence and shape multiple procedures, processes, training packages and frameworks



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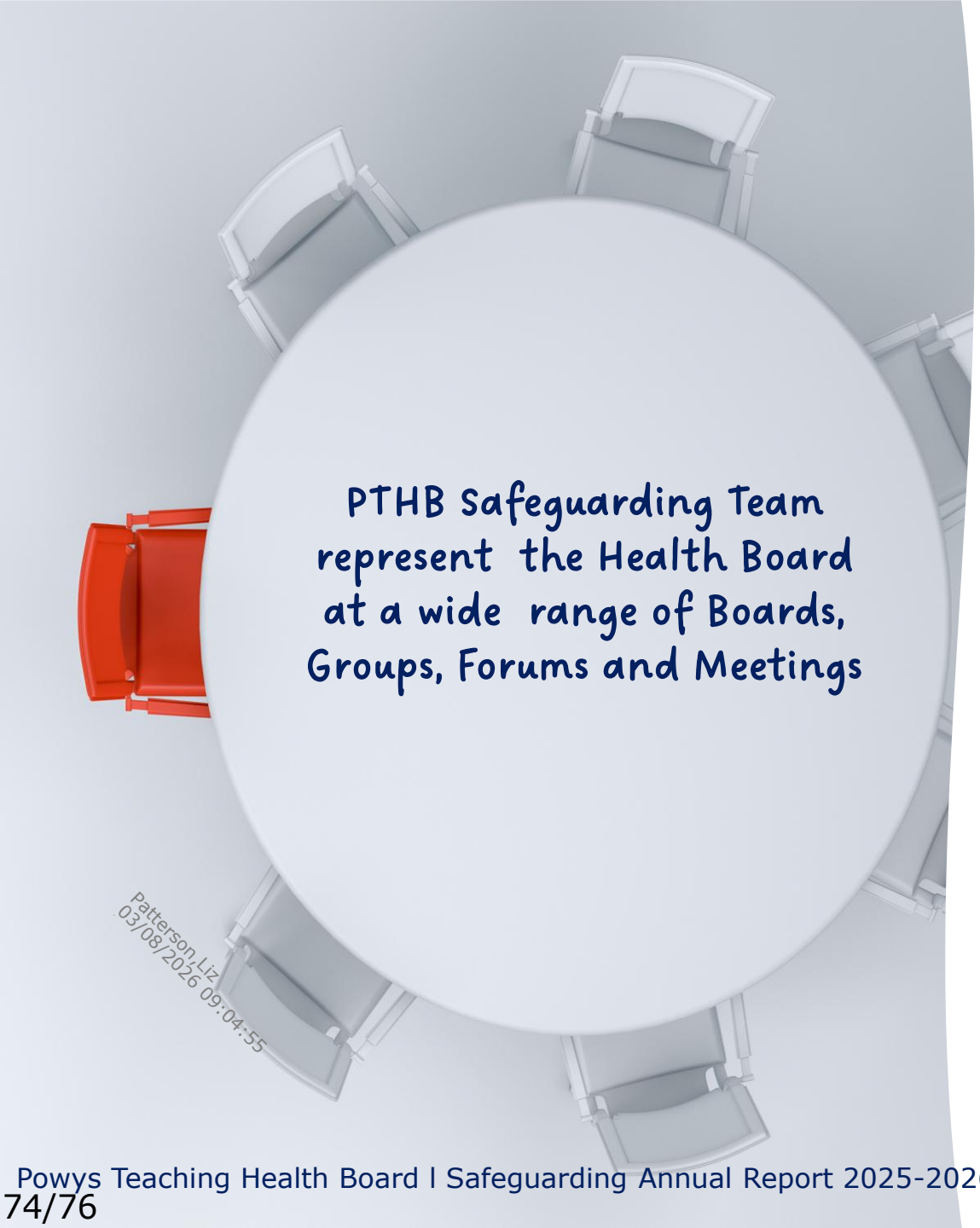

National Meetings

- NHS Wales Safeguarding Network
- Safeguarding Maturity Matrix Peer Review
- NHS VAWDASV Steering Group
- NHS Network Looked After Children (LAC) Steering Group
- NHS Training Sub-group
- NHS MCA Group
- LAC Cymru (Peer Group)
- National NHS Wales Strengthening Safeguarding Group

Local Meetings

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

Regional Meetings

- M&WWSB Board
- M&WWSB SUSR Group
- M&WWSB Training Sub-Group
- M&WWSB Policy, Procedure & Audit Sub-Group
- VAWDASV Strategic Group
- VAWDASV Training Sub-Group
- VAWDASV Delivery group
- VAWDASV Commissioning Group
- Regional 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 Operational 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.

Working practices continue within the Safeguarding Team to build resilience and to 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 Safeguarding Team members which builds strategies and resilience 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.

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Powys Teaching Health Board Safeguarding Priorities 2026-2027

- Engage in the National Strengthening Safeguarding year 2 implementation of the Framework and priorities
- Deliver the Corporate Parenting 'Promises' to Children Looked After improvement plan
- Improve response rate to the National Childrens Looked After and Carers Surveys via CIVICA
- Build upon and further embed the MCA improvements
- Deliver year 2 of the Safeguarding and VAWDASV Womens Health Plan
- Review the Safeguarding Assurance report into Strategic Safeguarding Group
- Continue to work improve safeguarding level 3 training compliance
- Work with the National Safeguarding Service to launch the RL Datix Safeguarding reporting module
- Work with the Regional Safeguarding Board, HIW and CIW to complete the planned Position of Trust review
- Evaluate the impact of safeguarding learning and quality improvement initiatives
- Strengthening assurance and audit engagement within adult services relating to the Was Not Brought Policy

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 4.5

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE	**04 AUGUST 2026**
Subject:	**Infection, Prevention and Control Annual Report 2024-25**
Approved and presented by:	Paul Hooton, Executive Director Nursing, Quality, Women and Family Health
Prepared by:	Gareth Thomas, Head of Infection Prevention & Control
Other Committees and meetings considered at:	Infection, Prevention and Control Committee - 07.07.2026 Executive Committee – 22.07.2026 who endorsed the paper.

PURPOSE:

To present the Infection Prevention and Control Annual Report 2025/26, providing assurance on compliance with statutory requirements, national standards, and the effectiveness of infection prevention and control arrangements across Powys Teaching Health Board. The report outlines key achievements, performance, risks and priorities for improvement.

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 2025/26 that appropriate systems, governance arrangements and controls are in place to support the prevention and management of healthcare associated infections across the Health Board.

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	

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

EXECUTIVE SUMMARY:

The Infection Prevention and Control (IPC) Annual Report 2025/26 provides assurance regarding the Health Board's compliance with infection prevention and control statutory requirements, national policy expectations, and local governance arrangements. The report demonstrates continued progress in reducing avoidable healthcare-associated infections, strengthening antimicrobial stewardship, improving decontamination governance, and maintaining high levels of audit and training compliance across Powys Teaching Health Board.

Key achievements during 2025/26 include maintaining zero cases of MRSA bacteraemia, achieving reductions in both Escherichia coli and Methicillin-Sensitive Staphylococcus aureus (MSSA) bacteraemia, and delivering a 50% reduction in hospital-onset Clostridioides difficile infection. High levels of compliance were also demonstrated through the IPC annual audit programme (92.3%), observational audit programme (95.4%), and mandatory IPC training compliance, with both clinical and non-clinical staff exceeding the organisational target of 85%.

The report provides assurance on the effectiveness of the Health Board's governance arrangements, with the IPC Committee continuing to oversee compliance, performance, risks and improvement activity. Significant progress has been made on the implementation of the Aseptic Non-Touch Technique (ANTT) programme and continued development of policies relating to antimicrobial resistance.

The Health Board has continued to strengthen its antimicrobial stewardship programme through the appointment of a dedicated Antimicrobial Stewardship Pharmacist, delivery of targeted education programmes, prescribing audits and implementation of national antimicrobial improvement initiatives. Performance against national antimicrobial prescribing indicators demonstrates positive progress against several key measures.

Decontamination services have achieved significant improvements during the reporting period, including successful implementation of electronic equipment traceability systems, strengthened governance arrangements, a Reasonable Assurance internal audit opinion and achievement of a green rating within the Institute of Healthcare Engineering and Estate Management (IHEEM) assessment for the first time in over a decade.

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Whilst positive progress has been demonstrated, the report identifies a number of areas requiring ongoing focus, including patient screening processes, sharps

safety, linen management, selected observational audit measures and completion of remaining actions associated with antimicrobial resistant organism management. These areas are supported by improvement plans and will continue to be monitored through established governance arrangements.

The report concludes that robust infection prevention and control systems remain in place across the Health Board and provides assurance that effective governance, surveillance, audit, education and quality improvement processes are supporting the delivery of safe, high-quality care.

Priorities for 2026/27 include achieving organisational ANTT accreditation, strengthening patient experience involvement, progressing national infection prevention initiatives, embedding lessons identified through COVID-19 inquiry recommendations, and continuing to improve compliance against national infection prevention and control standards

DETAILED BACKGROUND AND ASSESSMENT

The attached annual report provides a comprehensive overview of infection prevention and control performance, governance and assurance arrangements across Powys Teaching Health Board for the period 1 April 2025 to 31 March 2026. It details performance against key healthcare-associated infection indicators, antimicrobial stewardship priorities, decontamination services, audit programmes, training compliance and improvement priorities for the forthcoming year. The report demonstrates continued organisational commitment to reducing avoidable infections, supporting patient safety and maintaining compliance with national standards and statutory requirements.

The annual report provides assurance that Powys Teaching Health Board has effective infection prevention and control arrangements in place, has maintained compliance across the majority of key performance indicators, and continues to demonstrate improvement against local and national priorities. The report highlights significant achievements during 2025/26 alongside clear priorities for further improvement and development during 2026/27.

The Committee is therefore asked to take assurance from the report and the governance arrangements supporting infection prevention and control across the organisation.

IMPACT ASSESSMENT – NOT REQUIRED FOR THIS REPORT

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Infection Prevention & Control Annual Report 2025/26

Powys Teaching Health Board

Key Performance Highlights 2025/26

92.3%	**95.4%**	**0**	**50%**	**85.8%**
IPC Annual Audit Compliance	Observational Dashboard Compliance	MRSA Bacteraemia Cases	Reduction in hospital-onset Clostridioides difficile	Winter Measures Audit Baseline
↓	**↓**	**91%**	**86%**	**✓**
Reduction in S. aureus bacteraemia	Reduction in E. coli bacteraemia	IPC Level 1 Training	IPC Level 2 Training	High levels of assurance in Decontamination

Reporting period: 1 April 2025 – 31 March 2026

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Contents

Contents 2
Foreword 3
Introduction 4
Key Achievements 2025/26 4
Team Structure 5
Compliance Against Code of Practice for HCAI Reduction 6
Aseptic Non-Touch Technique (ANTT) 6
Management of Clinically Significant Antimicrobial Resistant Organisms (CSARO) 6
Reporting Structure 7
Antimicrobial Stewardship (AMS) 8
AMS Key Activities 2025/26 8
WHC 2025/039 Improvement Goals and AWTTC National Prescribing Indicators 2025-8 (NPI) 9
AMS Priorities 2026/27 9
Healthcare Associated Infections (HCAIs) 10
Clostridioides difficile (CDI) 10
Gram Negative Blood Stream Infections (E. coli, Klebsiella and Pseudomonas aeruginosa) 11
Methicillin-Resistant Staphylococcus aureus Bacteraemia (MRSA) 11
Methicillin-Sensitive Staphylococcus aureus Bacteraemia (MSSA) 11
Outbreak and incident management 12
Infection Prevention & Control Audit Programme 13
IPC Audit Programme – Observational Dashboard 15
Infection Prevention & Control Winter Measures Audit 16
Training compliance 17
Environmental Cleanliness 18
Continuous Improvement Measures 18
Decontamination 19
Decontamination Internal Audit 2025/26 19
Commissioning Arrangements 21
IPC Priorities for 2026/27 22
Conclusion 23

Patterson Liz 03/09/2026 09:04:53

Foreword

It gives me great pleasure to present my first Infection Prevention and Control annual report for 2025-26, highlighting another year of progress, resilience, and achievement. This report reflects our collective efforts to improve and sustain standards across the Health Board.

The past year has been marked by both opportunities and challenges. Through the dedication of our staff, the commitment of our Board, and the support of our partners and stakeholders, IPC has continued to adapt, innovate, and grow. We have remained focused on delivering high-quality services, improving operational effectiveness, and creating sustainable work across all areas of our work.

During 2025-26 we achieved significant milestones, including work in decontamination via our internal audit and via our IHEEM audit. These accomplishments are testament to the professionalism, expertise, and passion of our IPC team, who consistently demonstrate a commitment to excellence and continuous improvement.

Paul Hooton
Executive Director of Nursing, Quality, Women & Family Health

Paul Hooton	Executive Director accountable for Infection Prevention & Control & Decontamination
Gareth Thomas	Head of Infection Prevention & Control & Decontamination

Peterson,Liz
03/08/2026 09:04:55

Introduction

This Infection Prevention and Control annual report for 2025/26 highlights the continued commitment of Powys Teaching Health Board to delivering safe, high-quality care through robust infection prevention and control practices.

Healthcare Associated Infections (HCAIs) remain a significant risk to patient safety and wellbeing, with far-reaching consequences for individuals, families, and healthcare services. Preventing infection is fundamental to ensuring positive patient outcomes, maintaining public confidence, and supporting the effective delivery of healthcare across Powys.

Powys Teaching Health Board is committed to maintaining the highest standards of infection prevention and control across all services. Through strong governance, evidence-based practice, and continuous learning, we strive to minimise the risk of infection and create safe environments for patients, staff, and visitors.

The Health Board maintains a zero-tolerance approach to avoidable HCAIs and is dedicated to identifying opportunities for improvement. Infection prevention and control is recognised as a key indicator of organisational quality, safety, and effectiveness, underpinning our ambition to provide consistently excellent care.

Key Achievements 2025/26

- Achieved reductions in both E. coli bacteraemia and Staphylococcus aureus bacteraemia.
- Maintained zero cases of Pseudomonas aeruginosa and Klebsiella bacteraemia throughout the reporting period.
- Delivered a year-on-year reduction in hospital-onset Clostridioides difficile infection.
- Successfully completed a comprehensive IPC annual audit programme, demonstrating strong performance across a number of key indicators, with results available via MEG.
- Maintained high compliance with mandatory and statutory IPC level 1 and 2 training, exceeding the recommended 85% target threshold.
- Strengthened governance and assurance arrangements through enhanced reporting and oversight via the IPC Committee
- Achieved reasonable assurance rating via internal audit for decontamination services, providing confidence in the effectiveness of systems and processes.
- Secured a green rating in the IHEEM annual audit – the first time in ten years.
- Continued progress towards ANTT accreditation, with ANTT training embedded as mandatory training requirement in ESR.
- Successfully implemented the ANTT train-the-trainer programme, increasing organisational capacity and supporting the consistent delivery of best practice.

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Team Structure

A dedicated Infection Prevention and Control team is established and operates in accordance with an annual work programme aimed at ensuring compliance and continuous improvement.

Role	Responsibilities
Executive Director of Nursing, Quality, Women & Family Health	Accountable Executive for IPC. Chairs the quarterly Infection, Prevention and Control Committee, which reports to the Patient, Experience, Quality & Safety Committee (PEQS).
IPC Doctor / Consultant Microbiologist	Provides expert clinical and microbiological advice to the IPC team and the wider organisation, supporting decision-making on complex infection-related matters.
Head of IPC & Decontamination	Leads the IPC and Decontamination service, overseeing the annual work programme, coordinating the team, and driving compliance and continuous improvement across the Health Board.
Specialist Practitioner in IPC	Delivers specialist IPC advice and practice across designated areas, undertakes audit activity, supports staff education, and contributes to the development and implementation of IPC policies and procedures.
Specialist Nurse in IPC	Provides clinical IPC nursing expertise across the organisation, supporting staff with infection prevention practice, contributing to surveillance activity, and leading on patient-facing IPC initiatives.
IPC Nurse	Supports the delivery of day-to-day IPC activity, including audits, training, surveillance, and providing frontline advice and guidance to clinical staff across Health Board sites.
Business Administration Manager	Provides administrative support to the IPC team, managing communications, records, and business functions to enable the effective running of the service.

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Compliance Against Code of Practice for HCAI Reduction

A review of compliance against Welsh Government Code of Practice for the reduction of Healthcare Associated Infection was undertaken as part of the Health Board's IPC improvement plan. This review identified a number of actions to support ongoing compliance and continuous improvement.

The majority of actions against this was completed; however, the following actions remained outstanding at the end of the 2024/25 period, and were incorporated into the 2025/26 IPC work programme:

Aseptic Non-Touch Technique (ANTT)

- A train-the-trainer programme was successfully delivered during 2025/26 resulting in 19 staff members being trained to support the wider implementation of ANTT across the Health Board.
- ANTT is now mandated for all clinical staff. Further rollout, accreditation, competency assessment and ongoing training remain a key focus for 2026/27 to ensure consistent application of best practice.

Management of Clinically Significant Antimicrobial Resistant Organisms (CSARO)

- Guidance for staff relating to the management of CSAROs is currently being finalised. This guidance and policy are scheduled for completion during early Quarter 2 of 2026/27, supporting a consistent and evidence-based approach to the management of antimicrobial resistance.

A revised Code of Practice is anticipated during 2026/27.

The IPC team will review the updated requirements upon publication and work with relevant stakeholders across the Health Board to ensure full alignment with any new standards, expectations, and compliance requirements.

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03/08/2026 09:04:55

Reporting Structure

The accountable Executive for Infection, Prevention and Control in Powys Teaching Health Board sits with the Executive Director of Nursing, Quality, Womens & Family Health. They chair the quarterly Infection, Prevention and Control Committee, which reports upward to the Patient, Experience, Quality & Safety Committee (PEQS).

The Infection, Prevention and Control team are core members of operational groups across the organisation, as outlined below:

Operational 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
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 (*switching to quarterly from 2026/27*)

Patterson,Liz
03/08/2026 09:04:55

Antimicrobial Stewardship (AMS)

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.

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 has an established AMS Group chaired by the Chief Pharmacist, which meets quarterly and reports to the IPC Committee, chaired by the Executive Director of Nursing. The AMS Group oversees a system-wide programme of work to tackle AMR across Powys, in line with national recommendations, and is supported by the dedicated resource of an AMS Pharmacist.

AMS Key Activities 2025/26

- Completion of the AMS Improvement plan initiated in 2024, with migration to a comprehensive ongoing AMS workplan for the Health Board, delivered by the AMS pharmacist and with oversight from the AMS group.
- Development of antimicrobial prescribing resources and support, including an increasing repertoire of localised antimicrobial guidelines, posters and patient information leaflets.
- Delivery of specialist infection, AMR and AMS education and awareness sessions across the Health Board through induction, preceptorship, nurse/pharmacy training, and wellbeing roadshows.
- Delivery of a targeted programme of work in primary care informed by ongoing prescribing surveillance, incorporating data visualisation, audit and feedback, and education sessions.
- Delivery of a penicillin allergy de-labelling workstream across primary care and community hospitals to facilitate optimal antimicrobial prescribing and improve patient outcomes.
- Delivery of a programme of AMS work in community hospitals, including regular antimicrobial stock review and inpatient audit of antimicrobial guideline adherence with direct feedback to ward teams.
- Ongoing clinical support for primary care clinicians and Powys Teaching Health Board direct service employed staff prescribing and administering antibiotics.
- Representation of Powys Teaching Health Board at national level (WG AMR Human Health Delivery Group and Welsh Antimicrobial Pharmacy Group/subgroups) to influence national strategic direction and delivery.

Impact: *With the appointment of a dedicated AMS Pharmacist, Powys is better able to deliver an AMS programme. Regular audit, education, feedback and strengthened governance are improving prescribing practice across the health board, aligning Powys with national antimicrobial standards.*

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WHC 2025/039 Improvement Goals and AWTTC National Prescribing Indicators 2025-8 (NPI)

Goal	Target	Reference	Powys Teaching Health Board Progress (May 2025)
1a	Reduce overall antimicrobial consumption in primary care by 10% against a 2019/20 baseline by 2029/30	NAP Target 4a / WHC TUA(PC)/2025 / NPI 2025-8	Currently achieving target (10.5% reduction Q3 25/6)
1b	Reduce overall antimicrobial consumption in secondary care by 5% against 2019/20 baseline. NB: Powys Teaching Health Board unable to report – cannot access pharmacy data	NAP Target 4a / WHC TUA(SCI)/2025 / NPI 2025-8	–
2	Reduce prescribing of broad-spectrum antimicrobials in line with treatment recommendations	NPI 2025-8	Currently achieving reduction target
3	75% of antibiotics prescribed for respiratory tract infections are 5-day courses by 2028	WHC DOC(PC)/2025 / NPI 2025-8	Currently achieving overall target (76.8% combined RTI antibiotics Feb 2025)
4	70% of total antibiotics used from Access category by 2029/30	NAP Target 4b / WHC PTUA/2025	Not currently achieving target (65% for Q1-3 25/6). Local data suggest target met for GP in-hours prescribing (79.7% Dec 2025)

AMS Priorities 2026/27

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

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Healthcare Associated Infections (HCAIs)

Welsh Government sets annual reduction expectations for Healthcare Associated Infections and antimicrobial prescribing. Due to the relatively small size of Powys Teaching Health Board and its patient population compared with other Health Boards in Wales, rates are often low and can fluctuate significantly. As a result, direct benchmarking against other Health Boards is not always meaningful.

Clostridioides difficile (CDI)

The Health Board has observed an overall increase in CDI cases during 2025/26 compared with the previous year. While hospital-onset CDI cases have reduced, reflecting continued improvement in infection prevention and control measures, community-onset cases have increased which account for the main proportion CDI cases reported this year.

Key learning from Clostridioides difficile reviews		
Antimicrobial Prescribing	There remain instances where antimicrobial prescribing does not align with current guidance.	EOLAS guidance has been reiterated to staff. Learning from has been shared through the Community Hospital Forum, chaired by the Medical Director, as a key mechanism for disseminating learning across services. The findings have also been discussed at the IPC Committee and Ward Managers' Meeting, with a 7-Minute Brief circulated across the organisation. The learning was further presented through the CSG Quality & Safety Meeting and the IPC Committee. Ongoing monitoring and audit of prescribing practices will continue to ensure sustained improvement and compliance.
Clearance Sampling	Repeat stool samples are still being submitted to confirm microbiological clearance after treatment. Routine clearance testing is not recommended, as patients may continue to test positive for CDI despite clinical recovery.	A 7-Minute Brief was disseminated across the organisation. The learning was presented through the CSG Quality & Safety Meeting and the IPC Committee and was also discussed at the Ward Managers' Meeting.

Patterson,Liz 03/08/2026 09:04:55

Key learning from Clostridioides difficile reviews		
Gastric Acid Suppression Therapy	Proton pump inhibitors (PPIs) should be reviewed regularly and discontinued where there is no clear ongoing indication, as their use may increase the risk of CDI.	Community hospital forum, which is chaired by Medical Director as mechanism for sharing learning. Learning also discussed and shared at IPC Committee. Continue to monitor and audit prescribing practices
Antimotility Treatments	Cases continue to be identified where antimotility agents (e.g. loperamide) are prescribed. These medications are contraindicated in CDI, as they may delay toxin clearance and increase the risk of complications, and should therefore be avoided.	Community hospital forum, which is chaired by Medical Director as mechanism for sharing learning. Learning also discussed and shared at IPC Committee. Continue to monitor and audit prescribing practices
Microbiology Advice	Early consultation with Microbiology colleagues is encouraged in complex cases or in patients with recurrent infection, to support appropriate and effective treatment decisions.	

Gram Negative Blood Stream Infections (E. coli, Klebsiella and Pseudomonas aeruginosa)

The Health Board has observed an overall decrease in gram negative blood stream infections with zero cases of Klebsiella and Pseudomonas aeruginosa reported.

Methicillin-Resistant Staphylococcus aureus Bacteraemia (MRSA)

The Health Board has reported zero MRSA bacteraemia cases and has maintained this position since 2013/14.

Methicillin-Sensitive Staphylococcus aureus Bacteraemia (MSSA)

The Health Board observed an overall decrease in MSSA bacteraemia cases.

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03/08/2026 09:04:55

Outbreak and incident management

During the reporting period, an increase in acute respiratory illness and gastrointestinal outbreaks were observed across Powys Teaching Health Board sites, with most cases occurring during Quarter 3/4, reflecting the seasonal increase in circulating respiratory and enteric viruses.

All outbreaks were reported and managed in-line with the Health Board's Duty of Candour and incident management processes. Comprehensive reviews were undertaken following each outbreak, with key learning identified and disseminated through Quality & Safety governance structures, operational groups and the IPC Committee. Resulting actions and improvements were implemented to strengthen prevention and control practices and support organisational learning.

As Powys Teaching Health Board does not operate as an acute hospital trust, the overall impact on patient flow and operational capacity was less significant than that experienced within acute care settings. However, when beds were temporarily closed due to outbreaks, multidisciplinary risk assessments were undertaken. Where system pressures required patient transfers, decisions balanced patient safety, clinical need, risk, and system resilience, with IPC measures maintained throughout.

Ref	Hospital	Quarter	Organism	Outcome
OB-01	Knighton Hospital	November 2025 – Q3	*Influenza A*	Environment closed & enhanced IPC measures implemented per outbreak management process
OB-02	Ystradgynlais Community Hospital	March 2026 - Q4	*Norovirus*	Environment closed & enhanced IPC measures implemented per outbreak management process
OB-03	Ystradgynlais Community Hospital	March 2026 - Q4	*Norovirus*	Environment closed & enhanced IPC measures implemented per outbreak management process
OB-04	Bro Ddyfi Hospital	March 2026 – Q4	*Parainfluenza*	Environment closed & enhanced IPC measures implemented

Patterson,Liz 03/08/2026 09:04:55

Infection Prevention & Control Audit Programme

An annual audit is undertaken by the IPC team aligned with the Infection Prevention Society (IPS) guidance and best practice standards. Annual audits are undertaken using IPS-based tools and methodologies to provide robust assurance regarding compliance with IPC standards.

The IPC annual audit achieved an overall compliance score of 92.3%. Most audit domains demonstrated consistently high levels of compliance, with strong performance in environmental cleanliness, patient care areas, staff training and compliance, policies and procedures, and infection prevention controls.

Areas identified for improvement include patient screening, along with opportunities to strengthen performance in sharps safety, linen management and findings in sluice/dirty utility areas. These findings have informed targeted action plans and ongoing monitoring to support sustained improvement through the IPC Committee and other relevant operational groups.

Overall, the results demonstrate a positive culture of quality and compliance across the Health Board, with focused interventions planned to address identified gaps and further enhance IPC measures in the coming year.

Patterson,Liz
03/08/2026 09:04:55

Section	Performance
Section 1.1: General Management	High
Section 1.2: Patient Screening	Requires Improvement
Section 1.3: Staff Training & Compliance	High
Section 1.4: Policies, Procedures and Guidelines	High
Section 2.1: Environment – Corridors	High
Section 2.2: Patient Care Areas	High
Section 2.3: Environment – Patient Bathrooms	High
Section 2.4: Environment – Toilets	High
Section 2.5: Environment – Sluice/Dirty Utility	Requires Improvement
Section 2.6: Environment – Clean Utility	High
Section 2.7: Environment – Storeroom	High
Section 2.8: Environment – Domestic Cupboard	High
Section 2.9: Linen Management	Requires Improvement
Section 3: Patient Equipment	High
Section 4: Waste	High
Section 5: Isolation Precautions	High
Section 6: PPE	High
Section 7: Sharps Safety	Requires Improvement
Section 8: Food Hygiene	High

Overall Compliance: 92.3% (April 2025 – March 2026)

Areas identified as requiring improvement remain a key focus and are subject to ongoing oversight through the relevant safety groups and the IPC Committee. Progress against agreed actions is regularly monitored to provide assurance that improvements are being embedded and that compliance continues to increase and be sustained over time.

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IPC Audit Programme – Observational Dashboard

The shorter IPC observational dashboard demonstrates strong overall compliance performance of 95.4% across all submitted audit and observational activities between 1st April 2025 and 31st March 2026. This reflects a high level of engagement and adherence to organisational standards across those services included within this audit.

The medical equipment and sharps audit categories highlight that a small number of opportunities exist for further improvement. These will remain a focus for 2026/27 and monitored through the appropriate internal oversight group.

Observational Category	Performance
Environmental Cleaning Observational Checklist	High
Mattress Audit Tool	High
Sharps Audit Observation Chart	Requires Improvement
Wales Uniform Policy Observation Checklist	High
Bare Below the Elbow (BBE) Observational Audit	High
Hand Hygiene	High
Medical Equipment	Requires Improvement

Overall Observational Compliance: 95.4% (April 2025 – March 2026)

Areas identified as requiring improvement remain a key focus and are subject to ongoing oversight through the relevant safety groups and the IPC Committee. Progress against agreed actions is regularly monitored to provide assurance that improvements are being embedded and that compliance continues to increase and be sustained over time.

Patterson,Liz 03/08/2026 09:04:55

Infection Prevention & Control Winter Measures Audit

As we entered the Winter 2025/26 period, a series of audits were undertaken across our clinical environments to identify areas requiring improvement in winter preparedness and IPC measures. The findings enabled us to identify and target specific areas for improvement, allowing resources and interventions to be directed where they would have the greatest impact. The baseline audit reported a rate of 85.8% across the Health Board.

Compliance Item	Performance
Are there display posters at the entrance advising visitors to wear a mask?	Requires Improvement
Are masks available at the entrance to ward/department?	High
Are waste bins available at exit points for safe disposal of masks?	High
Are staff wearing visors when in clinical environments?	High
Is there evidence of ventilation measures on the ward?	High
Are staff aware and ensuring that visitors should not be visiting if ill?	High
Are patients appropriately isolated?	High
Is there evidence of transfer or document being correctly completed?	Requires Improvement

Baseline Compliance: 85.8% (27 observations, Oct 2025 – Jan 2026)

Areas identified as requiring improvement remain a key focus and are subject to ongoing oversight through the relevant safety groups and the IPC Committee. Progress against agreed actions is regularly monitored to provide assurance that improvements are being embedded and that compliance continues to increase and be sustained over time.

Patterson,Liz
03/08/2026 09:04:55

Training compliance

Mandatory IPC training is a core requirement for all staff across Powys Teaching Health Board, with compliance monitored and reported through the Electronic Staff Record (ESR) system.

IPC Level 1 is aimed at non-clinical staff and covers fundamental infection prevention and control principles relevant to their working environment. This level is required every three years, reflecting the nature of the work undertaken by this staff group.

IPC Level 2 is required for all clinical staff and must be completed annual, ensuring that those working directly with patients maintain up-to-date knowledge and competency in infection prevention and control practice. The higher frequency reflects the greater infection risk associated with clinical roles.

The majority of training across both levels is delivered via ESR, providing a flexible, accessible route for staff to complete their mandatory requirements. In addition to online learning, a programme of face-to-face sessions has been offered at sites across the Health Board throughout the year, supporting staff who benefit from more interactive or practical learning, and ensuring training remains accessible regardless of role or location.

The IPC team has also provided support to the Health Protection Team in delivering IPC training to care homes across the Powys area. This outreach activity extends the reach of the Health Board's infection prevention expertise beyond its directly managed services.

Compliance Item	Target	Performance
Infection Prevention and Control Level 1 Training	>85%	91%
Infection Prevention and Control Leve 2 Training	>85%	86%

IPC annual training compliance (data obtained from ESR)

Patterson,Liz
03/08/2026 09:04:55

Environmental Cleanliness

Powys Teaching Health Board recognises the importance of maintaining clean environments, particularly within areas identified as requiring critical levels of cleanliness.

The Support Services Department holds primary responsibility for maintaining hygiene and cleanliness standards across all Health Board environments. This includes clinical, non-clinical, and public areas, as well as any additional facilities utilised for healthcare purposes. Designated staff within relevant departments also undertake specific equipment cleaning responsibilities as required.

The Health Board's Environmental Cleanliness Standards Operating Procedure applies to all sites and staff. It sets out the required processes to ensure consistently high standards of cleanliness, supported by detailed method statements outlining procedure, frequency, and responsibilities. This framework applies to both Support Services and nursing staff.

To provide assurance on environmental cleanliness standards, the Facilities Department produces monthly reports covering key performance indicators. These reports support the monitoring and demonstration of service effectiveness across Powys Teaching Health Board sites and 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

Impact: *Reporting capability has evolved following the transition to Synbiotix cleanliness monitoring software, which provides enhanced reporting functionality and improved performance dashboards.*

Continuous Improvement Measures

Following IPC environmental audits, a range of continuous improvement measures have been implemented and will continue to be developed throughout the reporting period:

- Ongoing collaboration and communication with Facilities teams regarding reactive and routine cleaning matters
- Enhancement of audit feedback mechanisms
- Development of joint auditing approaches to validate findings and address variances between audit data and observational outcomes
- Delivery and monitoring of the Facilities Improvement Plan
- Re-establishment and support of the Environmental Cleanliness Group
- Expansion of targeted IPC training opportunities for Facilities staff

The anticipated introduction of updated National Standards for Environmental Cleanliness will inform further collaborative workstreams over the coming year, supporting the continued improvement of environmental cleanliness across Powys Teaching Health Board.

Powys Teaching Health Board 03/09/2025 09:04:55

Decontamination

The Decontamination Service made significant progress in governance, performance, and quality assurance through modernisation, stronger assurance processes, and effective collaboration with clinical and national partners. This success was underpinned by the leadership of a dedicated workstream and operational lead, whose direction has been critical in sustaining improvement.

A major achievement was the implementation of the Health Edge electronic tracking system, providing full traceability of equipment and addressing longstanding audit recommendations. This has strengthened compliance, audit readiness, and patient safety. Updated decontamination policies now align fully with national standards, reinforcing a consistent and robust governance framework.

Operational improvements have reduced infection risks and improved efficiency, including the introduction of single-use equipment and enhanced endoscopy storage systems. Investment in ultrasound decontamination processes has further strengthened assurance.

Strategic developments include a new Service Level Agreement for outsourced sterile services, improving accountability and resilience, alongside a trial of centralised dental instrument processing, showing benefits in quality and efficiency. The service has also supported wider quality improvement through dental audits in primary care.

Collaboration with HEIW has supported the development of national digital training resources, strengthening workforce capability. Assurance outcomes have been strong, with positive internal and external audit results, including a notable green IHEEM rating – an achievement not seen in the Health Board for over a decade.

Decontamination Internal Audit 2025/26

An internal audit of the decontamination service was undertaken during 2025/26 to provide assurance regarding the effectiveness of governance arrangements, compliance with national guidance, workforce competency, and the management of reusable medical devices and patient care equipment.

The audit concluded an overall opinion of Reasonable Assurance, reflecting that appropriate controls are largely in place and operating effectively.

Of the five audit objectives reviewed: two areas received Substantial Assurance, and three areas received Reasonable Assurance.

Patterson,Liz 03/08/2026 09:04:55

#	Objective	Related Findings	Assurance
1	Governance arrangements are in place to ensure oversight of decontamination matters including the monitoring of decontamination risks.	1, 2	Reasonable
2	Accessible Decontamination policies and procedures are in place at both a Health Board and localised level that reflect relevant national guidance.	–	Substantial
3	Roles and responsibilities of staff in relation to decontamination have been clearly defined and training resources are adequate.	3	Reasonable
4	Decontamination of reusable medical devices is consistently undertaken in accordance with the prescribed policies and procedures to ensure compliance with relevant national guidance.	–	Substantial
5	Record-keeping and monitoring arrangements have been established in relation to the decontamination of all reusable medical devices and patient care equipment. Audit programmes are comprehensive, and plans are in place to address any areas of non-conformance.	4	Reasonable

Decontamination internal audit findings

Patterson,Liz 03/08/2026 09:04:55

Commissioning Arrangements

Powys Teaching Health Board commissions care both within Wales and across the border in England. The team has continued to build and maintain strong relationships with counterparts in England, participating in meetings and attending post-infection reviews where Powys patients have been affected. This collaborative approach provides assurance to the Health Board that the potential causes of healthcare-associated infections (HCAIs) have been thoroughly examined and that any learning is identified and implemented by the commissioning organisation.

As we move into 2026/27, the IPC team will continue to strengthen these partnerships and share learning through the IPC Committee.

In relation to decontamination, our commissioning organisations continue to attend internal Decontamination Safety Group meetings, further strengthening governance and oversight.

Patterson,Liz
03/08/2026 09:04:55

IPC Priorities for 2026/27

Priority Area	Key Focus	Intended Impact
Audit & Training	Sustain and enhance IPC audit programmes and workforce training across the Health Board	Improved compliance, consistency, and staff competency
National CDI Work	Ongoing contribution to national CDI workstreams	Reduction in CDI rates and alignment with best practice
Patient Experience	Embed patient feedback into IPC planning and improvement	More person-centred, responsive IPC services
FMT Service Development	Establish a nurse-led Faecal Microbiota Transplant service for recurrent Clostridioides Difficile	Improved treatment options for recurrent infections
ANTT Accreditation	Achieve organisation-wide ANTT accreditation	Standardised aseptic practice and improved patient safety
COVID-19 Learning	Integrate Module 3 inquiry recommendations into routine practice	Stronger preparedness and resilient systems
Networks & Collaboration	Participating in HCAI Delivery, IPC and AMR networks	Shared learning and system-wide improvement
Gloves Off Campaign	Promote appropriate glove use and hand hygiene	Better practice and reduced costs/environmental impact
Standards & Assurance	Review against IPC Quality Statement and Code of Practice	Continuous quality improvement and compliance

Patterson,Liz
03/08/2026 09:04:55

Conclusion

This annual report demonstrates the sustained commitment of Powys Teaching Health Board to delivering high-quality, safe care through robust infection prevention and control practices. Throughout 2025/26, the IPC team has worked diligently across all areas of the organisation to maintain and improve standards, supported by strong governance arrangements and a dedicated multidisciplinary workforce.

Key achievements this year include maintained zero MRSA bacteraemia cases, year-on-year reduction in hospital-onset CDI, strong audit compliance scores of 92.3% (annual) and 95.4% (observational dashboard), a green IHEEM decontamination rating for the first time in nearly ten years, and continued progress with ANTT accreditation.

Looking ahead to 2026/27, the IPC team will build on these successes by focusing on the nine strategic priorities outlined in this report. The team remains committed to continuous improvement, national collaboration, and ensuring that infection prevention and control remain central to the delivery of excellent healthcare across Powys.

This report will be presented at the Infection Prevention and Control Committee in July 2026 and then onwards to the Patient, Experience, Quality and Safety Committee in August 2026.

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03/08/2026 09:04:55

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 4.6

PATIENT EXPERIENCE & QUALITY COMMITTEE	**04 AUGUST 2026**
Subject:	**Integrated Quality Report: Quarter 1 2026/27**
Approved and presented by:	Paul Hooton, Executive Director Nursing, Quality, Women & Family Health
Prepared by:	Director of Midwifery, Women & Family Health, Quality & Safety Interim Head of Quality & Safety
Other Committees and meetings considered at:	Executive Committee, 22 July 2026.

PURPOSE:

To provide an overview of quality and safety for Quarter 1, including progress against priorities identified in Quarter 4.

RECOMMENDATION(S):

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

- **NOTE** progress in embedding the revised Integrated Quality Report structure and principles;
- Take **ASSURANCE** from the triangulated analysis of quality and safety intelligence for Q1, and
- **DISCUSS** any concerns or lines of enquiry.

Approve/Take Assurance	Discuss	Note
Y	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	N	
4. Enable Joined up Care	Y	
5. Develop Workforce Futures	N	
6. Promote Innovative Environments	Y	
7. Put Digital First	N	
8. Transforming in Partnership	Y	

EXECUTIVE SUMMARY:

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This report provides the Executive Committee with an overview of quality and safety for Quarter 1 2026/27, building on the revised Integrated Quality Report structure introduced in Quarter 4.

The triangulated reporting approach continues to be embedded, providing a more consistent and integrated view of quality and safety across the Health Board. The key themes identified in Q4 - communication and patient engagement, access to care and timeliness, clinical decision-making, care coordination, and operational pressures - remain consistent across Q1. This provides assurance that organisational focus remains aligned to these priorities. Progress has been made in translating these themes into action through refined organisational priorities and the development of a thematic organisational learning approach, supported by a learning network to promote shared learning and improvement across the identified priority areas.

The Listening to People (LTP) framework has been successfully implemented from 1 April 2026. The Q4 report committed to developing a Health Board-wide Standard Operating Procedure (SoP) to support a robust and standardised local approach to implementing the Listening to People Regulations. The SoP has been developed, with work now focused on embedding the arrangements across services, providing a consistent framework for local management, quality assurance and governance of concerns.

Whilst early improvements are evident in governance, oversight and alignment of intelligence with improvement activity, evidence of measurable impact on outcomes and experience remains at an early stage, reflecting the recent implementation of a number of these arrangements.

Overall, the Executive Committee can take assurance that the Health Board has strengthened its understanding of quality and safety, has identified clear organisational priorities, and has established the foundations required to deliver improvement. The focus for Q2 will be to further embed these arrangements and demonstrate measurable impact against agreed priority areas.

1. INTELLIGENCE

This section summarises Q1 quality and safety intelligence, drawing on incidents, concerns, patient experience, Duty of Candour and claims data. It highlights key themes, trends and emerging signals to support risk identification, organisational learning and improvement.

1.1 Listening to People – Concerns

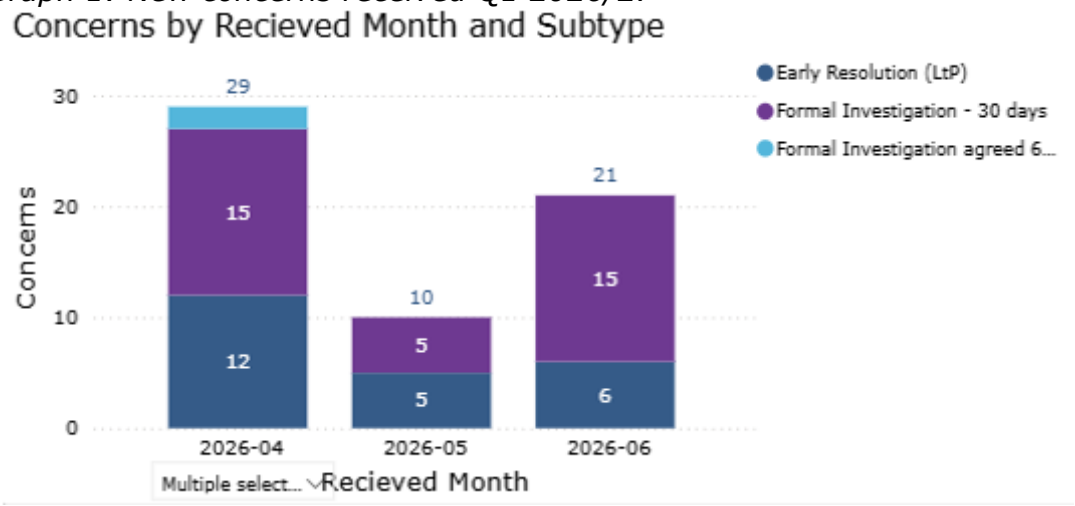
The All-Wales Listening to People Regulations were implemented from 1 April 2026, replacing the previous Putting Things Right arrangements. During Q1, the focus has been on establishing revised processes, governance arrangements and staff guidance, with an emphasis on early resolution and listening conversations.

Patterson, Liz 03/08/2026 21:04:55

Early resolution approach
The revised approach aims to resolve concerns through early resolution within 10 working days of acknowledgement, following a listening discussion with the complainant. Further work is required to embed consistent practice across services and ensure that learning from concerns is systematically used to support improvement. Should an early resolution exceed the 10-day timescale, under the framework, the concern will revert to a formal concern. Further wok is ongoing to support clinical teams with timely management of Early Resolution concerns.

Quarter 1 activity
In Quarter 1 2026/27, **35** formal and **23** early resolution concerns were raised, consistent with the rate and split of concerns over each quarter in the previous year.

Graph 1: New concerns received Q1 2026/27



A review of the organisational themes identified in Q1 are:

- **Access, Delays and Waiting Times** *(the strongest recurring theme)*
  - Delays in referrals being processed and long waits before being added to waiting lists
  - Delays in assessment and progression through care pathways, including concerns regarding access to services and ongoing support.
- **Communication, Engagement and Administrative Processes**
  - Lack of telephone support, difficulty contacting teams, calls not being returned, and limited administrative availability
  - Families not being kept informed, involved in decision-making, or provided with updates regarding progress through pathways.
- **Care, Treatment and Decision-Making**
  - Diagnostic concerns and clinical decision-making

Patterson,Liz
03/08/2026 09:04:55

- Concerns regarding specialist input, ongoing treatment plans, and the appropriateness of care provided.

➢ **Care Coordination and Continuity**
- Placement decisions, care packages and Continuing Healthcare arrangements.
- Care coordination, support planning and management across complex pathways.

➢ **Experience, Support and Relationships**
- Staff attitude, behaviour and communication style.
- Feeling unsupported, not listened to, or experiencing insufficient support throughout the care journey.

The themes listed above are taken from the complaint narrative and are therefore patient / family perspective as per the complaint. They are also consistent with previous reporting and continue to shape the organisational learning moving forwards. The analysis also identified a number of areas where concerns are concentrated and these include, Neurodevelopment, Mental Health and Autism services, whilst concerns around continuing health care packages also appear problematic. The Quality & Safety Team is currently working with service groups to review these findings, identify contributing factors and support the delivery of targeted improvement activity. Emerging learning is being incorporated into organisational learning programmes and will inform future reporting against the identified organisational priorities.

1.2 Incident Reporting

In Q1 2026/27 the following incidents were reported by level of harm:

Table 1: Level of harm Q1 – post investigation grading

Level of harm	Apr	May	Jun	Total
None	251	196	174	621
Low	65	52	55	172
Moderate	0	0	0	0
Severe	0	0	0	0
Catastrophic/Death	0	0	0	0
Investigation ongoing	105	116	212	433
TOTAL	**421**	**364**	**441**	**1226**

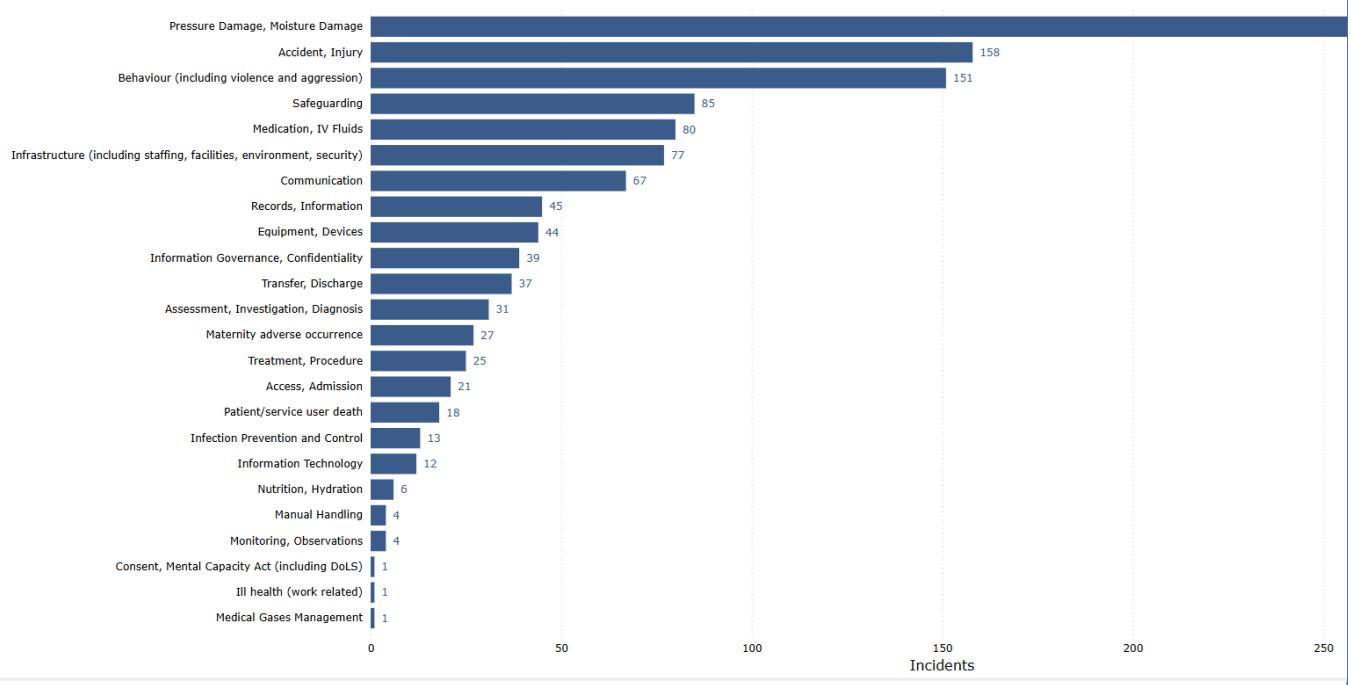
Table 1 shows the level of harm recorded following review or investigation of incidents reported during Q1 2026/27. Following review, the majority of incidents were recorded as either **no harm** or **low harm**, accounting for 793 of the 1,226 incidents reported. No incidents were recorded as moderate, severe or catastrophic/death harm following investigation during the quarter. This provides positive assurance that, where post-investigation harm has been completed, the residual harm profile remains low.

Patterson, Kate 03/08/2026 09:04:55

However, 433 incidents, representing approximately 35% of all incidents reported in Quarter 1, remained under investigation at the time of reporting and therefore did not have a final post-investigation harm assessment recorded. This limits the assurance that can currently be taken from the post-investigation harm profile, as outcomes remain subject to ongoing review and investigation.

In previous reports these incidents were reported as 'no value', and it was initially understood that this reflected incomplete harm grading. Further review has provided assurance that post-investigation harm assessment is a mandatory field upon closure of an incident and that the 'no value' category predominantly relates to incidents where investigation remains ongoing rather than deficiencies in data completion.
To improve clarity and transparency, future reporting will distinguish incidents with ongoing investigations from those with completed post-investigation harm assessments. This will provide a more accurate reflection of incident management activity and support improved interpretation of harm-based reporting over time.

Graph 2: Incidents by classification/type



Graph 2 indicates types of incidents reported in Q1. Accident and Injury incidents, which reduced by 32% compared to Q4. Whilst this is encouraging, further review is required to understand the factors contributing to this reduction and whether it represents a sustained improvement. Reductions were also seen in Pressure Damage, Transfer and Discharge, Infection Prevention and Control, and Patient Death incidents, providing some

Patterson, Liz
03/08/2026 09:04:55

assurance that existing prevention and oversight arrangements may be contributing to improvement.

Pressure Damage remains the highest-volume incident category and continues to require sustained focus through prevention activity, service-level review and triangulation with wider quality and safety intelligence. The Quality & Safety Team will work with the lead, attend and support panels and ensure that support is offered to underpin improvement in this area.

Increases were noted in Behaviour-related incidents, Safeguarding, Medication, Communication, Records Management and Information Governance. These categories indicate areas of potential operational and governance risk and should be explored further to determine whether the increase reflects deterioration, improved reporting culture, or changes in coding and classification.

Overall, Graph 4 provides moderate assurance that several high-volume categories are reducing, while identifying priority themes for further review in Quarter 2 and inclusion within the learning plans.

1.3 Early Warning Notifications

A total number of 3 Early Warning Notifications were submitted during Q1 2026/2027. Due to the small number of notifications, and the fact they were all unconnected and unrelated in nature, a detailed thematic analysis has not been undertaken, as this would provide limited organisational insight and may risk identifying individual cases.

Each notification has been subject to review through the appropriate governance processes, with learning shared with relevant services and stakeholders where appropriate. Whilst the incidents were unrelated in nature, they have provided opportunities to reinforce key principles relating to safe care, effective communication, governance, risk management and organisational learning.

The Health Board remains committed to ensuring that learning from significant events is identified, acted upon and shared proportionately. Learning arising from Early Warning Notifications continues to inform local improvement activity and contributes to the wider triangulation of quality and safety intelligence across the organisation.

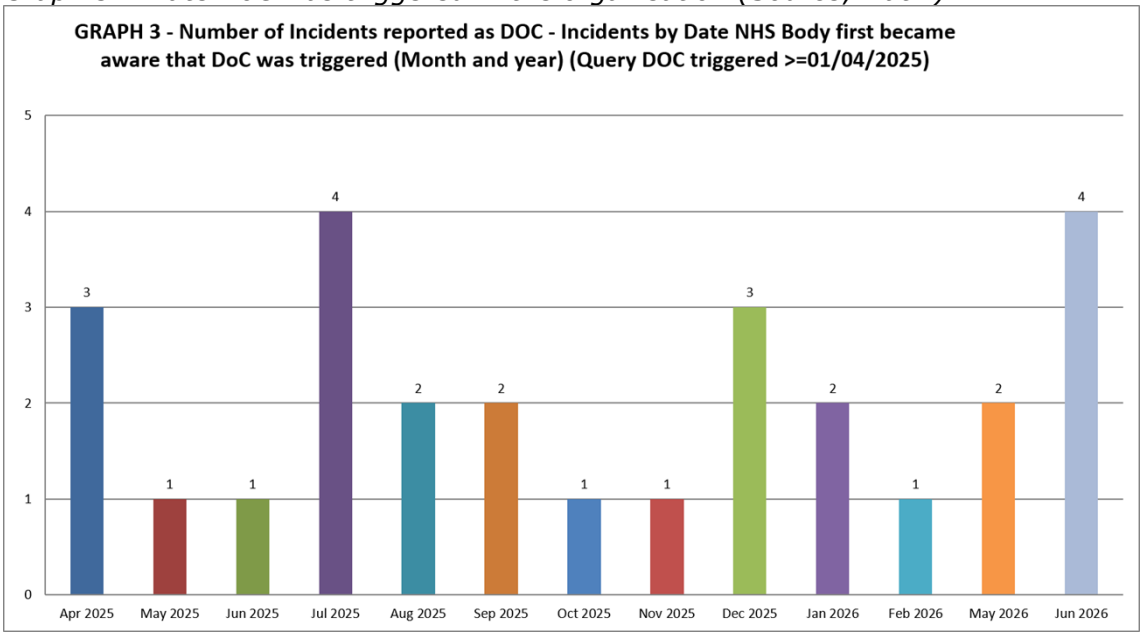
1.4 Duty of Candour

In Q1, 4 incidents triggered Duty of Candour (DoC), 3 of which currently remain open and under investigation. At this stage, no recurring themes or patterns have been identified from the incidents reviewed. Each case is being managed through the appropriate Duty of Candour process, with oversight to ensure timely communication, apology where required, involvement of

Patterson, Liz
03/08/2026 09:04:55

patients and/or families, and completion of investigation and learning actions.

Graph 3 – Date DoC was triggered in the organisation (Source; Datix)



1.5 Claims, Redress & Inquests

Table 2: Current position of Q1 activity

Category	Current Position	Q1 Activity
Redress	13 open cases (June 2021 – March 2026)	No new cases in Q1
Clinical Negligence	8 confirmed cases	No new cases in Q1
Personal Injury	<5 confirmed cases	No new cases in Q1
GMPI Claims	<5 confirmed cases	No new cases in Q1
Inquests	20 confirmed inquests	3 new cases in Q1

Table 2 shows a stable position across Redress, Clinical Negligence, Personal Injury and GMPI claims, with no new cases reported in Q1. This provides assurance that there has been no immediate increase in new claims activity during the period; however, continued oversight is required to ensure timely progression of existing cases and to identify any emerging learning.

Inquests remain the highest-volume category, with 20 confirmed cases, 3 of which are new cases reported in Q1. The ongoing thematic links highlight the need to maintain strong governance oversight, ensure learning is captured consistently, and triangulate findings with incidents, concerns and mortality review processes. Themes include:

- Mental health-related deaths
- Clinical decision-making and clinical risk assessment

Patterson, Liz 03/08/2026 09:04:55

1.6 People's Experience

The People's Experience Framework remains the strategic approach for improving how the Health Board listens to, learns from and responds to the experiences of patients, families and carers. This section therefore brings together patient feedback, compliments, survey intelligence, learning and progress against the People's Experience Framework to provide a consolidated overview of organisational performance and improvement.

Civica Feedback

Patient feedback collected through all surveys through Civica and wider engagement activity during Q1 provides important insight into patient experience across services. Overall, feedback remains positive, with a high proportion of responses indicating satisfaction with care received, reflected in over 2,000 comments recorded during the period. The table below demonstrates the total number of responses received into Civica for all types of active surveys and number of contacts via SMS.

Table 3: Civica response data Q1

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-26	36	9	30	549	202	347	5	1030	0
May-26	33	6	29	778	415	363	0	2766	0
Apr-26	29	5	28	769	447	322	2	3029	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

NB: responses via SMS are delayed by one calendar month, therefore not a complete representative of June 2026.

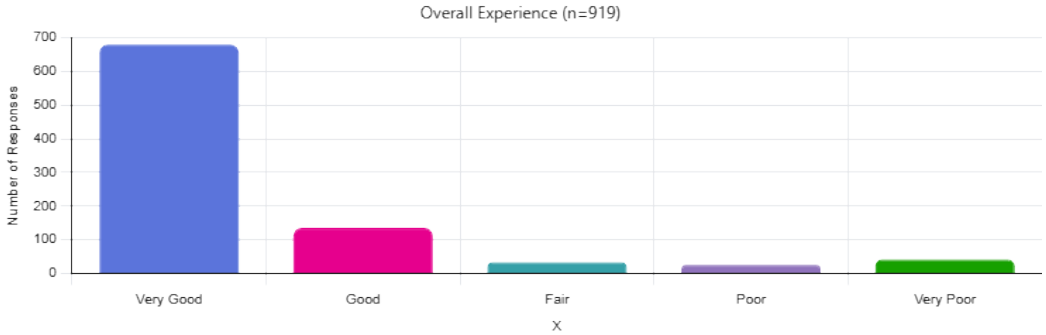
Table 4: Record you compliments

Month	Surveys			Responses			
	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
Jun-26	1	0	1	53	0	53	0
May-26	1	0	1	64	0	64	0
Apr-26	1	0	1	30	0	30	0

Compliments received via cards, letters or verbal comments are actively recorded through CIVICA and are outlined below, identifying 147 compliments were received in Q1. This is a drop from 214 in Q4 but relies on staff inputting their feedback onto the survey within Civica.

Patterson, Liz 03/08/2026 09:04:55

Table 5: Overall experience scores



Across all surveys within Civica the overall experience of people using our services was positive with 816 reporting their experience was either very good or good (very good: 680, good: 136).

People's Experience Survey

Analysis of the feedback received from the national People's Experience Survey (PES) which received 760 comments from April–June 2026 is overwhelmingly positive, with most respondents rating their experience as "Very Good" and expressing strong appreciation for staff and the care they received. Outstanding staff compassion and professionalism was the strongest and most consistent theme across the dataset.

Patients frequently describe staff as:

- Kind and caring
- Friendly and approachable
- Professional and knowledgeable
- Respectful and dignified
- Supportive and attentive

Many comments specifically mention staff going "above and beyond" and making patients feel valued as individuals.

Key improvement themes, although relatively uncommon, identified several issues which appeared repeatedly. These mainly focussed on:

- Parking and travel
- Appointment scheduling and administration (difficulty changing appointments and delayed responses from services)
- coordination between services (repeating history to multiple professionals and cross-border communication)

Learning arising from patient experience intelligence will be incorporated within the Health Board's developing thematic organisational learning approach, described in more detail under section 2. Triangulation.

Patterson, Kerry
03/08/2026 09:04:55

It should be noted that the All-Wales target for patient experience is 7.5, and there is a consistent score for PTHB, averaging 8.5. PTHB scored 8.46 at the

end of Q2 and were scoring 7th out of all Health Boards across Wales. The information reported into the national Beacons Dashboard has a time lag, and therefore the data set for the most recent month, often scores us below the target, but this is generally corrected the following month after the data lag is corrected.

1.7 Development of Quality Intelligence

The Intelligence section continues to evolve as the Health Board strengthens its approach to the triangulation and analysis of quality and safety information. During Quarter 1, reporting has been expanded to include a broader range of intelligence sources, including patient experience, complaints, incidents, Duty of Candour, claims and inquests.

As capacity and resilience within the Quality and Safety Team continues to improve, further development of this section is planned during Quarter 2. This will include enhanced thematic analysis and organisational learning arising from Bereavement Services, Medical Examiner scrutiny, Health Inspectorate Wales (HIW) inspections, external audits and other assurance activity.

The intention is to further strengthen the depth and breadth of organisational intelligence, bringing together learning from multiple sources to support a more comprehensive understanding of emerging risks, opportunities and quality priorities across the Health Board. This will support the continued development of a thematic organisational learning approach and enable more targeted improvement activity through the Health Board's learning and governance arrangements.

2. TRIANGULATION

2.1 Refined Thematic Analysis

Triangulation of quality and safety intelligence seeks to provide a broader understanding of organisational performance than can be achieved through the review of individual datasets in isolation. By bringing together learning from concerns, incidents, patient experience, Duty of Candour, claims, inquests and other sources of intelligence, the Health Board is able to identify recurring issues, emerging risks and opportunities for improvement that may not be apparent from a single source alone. This approach supports a more balanced and reliable assessment of quality and safety, strengthening organisational learning and informing priority setting.

Triangulation of Q1 intelligence demonstrates a high degree of consistency across intelligence sources and confirms that the core themes identified in Quarter 4 remain valid. Whilst individual datasets provide different perspectives, common themes continue to emerge relating to access and timeliness, communication and engagement, clinical decision-making and risk assessment, care coordination and continuity, and wider operational

Patterson, Liz 03/08/2026 13:04:55

pressures affecting service delivery. The consistency of these themes across multiple intelligence sources provides confidence that organisational focus remains directed towards the area's most likely to improve quality, safety and experience.

Importantly, triangulation is not intended to identify individual service issues in isolation, but rather to support a deeper understanding of the factors influencing quality and experience across the Health Board. This enables intelligence to be translated into organisational learning, supports the identification of shared priorities, and helps ensure improvement activity is informed by the collective experience of patients, families and staff.

The Health Board's current view of the principal organisational priorities for 2026/27, emerging from the available intelligence and providing the basis for ongoing organisational learning and improvement activity are:

- **Communication and patient engagement** – improving the clarity, consistency and timeliness of information and involvement of patients and families
- **Access to care and timeliness** – reducing delays across pathways, including assessment, treatment and response times
- **Clinical decision-making and risk assessment** – strengthening consistency and quality of clinical judgement and risk management
- **Care coordination and continuity** – improving integration across services and clarity of patient pathways
- **Operational and system pressures** – addressing workforce, environmental and process factors impacting service delivery and patient safety

The identification of these priorities is intended to drive organisational action as well as organisational understanding. During Quarter 1, improvement activity has focused on strengthening the systems, governance, learning and educational arrangements required to support sustainable improvement across these areas. Work is now underway to implement a more structured thematic approach to organisational learning, enabling intelligence from multiple sources to be translated into targeted improvement activity across the organisation.

It is recognised that many of the themes identified through triangulation represent complex and enduring challenges that are unlikely to be resolved within a single reporting period. Themes such as communication, access and timeliness, and care coordination are commonly reported across healthcare organisations and often reflect multiple interdependent factors across services and systems.

Patterson Liz
03/08/2026 09:04:55

The purpose of triangulated intelligence is therefore not solely to identify whether a theme is present, but to develop a deeper understanding of the specific issues contributing to that theme, monitor changes over time, and evaluate whether improvement activity is influencing the intelligence received.

Evidence of improvement may be demonstrated through a reduction in the prominence of a theme within the triangulated analysis, changes in the nature of the issues being reported, or shifts in the underlying factors contributing to concerns, incidents and patient experience. This approach supports a more meaningful assessment of organisational improvement than reliance on individual metrics or isolated datasets alone. During Q2, the Quality & Safety Team will be developing the Quality Management System and visual mechanisms for identifying impact of learning will be considered and included. Whilst we can provide clear qualitative intelligence, we will work to develop a mechanism to demonstrate a visual assessment and progress check.

As the organisational learning approach matures, the Health Board will continue to refine its understanding of these themes and use intelligence from multiple sources to assess the effectiveness of improvement activity and inform future priorities.

2.2 Translating Intelligence into Improvement

Following identification of the organisational priorities through triangulated intelligence in Quarter 4, Quarter 1 has focused on strengthening the organisational arrangements required to support learning, improvement and delivery. Work has progressed to establish a more structured organisational learning approach, enabling intelligence from patient experience, concerns, incidents, claims, inquests, audits, inspections and other assurance activities to be considered collectively rather than in isolation. The intention is to strengthen the organisation's ability to identify recurring issues, share learning and target improvement activity against the priorities emerging from triangulated intelligence.

As part of this approach, arrangements are being established to support a focused organisational learning programme, including a thematic approach to improvement activity. This will enable the organisation to concentrate learning, educational activity and improvement efforts around priority themes identified through intelligence, supporting a coordinated organisation-wide response and greater visibility of learning and improvement. Development of this approach has been undertaken in partnership with professional and educational colleagues to ensure that emerging organisational priorities are reflected within workforce development and education planning, strengthening the Health Board's

Patterson, Liz
03/08/2026 09:04:55

ability to respond consistently to recurring themes identified through triangulated intelligence.

Quarter 1 has also seen continued strengthening of the Quality & Safety function through a review of capacity and demand, refinement of team structures and processes, and the introduction of more systematic ways of working to improve efficiency, resilience and performance. Alongside this, work has been undertaken to further define the purpose, vision and strategic direction of the service, supporting a shift from a predominantly reactive approach towards one which is increasingly focused on organisational learning, improvement, foresight and assurance. These developments provide an important foundation for delivery of the organisational learning approach described within this report and have been supported through the commitment and engagement of the Quality & Safety Team.

2.3 Evidence of Impact

Quarter 1 provides early evidence that the revised Integrated Quality Report framework is supporting a more integrated understanding of quality, safety and experience across the Health Board. The most significant impact at this stage is seen in the improved ability to triangulate intelligence from concerns, incidents, patient experience, claims, inquests, IPC and Medical Examiner scrutiny into a more coherent set of organisational themes and improvement priorities.

Further progress has been made through the integration of People's Experience intelligence within the report, continued implementation of the Listening to People framework, strengthened governance arrangements, and the development of a more structured organisational learning approach. Collectively, these developments have enhanced organisational oversight and strengthened the connection between intelligence, learning and improvement activity.

It is recognised that measurable changes in organisational themes, outcomes and experience will take longer to emerge. Many of the priorities identified through triangulated intelligence represent complex and longstanding challenges which require sustained organisational focus over time. As outlined within this report, improvement will not solely be assessed by the presence or absence of individual themes, but through changes in their prominence, the nature of the issues identified, and the intelligence emerging from multiple sources over time.

During Quarter 2, further work will be undertaken to strengthen the Quality Management Framework and develop approaches for demonstrating the impact of organisational learning and improvement activity. This will support more systematic monitoring of progress against the identified priorities and provide greater visibility of organisational learning and its impact.

Patterson, Lin
03/08/2026 09:04:55

Overall, Quarter 1 demonstrates progress in establishing the foundations required to translate intelligence into organisational learning and improvement. The focus for Quarter 2 will be to further embed these arrangements and begin to demonstrate their impact through evolving intelligence and organisational learning outcomes.

3. COMPLIANCE

This section provides an overview of the Health Board's compliance with key regulatory and national standards across quality and safety. It is presented separately to ensure that assurance regarding performance and governance is clearly demonstrated, whilst maintaining a distinct focus on organisational learning and improvement within the preceding sections.

3.1 Listening to People

The Listening to People (LTP) framework continues to be embedded across the Health Board following implementation on 1 April 2026. National development of the reporting dataset and performance dashboard remains ongoing, with the Quality & Safety Team actively contributing to this work. Local reporting arrangements will be aligned to the agreed national approach to ensure consistency and comparability of data. This is anticipated to be ready for implementation in Q3.

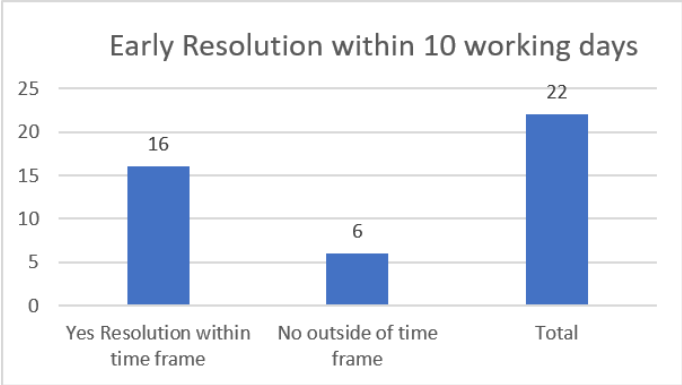
Whilst national reporting arrangements continue to develop, early local intelligence has been extracted to provide assurance regarding implementation. Initial indicators suggest the framework has been embedded safely, with services continuing to adapt to new processes and ways of working. Regular engagement has been maintained with Clinical Governance Leads across all service groups, providing oversight, support and opportunities to share learning and address emerging issues.

The Health Board will continue to monitor implementation closely during Quarter 2 as processes mature and the framework becomes further embedded within routine practice.

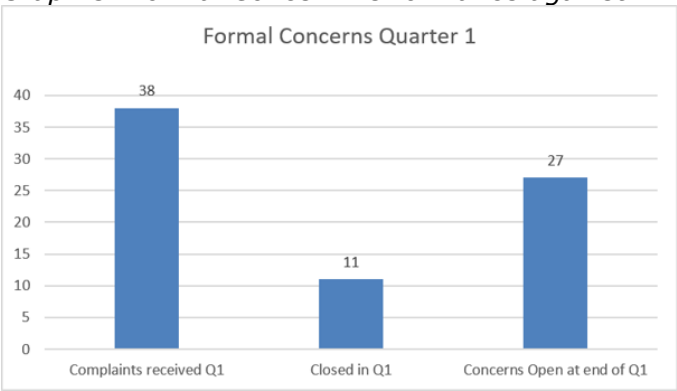
Early performance indicators:

Graph 4: Early Resolution Performance against LTP timeframes

Patterson,Liz
03/08/2026 09:04:55



Graph 5: Formal Concern Performance against LTP



The national target is for 40% of all complaints received by the Health Board to be managed as Early Resolutions, by the end of the year. The Health board is delivering a positive early indicator, with 36.8% of complaints managed as Early Resolutions in Q1.

3.2 PTR (Residual Cases)

At the end of Q1, **4** PTR cases remained open, one of which relates to a reopened case. The Health Board's intention is for these remaining cases to be concluded during Q2. This represents a significant improvement from the 21 open cases reported at the end of Q4 and reflects the considerable commitment and collaborative effort of both the Quality & Safety Team and service-level teams in reviewing, progressing and resolving concerns. The sustained focus on reducing the historic backlog has strengthened the overall position and provides assurance that concerns continue to be actively managed and progressed through the system.

3.3 Incident & NRI Compliance

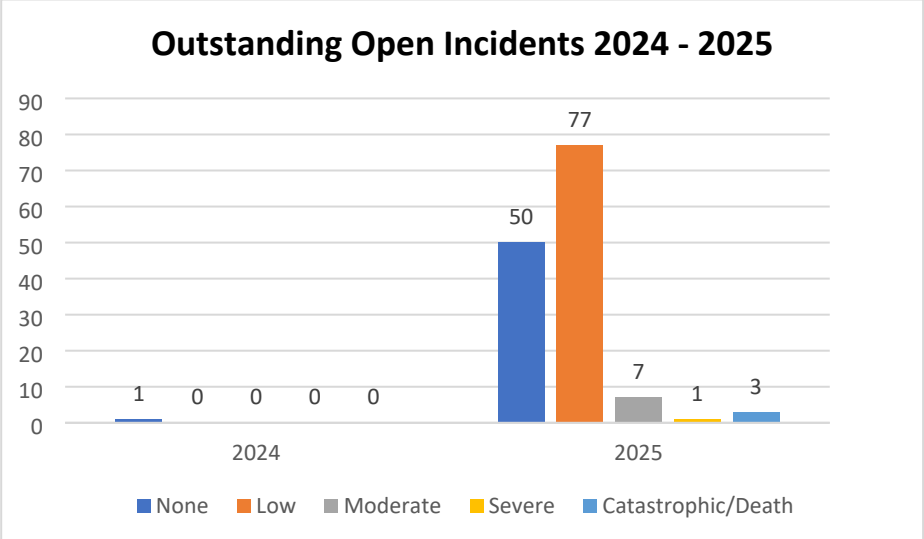
A small number of new Nationally Reportable Incidents (NRIs) were reported during Q1 and continue to be managed through established governance arrangements. Due to the low volume of NRI's and the public nature of this report, detailed analysis is not presented.

Patterson, Liz
03/08/2026 09:04:55

Work has continued to strengthen the quality, consistency and timeliness of investigation processes across all incidents, with a focus on ensuring that

learning is identified, shared appropriately and translated into improvement activity where required. A number of investigations were completed during the quarter, whilst some remain in progress reflecting the complexity of individual cases and the need to ensure thorough review and assurance. When reviewing outstanding incidents of a historic nature, this quarter saw the closure of **175** that were related to events across 2024 and 2025. This is an improvement; however, the graph below identifies that there remains a considerable volume of open incidents which need concluding and progressing to closure.

Graph 7: Open Incidents as at 20/07/26 (Source: Datix)



Incident Closure Improvement Trajectory

The Health Board has established an improvement trajectory to address the remaining backlog of open incidents whilst maintaining timely management of newly reported events. During Quarter 1, 175 (over 55%) of open historic incidents from 2024 and 2025 were closed, demonstrating progress in reducing the backlog. During Quarter 2, the focus will be on eliminating all remaining 2024 incidents, reducing the number of open 2025 incidents by at least 50%, and preventing backlog growth through strengthened service-level accountability, routine monitoring and enhanced quality assurance arrangements. Progress against this trajectory will be reported through the Health Board's governance structure and future Integrated Quality Reports.

Learning from incidents

Learning arising from incident and NRI investigations continues to be considered alongside wider sources of quality and safety intelligence, supporting a more integrated understanding of risk and organisational learning. A strengthened multidisciplinary quality assurance approach is

Patterson,Liz
03/08/2026 09:04:55

being implemented to improve oversight, support timely progression of investigations, and enhance the quality of reports and associated learning.

3.4 Claims / Redress Compliance

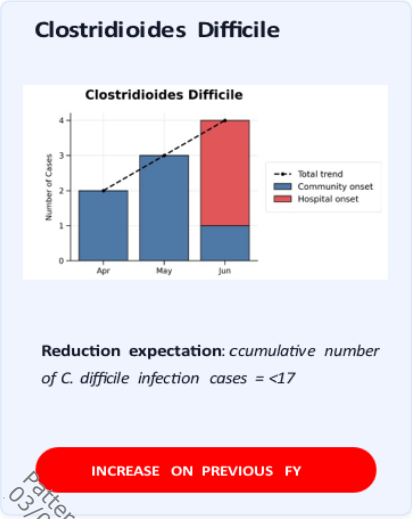
Performance has been maintained at the expected Health Board standard, providing assurance on robustness of current process. In Q1, offers have been made on three cases, one of which has settled and paid and an application for reimbursement has been made. Good relations with Welsh Risk Pool continue, providing assurance and oversight, alongside opportunities for improved learning and shared learning from areas across Wales.

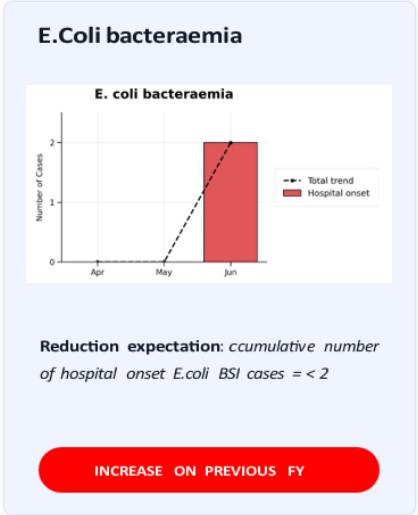
4. INFECTION PREVENTION & CONTROL (IP&C)

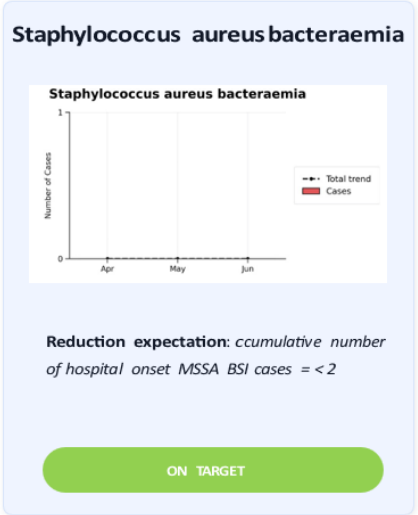
4.1 Surveillance Summary

Surveillance against organisms subject to mandatory reporting via Welsh Government demonstrates a mixed position during Q1 2026/27. Whilst there has been an increase in overall cases of *Clostridioides difficile* (CDI) and *Escherichia coli* bacteraemia compared with the previous financial year, reduction expectations for hospital-onset infections continue to be achieved in most areas.

The cumulative number of CDI cases remains within the Welsh Government reduction expectation of fewer than 17 cases and is therefore on target. Hospital-onset *E. coli* bloodstream infections (BSIs) also remain within the expected threshold of fewer than two cases. No hospital-onset cases of *Klebsiella* spp. or *Pseudomonas aeruginosa* bacteraemia were reported during the quarter, maintaining achievement against the target of zero cases. Similarly, hospital-onset *Staphylococcus aureus* bacteraemia remains within the expected threshold of fewer than two cases.







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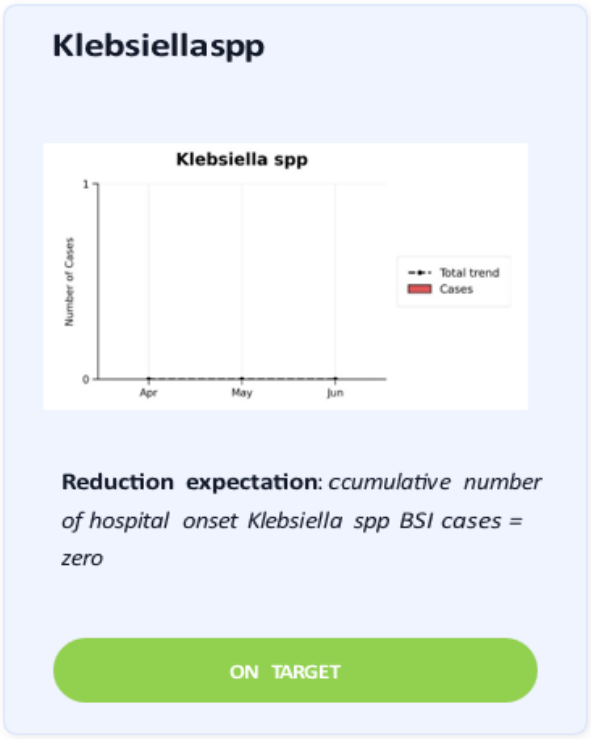
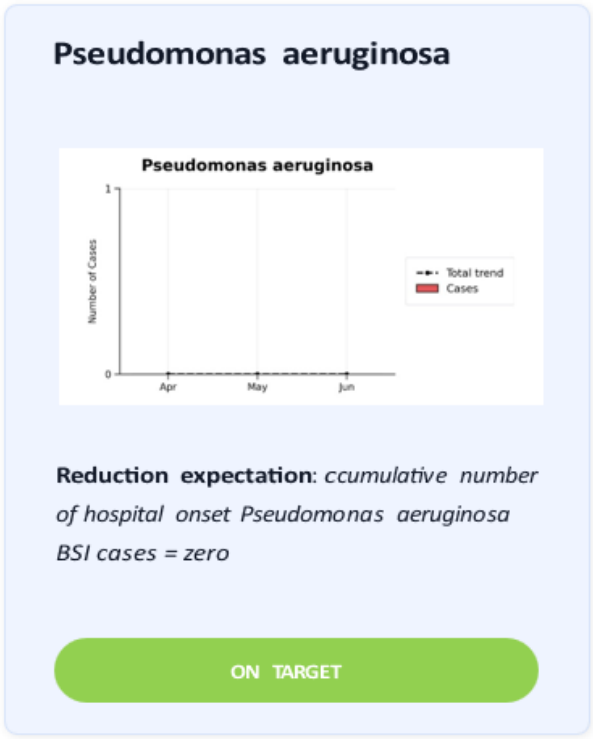




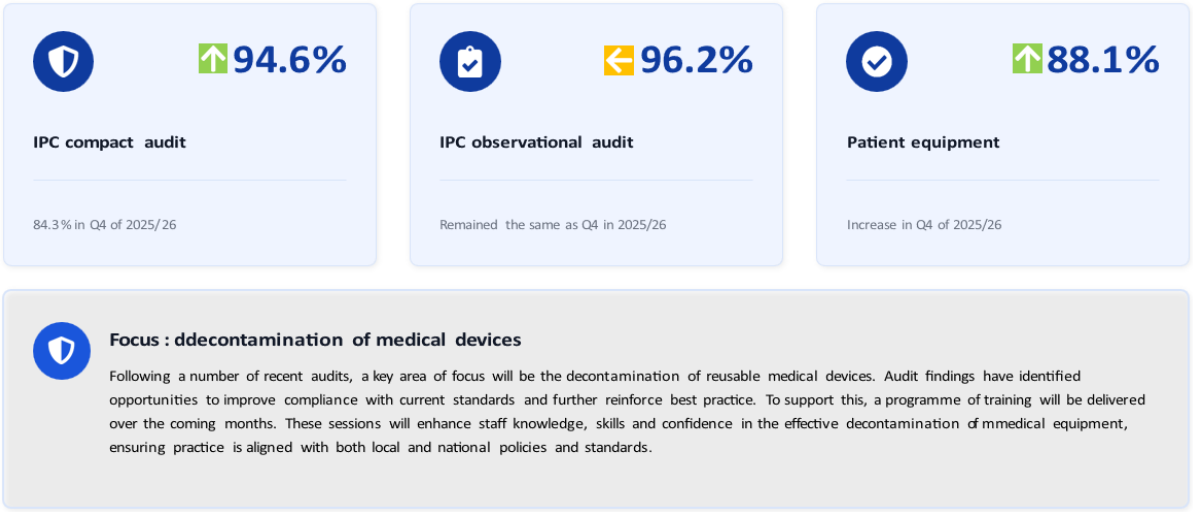
4.2 Compliance & learning from post infection reviews

A review of learning from CDI post-infection reviews identified several recurring themes, including communication and handover processes, escalation of positive microbiology results, recognition of clinical deterioration, compliance with treatment guidelines, appropriate sampling practices and medicines optimisation. Actions have been implemented to address these findings, including reinforcing escalation processes, promoting adherence to EOLAS guidance, sharing learning through governance structures, auditing practice, and providing targeted education to clinical teams. A seven-minute learning brief has also been circulated across the organisation to support wider dissemination of key lessons learned.

4.3 Audit

Compliance with IPC audit programmes remains strong. The IPC Compact Audit score improved to 94.6%, from 84.3% in Q4 2025/26. IPC Observational Audit compliance remained stable at 96.2%, whilst compliance relating to patient equipment cleaning and decontamination achieved 88.1%, showing improvement from the previous quarter. Audit findings have highlighted opportunities to further strengthen the decontamination of reusable medical devices, and a targeted programme of training is planned to enhance staff knowledge, confidence and compliance with local and national standards.

Patterson,Liz
03/08/2026 09:04:55



4.4 Training

Training compliance remains strong overall, with IPC Level 1 training exceeding the Health Board target at 88.16%. IPC Level 2 training compliance was 84.82%, marginally below the 85% target, and targeted actions are underway to improve compliance across clinical staff groups.

4.5 Incidents

Twelve IPC-related incidents were reported via Datix during Q1 2026/27. These comprised six healthcare-associated infection incidents, five relating to environmental cleanliness and one decontamination incident. Five incidents have been closed and seven remain under review. Learning from these incidents is being incorporated into ongoing quality improvement and assurance activities.

4.6 Policy development

Policy development activity continued during the quarter. A new organisational policy for Clinically Significant Antimicrobial Resistant Organisms (CSARO) and a new policy for the Recognition and Immediate Care of Deteriorating Patients in Community Hospital Settings was prepared for review and approval through the Policy Group. In addition, the revised MRSA

Patterson, Liz 03/08/2026 09:04:55

Policy was submitted for ratification through the appropriate governance process.

5. INSPECTIONS & FRAMEWORK IMPLEMENTATIONS

5.1 Health Inspectorate Wales Inspections

The Health Board continues to respond to actions arising from Health Inspectorate Wales (HIW) inspections and reviews. During Quarter 1, work has focused on strengthening the governance arrangements that support oversight, monitoring and assurance of regulatory actions across the organisation.

Whilst individual inspection findings continue to be managed through local ownership and existing governance arrangements, a review of organisational reporting and oversight mechanisms remains underway. This work is being progressed jointly by Corporate Governance and the Quality & Safety Team and is intended to establish a more consistent and systematic approach to the monitoring, reporting and assurance of inspection outcomes and associated improvement actions.

The Health Board recognises that opportunities exist to further strengthen the visibility and corporate oversight of regulatory actions. Development of enhanced reporting arrangements will be a priority during Quarter 2, supporting improved assurance regarding progress against inspection findings and the timely completion of associated actions.

In the interim, assurance can be taken that inspection findings continue to be addressed locally, and that work is actively progressing to establish a more robust organisational framework for oversight, monitoring and reporting.

5.2 People's Experience Framework

Since Quarter 4, progress has been made in establishing the governance, leadership and delivery arrangements required to support implementation. Following Executive Committee consideration of the People's Experience Framework progress report, it was agreed reporting of People's Experience would be incorporated within the Integrated Quality Report to support a more triangulated view of quality, safety and experience.

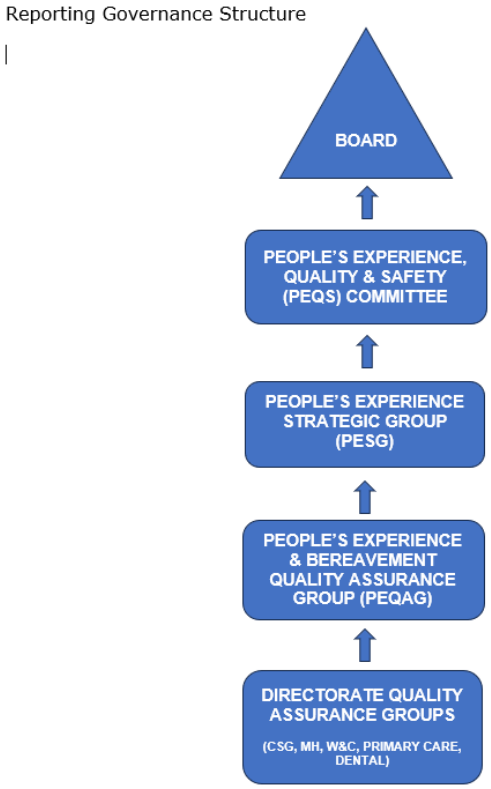
The NHS Wales People's Experience Framework has been implemented across the Health Board and is being used as the strategy for the health board. The required structures, processes and governance arrangements are in place. A People's Experience SOP is being drafted to sit alongside a People's Experience policy.

Continued work is focused on embedding the framework to ensure sustainable cultural change, greater staff confidence and consistency of

Patterson, Liz 03/08/2026 09:04:55

approach, and demonstrable impact on the experience of patients, service users, families and carers.

Progress will be monitored through the newly developed quality management structure from directorate level through to Board, as indicated below.



5.3 Bereavement Framework

The Bereavement Service continues to make progress in implementing the National Bereavement Framework, with a focus on improving the experience of bereaved families through service development, education, partnership working and organisational learning. Good progress has been made in strengthening governance arrangements, including the planned integration of Bereavement Services within wider Quality Assurance and People's Experience structures to support a more coordinated approach to learning and improvement.

The service continues to promote staff wellbeing through the Grief First Aider network and is progressing work to improve equity of access, strengthen community engagement and ensure bereavement support remains inclusive and responsive to the needs of the Powys population. Bereavement education continues to be delivered across the Health Board, supporting staff confidence and capability in delivering compassionate care.

Patterson, Liz 03/08/2026 09:04:55

Learning from bereaved families, patient feedback, complaints, compliments and Medical Examiner reviews continues to be considered collectively to

identify opportunities for improvement and strengthen the consistency and quality of bereavement support across care pathways.

Key priorities for the next reporting period include:

- Relaunch the Bereavement Stakeholder Group within the Quality Assurance governance structure.
- Strengthen collaboration with the Patient Experience Team to ensure learning from bereaved families informs service improvement.
- Continue development and promotion of the Grief First Aider network.
- Expand engagement with communities and organisations supporting people with protected characteristics.
- Continue delivery and evaluation of bereavement education across the Health Board.
- Increase community outreach and awareness of bereavement support services.
- Embed learning from patient feedback, complaints, compliments and Medical Examiner reviews into quality improvement activity.

Overall, assurance can be taken that progress continues to be made in strengthening bereavement support, governance and organisational learning, with a clear programme of improvement in place for Quarter 2.

5.4 Medical Examiner Service

The Medical Examiner (ME) Service continues to provide independent scrutiny of deaths, supporting clinical governance, organisational learning and assurance through the mortality review process. The service continues to contribute to the Health Board's quality governance arrangements by identifying opportunities for improvement, supporting reflective practice and providing independent oversight of the certification of deaths.

During Quarter 1, the service maintained stable operational performance and effective partnership working with General Practitioners, Registration Services, the Coroner's Office and the wider Medical Examiner network. Timeliness of clinical records submitted to the service continued to improve and remained in line with the Wales average.

Learning identified through Medical Examiner scrutiny continues to inform quality improvement activity across the organisation. Recurring themes relating to clinical assessment and diagnosis, investigations, communication, clinical documentation, death verification processes and DNACPR documentation have been reported through established governance structures, supporting local review, reflection and improvement activity.

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03/08/2026 09:04:55

The NHS Wales Shared Services Partnership Medical Examiner audit was completed during the reporting period and concluded Reasonable Assurance confirming that the Health Board has effective processes in place to support

mortality reviews and engagement with the Medical Examiner Service. An action plan has been developed in response to the findings and implementation is underway to strengthen oversight, improve the recording and tracking of learning, ensure timely review and dissemination of learning across the organisation.

Key priorities for the next reporting period include:

- Continue to strengthen the quality and consistency of ME scrutiny across the Health Board
- Monitor and reduce MCCD amendment rates through continued education and quality assurance
- Implement and monitor the actions arising from the ME audit
- Embed organisational learning arising from ME reviews within Clinical Governance processes
- Continue to improve collaborative working with partner organisations.

Overall, assurance can be taken that the Medical Examiner Service continues to provide effective independent scrutiny, supports organisational learning, and is progressing actions to further strengthen governance, shared learning and improvement.

6. CONTRACT QUALITY PERFORMANCE REVIEW

6.1 Quality Assurance

The Health Board continues to work with commissioned providers through established contract management and quality review arrangements to oversee the quality and safety of services provided to the Powys population. Routine commissioning meetings continue to support monitoring of performance, quality and emerging risks across commissioned services.

During Quarter 1, the Health Board has commenced a wider programme of work to strengthen its approach to quality assurance and quality management. As part of the Board Development Programme, colleagues from NHS Wales Performance and Improvement facilitated an interactive session with Board members focused on the development of a Quality Management System (QMS), recognising this as a key priority across NHS Wales organisations.

The initial phase of this work will focus on undertaking a local assessment to establish the Health Board's current position, identify areas of good practice and determine opportunities for further development. In parallel, the Health Board has commenced work with external partners to support the development of supporting structures, systems and mechanisms, drawing on established approaches and learning from organisations that have already implemented elements of a Quality Management System.

Patterson,Liz 03/08/2026 09:04:55

This work is being led collaboratively across the Health Board by the Executive Director of Nursing, Quality, Women and Family Health and will form a key component of strengthening the Health Board's overall approach to quality governance, organisational learning, assurance and continuous improvement. Progress against this programme will be reported through future iterations of this report.

Alongside the wider QMS development programme, work is underway between the Commissioning and Quality & Safety teams to strengthen the quality assurance arrangements for commissioned services. This includes the development of a commissioned services assurance framework, aligned to the wider Quality Management System, to support a more consistent approach to quality oversight, triangulation of intelligence and organisational assurance.

6.2 Commissioning Concerns Monitoring

Following the changes to planned activity for Powys patients receiving care through NHS England providers, the Health Board continues to monitor concerns and enquiries relating to the revised arrangements. The number of new enquiries received has continued to reduce during Quarter 1, n=7 demonstrating a sustained downward trend since the changes were introduced.

A total of 77 enquiries have been received since implementation of the service changes. The feedback received has provided valuable insight into the experiences of patients and families and continues to inform discussions with commissioned providers, organisational learning and future service development.

The Health Board remains committed to ensuring that patient experience is considered alongside quality, safety and performance information when reviewing the ongoing impact of these arrangements. No incidents of associated harm or Nationally Reportable Incidents have been identified in relation to the service changes.

5. CONCLUSION

This report demonstrates continued progress in the Health Board's approach to understanding, interpreting and responding to quality and safety intelligence. The triangulation of information from incidents, concerns, patient experience, Duty of Candour, claims, inquests and other assurance sources continues to demonstrate a high degree of consistency in the themes affecting quality, safety and experience across the organisation.

The organisational priorities identified through Quarter 4 remain valid and continue to be reflected across multiple intelligence sources. Many of these priorities, including communication and engagement, access and timeliness, clinical decision-making, care coordination and wider operational pressures, represent complex and

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enduring challenges that require sustained focus over time. Whilst immediate improvements in outcomes may not yet be evident, the Health Board has strengthened its understanding of the issues, the factors contributing to them, and the opportunities for improvement.

During Quarter 1, significant progress has been made in strengthening the organisational arrangements that support quality, safety and learning. This includes the continued implementation of the Listening to People framework, integration of People's Experience intelligence within the report, strengthening of Quality & Safety governance and assurance arrangements, and development of a more structured organisational learning approach to support improvement activity across identified priority areas.

The Health Board can therefore take assurance that appropriate processes are in place to identify, monitor and respond to quality and safety risks, and that progress continues to be made in strengthening the systems, governance and organisational learning required to support continuous improvement. Importantly, the organisational priorities identified through triangulated intelligence are now informing governance, education, learning and improvement activity across the organisation, providing a clearer and more coordinated response to the issues most consistently affecting quality, safety and experience.

NEXT STEPS:

- **Embed the organisational learning approach,** strengthening how triangulated intelligence is translated into improvement activity across the identified organisational priorities.
- **Broaden the intelligence available to future reports,** including enhanced thematic learning from Medical Examiner scrutiny, Bereavement Services, audits, inspections and other assurance activity.
- **Progress the development of the Health Board's Quality Management System,** including completion of the baseline assessment and implementation of supporting governance, assurance and improvement arrangements.
- **Strengthen quality assurance and oversight arrangements,** including Health Inspectorate Wales (HIW) inspections and commissioned services, to support a more consistent approach to organisational assurance and learning.

Patterson,Liz
03/08/2026 09:04:55

IMPACT ASSESSMENT

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

QUALITY:

	No impact	Negative	Positive	Both	
Safe					A Quality Impact Assessment must be undertaken for all reports requesting approval, ratification or decision in line with health board Duty of Quality processes (under development). In this space you should provide supporting narrative to explain the potential adverse and positive impacts that may arise from a decision being taken, and the steps being taken to mitigate adverse impacts. Where required, the full Quality Impact Assessment should be available as a supporting document to inform the decision making process.
Timely					
Effective					
Efficient					
Equitable					
Person Centred					
Workforce					
Leadership					
Culture					
Information					
Learn, Improve, Research					
Whole Systems Approach					

EQUALITY:

	No impact	Negative	Positive	Both	
Age					An Equality Impact Assessment must be undertaken for all reports requesting approval, ratification or decision in line with health board Equality Impact Assessment policies and procedures (CGP009). In this space you should provide supporting narrative to explain the potential adverse and positive impacts that may arise from a decision being taken, and the steps being taken to mitigate adverse impacts. Where required, the full Equality Impact Assessment should be available as a supporting document to inform the decision making process.
Disability					
Gender reassignment					
Marriage / civil partnership					
Pregnancy / maternity					
Race					
Religion or Belief					
Gender					
Sexual Orientation					
Welsh Language					
Socio-economic status					
Social exclusion					
Carers					

RISK ASSESSMENT:

	Level of risk identified				
	Very Low (0-3)	Low (4-8)	Moderate (9-12)	High (15-25)	
Clinical					A Risk Assessment should be undertaken for all reports requesting approval, ratification or decision in line with health board Risk Management Framework CGP005. In this space you should briefly describe the key risks and the steps being taken to manage them, and also how these risks relate to the Board's stated Risk Appetite.
Financial					
Corporate					
Operational					
Reputational					

Patterson,Liz
03/08/2026 09:04:55

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 4.7

Patient Experience & Quality Committee	**04 August 2026**
Subject:	**People's Experience Framework – July 2026**
Approved and presented by:	Paul Hooton, Executive Director of Nursing, Quality, Women and Family Health
Prepared by:	People's Experience Lead
Other Committees and meetings considered at:	

PURPOSE:

The purpose of this report is to provide the Committee with assurance that Powys Teaching Health Board has implemented the national People's Experience Framework (PEF), with arrangements in place for ongoing monitoring, reporting and assurance.

The paper also provides the draft policy developed locally for Powys Teaching Health Board (People's Experience and Listening Policy) providing opportunity for any contribution from the Committee into the policy development. Once in final draft this will be shared again with the Committee

This report is presented in line with the Committee's role in providing quality and people-experience assurance to the Board.

RECOMMENDATION(S):

The Committee is asked to:

- **RECEIVE** the report and take **ASSURANCE** that the NHS (national) Wales People's Experience Framework is being implemented within the Health Board
- **REVIEW** the draft PTHB People's Experience and Listening Policy providing any feedback ahead of the policy being produced into a final draft
- **AGREE** the final draft policy can be shared via Chair's Action for the Committee to consider recommendation to the Board in September.

Approve/Take Assurance	Discuss	Note
Y	Y	N

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03/08/2026 09:04:55

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

EXECUTIVE SUMMARY:

Background

In April 2025, Welsh Government launched the NHS Wales People's Experience Framework, placing a requirement on Health Boards to implement robust systems for capturing, analysing, responding to and learning from people's experience.

A PTHB People's Experience Lead was appointed in June 2025 to lead local implementation within PTHB. PEQS has previously noted the need for clearer governance, consistency and assurance regarding People's Experience arrangements.

Current Position

PTHB has adopted the national NHS Wales People's Experience Framework as its overarching framework. Local implementation will be supported through the People's Experience and Listening Policy and Standard Operating Procedure (SOP), which sets out roles, responsibilities, governance arrangements and processes for capturing, analysing, responding to and learning from feedback.

Evidence demonstrates that the requirements of the framework have been adopted across services, including mechanisms for capturing feedback through Civica and Datix and responding to people's experiences.

Governance arrangements are in place to support ongoing oversight and reporting. A new governance reporting structure, supported by agreed Terms of Reference, will take effect from September 2026 and will strengthen directorate-to-Board reporting, escalation of risks or challenges, and routine monitoring of People's Experience.

Patterson,Liz
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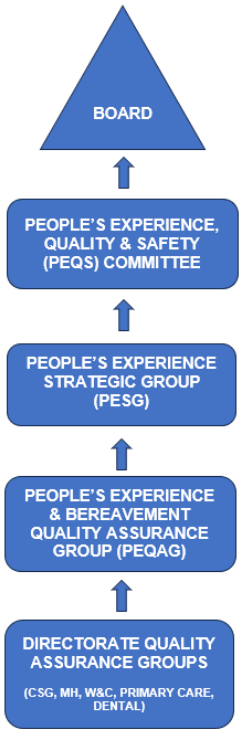
Reporting Governance Structure



The **PESG**, chaired by the Executive Director of Nursing, Quality, Women's & Family Health will provide strategic leadership, oversight, assurance, and coordination of quality, experience, and improvement activities across the Health Board.

The **PEQAG**, chaired by the Assistant Director of Quality & Safety, will be responsible for the implementation, delivery, monitoring and escalation of operational activities that enable the strategic objectives to be achieved.

Routine patient experience data continues to be reported through the Integrated Quality Report (IQR). Future quarterly IQR updates will be used to demonstrate progress with embedding, maturity, learning and impact.

PTHB Policy and Standard Operating Procedures

The draft (PTHB) People's Experience and Listening Policy is attached as a background paper for this Committee's review. It is currently out to internal consultation within PTHB as per our organisational procedures and will be supported by a Standard Operating procedure (sop), also out to internal consultation.

The Committee is invited to provide any feedback on the draft policy.

The policy will then be produced into final draft ahead of further Committee and Board consideration in September.

Conclusion

The Committee is asked to take assurance that the national People's Experience Framework is being implemented within PTHB, and will be supported by local policy, SOP and governance arrangements to enable consistent application and oversight. The next phase will focus on embedding and maturing the framework across services, with routine IQR reporting used to demonstrate progress, learning and impact to this Committee and for onward assurance to the Board.

Page 5 of 21 | 03/08/2026 09:04:55

Appendices

- Paper 4.7a - NHS Wales Peoples Experience Framework
- Background paper - Draft PTHB People's Experience and Listening Policy

NEXT STEPS:

1. Embed and mature the People's Experience Framework, with quarterly assurance updates provided through the Integrated Quality Report.
2. Finalise and implement the People's Experience and Listening Policy and supporting SOP to enable consistent application of the national framework across PTHB.

IMPACT ASSESSMENT – NOT REQUIRED FOR THIS REPORT

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03/08/2026 09:04:55

Llywodraeth Cymru
Welsh Government

GIG CYMRU NHS WALES

People's Experience Framework

Review date: August 2028

Patterson,Liz
03/08/2026 09:04:55

gov.wales

Contents

4	Aim
4	Scope
4	What is ‘People’s Experience’?
5	Health and Care Quality Standards
6	Duty of Quality – Person Centred quality standard
6	People’s Experience principles should be considered in line with the Duty of Quality
7	The use of and the difference between People’s Experience, Engagement, Patient Reported Experience Measurements (PREMS), Patient Reported Outcome Measurements (PROMs)
7	Use of Patient Reported Experience Measurements (PREMs)
8	Patient Reported Outcome Measurements (PROMs)
9	National People’s Experience Surveys
10	People’s Experience (core questions)
11	Scoring and benchmarking
11	Localised People’s Experience Feedback (Service Specific)
11	Carers/Families
11	Equality Monitoring
12	Values and staff experiences
12	Stories
12	Lived experience/people’s groups
13	Complaints
13	Incidents
13	Compliments

Patterson,Liz
03/08/2026 09:04:55

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

14	Good Practice Local Self-Assessment Tool Recommendation
16	Areas for Local Self-Assessment
21	Capacity and Capability to Effectively Collect Feedback
24	Analysis and Triangulation
26	Using People's Feedback to Drive Quality Improvement and Learning
28	Reporting and Publication
29	Appendix A: National Surveys Process Document
30	Appendix B: People's Experience Survey
33	Appendix C: Equality Monitoring
35	Appendix D: The Digital Stories Toolkit – Using Stories to Improve Quality

Patterson,Liz
03/08/2026 09:04:55

Aim

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

Scope

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

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

What is 'People's Experience'?

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

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

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

Health and Care Quality Standards

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

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

Patterson,Liz
03/08/2026 09:04:55

Duty of Quality – Person Centred quality standard

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

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

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

Patterson,Liz
03/08/2026 09:04:55

The use of and the difference between People's Experience, Engagement, Patient Reported Experience Measurements (PREMS), Patient Reported Outcome Measurements (PROMs)

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

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

Use of Patient Reported Experience Measurements (PREMs)

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

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

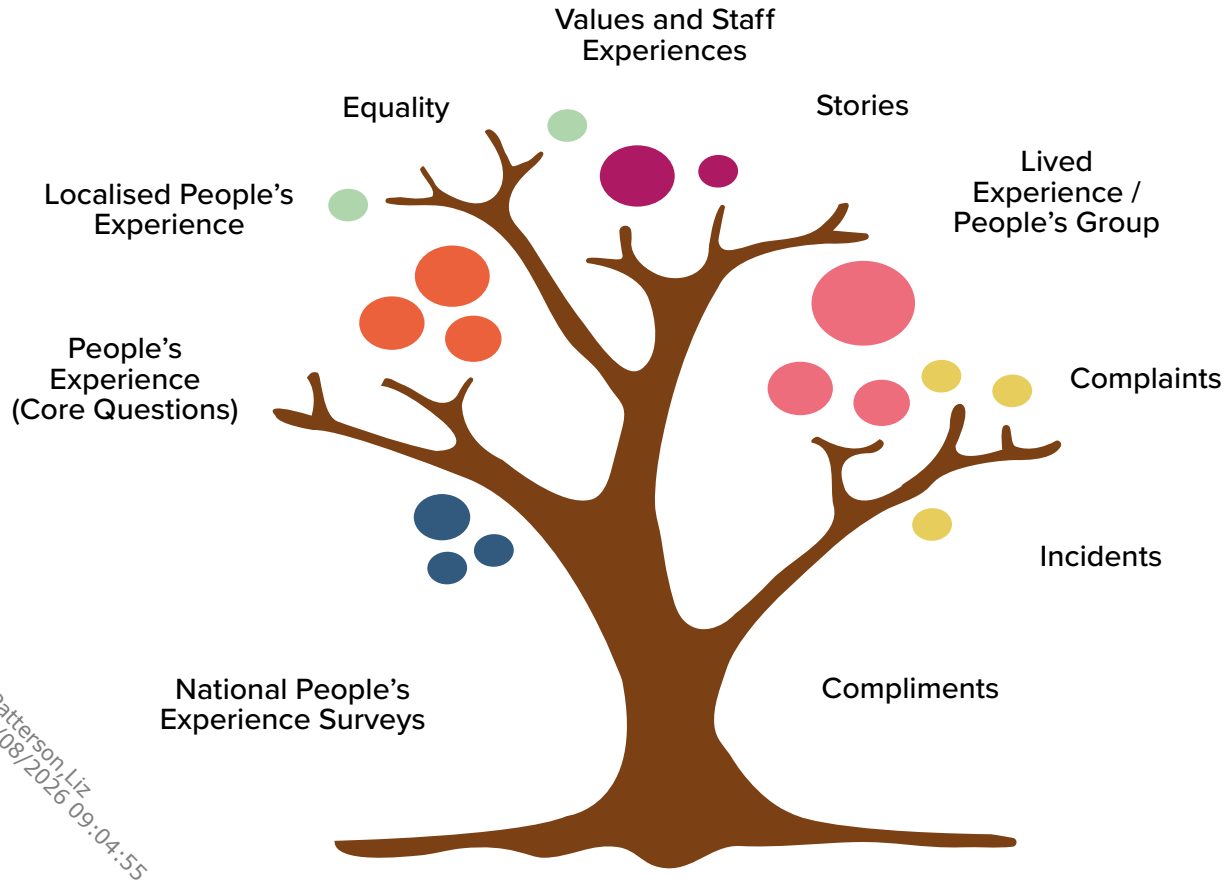
Patterson,Liz
03/08/2026 09:04:55

Patient Reported Outcome Measurements (PROMs)

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

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

Listening, Learning and Improving Tree



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03/08/2026 09:04:55

National People's Experience Surveys

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

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

Patterson,Liz
03/08/2026 09:04:55

People's Experience (core questions)

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

1. How would you rate your overall experience?

- ☐ Very poor
- ☐ Poor
- ☐ Neither good nor poor
- ☐ Good
- ☐ Very good

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

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

4a Which language would you prefer to communicate in?

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

Patterson, Liz
03/08/2021 09:04:55

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

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

Scoring and benchmarking

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

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

Localised People's Experience Feedback (Service Specific)

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

Carers/Families

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

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

Equality Monitoring

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

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

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

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

Values and staff experiences

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

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

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

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Stories

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

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

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

Lived experience/people's groups

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

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

Complaints

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

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

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

Incidents

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

Compliments

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

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

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

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03/08/2026 09:04:55

Good Practice Local Self-Assessment Tool Recommendation

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

National assurance is overseen by NHS Executive Wales.

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

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

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

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

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

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

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03/08/2026 09:04:55

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

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03/08/2026 09:18:55

Areas for Local Self-Assessment

Leadership

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

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

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

Pack Page 227 of 406
03/08/2026 09:04:55

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

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

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03/08/2026 09:04:55

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

Patterson,Liz
03/08/2026 09:04:55

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

Patterson,Liz
03/08/2026 09:04:55

Capacity and Capability to effectively collect feedback

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

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

Patterson,Liz
03/08/2026 09:04:55

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

Pack Page 233 of 406
03/08/2026 09:04:15

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

Paterson,Liz
03/08/2026 09:04:55

Analysis and Triangulation

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

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

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03/08/2026 09:15

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

Patterson, Liz
03/08/2026 09:04:55

Using People's Feedback to Drive Quality Improvement and Learning

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

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

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03/08/2026 09:04:55

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

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03/08/2026 09:04:55

Reporting and Publication

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

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

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Appendix A: National Surveys Process Document

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

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

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Appendix B: People's Experience Survey

Your NHS Wales Experience

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

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

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

How recent was the experience you are thinking of?

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

Thinking about this experience:

1. Was the time you waited:

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

2. Did you feel well cared for?

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

3. Were you treated with dignity and respect?

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

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

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

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

☐ Always ☐ Usually ☐ Sometimes ☐ Never

5. Did you feel that you were listened to?

☐ Always ☐ Usually ☐ Sometimes ☐ Never

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

☐ Always ☐ Usually ☐ Sometimes ☐ Never

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

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Thinking of your overall Experience

8. How would you rate your overall experience?

☐ Very poor ☐ Poor ☐ Neither good nor poor ☐ Good ☐ Very good

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

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

Thank you for taking the time to answer these questions

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Appendix C

Equality Monitoring

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

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

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

1. What is your age?

- ☐ 0-15 years
- ☐ 16-24 years
- ☐ 25-34 years
- ☐ 35-44 years
- ☐ 45-54 years
- ☐ 55-64 years
- ☐ 65-74 years
- ☐ 75+ years
- ☐ I prefer not to say

2. What is your gender?

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

3. At birth, were you described as:

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

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

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

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

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

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03/08/2026 08:04:55

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

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

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

White:

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

Mixed / multiple ethnic groups

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

Asian / Asian British

- [ ] Indian
- [ ] Pakistani
- [ ] Bangladeshi
- [ ] Chinese
- [ ] Any other Asian background

Black / African / Caribbean / Black British

- [ ] African
- [ ] Caribbean
- [ ] Any other Black / African / Caribbean background

Other ethnic group

- [ ] Arab
- [ ] Any other ethnic group
- [ ] I prefer not to say

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03/08/2026 09:04:55

Thank you for taking the time to answer these questions

Appendix D

The Digital Stories Toolkit – Using Stories to Improve Quality

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

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

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

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03/08/2026 09:04:55

Agenda item: 4.8

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE	04 AUGUST 2026
Subject:	**Maternity Services response to the Regulation 28 Prevention of Future Deaths Report (ENGLAND)**
Approved and presented by:	Paul Hooton, Executive Director of Nursing, Quality, Women and Family Health
Prepared by:	Senior Midwifery Team
Other Committees and meetings considered at:	Executive Committee 22 July 2026

PURPOSE:

The purpose of this report is to provide the Patient Experience, Quality and Safety Committee with assurance regarding the potential learning arising from a Regulation 28 (Prevention of Future Deaths) report following the deaths of Jennifer Cahill and Agnes Cahill in England. Although the circumstances did not occur within Powys Teaching Health Board or NHS Wales, the report identifies important themes relating to clinical care, decision-making and system processes that are relevant to maternity services nationally.

This paper summarises the key findings, outlines the All-Wales response, and provides assurance that the Health Board has reviewed the issues raised and has instigated action arising from learning. Furthermore, it outlines appropriate systems and monitoring arrangements are in place, and that the service is actively working to further strengthen the quality and safety of care to women, babies and their families.

RECOMMENDATION(S):

The Committee is asked to:

- Take **ASSURANCE:** the Health Board has reviewed findings of the Regulation 28 report and considered the relevance of the learning to local maternity services.
- **NOTE** the All-Wales response and the actions taken nationally and locally to

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strengthen assurance in the areas identified by the Coroner.

- **DISCUSS** and/or scrutinise the assessment and seek assurance regarding any concern, remaining gaps, risks and improvement opportunities.

Approve/Take Assurance	Discuss	Note
Y	Y	Y

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

EXECUTIVE SUMMARY:

A Regulation 28 (Prevention of Future Deaths) report was issued following the deaths of Jennifer Cahill (Mother) and Agnes Cahill (Baby) in England. The Coroner concluded that both deaths were due to complications at birth and contributed to by neglect, and identified a number of preventable factors relating to clinical care, decision-making and wider system processes. A link to the coroners report is available here - Jennifer Cahill and Agnes Cahill: Prevention of future deaths report - Courts and Tribunals Judiciary

Whilst the circumstances of these deaths did not occur within Powys Teaching Health Board or NHS Wales, the findings have wider relevance to maternity services and have prompted consideration at an All-Wales level. The Wales Maternity and Neonatal Strategic Clinical Network in NHS Performance and Improvement requested information from Welsh Risk Pool (WRP), and each health board in Wales, thus identifying national themes and recommendations. Locally, their applicability to maternity services within Powys has been assessed, and subsequently, opportunities for further learning and improvement have been identified.

The review has provided assurance that the areas highlighted within the Regulation 28 report align with existing governance, clinical and quality arrangements within the Health Board. Opportunities for ongoing learning, reflection and continuous improvement have also been identified and will continue to be monitored through established governance processes.

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This paper is presented to support Committee scrutiny, discussion and assurance, and demonstrates the Health Board's commitment to learning from national and external reviews to strengthen the quality and safety of care.

POSITION SUMMARY:

1. Findings, Learning and Considerations

1.1 Key findings of fact:

The Regulation 28 Report details the circumstances around the deaths and provides key findings of fact. Within the circumstances around the deaths there are points of relevance for consideration in addition to the matters of concern.

These relate to:

1. Assessment and acknowledgement of emerging risk factors during pregnancy
2. Access to adequate and functional equipment
3. IT connectivity issues
4. Fetal monitoring in labour
5. Effective neonatal resuscitation
6. Use of Maternity Early Warning Score (MEWS)
7. Communication between midwives and ambulance staff

The key findings of fact noted that Jen had not made an informed decision to have a home birth and if the out of guidance plan had been completed and all the relevant information provided to her, it is more likely than not she would have given birth in an alternative setting and both Jen and Agnes would have survived.

If the fetal heart rate monitoring had been conducted correctly and every 5 minutes, it was more likely than not an abnormal fetal heart rate would have been noted up to an hour before Agnes was born and an urgent transfer to hospital would have occurred. The Coroner reported that emergency services would have therefore been on scene when Agnes was born and effective resuscitation would have been administered which would likely have prolonged her life.

The Coroner reported that had this call been made it is more likely than not Jen would have survived as the aftercare delivered to her would have noted a perineal tear and administered medication to stem blood loss, immediately.

1.2 The matters of concern:

The Coroner identified ten specific matters of concern relating to clinical assessment, decision-making, communication, escalation and system oversight. A detailed summary of the concerns is provided in ***Appendix 1***.

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2. National Learning and Local Considerations

In response to the Regulation 28 (Prevention of Future Deaths) report, maternity services across Wales undertook a review to consider the relevance of the Coroner's findings to Welsh maternity services and to identify any opportunities for learning and improvement.

This work identified a number of recognised strengths within existing maternity services, alongside opportunities for further development relating to consistency of practice, workforce sustainability, quality assurance arrangements and the use of information to support oversight and learning.

Powys Teaching Health Board reviewed the key findings and associated themes through established maternity governance arrangements. In addition to considering the national learning, the Health Board undertook a local assessment against the issues identified by the Coroner to determine the extent to which existing systems, processes, guidance and oversight arrangements provide assurance in the relevant areas of practice.

The following section summarises the Health Board's assessment and assurance position in relation to the locally relevant themes arising from the Regulation 28 report.

3. Powys Assurance and Accountability

3.1 Out of guidance cases:

The Regulation 28 report highlighted concerns relating to the assessment, documentation and management of cases where individuals elected to receive care outside established clinical guidance. The findings emphasised the importance of ensuring that informed decision-making, risk assessment, multidisciplinary review and clinical oversight are consistently applied whilst continuing to support personalised care and individual choice.

Local review identified that the Health Board has established processes in place to support informed choice and shared decision-making. Powys Maternity Services supports informed choice and shared decision-making throughout pregnancy, birth and the postnatal period. Risk assessment and care planning are undertaken in line with All-Wales guidance and are reviewed throughout pregnancy to reflect any new or emerging clinical, medical, mental health or social risk factors. Women are supported to make decisions about their care and place of birth, including where those decisions fall outside established clinical guidance, through an informed decision-making process supported by individualised care planning, multidisciplinary input and appropriate clinical oversight. Consultant midwifery and obstetric advice is available where required, and when accepted by women.

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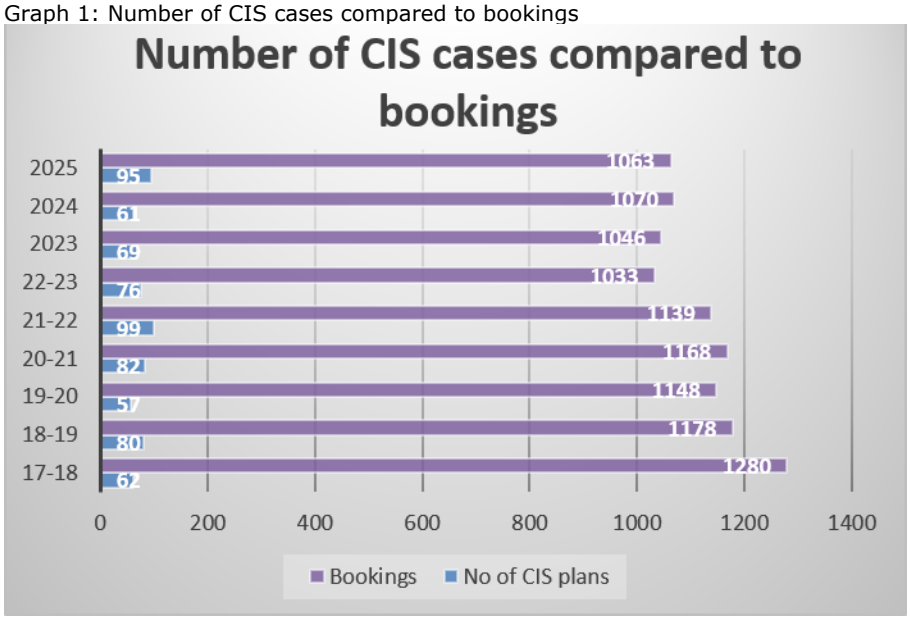
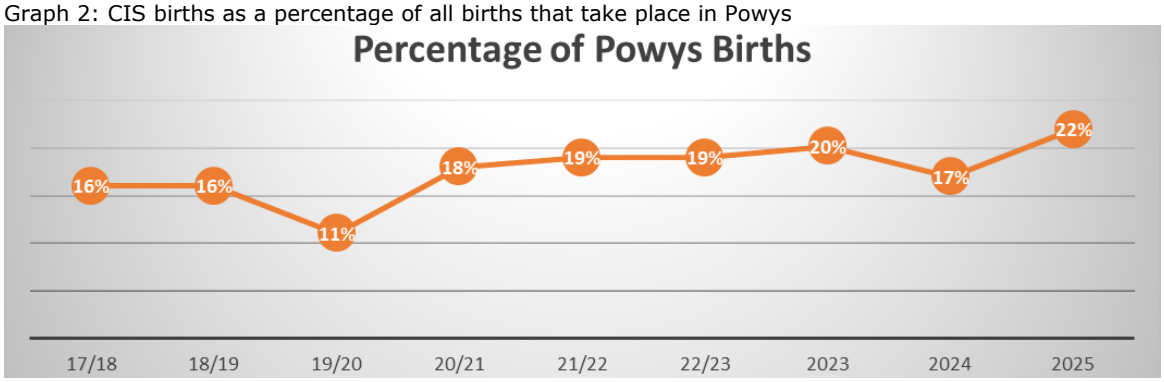
In 2025 there were 95 women that had a CIS plan in place out of 1063 bookings that took place.

Graph 1: Number of CIS cases compared to bookings



Graph 2: CIS births as a percentage of all births that take place in Powys



Local governance arrangements provide oversight of complex and out of guidance care decisions, enabling themes, learning and trends to be identified and reviewed through established maternity governance structures.

Whilst the review provided assurance regarding existing arrangements, opportunities for further refinement and continuous improvement have been identified. These include strengthening the consistency of documentation and decision-making records, further developing routine oversight and reporting arrangements, and enhancing the visibility of data relating to out of guidance cases to support organisational learning and assurance. The service is currently

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engaging with Welsh Risk Pool to ensure our local processes are clear, in line with legal frameworks, and enable midwives to access obstetric advice and oversight in cases where a woman declines a referral.

3.2 Community escalation and OCP/working hours:

Workforce sustainability, maintenance of competence, and the safe provision of community maternity services were outlined as priority areas within the Coroner report. Particular attention was drawn to workforce models supporting home birth provision, on-call arrangements and the need to ensure staff are able to provide safe care whilst maintaining appropriate rest, wellbeing and professional support.

Local review identified that Powys Teaching Health Board had already commenced a comprehensive review of community midwifery working arrangements. Recognising the unique challenges associated with providing maternity care across a large rural geography, the review sought to strengthen both staff wellbeing and service resilience whilst maintaining safe and sustainable service provision. The programme of work was developed through extensive engagement with midwifery staff and Trade Union representatives, ensuring that proposed changes reflected operational experience, professional concerns and the realities of delivering community maternity services across Powys.

The review resulted in the development of a revised rostering model designed to improve safe working arrangements for community midwives. Key changes include a protected seven-hour rest period prior to overnight on-call duties, provision of compensatory rest following on-call shifts, and a reduction in overnight on-call hours from 16 to 13 hours. The revised model also strengthens organisational oversight of staffing pressures, with any occasion where staffing falls below agreed levels reported through Datix to support escalation, risk management and executive visibility.

Recognising the significance of the proposed changes, implementation has been deliberately phased over an extended period to enable continued staff engagement, monitor outcomes and provide assurance that the revised arrangements achieve their intended benefits without introducing unintended consequences. Evaluation of the revised model remains ongoing, with final review and conclusion anticipated in September 2026.

This work represents a significant investment in the sustainability and safety of community maternity services and provides assurance that workforce wellbeing, staff experience and safe service delivery continue to be considered

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alongside clinical quality and safety outcomes.

3.3 Transfer management:

Issues relating to the recognition of clinical risk, escalation of concerns and timely transfer to appropriate services when complications arise during labour and birth were highlighted within the Regulation 28 findings. The findings reinforced the importance of effective communication, multidisciplinary decision-making and clear transfer pathways to ensure women and babies receive the right care, in the right place, at the right time.

Powys Maternity Services implemented the All-Wales Transfer from Community and Freestanding Midwifery Units Guideline in 2023. Transfers are Datix reported, reviewed and monitored through established governance arrangements, with joint review undertaken with the Welsh Ambulance Services University NHS Trust (WAST) where appropriate to support shared learning and service improvement. Families who experience transfer are also routinely invited to contribute feedback to inform service learning.

Timely recognition of deterioration remains a fundamental component of safe transfer management. Powys currently utilises a community maternity early warning score (MEWS) and associated escalation pathways to support the identification of clinical deterioration and prompt decision-making. Implementation of the All-Wales Community MEWS is planned for September 2026 and will provide a standardised approach to observations, escalation and documentation across Wales.

Transfer activity and ambulance response times are routinely monitored and benchmarked against national research to support assurance and informed decision-making regarding place of birth. Local review provided assurance regarding the effectiveness of current transfer arrangements, whilst identifying opportunities to further strengthen routine reporting and oversight of transfer trends and outcomes through existing maternity governance processes.

3.4 Intrapartum Fetal Surveillance & Intermittent Auscultation:

Recognition and escalation of fetal compromise, interpretation of fetal monitoring, and the decision-making processes supporting timely intervention were highlighted within the Regulation 28 findings. The findings reinforced the importance of maintaining robust systems, training and clinical oversight to support safe intrapartum care.

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Local review identified implementation of the All-Wales Fetal Surveillance Guideline and participation in the Intrapartum Fetal Surveillance Training

Programme Wales. The multidisciplinary programme supports a standardised approach to training across Wales and is delivered for Powys staff through neighbouring Health Boards. Current compliance is 92%, with all remaining staff booked onto forthcoming training sessions.

In addition, focused audits are commencing to review care and documentation against guideline standards. Local governance arrangements provide oversight of fetal surveillance practice, enabling themes, learning and trends to be identified and reviewed through established maternity governance structures.

3.5 Management of Post Partum Haemorrhage (PPH):

Delays or failings in the recognition and management of maternal deterioration following birth, including timely identification of post-partum haemorrhage and escalation of care where required can ultimately lead to death. The Coroner findings reinforced the importance of robust clinical assessment, effective emergency response and multidisciplinary management of obstetric emergencies.

Local review identified implementation of the All-Wales Guideline for the Prevention and Management of Post-Partum Haemorrhage and the use of standardised OBS Cymru documentation to support the assessment and management of women experiencing PPH. All cases requiring transfer are subject to review through established governance processes to support learning and quality improvement.

In 2025, six cases of post-partum haemorrhage occurring within Powys birth settings were reported via the Datix system, representing 3.5% of births within Powys. Whilst this is lower than the Wales recorded incidence of 4.9% in unassisted vaginal deliveries, assurance work is underway to provide confidence that all PPH are appropriately detected and reported.

Powys Maternity Services has delivered Community PROMPT Wales training since the national pilot programme in 2018. Management of post-partum haemorrhage forms a core component of the annual multidisciplinary training programme, enabling midwives and Welsh Ambulance Services clinicians to train together in the management of obstetric emergencies within community settings. Current compliance with PROMPT training is 92%.

Local review demonstrated a mature approach to the management of obstetric emergencies, supported by established guidance, multidisciplinary training and routine case review. Future work will focus on embedding learning from the transition to electronic patient records and maintaining assurance that

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emergency response processes, documentation and staff competencies continue to reflect evolving national standards and best practice.

3.6 Workforce Capability & Training:

Physiological Birth Training

The Regulation 28 report highlighted the importance of maintaining competence and confidence in supporting physiological labour and birth, particularly within community and midwifery-led settings. Powys midwives contributed to a Wales-wide survey undertaken by Consultant Midwives Cymru during 2025, the findings of which are informing the development of a national physiological birth education framework in collaboration with Health Education and Improvement Wales (HEIW).

Since 2024, Powys Maternity Services has delivered an annual physiological birth workshop for all midwifery staff, supported by wider clinical supervision and reflective learning opportunities. Newly Qualified Midwives also undertake placements within neighbouring Obstetric Units to support skill development and confidence in managing a range of clinical presentations. Consideration is underway regarding how similar opportunities may be expanded across the wider workforce.

Newborn Life Support training

Effective neonatal resuscitation was identified as an important theme within the Regulation 28 findings and subsequent national review activity. The Resuscitation Council UK (RCUK) Newborn Life Support programme forms the foundation of training for maternity staff, supplemented by annual refresher training and multidisciplinary simulation. Current compliance is 92%.

Recognising the challenges associated with delivering maternity care across a large rural geography, Powys has also supported participation in the Out of Hospital Newborn Life Support (OH-NLS) programme. This nationally accredited course brings together midwives, ambulance clinicians and emergency response teams to strengthen preparedness when managing neonatal emergencies outside acute hospital environments. Sixteen staff have completed NLS training to date, with a further ten places identified during 2026.

Together, these arrangements support the maintenance of skills and capability within the workforce to deliver safe and effective care.

3.7 Equipment and Resource:

The Regulation 28 findings reinforced the importance of ensuring that staff have timely access to appropriate equipment and resources to support the safe

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management of maternity and neonatal emergencies. Local review considered the availability, standardisation, maintenance and assurance arrangements relating to equipment used within community and birth centre settings.

All midwives carry standardised equipment bags supported by an agreed kit list and operational policy. Standardised emergency trolleys are also in place across all birth centres to promote consistency of response across maternity settings. Work is underway to further enhance neonatal emergency equipment through the introduction of oxygen saturation monitoring to align with current Resuscitation Council UK recommendations.

During 2026, equipment assurance processes were strengthened through implementation of an electronic monitoring system providing routine oversight of equipment, medication and environmental checks across maternity settings. In addition, emergency "grab boxes" containing key equipment, documentation and clinical algorithms are being introduced to support rapid access to resources during time-critical situations. Alongside these developments, implementation of the maternity electronic patient record (BadgerNet) has strengthened access to clinical information, documentation and governance oversight across maternity services. Together, these changes have enhanced standardisation, assurance and readiness across maternity services, supporting the safe management of obstetric and neonatal emergencies.

4. Conclusion

Whilst the circumstances that led to the Regulation 28 report did not occur within Powys Teaching Health Board or NHS Wales, the findings provide an important opportunity for reflection, learning and assurance.

Review of the themes identified by the Coroner, together with consideration of the subsequent All-Wales response, has provided assurance that Powys has established governance, clinical, workforce and quality arrangements in place across the areas identified within the report. The review has also highlighted opportunities to further strengthen documentation, oversight, reporting and assurance processes, many of which were already underway prior to publication of the Regulation 28 findings.

The work undertaken demonstrates the Health Board's commitment to learning from both local and external intelligence, and to using that learning to continuously improve the quality and safety of care provided to women, babies and families. Ongoing monitoring through established governance arrangements will ensure that identified actions are implemented, evaluated and embedded within routine practice.

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NEXT STEPS:
Learning arising from the Regulation 28 report has been incorporated into existing maternity governance, quality improvement and assurance processes. Progress will continue to be monitored through established governance arrangements to ensure identified actions are implemented, embedded and evaluated. Committee is asked to note reasonable assurance in relation to this matter.

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APPENDIX 1: Matters of Concern

The report outlines 10 matters of concern arising from the case as follows:

1. There is no national guidance in respect of home births. Specifically, robust evidenced based guidance on home birth care, similar to that which is in place for intrapartum care in a hospital setting.

2. There is an increase in the number of women with 'high risk pregnancies' requesting home births where required interventions cannot take place or would be significantly delayed and there is no robust framework for midwives supporting home birth care. There is no national guidance to support consistent practice across the country including, for example, details of clinical scenarios where women, following robust assessment, have been considered too high risk to safely receive care in a home-setting.

3. The lack of national guidance means there are differing models of care and unlike other specialities home births are not a specialist commissioned service. There is no national guidance considering the ethical responsibility and proportionality of offering a home birth model under the NHS framework.

4. Even though there is a very small risk of death, this is not something which is discussed with women particularly in relation to maternal death, even if the woman has a recognised risk such as a post-partum haemorrhage. There is no guidance to ensure the risk of death to both mother and baby is discussed with any woman considering a home birth irrespective of being considered high or low risk.

5. NICE guidance on intrapartum care (2023 updated June 2025) Section 1.3.3 only refers to the potential risk of death to a baby. There is no mention in the guidance of risk to the mother.

6. Terminology around pregnancies describes them as 'high' or 'low risk pregnancy' and leads women to consider that pregnancy encompasses all stages through to delivery of a child. Practice does not personalise or individualise risk so women can fully understand what the level of risk is for

Patterson,Liz
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them in actually being pregnant, or what the level of risk is for them in giving birth.

7. In order to maintain their skills, there is no set number of deliveries a community midwife must conduct following qualification. There is no mandated number of deliveries that any midwife (irrespective of the settings in which they are working) must complete once they have qualified as a midwife in order to maintain their registration. The level of experience of community midwives in conducting deliveries is not information routinely provided to women to inform their decision whether to have a homebirth.

8. No bespoke training needs analysis has been conducted focusing on midwives practicing in home birth teams.

9. The lack of national data collection means there is no data to evidence the number of women who are transferred in during labour or after birth, maternal or neonatal outcomes, number of women who are considered out of guidance.

10. The no national guidance on the model of staffing, training and experience for midwives providing home birth care.

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Agenda item: 4.9

PATIENT EXPERIENCE, QUALITY & SAFETY COMMITTEE	04 AUGUST 2026
Subject:	**Transition and Handover from Childrens to Adult Services – 26/27 Implementation Plan Update**
Approved and presented by:	Paul Hooton, Executive Director of Nursing / Director of Midwifery, Women and Family Health
Prepared by:	Head of Children's Nursing and Paediatric Services
Other Committees and meetings considered at:	Executive Committee 08 July 2026.

PURPOSE:

To provide a quarterly update of the 2026/27 implementation plan.

RECOMMENDATION(S):

The Committee is asked to:

- **RECEIVE** the report taking **ASSURANCE** an action plan is in place and progress is largely on track.

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/N	
4. Enable Joined up Care	Y	
5. Develop Workforce Futures	Y/N	
6. Promote Innovative Environments	Y	
7. Put Digital First	Y/N	
8. Transforming in Partnership	Y	

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EXECUTIVE SUMMARY:

The Transition and Handover Programme is well established at a strategic and governance level, with strong alignment to national guidance.

However, operational delivery is variable, with key areas including THP completion, Named Worker allocation, joint working with adult services, and outcome monitoring REQUIRING FURTHER FOCUS.

Targeted mitigation actions are in place, with the next phase focused on standardisation, strengthening accountability, improving data and monitoring, and ensuring consistent, seamless transitions for all young people.

PURPOSE:

This briefing provides an update on delivery against the Transition and Handover Monitoring and Review Plan (2026–2027), aligned to Welsh Government Transition & Handover Guidance (2022).
It sets out:

- Areas on track for compliance
- Areas slipping or at risk
- Mitigation actions to support recovery
- Key priorities for the next reporting period

STRATEGIC CONTEXT

The Transition and Handover Plan (THP) programme is a statutory and quality requirement, requiring:

- Early identification (age 13–14)
- Named worker for each young person
- Co-produced Transition & Handover Plans
- Joint working with adult services
- Monitoring of outcomes at 6 and 12 months post-transition

Delivery is overseen through Director-led governance arrangements and aligned to existing quality and performance frameworks.

DELIVERY OVERVIEW

Progress is positive in establishing governance, structures and policy alignment, with early implementation activity underway.

However, operational consistency and system embedding remain variable, with several elements partially implemented or at risk due to workforce capacity, digital limitations, and cross-system dependencies.

4. AREAS ON TRACK

4.1 Governance and Accountability – ON TRACK

Status:

- Designated senior leadership and oversight structures in place
- Programme governance aligned to Board and quality structures

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Evidence:

- Requirement for clear governance, accountability, and reporting mechanisms established

Impact:

- Provides clear accountability for delivery and escalation
- Enables structured programme monitoring

4.2 Policy Alignment and Programme Framework – ON TRACK

Status:

- Transition model aligned to Welsh Government guidance
- Clear framework established (THP, Named Worker, Rising-16 review)

Evidence:

- Defined national requirements including THP, Named Worker, and structured reviews

Impact:

- Ensures compliance with national standards
- Provides a consistent model for implementation across services

4.3 Early Identification Processes – IMPROVED

Status:

- Identification at ages 13–14 recognised and embedded in policy
- Implementation variable across services

Evidence:

- Requirement for early identification at age 13–14

Impact:

- Early planning improving in some areas
- Inconsistent application limits system-wide impact

5 AREAS REQUIRING CONTINUED FOCUS

5.1 Named Worker Allocation – REQUIRES FOCUS

Planned Position:

- All young people have a clearly identified Named Worker

Current Position:

- Allocation inconsistent across services and pathways

Evidence:

- Requirement for Named Worker pre- and post-handover

Key Issues:

- Workforce capacity pressures
- Lack of clarity in some pathways regarding responsibility

5.2 Transition & Handover Plans (THPs) – IN DEVELOPMENT

Planned Position:

- All transitioning young people have a co-produced, standardised THP

Current Position:

- THP completion and quality variable

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03/08/2026 09:04:55

- Limited consistency in co-production with CYP and families

Evidence:
- Requirement for standardised THP for every young person

Key Issues:
- Lack of standardised templates fully embedded
- Digital/system limitations
- Variation in practice across teams

5.3 Joint Working with Adult Services – IN DEVELOPMENT

Planned Position:
- Rising-16 reviews and joint planning embedded

Current Position:
- Inconsistent engagement with adult services
- Lack of consistency in establishing timely and quality of joint reviews

Evidence:
- Requirement for joint reviews and shared accountability

Key Issues:
- Cross-organisational coordination challenges
- Capacity pressures within children's/adult services

5.4 Continuity of Care (No Gaps) – FOCUSED WORK NOT STARTED YET

Planned Position:
- Seamless transfer with no disruption to care

Current Position:
- Risk of gaps during transition period in some pathways

Evidence:
- Requirement for no delays or gaps in care provision

Key Issues:
- Unclear accountability at point of transfer
- Scheduling and service capacity challenges

5.5 Monitoring, Outcomes and PREMs – NOT STARTED YET

Planned Position:
- Collection of feedback at 6 and 12 months post-transition

Current Position:
- Monitoring processes not yet fully implemented
- Limited evidence of outcome tracking

Evidence:
- Requirement to capture PREMs and evaluate outcomes

Key Issues:
- Lack of systematic data collection processes
- Digital and reporting limitations

5.6 Digital Systems and Documentation – WORKING WITH WCCIS

Planned Position:
- Digitally accessible, shared THP and integrated systems

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Current Position:

- Systems not yet fully interoperable or consistently used

Evidence:

- Requirement for integrated digital systems and documentation

Key Issues:

- IT system limitations (e.g. WCCIS/RIO integration)
- Variability in documentation practice

6. Mitigation Actions

6.1 Workforce and Accountability

- Clarify Named Worker responsibilities across all pathways
- Escalate workforce risks through governance structures
- Align workforce planning with transition requirements

6.2 Standardisation of THPs

- Introduce a standardised THP template across services
- Strengthen expectations for co-production with CYP and families
- Embed compliance through governance and audit

6.3 Strengthening Joint Working

- Formalise expectations for Rising-16 reviews
- Improve engagement with adult services through structured pathways
- Establish clear accountability for handover

6.4 Improving Continuity of Care

- Define accountability at each stage of transition
- Strengthen tracking of individual transitions
- Introduce escalation processes where delays occur

6.5 Monitoring and Evaluation

- Develop and implement PREMs collection process
- Establish routine monitoring at 6 and 12 months
- Align reporting with quality and performance governance

6.6 Digital and Systems

- Work with digital teams to improve access to shared records
- Strengthen use of WCCIS and consistent documentation standards
- Develop interim solutions where system limitations exist

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03/08/2026 09:04:55

7. Priorities for Next Reporting Period

Priority 1 – Achieve THP Compliance

- Ensure all eligible young people have a completed THP
- Improve consistency and quality of plans

Priority 2 – Strengthen Named Worker Model

- Achieve full coverage across all services
- Clarify roles and accountability

Priority 3 – Embed Joint Working with Adult Services

- Ensure all Rising-16 reviews are completed
- Improve coordination and shared planning

Priority 4 – Establish Monitoring and Outcomes Framework

- Implement PREMs collection
- Introduce routine outcome tracking

Priority 5 – Reduce Risk of Care Gaps

- Strengthen oversight of transitions
- Ensure continuity of care is consistently achieved

Patterson,Liz
03/08/2026 09:04:55

Powys Teaching Health Board (PTHB) Children & Young People's Transition and Handover Monitoring and Review Plan (2026-2027)

Summary Delivery vs Plan				Calculations
Delivery against Plan	RAG Status Definition	%	Comments	
% of activities on track	GREEN: On time or within 1 week of date, you know it will be on time	82%		18
% of activities at risk of delay	AMBER: 1-3 weeks or there is a risk it might be late	14%		3
% of activities which are late or confirmed as being late	RED: More than 3 weeks late or you definitely know its going to be late	0%		0
% of activities which are complete	Blue: Activity is complete	5%		1

Ref	Work Activities	Lead	Actionees	RAG Status	Plan Start	Plan Finish	Progress
1.0	GOVERNANCE - Health Boards and Trusts should have a clear accountability and delivery mechanism in place for ensuring implementation of the transition and handover guidance across all healthcare settings which report to the Board.						
1.01	Approve and publish PTHB Transition & Handover SOP for PTHB provider servi	RM/CD		G	Feb-26	Apr-26	
1.02	Engage with paediatric and adult team re SOP	RM/CD		G	May-26	Jun-26	
1.03	Implementation of SOP	RM/CD		G	Jun-26	Sep-26	*revised date*
1.04	Establish an Operational Group (MDT) to support implementation and delviery	RM/CD		A	May-26	Jun-26	*revised date*
1.05	Establish Transition Oversight Group (post T&F)	AS		A	Feb-26	Apr-26	Terms of Reference in draft form. Meetings to be established.
1.06	Embed quarterly & annual reporting into IQPR/PEQS	AS		G	May-26		
1.07	Define dispute pathways for transition risks	RM/CD		G	Apr-26	Jun-26	To be included as part of the SOP
1.08	Design and agree family facing transition information pack	RM/CD		G	May-26	Sep-26	revised date from June
1.09	Issue family facing transition information pack	RM/CD		G	Jun-26	Nov-26	revised date from Aug
2.0	TRANSITION AND HANDOVER SENIOR LEAD - Have you designated a T&H Senior Lead with accountability for ensuring implementtaion and quality of the transition and handover guidance across all primary, secondary tertiary and community services.						
2.01	Idenitfy Senior Lead for Transition in Delivered Childrens Services PTHB	CD / SD		G		Feb-26	
2.02	Identify Senior Lead for Transition in Childrens Commisioned services				Jan-27		
3.0	Transition and Hand Over Plan and Rising 16 - Every child and young person transferring from children to adult services should have a documented transition and handovr plan or equivalent.						
3.01	Design and implementation of a digital dashboard for Transition	RM/CD/KL		G	Mar-26	Jun-26	Have met with digital services and plans in place to develop a Transition referral on WCCIS
3.02	Highlighting children reaching 14+ and idenitfying the most appropiately placed professional to open the Tranistion Referral	RM/CD		G	Jun-26		
3.03	Adopt WG THP (e.g. with Ready Steady Go/Hello) across all services	RM/CD		G	Jun-26		PLans in place to determine the most appropriate reporting mechanism.
4.0	Key Worker - Are there Transition and Handover Named workers identified and appointed from the NHS body's childrens or adult services to support the transition and handover of healthcare for every child and young person.						
4.01	To establish most appropriately placed professional to be the key worker. (as above 3.02)	RM/CD		G		Oct-26	SOP to establish the most appropriately placed keyworker and to be involvedon WCCIS so the key worker can be clearly identified.
4.02	Ensure electronic records system can identify and report on key workers for th	RM/CD		B			Have already met with WCCIS
5.0	Monitoring - What monitoring arrangements are in plac for your health board or trust.						
5.01	Transition Oversight Group	AS		G	Apr-26		Terms of Reference in draft form. Meetings to be established.
5.02	Transition Operational Group to be formulated	CD/RM		A			Terms of Reference to be formulated and to ensure we have adequate representation from adult services
6.0	Mechanism to Capture - Health Boards and Trusts should have a mechanism to capture the child and young person / family / carer impression of the transition and handover process after 6 months and 12 months to help inform future service provision. In addition, a mechanism to capture how many people have made a representation under Putting Things Right.						
6.02	Patient Reported Experience Measures (PREM) Evaluation (Oversight Group)	AS		G	Jan-27		
6.03	To adopt Ready Steady Go 6 and 12 month feedback.	RM/CD		G	Jun-26	May-27	
7.0	Audit - How often do you monitor and review in relation to quality and effectiveness, patient satisfaction and activity?						
7.01	Deliver mandatory Transition & THP training across Childrens and young persons services and audit the number recieving training.	RM/CD		G	Jun-26	Dec-26	
7.02	Yearly notes audit for childrens services.	RM/CD	Operational Group	G	Apr-27		
8.0	Evaluation and Project Closure						

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Powys Teaching Health Board

Agenda item: 4.10

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE	**29 JULY 2026**
Subject:	**Antimicrobial Stewardship Report**
Approved and presented by:	Dr Kate Wright, Executive Medical Director
Prepared by:	Antimicrobial Stewardship Pharmacist
Other Committees and meetings considered at:	Executive Committee – 22 July 2026 who took assurance from the report.

RECOMMENDATION(S):

The Committee is asked to:

- **NOTE** three of the four goals are being achieved by the Health Board and its partners and take **ASSURANCE** plans are in place with both managed and contracted services to achieve goal four (70% of total antibiotic usage from the 'access' group).
- **NOTE** the requirement of strengthened antimicrobial stewardship leadership across the system to provide ongoing assurance, following the recent inclusion of other services in the reported data (e.g. community pharmacy independent prescribers and out-of-hours GP services).

Approve/Take Assurance	Discuss	Note
Y	N	Y

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	Optimal prevention and management of infection management, including the appropriate use (and avoidance) of antibiotics, and reduction of antimicrobial resistance, directly impacts the wellbeing of Powys residents and service users. This extends to young people and education providers, who have an important role in tackling AMR through education and training. The use of digital technologies and partnership working across organisations enabling the provision of remote specialist support to clinicians and patients, is integrated into the AMS workplan and will enable the delivery of care closer to home.
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	Y	
8. Transforming in Partnership	Y	

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03/08/2026 09:04:55

EXECUTIVE SUMMARY:

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.

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 (PTHB) has an established AMS Group chaired by the Chief Pharmacist, that meets quarterly and reports to the Infection Prevention and Control (IP&C) Group, chaired by the Executive Director of Nursing. The AMS Group oversees a system-wide programme of work to tackle AMR across Powys, in line with national recommendations, and is supported by the dedicated resource of an AMS Pharmacist.

SITUATION/BACKGROUND

AMS improvement goals reflect the UK's National Action Plan (NAP) and are affirmed by the Welsh Health Circular (WHC) 2025/039 Improvement Goals and the AWTTC National Prescribing Indicators 2025-8 (NPI):

Goal		Reference
1a	Reduce overall antimicrobial consumption in primary care by 10% against a 2019/20 baseline by 2029/30 (quarterly reduction of 7% against a baseline from 2019/20 = 2207 DDDs/1000 STAR-PU).	NAP Target 4a 2024-9 WHC TUA(PC)/2025 NPI 2025-8 (2026-7 spec)
1b	Reduce overall antimicrobial consumption in secondary care by 5% against 2019/20 baseline by 2029/30 ***NB: PTHB are currently unable to report as they cannot access the pharmacy data***	NAP Target 4a 2024-9 WHC TUA(SC)/2025 NPI 2025-8
2	Reduce prescribing of broad-spectrum antimicrobials (associated with more side-effects, antimicrobial resistance, and harms) in line with treatment recommendations	NPI 2025-8
3	75% of antibiotics prescribed for respiratory tract infections are 5-day courses in line with recommendations by 2028	WHC DOC(PC)/2025 NPI 2025-8
4	70% of total antibiotics used from Access category (preferred, narrow-spectrum agents with fewer side-effects and lower resistance potential) by 2029/30	NAP Target 4b WHC PTUA/2025

Patterson, Liz
03/08/2026 09:04:55

The progress PTHB has made towards these goals is outlined below.

ASSESSMENT

Goal 1a: Reduce overall antimicrobial consumption in primary care

PTHB are the lowest overall users of antimicrobials across Health Boards in Wales, which has made reducing total consumption in line with targets challenging (figure 1). Despite this, PTHB has demonstrated sustained progress in **achieving the target** of 7% quarterly reduction in the latest quarter (figure 2):

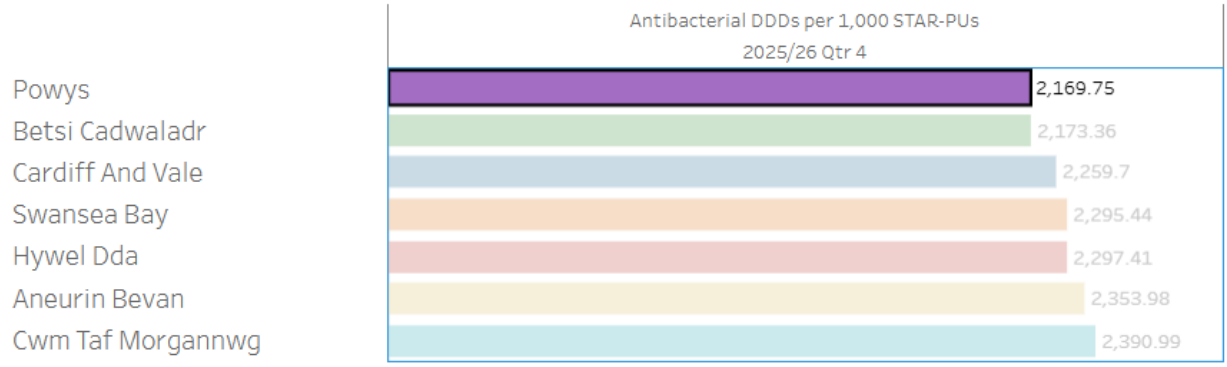


Figure 1: Total antimicrobial use across Welsh Health Boards for Q4 2025/6. Source: SPIRA NPI reporting tool

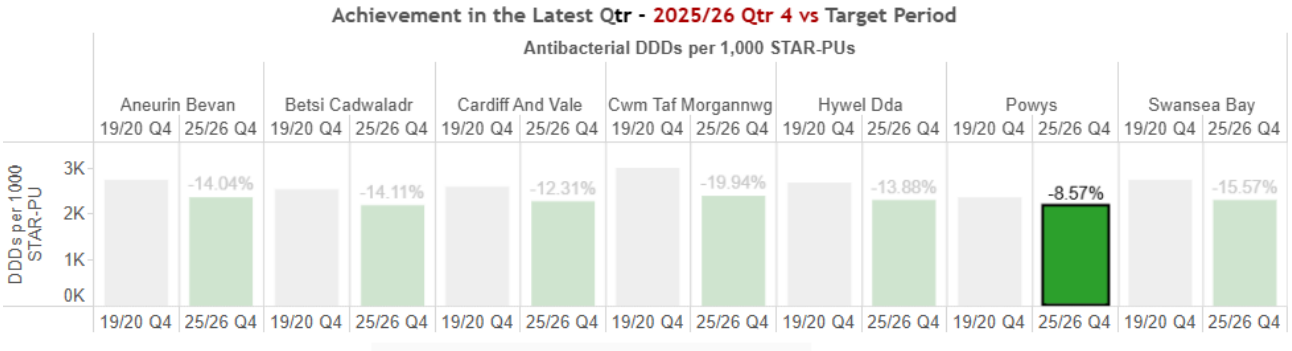


Figure 2: Progress against WHC reduction target of 10% for total antimicrobials in primary care. Source: SPIRA NPI Dashboard 9

Goal 2: Reduce use of broad-spectrum 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 has sustained progress in reducing 4C antimicrobial use following an ongoing targeted programme of work (including GP education sessions, audit and feedback and specialist clinical support) and are **currently achieving the target** to reduce 4C prescribing (figure 3):

Paper 2026-09-055

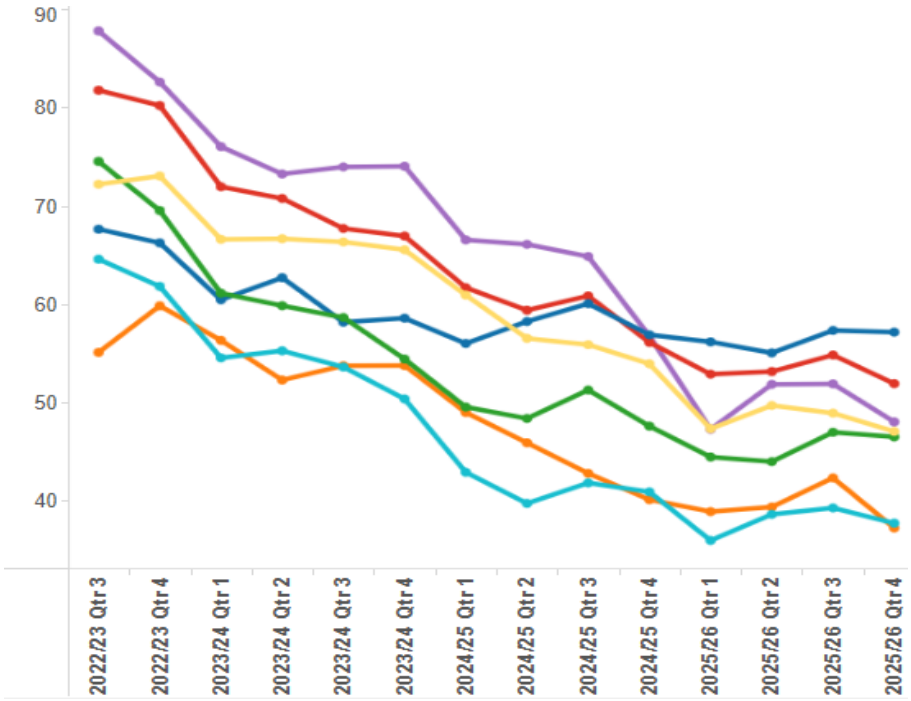


Figure 3: 4C antimicrobial use over time. PTHB is shown in purple. Source: SPIRA NPI Dashboard 2

Goal 3: Increase use of optimal course length (5 days) when treating respiratory tract infections

The use of 5-day courses of antibiotics (rather than 7-10 days) to treat respiratory tract infections has been recommended by NICE since 2019, following increasing evidence that shorter (3-5 day) courses are just as effective, and are associated with fewer harms and resistance, compared to longer (7-10 day) courses.

PTHB have sustained significant progress towards this target following a targeted programme of work between the medicines management team and GP practices, including incorporation of targets into the medicines management incentive scheme (figure 4):

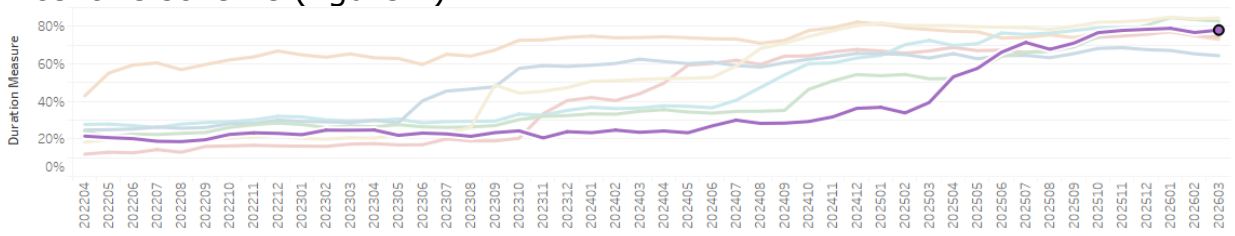


Figure 4: Percentage of RTI antibiotics prescribed as recommended 5-day courses (compared to 7-day courses) up to and including March 2026. Source: SPIRA Course Duration for RTI Antibiotics Tool

Patterson,Liz
03/08/2026 09:04:55

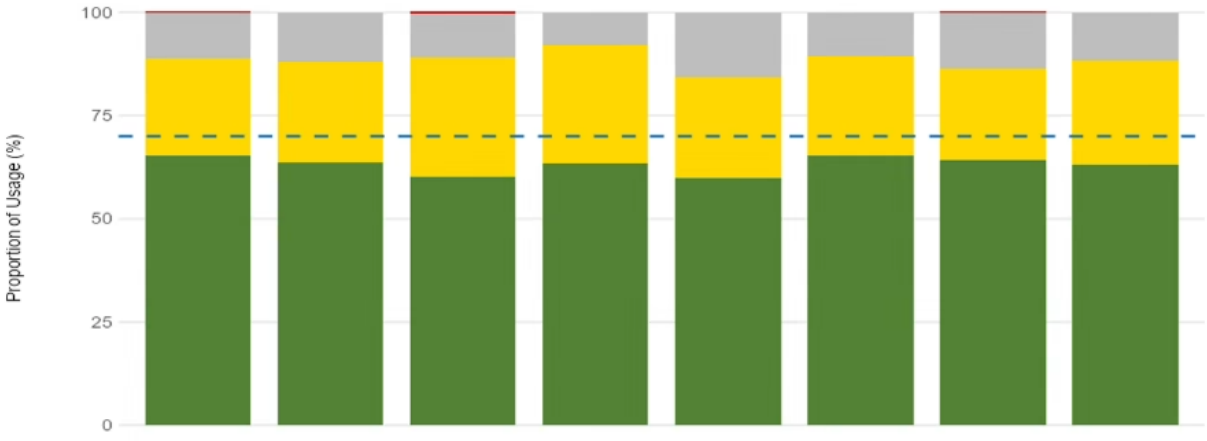
Powys is **currently achieving the target** of **75%** of RTI antibiotics being prescribed as 5-day courses. The rate of optimal prescribing of the individual antibiotics measured as part of this target in March 2026 are shown below:

Antibiotic	Target	Actual
Amoxicillin 500mg capsules	75%	84.8%
Doxycycline 100mg capsules	75%	71.1%
Clarithromycin 500mg tablets	75%	74.9%
Combined RTI antibiotics	**75%**	**78.1%**

Goal 4: Increase use of 'Access' antibiotic use

'Access' antibiotics are associated with fewer side-effects and resistance than those in the 'watch' and 'reserve' categories. The goal is to have **70%** of total antibiotic usage from the 'access' group.

PTHB are currently at **65.2%** (data from Q1-3 25/6 only), thereby **currently NOT achieving the target.** However, progress is similar across Health Boards in Wales and is likely due to the inclusion of GP out of hours and other prescribing data (e.g. pharmacist independent prescribers, dental).



	ABUHB	BCUHB	CAVUHB	CTMUHB	HDUHB	PTHB	SBUHB	Wales
Reserve	0.2	0.0	0.3	0.1	0.1	0.1	0.1	0.1
Other	11.0	11.9	10.8	7.9	15.7	10.4	13.6	11.6
Watch	23.6	24.5	28.8	28.5	24.2	24.3	22.1	25.2
Access	65.3	63.6	60.2	63.5	60.0	65.2	64.3	63.1

Local data shows GP in-hours access category prescribing at **79.7%** in December 2025, which indicates that out-of-hours and non-GP prescribing may be prescribing more non-access antimicrobials. Other factors include the appropriate reduction of access antibiotic durations (as per Goal 3) which has the unfortunate consequence of impacting access category proportion.

Plans to address this are in place, including:

Paterson,Liz 03/07/2026 21:04:55

- The delivery of a primary-care penicillin allergy delabelling project (to enable the wider use of access antibiotics)
- Targeted audit and feedback support for practices with higher volumes of regular 'watch' antibiotics (such as lymecycline).
- Proactive clinical support enabled by digital technologies (e.g. EPMA, clinical digital support) to promote real-time review and optimisation of antibiotic prescribing.
- Working with out-of-hours providers and non-medical prescribers to provide data and support for appropriate prescribing (e.g. audit, education, newsletters with AMS updates including guidelines and data)

NEXT STEPS:

The AMS Group continue to meet quarterly to discuss and update the AMS workplan (incorporating all goals listed above), which has now replaced the closed improvement plan. The group continue to report any concerns and assurances to the IP&C Committee. Actions and recommendations for clinical areas and provider organisations are cascaded accordingly, and the group has representation from across the system (e.g. dental, pharmacy, medical, primary care and inpatient areas).

IMPACT ASSESSMENT
Not required.

Patterson,Liz
03/08/2026 09:04:55

GIG CYMRU NHS WALES
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Agenda item: 4.11

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE	**04 August 2026**
Subject:	**Inpatient Ward Establishment Review 2025/26 – Safer Staffing Assurance**
Approved and presented by:	Paul Hooton, Executive Director of Nursing, Quality, Women and Family Health
Prepared by:	Head of Professional Practice and Standards (Nursing)
Other Committees and meetings considered at:	Executive Committee 22 July 20206

PURPOSE:

To provide Committee with assurance regarding the 2025/26 inpatient ward establishment reviews across mental health and physical health wards, to meet the requirements of the Nurse Staffing Levels (Wales) Act 2016.

RECOMMENDATION(S):

The Committee is asked to:

- Take **ASSURANCE** that inpatient wards are operating within safe staffing parameters in line with Nurse Staffing Levels (Wales) Act 2016
- **NOTE** the key themes, risks, and system pressures impacting sustainability of safe staffing (non-nursing factors) identified through establishment reviews
- **NOTE** the system-wide pressures impacting sustainability of safe staffing (non-nursing factors)
- **RECOMMEND** the paper to the Board for its September meeting.

Approve/Take Assurance	Discuss	Note
Y	Y	Y

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

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7. Put Digital First	Y/N	
8. Transforming in Partnership	Y/N	

EXECUTIVE SUMMARY:

The 2025/26 inpatient ward establishment reviews provide organisational assurance on nurse staffing across mental health and physical health wards in line with the Nurse Staffing Levels (Wales) Act 2016.

There is a consistent and positive position across all wards:

- Established staffing levels are appropriate and supporting safe care delivery
- No changes to current nursing establishments are recommended
- Workforce stability has improved, with reduced reliance on agency staffing
- Quality indicators remain stable, with low levels of harm and appropriate escalation

Safe care delivery is supported by strong ward leadership, committed teams, and improved recruitment and retention.
The reviews demonstrate that staffing levels are aligned to current patient acuity and demand. However, they also highlight that pressures impacting sustainability are primarily system-wide rather than related to nursing numbers.

Key system factors include:

- Delayed discharges and flow challenges
- Gaps in multidisciplinary team provision
- Increasing patient acuity and complexity

These factors result in nursing teams absorbing additional non-nursing workload, reducing time available for direct care, supervision and workforce development, and creating potential longer-term workforce risks.

Overall, there is clear assurance that inpatient wards are operating safely and in line with statutory requirements. Sustaining this position will depend on addressing wider system pressures rather than changes to nursing establishments.

BACKGROUND AND LEGISLATIVE CONTEXT

The Nurse Staffing Levels (Wales) Act 2016 places a statutory duty on health boards to have regard to the importance of providing sufficient nurses to allow patients to receive sensitive, safe and effective care.

The Act consists of five sections:

- **25A** refers to the Health Boards or Trusts' overarching responsibility to have regard to providing sufficient nurses in all settings

Patterson,Liz 03/08/2026 09:04:55

- **25B** requires Health Boards/Trusts to calculate and take all reasonable steps to maintain the nurse staffing level in all adult acute medical and surgical wards, and paediatric inpatients wards. Health boards/Trusts are also required to inform patients of the nurse staffing level on those wards

- **25C** requires Health Boards/Trusts to use a specific method to calculate the nurse staffing level in all adult acute medical and surgical wards

- **25D** relates to the statutory guidance released by Welsh Government

- **25E** requires Health Boards/Trusts to report their compliance in maintaining the nurse staffing level for each adult acute medical and surgical ward.

Although PTHB has no Section 25B areas, all wards remain subject to the overarching Section 25A duty.

METHODOLOGY

The 2025/26 inpatient ward establishment reviews were undertaken using a structured and standardised approach aligned to the requirements of the Nurse Staffing Levels (Wales) Act 2016.

Ward-level self-assessment

Ward Managers completed a standardised In-Patient Ward Establishment Review Tool, capturing activity, staffing, quality indicators, acuity and contextual factors. Returns were submitted centrally for review.

On-site Executive and senior nursing review

The Executive Director of Nursing, Quality, Women and Family Health, alongside senior nursing leadership, undertook visits to all 12 inpatient wards during February and March 2026. These visits provided direct observational assurance, validation of data, and professional discussion with ward teams.

Panel review and triangulation

A formal multidisciplinary panel, including nursing, managers, workforce and finance, reviewed each ward submission and visit findings. The panel:

- Tested assumptions and staffing models
- Considered workforce, financial and operational implications
- Agreed outcomes and required actions

This approach ensured establishment decisions were evidence-based, contextually informed and consistent across the organisation.

Pattinson,Liz 03/08/2026 09:04:55

ASSESSMENT FRAMEWORK AND ALIGNMENT TO THE NURSE STAFFING LEVELS (WALES) ACT 2016

The In-Patient Ward Establishment Review Tool provides a structured framework to assess staffing establishments across five domains:

1. Workforce and Activity

- Bed base, activity and length of stay
- Establishment, vacancies and uplift
- Rostered versus required staffing

2. Acuity and Dependency

- Welsh Levels of Care (WLoC) distribution
- SafeCare compliance
- Red flag indicators

3. Quality and Safety

- Falls, pressure damage and medication safety
- Complaints and patient experience
- Workforce indicators (training, PADR, absence)

4. Professional Judgement and Context

- Ward environment and layout
- Patient flow and discharge delays
- MDT support and system pressures

5. Governance and Risk

- RAG assessment across workforce, quality, environment and flow
- Escalation thresholds and risk context

The framework reflects the statutory requirement for a triangulated approach, bringing together acuity and dependency data, quality indicators and professional judgement to inform safe staffing decisions. This is supported by multidisciplinary review and direct ward observation, ensuring robust and consistent assurance.

KEY FINDINGS:

1. Safe Staffing Position

- Staffing models are broadly aligned to current demand and acuity
- SafeCare data (acuity), quality indicators, and professional judgement support safe staffing assurance
- No evidence to support increasing or reducing establishments at this time

2. Workforce Stability

- Significant reduction in agency usage
- Improved continuity of care and strengthened team cohesion
- Some fragility remains in:

Patterson,Liz 03/08/2026 09:04:55

- Band 2/3 workforce
- Skill mix and experience levels of registered nurses

3. Quality and Safety

Positive performance across:

- Falls
- Pressure damage
- Medication safety

Patient safety risks identified are system-driven rather than staffing deficits e.g. delays, capacity pressures

4. System Pressures Impacting Staffing

Across all wards, workload pressures are heavily influenced by:

- Delayed discharges and flow challenges
- Limited or inconsistent medical, pharmacy and therapy input
- Increased patient acuity and complexity (now baseline)

Ward managers described these factors as resulting in:

- Nursing staff absorbing non-nursing workload
- Reduced time for direct care, supervision and development
- Increased risk of fatigue and long-term workforce sustainability issues

5. Mental Health Specific Considerations

- Increasingly complex and unpredictable patient group
- Observation levels and risk management demands high
- Gaps in MDT provision (pharmacy, psychology, OT) impacting nursing workload

6. Physical Health Specific Considerations

Wards operating effectively but:

- Managing high levels of delayed care
- Absorbing system inefficiencies

These themes were consistently identified through ward reviews, professional judgement and multidisciplinary discussions. Staff report that delayed discharges, patient flow, acuity and multidisciplinary provision affect workload and safe staffing sustainability; further work is needed to test this against organisational

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data and understand whether these pressures are perceived, actual or both, to inform future workforce and service planning.

Key Risks

Patient Risk

- Delayed discharge leading to deconditioning and harm potential
- Delays in access to MDT input

Workforce Risk

- Risk of burnout and attrition
- Reliance on goodwill and informal workarounds

Organisational Risk

- System risks not always visible in formal reporting
- Stable metrics potentially masking underlying pressure

Strategic Risk

- Misalignment between service models and current patient need
- Long-term sustainability risk if system issues persist

CONCLUSION

The establishment reviews provide strong assurance on compliance with NHS Wales safer staffing requirements. There is a stable and safe staffing position across inpatient wards, with:

- No requirement to change establishment levels
- Positive workforce trends
- Safe delivery of care

However, sustaining this position is dependent on addressing system-level pressures, rather than changes to nursing numbers. While ward teams consistently identified delayed discharges, patient flow challenges, increasing acuity and gaps in MDT provision as factors affecting workload and staffing sustainability, further work is required to understand the extent to which these pressures are evidenced through organisational data and their impact on nursing workload, patient care and workforce sustainability.

NEXT STEPS:

- Ongoing monitoring of staffing assurance through SafeCare and quality metrics
- Enhanced oversight of system pressures affecting sustainable safe staffing
- Further analysis of delayed discharge, patient flow, acuity and MDT provision to understand their impact on nursing workload, patient care and workforce sustainability
- Use findings to inform future workforce and service planning

Patterson,Liz 03/08/2026 09:04:55

Appendix 1: Inpatient Ward Establishment Review Tool (Physical Health)

In-Patient Ward Establishment Review

Complete Ward details and Section 1 – 9 only

Ward		**Location**	
Review Period	1 Aug 2025 – 31 Jan 2026	**Type of Ward / Speciality**	
Prepared by (name/role)		**Date prepared**	

Section 1: Beds & Activity

Total bed spaces		**Beds currently in use**	
Bed types *(e.g. GP, Stroke, Medical, Rehab, Paediatric, Sec.136)*			
Average Length of Stay (ALoS) days *(Latest figure from the inpatient dashboard)*			
Notes *(e.g. admission/discharge patterns)*			

Section 2: Shift times

Paid length = Shift length – Unpaid break.

Shift	Start Time	End Time	Unpaid break	Shift Length (hrs)	Paid Length (hrs)
Early					
Late					
Long Day					
Night					
Twilight					

Patterson,Liz
03/08/2026 09:04:55

Section 3: Rostered Staffing (Mon-Sun)

Enter number of staff on shift. Include substantive + bank + agency. Right-hand side is for proposed staffing after review.

Current									Proposed						
Role	**Mon**	**Tues**	**Weds**	**Thurs**	**Fri**	**Sat**	**Sun**		**Mon**	**Tues**	**Weds**	**Thurs**	**Fri**	**Sat**	**Sun**
Long Day															
RN															
HCSW															
Early															
RN															
HCSW															
Late															
RN															
HCSW															
Night															
RN															
HCSW															
Twilight															
RN															
HCSW															

Section 4: Establishment numbers (WTE)

Uplift of 26.9% covers staff absences, statutory and mandatory training sickness and study leave. Multiply planned roster by 1.269 for total budgeted WTE.

	Planned Roster (WTE)	**+ 26.9% Uplift**	**Total Budgeted WTE**	**Actual in post (WTE)**	**Vacancies (WTE)**	**Expected Starters (WTE)**	**Expected Leavers (WTE)**
Band 7							
Band 6							

Peterson,Liz
03/08/2026 09:04:55

Band 5							
Band 4							
Band 3							
Band 2							

Summary of workforce issues and actions:

Section 5: SafeCare, Acuity and Dependency
Provide WLoC distribution, SafeCare completion times, compliance %, and red flags summary.

WLoC Level	**Level 1**	**Level 2**	**Level 3**	**Level 4 RN**	**Level 4 HCSW**	**Level 5 RN**	**Level 5 HCSW**
% of patient days							

SafeCare Completion: (timing/frequency)
SafeCare Compliance: (% completion over review period)

Red Flag Event	**Count**	**Notes**
Insufficient registered nurses on duty		
Unplanned omission in providing medications		
Delay in providing pain relief		
Shortfall in RN time		

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Acuity not met by current nurse staffing levels		
Vital signs not assessed or recorded		
Missed 'intentional rounding'		
Unable to provide 1:1 care		
Increase to surge beds		
Less than 2 RNs on shift		
Insufficient HCSW on duty		
Staff unable to take a break		
DATIX incident – related to nurse staffing		
DATIX incident – not related to nurse staffing		
MH 136 out of hours assessment & crisis beds		
MH Level of observation		
MH PMVA		
MH Self Harm		

Where compliance is reduced, describe planned improvements:

Section 6: WNCR Risk Assessments on Admission
Enter % completed within the required timeframe for each assessment

Risk Assessment	**Completion % (on admission)**
Continence	
Nutritional	
Manual Handling	
Pain	
Pressure Ulcer	

Page 10 of 23 03/08/2026 09:04:55

Falls	
Mouthcare	

Section 7: Quality Indicators (last 6 months)

Quality Indicator	Count	Notes/Context
Hospital acquired pressure damage (include grade 2-4 & unstageable) – avoidable		
Number of falls		
Medication errors		
Complaints received about nursing care - managed under Putting Things Right (PTR)		
Statutory & Mandatory training compliance - RNs		
Statutory & Mandatory training compliance - HCSWs		
PADR compliance - RNs		
PADR compliance - HCSWs		
Staff Absence (Long Term/Short Term) FTE % rates		

Section 8: Ward Environment & Context

Ward Environment
(e.g. layout, storage, access/egress, visibility of patients)

Out of Hours (OOHs) Support

Patterson,Liz 03/08/2026 09:04:55

(e.g. medical support provided / how accessed)

Site responsibilities

(Access to site/ward/hospital, additional responsibilities)

Multi-disciplinary support

(Roles, availability, frequency)

Bank and Agency Use

(Use over review period, including 6-month trend for agency and bank shifts)

Professional Judgment & Additional Ward Narrative

(e.g. case mix, admission/discharge profile, benchmarking, operational pressures, additional risks not captured elsewhere)

Patterson,Liz
03/08/2026 09:04:55

Section 9: RAG Risk Summary & Actions

Rate each area Green (1), Amber (2), or Red (3). Suggested thresholds: 7–10 = Monitor, 11–15 = Action plan, 16+ = Escalate.

Risk Area	Green (1)	Amber (2)	Red (3)	Score	Key actions / owner / date
Workforce (fill rate, vacancies, temporary staffing)	**G**	**A**	**R**		
Acuity & Dependency (WLoC fit to staffing)	**G**	**A**	**R**		
Quality & Safety (incidents, red flags)	**G**	**A**	**R**		
Environment/Infrastructure (layout, sightlines, isolation)	**G**	**A**	**R**		
Flow & Operating Pressures (admissions/discharges, surge beds)	**G**	**A**	**R**		
Governance & Compliance (training, PADR, SafeCare)	**G**	**A**	**R**		

RAG Descriptors

Risk Area	Green	Amber	Red
Workforce	Planned roster met or over; >90% fill; vacancies ≤5%; minimal bank/agency	Intermittent shortfalls; fill 80–90%; vacancies 5–10%; some temporary reliance	Frequent shortfalls; fill <80%; vacancies >10%; high agency reliance
Acuity & Dependency	Staffing meets WLoC consistently	Occasional mismatch between WLoC and staffing	Persistent mismatch; 1:1 unmet; frequent surge/boarding

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03/08/2026 09:04:55

Quality & Safety	Low incident rate; no red flags	Some red flags; no harm or mitigated	Multiple red flags; harm/near-miss incidents
Environment/Infrastructure	Layout supports observation and flow	Some limitations with mitigations in place	Layout significantly hinders observation/flow; safety concerns
Flow & Operating Pressures	Admissions/discharges managed within planned capacity; no surge beds required, patient flow stable	Occasional delays in discharge or admissions; intermittent use of surge beds; moderate operational pressure	Frequent delays or cancellations; persistent surge bed use; significant operational pressure impacting patient safety
Governance & Compliance	Statutory & mandatory training compliance >90%, PADR compliance >90%, SafeCare completion >90% and timely; risk assessments consistently completed	Compliance between 75-89%, occasional delays in SafeCare or risk assessments; PADR/training gaps notes but mitigated	Compliance <75%; frequent delays or omissions in SafeCare and risk assessments; significant PADR/training gaps impacting safety

Returns due by 10th February 2026

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03/08/2026 09:04:55

Appendix 2 - Inpatient Ward Establishment Review Tool (Mental Health)

In-Patient Ward Establishment Review

Complete Ward details and Section 1 – 9 only

Ward		**Location**	
Review Period	1 Aug 2025 – 31 Jan 2026	**Type of Ward / Speciality**	
Prepared by (name/role)		**Date prepared**	

Section 1: Beds & Activity

Total bed spaces		**Beds currently in use**	
Bed types *(e.g. GP, Stroke, Medical, Rehab, Paediatric, Sec.136)*			
Average Length of Stay (ALoS) days *(Latest figure from the inpatient dashboard)*			
Notes *(e.g. admission/discharge patterns)*			

Section 2: Shift times

Paid length = Shift length – Unpaid break.

Shift	Start Time	End Time	Unpaid break	Shift Length (hrs)	Paid Length (hrs)
Early					
Late					
Long Day					
Night					
Twilight					

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03/08/2026 09:04:55

Section 3: Rostered Staffing (Mon-Sun)

Enter number of staff on shift. Include substantive + bank + agency. Right-hand side is for proposed staffing after review.

Current									Proposed						
Role	**Mon**	**Tues**	**Weds**	**Thurs**	**Fri**	**Sat**	**Sun**		**Mon**	**Tues**	**Weds**	**Thurs**	**Fri**	**Sat**	**Sun**
Long Day															
RN															
HCSW															
Early															
RN															
HCSW															
Late															
RN															
HCSW															
Night															
RN															
HCSW															
Twilight															
RN															
HCSW															

Section 4: Establishment numbers (WTE)

Uplift of 26.9% covers staff absences, statutory and mandatory training sickness and study leave. Multiply planned roster by 1.269 for total budgeted WTE.

	Planned Roster (WTE)	**+ 26.9% Uplift**	**Total Budgeted WTE**	**Actual in post (WTE)**	**Vacancies (WTE)**	**Expected Starters (WTE)**	**Expected Leavers (WTE)**
Band 7							
Band 6							

Peterson,Liz
03/08/2026 09:04:55

Band 5							
Band 4							
Band 3							
Band 2							

Summary of workforce issues and actions:

Section 5: SafeCare, Acuity and Dependency
Provide WLoC distribution, SafeCare completion times, compliance %, and red flags summary.

WLoC Level	**Level 1**	**Level 2**	**Level 3**	**Level 4 RN**	**Level 4 HCSW**	**Level 5 RN**	**Level 5 HCSW**
% of patient days							

SafeCare Completion: (timing/frequency)
SafeCare Compliance: (% completion over review period)

Red Flag Event	**Count**	**Notes**
Insufficient registered nurses on duty		
Unplanned omission in providing medications		
Delay in providing pain relief		
Shortfall in RN time		

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Acuity not met by current nurse staffing levels		
Vital signs not assessed or recorded		
Missed 'intentional rounding'		
Unable to provide 1:1 care		
Increase to surge beds		
Less than 2 RNs on shift		
Insufficient HCSW on duty		
Staff unable to take a break		
DATIX incident – related to nurse staffing		
DATIX incident – not related to nurse staffing		
MH 136 out of hours assessment & crisis beds		
MH Level of observation		
MH PMVA		
MH Self Harm		

Where compliance is reduced, describe planned improvements:

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Enter % completed within the required timeframe for each assessment

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Page 18 of 23 03/08/2026 09:04:55

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Mouthcare	

Section 7: Quality Indicators (last 6 months)

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Statutory & Mandatory training compliance - RNs		
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PADR compliance - RNs		
PADR compliance - HCSWs		
Staff Absence (Long Term/Short Term) FTE % rates		

Section 8: Ward Environment & Context

Ward Environment
(e.g. layout, storage, access/egress, visibility of patients)

Out of Hours (OOHs) Support

Patterson,Liz 03/08/2026 09:04:55

(e.g. medical support provided / how accessed)

Site responsibilities

(Access to site/ward/hospital, additional responsibilities)

Multi-disciplinary support

(Roles, availability, frequency)

Bank and Agency Use

(Use over review period, including 6-month trend for agency and bank shifts)

Professional Judgment & Additional Ward Narrative

(e.g. case mix, admission/discharge profile, benchmarking, operational pressures, additional risks not captured elsewhere)

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03/08/2026 09:04:55

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Rate each area Green (1), Amber (2), or Red (3). Suggested thresholds: 7–10 = Monitor, 11–15 = Action plan, 16+ = Escalate.

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Acuity & Dependency (WLoC fit to staffing)	**G**	**A**	**R**		
Quality & Safety (incidents, red flags)	**G**	**A**	**R**		
Environment/Infrastructure (layout, sightlines, isolation)	**G**	**A**	**R**		
Flow & Operating Pressures (admissions/discharges, surge beds)	**G**	**A**	**R**		
Governance & Compliance (training, PADR, SafeCare)	**G**	**A**	**R**		

RAG Descriptors

Risk Area	Green	Amber	Red
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03/08/2026 09:04:55

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Returns due by 10th February 2026

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03/08/2026 09:04:55

IMPACT ASSESSMENT
Not required

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03/08/2026 09:04:55

Patient Experience, Quality and Safety COMMITTEE on 4 August 2026	Agenda Item 4.12
Subject:	Quality Management System Programme
Approved and Presented by:	Paul Hooton, Executive Director of Nursing, Quality, Womens and Family Health
Prepared by:	Head of Quality and Safety
Purpose:	To discuss the development and implementation of a Quality Management System in Powys Teaching Health Board
Recommendations:	The Patient, Experience, Quality and Safety Committee is asked to: • Take **ASSURANCE** an approach has been set out to develop a Quality Management System (QMS) for the Health Board. A further report will be provided to the October Committee.
Executive Summary:	The implementation of a Quality Management System (QMS) provides Powys Teaching Health Board with an opportunity to strengthen its approach to quality, safety and continuous improvement, whilst meeting the requirements of the Health and Social Care (Quality and Engagement) (Wales) Act 2020. Although the Health Board has many well-established elements of quality management, there is an opportunity to further integrate governance, quality intelligence, performance, planning and commissioning assurance to provide a clearer organisational view of risk, variation and priorities. This presentation outlines a phased approach to developing an integrated Quality Management System, commencing with a development plan, organisational maturity assessment and Programme Initiation Document to inform implementation. The Patient Experience, Quality and Safety Committee is asked to discuss the proposed approach and take assurance that the programme will establish a sustainable, organisation-wide framework that supports effective decision-making, organisational learning and the delivery of high-quality care.

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03/08/2026 09:04:55

Powys Teaching Health Board

Quality Management System Programme

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03/08/2026 09:04:55

Quality Management System – Why Now?

- Requirement of Health and Social Care Engagement (Wales) Act (2020) – Duty of Quality
- Opportunity to embed a sustainable Quality Management System for Powys
- Opportunity to align with Commissioning Assurance priorities
- Opportunities for cultural shift around quality engagement across the workforce

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03/08/2026 09:04:55

What NHS Wales is asking for

Current State

- Well-developed components of quality management
- Strong governance structures at sub-committee level
- Emerging improvement capability
- Increasing integration across executive-led systems
- Opportunity to further align quality, performance and planning at organisational level

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03/08/2026 09:04:55

Aspirational State

Integration of Quality Systems

- Improvement and alignment of priorities and interconnectivity of established governance, performance and planning

Quality Intelligence and Reporting

- Integrated reporting to provide clearer visibility of risk, variation and organisational priorities
- Enhancing triangulation of quality intelligence

Risk Management Alignment

- Establish clear governance arrangements that define responsibilities, reporting routes and accountability for quality management across the organisation.

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03/08/2026 04:04:03

Commissioned Services Assurance

- Integrate commissioned services into the Quality Management System through a consistent assurance framework that enables quality intelligence, contractual oversight and organisational learning to inform decision making across all commissioned care.

Proposed Approach

July	August - October	October onwards
Development Plan	Organisation-wide Maturity Assessment	QMS Implementation Programme
Vision	Gap Analysis	Workstreams
Governance	Mapping	Improvement Roadmap

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03/08/2026 09:04:55

Proposed Workstreams

- Leadership and Governance – Gap analysis
- Four quadrant mapping across the organisation
  - Reporting
- Workforce, Capability and Training
- Commissioning Assurance
- Quality Intelligence and Learning

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03/08/2026 09:04:55

Immediate Priorities

- Provide an update to NHSW Performance & Improvement for 31/07/2026
- Agree programme vision (Board Development Aug/Sept 2026)
- Draft the NHS Wales Development Plan
- Develop a Programme Initiation Document
- Complete the Maturity Matrix through organisational engagement
- Confirm governance arrangements
- Ongoing Stakeholder Engagement and Communication

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03/08/2026 09:04:55

Mattresses Follow-up

Final Internal Audit Report

2025/26

Powys Teaching Health Board

Contents

Executive Summary.....1
Appendix A: Progress of Agreed actions 2
Appendix B..... 7

Review Reference	PTH-2526-27
Fieldwork	April 2026
Executive Sign Off	24 April 2026
Audit Committee	May 2026
Executive Lead	Claire Madsen – Executive Director of Allied Health Professions, Health Sciences and Digital
Audit Team	Ian Virgill, Head of Internal Audit
	Lucy Jugessur, Deputy Head of Internal Audit

Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

We have completed a follow-up review of 'Mattresses'.

Our original Mattresses audit was reported in July 2025 and identified seven issues which resulted in an overall assurance rating of 'Limited Assurance'.

For 2025/26 we have revised our approach to reporting our follow-up audit work to ensure that we comply with the requirements of the new Global Internal Audit standards. As such we will no longer be providing an assurance rating as part of our follow-up reports.

The purpose of this follow up review is therefore to establish if management has now taken corrective measures to fully implement the agreed management actions and address the relevant key findings from our original report.

We note that the Audit, Risk and Assurance Committee has continued to monitor progress in implementing these actions through the internal audit tracker.

Overview

Our follow up review has confirmed that all seven agreed actions have been **implemented,** as follows:

Original Priority Rating	Number of agreed actions	Implemented / obsolete (Closed no further action required)	Action Ongoing (Further action required)	Not Implemented / Not due (Further action required)
High	5	5	0	0
Medium	2	2	0	0
Total	**7**	**7**	**0**	**0**

As part of our follow-up review, we met with the Head of Nursing for the Community Services Group to establish the progress that has been made with the implementation of the agreed actions. We then obtained and reviewed documentation and evidence to validate the stated position for each of the actions.

As noted above, this has enabled us to confirm that all the agreed management actions have been implemented.

Whilst implementation of the agreed actions has improved the management of Mattresses within the Health Board, ongoing work is required to ensure that the training that has been developed is delivered to all relevant staff, and the oversight and reporting arrangements continue to operate in order to provide effective ongoing assurance.

Further detail of the work undertaken by management to implement each of the agreed actions is provided in the table below.

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Appendix A: Progress of Agreed Actions

Ref	Previous Finding, Agreed Management Action, Original Responsibility & Timescale	Priority Rating	Current Status & work undertaken
Finding 1	**Lack of awareness and specific training on the Health Board's Mattress Policy.** Finding: 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. 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. Original Responsibility & Timescale: Linzi Shone, 30/07/25	**High Priority**	**Action Status: Implemented** A mattress Inspection Training programme is now in place and a record of attendance at the training by relevant staff is held on ESR. The latest training record confirms that 41 staff have received the training through sessions delivered to 7 individual wards. Work is ongoing to deliver the training to all relevant staff. There are challenges due to the disparate nature of the staff across Powys but ways to overcome this are being developed.

Patterson,Liz
03/08/2026 09:04:55

Ref	Previous Finding, Agreed Management Action, Original Responsibility & Timescale	Priority Rating	Current Status & work undertaken
Finding 2	**No monthly confirmation of compliance with the Health Board's policy.** Finding: 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. 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. Original Responsibility & Timescale: Zoe Client / Donna Jones / Paul Sussex, 31/08/25	**Medium Priority**	**Action Status: Implemented** Monthly mattress audits are now being consistently undertaken across all wards, and these confirm the cleaning, decontamination and maintenance status of all mattresses. Copies of the completed audits are being retained within a Mattresses Teams Channel. The Community Services Managers (CSM) for each of the 3 localities are undertaking oversight to confirm that the audits have been completed and this is recorded within a central file. Review of the central file confirmed that the oversight has been consistently undertaken and recorded by the CSMs since August 2024.

Patterson,Liz
03/08/2026 09:04:55

Ref	Previous Finding, Agreed Management Action, Original Responsibility & Timescale	Priority Rating	Current Status & work undertaken
Finding 3	**Monthly mattress audits not completed by all wards.** Finding: 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. 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. Original Responsibility & Timescale: Linzi Shone, 30/07/25	**Medium Priority**	**Action Status: Implemented** The requirement to ensure monthly mattress audits are undertaken across all wards has been communicated to all ward leaders by the Head of Nursing. Copies of completed audit forms are being retained within a central teams file and review of these confirmed that the monthly audits are now being consistently completed across all Powys wards. Review of a sample of completed audits also confirmed that the required templates are being consistently utilised.

Ref	Previous Finding, Agreed Management Action, Original Responsibility & Timescale	Priority Rating	Current Status & work undertaken
Finding 4	**Confirmation that actions are taken to address issues identified.** Finding: 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. 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. Original Responsibility & Timescale: Zoe Client / Donna Jones / Paul Sussex, 30/07/25	**High Priority**	**Action Status: Implemented** A mattress Asset register is now in place which includes comprehensive details of all mattresses across all Powys wards. Issues identified for the mattresses are not included within the register, but they are recorded on the monthly mattress audit forms completed by each ward. The details of the issues identified, actions taken and new items ordered are then recoded by the CSMs within the central file referenced under Finding 2 above. This provides an appropriate record of issues identified and how they have been addressed.

Patterson, Liz
03/08/2026 09:04:55

Ref	Previous Finding, Agreed Management Action, Original Responsibility & Timescale	Priority Rating	Current Status & work undertaken
Finding 5	**Retention of completed mattress audits.** Finding: 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. 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. Original Responsibility & Timescale: Zoe Client / Donna Jones / Paul Sussex, 31/08/25	**Medium Priority**	**Action Status: Implemented** Copies of completed audit forms are being retained within a central Teams channel. Review of the information retained in the Channel confirmed that copies of the monthly audit forms were present for all Powys wards.

Ref	Previous Finding, Agreed Management Action, Original Responsibility & Timescale	Priority Rating	Current Status & work undertaken
Finding 6	**Missing mattress audit information.** Finding: 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. Agreed Action: Staff will be reminded to ensure that all required information is included for all mattresses as part of every audit. Original Responsibility & Timescale: Zoe Client / Donna Jones / Paul Sussex, 30/08/25	**High Priority**	**Action Status: Implemented** Monthly audits are now being undertaken by all wards and copies of the audit forms are retained on a Teams Channel. Review of a sample of completed mattress audit forms confirmed that the required information is now being consistently recorded for all mattresses.

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03/08/2026 09:04:55

Ref	Previous Finding, Agreed Management Action, Original Responsibility & Timescale	Priority Rating	Current Status & work undertaken
Finding 7	**No central monitoring and reporting arrangements are in place.** <u>Finding:</u> 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. <u>Agreed Action:</u> 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. <u>Original Responsibility & Timescale:</u> Linzi Shone, 30/09/25	**High Priority**	**Action Status: Implemented** The CSMs for each of the 3 localities provide a regular update on Inpatient Ward Mattresses as part of the Community Service Group (CSG) Quality, Safety and Patient Experience slides that go to each meeting of the CSG Patient Experience Quality Group. The content of the slides provides effective assurance around the completion and oversight of mattress audits along with information on any issues identified and actions taken. The Head of Nursing for the Community Services Group confirmed that any significant concerns would be escalated as required although there haven't been any to date due to the system that has been implemented, and the resolution work undertaken.

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03/08/2026 09:04:55

Appendix B

Disclaimer

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit & Assurance Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Powys Teaching Health Board, and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of the Powys Teaching Health Board Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

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.

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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03/08/2026 09:04:55

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 6.1

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE	**29 JULY 2026**
Subject:	**Internal Audit (Mortality Reviews) – explanation**
Approved and presented by:	Helen Bushell, Director of Corporate Governance
Prepared by:	Helen Bushell, Director of Corporate Governance with information provided by the PTHB Quality & Safety team.
Other Committees and meetings considered at:	N/A
Appendices :	Internal Audit (Mortality Reviews)

PURPOSE:

The paper provides an explanatory note following the query raised in the Audit, Risk and Assurance Committee.

RECOMMENDATION(S):

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

- **NOTE** the information provided in relation to Mortality Reviews following the query raised in the Audit, Risk and Assurance Committee.

Approve/Take Assurance	Discuss	Note
Y	Y	x

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

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03/08/2026 09:04:55

SUMMARY

The Internal Audit on Mortality Reviews was presented at the Audit, Risk and Assurance Committee in July. The audit has a reasonable assurance attached to it.

Two queries were raised and referred to the Patient Experience, Quality and Safety Committee. The queries and responses are set out below:

1. How do we ensure learning from deaths is effectively captured and acted upon?

Within PTHB, learning from Medical Examiner reviews is considered through our established governance arrangements, specifically our mortality review meetings. These monthly meetings are attended by representatives from clinical services and primary care, and provide an opportunity to discuss Medical Examiner summaries and identify recurring themes. Services will then take away and share learning within their areas. Wider learning and updates are also communicated through a 6 monthly PTHB Medical Examiner Service newsletter.

Where it is identified from the ME summaries that areas of learning do not relate to care provided by PTHB services but other providers e.g. the local authority or other Health Boards/NHS Trusts, we will forward this to the relevant organisation for their consideration. The themes identified most commonly for PTHB services relate to communication and the Medical Examiner process rather than clinical care or treatment. Where learning relates to an individual clinician, it is managed through the appropriate processes and is not shared more widely.

2. How is learning from deaths that occur outside Powys captured and monitored?

If a Powys resident dies outside of PTHB, the ME process is undertaken by that health board or NHS Trust. If concerns, recommendations or learning are identified that relate to services provided by PTHB, the Health Board/NHS Trust undertaking the ME review will share the ME summary and information with us through our established inter-organisational governance processes and contacts. The ME summaries will be received by the PTHB Quality and Safety team and discussed in the monthly mortality review panels described above.

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03/08/2026 09:04:55

Mortality Reviews

Final Internal Audit Report

2025/26

Powys Teaching Health Board

Reasonable Assurance

Contents

Executive Summary 1
Findings & Agreed Action Plan 3
Appendix A 11

Review Reference	PTH-2526-24
Fieldwork	January - May 2026
Executive Sign Off	8th June 2026
Audit Committee	June 2026
Executive Lead	Kate Wright, Medical Director
Audit Team	Ian Virgil, Head of Internal Audit
	Lucy Jugessur, Deputy Head of Internal Audit

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GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

The overall objective of this audit was to review the adequacy of the systems and controls in place for mortality reviews, including the processes for dealing with deaths that are referred to the Health Board by the Medical Examiner for further review.

In 2013 the Chief Medical Officer for NHS Wales recommended that all patients who die in a hospital in NHS Wales have a mortality review. The purpose of the reviews is to generate learning about the quality of care and treatment and to identify and act on any concerns in the post-Francis era of candour.

The Medical Examiner Service for Wales provides independent scrutiny of all deaths that occur in Wales that are not referred directly for investigation to His Majesty's Coroner.

The Medical Examiner Service was created because it was recognised that an independent scrutiny of a death, undertaken by a Medical Examiner, who is a qualified and trained doctor but who is independent of any care provided and the organisation who provided it, allows the cause of death to be more accurately identified, and the circumstances surrounding the death to be more objectively assessed in order to identify any concerns about the treatment or care provided that may require further investigation.

The Medical Examiner Service for Wales has been operational and covering all areas of Wales since 1st January 2021, scrutinising deaths that have occurred both in hospital and in the community. However, the impact of COVID 19 meant that the capacity required to scrutinise all deaths in Wales not referred directly to a Coroner was not reached. The UK Government passed the required legislation for the scrutiny of all deaths not referred directly to a coroner by a medical examiner to be a legal requirement from September 2024.

Overview

We have concluded **Reasonable** assurance on this area. The core process for interacting with the Medical Examiner Service following a patient's death is generally functioning appropriately, although some elements of governance and application require strengthening to ensure the ongoing timeliness and effectiveness of the mortality review process.

The key matters requiring management attention include:

- An up-to-date approved policy is not in place, although work is in progress to rectify this.
- Further development of the Medical Examiner Service pages on the intranet is required.
- Deaths are not always promptly recorded on the Welsh Patient Administration System (WPAS).
- A review should be undertaken to determine the best mechanism to record and evidence panel reviews.
- Improvements are needed to the process for recording and evidencing responses to Medical Examiner Scrutiny Summaries received.
- Structured action regarding Medical Examiner Scrutiny Summaries is not up-to-date.
- An up-to-date Medical Examiner Service newsletter should be produced

Patterson, Kate
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Full details of matters arising are provided within the Findings & Agreed Action Plan. The following opportunities for enhancement have been identified that do not impact the overall opinion and are highlighted for management information:

- The Medical Examiner Service contact details on the public website are for the Mid & West Wales region whereas the South Wales East region covers Powys.

Scope & Assurance Summary

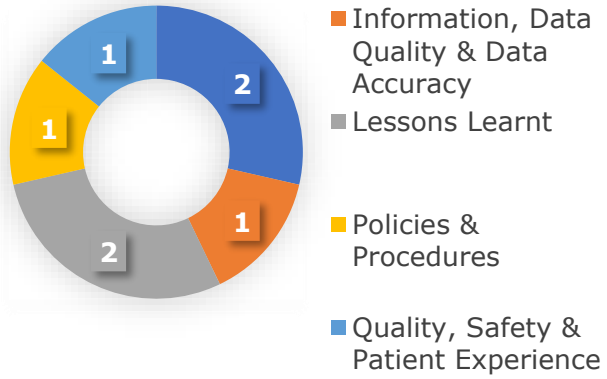
Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	The Health Board has appropriate policies and procedures in place setting out the mortality reviews process and interaction with the Medical Examiner Service.	1, 2	**Reasonable**
2	Robust processes are in place for interacting with the Medical Examiner Service and providing all required information following a patient's death.	3	**Reasonable**
3	Cases referred by the Medical Examiner are subject to appropriate review within the Health Board.	4, 5, 6	**Limited**
4	Adequate review and reporting of the mortality review process is undertaken within Service Groups, with dissemination across the Service Groups and escalation to Health Board Committees to ensure lessons are learned.	7	**Reasonable**

Management Actions

1 High Priority

6 Medium Priority

Themes



Risk Types

Quality or Safety Issues

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03/08/2026 09:04:55

Findings & Agreed Action Plan

Objective 1: The Health Board has appropriate policies and procedures in place setting out the mortality reviews process and interaction with the Medical Examiner Service.	**Reasonable**

Overview / Summary of Observations

GNP 081 'Standard Operating Procedure for the Medical Examiner Process in PTHB Community Hospitals' (the "Policy") is the current approved policy in place in relation to the mortality reviews process and interaction with the Medical Examiner Service. This is included on the Policies intranet page but was issued in May 2023 and has passed its scheduled date for review. However, an updated policy, standard operating procedure and terms of reference have since been developed, although they have not undergone an approval process.

The current approved policy appropriately covers the process to be followed from the death of a patient through to providing information to the Medical Examiner Service. However, it does not cover how the Health Board should deal with Medical Examiner Service Scrutiny Summaries subsequently received, although this is covered within the other documents which have since been developed.

The intranet and public website generally include appropriate information regarding the Medical Examiner Service although a couple of areas of improvement were identified.

An online Lunch & Learn session was held in January 2026 where the Lead Medical Examiner for Wales presented information on the GP's role in the certification of deaths and compliance with statutory requirements which was recorded and is available on the intranet. Whilst we note that the number of attendees/views is a relatively low proportion of the number of Powys GPs at around 20%, the Health Board's Medical Director has confirmed that the Medical Examiner also carried out visits to the GP practices within Powys.

	Key Findings	Risk & Impact	Agreed Management Action
1	**An up-to-date approved policy is not in place** The current policy in relation to the mortality reviews process and interaction with the Medical Examiner Service, which is included on the policies intranet page, is overdue for review. Patterson,Liz 03/08/2026 09:04:55	Threats to patient safety/opportunities to improve mortality rates are not identified or addressed/implemented.	**Agreed Action:** The policy in relation to the mortality reviews process and interaction with the Medical Examiner Service will be finalised, approved and added to the policies intranet page. **Expected Evidence of Implementation:** An up-to-date approved policy in relation to the mortality reviews process and interaction with the Medical Examiner Service is included on the policies intranet page.
		Medium Priority	**Officer:** Interim Head of Q&S **Target Implementation Date:** 31 July 2026
	Theme: Policies & Procedures	Control Operation	

2	**Medical Examiner Service Learn More section on the intranet** The Medical Examiner Service Learn More section on the intranet is currently empty.	Threats to patient safety/opportunities to improve mortality rates are not identified or addressed/implemented.	**Agreed Action:** The Medical Examiner Service Learn More section on the intranet will be populated with appropriate information.
			Expected Evidence of Implementation: Copies of relevant information within the Medical Examiner Service Learn More section on the intranet.
		Medium Priority	**Officer:** Bereavement Clinical Lead
	Theme: Communication & Engagement	Control Operation	**Target Implementation Date:** 31 August 2026

Patterson,Liz
03/08/2026 09:04:55

Objective 2: Robust processes are in place for interacting with the Medical Examiner Service and providing all required information following a patient's death.	**Reasonable**

Overview / Summary of Observations

The process from death to providing information to the Medical Examiner Service is as follows:

- The death is initially input onto the Welsh Patient Administration System (WPAS) by the ward so that relevant staff are aware of the death.
- Medical and nursing notes and charts are scanned by the ward and provided to the Information Governance Team who submit them to the Medical Examiner Service via the secure portal email system in accordance with data protection Subject Access Request requirements.
- The Medical Examiner Service reviews the medical records and liaises with the doctor to agree completion of the Medical Certificate of Cause of Death (MCCD) which is then provided to the next of kin so that they can obtain a death certificate from the Registry Office.
- If the Medical Examiner choses to issue a Scrutiny Summary, this is sent to the Health Board's dedicated email address for the points identified to be followed up and appropriate action taken, which is recorded and managed via the mortality module of the RL Datix computer system.

The Health Board's Policy set's out internal timescales for the recording of deaths and provision of information, including input of the death onto WPAS within 1 hour. However, there are no external timeframe targets imposed by the Medical Examiner Service, NHS Wales or Welsh Government. Therefore, we have taken a reasonableness approach when considering the time taken from date of death to finalisation of the MCCD and a Medical Examiner Scrutiny Summary being issued.

We reviewed the WPAS report for all deaths recorded in 2025/26 which indicated that only 42% of the 208 deaths were recorded in WPAS within 1 calendar day, with the time taken to record the remainder set out in the key finding below. Whilst this highlights that deaths are not being consistently recorded within the required 1 hour stated within the Policy, information provided by the Information Governance Team indicated that there were only a small number of deaths where there was a delay in providing the medical history documentation to the Medical Examiner Service, with the length of these delays being minimal. This is also supported by the data recorded on the 'Medical Examiner Service: Health Board Ranking' dashboard, which identifies that the Health Board's time between date of death and provision of notes is 2.52 days.

We also reviewed the spread of deaths across the various wards which did not highlight any anomalies which required further investigation.

From our detailed testing of a sample of 12 deaths we identified the following:

- In all cases, a detailed patient medical history was provided to the Medical Examiner Service.
- The number of calendar days from death to the MCCD being issued was:

Number of calendar days	Proportion
0 – 7 days	7/12 deaths (58%)
8 – 14 days	3/12 deaths (25%)
15+ days	2/12 deaths (17%) 16 and 42 days respectively

However, as noted above, there are no external timeframe targets imposed on the Health Board.

Key Findings		Risk & Impact	Agreed Management Action
3	**Deaths are not promptly recorded on WPAS** Only 42% of the 208 deaths in 2025/26 were recorded in WPAS within 1 calendar day, with the analysis of time taken being as follows: Number of calendar days taken to record deaths in WPAS: % — < 1: 42; 1 – 4: 39; 5 – 7: 2; 7 – 14: 4; 14 – 21: 4; > 21: 9 Whilst this is not causing a delay in the submission of notes to the Medical Examiner Service, it does highlight that deaths are not being consistently recorded on WPAS within the required 1 hour stipulated within the Health Board's policy.	Threats to patient safety/opportunities to improve mortality rates are not identified or addressed/implemented.	**Agreed Action:** Wards will be reminded that all deaths should be promptly recorded in WPAS.
			Expected Evidence of Implementation: Deaths are promptly recorded in WPAS.
		Medium Priority	**Officer:** Interim Head of Q&S **Target Implementation Date:** 31 July 2026
	Theme: Quality, Safety & Patient Experience	Control Operation	

Patterson,Liz
03/08/2026 09:04:55

Objective 3: Cases referred by the Medical Examiner are subject to appropriate review within the Health Board.	**Limited**

Overview / Summary of Observations

If the Medical Examiner Service choses to issue a Scrutiny Summary, this is sent to the Health Board's dedicated email address for appropriate action to be taken. This is recorded and managed via the mortality module of the RL Datix system which is a nationally prescribed system which Health Boards are expected to use to manage these cases.

The Bereavement Clinical Lead is responsible for initially reviewing the Medical Examiner Scrutiny Summaries received which are then dealt with in various ways according to the nature and severity of the points raised.

There are no external timeframe targets imposed by the Medical Examiner Service, NHS Wales or Welsh Government. Therefore, we have taken a reasonableness approach to the time taken to respond to points raised according to their nature and severity.

In addition to recording the reviews in the mortality module of the RL Datix system, a Learning from deaths panel dashboard spreadsheet in also used in relation to the panel reviews. However, this essentially duplicates the information recorded in Datix and our sample testing identified examples of data inconsistently recorded between them.

The Health Board is not required to send responses to the Medical Examiner Service. Action taken by the Health Board in response to points raised only needs to be communicated internally.

We obtained a report of all Medical Examiner Scrutiny Summaries received between 1 April 2025 and 15 January 2026 and, for a sample of 12, considered whether the evidence recorded in Datix and the Learning from deaths panel dashboard spreadsheet confirmed that appropriate action was taken regarding points raised in the Medical Examiner Service Scrutiny Summary and whether appropriate supporting documentation is filed within Datix. Findings were identified in 11 cases, which are summarised below.

Furthermore, no structured action has been taken regarding Medical Examiner Scrutiny Summaries received since 15 January 2026 due to staffing issues, although we have been informed by the Head of Professional Practice and Standards (Nursing) that the Assistant Medical Director has been informally reviewing them for serious / urgent matters that cannot wait.

	Key Findings	Risk & Impact	Agreed Management Action
4	**Learning from deaths panel dashboard spreadsheet** In addition to recording the reviews in the mortality module of the RL Datix system, which is a nationally prescribed system which Health Boards are expected to use to manage these cases, a Learning from deaths panel dashboard spreadsheet in also used in relation to the panel reviews. However, this essentially duplicates the information recorded in Datix and our sample testing below identified examples of data inconsistently recorded between them or incompletely recorded in the Learning from deaths panel dashboard spreadsheet:	Threats to patient safety/opportunities to improve mortality rates are not adequately identified or addressed/implemented.	**Agreed Action:** The mortality module of the RL Datix system will be used as the primary mechanism to record and evidence action taken in response to Medical Examiner Scrutiny Summaries received and a review will be undertaken to determine the best mechanism to record and evidence the panel reviews.

Page 8/12 2026-01-26 09:01:35

	• In two cases, the action taken was not fully recorded in the Learning from deaths panel dashboard spreadsheet and in one further case it was not recorded at all in the spreadsheet. • In three cases, the review panel date in the Learning from deaths panel dashboard spreadsheet was blank and in one case, the date closed was blank.		**Expected Evidence of Implementation:** The mortality module of the RL Datix system is consistently used and an appropriate mechanism has been put in place to record and evidence the panel reviews.
		Medium Priority	**Officer:** Interim Head of Q&S / Bereavement Clinical Lead **Target Implementation Date:** 31 August 2026
	Theme: Information, Data Quality & Data Accuracy	Control Design	
5	**Responses to action points in Medical Examiner Scrutiny Summaries received** For a sample of Medical Examiner Scrutiny Summaries received between 1 April 2025 and 15 January 2026, we considered whether the evidence recorded in Datix and the Learning from deaths panel dashboard spreadsheet confirmed that appropriate action was taken regarding points raised in the Medical Examiner Service Scrutiny Summaries and whether appropriate supporting documentation is retained within Datix. The following findings were identified: • In two cases, a letter was sent out to follow up the points raised but a reply was not received and this was not followed up, and in one case, while follow up of the Medical Examiner points raised was initiated, an adequate response was only received six months later. • In three cases, the review panel date was after the date closed. • In one case, while it went to review panel which determined that further investigation was appropriate, it did not go a second time to consider the result of the investigation. • Datix included numerous cells where data was missing, and while we acknowledge that not all cells in this national system are mandatory, we consider that completeness of data in Datix cells is preferable.	Threats to patient safety/opportunities to improve mortality rates are not identified or addressed/implemented.	**Agreed Action:** We will ensure that: • All required responses are obtained in a timely manner. • Cases will only be closed on Datix after the review panel has confirmed that this should occur. • Where a review panel has determined that further investigation is required, the case will be returned to the review panel to consider the result of the investigation. • Data is recorded in all cells in Datix.
			Expected Evidence of Implementation: Appropriate action is taken for all future cases, and this is fully recorded and evidenced within Datix.
		Medium Priority	**Officer:** Bereavement Clinical Lead **Target Implementation Date:** 30 September 2026
	Theme: Lessons Learnt	Control Operation	

Page 9 of 12
03/09/2026 04:04:55

6	**Structured action regarding Medical Examiner Scrutiny Summaries is not up to date** No structured action has been taken regarding Medical Examiner Scrutiny Summaries received since 15 January 2026 due to staffing issues, although we have been informed by the Head of Professional Practice and Standards (Nursing) that the Assistant Medical Director has been informally reviewing them for serious / urgent matters that cannot wait.	Threats to patient safety/opportunities to improve mortality rates are not identified or addressed/implemented.	**Agreed Action:** Structured action regarding Medical Examiner Scrutiny Summaries will be brought up to date i.e. the points raised in the Medical Examiner Service Scrutiny Summaries will be fed back to staff for lessons to be learnt and Datix will be updated to record the points raised and the Health Board's responses to them. **Expected Evidence of Implementation:** Structured action is up to date and recorded in Datix for all Medical Examiner Scrutiny Summaries received.
		High Priority	**Officer:** Interim Head of Q&S / Bereavement Clinical Lead
	Theme: Lessons Learnt	Control Operation	**Target Implementation Date:** 31 July 2026

Patterson,Liz
03/08/2026 09:04:55

Objective 4: Adequate review and reporting of the mortality review process is undertaken within Service Groups, with dissemination across the Service Groups and escalation to Health Board Committees to ensure lessons are learned.	**Reasonable**

Overview / Summary of Observations

The Medical Examiner Service intranet page includes a Medical Examiner Newsletter which provides a detailed and comprehensive overview of ME reviews for April – October 2025 which includes numbers, themes identified and learning and improvement actions which was also disseminated via the Practice Managers Meeting. However, a subsequent newsletter covering the period from November 2025 has not been produced.

Medical Examiner slides have been presented at the Integrated Quality and Performance Group which provides coordinated oversight of service performance and comprises Executive representation from all areas of the Health Board.

Appropriate oversight information has also generally been presented to the Patient Experience, Quality and Safety (PEQS) Committee, although this has been impacted more recently by the staffing issues identified under objective 3.

	Key Findings	Risk & Impact	Agreed Management Action
7	**An up-to-date Medical Examiner Service newsletter should be produced** A Medical Examiner Service newsletter which includes numbers, themes identified and learning and improvement actions has only been produced up to October 2025.	Threats to patient safety/opportunities to improve mortality rates are not identified or addressed/implemented.	**Agreed Action:** An up-to-date Medical Examiner Service newsletter from November 2025 onwards will be produced and disseminated. **Expected Evidence of Implementation:** Medical Examiner Service newsletters are produced and disseminated in a timely manner.
		Medium Priority	**Officer:** Bereavement Clinical Lead **Target Implementation Date:** 31 August 2026
	Theme: Communication & Engagement	Control Operation	

Patterson,Liz
03/08/2026 09:04:55

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]

Archwilio Cymru
Audit Wales

Improving Quality Governance

Powys Teaching Health Board

February 2026

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03/08/2026 09:04:55

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Patterson,Liz
03/08/2026 09:04:55

Contents

Audit snapshot	4
Key facts and figures	7
Our findings	8
Recommendations	17
1 About our work	20
2 Previous recommendations	23
3 Key terms in this report	25

Patterson,Liz
03/08/2026 09:04:55

Audit snapshot

What we looked at

1 Our review assessed progress made by Powys Teaching Health Board (the Health Board) in implementing our 2021 quality governance audit recommendations. It also considered progress made by the Health Board to review and implement corporate arrangements to meet the new Duties of Quality and Candour requirements, and related oversight and scrutiny.

Why this is important

2 Quality should be at the 'heart' of all aspects of healthcare and 'putting quality and safety' before anything else is one of the core values underpinning the NHS in Wales. Poor quality healthcare can be costly in terms of harm, waste, and variation.

3 During 2021-22, the Auditor General reviewed quality governance arrangements across all health boards and trusts in Wales. Our 2021 Review of Quality Governance at the Health Board found that it was committed to ensure high quality, safe and effective services and had taken steps to improve its quality governance arrangements. Work remained to embed these arrangements and articulate the quality priorities of the organisation. The Health Board also needed to ensure there were measures in place to show and monitor achievement to drive improvements across the full range of services provided and commissioned.

4 We made nine recommendations which focused on:

- the commissioning assurance framework;
- the clinical quality framework;
- alignment of frameworks;
- complaints on commissioned services;

Patterson, Lisa
03/08/2026 09:04:55

- quality and safety performance measures;
- DATIX training;
- statutory and mandatory training; and
- data analytics capacity.

5 In June 2020, the Health and Social Care (Quality and Engagement) (Wales) Act 2020 (the Act) became law. The Act has strengthened the duty to secure system-wide quality improvements. It also placed a Duty of Candour on NHS bodies, requiring them to be open and honest with service users when things go wrong and apply lessons learned.

What we have found

6 The Health Board has made some progress against our previous audit recommendations. New frameworks are in place to better articulate the arrangements for commissioning services, supported by improved monitoring of quality and safety measures. The Health Board has also met its statutory and mandatory training compliance target.

7 However, the Health Board still needs to set out its expected standards of care for commissioned services, and to ensure it produces regular Commissioned Services Performance Reports. These should include oversight of complaints about commissioned services, which is still a gap. Although the Health Board has made some progress to improve access to data, analytical capacity is also a gap, and the Health Board would still benefit from having a quality dashboard. The Health Board also needs to ensure appropriate corporate staff have received DATIX training.

8 The Health Board has made reasonable progress in embedding the duties of quality and candour. There was a clear implementation plan, and the Board receive regular updates on compliance. However, oversight of the uptake of relevant training needs to improve.

Patterson,Liz
03/08/2026 09:04:55

What we recommend

9 We have made four recommendations which replace six 2021 recommendations that are not yet complete, updated to reflect the current delivery context. These focus on:

- performance measures and outcomes for commissioned services
- oversight of complaints about commissioned services;
- DATIX training; and
- data analytics.

10 We have also made two new recommendations which focus on:

- the Commissioned Services Performance Reports; and
- oversight of duty of quality e-learning.

Patterson,Liz
03/08/2026 09:04:55

Key facts and figures

- Three of the nine previous recommendations are complete. There has been some progress against three recommendations and no action taken for the remaining three.

- 89% compliance with statutory and mandatory training in October 2025, compared with 85% in January 2024 and 82% in January 2023.

- Two ‘moderate harm and above’[1] incidents have needed the application of the Duty of Candour procedure during 2024-25, out of a total of 66 incidents.

[1] Moderate harm within the context of the Duty of Candour is defined as a patient safety incident that results in a moderate increase in treatment and significant, but not permanent, harm.

Patterson, Liz
03/08/2026 09:04:55

Our findings

Implementation of previous recommendations

The Health Board has aligned frameworks, exceeded training targets, and progressed data analytics, but has taken no action on complaints about commissioned services or corporate DATIX training

Commissioning Assurance Framework

11 Our 2021 review recommended that the Health Board reviews its Commissioning Assurance Framework to include measures on the standards of care provided or patient outcomes. This recommendation is in progress.

12 Since our review, the Health Board has replaced the Commissioning Assurance Framework with its Strategic Commissioning Framework (SCF). The Board approved this in September 2025. The SCF details the Health Board's approach to commissioning services for the population of Powys[2]. The scope of the SCF relates to services the Health Board provides and commissions from neighbouring NHS bodies.

13 The SCF is supported by the monitoring arrangements set out in the Integrated Quality and Performance Framework (IQPF) approved by the Board in May 2025. The IQPF sets out how the Health Board monitors, assures, and escalates the quality and performance of provider and commissioned services. The two frameworks work together as a single governance system.

Patterson, Liz
03/08/2026 09:04:55

[2] The SCF does not cover Primary Care, Continuing Health Care and out of area Mental Health placements which have separate governance arrangements.

14 Despite a consistent and integrated focus on quality across both the IQPF and SCF and a clear framework of how the Health Board will monitor standards of care and patient outcomes, it has not yet developed expected measures and outcomes for each of its commissioned providers.

15 The Health Board has recently recruited a people's experience coordinator, which it hopes will drive the identification and development of appropriate outcomes and measures.

Oversight of Clinical Quality Governance

16 Our 2021 review recommended that the Health Board develop a governance map for the organisation. This should clearly show the range of activities in place at the strategic and operational level to ensure there is a clear line of sight on quality and safety from service to Board and identify any overlaps or gaps between groups. This recommendation is complete.

17 The Health Board has introduced new oversight arrangements for clinical quality for both its provider and commissioned services. The Integrated Quality and Performance Report (IQPR) provides routine assurance on performance to the Finance and Performance Committee and Board. An Integrated Quality Report (IQR) is presented to the Patient Experience, Quality and Safety Committee every quarter with a specific focus on quality. This committee provides robust scrutiny on quality issues.

18 For commissioned services, lines of accountability are clear but mechanisms to provide strategic and operational oversight are not fully operational. Since our original review, the Health Board has:

- established a Commissioning Oversight and Assurance Group (COAG), chaired by the Executive Director for Planning, Performance and Commissioning with representation from across the organisation including finance, nursing, and quality;
- updated and strengthened its Contract Quality and Performance Review Meeting (CQPRM) process (change of frequency of meetings and reporting /escalation to COAG);

Patterson,Liz
03/08/2026 09:04:55

- recognised the effective alignment/interdependency of the IQPF and the Strategic Commissioning Framework (SCF); and
- committed to develop a monthly Commissioned Services Performance Report.

19 However, the Health Board needs to fully embed these arrangements. The COAG should report relevant information on commissioned services into the Executive Committee and onto the Finance and Performance Committee via the Commissioned Services Performance Report. Despite the Health Board setting up the COAG in summer 2025 and this group meeting regularly, the Commissioned Services Performance Report has not been presented to any committee. As a result, there is little assurance on the quality of commissioned services reported into relevant committees. Considering the Health Board updated the IQPF in May 2025, it should do this at pace to ensure there is sufficient oversight and scrutiny of clinical quality governance as intended.

20 The CQPRMs are taking place but frequency of meetings is decided by a range of factors including circumstances, performance, and any relevant contract risks. The Health Board may want to consider whether it needs a minimum meeting requirement each year to ensure oversight of each contract. At the time of our audit, updates from CQPRMs were verbal with no information on how often these meetings will be held and the level of data they will include.

Alignment of frameworks

21 Our 2021 review recommended that the Health Board review the potential for alignment of the Clinical Quality Framework and the Commissioning Assurance Framework. We have found that the Health Board has completed this recommendation.

Patterson,Liz
03/08/2026 09:04:55

22 The Health Board's IQPF replaced its Clinical Quality Framework and Commissioning Assurance Framework in 2024. The IQPF applies to all services the Health Board provides and those commissioned from neighbouring NHS bodies. It provides the monitoring arrangements for the Health Board's new Strategic Commissioning Framework. As a result, the Health Board's previously separate frameworks now work in a more aligned and coherent way.

Concerns and Complaints

23 In our 2021 review we found there needed to be greater oversight of complaints from Powys residents on commissioned services at committee level. There also needed to be clarity on the responsibility for monitoring and reporting complaints. We have found that there has been no progress in this area.

24 Whilst the Health Board has good oversight of complaints about the services it directly provides, challenges remain recording, analysing, and understanding complaints about commissioned services.

25 The Health Board told us it will monitor complaints about commissioned services as part of the Strategic Commissioning Framework (SCF). However, the SCF does not mention complaints. We were told oversight of complaints would be provided by the COAG, using intelligence from the CQPRMs, before escalating any relevant complaint reports to the appropriate committee. However, this process is not yet in place.

26 The current SCF does not include a requirement to ask for and/or explore any complaints made to the commissioned service by Powys patients. The SCF also does not include how the COAG will gather complaints about commissioned providers or how these complaints will be reported and escalated. The SCF is not specific enough in setting out the complaints process. As a result, there is still a lack of clarity about complaints about commissioned services.

Patterson,Liz
03/08/2026 09:04:55

27 This is a missed opportunity to hold commissioned services to account and use data to show trends. As found in our previous audit, current arrangements do not provide a formal process for identifying, managing, and reporting complaints about commissioned services to the Patient Experience, Quality and Safey Committee.

Quality and Patient Safety Performance Measures

28 In our 2021 review we recommended that the Health Board develop a quality dashboard which articulated the Health Board's quality and patient safety and performance measures. There has been some progress in this area.

29 The IQPF includes a range of both national and local performance measures including statutory and local key performance indicators. The IQPF also includes an escalation framework which includes performance triggers, expected actions and monitoring and support arrangements.

30 The IQPR clearly sets out each performance measure, its target, trend, and escalation status allowing clear oversight. Where performance from commissioned services is available, the report presents provider and commissioned services performance separately to avoid confusion.

31 The Health Board presents more detailed quality and patient safety performance measures in the IQR to the Patient Experience, Quality and Safety Committee quarterly. The IQR holds useful information, including:

- Concerns and Complaints (Putting Things Right PTR);
- Duty of Candour cases;
- Incident Reporting;
- Nationally Reportable Incidents; and
- Infection Prevention and Control.

Patterson,Liz
03/08/2026 09:04:55

32 However, we noted in our 2025 Structured Assessment that the IQR is very narrative and although interspersed with some useful data and graphs, the report needs to be clearer in how it identifies areas of concern. We have recommended a review of the structure of the IQR in our 2025 Structured Assessment.

33 The Health Board would still benefit from a dashboard which articulates the quality and patient safety performance measures and key performance indicators for the Health Board. This would more easily allow readers to measure success and see improvements.

DATIX training

34 In our 2021 review we found that not all corporate staff have received training and support on how to use the DATIX system[3] to report concerns and near misses. We have found there has been no action in this area.

35 All staff across the Health Board can access DATIX training via the Health Board intranet and the Health Board intends to pre-record training for ease of access. However, we have no evidence the relevant corporate staff have completed this training.

Statutory and mandatory training

36 Our 2021 review found that the Health Board was not achieving its statutory and mandatory training compliance target. This training is important for ensuring staff and patient safety, as well as wellbeing. We have found that the Health Board has completed this recommendation.

37 In October 2025 mandatory and statutory training compliance was 89%, exceeding the Health Board's target of 85%. This is an increase on 2023 and 2024 performance, and benchmarks positively against other health boards in Wales.

[3] Datix (specifically the **Once for Wales Concerns Management System - Datix Cymru**) is the standard, secure, cloud-based system used by NHS Wales to report, manage, and analyse patient safety incidents, risks, and concerns, including those triggering Duty of Candour

Pattern (3) 03/07/2026 09:04:55

Data Analytics

38 Our 2021 review recommended the Health Board build data analytics capacity within their operational teams to support them to better understand and evaluate their performance. We have found the Health Board has made some progress in this area.

39 The Health Board has digital dashboards which underpin performance reports held and managed by the operational digital team. The digital team maintain the dashboards, gathering data from the data owners and the performance team have overall oversight. These underpin a range of reports including performance reports to the People and Culture Committee. The dashboards include sickness absence rates, sickness rates by staff groups and reasons for absence. The IQPR to the Finance and Performance Committee also draw on the dashboards for triangulation.

40 Whilst digital dashboards underpin the performance reports, they are not interactive Power BI dashboards which staff can easily interrogate for scrutiny purposes. The Health Board would like to develop this going forward, and intends to set up an interactive, real time performance data dashboard with dedicated data analysts. However, this is not currently possible due to capacity.

41 The Health Board set up an Operational Leadership Group in 2025. One of the functions is the scrutiny and oversight of operational governance including quality, improvement, performance, and delivery. The group also recognises the need to build capacity in operational teams to analyse and evaluate performance.

Patterson,Liz
03/08/2026 09:04:55

Responding to the Duties of Quality and Candour

The Health Board has arrangements in place to embed the duties of quality and candour, but uptake of training has limited oversight

42 The Health and Social Care (Quality and Engagement) Act 2020 came into force on 1 April 2023. In advance of its introduction, the Health Board assessed its preparedness for following the Act against the Welsh Government baseline position.

43 The Executive Director of Nursing, Quality, Women and Family Health leads on both duties supported by the Assistant Director of Quality. The Health Board's Duty of Quality webpage includes the Health and Care Standards and links to relevant websites such as Healthcare Inspectorate Wales and the Public Service Ombudsman for Wales.

44 The Health Board articulated a clear approach to the implementation of both statutory duties. The Health Board set up an internal Implementation Board chaired by the Director of Therapies and Health Sciences with input from all Directorates. The Board met monthly to oversee the progress of implementation of the duties and report back to the National Team.

45 The Health Board delivered Board Development sessions on the Duty of Quality in 2023, and Independent Members attended a national training session. The Health Board undertook a training needs analysis for the Duty of Candour and made available training and a video to all staff.

46 In April 2024, the Patient Experience, Quality and Safety Committee received a Quality and Engagement Act Implementation Plan for the Duties of Quality and Candour. A dedicated Implementation Board and relevant directors oversaw delivery of this plan.

Patterson,Liz
03/08/2026 09:04:55

47 Following the introduction of the Duty of Quality, the Health Board updated its IQPF to include a quality and performance escalation process in March 2024. The Health Board reviews the escalation status for operational directorates and corporate departments monthly. The status considers quality and safety matters and patient experience.

48 The Annual Duty of Quality Report 2024-25 includes information on the Duty of Candour, including the number of times the duty was triggered in 2024-25 and the process the Health Board follows when this happens. This involves following the NHS Wales Putting Things Right procedure and steps are listed in the report for clarity.

49 At an operational level, the Health Board holds internal Integrated Quality and Performance Group (IQPG) meetings. IQPGs are the Health Board's key process for reviewing, challenging, and supporting directorates on quality, performance, finance, workforce, and delivery. They sit below the Executive Committee but above directorate/team-level meetings. These are a tool to oversee, challenge and review quality and performance across all domains but include a specific focus on quality and safety and patient experience. IQPGs can escalate issues to the Executive Committee and to relevant committees and the Board when necessary.

50 Routine performance is monitored though the IQR. As previously noted, the IQR is reported to the Executive Committee and the Patient Experience, Quality and Safety Committee to provide an update on the quality and safety agenda across the Health Board.

51 A Duty of Quality training package is available via the Electronic Staff Record (ESR). However, we were unable to assess how many staff need to undertake this training or how many have completed it. The Health Board needs to strengthen its arrangements for monitoring training compliance, to provide assurance that staff are being supported to understand and respond to the new duties.

Patterson,Liz
03/08/2026 09:04:55

Recommendations

52 We have made four recommendations which replace six 2021 recommendations that are not yet complete, updated to reflect the current delivery context. We have also made two new recommendations.

53 The status of the 2021 recommendations is set out in **Appendix 2**.

New recommendations replacing 2021 recommendations not yet complete

Commissioned provider performance measures

R1 The Health Board should develop performance and quality measures for each commissioned provider which it can monitor and measure in line with the Strategic Commissioning Framework. This will provide oversight and assurance on commissioned services and patient care (**paragraph 14**).

Complaints about commissioned services

R2 The Health Board should set out a mechanism in the Strategic Commissioning Framework about how it will provide assurance on complaints about commissioned services. This should include the mechanism for recording complaints and reporting them to the Patient Experience, Quality and Safety Committee (**paragraph 26**).

Patterson,Liz
03/08/2026 09:04:55

DATIX training

R3 The Health Board should ensure, record and report that all relevant corporate staff have received training and support on how to use the DATIX system to report concerns and near misses (**paragraph 35**).

Data analytics and dashboards

R4 The Health Board should explore opportunities within existing capacity to develop interactive digital dashboards to present performance indicators and help the reader to understand and evaluate success and challenges (**paragraphs 33 and 40**).

New recommendations

Commissioned Services Performance Report

R5 The Health Board should develop and present the monthly Commissioned Services Performance Report as outlined in the Integrated Quality and Performance Framework. This will develop oversight and scrutiny of the quality and safety of commissioned services as intended (**paragraph 19**).

Duty of Quality e-learning oversight

R6 The Health Board should strengthen its arrangements for duty of quality e-learning training by routinely monitoring and reporting on staff completion rates (**paragraph 51**).

Patterson,Liz
03/08/2026 09:04:55

Appendices

Patterson,Liz
03/08/2026 09:04:55

1 About our work

Scope of the audit

We have assessed whether:

- the Health Board has implemented previous audit recommendations arising from our 2021 review of its quality governance arrangements and is realising the intended outcomes and benefits of those recommendations; and
- there is a sound corporate approach to oversee and scrutinise the quality and safety of services in line with the Duty of Quality and Duty of Candour requirements.

Audit questions and criteria

Questions

Our audit addressed the following questions:

- Has the Health Board reviewed its commissioning assurance framework?
- Has the Health Board clearly set out the mechanisms in place to provide strategic and operational oversight of clinical quality governance?
- Had the Health Board aligned the Clinical Quality Framework and the Commissioning Assurance Framework?
- Does the Health Board have greater oversight of complaints from Powys residents on commissioned services?
- Are the Health Board's quality and patient safety measures clear?
- Has the Health Board completed training for relevant staff on the All-Wales concerns management system?
- Are all staff receiving the necessary statutory and mandatory training?

Patterson,Liz
03/08/2026 09:04:55

- Does the Health Board collect relevant quality and safety data to understand and evaluate performance?
- Has the Trust taken steps to implement arrangements to deliver both the Duty of Quality and Duty of Candour?

Criteria

In gathering evidence against the above questions, we were looking for the Health Board to demonstrate that it:

- had made the expected progress in implementing our 2021 audit recommendations (set out in **Appendix 2)** to address the issues and concerns found in the original audit; and
- was implementing the requirements of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 (the Act) in respect of the duties of quality and candour.

Methods

We undertook our audit work between July and September 2025.

We reviewed the following key documents:

- Integrated Quality and Performance Framework
- Strategic Commissioning Framework,
- People Experience Framework
- Health Board's Annual Plan
- Duty of Quality Annual Reports
- Committee reports, including Quality Assurance and Performance reports.

Patterson,Liz
03/08/2026 09:04:55

We interviewed the following:

- Executive Director of Nursing and Midwifery,
- Director of Corporate Governance/Board Secretary,
- Executive Director of Planning, Performance & Commissioning,
- Independent Member/Vice Chair/ Chair of Patient Experience, Quality and Safety Committee

We also asked the Health Board to complete and submit a self-assessment, setting out its view of progress against the 2021 recommendations. The Health Board submitted a completed self-assessment on 8 July 2025.

Patterson,Liz
03/08/2026 09:04:55

2 Previous recommendations

We made the following recommendations in 2021 following our review of the Health Board's quality governance arrangements. We have highlighted the status of these recommendations based on our follow up review and replaced outstanding recommendations where necessary.

Commissioning Assurance Framework

R1 Review the Commissioning Assurance Framework to include measures on the standards of care provided or patient outcomes (**Some progress – replaced by R1 2026**)

Clinical Quality Framework

R2 Develop a governance map for the organisation to clearly identify the range of activities in place at the strategic and operational level to ensure there is a clear line of sight from service to Board and identify any overlaps or gaps between groups (**Complete**).

Alignment of Frameworks

R3 Review the potential for alignment of the Clinical Quality Framework and the Commissioning Assurance Framework (**Complete**).

Concerns and Complaints

R4a Ensure that all complaints by Powys residents (directly and indirectly reported to the Health Board) on commissioned services are captured and reported to the Patient Experience, Quality and Safety Committee (**No action – replaced by R2 2026**).

R4b Update the Commissioning Assurance Framework to ensure clarity on responsibility for monitoring and reporting of complaints (**No action – replaced by R2 2026**).

Patterson,Liz
03/08/2026 09:04:55

Performance Measures

R5 Develop a quality dashboard which articulates the quality and patient safety performance measures and key performance indicators for the Health Board, to measure success and demonstrate improvements (**Some progress – replaced by R4 2026**).

DATIX

R6 Ensure that all corporate staff receive training appropriate to their role (**No action – replaced by R3 2026**).

Training

R7 Ensure that all statutory and mandatory training compliance meets the required target (**Complete**).

Data Analytics

R8 Build capacity within the operational teams to undertake analytical analysis within their teams to better understand and evaluate performance (**Some progress – replaced by R4 2026**).

Patterson,Liz
03/08/2026 09:04:55

3 Key terms in this report

Term	Description
Duty of Candour	The Duty of Candour is a legal requirement for Welsh NHS organisations to be open and honest with service users when harm occurs during their care. This includes communicating with the patient, investigating the incident, and learning from it to prevent future occurrences.
Duty of Quality	The Duty of Quality is a legal obligation on Welsh NHS organisations to continually improve the quality of healthcare services and outcomes for the people of Wales. The Duty requires a focus on quality in all strategic decisions and ongoing monitoring of progress in quality improvement
Power BI	Computer software used to analyse and view data to help support understanding of data.
Putting Things Right	The formal process for raising concerns and complaints about the NHS in Wales and its services.
Quality governance	The combination of structures, processes, and behaviours used by an organisation, particularly its board, to lead on and ensure high-quality performance, including safety, effectiveness, and patient experience.

Patterson,Liz
03/08/2026 09:04:55

Term	Description
Strategic Commissioning Framework	Sets out the Health Board’s approach to commissioning services for the Powys population.

Patterson,Liz
03/08/2026 09:04:55

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Patterson,Liz
03/08/2026 09:04:55

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Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Pattinson,Liz
03/08/2026 09:04:55

GIG CYMRU NHS WALES | Cyd-bwyllgor Comisiynu Joint Commissioning Committee

Joint Commissioning Committee

Highlight Report from the Quality, Safety and Outcomes Sub-Committee

Dyddiad y Cyfarfod / Date of Meeting	26/05/2026
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Helen Tyler, Head of Governance and Risk, NWJCC
Cyflwynydd yr Adroddiad / Report Presenter	Susan Elsmore, Chair of Sub-Committee and Lay Member, NWJCC
Noddwr yr Adroddiad / Report Sponsor	Carole Bell, Director of Nursing and Quality, NWJCC

Pwrpas yr Adroddiad / Report Purpose	For Assurance

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Health Boards	Various	Noted

1. SITUATION/BACKGROUND

This report had been prepared to provide NWJCC Joint Committee Members with a summary of the key issues considered by the Quality, Safety and Outcomes (QSOC) Sub-Committee at its public meeting on 27 April 2026.

Key highlights from the meeting are reported in Section 2.

Patterson,Liz
03/08/2026 09:04:55

2. HIGHLIGHT REPORT

(Links to reports highlighted – April 2026)

Status	Update
Alert / Escalate	**Maternity and Neonatal Services – Delivery Risks**: The Committee considered the findings of the Welsh Government–commissioned independent maternity and neonatal review (The Path to Safer Beginnings). While supporting progression of neonatal reconfiguration work as a NWJCC strategic priority, members raised concern regarding the achievability of proposed timescales. Delivery risks relating to neonatal reconfiguration and transport were identified as requiring ongoing close monitoring and escalation if timescales were not being met. **Mental Health Services – Patient Repatriation (St Andrew's Healthcare):** Continued reliance on placements at St Andrew's Healthcare, Northampton, and the complexity and duration of planned patient repatriation (anticipated to take up to 18 months) were highlighted as a patient safety and commissioning risk requiring an update and escalation to JCC level. **Secure and Specialist Beds – Capacity and Closures:** The closure of Ty Glyn Ebwy Eating Disorder Unit, combined with ongoing limitations in Welsh medium and high secure bed capacity, was escalated as a significant service continuity risk, with a requirement for Joint Committee oversight of actions. **Caswell Clinic – Escalation Status**: Caswell Clinic remains in Level 3 escalation. While admissions have recommenced and oversight arrangements remain robust, the outstanding action plan was awaited at the time of the QSOC meeting and was highlighted as a concern. See ***Appendix 1*** for the Escalation Trajectories of the services currently in escalation and the actions being undertaken to manage these. **Sub-Committee Effectiveness Review:** Early themes from the Committee effectiveness review highlighted the need to strengthen chief executive officer representation at QSOC meetings. Currently only one CEO is a nominated QSOC member.

Patterson,Liz
03/08/2026 09:04:55

Status	Update
Advise	Reports from each of the Directors of Commissioning were received. The following items were discussed. Director of Commissioning for Specialised Services • Obesity Surgery Services – Interim arrangements were being put in place to ensure continued access to specialist obesity surgery for patients in North Wales and North Powys following the Northern Care Alliance serving notice on their contract. • Specialist Audiology – Work was ongoing with providers to improve access and ensure performance improvements were sustainable for patients. • Intestinal Failure Services – Challenges remain in providing consistent support for patients requiring complex nutritional care, and these were being closely monitored. • Stroke Thrombectomy Services – A review is planned to ensure stroke services are organised in a way that provides safe and timely access across South Wales aligned to the Annual Plan 2026/27 delivery and strategic objectives. • Electronic Assistive Technology – Demand for communication and assistive technology, particularly for children and young people, was increasing, and options were being considered to improve access and clarity of responsibility. • Breast Reconstruction Surgery – Limited capacity for specialist breast reconstruction surgery was leading to long waiting times, and further work was underway to identify alternative options for patients. • Specialist Cancer and Transplant Services – Work was continuing to address risks to specialist service accreditation to maintain access to advanced cancer and transplant treatments. • Paediatric Neurology Services – Concerns about the reliability of specialist neurology clinics for children in parts of Southwest Wales were being addressed with providers to improve service delivery. Welsh Kidney Network (WKN) Report • Despite a recent change in governance arrangements (and the Network becoming a part of the NWJCC Specialised Services Directorate), the WKN Report continues to be presented as a separate agenda item at the QSOC meeting to fully capture work undertaken across the Network and in recognition of its wider pathway responsibilities beyond commissioned services.

Patterson,Liz
03/08/2026 09:04:55

Status	Update
	• The Sub-Committee received assurance regarding improved resilience in kidney transplant services following recent workforce appointments, alongside effective management of reported incidents, including learning from a previously reported CPO (antibiotic-resistant bacteria) outbreak. A newly identified dialysis water treatment risk in Cardiff was confirmed to be managed locally. Director of Commissioning for Ambulance Services/111 Report • The Committee discussed ongoing pressures across urgent and emergency care, noting that ambulance handover delays remain a quality and safety concern, despite some improvement following the introduction of the 45-minute handover standard. • Members also noted sustained and higher-than-expected demand for NHS 111 services over the recent Easter period, which exceeded previous years and continued beyond the bank holiday. • The Committee received assurance regarding Non-Emergency Patient Transport Services, acknowledging the challenging demand and capacity environment and noting that commissioners were providing oversight and challenge on options developed to address system pressures. • Members sought clearer differentiation in future reporting between realised and potential quality impacts, which was agreed. Director of Commissioning for MHLDVG Report • St Andrew's Healthcare, Northampton - Members noted that the service remains suspended from the Welsh Hospital Framework and subject to enhanced oversight. NHS England was overseeing patient relocations, with ongoing engagement with Welsh patients, families, and regulators. • Eating Disorder Services - Members noted the closure of the Ty Glyn Ebwy independent eating disorder service, with all Welsh patients now discharged. A national review of future eating disorder provision was underway to inform longer-term service models. • Caswell Clinic - Members noted that Caswell Clinic remains in escalation, with continued oversight in place. Progress against agreed safety and quality actions was being monitored to inform future de-escalation decisions. • Secure Services - Members discussed pressures on capacity within medium and high secure services. Future

Patterson,Liz
03/08/2026 09:04:55

Status	Update
	service reviews will consider estate, workforce, and service model developments. • Gender Dysphoria Services - Members received an update on changes to children and young people's gender services in line with national guidance. A phased review of the Welsh Gender Service was planned, supported by external expertise. • Perinatal Inpatient Services - Members noted that the Seren Lodge perinatal unit was now operational and receiving Welsh patients. Early patient feedback has been positive, with ongoing monitoring agreed. • Specialist CAMHS - Members noted progress at Ty Llidiard and generally positive inspection findings. • Concerns regarding out-of-hours medical cover were highlighted and were being addressed through routine performance monitoring. The Incident and Concerns Report highlighted • Six Nationally Reported Incidents (NRI) and one Early warning Notification during the reporting period for specialised services. Nineteen Ambulance Service and 111 NRIs were reported but the reporting period covered January 2026 up until May 2026. • Eleven incidents have been closed with more expected to be closed within the next reporting period. • Seven complaints have been received; five of which remain open. • No new referrals to the Ombudsman. A development session looking into incidents and NRI reporting will be scheduled to better understand NWJCC processes.
Assure	The Committee received the QSOC sub-committee's assigned risks from the NWJCC Operational Risk Register as of 31 March 2026. After QSOC scrutiny and review, the JCC will receive the March 2026 risk register at its May 2026 meeting. The following were highlighted; Whilst the reported risks were mostly unchanged, specific risks were discussed as detailed below: • Risk 78 – Emergency Ambulance Service Capacity: System pressures on ambulance capacity and handovers persist, with limited direct commissioning levers available to the JCC, requiring the risk to be reframed to reflect assurance, influence, and national engagement rather than operational control.

Patterson,Liz
03/08/2026 09:04:53

Status	Update
	• Risk 89 – Paediatric Neurology (North Wales): Ongoing workforce shortages due to vacancies and staff sickness continue to constrain service capacity, and the current risk score remains appropriate until staffing stabilises. • Risk 91 – Hereditary Anaemias (South Wales): Demand significantly exceeds commissioned capacity, but the risk is expected to reduce following review of a provider business case through the Collaborative Commissioning Leadership Group. • Risks 82 & 95 – Neuro-rehabilitation (Swansea Bay UHB and Cardiff & Vale UHB): Paused investment means the risks require reframing around risk tolerance and patient safety, rather than service delivery actions, with mitigations focused on quality and safety impacts. • Risk 65 – Renal Dialysis Capacity (All-Wales): Transplant-related risks have reduced following permanent recruitment and mutual aid arrangements, with further mitigation underway through transplant-first and patient fitness work. The Escalation Trajectories Report was received and is attached at **Appendix 1.** The Regulator Report (Healthcare Inspectorate Wales (HIW)/Care Quality Commission (CQC) was received. An update on regulatory activity was provided. A development session on Nationally Reported Incidents will take place to strengthen assurance to the Sub-Committee. The session will also look at Equality and Quality Impact Assessment reporting. The Committee received and endorsed the Annual Governance Statement.
Inform	**Presentation -** The Committee received a presentation summarising the findings of "The Path to Safer Beginnings", an independent national assurance review of maternity and neonatal services in Wales, and its relevance to future Joint Commissioning Committee (JCC) planning. All Wales Individual Patient Funding (IPFR) Report Members noted the improved attendance at IPFR panel meetings. Policy Validation Group

Patterson,Liz
03/08/2026 09:04:55

Status	Update
	The Sub-Committee approved the Terms of Reference, scope and supporting procedures for the Policy Validation Group, noting early strengthening of equality and quality impact considerations within policy development processes.
Appendices	Appendix 1 - Escalation Trajectories.

3. ASSESSMENT

Objectives / Strategy	
Dolen i Amcan (au) Strategol CBC **Link to JCC Strategic Objectives(s)**	Maximise Value
	Ensure Quality; Reduce Duplication; Improve Equity & Population Health; Facilitate Integration
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 Resilient Wales
	A Healthier Wales
Dolen i Hwyluswyr Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / **Link to Enablers of Quality** (Duty of Quality Statutory Guidance (gov.wales))	Leadership
	Culture and Valuing People; Learning, Improvement and Research; Whole-systems Perspective
Dolen i Feysydd Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / **Link to Domains of Quality** (Duty of Quality Statutory Guidance (gov.wales))	Effective
	Efficient; Equitable; Person-centred; Timely; Safe
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale

Asesiad o'r Effaith ar Ansawdd? / **Quality** *Have you undertaken a Quality Impact Assessment Screening?*		below: This is a summary of the latest meeting of the JCC
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: This is a summary of the latest meeting of the JCC
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)*	Yes (Include further detail below)	
	The performance of the services will be used to develop the Plan and identify the areas where resources may be required.	

4. RECOMMENDATIONS

The Joint Commissioning Committee is asked to:

- **Note** the highlights outlined in Section 2 of this report; and
- **Receive** the **report** as assurance

Patterson,Liz
03/08/2026 09:04:55

Executive Director Lead: Melanie Wilkey

Commissioning Lead: Krysta Hallewell

Commissioning Team: Neuro-Sciences

Date of Escalation Meetings: 23/02/2026

Date Last Reviewed by Quality & Patient Safety Committee: 27/04/2026

Service in Escalation:

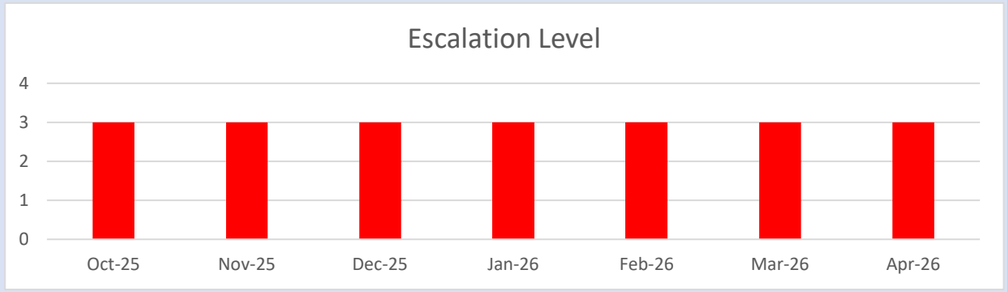
Specialist Auditory Implant Device Service

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ April 26
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
October 2025	**3**

Rationale for Escalation Status: Due to insufficient progress against agreed improvement actions monitored through the quarterly Service Performance Management meetings since January 2024, and continued underperformance against the RTT position relative to the specific ministerial target for this patient cohort, the Neurosciences, Long Term Conditions and Rare Conditions Commissioning Team recommends escalation to **Level 3 – Escalated Measures**.

The service now requires significant and sustained improvement, with Executive-level oversight and intervention necessary to address performance risks and secure recovery against agreed standards.

Background Information:

The escalation of the Cardiff and Vale Specialist Auditory Implant Device Service to Level 3 of the NWJCC Escalation Framework was initiated in October 2025 and endorsed by the NWJCC Senior Leadership Team.

The NWJCC assurance and confidence rating remains Low. A formal escalation letter was issued to Cardiff and Vale UHB on 6 October 2025. However, delays in confirming a named Executive Lead and Health Board availability resulted in a postponement of the initial escalation meeting.

The first formal escalation meeting was subsequently held on 22 January 2026.

Action (NWJCC Lead: Director of Commissioning):	Action Due Date	Completion Date
Escalation endorsed by SLT	Oct 25	Oct 25
Escalation letter sent to CVUHB	Oct 25	Oct 25
Escalation meeting to discuss detail and progress against action plan (every 4 weeks)	Ongoing	Ongoing

Patterson,Liz
03/08/2026 09:04:55

Issues/Risks:

February 2026 Update – Commissioning and provider teams to jointly clarify: Historic and current commissioning expectations for CT scans, where clinical interpretation of scans should take place and whether pathway changes created unintended delays.

April 2026 update the pre-surgical CT scan pathway remains an open action. Progress has been made on the Long Term Agreement (LTA), and the service will share the draft in due course. The service has highlighted the impact of additional activity undertaken to reduce backlog pressures, noting a decline in staff morale. There is a recognised risk that ongoing pressures on staff wellbeing may contribute to increased sickness absence. Escalation meeting planned for the 16th April has been moved to the 28th April at the request of the provider.

Patterson Liz
03/08/2026 09:04:55

Executive Director Lead: Sue O Leary

Commissioning Lead: Adrian Clarke

Commissioning Team: Mental Health

Date of Next Escalation Meetings: 30th April

Date Last Reviewed by Quality & Patient Safety Committee: 27/04/2026

Service in Escalation:

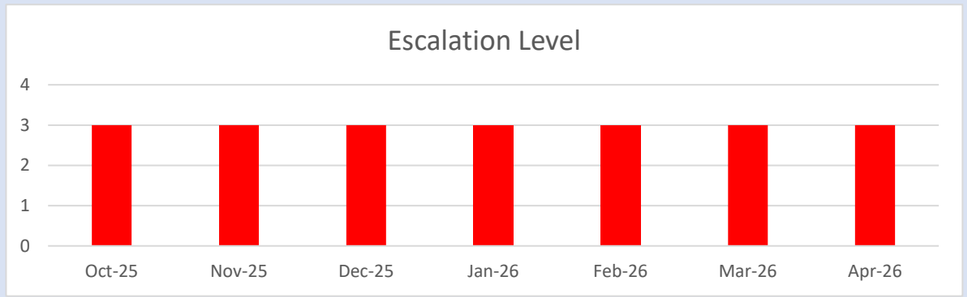
Caswell

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	⇔ April 2026
⇔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
January 25	**3**

Rationale for Escalation Status: The service has been placed under formal escalation due to sustained concerns relating to safety and quality within the facility. A site visit by NWJCC representatives in July 2025 identified significant safety and quality concerns. These were reported to the JC in September 2025, which commissioned a full-service review.

The review, undertaken between 15 September and 3 October 2025, assessed compliance with recognised Medium Secure Unit standards and included patient-level review. It identified serious safety and quality issues requiring urgent action.

Similar concerns had been raised in a 2022 NCCU review and were echoed in a June 2025 independent report on Swansea Bay University Health Board's Mental Health and Learning Disability services, which highlighted compromised care standards and weaknesses in leadership and oversight.

The findings indicate systemic governance and safety risks requiring immediate improvement action and strengthened executive oversight.

Background Information:

The escalation of the Caswell Clinic Service to Level 3 of the NWJCC Escalation Framework was initiated and endorsed by the NWJCC Senior Leadership Team in October 2025, following significant safety and governance concerns.

Following engagement with the Swansea Bay Executive Team, the service was placed in Level 3 escalation, with weekly improvement meetings established with Caswell senior leaders and monthly oversight meetings with the Health Board Executive. A detailed improvement plan aligned to recognised standards was developed, with a number of

Action (NWJCC Lead- Director of Mental Health AC)	Action Due Date	Completion Date
In Committee update to JCC members	October 2025	October 2025
Letter to SBUHB Executive team	October 2025	October 2025

Patterson Liz
03/08/2026 09:04:55

urgent actions identified. Admissions were paused pending assurance that immediate safety risks had been addressed.	JCC to meet with Caswell SLT on a weekly basis	Complete	Ongoing
	Suspension for new admissions to the clinic	Complete	Complete
The service remains in Level 3 escalation. Decisions regarding de-escalation will be taken jointly by the MHLDVG and NWJCC Nursing and Quality teams once sustained improvement and compliance are demonstrated.	JCC to meet with Caswell SLT on a fortnightly basis	Ongoing	Ongoing
	Clinic reopen to admissions	January 9th 2026	Completed
	HIW Visit – awaiting final report (update on HIW report provided within Item 4.7 – Regulator Report).	January 2026	Awaiting Report

Issues/Risks:

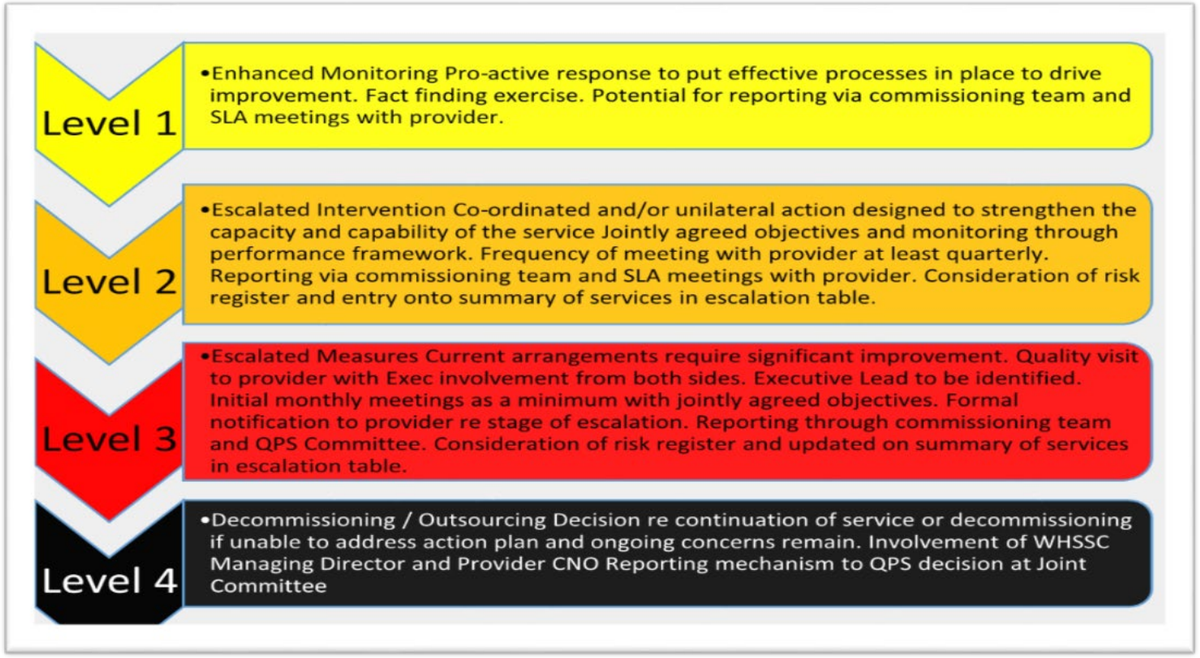
Caswell Clinic have been asked to complete the evidence section of the MHLDVG action plan but this has not been received to date. Once received this will be reviewed by the MHLDVG division, each action will reviewed against the evidence supplied with a view to understanding what level of progress has been made and what the ongoing escalation level will be. The current series of meetings between the MHLDVG and SBUHB have been suspended and will be rearranged following receipt of the updated action plan from the service in order to ensure that the ongoing meetings are relevant, with the appropriate personnel, and discuss relevant points of the action plan.

Patterson Liz
03/08/2026 09:04:55

Level 1 ENHANCED MONITORING	Any quality or performance concern will be reviewed by the Commissioning Team. Enhanced monitoring is a pro-active response to put effective processes in place to drive improvement. It is an initial fact finding exercise which should ideally be led by the provider and closely monitored and reviewed by the commissioning team. The enquiry will lead to one of the following possible outcomes: • No further action is required routine monitoring will continue. The concern which raised the indication for inquiry will be logged and referred to during the routine monitoring process to ensure this has not developed any further. • Continued intervention is required at level 1 and a review date agreed. • Escalation to Level 2 if further intervention is required There is the potential for reporting via commissioning team report to Quality Patient Safety Committee and through SLA meetings with provider
Level 2 ESCALATED INTERVENTION	Escalated intervention will be initiated if Level I Enhanced Monitoring identifies the need for further investigation/intervention. There should be a Co-ordinated and/or unilateral action designed to strengthen the capacity and capability of the service. At this stage there should be jointly agreed objectives between the provider and commissioner and monitored through the relevant commissioning team. Frequency of meeting with provider should be at least quarterly and possible interventions will include • Provider performance meetings • Triangulation of data with other quality indicators • Advice from external advisors • Monitoring of any action plans A risk assessment should be undertaken and logged on the Commissioning Team Risk Register. Where appropriate the risk will be included on the JCC Risk Management Framework. Reporting is via commissioning team report to Quality Patient Safety Committee report and SLA meetings with provider. The investigation will lead to on to the following possible outcomes: • Action plan and monitoring are completed within the allocated timeframe, evidence of progress and assurance the concern has been addressed. De-escalation to Level 1 for ongoing monitoring. • If the action plan is not adhered to and further concerns are raised by the Commissioning team or by the provider team or further concerns are identified it may be necessary to move to Level 3 Escalated Measures
Level 3 ESCALATED MEASURES	Where there is evidence that the Action Plan developed following Level 2 has failed to meet the required outcomes or a serious concern is identified a service will be placed in escalated Level 3. At this stage the quality of the service requires significant action/improvement and will require Executive input. In addition to routine reporting through QPS a formal paper will be considered by the JCC Corporate Directors Group (CDG) and an Executive Lead nominated. Formal notification will be sent to the provider re the Level of escalation and a request made for an Executive lead from the provider to be identified. An initial meeting will be set up as soon as possible dependant on the severity of the concern. Meetings should take place at least monthly thereafter or more frequently if determined necessary with jointly agreed objectives. Provider representation will depend on the nature of the issue, but the meetings should ideally comprise of the following personnel as a minimum: • Chair (JCC Executive Lead) • Associate Medical Director - Commissioning Team • Senior Planning Lead – Commissioning Team • JCC Head of Quality • Executive Lead from provider Health Board/Trust • Clinical representative from provider Health Board/Trust • Management representative from provider Health Board/Trust An agreed agenda should be shared prior to the meeting with a request for evidence as necessary. At the conclusion of the meeting a clear timeline for agreed actions will be identified for future monitoring and confirmed in writing if appropriate. Reporting will be through commissioning team to QPS Committee. Consideration of entry on the risk register and summary of services in escalation table for Chairs report to Joint Committee. Consideration to involve and have a discussion with Welsh Government may be considered appropriate at this stage. If there is ongoing concern relating patient care and safety with no clear progress, then further escalation will be required to Level 4. On the other hand, if progress is made through the escalation Level 3 evidence of this should be presented to CDG/QPS and a formal decision made with the provider to de-escalate to Level 2.

Patterson Liz
03/08/2026 09:04:55

Level 4 DECOMISSIONING/OUTSOURCING	Where services have been unable to meet specific targets or demonstrate evidence of improvement a number of actions need to be considered at this stage. This stage will require notification and involvement of the JCC Managing Director and CEO from the provider organisation. Both Quality Patient Safety Committee and Joint Committee should be cited on the level of escalation. The following areas will need to be considered, and the most appropriate sanction applied to help resolve the issue: 1. De-commissioning of the service 2. Outsourcing from an alternative provider. This may be permanent or temporary 3. Contractual realignment to take into account the potential need to maintain and agree an alternative provider. Involvement with Welsh Government and the Community Health Council is critical at this stage as often there are political drivers and levers that need to be considered and articulated as part of the decision making. Moving in and out of escalation and between Levels In addition to the Levels described above the process has introduced a traffic light guide within each level. The purpose of this is to help demonstrate the direction of travel within the level. It sets out an approach to help identify progress within the level and lays out the steps required for movement either upwards (escalation) or downwards (de-escalation) through the level. At every stage a red, amber or green colour will be applied to the level to illustrate whether more or less intervention is in place. Red being a higher level of intervention moving down to green. It will also help determine the easing of the escalated measures described and inform movement within the stages of escalation. As the evidence and understanding of the risks from a provider and commissioner become evident decisions can be made to reduce the level of intervention or there may be a need to reintroduce intervention should conditions worsen and trigger the re-introduction of measures if progress is unacceptable. In this way organisations will be able to understand what is being asked of them, progress will be easily identified, and it will help avoid any confusion. It will also help in the reporting to provide assurance that action is being taken to meet the agreed timescales.



SERVICES IN ESCALATION

Level of escalation reducing / improving position

Level of escalation unchanged from previous report/month

Level of escalation increasing / worsening position

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03/08/2026 09:04:55

GIG CYMRU NHS WALES | Cyd-bwyllgor Comisiynu Joint Commissioning Committee

Joint Commissioning Committee

Highlight Report from the Quality, Safety and Outcomes Sub-Committee

Dyddiad y Cyfarfod / Date of Meeting	21/07/2026
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Helen Tyler, Head of Governance and Risk, NWJCC
Cyflwynydd yr Adroddiad / Report Presenter	Susan Elsmore, Chair of Sub-Committee and Lay Member, NWJCC
Noddwr yr Adroddiad / Report Sponsor	Carole Bell, Director of Nursing and Quality, NWJCC

Pwrpas yr Adroddiad / Report Purpose	For Assurance

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Health Boards	Various	Noted

1. SITUATION/BACKGROUND

This report had been prepared to provide NWJCC Joint Committee Members with a summary of the key issues considered by the Quality, Safety and Outcomes (QSOC) Sub-Committee at its public meeting on 29 June 2026.

Key highlights from the meeting are reported in Section 2.

Patterson,Liz
03/08/2026 09:04:55

2. HIGHLIGHT REPORT

(Links to reports highlighted – June 2026)

Status	Update
Alert / Escalate	**Fragile Specialised Services and Workforce Pressures –** Members discussed continued fragility across a number of specialised services, including cardiac surgery, neurosurgery, intestinal failure services, thrombectomy pathways and renal dialysis capacity. Workforce sustainability, capacity constraints and service resilience were highlighted as recurring themes. Members requested that these issues be escalated to the Joint Committee and considered through the emerging Joint Committee Assurance Framework. **JACIE Accreditation Risks** – Risks relating to Bone Marrow Transplant and CAR-T services continue to be highlighted. Loss of accreditation would have significant implications for patient pathways and service delivery across Wales. Assurance continues to be sought regarding contingency planning. **Caswell Clinic** – Caswell Clinic remains in escalation, although significant progress has been made since escalation commenced. The Committee noted ongoing work towards de-escalation and requested a further lay member visit to review progress. Continued reliance on independent sector placements due to unavailable medium secure beds remains a concern. **Cardiac Surgery** – Members were advised that cardiac surgery services in Cardiff had moved to Level 2 escalation following the reporting period. Concerns remain regarding data quality, the absence of sufficient improvement plans and limited visibility of progress. See ***Appendix 1*** for the Escalation Trajectories of the services currently in escalation and the actions being undertaken to manage these. **All Wales Individual Patient Funding Request (IPFR) Panel** – Members welcomed improved health board attendance and panel resilience. Continued concerns regarding Powys Teaching Health Board attendance were highlighted and will be raised through appropriate forums and reflected in this highlight report.
Advise	Reports from each of the Directors of Commissioning were received. The following items were discussed. Director of Commissioning for Specialised Services • Services were generally stable during the reporting period with no new escalations reported at time of publication.

Patterson,Liz 03/08/2026 09:04:55

Status	Update
	Members discussed quality and sustainability risks across cardiac surgery, neurosurgery, intestinal failure, thrombectomy, dialysis services and PET-CT demand growth. The Committee requested enhanced future reporting on specific quality impacts. Welsh Kidney Network (WKN) Report • Members received assurance that there had been no significant changes to risks during the reporting period. Four Nationally Reportable Incidents are expected to close shortly, with learning and closure reports to be brought to a future meeting. The Committee welcomed continued development of governance reporting arrangements following integration of the WKN into NWJCC. Director of Commissioning for Ambulance Services and National Programmes • Members discussed ongoing demand and capacity challenges across Emergency Ambulance Services, NHS 111 Wales and Non-Emergency Patient Transport Services (NEPTS). Ambulance handover delays remain a significant quality and safety concern. Improvements to NHS 111 digital services and roster redesigns are planned. A further update on the NEPTS Improvement Board will be requested. Director of Commissioning for MHLDVG Report • The Committee received updates regarding St Andrew's Healthcare repatriation arrangements, the Adult Welsh Gender Service review, Cygnet Bury concerns and Caswell Clinic. Members noted continued progress in reducing the number of Welsh patients remaining at St Andrew's Healthcare and were assured that patient safety issues continue to be actively monitored. The Incident and Concerns Report highlighted • Members noted 12 new Nationally Reportable Incidents, 6 complaints, 1 Ombudsman referral and 19 closure reports. Particular attention was given to strengthening thematic analysis, organisational learning and assurance regarding how learning from WAST incidents is embedded across services. A Regulation 28 review regarding a Cardiac Incident is underway and the outcome will be reported back to QSOC.

Patterson Liz
03/08/2026 09:04:55

Status	Update
	• A development session looking into incidents and NRI reporting has been scheduled to better understand NWJCC processes.
Assure	The Committee received the QSOC sub-committee's assigned risks from the NWJCC Operational Risk Register as of 31 May 2026. After QSOC scrutiny and review, the JCC will receive the May 2026 risk register at its July 2026 meeting. The following were highlighted; Whilst the reported risks were mostly unchanged, Members noted emerging neurosurgery risks and welcomed work to strengthen strategic risk oversight through the Joint Committee Assurance Framework. The positive de-escalation of the hereditary anaemia service risk was also noted. Risk Management and Assurance Framework – The Committee endorsed the Risk Management Procedure, Joint Committee Assurance Framework (JAF), Risk Appetite Statement and strategic risk reporting arrangements for onward consideration by the Joint Committee. Members welcomed the strengthened approach to strategic risk management and assurance and were pleased with the progress made to strengthen Risk Management. The Escalation Trajectories Report was received and is attached at **Appendix 1.** The Committee received assurance regarding services currently in escalation and noted that updates had been considered through the Director reports. The Regulator Report was received. The Committee reviewed Healthcare Inspectorate Wales (HIW) and Care Quality Commission (CQC) activity and received assurance regarding ongoing monitoring and follow-up arrangements. Particular attention was drawn to the forthcoming Caswell Clinic inspection findings.
Inform	**Patient Story –** QSOC received a Welsh language patient story on chronic renal disease and home dialysis, highlighting the benefits of home therapies, the importance of early patient engagement, Welsh language accessibility and strong clinical support. The patient raised concerns about extended transport times and the suitability of food provision for dialysis patients. QSOC agreed that these issues should be reviewed, with further work to gather and analyse patient travel experiences, review transport coordination with WAST, and consider food provision feedback.

Patterson,Liz
03/08/2026 09:04:55

Status	Update
	The patient story and associated follow-up actions will be escalated to the Joint Commissioning Committee for awareness and assurance. **Blueteq Governance Arrangements –** Members approved the new Standard Operating Procedure for Blueteq form, strengthening governance controls around high-cost medicines commissioned by NWJCC. **Policy Validation Group** – Members received assurance regarding ongoing work to maintain and review commissioning policies, recognising both the importance of this work and the workforce constraints affecting delivery. **Forward Plan of Business** – The Committee reviewed and noted the 2026–27 Forward Plan.
Appendices	Appendix 1 - Escalation Trajectories.

3. ASSESSMENT

Objectives / Strategy	
Dolen i Amcan (au) Strategol CBC **Link to JCC Strategic Objectives(s)**	Maximise Value
	Ensure Quality; Reduce Duplication; Improve Equity & Population Health; Facilitate Integration
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 Resilient Wales
	A Healthier Wales
Dolen i Hwyluswyr Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / **Link to Enablers of Quality** (Duty of Quality Statutory Guidance (gov.wales))	Leadership
	Culture and Valuing People; Learning, Improvement and Research; Whole-systems Perspective
Dolen i Feysydd Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / **Link to Domains of Quality**	Effective
	Efficient; Equitable; Person-centred; Timely; Safe

(Duty of Quality Statutory Guidance (gov.wales))	
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable

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: This is a summary of the latest meeting of the JCC
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: This is a summary of the latest meeting of the JCC
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)*	Yes (Include further detail below)	
	The performance of the services will be used to develop the Plan and identify the areas where resources may be required.	

4. RECOMMENDATIONS

The Joint Commissioning Committee is asked to:

- **Note** the highlights outlined in Section 3 of this report; and
- **Receive** the report as **assurance**.

Patterson,Liz
03/08/2026 09:04:55

Executive Director Lead: Melanie Wilkey

Commissioning Lead: Krysta Hallewell

Commissioning Team: Neuro-Sciences

Date of Escalation Meetings: 28/04/2026

Date Last Reviewed by Quality & Patient Safety Committee: 27/04/2026

Service in Escalation:

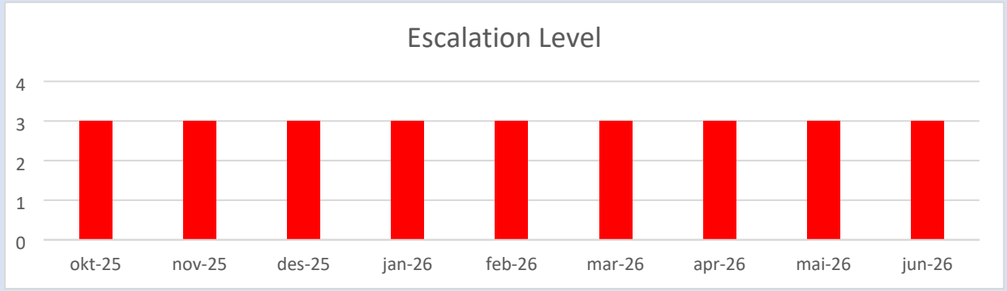
Specialist Auditory Implant Device Service

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ June 26
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
October 2025	**3**

Rationale for Escalation Status: Due to insufficient progress against agreed improvement actions monitored through the quarterly Service Performance Management meetings since January 2024, and continued underperformance against the RTT position relative to the specific ministerial target for this patient cohort, the Neurosciences, Long Term Conditions and Rare Conditions Commissioning Team recommends escalation to **Level 3 – Escalated Measures**.

The service now requires significant and sustained improvement, with Executive-level oversight and intervention necessary to address performance risks and secure recovery against agreed standards.

Background Information:

The escalation of the Cardiff and Vale Specialist Auditory Implant Device Service to Level 3 of the NWJCC Escalation Framework was initiated in October 2025 and endorsed by the NWJCC Senior Leadership Team.

The NWJCC assurance and confidence rating remains Low. A formal escalation letter was issued to Cardiff and Vale UHB on 6 October 2025. However, delays in confirming a named Executive Lead and Health Board availability resulted in a postponement of the initial escalation meeting.

The first formal escalation meeting was subsequently held on 22 January 2026.

Action (NWJCC Lead: Director of Commissioning):	Action Due Date	Completion Date
Escalation endorsed by SLT	Oct 25	Oct 25
Escalation letter sent to CVUHB	Oct 25	Oct 25
Escalation meeting to discuss detail and progress against action plan (every 4 weeks)	Ongoing	Ongoing

Issues/Risks:

Patterson Liz
03/08/2026 09:04:55

February 2026 Update – Commissioning and provider teams to jointly clarify: Historic and current commissioning expectations for CT scans, where clinical interpretation of scans should take place and whether pathway changes created unintended delays.

April 2026 update the pre-surgical CT scan pathway remains an open action. Progress has been made on the Long-Term Agreement (LTA), and the service will share the draft in due course. The service has highlighted the impact of additional activity undertaken to reduce backlog pressures, noting a decline in staff morale. There is a recognised risk that ongoing pressures on staff wellbeing may contribute to increased sickness absence. Escalation meeting planned for the 16th April has been moved to the 28th of April at the request of the service.

June 2026 – There has been significant progress in addressing the 52 week waits in the service and there are no patients currently at 52 weeks working towards a 36-week target. Work ongoing with the review and rebasing of the LTA. The pre surgical scan pathway is still an open action with an SOP in draft. An operational manager has been moved into the service for support but there are still some concerns around stress wellbeing with the service being stretched due to increased activity to reduce the longest waiters.

Patterson Liz
03/08/2026 09:04:55

Executive Director Lead: Sue O'Leary

Commissioning Lead: Sue O'Leary

Commissioning Team: Mental Health

Date of Escalation Meetings: 30/04/2026

Date Last Reviewed by Quality & Patient Safety Committee: 27/04/2026

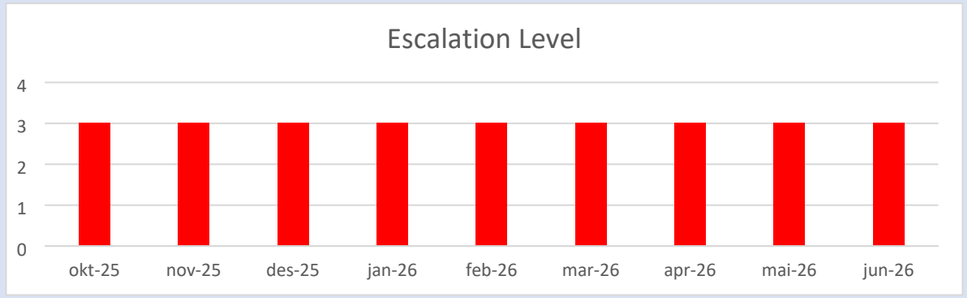
Service in Escalation: Caswell

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ June 2026
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
January 25	**3**

Rationale for Escalation Status: The service has been placed under formal escalation due to sustained concerns relating to safety and quality within the facility. A site visit by NWJCC representatives in July 2025 identified significant safety and quality concerns. These were reported to the JC in September 2025, which commissioned a full-service review.

The review, undertaken between 15 September and 3 October 2025, assessed compliance with recognised Medium Secure Unit standards and included patient-level review. It identified serious safety and quality issues requiring urgent action.

Similar concerns had been raised in a 2022 NCCU review and were echoed in a June 2025 independent report on Swansea Bay University Health Board's Mental Health and Learning Disability services, which highlighted compromised care standards and weaknesses in leadership and oversight.

The findings indicate systemic governance and safety risks requiring immediate improvement action and strengthened executive oversight.

Background Information:

The escalation of the Caswell Clinic Service to Level 3 of the NWJCC Escalation Framework was initiated and endorsed by the NWJCC Senior Leadership Team in October 2025, following significant safety and governance concerns.

Following engagement with the Swansea Bay Executive Team, the service was placed in Level 3 escalation, with weekly improvement meetings established with Caswell senior leaders and monthly oversight meetings with the Health Board Executive. A detailed improvement plan

Action (NWJCC Lead- Director of Mental Health AC)	Action Due Date	Completion Date
In Committee update to JCC members	October 2025	October 2025
Letter to SBUHB Executive team	October 2025	October 2025

Patterson,Liz
03/08/2026 09:04:55

aligned to recognised standards was developed, with a number of urgent actions identified. Admissions were paused pending assurance that immediate safety risks had been addressed.

February 2026 Update

Admissions were suspended in September 2025 due to significant staff and patient safety concerns. Immediate risk mitigation actions were implemented over a three-month period. Assurance was received in January 2026, and admissions recommenced on 9 January 2026.

Robust oversight remains in place, including:

- **Weekly meetings between MHLDVG and Caswell senior leadership to monitor delivery of the action plan, with independent verification of completed actions.**
- **Fortnightly meetings between the MHLDVG Director and Swansea Bay Executive Team to seek further assurance and address delivery risks.**

The service remains in Level 3 escalation. Decisions regarding de-escalation will be taken jointly by the MHLDVG and NWJCC Nursing and Quality teams once sustained improvement and compliance are demonstrated.

JCC to meet with Caswell SLT on a weekly basis	Complete	Complete
Suspension for new admissions to the clinic	Complete	Complete
JCC to meet with Caswell SLT on a fortnightly basis	Complete	Complete
Clinic reopen to admissions	January 2026	January 2026
JCC to meet with Caswell Team and Executive Lead monthly	April 2026	ongoing

Issues/Risks:

The service remains in Level 3 escalation. Decisions regarding de-escalation will be taken jointly by the MHLDVG and NWJCC Nursing and Quality teams once sustained improvement and compliance are demonstrated.

Caswell Clinic remain in Level 3 escalation. Discussions have been held within JCC to establish what needs to be done in order to reduce the level of escalation in the future. Caswell Clinic have been asked to complete the evidence section of the MHLDVG action plan. This will give the JCC a description of what the service has done in order to resolve or mitigate the issues raised at the time of the initial review. Once that has been received by the MHLDVG division, each action will be reviewed against the evidence supplied with a view to understanding what level of progress has been made and what the ongoing escalation level will be. The current series of meetings between the MHLDVG and SBUHB have been suspended and will be rearranged following receipt of the updated action plan from the service in order to ensure that the ongoing meetings are relevant, with the appropriate personnel, and discuss relevant points of the action plan".

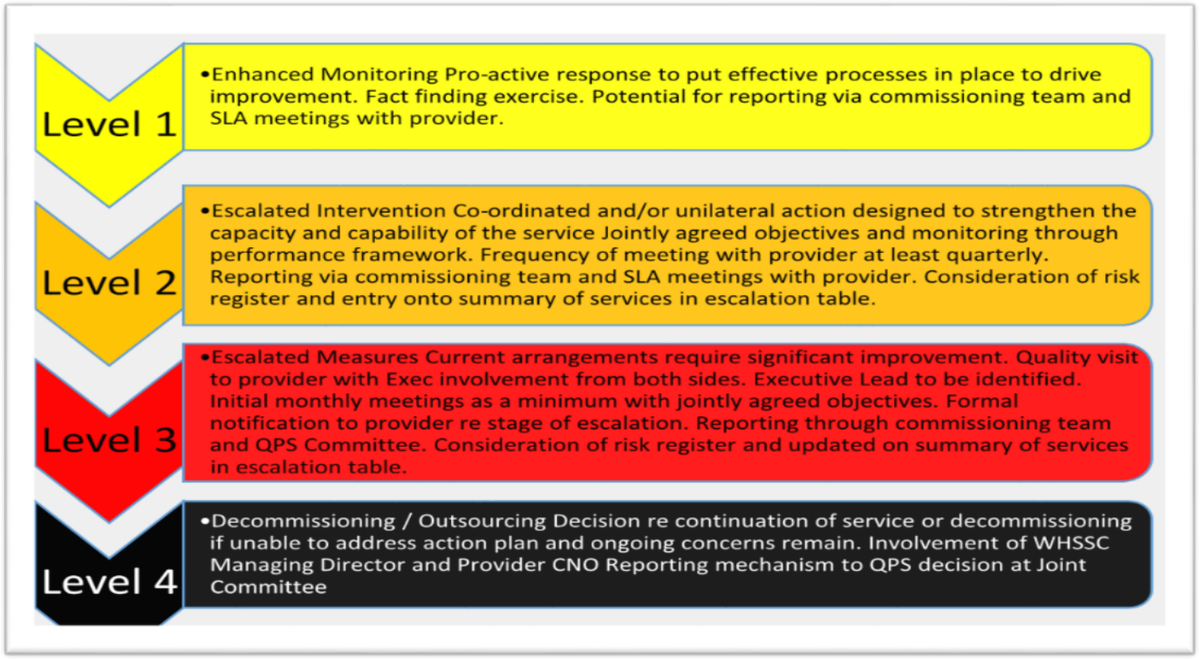
June 2026 – Following receipt of a consolidated report in late April 2026 evidencing significant progress against the original review findings, commissioning, quality safety and medical teams have undertaken a detailed assessment to identify the remaining actions required for de-escalation to level 2 monitoring. More integrated oversight arrangements are in place, via monthly escalation meetings from April 2026, with ongoing engagement with the service to support delivery. A clear set of outstanding actions are in place with the health board, with a commitment to review and sign off evidence on a rolling basis.

Data Source 04/08/2026 09:04:55

Level 1 ENHANCED MONITORING	Any quality or performance concern will be reviewed by the Commissioning Team. Enhanced monitoring is a pro-active response to put effective processes in place to drive improvement. It is an initial fact finding exercise which should ideally be led by the provider and closely monitored and reviewed by the commissioning team. The enquiry will lead to one of the following possible outcomes: • No further action is required routine monitoring will continue. The concern which raised the indication for inquiry will be logged and referred to during the routine monitoring process to ensure this has not developed any further. • Continued intervention is required at level 1 and a review date agreed. • Escalation to Level 2 if further intervention is required There is the potential for reporting via commissioning team report to Quality Patient Safety Committee and through SLA meetings with provider
Level 2 ESCALATED INTERVENTION	Escalated intervention will be initiated if Level I Enhanced Monitoring identifies the need for further investigation/intervention. There should be a Co-ordinated and/or unilateral action designed to strengthen the capacity and capability of the service. At this stage there should be jointly agreed objectives between the provider and commissioner and monitored through the relevant commissioning team. Frequency of meeting with provider should be at least quarterly and possible interventions will include • Provider performance meetings • Triangulation of data with other quality indicators • Advice from external advisors • Monitoring of any action plans A risk assessment should be undertaken and logged on the Commissioning Team Risk Register. Where appropriate the risk will be included on the JCC Risk Management Framework. Reporting is via commissioning team report to Quality Patient Safety Committee report and SLA meetings with provider. The investigation will lead to on to the following possible outcomes: • Action plan and monitoring are completed within the allocated timeframe, evidence of progress and assurance the concern has been addressed. De-escalation to Level 1 for ongoing monitoring. • If the action plan is not adhered to and further concerns are raised by the Commissioning team or by the provider team or further concerns are identified it may be necessary to move to Level 3 Escalated Measures
Level 3 ESCALATED MEASURES	Where there is evidence that the Action Plan developed following Level 2 has failed to meet the required outcomes or a serious concern is identified a service will be placed in escalated Level 3. At this stage the quality of the service requires significant action/improvement and will require Executive input. In addition to routine reporting through QPS a formal paper will be considered by the JCC Corporate Directors Group (CDG) and an Executive Lead nominated. Formal notification will be sent to the provider re the Level of escalation and a request made for an Executive lead from the provider to be identified. An initial meeting will be set up as soon as possible dependant on the severity of the concern. Meetings should take place at least monthly thereafter or more frequently if determined necessary with jointly agreed objectives. Provider representation will depend on the nature of the issue, but the meetings should ideally comprise of the following personnel as a minimum: • Chair (JCC Executive Lead) • Associate Medical Director - Commissioning Team • Senior Planning Lead – Commissioning Team • JCC Head of Quality • Executive Lead from provider Health Board/Trust • Clinical representative from provider Health Board/Trust • Management representative from provider Health Board/Trust An agreed agenda should be shared prior to the meeting with a request for evidence as necessary. At the conclusion of the meeting a clear timeline for agreed actions will be identified for future monitoring and confirmed in writing if appropriate. Reporting will be through commissioning team to QPS Committee. Consideration of entry on the risk register and summary of services in escalation table for Chairs report to Joint Committee. Consideration to involve and have a discussion with Welsh Government may be considered appropriate at this stage. If there is ongoing concern relating patient care and safety with no clear progress, then further escalation will be required to Level 4. On the other hand, if progress is made through the escalation Level 3 evidence of this should be presented to CDG/QPS and a formal decision made with the provider to de-escalate to Level 2.

Patterson,Liz
03/08/2026 09:04:55

Level 4 DECOMISSIONING/OUTSOURCING	Where services have been unable to meet specific targets or demonstrate evidence of improvement a number of actions need to be considered at this stage. This stage will require notification and involvement of the JCC Managing Director and CEO from the provider organisation. Both Quality Patient Safety Committee and Joint Committee should be cited on the level of escalation. The following areas will need to be considered, and the most appropriate sanction applied to help resolve the issue: 1. De-commissioning of the service 2. Outsourcing from an alternative provider. This may be permanent or temporary 3. Contractual realignment to take into account the potential need to maintain and agree an alternative provider. Involvement with Welsh Government and the Community Health Council is critical at this stage as often there are political drivers and levers that need to be considered and articulated as part of the decision making. Moving in and out of escalation and between Levels In addition to the Levels described above the process has introduced a traffic light guide within each level. The purpose of this is to help demonstrate the direction of travel within the level. It sets out an approach to help identify progress within the level and lays out the steps required for movement either upwards (escalation) or downwards (de-escalation) through the level. At every stage a red, amber or green colour will be applied to the level to illustrate whether more or less intervention is in place. Red being a higher level of intervention moving down to green. It will also help determine the easing of the escalated measures described and inform movement within the stages of escalation. As the evidence and understanding of the risks from a provider and commissioner become evident decisions can be made to reduce the level of intervention or there may be a need to reintroduce intervention should conditions worsen and trigger the re-introduction of measures if progress is unacceptable. In this way organisations will be able to understand what is being asked of them, progress will be easily identified, and it will help avoid any confusion. It will also help in the reporting to provide assurance that action is being taken to meet the agreed timescales.



SERVICES IN ESCALATION

Level of escalation reducing / improving position

Level of escalation unchanged from previous report/month

Level of escalation increasing / worsening position

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Powys Teaching Health Board

Agenda item: 6.3

PATIENTE EXPEREINCE, QUALITY AND SAFETY COMMITTEE	**04 AUGUST 2026**
Subject:	**Committee Effectiveness: Governance Development Plan 2026-27**
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 – Governance Development Plan 2026-27

PURPOSE:

This report provides the Committee with the plan for continuous development, based upon the matters identified as actions arising the 2025-26 annual review of Committee effectiveness.

The 2026-27 plan comprises of actions arising from and relevant to all Committees (Cross Committee Action Plan) and the Board.

RECOMMENDATION(S):

The Committee is asked to:

a. **RECEIVE** the Governance Development Plan 2026-27 and
b. **TAKE ASSURANCE** that the implementation of development actions will be monitored and reported on 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 improvement.

PTHB has adopted a two-yearly approach to Committee Effectiveness Reviews, with an in-depth questionnaire in year 1 and a more informal facilitated discussion approach in year 2. 2025/26 constitutes year 2 of the current cycle, and in March 2026 a Board Development session provided Board members with the opportunity to discuss in a shared environment the effectiveness of our Committees.

A key aspect of the effectiveness review is the formulation of actions based upon identified opportunities for continuous improvement as part of the process.
The outcome of the Board Development discussion and the actions arising have been reviewed and formed into a development plan by the Corporate Governance team, which has subsequently been received and supported by the Chair's Forum and Board Development.

Implementation of the Governance Development Plan 2026-27 (Appendix A) will be monitored by the Corporate Governance team throughout the year, and an update on implementation will return to the Committee in Q4 of 2026/27.

NEXT STEPS:

Implementation of the Governance Development Plan 2026-27 (Appendix A) will be monitored by the Corporate Governance team throughout the year, and an update on implementation will return to the Committee in Q4 of 2026/27.

Appendix A – Governance Development Plan 2026/2027.

Patterson,Liz
03/08/2026 09:04:55

Committee Effectiveness: Governance Development Plan 2026–2027

Theme	Action	Owner	Timeline	Status
Committee Agenda Focus	a) Executive/Assistant Directors to feedback where greater clarity re the expected content/focus of agenda items would be beneficial b) Committee Chair's to provide clarity in meetings regarding the content/discussion required around agenda items	Governance Team / Executive Directors / Committee Chairs	Q1	Underway
Committee Agenda Focus	Review of proportionality of Committee reporting across key services/areas of risk as part of the development of annual work programmes	DCG / Governance Team / Executive Directors / Chairs	Q1	Underway
Board Member Training	Focused Board Member training on key areas e.g. financial recovery, scrutiny vs assurance etc. as part of	PTHB Chair / DCG	Q2	Not yet due

Patterson,Liz
03/08/2026 09:04:55

	structured Board Development programme			
Organisational Learning	Undertake to identify a comparable organisation for benchmarking of key data beyond NHS Wales	DCG / Governance Team / DPP&C	Q3	Not yet due
Organisational Learning	Identify partners or opportunities to hear from and share learning with relevant organisations and sectors	PTHB Chair / DCG / Committee Chairs	Q4	Not yet due
Board Out and About	Review potential for half-day IM out and about sessions as part of Board Development twice per year	PTHB Chair / DCG	Q2 – Q4	Not yet due

Patterson,Liz
03/08/2026 09:04:55

Subject:	Chair/Vice Chair/Board Out and About Programme
Approved and Presented by:	Helen Bushell, Director of Corporate Governance/Board Secretary
Author:	Deputy Board Secretary
Purpose:	Throughout 2025/26 Board Members undertook a programme of visits to PTHB sites and services, and sites and services from which the Health Board commissions services, this presentation provides a summary of those visits and the key themes arising from the feedback provided. Please note this paper was produced for the April Committee and has not been updated since that point. The report will be provided on a bi-annual basis.
Recommendations:	The Patient Experience, Quality and Safety Committee is asked to: • **TAKE ASSURANCE** that an appropriate programme of Board Member visits was undertaken since October 2025 and that there are established mechanisms for recording and, where appropriate, actioning the arising feedback.
Executive Summary:	During the year, the Chair, Vice Chair and Independent Members of the Board undertake a programme of visits to PTHB sites and services, and sites and services from which the Health Board commissions services. This is an important element of the Board's approach to ensuring that Independent Members of the Board are able to effectively formulate triangulated assurance by being given the opportunity to observe operational services and the experience of patients directly. The programme of visits is also an important interface between Members of the Board and members of staff, patients and their families/loved ones by providing opportunity for personally listening, learning and receiving feedback. This presentation provides an overview of the Board Out and About Programme delivered from October 2025 and provides a summary of the key themes arising through analysis of the feedback collected from Board Members following each visit. It should be noted visits were undertaken in the first half of the year but not recorded in this presentation – the presentation relates to when the feedback/recording mechanisms

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Summary of Board Out and About Programme 2025/26 (13 visits)

Date of Visit	Site, Team or Service Visited	Stakeholders engaged
23 October 2025	Brecon Hospital: Bannau Ward, Epynt Ward & Minor Injury Unit (MIU).	Staff Members
30 October 2025	Mid and South Powys District Nurse Teams: Knighton, Builth Wells & Rhayader, Crickhowell & Talgarth	Staff Members; Patients
12 November 2025	Adults & Older Adults Community Mental Health Team, Ystradgynlais	Staff Members
18 November 2025	Machynlleth Patients Forum	Staff Members; Patients
24 November 2025	Commissioned Services - Hywel Dda UHB: Bronglais Hospital	Staff Members
2 December 2025	Community Mental Health Team (CMHT) Bronllys	Staff Members
9 December 2025	Commissioned services - Cwm Taf Morgannwg UHB: Royal Glamorgan Hospital	Staff Members
7 January 2026	Joint Interagency Meeting Panel (JIMP)	Staff Members
20 January 2026	District Nurses Forum	Staff Members
20 January 2026	Neuro-Developmental (ND) Parents' Coproduction Group	Patients; Family, Friends, Loved Ones;
17 February 2026	Community Frailty Team	Staff Members
17 February 2026	Child and Adolescent Mental Health Services (CAMHS) Crisis Team	Staff Members
1 April 2026	Crosfield House Care Home, Rhaeadr	Staff Members; Patients; Family, Friends, Loved Ones

Patterson,Liz
03/08/2026 09:04:55

Matters to Affirm and Celebrate: Key Themes

Key Matters to Affirm and Celebrate - themes arising from visits since October 2025 included:

- **Strong Workforce Culture, Leadership & Staff Experience:** Staff consistently described as diligent, motivated, dedicated staff; Clear sense of team identity, belonging and mutual support; Positive perception of PTHB as a great place to work; Improved recruitment and retention, including stability in key teams; Positive experiences for international recruits, feeling welcomed and supported.

- **Compassionate, Person-Centred Care:** Repeated emphasis on care, compassion, and time given to patients and carers; Positive feedback from patients, relatives, and communities; Focus on "what matters" to patients and patient goals.

- **Integration & Partnership Working:** Strong multidisciplinary team (MDT) working across services; Strong partnerships between PTHB, PCC and independent providers; Positive relationships with care homes and third sector providers; Evidence of integrated service models improving efficiency and outcomes; Appetite to strengthen and formalise strategic partnerships further.

- **Service Improvement, Innovation & System Impact:** Tangible improvements in clinical environment and facilities in some sites, use of data, co-production and continuous improvement approaches.

Patterson,Liz
03/08/2026 09:04:55

Area for Improvement or Concern: Key Themes

Key themes arising from feedback from visits since October 2025 included:

- **Capacity, Workforce Pressures & Sustainability Risks:** Concerning workload levels, persistent staffing gaps, slow recruitment ad on-boarding delays; Reliance on locums; Increasing clinical demand; vulnerability of small teams and insufficient management capacity.

- **System Complexity:** Geographical challenges leading to isolation and inter-county differences; interface challenges related to hospital discharge; cross-border working and Continuing Health Care; lack of clarity around roles and responsibilities in some partnerships, duplication in inefficient pathways and uncoordinated care planning; Limited shared systems and several digital incompatibilities across digital platforms.

- **Environment, Infrastructure & Systems:** Inadequate physical environments; insufficient clinical space; gaps in equipment provision and administrative support; digital and operational system challenges; high administrative burden on clinicians in some services.

- **Strategic Clarity :** Poor perception of top-down change due to limited engagement; poor Board to Ward communication resulting low awareness of key changes and programmes e.g. Better Together; public and stakeholder concern regarding system changes and access; uncertainty linked to short-term funding models in some services; limited visibility of management in some localities.

Patterson,Liz
03/08/2026 09:04:56

As a result of the areas of concern identified by the Board Out and About Programme several detailed and service specific actions points are raised with and actioned by the relevant Executive Directors and Senior Mangers throughout the year.

Board Out and About Programme 2026/27

Into 2026/27:

- A Programme of Board Visits will continue to be planned and delivered in 2026/27 with the support of the Corporate Governance Team.
- The guidance put in place in 2025/26 will be reviewed and either reconfirmed or updated (available via Board Member Library)
- Feedback from visits will continue to be collected, analysed and actioned as appropriate by the Corporate Governance Team.
- Work will be undertaken to review the wider involvement of Independent Members in the programme, including the potential for half-day Board Out and About visits inclusive of all Independent Board members linked to Board Development sessions.
- Bi-annual reporting in relation to the delivery and findings of the programme will be reported to this Committee.

Patterson,Liz
03/08/2026 09:04:55

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Powys Teaching Health Board

Agenda item: 6.5

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE	**22 JULY 2026**
Subject:	**Electronic Prescribing and Medicines Administration (ePMA) system update - Ministerial Priority and IMTP Critical Action**
Approved and presented by:	Dr Kate Wright, Executive Medical Director Chief Pharmacist
Prepared by:	Head of Digital Programmes Chief Pharmacist Clinical Informatics Lead Nursing
Other Committees and meetings considered at:	Executive Committee - 22 July 2026 who accepted the recommendations.

PURPOSE:

To provide an assurance update on the Electronic Prescribing and Medicines Administration Programme, highlighting:

- Current delivery confidence
- Key risks and constraints

RECOMMENDATION(S):

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

- Take **ASSURANCE** that Phase 1 inpatient delivery remains on track, with governance, clinical safety, training, business continuity, and onboarding arrangements in place and actively managing risk.
- **NOTE** the programme remains **GREEN**, with delivery progressing across eight hospital sites and twelve wards; however, delivery confidence is dependent on active management of pharmacy capacity, GP/Out of Hours training compliance and SBUHB service adoption.
- **NOTE** the principal risks to delivery confidence, including pharmacy workforce constraints in South Powys, training compliance for GP and Out of Hours clinicians, Welsh Government expectations for delivery within 12 months, and the current position regarding SBUHB Out of Hours adoption.
- **NOTE** that no formal decision is required at this stage; escalation routes are in place should tolerances be exceeded.

Approve/Take Assurance	Discuss	Note
Y	N	Y

Patterson,Liz 03/08/2026 09:04:55

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	

Patterson,Liz
03/08/2026 09:04:55

EXECUTIVE SUMMARY:

Programme Status: GREEN – Delivery feasible and on track for completion.

The electronic prescribing of medicines management programme is progressing well and gaining momentum as we complete implementation at the fifth hospital site.

What is working well (Assurance)

- Six wards out of twelve have been successfully onboarded.
- Powys are the first health board in Wales to start both reading medicines on hospital admission and writing discharge medicines with the SMR, a significant step in helping to create a consolidated medicines record for patients.
- Powys is the second health board to go live with the BetterMeds system.
- Early clinical safety benefits are emerging through improved visibility and legibility of prescriptions at the point of administration. For paracetamol, the system is supporting safer administration by making dose timing clearer, supports the four-hour minimum interval, and helps staff identify when the 24-hour maximum dose has been reached, controls that were less reliable in paper-based processes.
- Early adopter feedback indicates positive adoption and user experience, with a structured process in place to capture lessons learned and feed improvements into future rollout phases.

Key Issues and Constraints

Issue	Mitigation
Pharmacy Resource Gap There was insufficient pharmacy capacity to support safe implementation across South Powys in June.	Rollout requires significant engagement and preparation from ward teams, supported by pharmacy, nursing, medical, digital and operational colleagues. In light of current vacancies and to ensure each site receives the right level of support, the rollout plan has been reviewed and rescheduled. The revised sequence prioritises North Powys wards while recruitment progresses, maintaining a safe and well-

Patterson.Liz 03/08/2026 09:04:55

	supported approach to implementation.
GP and Out of Hours Training Compliance Training uptake has been slower than required. Six incidents have occurred where GPs have reverted to paper processes due to lack of system access.	This has been escalated through the Project Board SRO, Out of Hours Shropdoc Medical Director, Assistant Director of Primary Care and Practice Managers.
Welsh Government Timelines Welsh Government has directed completion across inpatient and outpatient settings within 12 months.	Discussions are underway to confirm the scope and sequencing of Phase 2 outpatient delivery, which will commence following completion of Phase 1 Mid-October 2026.
No appetite to use the ePMA system OOH at SBUHB The OOH service has 180+ clinicians, with a high turn-over of staff and unstructured rotas and last-minute changes, making training of their staff difficult.	Ystradgynlais will be the last site to go live. Pending resolution or mitigation.

Delivery outlook

Phase 1 inpatient delivery remains on track, although delivery confidence is dependent on continued active management of pharmacy workforce capacity, GP and Out of Hours training compliance, and cross-border operational adoption.

ePMA is now operating as a live medicines safety system. Safe use depends on ongoing pharmacy clinical governance, including maintenance of the drug dictionary, formulary, clinical decision support, safety alerts, incident review and upgrade testing. This specialist clinical informatics function and continued delivery confidence is therefore dependent on ensuring sustainable pharmacy capacity to support both rollout and business-as-usual optimisation.

Phase 2 is more complex due to the number and diversity of outpatient clinics, outreach consultants and community service settings providing direct care to Powys patients. Further scoping and sequencing will therefore be required before Phase 2 delivery confidence can be fully confirmed.

Patterson,Liz
03/08/2026 09:04:55

Outpatient implementation will provide a significant opportunity to strengthen assurance around clinic prescribing, which has historically been harder to track due to paper-based processes, fragmented prescribing routes and delays in retrospective reporting. Phase 2 is a major opportunity to improve safety, assurance, efficiency and patient experience across outpatient and community-facing pathways.

Overall assurance
The committee can take assurance that the programme remains under active control for Phase 1, with appropriate governance, clinical safety, training, business continuity, and escalation arrangements in place. The assurance position is balanced: delivery remains feasible, but continued executive oversight is required to ensure workforce, training and neighbouring health board constraints do not affect agreed tolerances.

PROGRAMME UPDATE

The ePMA Programme has successfully progressed from mobilisation through to live deployment on the 5 May 2026 with our early adopter site, delivering key achievements across governance, system configuration, testing, training, and rollout. Core build and integration, including Shared Medicines Record functionality, have been completed and assured through robust User Acceptance Testing and clinical sign-off processes. Initial sites are now live with positive early feedback, supported by structured training, business continuity arrangements, and ward-based adoption materials. The programme has also established foundations for benefits tracking and national reporting, with early adopter status and delivery recognised as strong in comparison to other health boards.

Training, workforce readiness, and adoption

- Training materials have been developed and deployed across clinical groups, including nursing, pharmacy and prescribers using Moodle as the software platform to host the literature and videos.
- Compliance with training requirements is monitored through Moodle, and system access is only granted once the required modules have been completed.
- Team based training sessions have been delivered aligned to site rollout, ensuring readiness at each onboarding phase.
- Checks and training compliance processes have been established to support safe system access, i.e., access is only granted once training has been completed and validated by a member of staff.
- Medication carts have been deployed across all hospital sites.

Patterson Liz
03/08/2026 09:04:55

- Quick reference guides and SOPs have been developed to support safe system access and support in hours and out of hours.
- A robust process is in place to ensure agency nurses have received system training prior to booking a shift.

Clinical Engagement and feedback

- A survey has been developed to capture early adopter site feedback, with initial reports indicating positive adoption and user experience.
- A process for continuous feedback and lessons learned at each site rollout has been established which is being fed back to the supplier including future enhancements.

Reporting & Benefits

- A BI dashboard has been developed to support benefits realisation, reporting on system usage, medicines safety, workflow efficiency and incident trends. An application is also being developed to support Subject Access Requests, audit requirements and user access management.
- Electronic medicines administration records are now supporting Medical Examiner processes, reducing reliance on paper-based records and improving availability of information for audit and assurance purposes.
- Early benefits are beginning to emerge through improved access to medicines information, enhanced prescribing visibility, clearer administration records and reduced reliance on paper processes. Authorised staff can access medicines information remotely, supporting clinical decision-making across Powys' geographically dispersed services.
- Medication-related incidents will continue to be monitored through Datix and programme governance. It is recognised that incident reporting may initially increase as digital visibility and user familiarity develop following implementation.
- While it is too early to demonstrate a sustained reduction in medication-related incidents locally, published evidence shows that electronically prescribed medicines systems can significantly reduce prescribing errors by around 50% or more through improved legibility, decision support and standardised prescribing processes. Formal evaluation of local benefits will be completed as part of the Phase 1 benefits review

Business Continuity

Business continuity arrangements for ePMA are established which formed a core component of go-live readiness and safe ongoing operation.

Patterson,Liz 03/08/2026 09:04:55

- A formal SOP has been developed and sets out clear processes for entering, operating within, and recovering from downtime scenarios, including ward-level checklists and central decision-making to enact BCP.
- All clinical areas are equipped to revert to standard paper drug charts and prescribing processes, ensuring continuity of prescribing, administration, and discharge activity during system outages.
- Each ward has access to designated BCP devices containing laptops, printers, stationery, and paper charts, with daily checks required to ensure operational readiness.
- Disaster recovery and technical resilience is in place with the supplier which includes secure backup, recovery solutions, and failover capabilities to restore services following disruption.

PRIORITY ACTIONS (NEXT 8-12 WEEKS)

Action	Target Date	Risk Mitigated
Complete Phase 1 inpatient rollout across twelve wards and eight hospital sites, as set out in Appendix A.	16 October 2026	Project Rollout Plan agreed. Clinical and non-clinical resource aligned to support.
Develop an app for retrieving Subject Access Request data and system access audit requirements.	30 September 2026	Reduces reliance on manual processes and strengthens audit, reporting and information governance controls.
Complete Phase 1 benefits review.	30 September 2026	Confirms early benefits and validates baseline assumptions
Confirm Phase 2 outpatient scope, sequencing, and readiness criteria.	31 July 2026	Reduces risk of premature rollout into more complex outpatient and community settings.
Confirm software upgrade v3.19 deployment plan with supplier, including testing, clinical safety review, and implementation date.	30 September 2026	Ensures upgrade activity is safely planned and clinically assured.
Hold lessons learned workshop following Phase 1 rollout.	30 October 2026	Captures operational learning, strengthens future rollout planning, and supports continuous improvement.

Patterson,Liz
03/08/2026 09:04:55

CONCLUSION

The adoption of ePMA is beginning to demonstrate positive operational benefits through improved medicines visibility, reduced reliance on paper processes and support for remote clinical workflows. Powys is such a vast geographical area with some staff attending the clinical environment 2-3 times a week, supporting remote working for the team is extremely valuable.

Phase 1 inpatient delivery remains feasible and on track, with clear governance, clinical safety, training, business continuity, and escalation arrangements in place. Continued executive oversight is required to ensure key risks relating to pharmacy capacity, training compliance, national timeline expectations, and adoption remains within agreed tolerances.

NEXT STEPS:

- Continue Phase 1 rollout in line with the agreed delivery plan and site readiness criteria.
- Monitor pharmacy workforce constraints and escalate if capacity affects safe go-live readiness or delivery tolerances.
- Maintain training compliance controls for GP and Out of Hours clinicians, with access only granted following completion and validation of required training.
- Confirm the operational approach for SBUHB Out of Hours adoption ahead of Ystradgynlais go-live readiness review.
- Complete the Phase 1 benefits review by 30 September 2026, including usage, incident, workflow, and paper reduction measures.
- Confirm the supplier release plan and clinical safety assurance requirements for software upgrade v3.20.
- Complete Phase 1 lessons learned workshop and incorporate learning into Phase 2 planning.
- Return to Executive Committee if delivery confidence changes or if escalation is required against workforce, training, national timeline, or other constraints.

IMPACT ASSESSMENT - NOT REQUIRED

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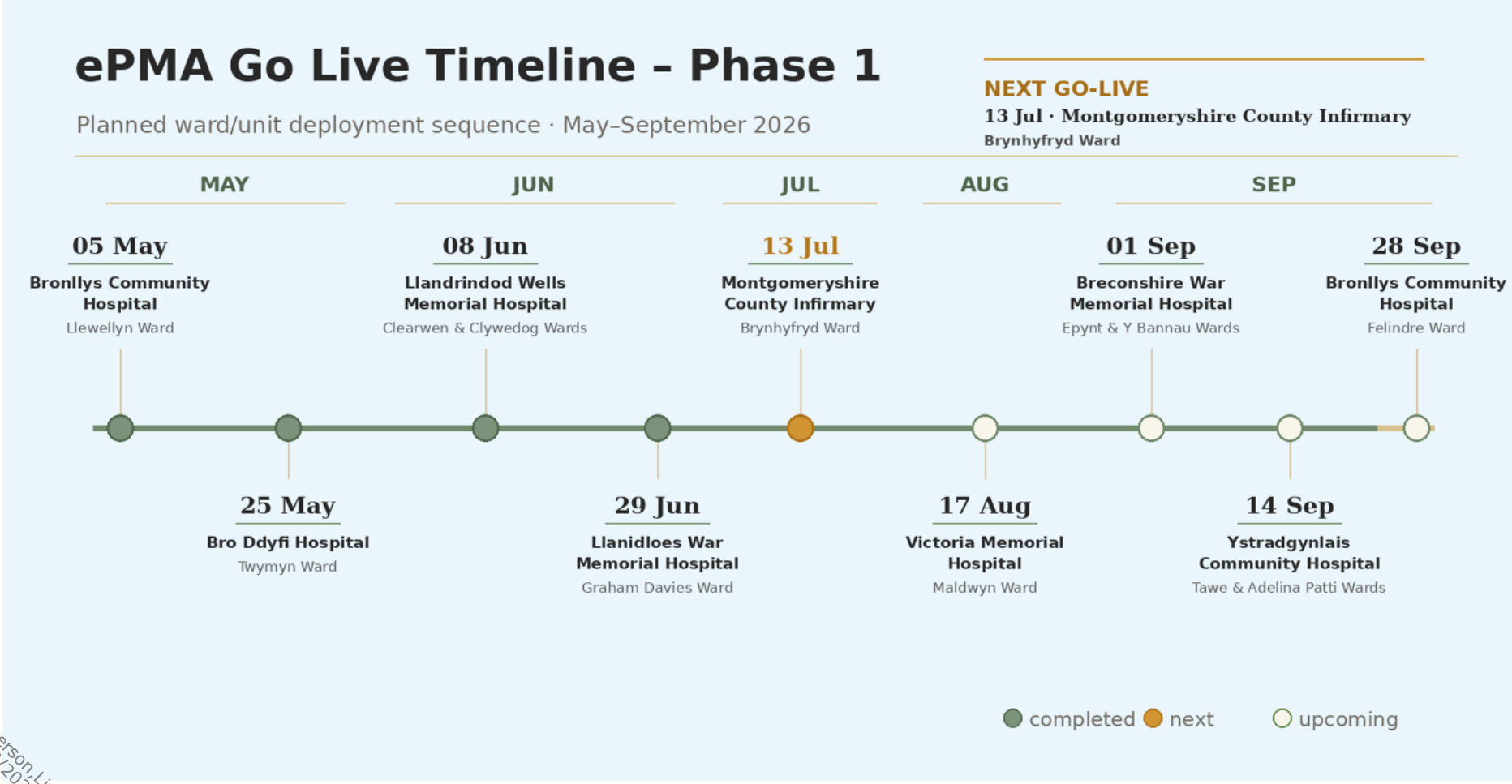
Appendix A – Phase 1 Delivery Plan



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Powys Teaching Health Board

Agenda item: 7.6

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE	**29 JULY 2026**
Subject:	**Committee Risk Register Update**
Approved and presented by:	Helen Bushell, Director of Corporate Governance
Prepared by:	Corporate Governance, Risk and Assurance Officer
Other Committees and meetings considered at:	N/A
Appendices :	Appendix A – Committee Risk Register

PURPOSE:

The purpose of the Committee Risk Register is to draw together relevant risks for the Committee from the Strategic Risk Register (SRR), to provide a summary of the significant risks to delivery of the health board's strategic objectives.

RECOMMENDATION(S):

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

- **NOTE** the update that the next Committee Risk Register will be presented at the next meeting in 2026.

Approve/Take Assurance	Discuss	Note
Y	Y	x

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	The corporate risks are a reflection of the significant risks to the delivery of the health board's strategic objectives and therefore underpin all wellbeing objectives.
2. Provide Early Help and Support	Y	
3. Tackle the Big Four	Y	
4. Enable Joined up Care	Y	
5. Develop Workforce Futures	Y	
6. Promote Innovative Environments	Y	
7. Put Digital First	Y	
8. Transforming in Partnership	Y	

COMMITTEE RISK REGISTER

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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.

The Board is actively undertaking an annual review of its Strategic Risk Register (SRR) to ensure that the risks continue to accurately reflect and align with the Health Board's strategic priorities. Following review, a summary of the revised SRR will be presented to the Board in July for consideration and subsequently the revised SRR to the Board for approval in September. The updated Committee Risk Register (CRR) will be provided to the Committee at its next meeting in 2026.

NEXT STEPS:

The Committee will continue to seek assurance on the ongoing development and management of patient experience, quality and safety risks as set out above.

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03/08/2026 09:04:55

Patient Experience, Quality and Safety Committee 2026-27

Theme	Item Title	April 30/04/2026	August 04/08/2026	October 15/10/2026	February 04/02/2027	Rationale
Governance	Minutes of previous meeting	✓	✓	✓	✓	
Governance	Declaration of Interests	✓	✓	✓	✓	
Governance	Action Log	✓	✓	✓	✓	
Governance	Committee Risk Register	✓	✓	✓	✓	
Governance	Annual Work Programme	✓				
	Board Out and About 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				✓	
Governance	Review of Terms of Reference Power of Discharge Group				✓	
	Chairs Report (update on PoDGp, out and abouts and aob relating to PEQS)			✓	✓	
Quality	Integrated Quality Report to include:	✓	✓	✓	✓	
Quality	PSOW Annual Letter (within IQR - when received)			✓		
Quality	National Programmes and Initiatives		✓	✓	✓	
Quality	Integrated Quality and Performance Framework (timing to be confirmed)					
Quality	Maternity Services reporting	✓	✓	✓	✓	
Safeguarding	Safeguarding Annual Report		✓			
	PHW Test and Post incident	✓				
Research, Development and Improvement	Quality based improvement / learning		☒	✓	✓	
Research, Development and Improvement	Research, Development and Innovation			✓		
Patient Experience	Patient Experience Framework	✓				
Patient Experience	Patient Story		✓	✓	✓	
Primary Care	Patient Experience in Primary Care		☒	✓		Will form part of patient experience framework.
Primary Care	Primary Care - dental quality			✓		
MH Compliance	MH Power of Discharge Annual Report including MH compliance with legislation and update				✓	
Clincial Audit	Annual Programme Clinical Audit	✓				
Clincial Audit	Clincial Audit Annual Closure Report			✓		
Clincial Audit	In year 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			✓		
	Duty of Quality Annual Report		✓			
	Annual Report Medical Devices and Point of Care Testing			✓		
	Transition of Care Annual Report		✓			
	Nurse Staffing Levels		✓			
Infection Prevention and Control	Chief Nursing Officer IPC statement	✓				
Infection Prevention and Control	IPC Annual Report		✓		✓	
	Mortality Annual report date tbc			✓		
Other	Corporate Parenting Charter update			✓		
	Staff experience of ND Services in escalation (post escalation)					
	JCC Quality Safety and Outcomes Sub-Committee Hightlight Report (as held)	✓	✓	✓	✓	
	EPMA update		✓			
	Monitoring ongoing improvement and barriers to implementation re WHC 37 Infected Blood Inquiry (Blood Transfusions)			✓		
	Six-monthly update on Antimicrobrial stewardship		✓		✓	
	Monitoring Report Mental Health Services post escalation	☒				
Escalated Items:						
	Civica (Patient Experience - see above)	✓	✓	✓	✓	
	Neurodiversity (referred from D&P Oct 2024)	✓	✓	✓	✓	
	Quality Management System		✓			
In Committee						
	Report on suicides	✓				
	Transition of Care Report (to each meeting until agreed can be bi-annual)	✓	In main meeting	✓	✓	
	PHW Test and Post Sexual Health Service Incident	✓				

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13/08/2026 09:04:55

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Powys Teaching Health Board Glossary (Last updated juli 26)

Acronym	
AD ECP	Associate Director of Estates, Capital & Property
ACEO	Acting Chief Executive Officer
ADoF	Acting Director of Finance
ADCEO / EMD	Acting Deputy Chief Executive / Executive Medical Director
CEO	Chief Executive Officer
DCEO / ED FC&SS	Deputy Chief Executive Officer / Executive Director of Finance, Capital & Support Services
DCG	Director of Corporate Governance
D I&T	Director of Improvement & Transformation
E MD	Executive Medical Director
ED PH	Executive Director of Public Health
ED PC&T	Executive Director of People, Culture & Transformation
ED PP&C	Executive Director of Planning, Performance and Commissioning
ED AHPHS&D	Executive Director of Allied Health Professions, Health Sciences and Digital
ED NQW&FH	Executive Director of Nursing, Quality, Women and Family Health
ED PCCMH	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
AF	Audit Findings
APB	Area Planning Board
AGS	Annual Governance Statement
BAF	Board Assurance Framework
BCUHB	Betsi Cadwaladr University Health Board
BMA	British Medical Association
CAAP	Clinical associate in applied psychology

Patterson, Sian
03/08/2025 09:09:55

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 Taf 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
DOI	Declaration of Interest
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

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03/08/2023 09:04:55

F&P	Finance and Performance Committee
GDS	General Dental Services
GIRFT	Getting It Right First Time
GLP-1	Glucagon Like Peptide
GMC	General Medical Council
GMS	General Medical Services
GP	General Practitioner
GNCC	General Nursing Complex Care Team
G&H	Gifts and Hospitality
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
IBG	Investment Benefit Group
ICB	Integrated Care Board
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

Patterson, Liz
03/08/2026 09:04:55

LA	Local Authority
LHB	Learning Health Board
LMC	Local Medical Committee
LPF	Local Partnership Forum
LRF	Local Resilience Forum
LTA	Long Term Agreement
MAC	Mindfulness, Acceptance and Compassion Team
MD	Ministerial Direction
MD's	Minimum Data Set
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
ODEC	Organisational Development, Engagement and Communications
OOC	Out of County
OOH	Out of Hours
ORS	Opinion Research Services
OSCE	Objective Structured Clinical Examination
OT	Occupational Therapy
PA	Physician Associate
PADR	Personal Appraisal Development Review
PAVO	Powys Association of Voluntary Organisations
PET CT	Positron Emission Tomography Computed Tomography
PCC	Powys County Council
PEQS	Patient Experience, Quality and Safety Committee

Pattern Audit
03/08/2026 09:10:55

PHE	Public Health England
PHW	Public Health Wales
PMVA	Prevention and Management of Violence and Aggression
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
REES	Race Equality Employment Standard
RIIC	Research, Innovation & Improvement Coordination
RIF	Regional Investment Fund
RISP	Radiology Information System Procurement
RJAH	The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
RN	Registered Nurse
RPB	Regional Partnership Board
RTT	Referral to Treatment
RTS	Routemap To Sustainability
RMF	Risk Management Framework
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	The Shrewsbury and Telford Hospital NHS Trust
SPB	Strategic Programme Board
SRO	Senior Responsible Owner
TACODEC	Tactical Organisation Development, Engagement and Communication
TI	Targeted Intervention

Patterson, Liz 03/08/2023 09:04:55

ToR	Terms of Reference
TRAC	Online Recruitment Management System
T&V	Transformation & Value
TUPE	Transfer of Undertakings Protection of Employment
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
WRES	Workforce Race Equality Standard
WTE	Whole Time Equivalent
WVT	Wye Valley NHS Trust
WCD	Written Controlled Document
YTD	Year to Date

Patterson,Liz
03/08/2026 09:04:55