Patient Experience, Quality and Safety Committee

Thu 05 February 2026, 09:30 - 12:30

Agenda

09:30 - 09:30
0 min

1. PRELIMINARY MATTERS

PEQS_Agenda_05FEB2026 FINAL.pdf (3 pages)

1.1. Welcome and Apologies

1.2. Declarations of Interest

PEQS_1.2_Register of Interests 2025-26.pdf (3 pages)

1.3. Patient Story

09:30 - 09:30
0 min

2. CONSENT AGENDA BUSINESS

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

09:30 - 09:30
0 min

3. ITEMS FOR APPROVAL / DECISION / RATIFICATION

3.1. Minutes of the previous meeting: 23 October 2025

PEQS_3.1_Minutes 2025-10-23 PEQS unconfirmed.pdf (15 pages)

3.2. Committee Action Log

PEQS_3.2_Action Log Feb26.pdf (1 pages)

09:30 - 09:30
0 min

4. ESCALATED ITEMS

4.1. Children's Neurodiversity Services

PEQS_4.1_ND Services.pdf (6 pages)

4.2. Peoples Experience Framework update

PEQS_4.2_People's Experience Strategy cover Report Jan26.pdf (5 pages)

09:30 - 09:30
0 min

5. ITEMS FOR ASSURANCE

5.1. Integrated Quality Report

PEQS_5.1_Integrated Quality Report Paper Jan 2026 (003).pdf (19 pages)

5.2. Maternity Assurance Report

PEQS_5.2_Maternity Assurance Report.pdf (14 pages)

5.3. Patient Experience in Primary Care

PEQS_5.3_GMS Access Report 050226.pdf (20 pages)
PEQS_5.3a_App1 GMS access report.pdf (3 pages)
PEQS_5.3b_Patient questionnaire.pdf (8 pages)

5.4. Annual Report of Accountable Officer for Controlled Drugs

PEQS_5.4_CDAO Annual Report 2025-26.pdf (16 pages)

5.5. Terms of Reference Review

PEQS_5.5_Patient Experience, Quality and Safety Terms of Reference Review Cover.pdf (2 pages)
PEQS_5.5a_PEQS ToR for review Feb26.pdf (11 pages)

5.6. Committee Risk Register

PEQS_5.6_Committee Risk Register Cover.pdf (2 pages)
PEQS_5.6a_Appendix A - Committee Risk Register.pdf (18 pages)

09:30 - 09:30
0 min

6. ITEMS FOR DISCUSSION

09:30 - 09:30
0 min

7. CONSENT AGENDA

7.1. Internal Audit Reports:

7.1.1. Decontamination (Reasonable Assurance)

PEQS_7.1a_Decontamination Final Internal Audit Report.pdf (11 pages)

7.1.2. Continuing Health Care (Reasonable Assurance)

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

7.1.3. MH and LD Triage and Assessment Process (Reasonable Assurance)

PEQS_7.2c_MH and LD Triage and Assessment Process Final Internal Audit Report.pdf (11 pages)

7.2. Corporate Parenting Charter update

PEQS_7.2_Corporate Parenting Charter and Promises.pdf (5 pages)

7.3. Update on implementation of management action for DoLS Internal Audit Report

PEQS_7.3_MCA DoLS Audit Update.pdf (4 pages)

7.4. Six monthly update on antimicrobial resistance

PEQS_7.4_Antimicrobial Stewardship Report.pdf (6 pages)

7.5. JCC highlight report from Quality, Safety and Outcomes Sub-Committee 06 October 2025

PEQS_7.5_JCC - QSO Highlight Report 6 Oct.pdf (13 pages)

7.6. Committee Governance Action Plan

PEQS_7.6_Committee Continuous Development Plan 2025-26 February 2026.pdf (5 pages)

7.7. Work Programme

PEQS_7.7_Work Programme Feb26.pdf (1 pages)

7.8. Glossary

PEQS_7.8_Powys Teaching Health Board Glossary.pdf (6 pages)

09:30 - 09:30
0 min

8. OTHER MATTERS

8.1. Any Other Urgent Business

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

8.3. Committee reflections

8.4. Date of the Next Meeting: 30 April 2026

8.5. Confidential Items

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

8.6. Welcome and Apologies

8.7. Declarations of Interest

8.8. Transition of Care Annual Report 2024/25

8.9.

POWYS TEACHING HEALTH BOARD
PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE

THURSDAY 05 FEBRUARY 2026
09:15 – 12:30
VIA MICROSOFT TEAMS

AGENDA				
Time	**Item**	**Title**	**Attached/Oral**	**Presenter**
	1	**PRELIMINARY MATTERS**		
09.15	1.1	Welcome and apologies	Verbal	Chair
	1.2	Declarations of interest	Verbal	All
	1.3	Patient Story – Mr Brown's Story (stroke services)	Presentation	Executive Director of Nursing, Quality, Women and Family Health and Executive Director of Allied Health Professions, Health Science and Digital
	2	**CONSENT AGENDA BUSINESS**		
The Chair will ask if there are any items from the Consent Agenda (Item 7) that Committee Members wish to bring forward to the main agenda.				
	3	**ITEMS FOR APPROVAL / DECISION / RATIFICATION**		
09.25	3.1	Minutes of previous meeting: • 23 October 2025	Attached	Chair
	3.2	Committee Action Log • JAG accreditation	Attached	Chair
	4	**ESCALATED ITEMS**		
09.30	4.1	Children's Neurodiversity Services	Attached	Executive Director of Planning, Performance and Commissioning
09.45	4.2	People Experience Framework update	Verbal	Executive Director of Nursing, Quality, Women and Family Health
	5	**ITEMS FOR ASSURANCE**		
10.05	5.1	Integrated Quality Report	Attached	Executive Director of Nursing, Quality, Women and Family Health
10.35	**COMFORT BREAK (15 minutes)**			
10.50	5.2	Maternity Assurance Report	Attached	Executive Director of Nursing, Quality, Women and Family Health
11.20	5.3	Patient Experience in Primary Care	Attached	Executive Director Primary, Community Care and Mental Health
11.40	5.4	Annual Report of Accountable Officer for Controlled Drugs	Attached	Executive Medical Director

11.55	5.5	Terms of Reference Review	Attached	Director of Corporate Governance
12.00	5.6	Committee Risk Register	Attached	Director of Corporate Governance
	6	**ITEMS FOR DISCUSSION**		
		There are no items for discussion		
	7	**CONSENT AGENDA**		
	7.1	Internal Audit Reports: • Decontamination (Reasonable Assurance) • Continuing Health Care (Reasonable Assurance) • MH and LD Triage and Assessment Process (Reasonable Assurance) **Purpose**: Information	Attached	Director of Corporate Governance
	7.2	Corporate Parenting Charter annual update **Purpose:** Assurance	Attached	Executive Director of Nursing, Quality, Women and Family Health
	7.3	Update on implementation of management actions for DoLS Internal Audit Report **Purpose:** Assurance	Attached	Executive Director of Nursing, Quality, Women and Family Health
	7.4	Six monthly update on antimicrobial resistance **Purpose:** Assurance	Attached	Executive Medical Director
	7.5	Joint Commissioning Committee highlight report from the Quality, Safety and Outcomes Sub-Committee 06 October 2025 **Purpose:** Assurance	Attached	Executive Director of Nursing, Quality, Women and Family Health
	7.6	Committee Governance Action Plan **Purpose**: Assurance	Attached	Director of Corporate Governance
	7.7	Work programme **Purpose**: Information	Attached	Director of Corporate Governance
	7.8	Glossary **Purpose**: Information	Attached	Director of Corporate Governance
	8	**OTHER MATTERS**		
12.05	8.1	Any Other Urgent Business	Oral	Chair
	8.2	Items to be brought to the attention of the Board and/or other Committees	Verbal	Chair
	8.3	Committee Reflections	Verbal	Chair
	8.4	Date of the next meeting: 30 April 2026		

8.5 The Chair, with advice from the Director of Corporate Governance, has determined that the following items include confidential or commercially sensitive information which

is not in the public interest to discuss in an open meeting at this time. The Board is asked to take this advice into account when considering the following motion to exclude the public from this part of the meeting: Motion under Section 1(2) Public Bodies (Admission to Meetings) Act 1960 ***"Representatives of the press and other members of the public shall be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest"***				
12.10	8.6	Welcome and Apologies	Verbal	Chair
	8.7	Declaration of Interest	Verbal	Chair
	8.8	Transition of Care Annual Report 2024/25	Attached	Executive Director of Nursing, Quality, Women and Family Health
12.30	Close			

POWYS TEACHING HEALTH BOARD - REGISTER OF DECLARATION OF INTERESTS 2025-26								Updated: November 2025
Position	**Name**	**Interest Category**	**Interest Situation**	**Relevant Dates from**	**Relevant Dates to**	**Description of Declaration**	**Comment**	**Date Returned**
INDEPENDENT MEMBERS								
PTHB Chair	**Carl Cooper**	Indirect Interests	Loyalty Interests	2018	Ongoing	Sole Trader, Mandy Williams, Consulting	NIL	29/05/2025
		Indirect Interests	Loyalty Interests	2025	Ongoing	Family member is an employee of Cardiff & Value University Health Board (non Director).	Nil	
Vice Chair	**Kirsty Williams**	Non Finanical personal interests	Loyalty Interests	Feb-25	Current	Co Director of Samaritans Powys	None	22/04/2025.
		Non Finanical personal interests	Loyalty Interests	Nov-22	Current	Director of ILEP Ltd a subsiduary of Cardiff University	None	Left the Health Board on 30 September 2025
		Indirect Interests	Outside Employment	Feb-24	Ongoing	Commissioner for South Wales Fire and Rescue	Ministerial Appointment	
		Non Finanical personal interests	Loyalty Interests	2024	Current	Vice Chair of Brecknock YFC Board of Management	NIL	
Independent Member (General)	**Rhobert Lewis**	Non Financial professional interests	Outside Employment	Nov-21	Current	Chair NPTC Group of Colleges	NIL	30/05/2025
		Indirect Interests	Outside Employment	Nov-21	Current	External member Cross-party STEMM Group Welsh Government	NIL	
Independent Member (Trade Union)	**Cathie Poynton**	NIL	NIL	NIL	NIL	NIL	NIL	01/05/2025
Independent Member (finance)	**Steve Elliot**	Non Financial professional interests	Outside Employment	04/02/2024	Current	Spouse Directorship of Oshi's World Private Limited Company and a Trustee of Oshi's World Charity	NIL	17/04/2025
Independent Member (General)	**Ronnie Alexander**	Indirect Interests	Outside Employment	01/10/2018	Current	Lay Observer to HEIW Participation in ARCPs and Pharmacy Advisory Board	Small half-day or daily payment dependant on booking availability	15/05/2025
		Indirect Interests	Outside Employment	2012	Current	Partner-Director of RA and CJ Consulting Limited	Dividend Payment only	
		Indirect Interests	Outside Employment	2017	Current	Member of Finance, Risk and Audit Committee Hafod/Hendre Housing Association	Remunerated	
		Indirect Interests	Outside Employment	Mar-21	Current to Dec-27	Independent Monitoring Authority (IMA) – Non Executive Director	Remunerated	
		Indirect Interests	Shareholdings and other ownership interests	2012	Current	Director of RA and CJ Consulting Limited	Dividend Payment only	
Independent Member (University)	**Simon Wright**	Financial Interests	Outside Employment	2015	Current	Personal: Academic Registrar, Cardiff University-Various Healthcare Programmes	Salaried Employment	18/06/2025
		Indirect Interests	Loyalty Interests	2001	Current	Sister: Senior Operational Manager, Milestone Trust, Bristol	Salaried Employment	
		Indirect Interests	Loyalty Interests	2021	Current	Spouse: District Nurse, Cardiff and Vale UHB	Salaried Employment	
Independent Member (Third Sector)	**Jennifer Owen Adams**	Non Financial professional interests	Loyalty Interests	Jun-16	Ongoing	Member (not a NED) of Glas Cymru the holding company of Dwr Cymru/Welsh Water	None	10/06/2025
		Non Financial professional interests	Loyalty Interests	07.02.2025	09.02.2028	PAVO-Vice Chair	None	
		Non Financial professional interests	Loyalty Interests	01.09.2024	01.06.2028	Coopted Member of PAVO	None	

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

Executive Director of Public Health	**Mererid Bowley**	Non-Finanical professional Interest	Loyalty Interest	NIL	NIL	Member of Faculty of Public Health	Previously declared on annual Declaration of Interest form issued by corporate team since commencement of role. (Transferring recording of	14/05/2025
		Financial Interest	Shareholdings and other Ownership interests	NIL	NIL	Husband works for Mitie Engineering who hold contracts/work with some NHS bodies/organisations. Shares held by husband and myself and Mitie Company	Previously annually since start of employment through completion of declarations of interest form issued by corporate team annually.	
Director of Corporate Governance/ Board Secretary	**Helen Bushell**	Non-Finanical professional Interest	Outside Employment	Nov-21	Current	Self - School Governor – Langynwyd primary school (Bridgend)	Not remunerated	18/06/2025
		Indirect Interests	Outside Employment	Aug-16	Current	Partner is the Chair of a Housing Association who provide social housing across a large geographical area (including Powys).	Remunerated part time role, 2-4 days per month	
		Indirect Interests	Outside Employment	Jul-24	Oct-24	Partner is listed on the Bank for PTHB - working occasionally for the organisation by dual agreement.	Paid per hour/day of work	
		Indirect Interests	Outside Employment	Sep-22	Current	Parnter - Public Appointment - Youth Work strategy and implementation Board - Oct 22 - Sept 24	Remunerated 2-4 days per month	
Director of Strategic Improvement and Transformation	**Lucie Cornish**	Nil	Nil	Nil	Nil	Nil	Nil	13/11/2024
Executive Director of Planning, Performance & Commissioning	**Nicola Johnson**	Nil	Nil	Nil	Nil	Nil	Nil	30/05/2025
Executive Director of Primary, Community Care and Mental Health	**Elaine Lorton**	Financial Interests	Outside Employment	Apr-24	Current	Independent Member – ateb - housing Association	Remunerated	30/05/2025
		Non Financial professional interests	Outside Employment	Nov-19	Current	Chair of the Board - Wet Wales Care and Repair	Voluntary	
		Indirect Interests	Outside Employment	Mar-23	Current	Family Member is an employee of Hywel Dda University Health Board (non Director)	Nil	
		Indirect Interests	Outside Employment	Sep-23	Current	Family Member employee of Aneurin Bevan Univeristy Health Board (non Director)	Nil	
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	Nil	25/10/2025 Started with PTHB October 2025

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE

UNCONFIRMED MINUTES OF THE MEETING HELD ON 23 OCTOBER 2025 at 09:30 VIA MICROSOFT TEAMS

MEMBERS		
Simon Wright	SW	Independent Member (Chair)
Mick Giannasi	MG	Independent Member (General)
Jennifer Owen Adams	JOA	Independent Member (Third Sector)
Ian Thomas	IA	Independent Member (General) (to 12.30)
Chris Walsh	CW	Independent Member (Local Authority)
IN ATTENDANCE		
Zoe Ashman	ZA	Assistant Director Nursing, Quality and Safety
Jonathan Boyd	JB	Chief Pharmacist (12.10 – 12.25)
Carl Cooper	CC	Chair of PTHB Board (observing)
Amanda Edwards	AE	Assistant Director Innovation and Improvement
Stella Gwynne	SG	Deputy Board Secretary
Jayne Laurence	JWS	Assistant Director Primary Care (11.45 – 12.10)
Elaine Lorton	EL	Executive Director of Primary Care, Community and Mental Health
Claire Madsen	CM	Executive Director of Allied Health Professionals, Health Sciences and Digital (from 11.21)
Chris Moss	CMo	Assistant Director Performance and Commissioning (09.35 – 10.13)
Paul Hooton	PHo	Executive Director of Nursing, Quality, Women and Family Health
Liz Patterson	LP	Head of Corporate Governance
Alexander Simmonds	AS	Deputy Director Allied Health Professions
Aime Symes	AS	Director of Midwifery, Women and Family Health (to 11.40)
Hayley Thomas	HT	Chief Executive
Kate Wright	KW	Executive Medical Director
APOLOGIES FOR ABSENCE:		
Helen Bushell	HB	Director of Corporate Governance / Board Secretary
Nicola Johnson	NJ	Executive Director Planning, Performance and Commissioning

1. PRELIMINARY MATTERS

1.1 WELCOME AND APOLOGIES (PEQS/25/58)

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

The newly appointed Executive Director of Nursing, Quality, Women and Family Health (PHo) was welcomed to the meeting.

1.2 DECLARATIONS OF INTEREST (PEQS/25/59)

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

2. CONSENT AGENDA BUSINESS

SW asked Members if they wished to bring forward any items from the Consent agenda to the main agenda. No items were raised by Committee Members.

SW noted that the Internal Audit report on the duty of Candour under the consent agenda would likely be of relevance to the discussion at Item 5.1 Integrated Quality Report on incident closure data.

3. ITEMS FOR APPROVAL / DECISION / RATIFICATION

3.1 MINUTES OF PREVIOUS MEETING (PEQS/25/60)

The minutes of the meeting held on 31 July 2025 were **CONFIRMED** as an accurate record, subject to the amendment of ZA's job title to *Assistant Director of Nursing, Quality and Safety*.

3.2 COMMITTEE ACTION LOG (PEQS/25/61)

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

- PEQS/24/83 (Transition of Care Annual Report) – request to defer to February 2026 Concern was expressed at the ongoing delays to the production of this report. The Committee expressed a clear expectation that future annual reports would be expected in a timely manner to the annual August Committee meetings.
- PEQS/25/14 (Staff experience of Mental Health and Learning Disability Services in escalation) – request to defer to February 2026.
- PEQS/25/08 (Funding for ND Services) – request to defer to February 2026.
- PEQS/25/37 (Quality of assessments in ND Services) – to be covered under item 4.1

The change of date requests were accepted.

Independent Members asked the following questions for assurance:

Should the Committee be concerned that a number of actions have been requested for deferral, and what is driving the delays?

HT acknowledged the substantial concern regarding the position in relation to open actions and undertook to complete an assessment of the position against reporting requirements to be brought to the next meeting.

Action: Chief Executive

Should action ARA/24/075 (Deprivation of Liberty Safeguards), noted for closure as a monitoring report is due to the Committee in February 2026, be retained as an open action until this report has been received?

SG agreed that it was appropriate that this action remained as an open action until the monitoring report had been received.

Could a verbal update be given on action PEQS/25/08 (funding for Neurodevelopmental services)?
AS advised a business case had been presented to the Investment and Benefits Group (IBG). The IBG were recommending to Executive Committee that the business case be approved. The outcome will be reported to the February 2026 Committee meeting in line with the extended deadline.

4. ESCALATED ITEMS

4.1 CHILDREN'S NEURODIVERSITY SERVICES (PEQS/25/62)

CMo joined 09.35

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

- The service had been escalated to level 3 due to specific triggers, detailed in the paper, and following an assessment showing significant progress, the Executive Committee approved a recommendation to de-escalate the service to level 2A.
- Two outstanding actions were incorporated into an updated implementation plan.
- A new model, including validated assessment tools, was being rolled out from November.
- Risks were identified around diagnostic oversight, implementation costs, and referral demand.
- Referral management changes had led to a reduction in assessments, with referrals now directed via a single point of access.
- Current waiting times were outlined, including patients waiting over 104 weeks, and a trajectory for improving wait positions was provided.
- The service was undertaking further assessments under the Integrated Quality and Performance Assessment Framework and reviewing sustainability conditions.
- Monthly meetings of the Escalation Oversight Group were scheduled to monitor progress and report to the Executive Committee and this Committee.

AS added that despite limited September data, the service was expected to meet the 104-week wait target. Internal measures had been taken, including cleansing the data to exclude cases where appointments were offered but not attended due to cancellations by the family, and clarifying how to account for children transferred from other health boards in relation to their waiting times. These adjustments revealed fewer true breaches than initially reported. Prioritisation of rescheduled appointments also supported progress and barring unforeseen issues such as high staff sickness, the team anticipated maintaining compliance with the 104-week target.

Independent Members asked the following questions for assurance:
What assurance can be given that in assessing the service for de-escalation clear, objective metrics and delivery thresholds (such as waiting times) can be sustainably met?
CMo advised that de-escalation criteria had been developed to include the conditions for sustainability, along with the performance and metrics required to meet this. The metrics will be circulated to Committee and progress will be included in the next report to the Committee.
Action: Executive Director for Planning, Performance and Commissioning

Can assurance be given that whilst addressing the backlog and waiting times, assessment quality is being maintained?
AS agreed the importance of maintaining assessment quality and explained that the use of validated tools was intended to standardise the assessment process across practitioners. Assessments were reviewed by a separate multidisciplinary team (MDT), ensuring that no single individual was solely responsible for diagnostic decisions. The validated tools formed

only part of the overall assessment, with the MDT playing a central role. Improvements had been implemented not only due to escalation but also in response to feedback from families, whose concerns and experiences had informed the changes.

Is there sufficient resource to implement the validation tools which enable assessments to be undertaken effectively? Are the validations tools being applied consistently across the team?
AS acknowledged that the implementation of validated tools is a cost pressure and risk. Actions are being taken via an application to the IBG to secure a sustainable service.

Is there a reputational risk of having 16 patients waiting over 104 weeks?
HT advised that the annual plan had been developed with the intention of ensuring there were no waits beyond 104 weeks and the team are focussing on ensuring this target is met and maintained. Other Health Boards also struggle with this service and benchmarking data would be beneficial in the next report.
Action: Executive Director for Planning, Performance and Commissioning

What notice do parents receive for appointments, particularly where children are 'not brought', and do missed appointments affect a child's position on the waiting list?
AS advised that the team worked with families to rebook appointments with the intention of ensuring that the 104 week wait is not breached. Whilst the triage system is in place for new referrals, there are some patients already on the list who it may be possible to signpost elsewhere.

CM advised that the Was Not Brought policy had been strengthened with strong operating procedures and processes. Regular monitoring of children not brought takes place.

The Committee noted that whilst there was evidence of robust oversight sustainability still felt challenging in relation to the continuing long waits, workforce challenges and uncertainty regarding funding.

The Committee:

1. Took **ASSURANCE** that the implementation of the IQPF Escalation Oversight mechanism is providing robust oversight of the quality improvement and risk mitigation work being undertaken within Neurodevelopmental Services.
2. **NOTED** and **DISCUSSED** the contents of the report and including the progress made on the implementation plan, and updated maturity assessment.
3. Took **ASSURANCE** that ongoing monitoring and evaluation mechanisms are in place as part of the Integrated Quality and Performance Framework.

CMo left 10.13

4.2 PEOPLE'S EXPERIENCE FRAMEWORK UPDATE (PEQS/25/63)

ZA presented the People's Experience Framework paper which provided an update regarding the implementation of the Framework.

Independent Members asked the following questions for assurance:
When completing the self-assessment, what was the response rate across the services?
ZA confirmed that compliance across the services had been 100%.

Given its positive feedback, should the implementation of SMS texting to seek patient feedback be mandated rather than only encouraged?

ZA advised that there was a cost associated with SMS texting and the Health Board are targeting the approach for best value, for example in relation to appointment reminders.

Has the semantic shift from 'patient' to 'people' been driven by Welsh Government and was this consulted on?
ZA confirmed the change in terminology was introduced through extensive public engagement across Wales. The aim was to broaden the scope of feedback collection beyond patients, recognising that everyone's experience within the health system matters. This shift aligns with upcoming regulatory changes, such as the rebranding of the PTR (Putting Things Right) regulations to "Listening to People" from April 2026, reinforcing the emphasis on inclusive language and experience.

How will collaboration with external agencies such as Llais and PAVO be structured to ensure consistent definitions and shared understanding of experience across organisations?
ZA advised there is a robust structure in place for collaboration with Llais and PAVO. Both organisations participate in the People's Experience Group and also engage in separate meetings to share feedback in both proactive and reactive ways.

How can the Health Board be assured that the organisation is actively learning from the information received, triangulating it with other learning processes, and clearly demonstrating that learning? How does the Health Board feedback to stakeholders that their input has been heard and acted upon?
ZA noted that the service had begun working locally with teams to ensure feedback received through platforms like Civica and advocacy channels is shared and understood at the local level to influence services. As part of implementing the framework and conducting self-assessments, teams were keen to understand the nature of the feedback. However, it was noted that some teams retained their own feedback without sharing it centrally, which limited organisational oversight. Efforts are underway to establish a more robust and consistent process for collecting and sharing feedback across all areas.

Given Civica's central role in delivering the People's Experience Framework, what is the current challenge in ensuring the system is fit for purpose?
ZA advised the Civica reporting hierarchy had been reviewed and refined to make feedback more accessible and relevant to individual teams. Previously, services were grouped too broadly, but the updated structure allows for more targeted insights. This is expected to be in place by November.

Is receiving feedback from 10% of people using commissioned services sufficient, or should this area be prioritised further to improve response rates and inform strategy?
PHo agreed that feedback from people using commissioned services needs greater focus although current capacity may be limited. The Health Board should be equally accountable for the care it commissions as for the care that it provides.

Is there a more detailed implementation plan behind the general Quarter 3 target mentioned in the paper, and if so, how is it being progressed and monitored given the lack of clear milestones or deliverables in the report?
ZA confirmed the implementation plan would be monitored by the Patient Experience Group. The implementation plan will be brought to the next meeting of the Committee.
Action: Executive Director of Nursing, Quality, Women and Safety

Are compliments currently underrepresented?
ZA confirmed that the organisation receives many compliments, but they are not recorded uniformly and there is work to do to improve this.

How are different cultural perspectives, such as those within Welsh-speaking communities, being considered in the shift from referring to individuals as "patients" to "people"?
ZA advised that this question had not been raised locally or nationally.

The Committee:

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

5.ITEMS FOR ASSURANCE

5.1 INTEGRATED QUALITY REPORT (PEQS/25/64)

ZA introduced the report and drew attention to the following areas:
Concerns and PTR Compliance

- PTR response rate: 94.7% of formal concerns responded to within 30 days; average response time is 29 days.
- Volume: Monthly concerns remain steady (5–8), mostly resolved promptly within 2–3 days.
- Themes: Difficult to define due to low numbers.
- Regulatory update: PTR regulations will be replaced by the *Listening to People* framework from April 2026, introducing managed timeframes and a strengthened duty of candour.

Duty of Candour and Redress

- Reporting: Some over-reporting noted last year; now being addressed with clearer triggers and team support.
- Redress: 8 cases have triggered redress since inception.
- Compliance: 100% compliance with reimbursement processes; no penalties received.

Incident Management

- Volume and Harm Levels: Most incidents are low or no harm; some initially reported as severe are later downgraded after review.
- Review Process: Incidents reviewed within 48 hours; moderate/severe cases managed under duty of candour or national reporting.
- Backlog: Incidents from 2021–2024 targeted for closure by Christmas; 2025 incidents to be managed early next year.
- Compliance: Current closure compliance is 34%, monitored weekly/monthly.

National Reportable Incidents (NRIs)

- Progress: Many NRIs closed in Q2; others downgraded after investigation.
- Family Communication: Outcomes and closure letters shared with families.

Framework and Governance

- Incident Management Framework: Under review for improved robustness and timeliness; update due to Executive Committee in November.
- Complex Cases: Some delays due to external factors (e.g. criminal investigations, other organisations).

- Sign-off Process: Sometimes delayed due to further information requests; being reviewed for efficiency.

Infection Control and ANTT (Aseptic Non-Touch Technique)

- Q2 Performance: No lost days due to infection.
- ANTT Training: Delivered to 17 staff; final improvement plan action now complete.

Regulatory and External Engagement

- Public Services Ombudsman for Wales: A revised letter received, and response submitted; no increase in concerns this year, however, the reported compliance rate of 33% with recommendations in 2024/25 is noted and immediate action is being taken to strengthen internal monitoring and escalation to ensure the agreed recommendations are implemented within the timescales set.
- Healthcare Inspectorate Wales: Outstanding actions reducing; no overdue actions.
- Bereavement Framework: Active development across services; stakeholder engagement underway.
- Medical Examiner: Positive data; timeliness improvements in progress.
- Regulation 28: Action plan submitted early following a Coroner's Notice.

Quality Improvement and Future Planning

- Acute Deterioration Workstream: NEWS2 (National Early Warning Score 2) implemented; future work includes enabling families to raise concerns.
- Welsh Health Circular: Expected in 2026; implementation by 2027.
- Service-Level Reporting: Maternity, community, and mental health services show low concern volumes and active learning.
- Commissioned Services: Feedback and concerns triangulated with NRIs and internal data; ongoing collaboration with commissioning teams.

SW drew attention to the high volume of historic incidents that had not been closed within expected timeframes (5-7 days) querying why this had not been previously reported to Committee and asking for clarity on potential impact, including whether opportunities for learning or communication with those who had raised concerns had been missed. The need for urgent action and sustainable assurance measures to prevent recurrence was stressed and further views from the Committee were invited.

Independent Members asked the following questions for assurance:
Given the depth of the report and the recent deep dive into the data, what areas are performing particularly well, and what should the committee be most focused on to ensure continuous improvement in quality across the organisation?
ZA expressed the opinion that there were opportunities to improve the timeliness and sustainability of incident closure and the potential to better capture and use positive and negative experience to inform system development.

The report highlights commendable work and good practice but also indicates challenges in managing the volume of incidents, complaints, and concerns which may affect response times and learning effectiveness. The Committee should seek assurance on resourcing, prioritisation, and oversight, especially for NRIs and serious harm cases, and consider a deeper dive into this area may be warranted in future meetings or outside the committee setting.
EL acknowledged that there were three operational areas that were underperforming in closing incidents and emphasised the need to share learning across teams to ensure the administrative follow-up after initial reviews is handled consistently. While confident that actions are in place to address the backlog and maintain oversight going forward, it was acknowledged that learning has not yet been fully shared due to the volume of open cases.

Improvements are expected by the next meeting in February, with the backlog cleared and only current year incidents remaining.

KW noted that Mental Health services previously under escalation were now performing well and noted that the weekly Datix huddles that had helped maintain timely reporting had been shared as good practice via the Learning Group. However, there is a need to ascertain if this learning has been effectively cascaded across the organisation.

HT noted the information contained within the report which had been presented to the Executive Committee last week. Further detail had been provided to the Executive Committee which demonstrated on a line manager basis where the backlog in closure of incidents were. This is in four or five key areas, and it will be important to move swiftly from reporting the problem to supporting targeted action to ensure it is addressed. This may be a result of capacity concerns in particular areas, and potentially capability concerns regarding sign off of the response. HT suggested that the Committee may request a further report in February and additionally an interim report in one month to provide clarity on actions taken to address the backlog and progress in addressing it.

The Committee requested the further report on actions taken to address the backlog of incident closure and progress thereon to be provided one month after the Committee and to the next meeting of the Committee in February 2026.
Action: Executive Director of Nursing, Quality, Women and Family Health

Independent Members also made the following observation:
Given that Quarter 2 data in the report is only partially complete, is there a way to better align reporting cycles with the committee's meeting schedule to avoid delays in scrutiny, potentially up to six months.
Action: Director of Corporate Governance

The Committee **RECEIVED** the report and took **ASSURANCE** that Quality and Safety is appropriately monitored and reported and that continued actions are in place to further develop quality and safety monitoring and reporting.

5.2 MATERNITY ASSURANCE REPORT (PEQS/25/65)

AS presented the report which assessed maternity services against the 10 recommendations made in the independent review of maternity services in Swansea Bay University Health Board and drew attention to the following matters:

- The service is safe and stable with an overall conclusion of partial assurance with some areas of reasonable and substantial assurance.
- Plans are in place to address the remaining gaps over the next three to six months

Independent Members asked the following questions for assurance:
It is of concern that some services that are commissioned are sub-standard. Can future reports provide additional detail on how assurance is provided and how oversight will be strengthened through the development of the dashboard and improved use of data.
Action: Executive Director of Nursing, Quality, Women's and Family Health

Is the research on extending the Maternity Early Warning Scores to community settings linked to a University and what is the delivery timescale?
AS confirmed the research is tied to Swansea University and it is expected to report in December. In the meantime, existing arrangements for monitoring patients remain in place.

Is foetal monitoring training provided locally or nationally?
AS confirmed the training was provided nationally.

HT noted that the Health Board have worked with neighbouring Health Trusts and Boards on maternity inquiries over many years. This self-assessment against the findings of the Swansea Bay report is ahead of the imminent national self-assessment. It will be necessary to strengthen the maternity dashboard along with other matters identified in the report over the next few months. The Board will also need to take the opportunity to reflect on the balance of the organisation as a provider and commissioner.
Action: Director of Corporate Governance

The Committee:

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

5.3 PATIENT EXPERIENCE – DENTAL QUALITY INCLUDING: ACTION 'HOW QUALITY IS MEASURED IN GENERAL AND COMMUNITY DENTAL SERVICES' (PEQS/25/66)

JL joined the meeting 11.45

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

- The paper offers assurance on the multiple processes in place to monitor the quality and safety of General Dental Services (GDS) and complements the broader Commissioning and Assurance Framework report recently reviewed by the Executive team and presented to the Finance and Performance Committee.
- NHS dentistry monitoring is led by the GDS Monitoring Group, which includes clinical, financial, and contractual representatives.
- Around 10–11 key monitoring processes contribute to overall assurance.
- Dentists must be registered with the General Dental Council and listed on a Welsh dental performance list.
- A formal performance list review group reviews concerns and escalates unresolved issues to the national framework, potentially leading to licence conditions or suspension.
- Contractors submit annual self-audits; non-compliance is followed up locally.
- Annual and mid-year contract reviews are conducted, with overlap between quality and contractual aspects.
- Locally, five record card reviews were conducted in the past year, some with repeat reviews and action plans.
- Two performers had conditions placed on their registration, including one suspension.

Independent Members asked the following questions for assurance:
How does the Health Board triangulate the contractors self-reporting with other data sources?
JL confirmed that triangulation is in place, specifically regarding quality, contractors conduct self-audits, and during mid-year and end-of-year review visits, higher-risk areas of those audits are spot-checked. Examples include examining autoclave calibration certificates and fire compliance documentation. A list of high-risk areas is maintained for

these checks, and every practice receives an annual review visit to ensure at least yearly verification of the issues identified by the contractors themselves.

The paper outlines the quality of dental service, but not the effectiveness of these services. Where is this information provided?
JL advised that under revised reporting arrangements the Finance and Performance Committee recently received information on budget, under-delivery, financial clawback, and service recommissioning. It is intended to provide a further report on access to dental services. A suite of reports are presented to Executive Committee over the year to cover all aspects of dental services and routed to Board Committees as appropriate.

HT acknowledged challenges in presenting a complete view of dental service monitoring, noting previous discussions at Executive Committee. The balance between comprehensive reporting and avoiding repetition across multiple committees remains unresolved. While separating components are being trialled, HT suggested the Chairs Forum reflect on the best reporting approach, with a possible return to the previous method.
Action: Director of Corporate Governance

What does the monitoring process look like from the perspective of a dentist. Is the level of scrutiny and challenge proportionate, and are clinicians able to focus on their clinical responsibilities without being burdened by the process?
JL confirmed that most elements of the monitoring process were part of national NHS regulation, and the systems in place locally were designed to monitor what was already required nationally under the dental contract and its supporting regulations.

What is the process following the identification of quality and probity issues flagged by the NHS Business Services Authority (NHSBSA). Do the NHSBSA conduct further investigations themselves or is the matter was referred to the Health Board, potentially involving counter fraud?
JL explained that the NHSBSA was responsible for conducting all fact-finding, evidence gathering, and review activities and submit their independent report to the Health Board. The Health Board then determine the appropriate course of action based on the report's findings. This could involve escalation to the performance list review group, referral to the counter fraud department if the issue related to probity, or the implementation of a local action plan within the GDS Monitoring Group. The Health Board also met with the relevant practice and dentist as part of the follow-up process.

Given that dentists do not have NHS email addresses and cannot use the Datix system for reporting, is the alternative time-consuming, and are there any plans to provide dentists with NHS email accounts to enable integration into the standard data management system, which could improve understanding of challenges and incidents?
JL confirmed that the lack of NHS email addresses meant that dentists were unable to submit electronic reports on Datix but was not aware of any plans to issue dentists with NHS email accounts.

The Committee

- **RECEIVED** the report, and
- Took **ASSURANCE** that systems and clinical governance processes are in place to monitor the quality of primary care dentistry.

JL left 12.05

5.4 CLINICAL AUDIT: 2024/25 UPDATE ON OUTSTANDING ITEMS, AND 2025/26 PROGRESS REPORT (PEQS/25/67)

KW presented the report outlining that the summary from 2024/25 indicated that most outstanding audits were now complete or in progress with podiatry flagged red although that was not clinically critical. The audit plan for 2025/26 was progressing well, with most audits either underway or completed, and none appearing significantly overdue. It was noted that the Surgery and Endoscopy Service was reviewing its audit plan to address duplication with an update expected in due course. Additionally, work was ongoing to establish how service groups were integrating audits into their clinical governance mechanisms, in line with the committee's action plan.

CM confirmed that delays in relation to the podiatry audit related to the recording of appointments and collection of data and was not clinically risky.

Independent Members asked the following questions for assurance:
There are a number of yellow status audits (external factor influenced). Is this a growing trend?
KW confirmed that a number of audits were waiting for national digital systems which had been delayed. It will be necessary to check to ascertain if it is necessary to undertake any manual audits in the meantime.

HT advised that the clinical audit plan showed improved balance across service areas compared to previous years. This progress was acknowledged; however, further development was needed to align audit activity with areas requiring attention. A potential area includes revisiting audit activity in inpatient ward areas within the Community Services Group. Targeted work had addressed previously lighter areas, and the overall approach was seen as maturing year on year.

The Committee:

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

5.5 MEDICINES MANAGEMENT ANNUAL REPORT 2024/25 (PEQS/25/68)

JB joined the meeting 12.10

JB presented the report and drew attention to the following areas:

- The Community Services Team supports hospital wards by ensuring safe medication use, assisting medical and nursing staff, and preparing patients for discharge with training in self-administration.
- The Primary Care Team works closely with GP practices and contributes significantly to cost-saving initiatives with efforts focussed on using cost-effective medicines, resulting in strong financial returns and successful projects.
- The Vaccines Team conducts audits to reduce waste, is preparing for a new central flu vaccine procurement process and works with providers to ensure smooth delivery and high vaccination rates.
- A dedicated Antimicrobial Pharmacist was recruited last year which has led to major improvements in data, especially regarding broad-spectrum antimicrobials. The Health Board is now performing well compared to others, particularly in reducing use of co-amoxiclav.
- Plans are underway to launch an electronic prescribing and medicines administration (EPMA) system initially for inpatient wards, with future rollout to outpatient settings

which is expected to improve patient safety and generate valuable data on medicine use and delivery.

Independent Members asked the following questions for assurance:
What actions are being taken to reduce the pharmaceutical bill and improve efficiency?
JB explained that the two main areas of focus were primary care prescribing and horizon scanning for drugs coming off patent. The team worked with GP practices to ensure patients were prescribed the most cost-effective options, particularly within the anticoagulant group known as DOACs. It was important to maintain strong relationships with practices, as the team did not have the resources to implement changes directly. Instead, there is a focus on educating prescribers to encourage sustainable prescribing practices that support cost savings.

Are the costs savings being achieved without compromising quality, and whose responsibility is it to ensure patients are being adequately reassure when their medication changes?
JB responded that patient reassurance was a key concern and often the most time-consuming aspect for GPs and prescribers. The team provided appropriate letters and patient information material and offered to speak directly with patients to address queries at the request of GPs. For high-cost biologic drugs, patients were introduced early in the consent process to the concept of biosimilars (cheaper alternatives that offer the same therapeutic effect). This approach helped manage expectations and reinforced the message that cost-effective prescribing did not compromise care quality.

The 15% switch rate is noted, given the cost savings that can be made what more can be done to increase acceptance?
JB noted that the 15% switch rate related to decision support software used in GP practices which suggest more cost-effective alternatives. The acceptance rate could potentially reach 20% but it was important to avoid message fatigue among prescribers.

How is the consistency and uptake of discharge medicines reviews being managed across commissioned services?
JB explained that discharge medicines reviews were a service offered by community pharmacies to patients following hospital discharge. Implementation was challenging in Powys due to geographical factors and the absence of a centrally located district general hospital. However, the Health Board supported community pharmacists and encouraged uptake of the service through commissioned providers. Patients often had questions once they returned home, and strengthening these connections helped improve outcomes.

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

5.6 MEDICAL DEVICES AND POINT OF CARE TESTING ANNUAL REPORT 2024/25 (PEQS/25/69)

CM presented the report noting key achievements of the service includes progress on audit recommendations, a robust equipment catalogue, a new cost-effective maintenance contract, and the rollout of new glucose monitors and radiography equipment. Remote monitoring software has eased workload, and environmental sustainability is prioritised in contract decisions. Although the team does not manage the equipment budget, it has delivered notable cost savings, particularly for community services.

Independent Members asked the following questions for assurance:

Have delays in syringe driver training led to patients being unable to return to the Health Board, potentially causing delayed transfers elsewhere in the system, or, have patients ready for discharge been prevented from going home due to a lack of skills among community teams to manage syringe drivers?
CM responded that no incidents had been reported indicating such delays.

To what extent is future service repatriation being considered in the organisation's strategy for equipment purchasing? Is the current approach focused only on short-term needs or is there a longer-term plan to support the delivery of repatriated services through investment in medical equipment?
CM responded that the team was very proactive including having business cases prepared in advance to take advantage of end-of-year funding opportunities. The successful acquisition of advanced radiology equipment, including one of only two machines capable of 360-degree jaw imaging, and the addition of AI diagnostic tools was one such example. In addition, the rollout of state-of-the-art glucose monitoring and respiratory testing equipment, has supported the repatriation of respiratory services. The team consistently looked ahead to identify opportunities for repatriation and ensured that the necessary equipment was secured to support service delivery.

The Committee **RECEIVED** the report and took **ASSURANCE** that the necessary responsibilities in relation to Medical Devices and Point of Care Testing are being met.

5.7 COMMITTEE RISK REGISTER (PEQS/25/70)

SG presented the report noting the data was the same as that presented to the meeting in July. Board would receive an updated Strategic Risk Register to its meeting in November.

The Committee
- **RECEIVED** the corporate risks within the committee's remit, 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

7.1 INTERNAL AUDIT REPORTS (PEQS/25/71)

The Committee **RECEIVED** the Duty of Candour (Reasonable Assurance) Internal Audit Report which had been received by the Audit, Risk and Assurance Committee on 07 October 2025.

7.3 WORK PROGRAMME (PEQS/25/72)

The Work Programme was **RECEIVED.**

8. OTHER MATTERS

8.1 ANY OTHER URGENT BUSINESS (PEQS/25/73)

There were no items of any other business.

8.2 ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND/OR OTHER COMMITTEES (PEQS/25/74)

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.

8.3 COMMITTEE REFLECTION (PEQS/25/75)

The following summary of business and reflections were provided by members:
- SW was commended for chairing his first meeting effectively, managing time well despite a packed agenda.

- Members praised the high quality and depth of the papers presented, noting they covered significant and complex issues.
- There was a suggestion to improve how colleagues present papers, focusing on a brief summary of key points rather than a longer reading through them to both better guide and allow time for Committee questions and discussions.
- Members emphasised the importance of arriving prepared, having read the papers, to allow meaningful discussion.
- The papers offered a valuable window into the organisation, highlighting both pressures and examples of good work by small, dedicated teams.
- Common challenges were noted across services, including data quality, reporting gaps, workforce capacity, delayed digital implementation, and service backlogs.
- Incremental fixes were insufficient and that broader transformation was needed to address systemic issues.
- HT echoed the need to reflect on sustainability across services and suggested carving out time to align this with annual planning priorities.
- The openness and receptiveness of the Executive team to Committee discussions were highlighted as a key strength moving forward.

8.4 DATE OF NEXT MEETING (PEQS/25/76)

The date of the next meeting is scheduled on 05 February 2025 via Microsoft Teams.
Meeting closed 12.39.

8.5. CONFIDENTIAL MATTERS

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

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

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

PRESENT		
Simon Wright	SW	Independent Member (Chair)
Mick Giannasi	MG	Independent Member (General)
Jennifer Owen Adams	JOA	Independent Member (Third Sector)
Ian Thomas	IA	Independent Member (General)
Chris Walsh	CW	Independent Member (Local Authority)
IN ATTENDANCE		
Carl Cooper	CC	Chair of PTHB Board
Stella Gwynne	SG	Deputy Board Secretary
Liz Patterson	LP	Head of Corporate Governance
Hayley Thomas	HT	Chief Executive
Kate Wright	KW	Executive Medical Director
APOLOGIES FOR ABSENCE:		
Helen Bushell	HB	Director of Corporate Governance / Board Secretary

8.6 WELCOME AND APOLOGIES FOR ABSENCE (PEQS IC/25/77)

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

8.7 DECLARATIONS OF INTEREST (PEQS IC/23/78)

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

8.8 MINUTES OF THE IN-COMMITTEE MEETING HELD ON 31 JULY 2025 (PEQS IC/25/79)
The minutes of the In-Committee meeting held on 31 July 2025 were **APPROVED**.
8.10 ANY OTHER BUSINESS (PEQS IC/25/80)
There was no other business.

Meeting closed at 12.43

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 (05 February 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/25/14	Executive Director of Primary, Community Care and Mental Health.	Staff Experience of Mental Health and Learning Disability Services in escalation	To receive an assurance report on post escalation monitoring after one year	**Update 31.07.2025** Not yet due **Update 23.10.2025:** Agenda prioritised for October, item added to work programme for Feb 2026, date change requested **Update 05.02.2026: Agenda item deferred in discussion with Committee Chair due to agenda pressure. Item moved to April 2026**	Oct-25	Apr-26	At risk
25-Oct-25	PEQS/25/62b	Executive Director of Planning, Performance and Commissioning	Children's Service Neurodiversity	Benchmarking waiting times for ND services	**Update 05.02.2026:** Action not yet actioned, date change requested to April 2026.	Feb-26		At risk
25-Oct-25	PEQS/25/63	Executive Director of Nursing, Quality, Women and Family Health	People's Experience Framework	Implementation plan to be brought to next meeting of PEQS	**Update 05.02.2026:** Agenda item / update on agenda for 05.02.26. Implementation plan not provided - proposed that the item is discussed and further action agreed	Feb-26		At risk
25-Oct-25	PEQS/25/65b	Director of Corporate Governance	Maternity Assurance Report	Board to be given an opportunity to reflect on the balance of the organisation as a commissioner and provider	**Update 05.02.2026:** This action has been transferred to the Board development agenda. It is not intended to report back to PEQS on this action.	Feb-26		Transferred
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.	Feb-26		Transferred
OPEN ACTIONS - IN PROGRESS BUT NOT YET DUE OR ARE ONGOING - (05 February 2026)								
OPEN ACTIONS - IN PROGRESS BUT NOT YET DUE								
30-Apr-25	PEQS/25/12	Executive Medical Director	Clinical Audit Programme	The Annual Clinical Audit Report to include detail on assurance routes for reporting	**Update 31.07.2025** Clinical Audit is rapidly evolving and this action will be addressed in more detail in the July 2026 Plan	Jul-25	Jul-26	On track
ACTIONS RECOMMENDED FOR CLOSURE (MEETING 05 February 2026)								
25-Oct-25	PEQS/25/62a	Executive Director of Planning, Performance and Commissioning	Children's Service Neurodiversity	De-escalation criteria metrics to be circulated to PEQS and included in the next report to PEQS	**Update 05.02.2026:** Conditions of sustainability circulated via email on 28.11.2025	Feb-26		Completed
25-Oct-25	PEQS/25/64b	Director of Corporate Governance	Integrated Quality Report	Check cycle of PEQS meetings to ensure timely data reporting	**Update 05.02.2026:** This has been checked and agreed with the AD Nursing, Quality and Safety	Feb-26		Completed
14-Jan-25	ARAC/24/075	Executive Director of Nursing, Quality, Women and Family Health	Items to be brought to the attention of other Committees	Deprivation of Liberty Safeguards to be transferred to PEQS for monitoring progress against recommendations	**Transferred to PEQS Committee from ARAC** **Update 11.02.25:** Item added to work programme for 2025/26. The internal audit report has been shared for information within the agenda and papers for the 11.02.25 meeting DCG undertook to confirm date for this to be considered with EDNQWFH - agreed as July 2025 **Update 31.07.2025:** monitoring report included at agenda item 5.5. Committee to agree future monitoring arrangements **Update 23.10.2025:** update aginst audit action provided to ARAC in October, update scheduled to PEQS Committee in February 2026 **Update 05.02.2026:** The progress report is included on the PEQS agenda at item 7.3. All actions against recommendations complete. Request closing this action and advising ARAC of postition.	Jul-25	Feb-26	Completed
30-Apr-25	PEQS/25/08	Executive Director of Planning, Performance and Commissioning	Children's Service Neurodiversity	Details regarding funding for service to be included in the next update to Committee	**Update 31.07.2025** A verbal update will be given at the meeting **Update 23.10.2025:** further work is required in this area, date change requested to next meeting in Feb 26 **Update 05.02.2026:** Actions included within scheduled agenda item/paper.	Jul-25	Feb-26	Completed
25-Oct-25	PEQS/25/61	Director of Corporate Governance	Action Log	Assessment of the number of actions remaining open for PEQS	**Update 05.02.2026:** Review undertaken and all actions fully updated.	Feb-26		Completed
25-Oct-25	PEQS/25/64a	Executive Director of Nursing, Quality, Women and Family Health	Integrated Quality Report	Actions taken to address the backlog of incident closure and progress thereon to be provided one month after the October 2025 meeting of PEQS and to the next meeting in February 2026	**Update 05.02.2026:** An interim report was provided to PEQS Members on 03.12.25. **Update 05.02.26 -** Interim update provided as scheduled in December. Further update provided in the IQR for Feb 2026 meeting	Feb-26		Completed
25-Oct-25	PEQS/25/65a	Executive Director of Nursing, Quality, Women and Family Health	Maternity Assurance Report	Future maternity assurance reports to include additional detail on assurance on commissioned services	**Update 05.02.2026:** This information is included within the report to the February 2026 meeting but recognise there is more work to do. Item also added to the 2026/27 work programme.	Feb-26		Completed
11-Feb-25	PEQS/24/83	Executive Director of Nursing, Quality, Women and Family Health	Transition of Care Annual Report	Transition of Care Annual Report to be brought to July meeting where a review of the frequency of monitoring will take place	**Update 31.07.202:** the Annual Report has not been completed - a request to defer to October meeting **Update 23.10.2025:**due to staff change and resource prioritisation, the report has been drafted but not completed - change request made to Feb 2026 **Update 05.02.2026:** Update paper provided within In-Committee agenda. Action marked as closed as position clarified.	Jul-25	Feb-26	Completed

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 4.1

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE	**05 February 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 and 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; 05 February 2025; 19 March 2025 and 23 April 2025; 23 July 2025; 15 October 2025. Patient Experience, Quality and Safety Committee 07 Nov 2024, 11 February 2025; 29 April 2025; 31 July 2025, 23 October 2025. This report is scheduled to Executive Committee on 4 February 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 (PEQS) Committee with an update on current progress.

RECOMMENDATION(S):

The Committee is asked to:

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

3. **TAKE ASSURANCE** from the ongoing monitoring and evaluation mechanisms in place as part of IQPF.		
Approve/Take Assurance	**Discuss**	**Note**
Y	Y	N

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

EXECUTIVE SUMMARY

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

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

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

DETAILED BACKGROUND AND ASSESSMENT

Background

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

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

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

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

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

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

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

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

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

The aim of the EOG is to:

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

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

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

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

Progress to date

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

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

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

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

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

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

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

The most recent meeting of the CYP Neurodevelopmental Service EOG was held on the 20 November 2025 (bi-monthly meeting scheduled for January 2026, cancelled due to apologies) with the following progress updated noted:

- Business Case was presented to the Health Board Investment and Benefits Group (IBG) on the 18 August 2025 seeking recurrent financial investment to deliver a sustainable, robust service which is compliant with both Welsh Government standards and NICE; and which will deliver timely assessments,

pre and post diagnostic support. It was agreed in principle and a request made to summarise the business case and presented to the Executive Committee (planned for February 2026 tbc).

- New model roll out November clinics (Validated Assessment Tools) including wider support from CAMHS January 2026 onwards.

- Risks identified:
  - 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.
  - Formal notification that ND RIF funding will cease from 31/03/2026 (£154,000). Final year of RIF is being ringfenced to pilot a multi-agency single point of access for emotional wellbeing and ND.
  - Anticipate wider NDIP funding from WG will continue (£234,000) but yet to be confirmed.

- Performance
  - Expected impact of role of out multi-agency early help and support, single point of access (SPOA) panel. Anticipated that referrals will be reviewed in the SPOA and directed accordingly with those to be accepted through diagnostic assessment waiting list pulled through to referrals for the team.
  - Waiting List - Total of 905 CYP waiting for a first appointment on 31st December 2025; 7 waiting >104 weeks.

Neurodevelopment (ASD and ADHD)		Census Date									
		30/06/2025	31/07/2025	31/08/2025	30/09/2025	31/10/2025	30/11/2025	31/12/2025	31/01/2026	28/02/2026	31/03/2026
Activity Date Range		01/06-30/06	01/07-31/08	01/08-31/08	01/09-30/09	01/10-31/10	01/11-30/11	01/12-31/12	01/01-31/01	01/02-28/02	01/03-31/03
Actuals	Patients waiting up to and including 182 days (<26weeks)	230	240	210	182	179	206	209			
	Patients waiting 183 days and over up to and including 364 days (26 -51 weeks - 1 Year)	274	236	231	237	222	177	178			
	Patients Waiting up to an including 364 days (<52 weeks - 1 Year)	504	476	441	419	401	383	387	0	0	0
	Patients waiting 365 days and over up to and including 729 days (52 - 103 weeks, 1-2 years)	518	569	501	503	491	513	511			
	Patients waiting 730 days and over up to and including 1094 days (104 - 155 weeks/ 2-3 years)	2	43	22	3	0	1	7			
	Patients waiting 1095 days and over up to and including 1459 days (156-207 weeks/ 3-4 years)	0	0	0	0	0	0	0			
	Patients waiting 1460 days and over (>=208 weeks/ 4 years)	0	0	0	0	0	0	0			
	Total Waiting	1024	1088	964	925	892	897	905	0	0	0

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

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

Next steps

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

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

The service has previously completed a baseline assessment in November 2024, and an assessment review in March 2025, which have been presented to PEQS. A further assessment review will be undertaken by the service and presented to the next meeting of the EOG on the 24 February 2026.

A Conditions for Sustainability self-assessment tool has also been developed as part of the EOG process, designed to be used for self-assessment of the service against a number of domains identified as essential for a sustainable service. The service has previously undertaken an assessment review in April 2025 which was presented to PEQS. A further assessment review will be undertaken by the service and presented to the next meeting of the EOG on the 24 February 2026.

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

Regular progress reports will continue to be presented to future meetings of both the Executive Committee and PEQS.

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Agenda item: 4.2

Patient Experience and Quality Committee	**05 FEBRUARY 2026**
Subject:	**People's Experience Framework – January 2026**
Approved and presented by:	Executive Director of Nursing, Quality, Women and Family Health
Prepared by:	People's Experience Lead
Other Committees and meetings considered at:	Executive Committee – 29 January 2026 who supported the paper to PEQS.

PURPOSE:

The purpose of this report is to provide the People, Experience and Quality & Safety Committee (PEQS) with a focused update on the progress of Powys Teaching Health Board in implementing the national People's Experience Framework (PEF), including:

- progress since the last PEQS report
- the current status of the draft PTHB People's Experience Strategy
- the proposed timeline for completion, consultation and approval of the Strategy
- arrangements for implementation, monitoring and ongoing assurance.

This report does not cover the routine reporting on Patient Experience, which is reported through the Integrated Quality Report (IQR).

This report is presented to PEQS 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 updating on progress in developing the PTHB Peoples Experience Framework **NOTING** the later than anticipated timescale to finalise the Framework;
- Take **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.

Approve/Take Assurance	Discuss	Note
Y	Y	Y/N

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	Use this space to provide a brief narrative explanation of alignment with the health board's wellbeing objectives including reference to our strategic priorities. This can include reference to the Board Assurance Framework.
2. Provide Early Help and Support	Y	
3. Tackle the Big Four	N	
4. Enable Joined up Care	Y	
5. Develop Workforce Futures	N	
6. Promote Innovative Environments	N	
7. Put Digital First	N	
8. Transforming in Partnership	N	

EXECUTIVE SUMMARY:

1. Situation

1.1 In April 2025, Welsh Government launched the national People's Experience Framework, placing a requirement on Health Boards to implement robust systems for capturing, analysing and acting on people's experience.

The People's Experience Lead was appointed in June 2025 to lead implementation of the national People's Experience Framework within PTHB.

1.2 At PEQS, members previously noted the need for clearer governance, consistency and assurance regarding People's Experience arrangements. Additionally noting the requirement for clear oversight, delivery milestones and assurance reporting against the implementation of the framework.

Therefore this report provides:

- Details of the self-assessment undertaken for benchmarking to inform the strategy and provide a current position
- A PTHB-specific Strategy for implementation of the national People's Experience Framework, for early noting and comment by committee members, with formal consultation for public, staff and stakeholders to follow
- Progress against the implementation plan (appendix 1)

1.3 This report does not provide detail of current patient experience as this is routinely reported within the IQR. This report is by exception to provide updates, including clarity on the framework's development status and implementation timeline. Future quarterly progress updates against the framework implementation will feature in the IQR.

2. Current Position

2.1 A draft Powys Teaching Health Board People's Experience Strategy has been developed, aligned to the Welsh Government national People's Experience

Framework and the Duty of Quality requirements. This provides the foundation for a consistent, system-wide approach to capturing, analysing and acting on people's experience and fully implementing the framework. The draft strategy is included in the Committee papers as background paper to offer assurance of progress, and will be made available into the public domain in due course.

2.2 To inform this work, a system-wide self-assessment has been completed by services, providing a clear baseline of current practice across all framework domains. The self-assessment has identified both, areas of strength, and areas requiring further development, and has been used to shape priority actions and the structure of the Strategy and implementation plan.

2.3 Furthering this, the People's Experience Lead has been undertaking a series of actions, required as essential to underpin the wider implementation. These include enhancing and promoting Patient Experience across the health board through:

- Developing and improving systems and processes for capturing patient experience and monitoring / responding to this more robustly
- Developing the Civica Hierarchy to ensure appropriate oversight and system function can be achieved
- Increasing the number of users of patient experience systems – this has doubled over the past 6 months and is improving the level of detail and quality of information coming through
- Working directly with patients to understand patient experience and to promote the role
- Working closely with service level leads to support delivery of patient experience objectives at a local level

3. PEF Self-Assessment

3.1 All services have undertaken a self-assessment against the People's Experience Framework (PEF) to further understand how they currently capture feedback and people's experience. The below is a high-level summary of PTHB's current position against the framework self-assessment.

	Maturity Position – Developing
Strengths	• Clear organisational commitment to person-centred care • Strong values alignment among staff • Feedback mechanisms in place (formal & informal) • Positive staff engagement and local ownership • Evidence of feedback informing improvements • Growing recognition of experience as part of quality & safety

Gaps	• Variable practice across services • Dependent on local leadership & capacity • Limited systematic analysis & triangulation of feedback • Inconsistent reporting of outcomes & learning • Limited organisational assurance • Improvements not consistently measurable or visible
Next Steps	• Strengthen consistency and coordination across services • Embed routine analysis and triangulation of experience data • Improve visibility of impact and outcome measures • Enhance reporting and learning pathways • Strengthen governance & organisational oversight • Progress maturity through systematic and sustainable approaches

3.2 As an outcome from the service-level self-assessment, each service has a bespoke action plan. Services are expected to provide quarterly updates on progress against actions implement the PEF within the CSG. Alongside ongoing monitoring of compliance against the self-assessment actions, services will be asked to produce quarterly 4-quadrant reports demonstrating how they are obtaining people's feedback, any themes or trends, and identify what learning is required both within their service areas but also that can be shared across PTHB. An update on this will feature in the IQR on a quarterly basis herein.

4. People's Experience Strategy

4.1 Part of the People's Experience Framework requires organisations to have a strategically endorsed system-wide strategy emphasising quality, continuous improvement and ongoing learning. A draft document has been developed with the aim that it will be shared with staff and stakeholders for consultation. This consultation will launch in March and close in May, allowing meaningful consult.

4.2 This is likely to come back to PEQS for final approval in the July/August quarterly report. Committee is asked to note that progress continues as reported, and the formal approval of the Strategy does not impinge on on-going development of this work.

5. PEF Implementation Plan

5.1 An implementation plan has been developed to ensure al actions required are identified and will report progress as appropriate. An overview of progress will be reported in the IQR quarterly updated in future reports.

5.2 A Risk and Issues Log will be prepared and monitored as part of the roll out and escalation reporting by exception will also feature in the IQR.

6. Conclusion

6.1 Committee is asked to note the progress within the report and take assurance that implementation of the national Patient Experience Framework is underway and making progress (recognising it is behind the initially planned schedule); robust monitoring and reporting systems are now in place for committee to receive regular assurance and oversight of this work.

NEXT STEPS:

1. Consultation of the Patient Experience Strategy is due to launch in March; consultees include staff, patients and stakeholders.
2. Bring back the PES for PEQs approval in July/August, ready for Board consideration, likely in September 2026.
3. Continue with the implementation plan, reporting on progress in the quarterly IQR report to PEQs.

IMPACT ASSESSMENT – NOT REQUIRED FOR THIS REPORT

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Powys Teaching Health Board

Agenda item 5.1

Patient Experience Quality and Safety Committee	**05 February 2026**
Subject:	**Integrated Quality Report: Quarter 3**
Approved and presented by:	Paul Hooton, Executive Director Nursing, Quality, Women & Family Health
Prepared by:	Heidi Sinclair, Head of Quality and Safety
Other Committees and meetings considered at:	Executive Committee, 21 January 2026.

PURPOSE:

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

RECOMMENDATION(S):

The Executive Committee are asked to:

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

Approve/Take Assurance	Discuss	Note
N	Y	Y

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

EXECUTIVE SUMMARY:

1 Background

The purpose of this report is to provide the Executive Committee with an update on the quality and safety agenda for Powys Teaching Health Board (PTHB).

2. Specific matters for consideration by this meeting (Assessment)

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

The RLDatix system – Risk Register

- Due to technical issues within the RLDatix system, and no sufficient work around available, the roll out of Risk within the system has been paused. The Corporate Governance team lead this work and are working with neighbours, partners and the OFW team to source a resolution. The issues have been reported to the Audity, Risk and Assurance Committee.
- The absence of a fully implemented risk register limits the oversight of all Health Board risks in one place. The Quality and Safety Team are working with the Corporate Governance Team to support communications with the teams and ensure safe and consistent messaging is delivered.

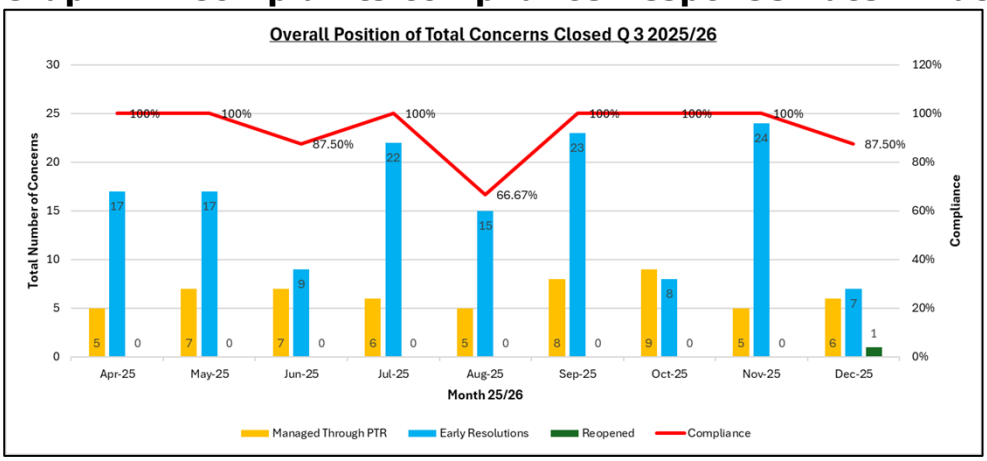
2.2 Putting Things Right – Concerns

The management of concerns compliance within 30 working to date for 2025/26 compliance is **75.7%.** This is a decrease on Q2 reporting (94.7%). However, an area of focus is the mean response time of 22 working days, with a primary focus on the sign off process as the main area for improvement. **Q3 (Graph 2)** has seen an overall improvement of 6 days (Q2 - 28 days mean).

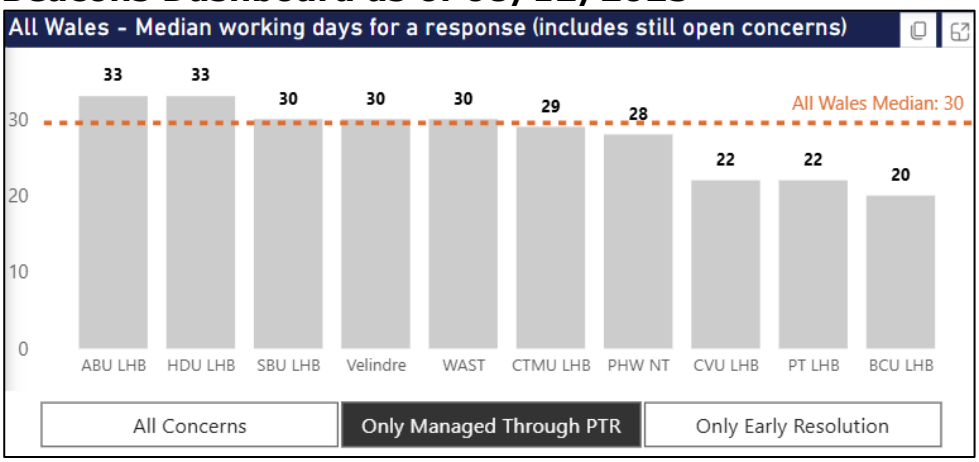
Challenges to concern compliance have been experienced in the latter part of Q3 and are expected to continue into early Q4, in part due to the Q&S Team experiencing capacity issues. This has affected the timely response to concerns and enquiries. The team is being supported to manage priorities to maintain compliance, and further work is underway to resolve capacity issues.

Compliance challenge has also been experienced as a result of commissioned services providing outcomes to investigations and concern responses outside of timeframe. The Health Board has received notice from a number of commissioned Health Boards and NHS Trusts that outcomes from investigations involving Powys patients can be expected to take up to 60 working days. This is an issue that will potentially be remedied by the introduction of the Listening to People Regulations for those within Wales and we are committed to working with our partners in England to resolve issues. Further work will also be undertaken within the ongoing Commissioning improvement work to ensure compliance is not impacted where systems and processes differ between England and Wales.

Graph 1 – Complaints compliance Response Rate – Datix Source.



Graph 2 – All Wales Median Working days for Concerns Response – Source Beacons Dashboard as of 08/12/2025

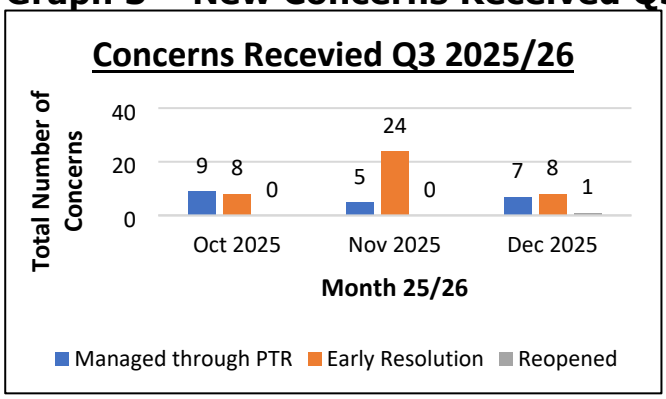


In Q3 2025/26, 20 formal concerns have been raised through PTR. Issues identified:

- Clinical Treatment & Assessment.
- Attitude and Behaviour
- Access.
- Communication

A thematic review is underway at service level, with learning and associated actions being monitored through service group quality and safety meetings. The Quality and Safety Team will support a wider organisational review to identify health board wide themes and trends and any key learning. This will be reported in the next quarterly report.

Graph 3 – New Concerns Received Q3 2025/26

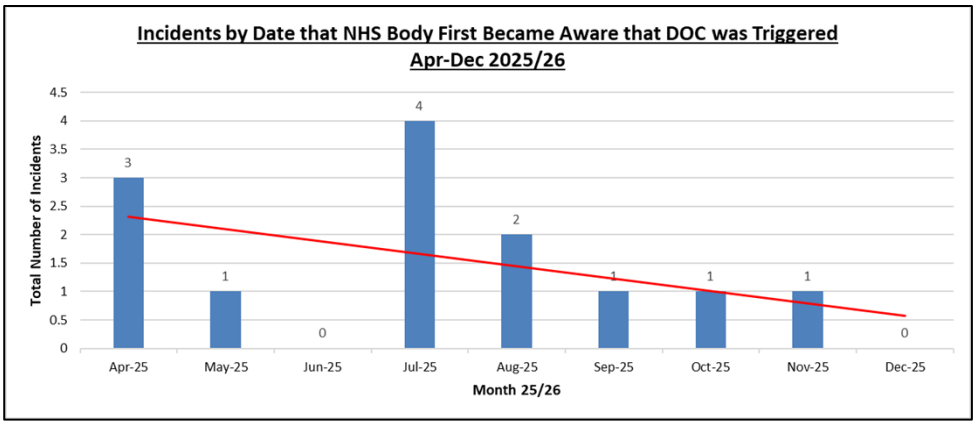


The current PTR regulations are under review by Welsh Government, and it is anticipated that the new regulations, **Listening to People**, will be released in February 2026, in readiness for implementation on 1 April 2026. Proposed changes and potential impact were presented at Executive Committee on 9 July 2025. Preparedness meetings have been arranged with Heads of services to discuss implementation, and the Quality and Safety team are currently undertaking review of policy, procedure and a staffing and training needs analysis. Progress on this will continue to be reported quarterly through this report.

2.3 Duty of Candour (DoC)

There have been 2 Duty of Candour cases during Q3 2025/26; this is a marked reduction on same period in 2024/25 (19 cases). It is considered that previous systems and service caution contributed to DoC in cases that may have fell short of the criteria, and the reduction is attributed to colleagues increased awareness and understanding of the requirements of the Act. All DoC review meetings include Heads of Service and Quality and Safety to support the process of proportionate reporting. Assurance should be taken that robust rapid review processes and proportionate reporting in line with the national reporting criteria is now further embedded.

Graph 4 – Date DoC was triggered in the Organisation (09/01/2026 – Datix)



There are currently 10 open DoC case in various stages of investigation (24 cases were open in Q2). Of the 2 DoC cases triggered in Q3, no themes were identified.

8 DOC cases have triggered redress.

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

2.4 Claims, Redress & Clinical Negligence Position

Redress

11 confirmed cases.

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

Redress processes will also be subject to change with the introduction of the Listening to People Regulations.

Whilst we are noted to have excellent performance against compliance standards with WRP, we are not currently compliant with the LFER process, having breached one redress case. Similarly, the LFER process has breached one claim case. Good communication with WRP has been ongoing to mitigate this situation and, as noted in section 2.2 of this report, the team are being supported with capacity issues.

Clinical Negligence

10 confirmed cases.

Personal Injury
<5 confirmed cases.

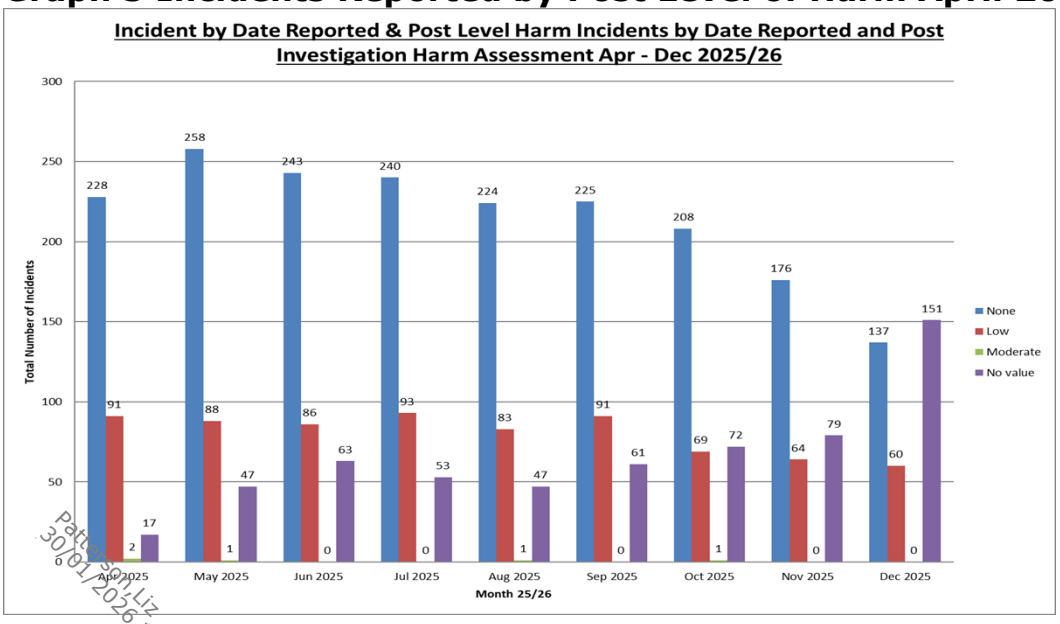
General Medicine Practice Indemnity (GMPI) Claims
<5 confirmed cases.

Inquests
18 confirmed inquests.
3 inquests to be closed upon completion of the hearings and all invoices paid.
1 pre-inquest review hearing listed end of January 2026
1 pre-inquest review hearing listed March 2026
2 inquests listed March 2026, staff called to give evidence.
1 inquest listed in April 2026 for 4 days, staff called to give evidence.

We have had one case where we did not meet a deadline for submission of statements to the Coroner which poses a risk of penalties or a summons from court, although this has not been issued in this case. A review of processes in the Quality and Safety Team has identified room for improved communication and escalation to the Head of Service and Executive Director in these instances and work is ongoing to improve this.

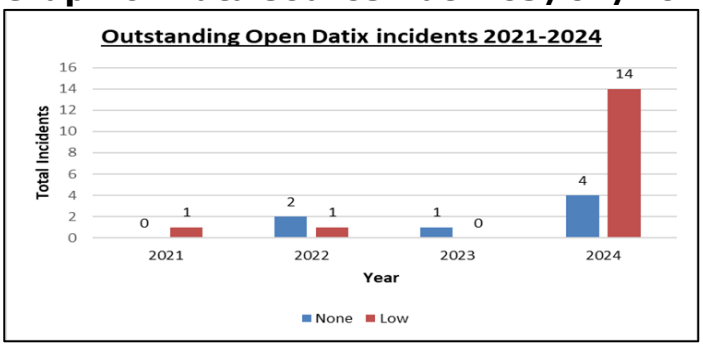
2.5 Incident Management
Graph 5 demonstrates stability in reporting across the year, and that most incidents are reported as low or no harm. A no value reporting category has been noted in Q1 and continues to be under review. No value incidents are those where the investigation is partially investigated or incomplete. There has been a gradual rise of no value incidents from May 2025. During Q2 a total of **291 'no value'** incidents have been closed, and in Q3 this continues to be a priority for CSGs.

Graph 5 Incidents Reported by Post Level of Harm April 2024-Dec 25/26

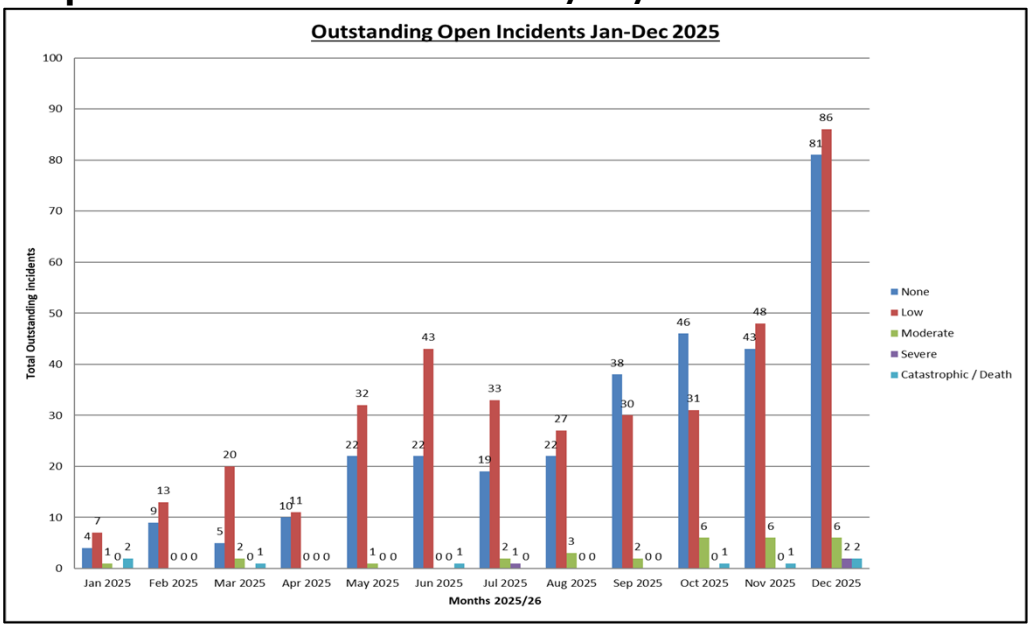


In Q2 the closure of incidents was reported as requiring improvement across the Health Board. During Q3 **ALL** outstanding moderate and above incidents from 2021-2024 were investigated and closed and **Graph 6** indicates that now only 16 'low' and 7 'no' harm incidents remain open from this period. These will closed January 2026 pending outcomes from investigations.

Graph 6: Data source Datix 09/01/2026



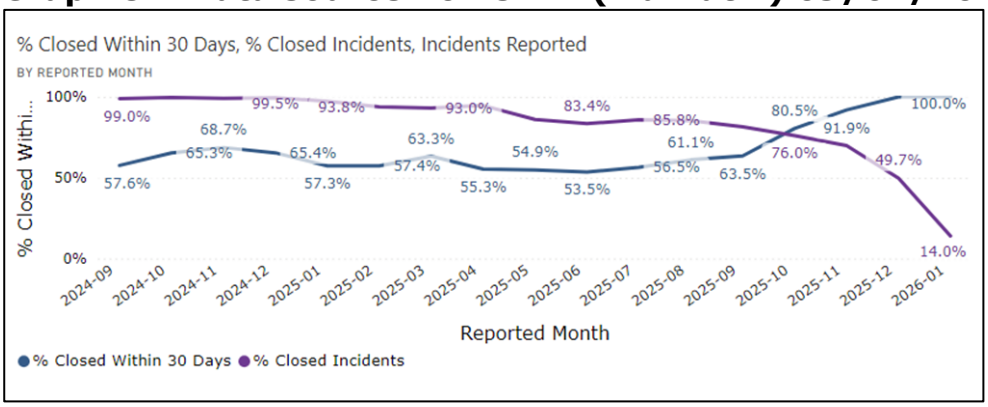
Graph 7 – Data source Datix 09/10/2025



Graph 7 demonstrates the outstanding incidents reported between January and December 2025. In Q2 it was reported that a total **408** 'none' and **554** 'low' incidents have been reported that have not been reviewed and closed within 7 days. Across the year to date there remains **89** 'moderate' incidents, **17** 'severe' and **10** 'catastrophic/death' incidents that remain open.

In Q3 **338** 'low' and **257** 'none' incidents remain open from this period. **78** 'moderate', **16** 'severe', and **6** 'catastrophic/death' incidents have been closed. Progress has been shared with all Heads of service, and a planned trajectory of closure has been established.

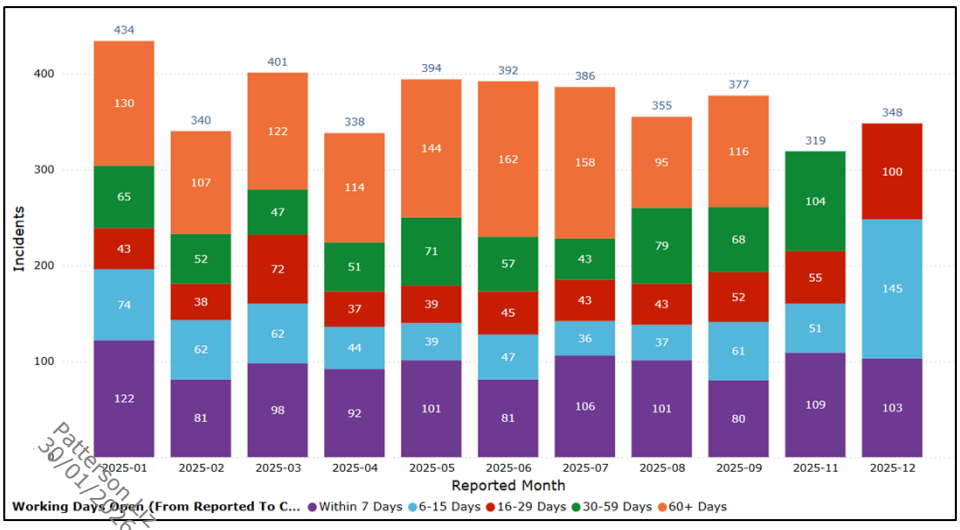
Graph 8 – Data source Power BI (via Datix) 09/01/2026



In Q2 it was reported that the 'at month' closure compliance rate was 34%. **Graph 8** demonstrates that since September 2025, there has been an improvement of 'in month' closures, with only 14% of incidents remaining open after 30 working days.

Of note for January to December 2025 **4459** incidents have been reported in total and **5015** have now been closed for the period (including outstanding incidents 2021-24).

Graph 9 - Data source Power BI (via Datix) 09/01/2026



Graph 9 indicates the time taken to investigate and close an incident from date reported. The Quality and Safety team provide regular updates for Datix training for reporters and managers where reporting time frames are emphasised. Heads of Service are also sent a weekly report providing the position on moderate incidents and going forward it will include service position on 'at month' data compliance.

The Incident Management Framework has been reviewed in line with the People's Experience Framework and Listening to People Regulations, and this has triggered a review of processes within the Health Board of the governance structure regarding the monitoring and escalation of incidents. A further update will be provided in Q4.

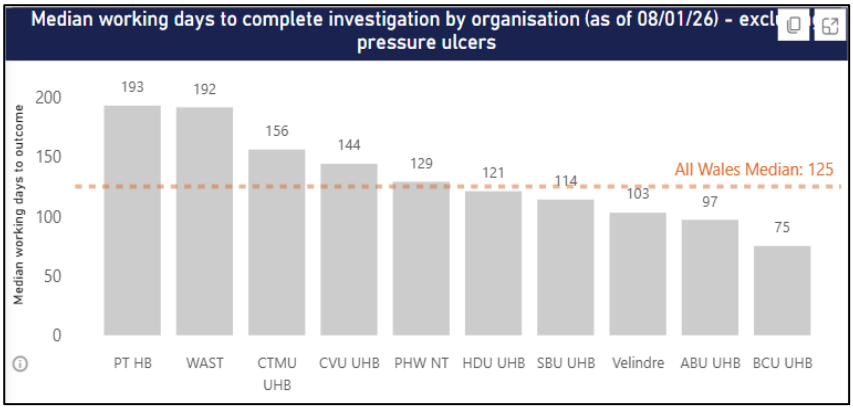
2.6 Early Warning Notifications (previously No surprises notifications)
1 Early Warning Notification have been submitted during Q3 2025/2026, this relates to contracted dental services and processes are currently underway for the multi-professional review and rectification of this matter.

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

- 5 open (3 awaiting sign off)
- 4 Closed (During Q3)
- 4 Downgraded (During Q3)

Improved timeliness of investigations is a focus for 2025/26 as 67% of open investigations remain open for >90 working days with the average completion time of 191 days. Some of this can be attributed to complex mental health cases which are anticipated to be completed by 120days. Investigation timeliness requires an improvement to ensure outcomes are shared with families and learning consolidated.

Graph 10 All Wales Median Working days for NRI Closure – Source Beacons Dashboard as of



3. People's Experience

3.1 Patient Engagement

3.1.1 Temporary Service Change

Feedback has been obtained from patients regarding the Temporary Service Changes across the Health Board. The engagement visits identified consistently positive feedback on staff compassion and care quality, alongside several operational challenges affecting patient flow and discharge efficiency. Improvements to information displays, patient communication, and activity provision were also highlighted.

3.3.2 Better Together Engagement Events
Feedback has been obtained regarding patient experience and bereavement experience at Better Together Engagement events, which sought to seek people's views on the proposed changes to how services are offered. A positive turn out of people attended the Brecon event with multiple people wishing to share both positive and negative experiences of health care in Powys. People were encouraged to share their views both via paper copies of the PES at the time or via the Concerns Team at a time more convenient to them. Enquiries were welcomed and responded to within the next 2 working days to support and signpost people of how to access health care.

3.2 People Stories

People stories have continued to be promoted and encouraged at every opportunity with service leads or patients themselves. Whilst initial engagement is positive, only a small number of stories have been recorded. Stories this quarter have been from patients accessing the Pulmonary Rehabilitation and Peri-Mental Health Services.

Stories will continue to be promoted, and service leads asked to actively identify patients who may be willing to share their story. The aim is for more staff to be trained in Digital Storytelling to allow better access for patients to provide a story, at locations and times convenient to them. It is anticipated that this will increase the learning and quality improvement. A rolling programme of service patient story expectation will be established by end of January 2026.

3.3 Civica

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

Table 1. New Civica surveys – Total responses received – Oct-Dec 2025.

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
Dec-25	36	7	30	506	153	353	1	866	0
Nov-25	38	9	34	794	387	407	7	2932	0
Oct-25	36	8	32	860	453	407	2	3181	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

Table 1 (pulled on 07/01/2026) shows the number of new surveys added to Civica, the total number of responses received and number of contacts via SMS. Note that

responses via SMS are delayed by one calendar month, therefore not a true representative of December 2025.

Graph 2 below provides an overview of responses to the PES by service areas, as per the current hierarchy. The Civica structures and hierarchy for reporting has been reviewed and awaiting implementation by Civica therefore will be more representative of all services within PTHB.

Graph 2 – Heatmap responses to PES by service area – Q3 2025/2026 sourced from Civica on 07/01/2026

Services	Responses	2 - How would you rate your overall experience?	6 - Were you able to communicate in your preferred language?	7 - Was the time you waited:	8 - Did you feel well cared for?	9 - Were you treated with dignity and respect?	10 - Did you feel that you were listened to?	11 - Were you involved as much as you wanted to be in decisions about your care?	12 - Were things explained to you in a way you could understand?	Overall
		People's Experience Survey (PES)	People's Experience Survey (PES)	People's Experience Survey (PES)	People's Experience Survey (PES)	People's Experience Survey (PES)	People's Experience Survey (PES)	People's Experience Survey (PES)	People's Experience Survey (PES)	
Community: e.g. your home, mobile unit, public place	4	75	100	100	67	-	-	-	-	83
Feedback - concerns team only	11	25	100	50	30	53	33	27	43	45
General Practice (GP)	13	42	97	55	36	61	42	50	53	54
Hospitals and services outside Powys	3	42	100	50	50	50	50	50	50	54
Other services not on a hospital site: e.g. mental health, Glan Irfon	1	100	100	100	100	100	100	100	100	100
PTHB Service Setting	40	79	97	82	85	87	80	78	86	84
Unmapped	433	85	99	83	88	94	88	86	90	89
	Overall	82	99	82	85	92	85	83	88	87
	Benchmarks	85	85	85	85	85	85	85	85	

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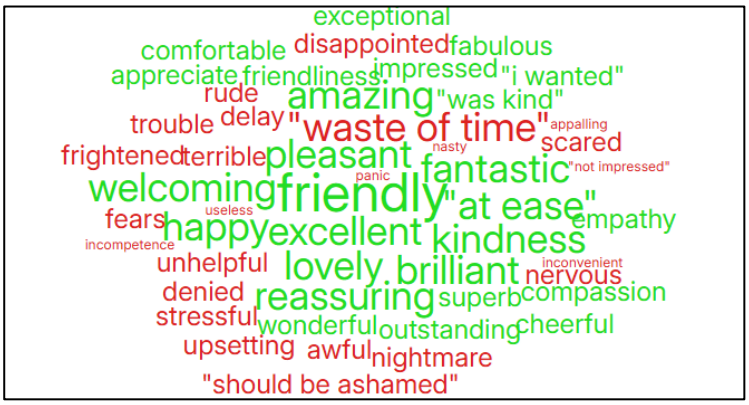
60 new users have been added to the Civica system to allow increased availability to input, record and monitor feedback in service areas.

Image 3 demonstrates a wordle of all words on the emotions expressed within PES's received throughout Q3

Image 3 – Civica word cloud (generated on 07/01/2026).



It has been recognised that sometimes the red words that can be pulled through may be in relation to a positive comment or experience, and work is continuing with Civica at a national level to determine if a resolution to this can be found.

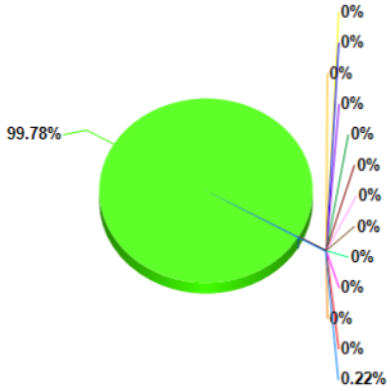
CIVICA - Accessible information

Nationally, a new Accessible Information Framework is pending for release, however we currently obtain feedback to ensure a person's preferred language is used. Further work will be undertaken once the new framework is available.

Graph 4– Source CIVICA Accessible Information (07/01/2026) Q3 25/26

Question 5: Which language would you prefer to communicate in?

Available Answers	Responses	Score (%)
Welsh	1	0.22%
English	455	99.78%
Polish	0	0.00%
Romanian	0	0.00%
Panjabi	0	0.00%
Urdu	0	0.00%
Portuguese	0	0.00%
Spanish	0	0.00%
Arabic	0	0.00%
Bengali	0	0.00%
Gujarati	0	0.00%
Italian	0	0.00%
British Sign Language	0	0.00%
Other, please specify:	0	0.00%
Total	456	100%



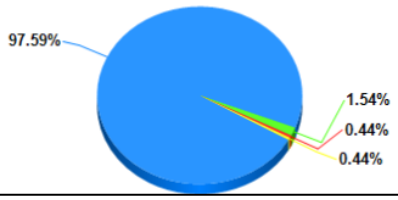
Graph 5 - Source CIVICA Accessible Information (07/01/2026) Q3 25/26

Question 6: Were you able to communicate in your preferred language?

Available Answers	Responses	Score (%)
Always	445	97.59%
Usually	7	1.54%
Sometimes	2	0.44%
Never	2	0.44%
Total	456	100%

View Demographic Report

Create new action



3.4 LLAIS

Llais undertook an engagement event in the Newtown locality in April 2025, subsequently publishing a report in December 2025. This is the ninth report in a rolling programme aligned with the 13-locality model of the Powys Regional Partnership Board. [Llais Powys Region - Newtown Locality Engagement Report - April 2025 | Llais]

3.5 PAVO

No Report submitted for Q3.

4. Infection Prevention and Control (IP&C)

During Quarter 3, there were no inpatient bed days lost as a result of Infection Prevention and Control (IP&C) issues, providing assurance regarding the effective management of infection risks across inpatient services.

Two outbreaks were reported during the period: Influenza A at a Powys Teaching Health Board–managed care home, for which a NRI was submitted, and COVID-19 on an inpatient Ward, Ystradgynlais. Both incidents were managed in line with established outbreak control procedures.

In preparation for winter pressures, a mask-wearing escalation and trigger framework for Acute Respiratory Infections (ARIs) has been developed to support timely and proportionate infection control responses.

Learning from previous post-infection reviews continues to be systematically embedded into routine practice across the Health Board, reinforcing a culture of continuous improvement and organisational learning.

The IP&C team remains actively engaged in key national workstreams, including improving compliance with Aseptic Non-Touch Technique (ANTT) and contributing to the Clostridioides difficile (CDI) improvement programme, with a specific focus on strengthening the integration of patient experience into infection prevention and control practices.

Strong collaborative links are maintained with commissioned services, enabling ongoing monitoring of infection rates and effective sharing of learning in relation to Powys patients.

The Healthcare-Associated Infection (HCAI) Improvement Goals for 2025–2027, issued in October 2025 for immediate implementation, are now being actively progressed, with work underway against the required actions.

Reduction expectation number	Domain	Cases reported (April – December 2025/26)	Cases reported (April – December 2024/25) Comparison
E. coli bacteraemia			
1.	A reduction of at least 10% in cases of hospital onset E. coli BSI is expected vs the cases in 2024-2025	1 case reported (**equivalent to previous period in 2024/25**)	1 case reported
P. aeruginosa bacteraemia			

2.	A reduction of at least 10% in cases of hospital onset Pseudomonas aeruginosa BSI vs the cases in 2024-2025	0 cases reported (**equivalent to previous period in 2024/25**)	0 cases reported
Klebsiella spp. Bacteraemia			
3.	A reduction of at least 10% in cases of hospital onset Klebsiella spp BSI vs the cases in 2024-2025	0 cases reported (**equivalent to previous period in 2024/25**)	0 cases reported
Clostridioides difficile			
4.	To reduce the overall burden of C. diff infection by at least 25% against the 2024-25 counts	19 cases reported (**1 more than equivalent period in 2024/25**)	18 cases reported
Staphylococcus aureus bacteraemia			
5.	MSSA Improvement Goal: A decrease of at least 20% compared to the 2024/25 baseline counts for all Health Boards MRSA Improvement Goal: All Health Boards should have fewer MRSA BSI cases in 2025/26 than in 2024/25	1 case reported (**equivalent to previous period in 2024/25**)	1 case reported

5 Health and Social Care Inspections Regulatory Recommendations

5.1 Health Inspectorate Wales Inspections

Of the 87 actions identified by HIW 62 actions are complete, 5 are underway and 22 are not yet due (as of December 2025).

The full improvement plan for Llandrindod Wells Minor Injuries Unit has been received and of the 20 actions identified, 17 are complete with 2 actions underway and one is not yet due (as of December 2025).

The full improvement plan for Ystradgynlais Community Mental Health Team has been received and of the 23 actions identified, 5 are complete and 18 are not yet due (as of December 2025).

Graph 11 Summary of Outstanding actions by inspection/national review as at 05/01/2026

Year/ Reference No	Inspection Title	Recommendations Made / Actions	Recommendations / Actions Complete	Recommendations / Actions Overdue (agreed timescale)	Actions underway	Recommendations / Actions Not Yet Due
232405	HIW National Review of CAMHS	20	18		1	1
242509	HIW Inspection Clywedog Ward	17	16		1	
252601	HIW Unannounced Inpsection Felindre Ward - full Improvement Plan	7	6		1	
252604	HIW Unnanounced Inspection Llandrindod Wells MIU - Full Improvement Plan	20	17		2	1
252602	HIW Inspection of Ystradgynlais CMHT	23	5			18
		87	62	0	5	22

In addition, HIW undertook an unannounced inspection of Maldwyn Ward, Victoria Memorial Hospital 5 and 6 November 2025 resulting in 9 improvement plan actions which will be completed in full by March 2026. The improvement plan has been sent for Executive assurance, and the full report is awaited.

HIW undertook an unannounced visit of Twymyn Ward, Bro Ddyfi Community Hospital on 16 and 17 December 2025, which resulted in 1 immediate improvement, which has been sent for Executive assurance and the full report is awaited.

6. Bereavement Framework

6.1 Objectives of the Nation Bereavement Framework (NBF):

- **Development and Roll-out of Bereavement Pathways** - A dedicated pathway is currently being designed with Maternity Services, tailored specifically to Powys Teaching Health Board (PTHB).
- **Engagement with Bereaved Individuals** - Visits to hospital sites across Powys took place in September and October 2025 and Wellbeing Events are being held across various community sites throughout November, December, January, and February. Feedback is being actively used to shape and improve bereavement services. Further outreach events are being planned in conjunction with the People's experience Lead and will be rolled out across Powys during the coming months.
- **Out-of-Hours Support - '**Out of Hours Bereavement Support' booklet has been created and published and added to the Bereavement Packs supplied to every Bereaved individual/family.
- **Provision of support to people with Protected Characteristics :–**

- Bereavement packs are accessible in English and Welsh.
- Plans being made for an audio version of the Bereavement Booklet.
- The Bereavement Lead regularly communicates with the Equality service to ensure any updates are incorporated in the SharePoint page, along with updates from the National Bereavement Leads Group.
- A cultural competency booklet has been developed to support all staff groups to feel more confident and culturally competent when supporting bereaved people.

As well as the diversity of our communities and the importance of dignity, respect and kindness at the end of life, the booklet also recognises the unique rural context of Powys and the challenges it brings.

Success during Q2 2025/2026:

- Support for Families - Ongoing collaboration with Maternity Services is focused on strengthening support for women and families who have experienced baby loss. Two members of staff have volunteered to act as bereavement champions. An action plan has been developed to monitor and progress identified priorities.
- Raising Awareness - Baby Loss Awareness Week. On Monday 13 October 2025, the PTHB Bereavement Lead and Bereavement Champion Midwife, ran a session at Brecon War Memorial Hospital to raise awareness of Baby Loss. The tables featured an array of cakes, a prize-every-time raffle and angel charm key rings. Staff, patients and their respective family members took part in the fundraising efforts. Staff and visitors were also able to browse a selection of information booklets, support packs, memory boxes, and other valuable resources, with the bonus of cake, too. The event was a success, raising a total of £160 which has been added to the Bereavement Fund, used to continue supporting those navigating loss.
- Baby and Child Loss Remembrance Service – On Thursday 11 December 2025 a Remembrance Service was held at St Davids Church, Llanfaes, to remember and honour the babies and children of South Powys. The event brought bereaved parents and families and Health Board staff together to remember and reflect on little lives taken so soon.

6.2 Medical Examiner

An extraordinary stakeholder panel meeting occurred with the Medical Examiner Service 4 December 2025 to provide a brief update on the Health Board position. Overall, feedback was very positive. The Registrars were in attendance and confirmed that they have experienced no issues with the registration of deaths in Powys; all processes are functioning as expected. They have recently introduced a new online system for booking death registration appointments. To support bereaved families, an information leaflet has been created for inclusion in the Bereavement Packs, outlining how to access this new system.

The Coroner's Office also offered positive feedback, noting no concerns.

The Chief Medical Examiner for Wales attended and highlighted that the proformas completed by GPs for the Medical Examiner Service in Powys are exemplary and the data for October and November 2025 indicates an improvement in the time taken for medical records to be received by the ME following a death, bringing Powys in line with the Wales average. However of note, a relatively high return rate for Medical Certificates of Cause of Death (MCCDs). Of 200 cases reviewed between September and December 2025, 59 were returned for amendments or additional detail. This will be addressed with

GPs during their refresher training, due to be provided by the Chief Medical Examiner for Wales at the Primary and Community Care Academy as a 'Lunch and Learn' session on 14 January 2026.

Refresher training sessions will also be delivered throughout January and February 2026 for all Primary Care administrative staff involved in the Medical Examiner process. These sessions will be a valuable opportunity to reinforce key elements of the process and support consistent compliance across all practices.

10. Contract Quality Performance Review Meeting (CQPRM) – Commissioning Q3

Across commissioned providers, the quality position remains broadly stable, with existing governance arrangements continuing to operate. We note, improving elective performance, and generally positive patient experience. However, system pressures continue to present material quality risks, particularly in relation to urgent and emergency care, workforce sustainability, infection prevention and control, and data integrity.

10.1 Key Areas of Strength

1. Clinical Effectiveness and Outcomes

Significant improvement has been reported in elective recovery, including substantial reductions in long waits, improved diagnostics performance, and strong surgical outcomes in specialist services.

Enhanced recovery pathways and outcome measures (including PROMs) demonstrate high-quality planned care in elective and specialist settings .

2. Patient Experience

- Overall patient experience remains positive, with strong Friends and Family Test results in several services and good use of patient stories to inform learning.
- Complaints performance shows reasonable timeliness of responses, with learning themes being reviewed through formal governance routes .

10.2 Key Quality Risks and Challenges

1. Quality Governance and Assurance
   - All providers demonstrate governance frameworks, however, the quality and effectiveness of these differ between organisation.
   - Although Board and committee-level oversight of safety, mortality, incidents, and patient experience is currently offered, it is recognised that a programme of quality improvement across commissioned services assurance is required. This is currently underway and chaired by the Executive Director of Planning, and the Quality and Safety Team contribute to this work.

2. Infection Prevention and Control
   - Rising healthcare-associated infections, particularly community-onset bacteraemia (including E. coli, Klebsiella, and C. difficile), remain a consistent risk across providers.

- Contributory factors include catheter management, antimicrobial stewardship, ANTT compliance, and workforce pressures, with improvement actions underway but requiring sustained focus.

3. Urgent and Emergency Care Pressures
   - Emergency Department crowding, prolonged waits, and flow challenges continue to present safety risks, particularly during winter escalation.
   - These pressures increase the risk of delayed recognition of deterioration, compromised patient experience, and staff strain, despite mitigation through surge planning and additional capacity measures .

4. Workforce Sustainability and Culture
   - Workforce pressures are a recurring theme, including sickness absence (notably stress-related), reliance on temporary staffing, training compliance gaps, and variable staff experience.
   - While staffing levels are generally maintained safely, ongoing pressure presents a risk to quality consistency, staff wellbeing, and delivery of improvement programmes.

4. Safety Incidents and Never Events
   - Although Never Events remain infrequent, a small number of open investigations and emerging safety themes (including medication errors and procedural risks) highlight the need for continued vigilance and timely completion of investigations.

5. Data Quality and Digital Risks
   - Data integrity and digital system risks (including EPR implementation, clinical coding timeliness, and reporting accuracy) pose a growing quality and safety concern.
   - These risks have potential downstream impacts on waiting list validation, performance reporting, and clinical decision-making .

10.3 System-Wide Themes and Learning

Across providers, consistent learning themes include:

- The importance of clear communication with patients and families, particularly during delays, transfers, and periods of clinical deterioration.
- Strengthening handover and documentation processes across organisational boundaries.
- Embedding learning from incidents, complaints, and mortality reviews into routine practice.
- Sustaining improvement momentum while managing winter pressures and workforce fatigue.

10.4 PTHB Actions:

- Contributing to the locally led commissioned services quality improvement programme – working with cross-border partners where required.

- Maintaining focus on the relevant areas of concern via the CQPRM with oversight of any additional internal action plans, implementation, and learning.
- Continue to work with commissioned partners to develop PROMS and PREMS data sharing in line with the People's Experience and new Listening to People Frameworks and this will evolve in reporting through Q3/4 2025/26.
- The Q&S Team will be working with PTHB Digital and BCUHB to develop Quality Safety Management System Power Bi Reporting platforms which will further support reporting requests with commissioned providers

10.5 Commissioning Concerns Monitoring

Following the changes to planned activity regarding Powys patients provided by NHS England, the Health Board have received 31 concerns which have been managed as enquiries for Q3 (Q2 – 31).

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

NEXT STEPS:

Key Matters for Committee:

1. **Continue to support the quality improvement of commissioned services quality assurance.**
   Continue to contribute to this programme of work, building on foundations to strengthen and improve quality and safety of PTHB patients.

2. **Ensure the required support and resource is available to support the implementation of the People's Experience Framework.**
   ACTION taken: A strategy to implement the PEF has been completed and all services have completed the Self-Assessment to further inform a PEF gap analysis.

3. **Implementation of Listening to People Regulations**
   Preparedness meetings are in place to discuss the readiness of the Health Board to implement the new Regulations in April 2026, including review of process, existing policies and service requirements.

IMPACT ASSESSMENT – NOT REQUIRED FOR THIS REPORT

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 5.2

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE	**05 FEBRUARY 2026**
Subject:	**Maternity Services Assurance Report**
Approved and presented by:	Paul Hooton, Executive Director Nursing, Quality, Women & Family Health
Prepared by:	Head of Midwifery, Sexual and Women's Health Director of Midwifery, Women and Family Health
Other Committees and meetings considered at:	Executive Committee - 29 January 2026 who supported the paper to PEQS.

PURPOSE:

This paper provides assurance to the Committee on the safety, quality, and effectiveness of maternity services within Powys Teaching Health Board. It summarises engagement with national assurance programmes, including the All Wales Maternity and Neonatal Assurance Assessment and the Maternity and Neonatal Safety Support Programme (MatNeo SSP) Implementation Network Oversight Group.

The report highlights local initiatives to strengthen governance, oversight, and service improvement, including the Quality Improvement Forum, workforce redesign, Midwife On-Call arrangements, and the implementation of the mandated electronic patient record system, BadgerNet. It also reflects ongoing service review under new leadership.

The paper is intended to provide confidence that Powys is actively monitoring, learning, and improving maternity services while recognising positive achievements and developments.

RECOMMENDATION(S):

The Committee is asked to:

- **RECEIVE** the report **NOTING** the updates provided in relation to the All-Wales Maternity and Neonatal Assurance Assessment is pending and agree to receive a further update once published, most likely in time for the next PEQS Committee meeting.
- Take **ASSURANCE in relation to the** progress made, the risks identified, and the actions underway, and to take largely reasonable assurance that maternity services in Powys are being overseen through robust governance,

aligned to national direction and responsive to both staff and women's experiences.

Approve/Take Assurance	Discuss	Note
Y	Y	Y

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

EXECUTIVE SUMMARY:

In 2025, the Quality Statement for Maternity and Neonatal Services was launched, setting out expectations for leadership, governance, safety, and patient experience. Powys Teaching Health Board is fully engaged in all national frameworks, including the All Wales Maternity and Neonatal Assurance Assessment; the Maternity and Neonatal Safety Support Programme (MatNeo SSP); and the Midwifery Unit Self-Assessment (MUSA) framework. These programmes provide evidence-based standards, benchmarking, and national guidance, ensuring Powys aligns with Welsh priorities.

Locally, Powys has actively participated in these assessments, completing the Health Board self-assessment and hosting a national team walk round, providing insight into governance, culture, and staff experience. Early findings show a committed workforce, strong team relationships, and positive staff engagement, with no immediate safety concerns. The maturity scoring matrix has identified areas requiring further development or established practice.

The Health Board continues to embed national priorities into local services. MatNeo SSP supports implementation of safety tools, audits, and structured learning, while MUSA ensures freestanding midwifery units and home birth remain central to improvement, with initial themes completed and the next cycle focused on priorities identified by staff and service users.

Locally initiated and led workforce initiatives, including Band 7 redesign and Midwife On-Call arrangements, are improving leadership, staff wellbeing, and retention. Digital transformation through the BadgerNet electronic maternity record, going live in March 2026, will strengthen oversight, audit capability, and cross-border visibility of care.

Positive developments include Baby Friendly Initiative Level 1 accreditation, the first team member enrolled on tongue tie training, improvements in roster management, and the regular sharing of birth stories, all of which support quality, safety, and staff morale. Key risks relate to sustainability of MatNeo SSP roles which are nationally funded on short-term funding; embedding improvement actions from MUSA; and managing change across teams during workforce redesign and digital transformation.

Overall, Powys Teaching Health Board is actively monitoring, learning, and improving maternity services. The combination of national engagement, local initiatives, visible leadership, and structured improvement activity provides assurance to the Committee that services are safe, effective, and responsive to women, families, and staff.

POSITION SUMMARY:

1. All Wales Maternity and Neonatal Assurance Assessment:

As part of the All-Wales Maternity and Neonatal Assurance Assessment, (About the assessment - NHS Wales Performance and Improvement) Powys Teaching Health Board completed a comprehensive maternity and neonatal self-assessment using a nationally prescribed electronic template. The self-assessment covered key areas including leadership and governance, safety culture, workforce, incident management, patient experience, training and education, and quality improvement arrangements.

The self-assessment process required formal sign-off by an Executive lead and an Independent Member, ensuring senior accountability and oversight of the information provided. The exercise prompted internal reflection and discussion across the service, supporting a shared understanding of current strengths and challenges.

The self-assessment highlighted a number of positive areas, including strong staff commitment to high-quality care, positive feedback from women and families, progress in professional development, and improving leadership visibility. It also identified areas requiring further focus, such as ensuring consistent operational leadership across sites, strengthening assurance mechanisms to track improvement actions, and managing workforce pressures within a rural service model.

Overwhelmingly, the self-assessment statements largely scored at levels 2 and 3, indicating a satisfactory standard yet demonstrating development and establishment in practice. While the full national report is awaited, the maternity leadership team has proactively benchmarked local arrangements against the national standards thus identifying opportunities for further strengthening governance, documentation and assurance. These areas are reviewed through the Quality Improvement Forum to ensure that learning from the assessment is translated into meaningful and measurable improvement.

Following submission of the self-assessment, a national team undertook a walk round of maternity services. This involved direct engagement with staff across different roles and settings, providing an opportunity to explore lived experience, culture and operational realities.

Feedback from the walk round reflected a workforce that is highly committed to women and babies, with strong team relationships and pride in their work. Staff spoke positively about leadership accessibility, recent improvements in communication, and opportunities to influence change. Challenges raised included workload pressures, and a desire for staff to be more actively involved in any redesign or service change.

2. Swansea Bay University Health Board (SBUHB) Maternity Report progress:

The service reported on the progress of local work against the SBUHB Maternity Report, to this committee in October 2025; **partial assurance** was provided against these standards. Local work has progressed, as has partnership working with our commissioning team and commissioned providers.

An updated progress plan against the recommendations from SBUHB report can be seen in appendix 1. Progress with Recommendation 1: Single Point of Access for Triage has been upgraded from 'Assurance largely limited' to 'Assurance largely substantial' as a result of further and enhanced monitoring processes. Further to this, committee should note that ongoing improvement work should enable this to move to 'Assurance Largely Substantial' within the next financial year.

Overall, the improvement in Recommendation 1 concludes all actions are now either largely reasonable or largely substantial with regard to assurance.

3. National Maternity Improvement and Assurance Programmes:

Powys Teaching Health Board continues to engage with national maternity improvement and assurance programmes to strengthen the safety, quality and sustainability of its midwifery-led maternity services. Two key programmes support this work: the Maternity and Neonatal Safety Support Programme (MatNeo SSP) and the Midwifery Unit Self-Assessment (MUSA) Framework. While distinct in purpose, together they provide complementary assurance on clinical safety, quality improvement, service user experience and workforce capability, within the context of Powys' rural and midwifery-led model of care.

Maternity and Neonatal Safety Support Programme (MatNeo SSP):

MatNeo SSP provides the national safety framework (Maternity and Neonatal Safety Support Programme Implementation Network - NHS Wales Performance and Improvement) through which Powys delivers and monitors key maternity and neonatal safety priorities. The national team has recently developed an electronic tool to track the improvement progress and highlight areas where further action is needed. Once quarterly data is captured through this tool, progress will be shared with the Committee to provide clearer insight into local performance. The

below table is the workstreams that the MatNeo team expect us to be demonstrating compliance with a plan to be achieving 100% by 2027.

Work Stream
Leadership & Culture
Workforce, Education & Training
ED&I
Perinatal Optimisation
Recognition and Escalation of Deterioration, Including Urgent and Emergency Care
Family Centred Care and Choice
Optimising Maternal Health
Quality Management & Improvement
Care

Progress to date (see table below) includes sustained delivery across priority workstreams such as early warning systems, maternity triage and audit, and feedback processes. Audit activity is established, learning is routinely shared with staff, and several areas of work are transitioning into business as usual, demonstrating growing local ownership and maturity. Participation in national working groups, including Community Modified Early Warning Score development, ensures that Powys both contributes to and benefits from, All-Wales learning, while adapting national expectations to a midwifery-led service without an on-site obstetric unit.

Recruitment of MatNeo Workforce – Recruitment complete of 8a and 7 role	
MEWS - Engagement with the ongoing economic evaluation of MEWS by consultant midwives	
MEWS – Community MEWS working group	
NEWTT2 - Guideline Ratified and Launched July 25	
NEWTT2 – Snapshot Audit 3 months post implementation – Review of National Audit Tool (October 2025)	
BSOTS/Triage – BSOTs health check completed with senior team	
BSOTS/Triage – Implement national BSOTS audit tool to monitor telephone calls monthly	
BSOTS/Triage – Rapid Access Card	
EDI – Perinatal Engagement Framework	
MUSA – Powys priorities	

RAG Key

	Significant issues or delays that require immediate action
	Potential issues that need monitoring and urgent corrective actions
	On track and no immediate issues
	Completed

The principal risk relates to the sustainability of the current non-recurrent externally funded MatNeo SSP roles beyond March 2026. While national

continuation of the programme is anticipated, uncertainty around ongoing funding presents a risk to local delivery and we currently await a decision at National level. The ongoing wider assessment of workforce will identify if any local opportunity exists.

Midwifery Unit Self-Assessment (MUSA):

The Midwifery Unit Self-Assessment Framework (MUSA Framework) provides a nationally recognised, evidence-based approach to assessing and improving midwifery units. For Powys, MUSA is particularly relevant as it places freestanding midwifery units and home birth at the centre of improvement activity, reflecting the Health Board's core model of care.

As part of the MUSA framework, Health Boards were asked to focus on three priority improvement themes over a 12-month period; Bio-Psycho Social Model of Care; Professional and Physical Boundaries; and Clinical Governance. The service is now engaging with staff and service users to identify the next priority themes, ensuring future work focuses on what matters most to women, families and the workforce. A celebration event took place with all Wales Health Boards in December, empowering midwives to recognise the hard work and dedication in delivering this work.

A key example of MUSA-driven improvement is Powys' strategic focus on protecting and increasing midwifery-led birth, in response to local data reflecting a UK-wide decline in uptake of home birth and freestanding midwifery unit birth. Targeted interventions have included the routine sharing of positive birth stories, tailored antenatal education sessions supporting informed choice, and mandatory physiological birth training for midwives, to strengthen confidence and skills.

This work has delivered measurable impact, halting the downward trend in freestanding midwifery unit births, achieving a modest increase in home birth rates, and improving both staff confidence and women's understanding of birth options. The work has been recognised beyond Powys, including submission to the International Confederation of Midwives 2026 conference.

Importantly, midwives recognise that not all women are suitable for midwifery-led care. All women are risk-assessed in line with NICE and All Wales guidance, and referrals to Consultant-Led Care (CLC) units are made where appropriate. Powys is not encouraging women to birth outside of the recommended setting; instead, the service supports informed choice within safe, evidence-based boundaries, ensuring that midwifery-led care is delivered only when clinically appropriate. This process has recently be strengthened and continued improvements include seeking Leagal and Risk advice, and opinion from other Stakeholders such as the Caldicott Guardian.

Taken together, MatNeo SSP and MUSA provide complementary assurance that Powys Teaching Health Board is delivering safe, effective and person-centred maternity services, while protecting and strengthening its midwifery-led model of care.

4. Care Outside Guidance / Manchester Regulation 28 Response:

In line with all Health Boards in Wales, Powys has reviewed the recent Regulation 28 case in Manchester, where a mother and baby tragically died following a birth in a midwifery-led setting. Locally, Powys has a detailed Care Outside of Guidance guideline, which has been updated based on feedback from women, staff, and the Regulation 28 review. These interim improvements support staff in responding safely when women choose to birth outside recommended guidance. Relevant corporate teams, including Information Governance, Welsh Risk Pool, and Health and Safety, are actively involved in supporting decision-making where additional oversight or guidance is required.

A key challenge remains the relationships with commissioning services. To address this, the Health Board is developing a draft agenda to ensure that all partner Health Boards are engaged in supporting Powys staff and birthing people, ensuring a safe, supported, and positive birth experience wherever women choose to give birth. This work will be aligned with the anticipated All-Wales guidance expected later this year.

5. Quality Improvement Forum: Strengthening Local Assurance & Accountability

To strengthen local assurance and ensure that improvement activity leads to meaningful and sustained change, Powys maternity services have established a Quality Improvement Forum spanning maternity, women's and children's services. This forum provides a single, structured mechanism to oversee system-level quality improvement, replacing multiple fragmented action plans with one consolidated and prioritised approach.

The Quality Improvement Forum will act as the central point through which learning from national programmes, assurance activity, incidents, complaints, service user feedback and staff experience is reviewed and translated into improvement action. By consolidating improvement activity into a single forum, actions are clearer, duplication is reduced, and focus is maintained on interventions that deliver the greatest benefit for women, babies and staff.

The forum brings together clinical leaders, operational managers and corporate colleagues, including quality, workforce, finance and change management, to ensure improvement actions are clearly owned, appropriately resourced and delivered at pace. Crucially, it will provide a consistent route for tracking progress, monitoring impact and holding individuals and teams accountable for delivery, while maintaining oversight of risks and escalation where required.

6. Workforce Initiatives: Supporting Sustainability, Experience & Retention

Strengthening and sustaining the maternity workforce remains a key priority for Powys Teaching Health Board, particularly in the context of national workforce pressures and increasing complexity of care. This work aligns with the Strategic

Perinatal Workforce Plan (2025-2028 heiw.nhs.wales/files/strategic-perinatal-workforce-plan1/), launched nationally to support a sustainable, skilled and resilient perinatal workforce and Powys is committed to working within this framework to inform local planning and decision-making.

A significant programme of work has been undertaken to review and redesign the midwife on-call arrangements. Following extensive engagement and consultation through OCP (Organisational Change Process), a new model has been agreed and will commence in February 2026, with a planned review period thereafter. This work has been designed to improve work–life balance, enhance staff satisfaction and retention, and support a positive experience for women and families; but more importantly being focussed on the safe working practices of midwives enabling safe and effective service delivery. The importance of this work has since been outlined within the Manchester Regulation 28, and our on-call processes have been requested to be shared across Wales for wider learning.

Further to this, a full review with potential for redesign of the Band 7 midwifery workforce across Powys, aiming to standardise operational leadership, embed specialist roles consistently across all sites and strengthen governance and assurance, while maintaining strong clinical leadership. We are engaging with colleagues in these roles, workforce and Trade Union partners to deliver this meaningfully.

7. Digital Transformation: National Electronic Maternity Records Implementation

Powys Teaching Health Board is implementing the NHS Wales mandated electronic maternity record system, BadgerNet, scheduled to go live on 2nd March 2026. This is a major strategic investment in digital capability. It will improve safety, integration of care, clinical oversight and audit across maternity services.

Cross-border care is a significant factor for Powys, as women frequently access services in neighbouring Health Boards and All-Wales hospitals. Currently, it is difficult to see the full patient journey in real time, as systems are not fully integrated across Wales. Once the all-Wales approach goes live, Powys clinicians will gain visibility of care provided elsewhere. In particular, the two main English trusts where our women commonly receive care, Wye Valley NHS Trust and The Shrewsbury and Telford Hospital NHS Trust, already use BadgerNet. This integration will provide much better oversight of women when they are receiving care from these commissioned providers, reducing delays, avoiding duplication, supporting safer clinical decision-making, and delivering a more coordinated experience for women and families.

The system also improves oversight of quality and safety. Accessible, consistent data supports timely audit, learning from incidents, and alignment with national reporting. This strengthens governance and ensures the Health Board can demonstrate compliance with statutory requirements.

At a National Level, there are a number of emerging concerns regarding existing digital systems and the interface with BadgerNet. These have been escalated to the national programme board reporting directly into Welsh Government.

8. Leadership, Culture & Service Review

Powys Teaching Health Board has strengthened leadership in maternity services with the restructure and appointment of new senior leaders who provide visible, values-based oversight across the service. This renewed leadership capacity has enabled a full review of maternity, women's and children's services that aligns with national strategic expectations and local priorities.

This work reflects and supports national direction. The All-Wales Perinatal Engagement Framework, published in 2025, sets out how health boards should engage women, families and communities in shaping services, and emphasises leadership that promotes inclusion, listening and continuous improvement. Similarly, the Quality Statement for Maternity and Neonatal Services reinforces the role of leadership and governance in driving quality and outcomes across Wales.

Locally, the maternity service review is being undertaken collaboratively with human resources, finance and change management colleagues. Staff are actively involved in shaping improvements, and communication with the workforce has been strengthened through transparent briefings and video updates. This supports a culture where staff feel informed, valued and part of ongoing development.

With transformational change, even where good communication is achieved, there is always a risk to workforce satisfaction. The midwifery workforce have cited disappointment at the return of the service fleet vehicles, despite this being a cost effective, strategic decision with good communication. Service leaders will continue to monitor the cultural impact and mitigate this wherever possible.

The national Strategic Perinatal Workforce Plan (2025–2028) provides further context, emphasising the importance of compassionate leadership, supportive culture and workforce development across perinatal services. Powys is committed to working within this three-year strategic framework, which reinforces local workforce initiatives and supports the embedding of a sustainable, skilled and motivated workforce.

9. Achievements:

Powys Teaching Health Board continues to make tangible improvements in maternity care. The service has achieved Baby Friendly Initiative Level 1 accreditation, demonstrating adherence to safe infant feeding practices and reinforcing quality standards. In clinical skill development, the first team member has been enrolled on a specialised tongue tie course, which will improve care for mothers and babies across the Health Board, bringing care closer to home and reducing the financial burden with currently outsourced clinics.

CONCLUSION:

This report demonstrates that Powys Teaching Health Board is actively engaged with all required national maternity assurance and improvement frameworks and is responding proportionately to emerging expectations. Current intelligence from national assurance activity, workforce review and digital transformation provides early visibility of strengths, pressures and areas requiring further focus.

There is no evidence of immediate safety concerns. However, some early indicators highlight the cumulative impact of change on staff, and the importance of clear prioritisation, strong leadership and effective cross-border working to sustain the midwifery-led model safely. These themes are now shaping local improvement activity and will continue to inform decision-making over the coming year.

The Committee is asked to note the progress made, the risks identified, and the actions underway, and to take **largely reasonable assurance** that maternity services in Powys are being overseen through robust governance, aligned to national direction and responsive to both staff and women's experiences.

IMPACT ASSESSMENT – NOT REQUIRED FOR THIS REPORT

APPENDIX 1 - PTHB Progress against recommendations from SBUHB Report

Recommendation	Local Provision	Improvements in Progress / Required	Commissioned Services	National Action	Assurance Status
1. Single Point of Access for Triage	BSOTS triage system implemented; midwife call handler assigned; digital triage board used; monthly audits conducted.	Improve data collection for red calls; extract thematic learning; revise communication for non-triage calls: **Jan 26 - IN PROGRESS**	No current assurance mechanisms; standardised IQPD report templates in draft. **Jan 26 – DRAFTED AND IN CONSULTATION**	All-Wales centralised telephone triage system in development (WAST).	Assurance largely reasonable **Jan 26 - UPGRADED**
2. Senior Clinical Oversight	No local action required for midwifery care (applies to Obstetric, Neonatal, ITU, Paediatric Radiology).	N/A	No current assurance mechanisms; All-Wales standardised IQPD report templates in draft. **Jan 26 – DRAFTED AND IN CONSULTATION**		Assurance largely reasonable **Jan 26 – NO CHANGE**
3. Maternity Early Warning Scores (MEWS)	MEWS charts not used routinely in community; only for unwell women or emergencies and have been implemented	Research award to develop community MEWS chart for national adoption (completion by year end). **Jan 26 – IN PROGRESS anticipated March 26.**	No current assurance that this has been rolled out – checking with network. **Jan 26 – Not rolled out across community in Wales – awaiting research outcome**		Assurance largely reasonable **Jan 26 – NO CHANGE**
4. Improve Investigations Quality	Incident management framework implemented (July 2023); under review after 2 years of learning.	Enhance rigour, external oversight, and challenge; learning from investigations to inform changes; to be discussed at Exec committee Nov 2025. **Jan 26 – IN PROGRESS**	Further work required to work in partnership with commissioned services when undertaking reviews of PTHB patients. **Jan 26 – Under consideration of Commissioning improvement work**		Assurance largely reasonable **Jan 26 – NO CHANGE**

5. Compassionate, Trauma-Informed Care	Birth reflections offered to all Powys residents in and out of county births; 5 midwives, 4 health visitors involved; 'Rewind' technique available; Excel tracking.	Reinstate annual report; improve feedback sharing; proactively contact previous service users; dashboard development needed. **Jan 26 – IN PROGRESS**	Referrals to equivalent services for out-of-county births; common themes: communication, control, being heard.	Traumatic Stress Wales group working on national improvements.	Assurance largely substantial **Jan 26 – NO CHANGE**
6. Governance Enhancements	Governance arrangements established; observational assessment underway; Director of Midwifery leading review.	Develop shared ownership systems for incident response; local framework in development; dashboard improvement required. **Jan 26 – IN PROGRESS; reporting structures and agenda items across WCFH implemented**	Quarterly meetings with providers; agenda template in review; standardised IQPD templates in draft. **Jan 26 – DRAFTED AND IN CONSULTATION**		Assurance largely reasonable **Jan 26 – NO CHANGE**
7. Fetal Monitoring Training	Training limited to intermittent auscultation; CTG monitoring withdrawn; external training provision; 85% compliance (target 95% by Sept 26).	Increase compliance to meet national target. **Jan 26 –TNA and plan complete. On track.**	N/A		Assurance largely substantial **Jan 26 – NO CHANGE**
8. Induction of Labour (IOL) Process	No local IOL provision; no direct assurance required.	Strengthen assurance with commissioned providers for safe, timely, equitable IOL access; robust reporting and oversight in development.	Assurance sought from commissioned providers. **Jan 26 – DRAFTED AND IN CONSULTATION**		Assurance largely reasonable **Jan 26 – NO CHANGE**

9. Policy and Procedure Review	Database of policies, guidelines, SOPs; monthly reporting to PAG; approval via health board committee.	Review all policies for fitness and assurance; priority focus on safety-impacting policies; 6-month review period. **Jan 26 – IN PROGRESS**	PTHB representation in national policy development.		Assurance largely reasonable **Jan 26 – NO CHANGE**
10. Wider Engagement Plan	CIVICA surveys launched; feedback via text messaging; limitations in provider attribution and poor experience identification.	Feedback challenges being addressed; Director of Midwifery committed to improvement; consider proactive engagement with service users. **Jan 26 – IN PROGRESS**	CIVICA data in IQPD reports; annual CQC survey for English providers; 4 Welsh HBs yet to launch CIVICA for maternity.		Assurance largely substantial **Jan 26 – NO CHANGE**

Key:

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

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

Agenda item: 5.3

Patient Experience, Quality and Safety Committee	**DATE 05 February 2026**
Subject:	**GMS Access and Patient Experience**
Approved and presented by:	Elaine Lorton, Executive Director of Primary Care, Community & Mental Health
Prepared by:	Assistant Director of Primary Care
Other Committees and meetings considered at:	Executive Committee – 21 January 2026

PURPOSE:

The purpose of this paper is to provide assurance to the Executive Committee regarding the General Medical Services Access and patient experience.

RECOMMENDATION(S):

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

- **RECEIVE** the report taking **ASSURANCE** appropriate mechanisms are in place to collect and monitor patient access and experience.

Approve/Take Assurance	Discuss	Note
Y	Y	Y

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:

1. Focus on Wellbeing	Y	Use this space to provide a brief narrative explanation of alignment with the health board's wellbeing objectives including reference to our strategic priorities. This can include reference to the Board Assurance Framework.
2. Provide Early Help and Support	Y	
3. Tackle the Big Four	N	
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	N	

EXECUTIVE SUMMARY:

Patient experience, access and activity monitoring to general medical services (GMS) remains a central focus for the Primary Care GMS contracting team, with numerous systems in place to ensure continuous oversight and improvement. Monitoring is increasing with the availability of different dashboards which allows the quarterly Access Forum meetings to provide a structured platform for detailed review, discussion, and targeted support to practices. Areas of concern are discussed with practices on an individual basis and if necessary action plans are put in place and also escalated to executive level if appropriate.

Opening hours are monitored ensuring practices maintain contractual hours providing equitable access across the Powys footprint.

Contact activity is monitored monthly and highlights the scale of activity across practices. Between April and October 2025, surgeries handled 650,779 calls, issued 1,947,826 prescription items, and processed 252,288 digital requests. During the same period, practices generated 57,805 referrals, issued 12,767 fit notes, and managed significant administrative and communication volumes, including 364,070 letters/emails and 518,740 text messages. This demonstrates the complexity and demand within primary care and reinforces the need to monitor additional capacity provision to manage peak demand.

Additional national capacity funding has enabled GP Practices to take on additional clinical and administrative resource. This is available to practices on a capitation basis. The full allocation for 2024/25 was used by practices, which enabled practices to provide in excess of 9,552 additional hours (clinical and non-clinical), which provided over 17,215 additional appointments. Most practices use the funding to increase clinical sessions by engaging a range of MDT team members, tailored to clinical needs and patient demand. For the first six months of 2025/26, practices have delivered more than 6,340 additional hours (both clinical and non-clinical), resulting in over 8,870 extra appointments.

Practice capacity to manage patient demand is reported through a national escalation framework. Practices are contractually obliged to ensure that they update the Escalation Framework on the last working day of each month and if there is a significant change in practice circumstances that may impact on access. There are consistently 4 Powys practices (25%) reporting Level 4 escalation. A targeted piece of work is about to commence to work with practices to actively review their escalation status against the national criteria. The Powys Level 4 escalation is consistently higher than the all Wales average and the Health Board needs to further understand the rationale for this.

Compliance with Access Standards is rigorously tracked, and all practices have confirmed adherence for both the first and second quarters of 2025–26. The introduction of Mid-Year Reflective Reports has added a further layer of scrutiny,

with every practice submitting their report to meet contractual obligations for 2025–26.

Patient feedback indicates a positive experience of care. Most respondents felt listened to (67% always, fewer than 2% never) and well cared for (66% always). Waiting times were generally acceptable, with 76% reporting they were about right or shorter than expected, though 24% hoped for quicker access. Involvement in decisions was also strong, with 65% always feeling included and fewer than 3% reporting they were not involved. These findings will inform improvement actions and feed into the PTHB Patient Experience Steering Group.

In addition, the rollout of the NHS App is under continuous observation, with monthly monitoring at practice level to assess uptake and engagement, with 26,219 patients in Powys now registered with the NHS App. Work is underway with national partners to develop a roadmap for enhancements, including e-triage, integrated appointment booking, and test result visibility, as part of the new GMS contract agreement for 2025–26. Overall Powys engagement with the App is increasing, with logins rising from 22,268 in April 2025 to 27,494 in December 2025, totalling 279,629 (total logins) for the calendar year. Usage is strongest for repeat prescriptions (76,249), while appointment bookings (3,789) present an opportunity for further growth.

Civica patient feedback responses are discussed at the PTHB Patient Experience Committee, noting that the Civica feedback for Primary Care has a very small number of respondents.

The Primary Care Department works closely with external stakeholder such as Llais, which provides independent advice and reports based on community engagement programmes. These insights offer valuable qualitative data that complement internal monitoring.

Healthcare Inspectorate Wales (HIW) also conduct inspections. Feedback from this inspection, along with any relevant reports from Llais, are reviewed with individual practices as well as informing monitoring processes, including unified contract desk-top reviews

Together, these internal and external mechanisms allow an understanding of patient experience across Powys. While challenges remain—particularly in terms of sourcing actionable data, the Primary Care department continues to refine its approach to ensure that patient voices inform service development and quality improvement. These various monitoring processes are shared with the PTHB Access Forums enabling collaborative review of data, sharing good practice, and discussing areas for improvement.

INTRODUCTION

Ensuring timely access to General Medical Services (GMS) and delivering a positive patient experience are central priorities for the Primary Care, GMS contracting team.

Access and experience are monitored through a range of mechanisms designed to provide assurance, identify areas for improvement, and support practices in meeting contractual obligations. These include:

- **Monitoring Opening Hours** – ensuring practices maintain contractual hours and provide equitable access across the Powys footprint.
- **National Escalation Framework** – practices are contractually obliged to ensure that they update their Escalation status on the last working day of each month and if there is a significant change in practice circumstances that may impact on access.
- **Access Standards** – requiring practices to demonstrate compliance with core requirements such as telephone responsiveness, digital access, and appointment availability.
- **Monthly Contact Activity Monitoring** – tracking call volumes, digital requests, and appointment patterns to identify trends and pressures. Performance Dashboards provide real-time data on call handling, digital requests, prescription volumes, and other operational indicators.
- **Monitoring Additional Capacity** – reviewing the provision of extra clinical and administrative resources to meet demand.
- **Monitoring NHS Wales App Usage and Promoting Adoption** – tracking registrations, logins, and service utilisation while encouraging greater uptake of digital tools.
- **Access Forums** – multi stakeholder group enabling collaborative review of data, sharing of good practice, and discussion of improvement actions.
- **Patient Experience Surveys** – capturing feedback on key aspects of care, including communication, involvement in decisions, and waiting times.
- **Patient Experience Steering Group** - The Primary Care Department contributes regularly to the PTHB Patient Experience Steering Group, drawing on data submitted, in part, from the Access Standards submissions for 2024–25.

Together, these approaches offer a comprehensive view of how patients access GP services and experience care, supporting continuous improvement and equitable service delivery across Powys.

CORE OPENING HOURS & CORE CONTRACT REQUIREMENTS (mandatory)

Core hours are defined as the period beginning at 8:00am and ending at 6:30pm on a working day. Practices must be **open and physically accessible** to patients between 8:30am and 6:00pm on each working day, ensuring access to services throughout the core hours. It is important to note that this does not include the requirement to offer appointments throughout the core hour period.

The National Health Service (General Medical Services Contracts) (Wales) Regulations 2023, **Paragraph 18**

18 2) A contract must also—

(a)contain a term which requires the contractor to—

(i)make appointments for unified services available to its patients for such proportion of the core hours on each working day as is appropriate to meet the reasonable needs of those patients,

(ii)have in place arrangements for its patients to access unified services throughout the core hours in case of emergency,

(iii)ensure that all practice premises, other than any practice premises specified in paragraph (3), are open and physically accessible to patients—

(aa)at all times between 8.30am and 6.00pm on each working day, and

(bb)for such other periods in core hours as may be required to enable the contractor to comply with the requirements in regulation 17, regulation 18 and Schedule 3, and

(b)state the period (if any) for which any services, other than unified services, are to be provided.

(3) The practice premises specified in this paragraph are those for which the Local Health Board has agreed, in writing with the contractor, more limited opening hours because the practice premises are not one of the contractor's main sites.

Many practices commission Shropdoc to provide telephone cover during the margins at the beginning and the end of the day i.e. the time between 8:00am–8:30am and 6:00pm–6:30pm. This is a historical agreement accepted by PTHB, noting that practices have the responsibility to ensure they continue to meet regulatory requirement.

GMS ESCALATION FRAMEWORK

Practices are contractually obliged to ensure that they update the Escalation Framework on the last working day of each month and if there is a significant change in practice circumstances that may impact on access.

There are consistently 4 Powys practices (25%) reporting Level 4 escalation. This primarily relates to practices being unable to manage patient demand which can be impacted further with practice staff absence. Vacancies and sickness are an ongoing challenge for practices. Across some disciplines, Powys Practice absences are consistently higher than the all-Wales average.

A targeted piece of work is about to commence with Powys practices and the Local Medical Committee to actively review Practice escalation status against the national criteria. There are a number of practices that consistently report at the same level and Powys is consistently high for reporting at level 4 and the health board needs further assurance that the reporting levels are accurately reflecting circumstances.

Nationally there is a theme across all Health Boards that some practices are using the escalation tool as a political point to raise awareness of the general high

demand in GMS, rather than an actual operational pressure being experienced at the time of reporting. This is not using the tool for its intended purpose. National discussions are taking place to consider how best to address this issue.

As can be seen from the table below, Level 4 in Powys is significantly above Wales average (25% vs 7%)

Date: 01/01/26	Levels				
	1 (%)	2 (%)	3 (%)	4 (%)	5 (%)
Aneurin Bevan University Local Health Board	55	39	6	0	0
Betsi Cadwaladr University Local Health Board	27	49	19	5	0
Cardiff and Vale University Local Health Board	19	44	26	11	0
Cwm Taf Morgannwg University Local Health Board	34	36	23	7	0
Hywel Dda University Local Health Board	13	28	45	15	0
Powys Teaching Local Health Board	13	25	38	25	0
Swansea Bay University Local Health Board	23	50	25	2	0
Wales	29	41	23	7	0

Primary Care Information Portal (PCIP)

Ongoing common themes for escalation include:

- On the day demand, triage and face to face appointments
- MDT sickness
- Practices having to work longer hours, over and above core hours, to meet patient need/demand.

ACCESS STANDARDS – CORE CONTRACT (MANDATED) & ACCESS STANDARDS (OPTIONAL)

Background

Initiatives to support access improvement in GMS have continued to develop year on year since the introduction of the Phase 1 Access Standards in 2019.

These initial Phase 1 Standards focussed on systems and processes to make it easier for patients to contact their GP practice. As a result of the GMS Contract agreement for 2022/23, the Phase 1 Access Standards, transferred to Unified Services as of 1 April 2023 which were set out in the National Health Service (General Medical Services Contracts) (Wales) Regulations 2023. These came into force on 1 October 2023.

As part of unified services, the contractor must self-declare the reported position quarterly that the requirements have been met and if requested be prepared to provide the evidence to the Health Board.

Additional Access Standards were introduced in April 2022 as a reflective phase where practices are required to make improvements to access based on patient experience and use care navigation to take a forward-looking and planned approach to appointments. Practice participation in the Access Standards is optional.

Core contract access requirements (mandated)

The core contract access requirements as stated in the National Health Service (General Medical Services Contracts) (Wales) Regulations 2023, **Schedule 3 Paragraph 4** state that the contractor must:

- *Have a telephone system with a recording function for incoming and outgoing lines, that stacks calls and allows for the analysis of call data.*
- *Have a telephone introduction message recorded bilingually in Welsh and English that in total lasts no longer than 2 minutes.*
- *Ensure that patients and care homes can order repeatable prescriptions digitally.*
- *For the duration of core hours, ensure that patients can digitally request a non-urgent appointment or a call back, and that the necessary governance arrangements are in place for this process.*
- *Publicise information via the practice's online resource on:*
  - *The access requirements and*
  - *How patients can:*
    - *Access the contractor's services, and*
    - *Request an urgent, routine and advanced consultation.*
- *Offer a same day consultation for:*
  - *Children under 16 with acute presentations, and*
  - *Patients clinically triaged as requiring an urgent assessment.*
- *Offer pre-bookable appointments to take place during core hours.*
- *Actively signpost patients to appropriate services:*
  - *Available from the members of the contractor's cluster,*
  - *Provided or commissioned by the Local Health Board, or*
  - *Available locally or nationally.*

Access Standards (optional)

In addition to the core mandatory standards, optional Access Standards are also available for practices wishing to demonstrate enhanced access commitments. Participation in these optional standards requires completion of:

- A national patient experience survey
- An Equality Impact Assessment (EIA)
- A mid-year reflective report
- An end of year reflective report detailing alignment with the six access standards ensuring reflection and discussion on Patient Engagement, the National Patient Experience Survey, Digital requests and care navigation and Telephone System Intelligence. It is expected that the Reflective Report is discussed at collaborative level.
- A corresponding action plan

Monitoring the Access Standards

During the 2024-25 period, 100% of practices engaged with the Access Standards, achieving full (100%) compliance across PTHB. Practice evidence was submitted and reviewed to confirm compliance.

From 2025-26, additional reporting requirements have been introduced, including the submission of a mid-year reflective report at the end of Quarter 2. This new requirement aims to support continuous improvement and greater transparency in practice access and performance. All Practices have submitted their mid-year reports. Fifty percent were asked to resubmit with additional evidence to provide more robust assurance of their achievement against the Access Standards requirements in this area.

Practice Access Standards Compliance Table

Core Contract Compliant	***2024-2025 Achieved***	***2025-26 Mid-Year Report Achieved***
100%	100%	100%

The Mid-Year Reflective reports

Following the submission of the mid-year reflective reports, the Primary Care team has collated and analysed the information provided by Practices. A summary of the different approaches being used to meet contractual obligations, focusing on improving existing requirements and processes to enhance patient experience.

The areas summarised include:

- Service Delivery and Communication,
- Progress and Actions to Remove the 8am Bottleneck,
- Concerns and Complaints Related to Access,
- Communicating Access Options and Services.

These examples, drawn from numerous Practices, will be shared through the Access Forum to promote collaboration and the sharing of good practice. A detailed breakdown is included in **Appendix 1,** and this work will continue to ensure sustained improvements in service delivery and access.

Future Access Standards

A review of Access Standards has commenced, undertaken by a national tripartite 2025–26 Working Group, to determine which elements should form part of the core contract and what additional access requirements are needed. The group will also identify any changes to national; reporting and standards, with implementation planned from 1 April 2026, which PTHB will comply with.

CONTACT ACTIVITY

Practices are required to update their appointment and contact data monthly through the national Primary Care Information Portal (PCIP) and also make it available to patients. The National Health Service (General Medical Services Contracts) (Wales) Regulations 2023, **Paragraph 23 - Activity and Appointment Data**

23.—(1) A contract must contain a term requiring contractors to—

(a)maintain their mapped appointments in the relevant section of the Primary Care Information Portal;

(b)review their submission data at least once a month;

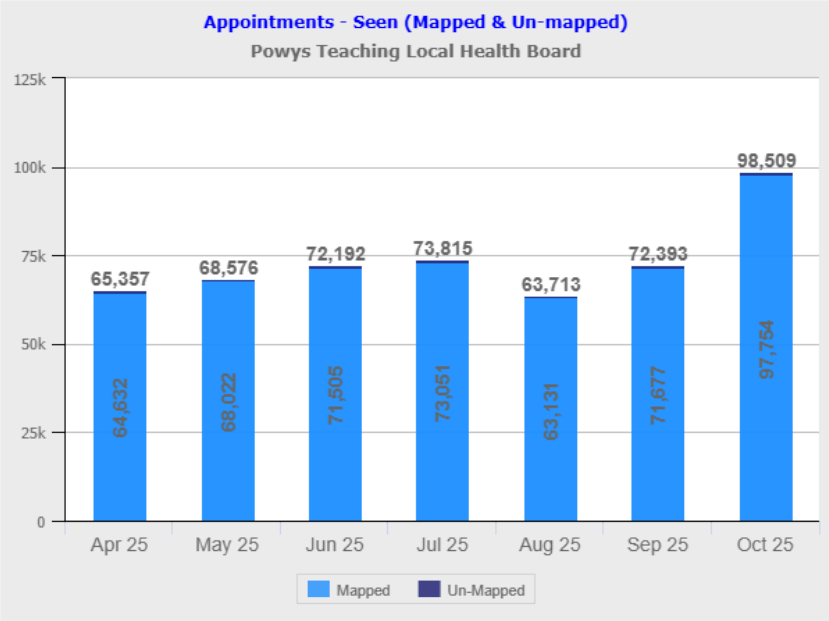
(c)ensure the mapped categories are up-to-date; and

(d)ensure their server is at all times switched on, maintained and available to enable the relevant software to extract the data.

(2) The activity and appointment data across the GP Collaborative must be discussed at GP Collaborative meetings by the authorised representatives from the member practices comprising the GP Collaborative, with the aim of developing measures across those member practices to manage demand and standardise good practice and, where applicable, data quality.

Welsh Government has confirmed that the Powys average contacts is above all Wales average. Factors influencing this include population demographics and the large number of Local Supplementary Services that PTHB offers, supporting the 'shift left' agenda.

2025-26 Total Practice Contacts per month (as published on the PCIP)



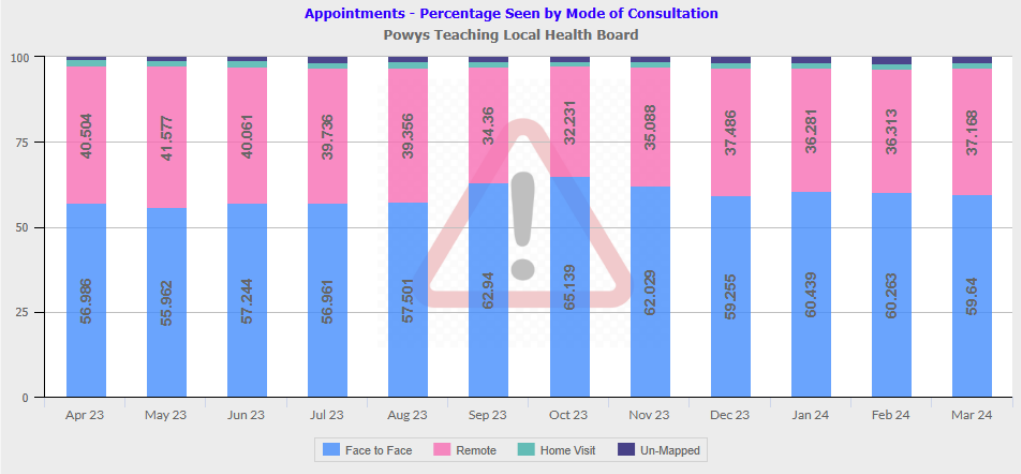
2023 – 2026 Total Practice Contacts per month (as published on the PCIP)

Month	2023-24	2024-2025	2025-2026
April	67,415	83,052	65,357
May	77,617	78,199	68,576
June	80,836	73,782	72,192
July	75,302	74,960	73,815
August	76,543	69,396	63,713
September	82,439	75,926	72,393
October	93,406	94,595	98,509
November	82,956	80,004	70,839
December	71,630	74,384	
January	89,738	83,656	
February	82,210	74,213	
March	77,971	77,677	
Total	958,063	939,844	514,555

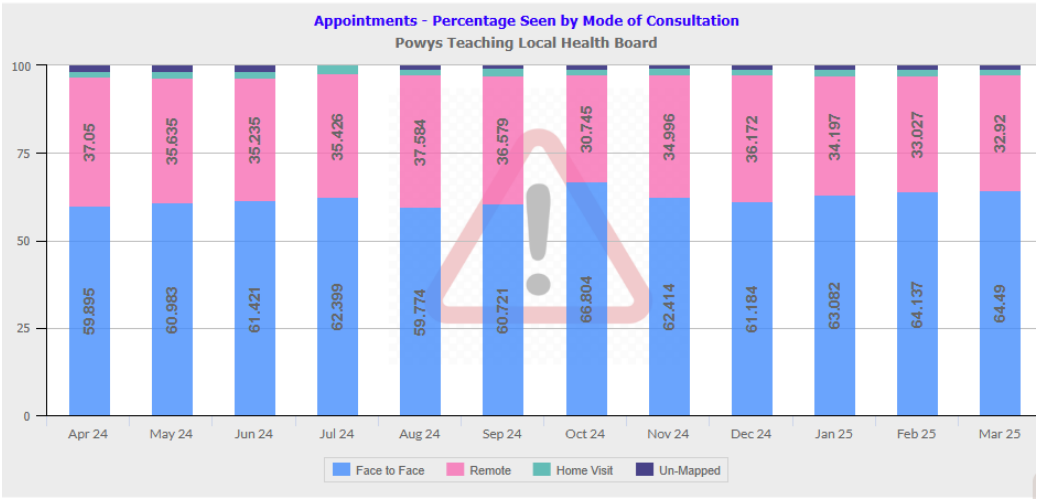
A comparison of the data from April to November across the three years indicates that overall Practice contacts appear to be decreasing each month.

However, the comments received from Practices indicate that they feel the demand is increasing. This will be discussed at a future Access Forum to further understand the granularity behind this high level data.

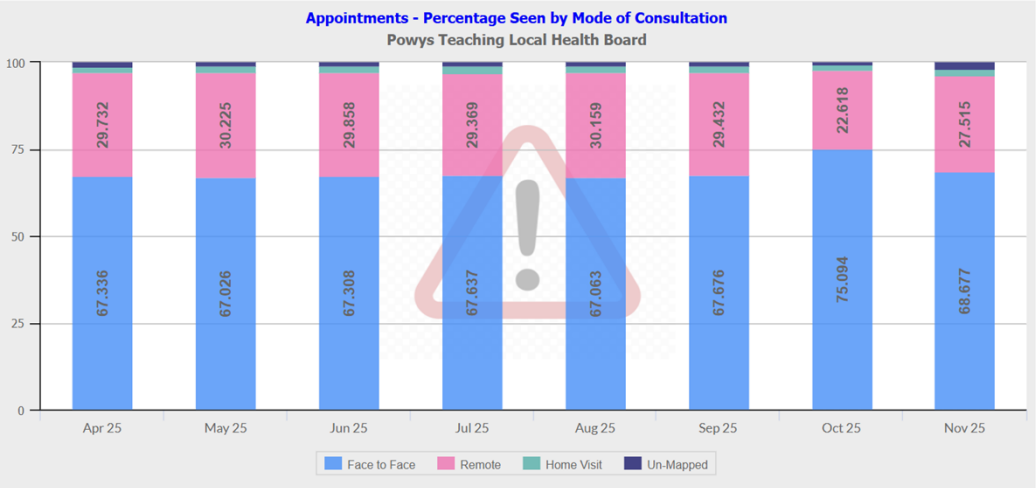
2023-24 Total Practice mode of consultation (as published on the PCIP)



2024-25 Total Practice mode of consultation (as published on the PCIP)



2025-26 Total Practice mode of consultation (as published on the PCIP)



Summary of Total Practice mode of consultation (as published on the PCIP) 2023 - 2025

	Remote	Face-to-face	Home visits
2023-2024	450,161	714,359	14,902
2024-2025	419,565	747,304	16,709

Excluding the 2025/26 data as not yet complete a comparison of the 2023/24 and 2024/25 data is showing that remote consultations appear to be decreasing and face to face consultations and Home Visits are increasing. This will be discussed at a future Access Forum to further understand practices access model.

Contact Breakdown (as published on the PCIP)

Contact Type	October 2025	Apr – Oct 2025 Total
Total number of calls to surgery	98,334	650,779
Items issued via prescription	287,474	1,947,826
Referrals Made	8,286	57,805
Fit Notes Issued	2,058	12,767
Administrative Communications Issued (letters/emails)	58,932	364,070
Text Messages Sent and Received	107,354	518,740
Total digital requests submitted to practice	43,149	252,288

The PCIP data can be further extrapolated down to individual practice level.

Monthly Monitoring – Practice Activity Data

In addition to the data available on the PCIP and as part of the PTHB evolving approach to monitor access, the Primary Care Department, in collaboration with the Medicines Management Team has developed a new dashboard to enable effective analysis across practices. The dashboard draws information from the PCIP and highlights anomalies and outliers. The information is then shared at the quarterly Access Forum to support standardisation and refinement of reported data.

These tools and datasets will strengthen monitoring and provide meaningful support to practices. The dashboard will play a role in identifying trends, driving improvements, and ensuring equitable and effective access to services across Powys.

ADDITIONAL CAPACITY

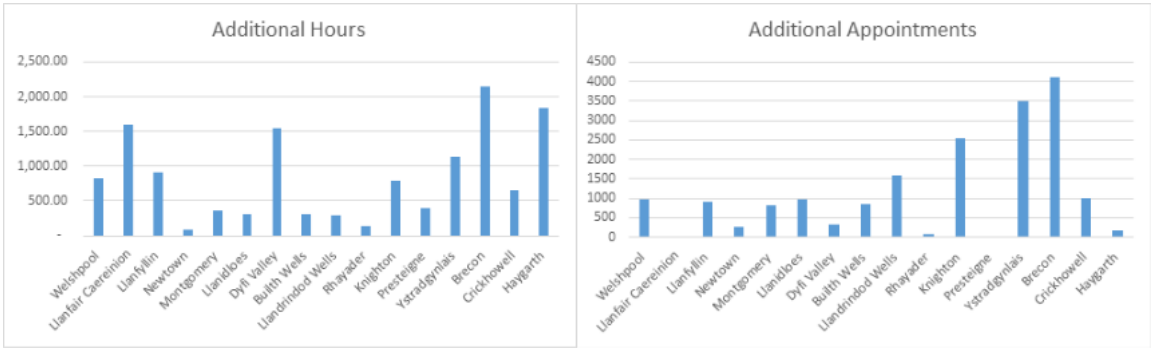
From 1st April 2022, three-year recurrent national funding on a 50% match funding basis was made available to enable GP Practices to take on additional clinical and administrative resource (paid on evidence of additional hours worked). Following tripartite negotiations, the funding was extended for 2025-26.

The PTHB allocation each year has been £183k. This was available to practices on a capitation basis. The full allocation was used by practices.

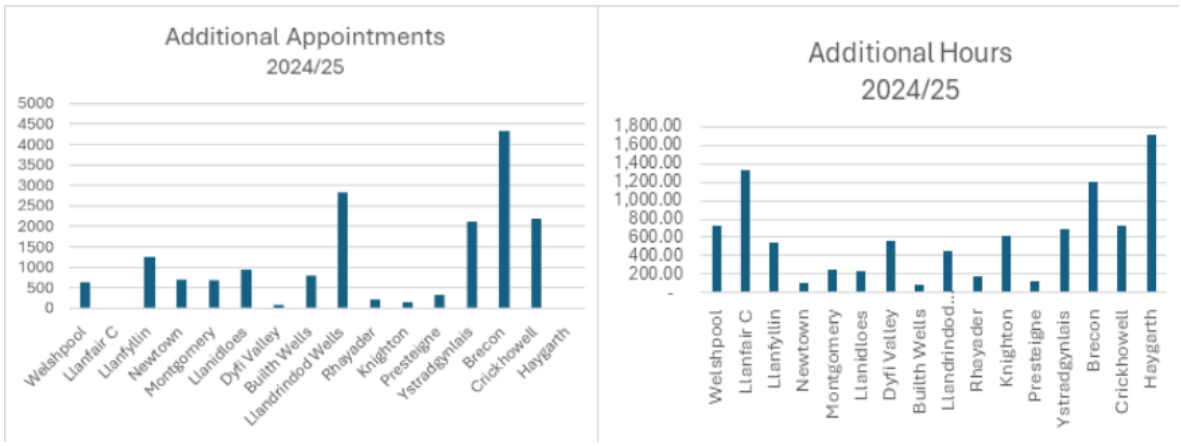
During 2024/25 the funding has enabled practices to provide in excess of 9,552 additional hours (clinical and non-clinical), which provided over 17,215 additional appointments. Most practices used the funding to increase clinical sessions by engaging a range of MDT team members, tailored to clinical needs and patient demand. The funding could also be allocated to administrative hours to enhance patient services, rather than solely increasing appointment availability. During 2023/24, the funding provided a total additional 12,545 hours which equated to 18,036 patient appointments.

The varied approach to the utilisation of the funding is illustrated in the graphs below.

Additional Capacity 2023-24



Additional Capacity 2024-25



For the first six months of 2025/26, practices have delivered more than 6,340 additional hours (both clinical and non-clinical), resulting in over 8,870 extra appointments.

To date, 3 practices have yet to claim the 2025/26 funding as they will likely use the additional resources over the winter period. Five practices have claimed their full funding allocation already.

From April 2026, the Additional Capacity Fund will be added to the national Workforce Fund (with no matching requirement), and the Additional Capacity Fund as it currently operates will cease at the end of March 2026.

The Workforce Fund will be allocated to health boards on a population basis. Practices will be able to apply to utilise this funding from the health board on a Capitation basis. Practices must make initial applications by 31 January 2026 and draw down throughout the year based on actual need and claims.

NHS WALES APP

Implementation and functionality of the NHS Wales APP is an evolving process. The NHS Wales App is designed to allow patients who are registered with a GP practice in Wales to access health and care services and share information with those of their choosing. Some of the functions include booking GP Practice appointments, ordering repeat prescriptions and viewing health records.

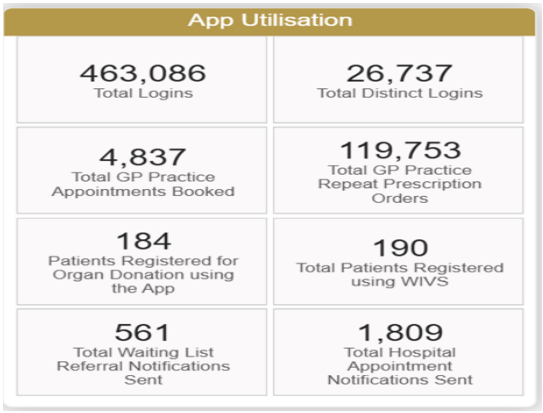
Since March 2025, the expectation is that Practices have enabled the repeat prescribing functionality of the NHS Wales App. The other contractual changes in the guidance include that Practices must assist patients with the Welsh Identity Verification Service (WIVS) process to enable patients to access the NHS Wales App. To note, the GMS expectation to support the role out and functionality of the APP is detailed in guidance as opposed to being detailed in regulation.

From November 2025, the Waiting List Referrals and Hospital Appointments feature launched across most health boards in Wales. This gives patients the ability to view outpatient referrals (once accepted) and outpatient appointment details within the App. Patients can also access health advice while they wait and, in most cases, see contact details to request changes or cancellations.

While the new NHS Wales App feature is a positive step, it creates challenges for Powys practices because many referrals go to hospitals in England, where this functionality is not supported. This leads to gaps in information for patients, and inequity, causing confusion and additional queries for practices. This adds to the ongoing PTHB digital cross border challenges.

Monitoring the Uptake of the NHS App

A dashboard has been developed to provide real-time insights into user engagement and service utilisation. It offers a comprehensive view of App adoption and usage at national, regional, and individual practice levels.



The NHS Wales App Dashboard, All Powys Practices, last accessed 28th December 2025

The NHS Wales App Dashboard provides detailed practice-level metrics, including the number of registered patients and the proportion of active users.

Overall Powys engagement is increasing, with logins rising from 22,268 in April 2025 to 27,494 in December 2025, with total logins at 279,629 for the calendar year.

Usage is strongest for repeat prescriptions (76,249), while appointment bookings (3,789) present an opportunity for further growth.

Month Year	App Registered patients	Logins	Appointment Bookings	Repeat Prescription Orders
Dec 2025	571	27494	241	6395
Oct 2025	945	26805	347	6996
Jul 2025	848	24052	351	6829
Apr 2025	1237	22268	330	6091
Total *31/12/2024 – 30/12/2025*	**10,631**	**279,629**	**3,789**	**76,249**
Total Overall	**26,219**	**464,103**	**4,847**	**120,036**

The new GMS contract agreement for 2025–26 introduces further progress on NHS Wales App functionality for patient record access. From 1 January 2026, patients will, by default, be able to view agreed coded elements of their record (excluding free text and test results) once the functionality is enabled. Rollout is planned between 1 January and 31 March 2026. As a minimum, a secure summary record will be available, including documented allergies, immunisations, and health conditions. This forms part of the NHS Wales App workstream under Digital, Data and Technology (DDaT) governance.

In addition, tripartite representation will join a working group with Digital colleagues and DHCW to progress development of e-triage and appointment booking within the NHS Wales App, and to determine how test results will be released. The working group will also explore authorised 'by proxy' access controls for carers and parents, with the intention of this being rolled out by March 2026.

PTHB ACCESS FORUM

The PTHB Primary Care GMS Access Forum meets quarterly to review and monitor performance against the GMS Access Standards and other access areas. The membership includes:

- Assistant Director of Primary Care
- Head of Primary Care
- Head of Primary Care Contracting
- GMS Contracts Manager
- Primary Care Cluster Development Manager
- LMC Representative
- North GMS Collaborative Representative
- Mid GMS Collaborative Representative
- South GMS Collaborative Representative
- Regional Director, Llais (Observer)

The purpose of the Access Forum is to drive improved and sustainable access to GMS across PTHB by reviewing and monitoring access performance using the current Access Standards, identifying and addressing access issues across the Health Board to enhance patient experience, and analysing themes from access-related complaints and patient feedback.

The Forum also considers Cluster IMTP priorities, Reports from Llais and Health Inspectorate Wales and identifies areas for improvement, shares learning and best practice.

PATIENT EXPERIENCE - The National Patient Experience Survey Data

The Access Standards require practices to complete the National Patient Experience Survey, summarise the findings, develop an action plan, and demonstrate improvements (**Appendix 2 – National Patient Experience Data Questionnaire).**

In line with monitoring and assurance responsibilities, PTHB Executive requested more detailed feedback from patients on services provided by GMS across Powys. Therefore, Practices were asked to submit raw, anonymised data collected from the 2025/26 National Patient Experience Survey, acknowledging that some may not yet have achieved the target of 25 completed questionnaires per 1,000 registered patients.

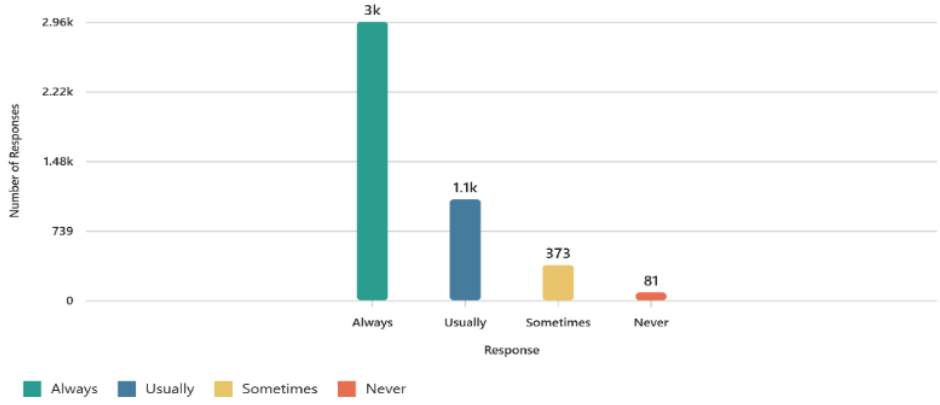
To date, 4,493 patient responses have been received from 15 practices. It should be noted that although the survey is administered by practices, it covers both primary and secondary care, so responses may relate to either.

As the data has only been received recently, it continues to be analysed. Analysis of the data and emerging themes will be shared with the Access Forum as they develop and updated in future reporting.

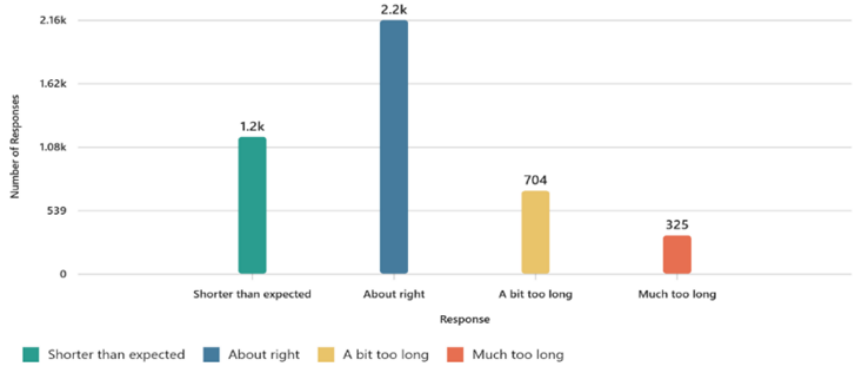
Overall, patient feedback indicates a positive experience of care. Areas analysed to date include:

- Most respondents felt listened to (67% always, fewer than 2% never) and well cared for (66% always).
- Waiting times were generally acceptable, with 76% reporting they were about right or shorter than expected, though 24% hoped for quicker access.
- Involvement in decisions was also strong, with 65% always feeling included and fewer than 3% reporting they were not involved.

Did you feel well cared for?



From the time you realised you needed to use this service, was the time you waited:



This feedback is provided to us at Practice level, and we are in the process of analysing the data which will be presented to the PTTHB Patient Experience Steering Group.

PTHB PATIENT EXPERIENCE STEERING GROUP

The Primary Care Department contributes regularly to the PTHB Patient Experience Steering Group, drawing on data submitted, in part, from the Access Standards submissions for 2024–25.

Civica information

Since January 2025, a process has been in place for the Primary Care Senior Nurse Practitioner to review and discuss Civica patient feedback responses with identified GP practices. However, the Civica feedback for Primary Care has a very small number of respondents. In addition, there is limited detail provided in the feedback, which makes it very difficult for follow-up.

OTHER PATIENT EXPERIENCE & EXTERNAL BODIES

In addition to patient surveys, the Primary Care Department works closely with external stakeholder such as Llais, which provides independent advice and reports based on community engagement programmes. These insights offer valuable qualitative data that complement internal monitoring.

Healthcare Inspectorate Wales (HIW) also conduct inspections. Feedback from this inspection, along with any relevant reports from Llais, are reviewed with individual practices as well as informing monitoring processes, including UCAF desk-top reviews and the PTHB Access Forum, ensuring that external feedback is considered in both planning and improvements.

Together, these internal and external mechanisms allow an understanding of patient experience across Powys. While challenges remain—particularly in terms of sourcing actionable data, the Primary Care department continues to refine its approach to ensure that patient voices inform service development and quality improvement.

Appendices

Appendix 1 – Summary of Mid-Year Reports

Appendix 2 – Template for National Patient Experience Survey

NEXT STEPS:

1. To incorporate where appropriate the access findings into the Unified Contract Assurance Framework process as agreed with the GMS Contract Monitoring Group.
2. Continue to develop the Access Dashboard and use to progress discussions with Practices.
3. Share lessons learned from mid-year reflective reports via Access Forum.
4. To review patient contacts and mode of contact via the Access Froum.

5. Continue to analyse raw patient survey data from the Practice patient experience surveys undertaken, to enable further analysis of patient experience.
6. To request raw patient survey data from practices as an annual requirement, to support patient experience assurance.

IMPACT ASSESSMENT
Not required.

Key Points/Summary Mid-Year Reflective Reports November 2025

1. Service Delivery and Communication	
Category	***Examples***
Flexible Access	• Telephone: Call-back functionality, structured call flows, department routing. • Email, practice website, face-to-face consultations. • Accurx: SMS messaging, self-booking links, reminders, questionnaires (reduces phone traffic). • NHS Wales App: Repeat prescriptions, personal details, immunisation history • Klinik Digital Triage: Launched at one Practice in Oct 2025 for online clinical/admin requests; phone-assisted triage ensures equity. • Titan PMR (Patient Medication Record (pharmacy software system)): Automated SMS
Improved Patient Communication	• High mobile number collection and recording onto patient record. • Clear guidance on best times/methods to contact practice via SMS, website, social media. • Batch messaging for targeted campaigns (e.g., flu clinics, vaccination invites). • Comfort greetings & signposting: Telephone system promotes alternative services (111 Press 2, Common Ailments) and practice website resources.
Operational Efficiency & Safety Nets	• Effective use of Call-back systems • Queue monitoring with visible dashboards for rapid staffing capacity adjustments. • Overflow routing & cross-trained staff for resilience during peak demand. • Task management: Structured logging of follow-ups to avoid missed requests. • Call logs and metrics monitored for continuous improvement.
Appointment Availability	• Wide range of appointments across the Multi-Disciplinary Teams (face-to-face and telephone) from 8 am–6 pm. • Self-booking links empower patients. • Automated reminders reduce DNAs

2. Progress and Actions to Remove the 8am Bottleneck	
Action Area	***Details***

Care Navigation and Triage	Trained staff triage calls at first contact, directing patients appropriately and resolving queries without repeat calls
Digital Triage	Accurx currently supports safe prioritisation; Klinik launching Oct 2025 for enhanced triage
Appointment Systems	Balanced mix of urgent same-day and routine pre-bookable slots to reduce pressure at opening time
Staggered Release of Appointments	Routine appointments released in batches
Online Access Routes	Accurx for self-booking, fit notes, medication queries, secure messaging; NHS Wales App for booking and prescriptions; Klinik for online or phone-assisted triage
Call Management Improvements	Telephone system includes call queuing, call-back functionality, structured call flows, department routing; dashboards enable rapid deployment of extra staff during peaks
Audit and Ongoing Monitoring,	Regular analysis of call data and patient feedback informs staffing and system improvements

3. Concerns / Complaints Related to Access (1 April 2025 – 30 September 2025)

Theme	***Details / Complaint***	***Action / Outcome***
Digital Access Concerns	Frustration with completing Accurx forms	Patient education identified as key
Waiting Times for Routine Appointments	Informal concerns about delays for non-urgent GP appointments	Monitoring and review of appointment availability
Clinical Allocation	Complaint about being seen by a nurse instead of a GP	Investigation confirmed clinical appropriateness and competence
Continuity of Care	Two separate GP consultations needed for same condition	EMIS appointment configuration updated for timely follow-up
Telephone Access	Long waits to get through; lack of same-day appointments at peak times	Review of call handling and appointment allocation

Communication Between Primary and Secondary Care	Frustration with delays and unclear referral/hospital waiting times	Ongoing liaison to improve clarity and timeliness

4. Communicating Access Options and Services - Ensuring Communication Reaches the Whole Population	
Communication Channel	***Purpose/Use***
Practice Website	Access info, service changes, self-care resources, urgent care guidance, contact form
Social media (Facebook etc.)	Share updates, health campaigns, engagement opportunities
Accurx, Email & Telephone	Appointment booking, reminders, questionnaires, urgent notifications, targeted engagement
Printed Materials	Posters, leaflets, welcome packs in practice and community venues
In-Practice Displays	Digital screens, Jayex boards, QR codes for quick access to health services
Face-to-Face Communication	Care Navigators and reception staff provide info during visits
Community Engagement	Updates via newsletters, community centres, collaboration with local groups
Local Media	Information in local newspapers for non-digital audiences
Patient Participation Groups	Active involvement in communication and feedback
Inclusive Access	Telephone and in-person booking for digitally excluded patients
Accessible Formats	Large print and easy-read materials for visual or cognitive impairments
Bilingual Communication	Welsh and English supported across all platforms
Translation & Interpretation	Multilingual website options, interpreter support, BSL via SignLive
Disabled Access Improvements	Upgraded hearing loops

Your NHS Wales Experience

Questionnaire (Version 2)

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 4 options and you are asked to tick the answer that you feel best describes how you feel.

Some of the questions have 'not applicable'. Please tick this if the question is not relevant to your experience.

We do not need to know your personal details but have asked some general questions at the end about who you are. This is so we can make sure we are asking all groups of people about their experience.

If there is anything we have not asked you, please use the space at the end of this survey to tell us.

If you would like to discuss this survey or ask any questions about it please contact:

How recent was the experience you are thinking of?

- ◯ In the last 6 months
- ◯ Between 1 and 2 years ago
- ◯ Between 6 months and 1 year ago
- ◯ More than 2 years ago

OFFICE USE ONLY

Area and location code:

Date of distribution:

Thinking about your overall first impressions of the care you received

1 Did you feel that you were listened to?

- ○ Always
- ○ Usually
- ○ Sometimes
- ○ Never

2 Were you able to speak in Welsh to staff if you needed to?

- ○ Always
- ○ Usually
- ○ Sometimes
- ○ Never
- ○ Not applicable

3 From the time you realised you needed to use this service, was the time you waited:

- ○ Shorter than expected
- ○ About right
- ○ A bit too long
- ○ Much too long

Thinking about the place where you received your care

4 Did you feel well cared for?

- ○ Always
- ○ Usually
- ○ Sometimes
- ○ Never

5 If you asked for assistance, did you get it when you needed it?

- ○ Always
- ○ Usually
- ○ Sometimes
- ○ Never
- ○ Not applicable

Thinking about your understanding and involvement in care

6 Did you feel you understood what was happening in your care?

- ○ Always
- ○ Usually
- ○ Sometimes
- ○ Never

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

- ○ Always
- ○ Usually
- ○ Sometimes
- ○ Never

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

- ○ Always
- ○ Usually
- ○ Sometimes
- ○ Never

Overall Experience

9 Using a scale of 0 – 10 where 0 is very bad and 10 is excellent, how would you rate your overall experience?

0	1	2	3	4	5	6	7	8	9	10
○	○	○	○	○	○	○	○	○	○	○

Very Bad — Average — Excellent

Thinking of your responses

10 **Was there anything particularly good about your experience that you would like to tell us about?**

11 **Was there anything that we could change to improve your experience?**

Patterson,Liz
30/01/2026 15:02:31

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

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, please describe:

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

Thank you for completing this questionnaire

Mae'r ddogfen yma hefyd ar gael yn Gymraeg.
This document is also available in Welsh.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 5.4

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE	**05 FEBRUARY 2026**
Subject:	**Controlled Drugs Accountable Officer (CDAO) Annual Update – October 2024 to September 2025**
Approved and presented by:	Kate Wright, Executive Medical Director
Prepared by:	Jonathan Boyd, Chief Pharmacist
Other Committees and meetings considered at:	Executive Committee - 21 January 2026

PURPOSE:

To provide the Committee with assurance on the arrangements for the safe and secure management and use of controlled drugs across Powys Teaching Health Board, summarising key governance controls, risks, learning, and priorities for the year ahead in line with statutory requirements.

RECOMMENDATION(S):

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

- **RECEIVE** the contents of the Controlled Drugs Accountable Officer (CDAO) Annual Update for October 2024 to September 2025.
- Take **ASSURANCE** that appropriate governance arrangements are in place for the safe and secure management and use of controlled drugs across Powys Teaching Health Board, in line with statutory requirements.

Approve/Take Assurance	Discuss	Note
Y	N	Y

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	This paper supports the Health Board's wellbeing objectives by strengthening governance arrangements that reduce the risk of medicines-related harm, misuse, and dependence associated with controlled drugs. Enhanced monitoring, prescribing surveillance, and incident reporting support early identification of risk and timely intervention. The report demonstrates effective joined-up working, with multi-agency intelligence sharing through the
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	Y	

8. Transforming in Partnership	Y	Controlled Drugs Local Intelligence Network supporting coordinated, system-wide responses. Ongoing workforce development, digital assurance tools, and national work to standardise training further support safe, consistent care in line with the Health Board's strategic priorities.

EXECUTIVE SUMMARY:

Controlled drugs are essential medicines but carry a higher risk of harm through error, misuse, dependence, or diversion. The Controlled Drugs (Supervision of Management and Use) (Wales) Regulations 2008 require Powys Teaching Health Board to maintain robust governance arrangements and clear executive accountability for their safe and secure management.

This paper provides the Committee with assurance on controlled drugs governance for the period October 2024 to September 2025, summarising the operation of key controls, learning from incidents, prescribing surveillance, and priorities for continued improvement.

Over the reporting period, governance arrangements have continued to strengthen and mature. The Controlled Drugs Local Intelligence Network (CDLIN) has met quarterly and remains a central assurance mechanism, enabling effective multi-agency intelligence sharing and coordinated responses to risk. Incident reporting has increased, reflecting improved awareness and reporting culture, particularly within community pharmacy, where reporting has doubled during the year. Prescribing surveillance has been enhanced and continues to provide early warning of emerging risks, supporting targeted engagement with GP practices.

Progress has also been made in improving the timeliness of controlled drug destruction, reducing the risks associated with holding expired or unwanted stock. A complete and up-to-date suite of controlled drug Standard Operating Procedures is now in place, supported by routine declarations and self-assessments in primary care, which are embedded as business-as-usual assurance arrangements.

The report recognises that further work is required, particularly to improve incident reporting from care homes and to sustain consistent engagement across all sectors. These risks are clearly identified and actively managed through targeted support, escalation where required, and continued collaboration with partners.

Overall, the arrangements described in this report provide a sound and improving level of assurance that Powys Teaching Health Board is meeting its statutory responsibilities for controlled drugs governance and is taking proportionate action to safeguard patients and the public. The priorities set out for the year ahead focus on consolidating good practice, strengthening consistency, and embedding learning across the system.

NEXT STEPS:
Following consideration by the Committee, the Controlled Drugs Accountable Officer will continue to work with the Medicines Management Team, the Controlled Drugs Local Intelligence Network, and partner organisations to deliver the priorities set out in this report. This will include strengthening incident reporting and learning, sustaining engagement across primary care and community pharmacy, improving assurance in care homes, and continuing to monitor prescribing risks. Progress against these priorities will be kept under review through established governance arrangements, with key risks, learning, and assurance updates escalated as appropriate through the Controlled Drugs Local Intelligence Network and Health Board committee structures.

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					

Controlled Drugs Accountable Officer (CDAO) Annual Update
October 2024 – September 2025

1. Introduction

Controlled drugs are essential medicines with higher inherent risk of harm through error, misuse, dependence, and diversion. Following national reforms to strengthen controlled drugs governance, designated bodies in Wales must maintain robust systems for the safe management and use of controlled drugs across all settings.

This annual report summarises controlled drugs governance in Powys Teaching Health Board for October 2024 to September 2025, including: the operation of the Controlled Drugs Local Intelligence Network (CDLIN); incident themes and learning; assurance arrangements (SOPs, authorised witnessing, declarations/self-assessment, training); prescribing surveillance; and key priorities for the year ahead. The report is intended to provide Board-level assurance and to highlight areas requiring additional focus or organisational support.

2. Controlled Drugs Accountable Officer (CDAO)

Controlled drugs are medicines that require additional safeguards because of their potential to cause harm through misuse, dependence, or diversion. In Wales, the Controlled Drugs (Supervision of Management and Use) (Wales) Regulations 2008 require all NHS organisations to have clear accountability and oversight for how these medicines are managed.

Powys Teaching Health Board complies with these requirements by appointing a Controlled Drugs Accountable Officer. The CDAO role in Powys has been held by the held by the Executive Medical Director during hand over of Chief Pharmacists. It is planned that the new Chief Pharmacist will shortly take over the role. They will report to the Executive Medical Director providing clear leadership and accountability. The Health Board is required to have a CDAO in place at all times and to formally notify Healthcare Inspectorate Wales (HIW) of any appointment or change; this requirement is met.

The CDAO is responsible for ensuring that robust systems and controls are in place across all Health Board services and relevant commissioned or contracted providers. This includes oversight of how controlled drugs are prescribed, stored, administered, destroyed, and monitored. The role is supported operationally by

the Medicines Management Team and through the Controlled Drugs Local Intelligence Network.

In practice, the CDAO provides assurance by:

- ensuring clear policies and standard operating procedures are in place and kept up to date;
- overseeing the reporting, investigation, and learning from controlled drug incidents;
- monitoring prescribing and usage patterns to identify emerging risks;
- ensuring concerns are escalated appropriately through Health Board governance structures; and
- coordinating information sharing and action with partner organisations through the CDLIN.

Together, these arrangements provide the Health Board with confidence that controlled drugs are managed safely and that risks to patients, and the public are identified early and addressed.

3. **Powys Controlled Drugs Local Intelligence Network (CDLIN)**

The Powys CDLIN continues to operate as a core assurance mechanism for the Health Board, supporting the Accountable Officer in identifying, monitoring, and responding to risks associated with controlled drugs across the Powys health and care system.

The CDLIN provides a structured forum for regular multi-agency intelligence sharing and triangulation, drawing together information from incident reports, prescribing surveillance, professional concerns, safeguarding intelligence, and enforcement activity. This enables early identification of emerging risks and coordinated, proportionate responses where concerns are identified.

The network maintains strong and consistent multi-agency engagement, including representation from NHS services, regulators, police, local authority, substance misuse services, counter-fraud, and other key partners. This breadth of membership ensures that controlled drug concerns are considered from clinical, regulatory, and safeguarding perspectives, reducing the risk of fragmented oversight.

During this reporting period, the CDLIN met quarterly, with four meetings held between October 2024 and September 2025. Each meeting reviewed occurrence reports, incident themes, and partner updates, and sought assurance that concerns had been appropriately investigated, actions taken, and learning shared. Where required, enhanced monitoring or escalation routes were agreed.

Through its ongoing operation, the CDLIN continues to provide assurance that:

- controlled drug risks are actively monitored rather than reactively managed;
- intelligence is triangulated across organisations and sectors;
- learning is shared to prevent recurrence; and
- patient and public safety remains central to decision-making.

4. CD incident reports/Quarterly Occurrence Reports

Arrangements remain in place to ensure that concerns relating to controlled drugs are promptly reported, logged, investigated, and reviewed. Powys Teaching Health Board operates a dual-route reporting system, using the national Once for Wales incident reporting system alongside a dedicated controlled drugs reporting process to ensure the Controlled Drugs Accountable Officer (CDAO) receives sufficient detail to provide effective oversight.

Quarterly Occurrence Reports are received by the Controlled Drugs Local Intelligence Network (CDLIN) from designated bodies operating within Powys, including:

- Powys Teaching Health Board
- Welsh Ambulance Services NHS Trust

In addition, the CDLIN receives regular intelligence updates from key partners including Dyfed-Powys Police, the General Pharmaceutical Council, the Ministry of Defence, out-of-hours GP services, and substance misuse services. This enables triangulation of intelligence across clinical, regulatory, and enforcement perspectives.

Incident volumes and trends

The number of controlled drug incidents reported through formal Occurrence Reports has increased during the reporting period:

Designated body	**Number of incidents reported to CD LIN Oct 23 – Sept 24**	**Number of incidents reported to CD LIN Oct 24 – Sept 25**
Powys Teaching Health Board	48	84
Welsh Ambulance Service	3	8

The increase in reporting is interpreted as a positive indicator of improved awareness, transparency, and reporting culture, rather than evidence of deteriorating practice. In particular, community pharmacy reporting continues to grow, reflecting stronger relationships and more effective shared learning across the network

Key incident themes

The most commonly reported themes during the year included:

- dispensing and prescribing errors or queries;
- balance discrepancies and record-keeping issues;
- loss, damage, or safe custody breaches;
- administration errors;
- inappropriate destruction processes; and
- drug-related harm, including suspected fatal poisonings.

Welsh Ambulance Service incidents were primarily related to accidental loss during preparation and documentation omissions.

Learning, surveillance, and escalation

The CDLIN seeks explicit assurance that all reported incidents are fully investigated, concluded appropriately, and that learning is shared. Over the last two years, incident data mapping has been strengthened to:

- identify recurring themes;
- highlight services or locations experiencing multiple incidents; and
- identify areas with little or no reporting.

This has enabled targeted interventions and enhanced surveillance where required, providing greater confidence that risks are being proactively managed rather than reactively addressed.

5. CD Standard Operating Procedures (SOPs)

Powys Teaching Health Board has a complete and up-to-date suite of Standard Operating Procedures (SOPs) in place to support the safe, secure, and lawful management of controlled drugs. These SOPs cover all key stages of the controlled drugs pathway, including ordering, storage, prescribing, administration, record keeping, monitoring, destruction, and management of concerns or incidents.

The SOPs are a core control within the medicines governance framework, providing clear expectations for staff and ensuring consistent practice across Health Board services and relevant contracted providers. They are treated as live documents, with defined ownership and regular review to reflect incident learning, audit findings, CDLIN discussions, and updates to national guidance.

All controlled drug SOPs are aligned with national best practice and sit alongside the Health Board's overarching Medicines Policy, providing assurance that controlled drugs are managed safely and in line with statutory and professional requirements.

6. CD destruction/Authorised witnesses (Regulation 10)

Our CDAO remains responsible for ensuring that robust arrangements are in place for the safe and lawful destruction of controlled drugs across the Health Board and any services delivered on its behalf.

To support this, we maintain a trained pool of nine Authorised Witnesses within the Medicines Management Team. All Witnesses operate under an approved standard operating procedure and are subject to appropriate professional standards and safeguarding checks. This provides assurance that controlled drugs are destroyed securely, consistently, and in line with legal requirements.

Over recent years, internal processes have been strengthened to improve the timeliness of destruction, reducing the risk associated with holding expired or unwanted controlled drugs. Demand for authorised witnessing has continued to increase across all sectors, reflecting improved compliance and awareness.
Importantly, performance has continued to improve. The proportion of destruction requests taking longer than 28 days has steadily reduced year on year, from 59% in 2020–21 to 18% in 2024–25, demonstrating sustained improvement in responsiveness despite rising activity.

These arrangements provide assurance that controlled drugs awaiting destruction are managed safely, that delays are minimised, and that risks of diversion or inappropriate storage are actively controlled.

Time period	Number of requests received to witness the destruction of CDs (% by area)
October 2020 – September 2021	41 (56% hospital, 34% pharmacy, 5% GP, 5% dentist)
October 2021 – September 2022	69 (63.8% hospital, 27.5% pharmacy, 7.2%GP, 1.5% dentist)
October 2022 – September 2023	88 (61.3% hospital, 18.2% pharmacy, 12.5% GP, 8% dentist)
October 2023 – September 2024	78 (51.3% hospital, 25.6% pharmacy, 15.4% dentist, 7.7% GP)
October 2024 – September 2025	103 (46% hospital, 22% pharmacy, 21% dentist, 11% GP)

The percentage of requested destructions waiting more than 28 days from the date that the request was received, to the date that the Authorised Witness attended, continues to decline (59% (Oct 20 – Sept 21), 32% (Oct 21 – Sept 22), 22% (Oct 22 – Sept 23), 19% (Oct 23 – Sept 24), 18% (Oct 24 – Sept 25).

7. Declarations and self-assessments (Regulation 12)

Declarations and self-assessments are now embedded as business-as-usual assurance arrangements to confirm that controlled drugs are being managed safely in primary care. The Accountable Officer requires general medical practitioners on the Health Board's performers list to complete declarations, providing assurance on the use and management of controlled drugs at practice level.

During 2024/25, declarations were reviewed to identify risks, inform targeted follow-up, and support proportionate assurance activity where required. A standardised digital process is now in place, enabling consistent collection and review of declarations from individual practitioners.

Declarations will continue to be required for new additions to the performers list, with periodic re-submission on a three-year cycle. Any concerns identified are addressed through follow-up, support, or escalation as appropriate. These arrangements are complemented by the powers of national regulators, providing additional system-wide assurance.

8. Education and training resources

Training and education arrangements remain in place to ensure that staff involved in the management and use of controlled drugs are appropriately trained and competent, in line with regulatory requirements.

All Authorised Witnesses are required to complete role-specific training and demonstrate competence before undertaking controlled drug destruction duties, providing assurance that high-risk activities are carried out safely and consistently.

During 2024/25, targeted education continued to support safer prescribing and harm reduction, particularly in relation to opioids and other high-risk medicines. Clinicians across Powys have engaged with nationally recognised learning resources and All Wales guidance on analgesic stewardship and pain management, supporting more consistent, evidence-based prescribing.

Looking ahead, the national Directors of Pharmacy group is working to commission standardised controlled drugs training on an All-Wales basis. This will improve competence, consistency, and shared expectations across Health Board boundaries, further strengthening system-wide assurance.

National educational resources, including those provided by Health Education and Improvement Wales and Opioids Aware, continue to be actively promoted to clinicians and patients. Patient stories remain an important part of this approach, reinforcing the real-world risks associated with inappropriate opioid use and supporting shared decision-making.

9. Monitoring CD Prescribing

The Medicines Management Team routinely monitors controlled drug prescribing patterns across Powys as a key early-warning and safeguarding control. Monitoring focuses on identifying high-risk prescribing, emerging trends, and unwarranted variation that may increase the risk of harm, dependence, or diversion.

A defined set of indicators is used to track:

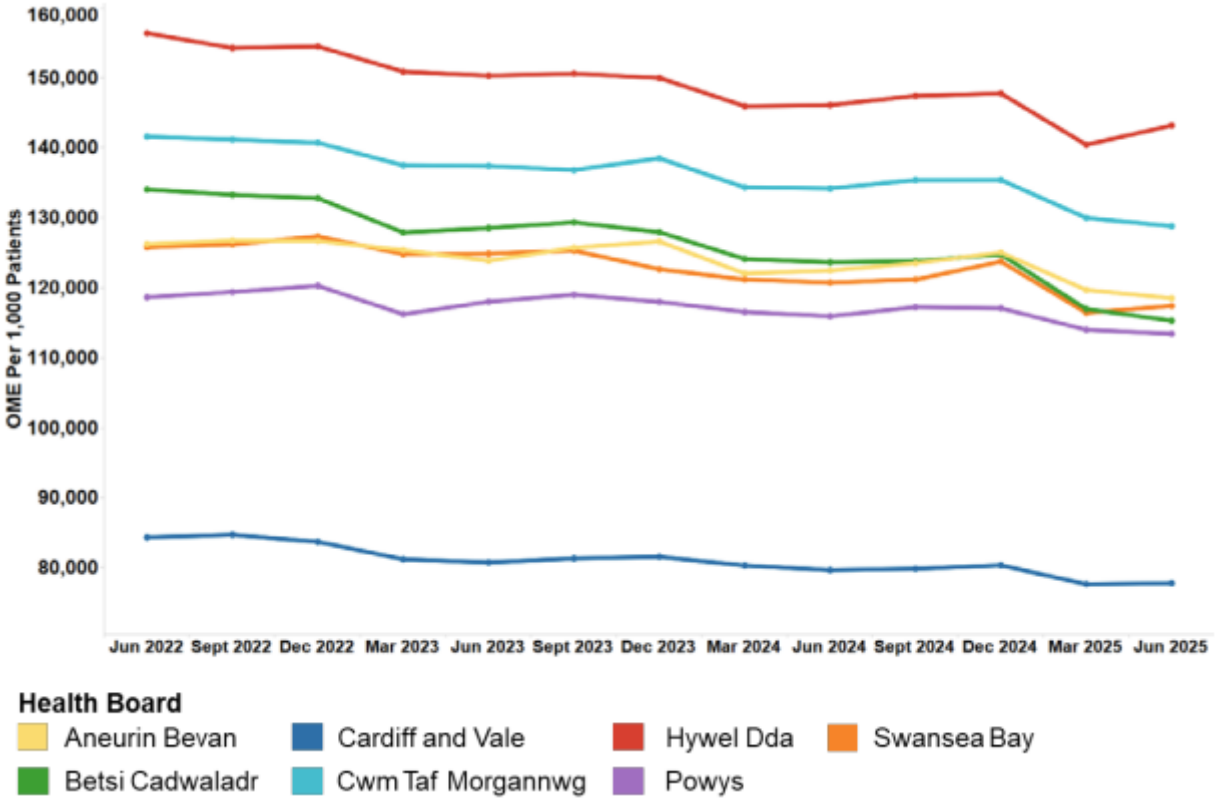
- overall and high-dose opioid use;
- prescribing of other high-risk controlled drugs, including hypnotics and gabapentinoids; and
- potentially excessive or inappropriate prescribing, such as prolonged supplies or rapid changes in volume.

Prescribing data are reviewed to understand both absolute levels of use and changes over time, enabling the early identification of practices or services that may require additional support, intervention, or assurance activity.

The outputs from this monitoring directly inform the prioritisation of controlled drugs–focused work within the Medicines Management Team. Summarised findings and emerging risks are reported quarterly to the Local Intelligence Network, ensuring intelligence is shared and actions are coordinated where necessary.

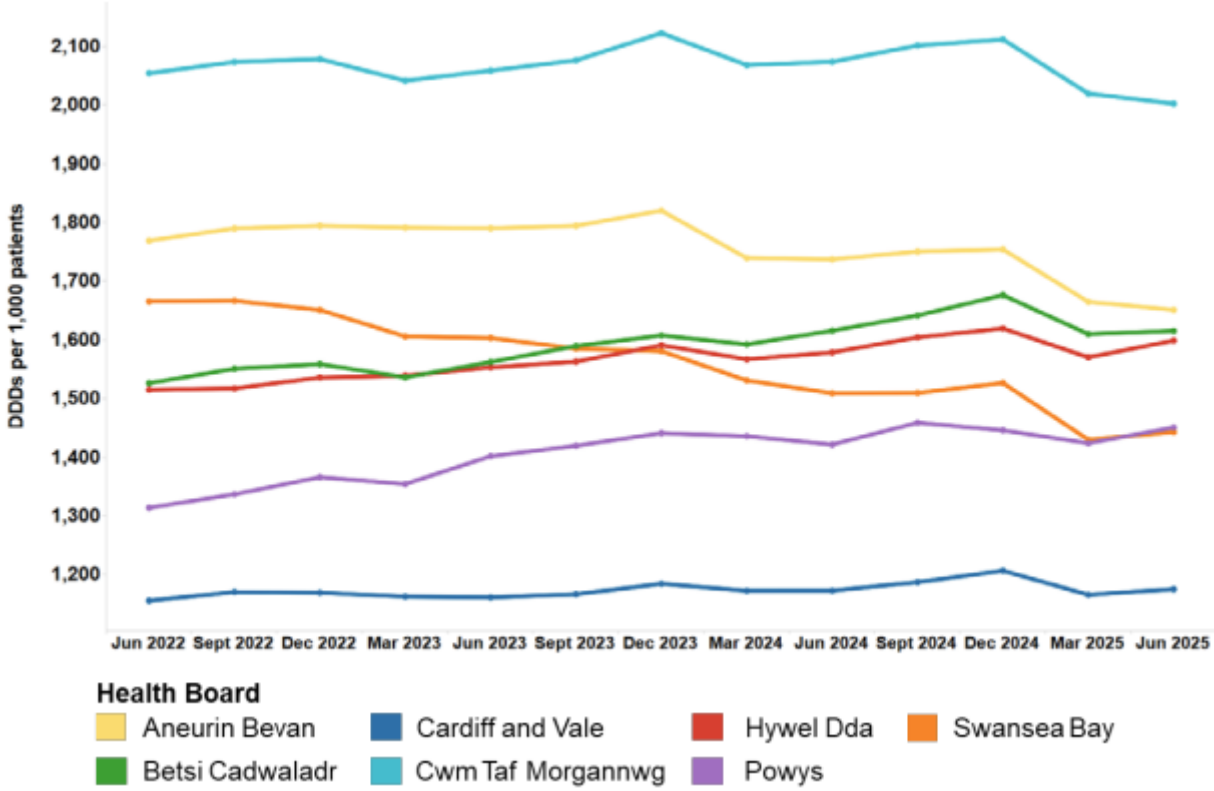
Graph 1 – Opioid burden (OME per 1,000 patients)

This graph shows that Powys Teaching Health Board consistently performs better than the national average, with opioid prescribing remaining well below national levels. The trend demonstrates a sustained and gradual reduction over time, providing assurance that opioid use in Powys is being actively managed and that efforts to reduce the risk of dependence and harm are having a positive impact.



Graph 2 – Pregabalin and gabapentin prescribing (DDD per 1,000 patients)

This graph shows a more mixed picture. While Powys Teaching Health Board continues to perform comparatively well against other health boards, prescribing of pregabalin and gabapentin has increased over time, reflecting a wider national trend. Future work will focus on learning from best practice in other health boards and providing targeted support to individual GP practices to promote safe, evidence-based use and reduce the risk of harm.



Performance indicators are used as a clinical safety and safeguarding tool to support the appropriate use of opioids, hypnotics, and gabapentinoids in primary care, helping to reduce the risks of dependence, misuse, diversion, and adverse drug reactions. The data enable the Medicines Management Team to identify priority practices and themes and target support where it is most needed.

As flagged in last year's report, further work was undertaken to understand the drivers of growth in some Schedule 2 controlled drug prescribing. This has shown that increases in both volume and cost are largely associated with ADHD prescribing, providing clarity on the underlying cause and enabling more informed monitoring and engagement.

GP practices receive quarterly prescribing reports showing their performance relative to peers. Where potentially excessive or inappropriate prescribing is identified, practices are contacted and expected to provide an explanation and, where appropriate, adjust prescribing practice. Most practices respond promptly and constructively; more focused follow-up continues with a small number of practices where risks or engagement concerns persist. Together, these arrangements provide assurance that prescribing risks are actively identified, understood, and managed, rather than simply reported.

10. Plans for the year ahead

To continue meeting statutory requirements, safeguard patients, and maintain public confidence, controlled drugs governance will remain a core priority for the Health Board. The focus for the coming year is on strengthening consistency, improving reporting, and embedding learning across all sectors.

Our key priorities:

1. Awareness and accountability
Maintain clear awareness across the Powys health and care system of the role of the CDAO, individual responsibilities for controlled drug governance, and the duty to cooperate and report concerns promptly.

2. Incident reporting and learning
Further strengthen the reporting, investigation, and sharing of learning from controlled drug incidents, ensuring timely escalation and consistent follow-up.

3. Primary care assurance:
- Embed declarations and self-assessments as routine assurance for all GPs on the performers list.
- Improve engagement with GP practices where controlled drug incident reporting remains low, using targeted support and escalation where required.

4. Care home governance
Increase controlled drug incident reporting from care homes and strengthen governance arrangements through closer collaboration with care homes and the local authority, supported by dedicated pharmacy technician resource.

5. Prescribing risk and harm reduction
Continue to strengthen scrutiny of controlled drug prescribing across primary and secondary care, including opioids, gabapentinoids, and other high-risk medicines. The rollout of electronic prescribing and medicines administration (ePMA) will further enhance visibility and assurance in community hospitals.

6. Multi-agency working and substance misuse pathways
Work with the Area Planning Board and partner organisations to address prescribing-related dependence, improve access to substance misuse services, and strengthen harm-reduction support through community pharmacy and other services.

7. System-wide assurance and consistency
Contribute to national work with Welsh Government and other CDAOs to develop standardised assurance arrangements, including for private clinicians seeking approval to requisition controlled drugs, ensuring consistent and proportionate oversight across Health Board boundaries.

11. Conclusion

Over the last 12 months, our Health Board has continued to strengthen controlled drugs governance, supported by regular operation of the Local Intelligence Network, improved intelligence sharing, and enhanced monitoring arrangements. Progress has been made in improving the timeliness of controlled drug destruction, strengthening prescribing surveillance, and sustaining constructive engagement with GP practices through regular feedback on prescribing risks and improvement actions. Education and guidance continue to support safer, more consistent prescribing.

While further improvement is required to increase incident reporting from care homes, this remains a clearly identified and actively managed risk. Engagement with community pharmacy contractors has continued to improve, with a twofold increase in incident reporting during the reporting period, strengthening system-wide learning and assurance.

Over the coming year, the Controlled Drugs Accountable Officer (CDAO), working with the CDLIN and Area Planning Board, will build on this progress to further embed consistent, safe, and coordinated arrangements for the management and use of controlled drugs across Powys, maintaining a strong focus on patient safety and public protection.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 5.5

Patient Experience, Quality and Safety Committee	**05 FEBRUARY 2026**
Subject:	Patient Experience, Quality and Safety Committee Terms of Reference
Approved and presented by:	Helen Bushell, Director of Corporate Governance and Board Secretary
Prepared by:	Deputy Board Secretary
Other Committees and meetings considered at:	N/A

PURPOSE:

The purpose of this paper is for the Committee to consider the Terms of Reference of the Patient Experience, Quality and Safety Committee in order to ensure that they remain fit for purpose.

RECOMMENDATION(S):

The Committee is asked to:

- **ENDORSE** the proposed amendments to the Terms of Reference;
- **IDENTIFY** any further potential amendments;
- **AGREE** that the Chair of the Committee and Director of Corporate Governance will finalise the revised Terms of Reference for presentation to the Board in May 2026 for approval.

Approve/Take Assurance	Discuss	Note
Y	Y	

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

EXECUTIVE SUMMARY:

Under the Standing Orders of the Health Board, Board Committees are required to review their Terms of Reference on an annual basis.

The existing Terms of Reference (May 2025) for the Patient Experience, Quality and Safety Committee together with tracked changes of proposed amendments are attached as Appendix A.

Any suggested changes will need to be recommended to the Board for approval.

The Chair of the Committee and Director of Corporate Governance will take forward any recommendations and/or final amendments to the Board in May 2026 to take effect into 2026/27.

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

Section of Terms of Reference	Updates
3 – Delegated Powers and Authority	Updates to reflect changes in regulations and the move to the Peoples Experience Framework
Tidying up	The document has undergone general tidying up to ensure correct formatting, job titles etc.

NEXT STEPS:

The Chair of the Committee and Director of Corporate Governance will take forward any recommendations to the Board in May 2025 to take effect into 2025/26.

APPENDICES

a. Patient Experience, Quality and Safety Committee Terms of Reference (Approved May 2025 with suggested amendments February 2026)

Patient Experience, Quality and Safety Committee

Terms of Reference & Operating Arrangements

~~Approved~~ Draft ~~May~~February 202~~5~~6~~5~~

1. INTRODUCTION

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

"*The Board may and, where directed by the Welsh Government must, appoint Committees of the Health Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of its business extends equally to the work carried out on its behalf by committees*".

1.2 The Health Board has established a committee to be known as the **Patient Experience, Quality and Safety Committee** (referred to throughout this document as 'the Committee'). The Terms of Reference and operating arrangements set by the Board in respect of this committee are provided below.

2. PURPOSE

2.1 The scope of the Committee extends to the full range of PTHB responsibilities. This encompasses all areas of patient experience, quality and safety relating to patients, carers and service users, within directly provided services and commissioned services. The Committee will embrace the Health and Care Quality Standards as the Framework in which it will fulfil its purpose:

- Safe
- Effective
- Timely
- Person Centred
- Efficient
- Equitable

2.1 ADVICE

The Committee will provide accurate, evidence based (where possible) and timely advice to the Board and its committees in respect of the development of the following matters, consistent with the Board's overall strategic direction

- Citizen Experience; and
- Quality and Safety of directly provided and commissioned services.

2.2 ASSURANCE

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

a. The robustness of the Board's Clinical Quality Framework;
b. the experience of patients, citizens and carers ensuring continuous learning;
c. the provision of high quality, safe and effective healthcare within directly provided and commissioned services;

d. the effectiveness of arrangements in place to support Research and Innovation and
e. compliance with mental health legislation, including the Mental Health Act 1983 (amended 2007) and the Mental Capacity Act 2005.

3 DELEGATED POWERS AND AUTHORITY

3.1 With regard to the powers delegated to it by the Board, the Committee will:

A. Seek assurance that the Health Board's has relevant total quality management frameworks in place (via the Integrated Quality and Performance Framework and other associated plans) to ensure quality is central to health board activity, is aligned to national standards and is embedded in practice.

B. Seek assurance that arrangements for capturing the **experience of patients, citizens and carers** are sufficient, effective and robust, including:

- the delivery of the ~~Patient Experience Framework~~ People's Experience Framework;
- patient experience in primary care; and
- the implementation of ~~Putting Things Right~~ Listening to People regulations (to include patient safety incidents, complaints, compliments, clinical negligence claims and inquests) reporting trends, with particular emphasis on ensuring that lessons are learned.

C. Seek assurance that arrangements for **the provision of high quality, safe and effective healthcare** are sufficient, effective and robust, including:

- the systems and processes in place to ensure efficient, effective, timely, dignified and safe delivery of directly provided services;
- the commissioning assurance arrangements in place to ensure efficient, effective, timely, dignified and safe delivery of commissioned services;
- the arrangements in place to undertake, review and act on clinical audit activity which responds to national and local priorities;
- the recommendations made by internal and external review bodies, ensuring where appropriate, that action is taken in response;

- the arrangements in place to ensure that there are robust infection, prevention and control measures in place in all settings;
- receipt of the Medical Appliances Annual Report;
- the development of the Bboard's Duty of Quality Annual Report; and
- performance against key quality focussed performance indicators and metrics.

D. Seek assurance on the arrangements in place to support **Improvement and Innovation**, including:
   - an overview of the research and development activity within the organisation;
   - alignment with the national objectives published by Health and Care Research Wales (HCRW);
   - an overview of the quality improvement activity within the organisation.

E. Seek assurance that arrangements for **compliance with mental health legislation** are sufficient, effective and robust, including:
   - the Mental Health Act 1983 Code of Practice for Wales and associated regulations;
   - the Mental Capacity Act 2005 Code of Practice and associated regulations;
   - the Mental Capacity Act 2005 Deprivation of Liberty Safeguards Code of Practice and associated regulations; and
   - the Mental Health Measure (Wales) 2010.

3.2 The Committee will consider and recommend to the Board for approval those policies reserved for the Board and delegated to this Committee for review, in-line with the Board's Management of Policies and Other Written Control Documents Policy and Scheme of Delegation and Reservation of Powers.

3.3 The Committee will seek assurances on the management of strategic risks delegated to the Committee by the Board, via the Strategic Risk Register.

Authority

3.4 The Committee is authorised by the Board to investigate or have investigated any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the Health Board relevant to the Committee's remit and ensuring patient/client and staff confidentiality, as appropriate. It may seek any relevant information from any:

- employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and
- any other committee, sub committee or group set up by the Board to assist it in the delivery of its functions.

3.5 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary (subject to the Board's procurement, budgetary and any other applicable standing requirements).

Access

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

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

Sub Committees

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

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

Committee Programme of Work

3.10 Each year the Board will determine the Committee's priorities for its annual programme of work, based on the Board's Assurance Framework and Strategic Risk Register. This approach will ensure that the Committee's focus is directed to the areas of greatest assurance needs. This will therefore mean that these Terms of Reference are provided as a framework for the Committee's annual programme of work and is not an exhaustive list for full coverage. This approach recognises that the Committee's programme of work will be dynamic and flexible to meet the needs of the Board throughout the year.

4 MEMBERSHIP

Members

4.1 Membership will comprise:

Chair	Vice Chair of the Board
Vice Chair	Independent Member of the Board
Members	Independent Members of the Board x2

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

The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

Attendees

4.2 In attendance: The following Executive Directors of the Board will be regular attendees:

- Executive Director of Nursing, Quality, Women and Family Health (Officer Lead)
- Executive Director of Allied Health Professions, Health Science and Digital
- Executive Medical Director
- Executive Director of Public Health
- Executive Director of Primary Care, Community and Mental Health

4.3 By invitation:

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

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

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

Secretariat

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

Member Appointments

4.4 The membership of the Committee shall be determined by the Board, based on the recommendation of the Chair of PTHB - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

4.5 Members shall be appointed to hold office for a period of one year at a time, up to a maximum of their term of office. During this time a member may resign or be removed by the Board.

4.6 Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Board, based upon the recommendation of the Chair of PTHB.

Support to Committee Members

4.7 The Director of Corporate Governance / Board Secretary, on behalf of the Committee Chair, shall:

- arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and
- ensure the provision of a programme of development for committee members as part of the Board's overall Development Programme.

5 COMMITTEE MEETINGS

Quorum

5.1 At least **three** members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice Chair.

5.2 Where members are unable to attend a meeting and there is a likelihood that the Committee will not be quorate, the Chair can invite another independent member of the board to become a temporary member of the Committee.

Frequency of Meetings

5.3 The Chair of the Committee shall determine the timing and frequency of meetings, which shall be held no less than four times a year, and in line with the Health Board's annual plan of Board Business.

5.4 The Chair of the Committee may call additional meetings if urgent business is required to be taken forward between scheduled meetings.

Openness and Transparency

5.5 Section 3.1 of PTHB Standings Orders confirms the Board's commitment to openness and transparency in the conduct of all its business and extends equally to the work carried out on its behalf by Committees. The Board requires, wherever possible, meetings to be held in public. The Committee will:

- hold meetings in public, other than where a matter is required to be discussed in private (see point 5.6);
- meetings may be held virtually with opportunities extended to the public to observe meetings held virtually on request;
- issue an annual programme of meetings (including timings and venues) and its annual programme of business;
- publish agendas and papers on the Health Board's website in advance of meetings;
- ensure the provision of agendas and minutes in English and Welsh and upon request in accessible formats, such as Braille, large print, and easy read;
- where appropriate items may be included as 'consent' items (items that do not require discussion or debate either because they are routine or have already been unanimously agreed. A Consent Agenda allows the Committee to approve all these items together without discussion which can free up the meeting for more substantial discussion. When using a Consent Agenda, the Chair will invite members to request a discussion on any item on the Consent Agenda. If a request is made this item will move onto the Main Agenda for discussion); and
- through PTHB's website, promote information on how attendees can notify the Health Board of any access needs sufficiently in advance of a proposed meeting, e.g., interpretation or translation arrangements, in accordance with legislative requirements such as the Equality Act 2010 and Welsh Language Standards 2018.

Withdrawal of individuals in attendance

5.6 There may be circumstances where it would not be in the public interest to discuss a matter in public, e.g., business that relates to a confidential matter. In such cases the Chair (advised by the Director of Corporate Governance / Board Secretary where appropriate) shall schedule these issues accordingly and require that any observers withdraw from the meeting. In doing so, the Committee shall resolve:

That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with

Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67).

In these circumstances, when the Committee is not meeting in public session it shall operate in private session, formally reporting any decisions taken to the next meeting of the Committee in public session.

Other meeting arrangements

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

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

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

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, the Board retains overall responsibility and accountability for all matters relating to patient experience, quality and safety. The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.2 The Committee, through its Chair and members, shall work closely with the Board's other committees, joint and sub committees and groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business (holding joint meetings where appropriate);
- sharing of appropriate information; and
- appropriate escalation of concerns.

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

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

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

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

- bring to the Board's specific attention any significant matters under consideration by the Committee;

- ensure appropriate escalation arrangements are in place to alert the Chair of PTHB, Chief Executive or Chairs of other relevant committees/groups of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

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

7.2 The Director of Corporate Governance / Board Secretary shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of further committees established.

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

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum

9. CHAIR'S ACTION ON URGENT MATTERS

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

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

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

10. REVIEW

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

Agenda item: 5.6

Patient Experience, Quality and Safety Committee	Date: 04 February 2026
Subject:	**Committee Risk Register**
Approved and presented by:	Helen Bushell, Director of Corporate Governance
Prepared by:	Deputy Board Secretary
Other Committees and meetings considered at:	Executive Committee – 19 November 2025 Board – 29 November 2025
Appendices :	Appendix A – Committee Risk Register

PURPOSE:

The purpose of the Committee Risk Register is to draw together relevant risks for the Committee from the Strategic Risk Register (SRR), to provide a summary of the significant risks to delivery of the health board's strategic objectives. This copy of the Committee Risk Register is based upon the SRR received by the Board on 26 November 2025.

RECOMMENDATION(S):

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

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

Approve/Take Assurance	Discuss	Note
Y	Y	x

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	The corporate risks are a reflection of the significant risks to the delivery of the health board's strategic objectives and therefore underpin all wellbeing objectives.
2. Provide Early Help and Support	Y	
3. Tackle the Big Four	Y	
4. Enable Joined up Care	Y	
5. Develop Workforce Futures	Y	
6. Promote Innovative Environments	Y	
7. Put Digital First	Y	
8. Transforming in Partnership	Y	

COMMITTEE RISK REGISTER

The Committee has routinely received a Committee Risk Register which draws together relevant risks from the Corporate Risk Register (CRR) to provide a summary of the significant risks to the Health Board's within the Committee's remit.

This copy of the Committee Risk Register is based upon the received by the Board on 26 November 2025.

The Committee Risk Register is attached at **Appendix A.**

NEXT STEPS:

The Committee will continue to seek assurance on the ongoing development and management of patient experience, quality and safety risks as set out above.

The next Strategic Risk Register update is due to the Board on 25 March 2026.

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

Committee Risk Register

Patient Experience, Quality and Safety Committee

February 2025

STRATEGIC RISK DASHBOARD – NOVEMBER 2025

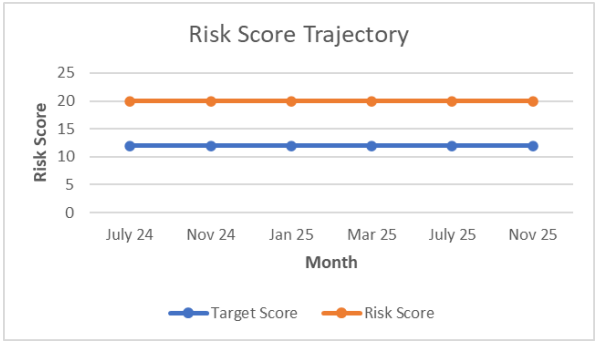
Risk Lead	Risk ID	Risk Category	Risk Description There is a risk that:	SCORE (Likelihood x Impact)	Trend	Board Risk Appetite	At Target ✓/×	Lead Board Committee	Link to Strategic Priorities:
EDPP&C	SRR 003	**Performance and Service Sustainability**	The Health Board is unable to respond to the demand for commissioned services	**5 x 4 = 20**	➔	Open	×	Patient Experience, Quality and Safety	SP 11 and WBO 8
EDPCCMH	SRR 004	**Performance and Service Sustainability**	The Health Board is unable to respond to the demand for provided services.	**4 x 4 = 16**	➔	Open	×	Patient Experience, Quality and Safety	Several SPs and WBOs 4 and 8

KEY:

Executive Lead	
EDPP&C	Executive Director of Planning, Performance and Commissioning
EDPCCMH	Executive Director of Primary Care, Community and Mental Health
Trend	
*	**New risk**
➔	**Risk score unchanged since last report**
↓	**Risk score decreased since last report**
↑	**Risk score increased since last report**

RISK HEAT MAP – NOVEMBER 2025

Almost certain 5				**SRR 003 – Commissioning**	
Likely 4				**SRR 004 – Provider**	
Possible 3					
Unlikely 2					
Rare 1					
LIKELIHOOD X IMPACT	**Insignificant 1**	**Minor 2**	**Moderate 3**	**Major 4**	**Catastrophic 5**

SRR 003	There is a risk that the Health Board is unable to respond to the demand for commissioned services	
Current Risk Score: **20**	**Risk rating detail:** (likelihood x impact) Current: L5 x I4 = 20 Inherent: L5 x I4 = 20 Target: L3 x I4 = 12	**Risk Category:** Performance and Service Sustainability **Boards Risk Appetite:** **Open**
Executive Lead: Executive Director of Planning, Performance & Commissioning		**Assuring Committee:** Patient Experience, Quality & Safety Committee
Latest review date: October 2025 **Added to register:** July 2024 **Link to Strategic Priorities and Wellbeing Objectives:** SP 11 and WBO 8		**Cause of risk and rationale for current score:** • Increase in demand, inequality of access, complexity of patient needs, or failure to respond to demand pressures • Planned Care NHS Wales – number of patients waiting > 52 weeks improved however only SBUHB compliant for Powys residents. Very long waits (>104 weeks) continue to increase. SBUHB has reported no Powys resident pathways > 104 weeks. Challenges remain with in-reach provision due to capacity fragility and complex diagnostic delays. • Planned Care NHS England: PTHB requested NHSE providers to deliver to NHSW waiting times targets. WVT reporting 69.4% of pathways waiting <26 weeks for treatment. SATH reporting more challenged position. No patients >104 weeks but continuing to report patients >52 weeks. RJAH remains most challenged provider for

		long waiters. 78 > 104 weeks reported in July. Very long waits exceed 200 weeks, especially for complex spinal. • ~~Planned care recovery continuing to accelerate in NHSE.~~ • ~~High volumes of patients waiting > 52 weeks and > 104 weeks in NHS Wales. Cabinet Secretary expectations to improve waiting times in NHS Wales.~~ • The risk relates to the Timely, Equitable, Effective and Patient Experience elements of the Duty of Quality. **Risk materialising could result in:** • Poorer outcomes and experience for the citizens of Powys • Difficulty in balancing performance and financial plan

Controls (What has been implemented to manage the risk?)		**Sources of Assurance**	**Level of Assurance**	**Highest Assurance provided to:**
3.1	For Planned Care Services - Regular review of demand pressures by looking at referral levels into services	Referral data into services from commissioning data sets and supplementary reports received from commissioned providers. Low assurance currently due to robustness of referral data. Exploring alternative data sources (e.g. activity) whilst working through improved data set for GP referrals.	Limited	Executive Director

3.2	For Urgent & Emergency Services – Regular review of demand pressure by reviewing attendance rates and emergency inpatient volumes	Attendance data into services from commissioning data sets and supplementary reports received from commissioned providers	Reasonable	Executive Director
3.3	Using demand data to plan to commission sufficient service provision for all services provided out of county, noting the need to agree a balanced finance and performance position as part of the IMTP process	Demand, activity and financial information from commissioning datasets used to inform contract plans	Reasonable	Executive Director
3.4	Reviewing where services do not meet clinical and operational standards	Various data sources including operational & performance data.	Limited	Executive Director
3.5	Improving the outcomes and experience data capture to inform future reporting on commissioned services to the Finance and Performance Committee and Board as well as future planning	Various data sources including operational & performance data. Qualitative information from QMS, PROMS & PREMS reporting, concerns, NRIs, clinical audit, regulatory inspections	Limited	Executive Director

Mitigating Actions (What more will we do?)

Action	Lead	Action update	Deadline	Action on Target
<u>Planned Care</u> ▪ Continue regular meetings with commissioned service providers. ▪ Secure performance improvement trajectories from providers.	Executive Director of Planning, Performance and Commissioning (supported by DPCCMH)	Performance Trajectories and details on harm reviews for Powys residents requested from commissioned service providers in NHS England and	April 2025 and ongoing	~~On track~~ Delayed (Procurement)

▪ Insourcing contract extended to offer Powys residents experiencing long waits in commissioned service providers in NHS Wales to be treated in Powys. ▪ Ongoing scrutiny and oversight through CQPR meetings with escalation through Integrated Quality and Performance Report. ▪ Continuing to work to obtain robust data for referrals from NHSW and NHSE GPs for Powys residents.		NHS Wales to understand expected performance 2025/26 and to be reviewed and discussed through CQPRMs. Planned Care Insourced provision tender exercise delayed. Mitigating actions put in place to ensure continuity of service provision whilst tender exercise undertaken. Paper presented to Executive Committee for decision. Established Commissioning Oversight and Assurance Group (COAG), chaired by Exec DPPC, to provide a forum for internal oversight and escalation of performance monitoring of commissioned non-specialist services.		
▪ Cancer	MD (supported by DPPC)	Added to this version of the risk register. Actions to be agreed.	TBA	TBC

Commented [NJ1]: Can we put anything in about revived cancer Working Group?

Commented [NJ2R1]: Also COAG will cover all specialities

		Cancer Working Group chaired by Medical Director. CQPRMs and COAG cover all specialties with commissioned providers. Cancer Deep Dive to be presented to F&P Committee October 2025.		
Urgent and Emergency Care ▪ CQPRMS cover all specialties with commissioned providers including UEC. ▪ Continued work on 6 Goals plan to reduce admissions and secure timely discharge. ▪ Strengthening arrangements for admissions to community beds in NHSE. ▪ Continue series of regular meetings with WAST and commissioned service providers. ▪ Continue commissioning of ambulance services in partnership through the Joint Commissiong Committee	DPPC (supported by DPCCMH)	CQPRMS and COAG cover all specialties including urgent and emergency care. Historically had regular meetings (ICAP and Q&S) with Health Boards and WAST to cover performance, patient experience, incidents and resultant investigations, clinical indicators. Several recent ICAP meetings have been cancelled. Regular attendance at CCLG and sub- committee structure. New governance structure ~~being~~ developed by the JCC	April 2025 and ongoing	On track

▪ Secure performance improvement trajectories and improvement plans from providers.		with establishment of Ambulance Services and 111 Collaborative Commissioning Integration Group. ~~Terms of Reference awaited.~~ Standing agenda item in CQPRMs to review improvement plans, patient experience, and patient harm.		
<u>All indicators</u> There are some performance indicators that continue to fail the operational standard e.g. Single Cancer Pathway, 4 Hour ED waits. The Health Board will develop a suite of indicator sub-sets to determine if any improvement is being made towards achievement of the overall target.	DPPC	Integrated Quality and Performance Framework (IQPF) has been reviewed and refreshed for 2025/26. As part of the IQPF, the Integrated Quality and Performance Report will continue to provide information across the NHS Wales Performance Framework measures including Cancer and 4 hour ED waits.	April 2025 and ongoing	On track
Additional information:				
Rationale for current score: **<u>Planned Care</u>** **NHS Wales** • Latest validated position to month 5 as per IQPR month 5 report presented to Executive Committee 15th October 2025.~~1~~ (April 2025):				

- Swansea Bay UHB and Hywel Dda UHB continue to meet the stage 1 waits target reporting zero pathways over 52 weeks for Powys residents. However, the overall position in Wales increases in pathways over 52 weeks with Aneurin Bevan UHB and Cwm Taf Morgannwg UHB reporting special cause concern.
- Only Swansea Bay UHB remains compliant in April reporting no pathways over 104 weeks. All other providers bar Cardiff and Vale UHB continue to report special cause improvement. But the overall number increases from 41 in March to 62 in April 2025.

Challenges

• NHS Wales Planning and Performance Frameworks 2025/26:
  ○ No patients waiting over 104 weeks for referral to treatment.
  ○ No patients waiting over 52 weeks for new outpatient appointment.
  ○ No patients waiting over 8 weeks for specified diagnostics.
• Welsh acute care providers continue to experience ongoing challenges due to increased demand and service sustainability issues.
• Powys residents who can have their pathways within the Powys as a provider have the quickest reported care, and with English acute health trusts providing more timely access for residents in the North & East of the county. Those residents living in southwest health economy wait the longest.
• Long wait pressure by treatment specialty remains within General Surgery, Trauma & Orthopaedics, ENT, and Ophthalmology.

Actions & Mitigations
• Welsh including Powys provider services, have mobilised additional capacity including insourcing, outsourcing, increase usage of additional payments for clinical activity. • Ongoing repatriation scoping workstream for Powys residents who may be able to have treatment/care within PTHB or alternative provider. • Continued to engage on a regular basis with all commissioned providers via contracting, quality and performance meetings. These meetings are used to discuss challenges and highlight key concerns but primarily to support the best possible care for Powys responsible patients within current health contracts. Also note progress against GIRFT pathway and case mix recommendations are discussed and noted. • PTHB developed productive pathways for planned care with actions including referral management, effective clinically led pathways, implementation of GIRFT recommendations, theatre utilisation improvement. • All Welsh providers have been formally contacted to request confirmation of when those patients waiting > 104 weeks will be seen.

NHS England

- Latest validated position month 12 (March 2025):

- Powys residents in England have consistently waited less time for treatment except for Robert Jones & Agnes Orthopaedic Hospital NHS Foundation Trust (RJAH), all wait bands are reporting special cause concern at an aggregated level.
- **Wye Valley NHS Trust (WVT)** reports the best performance of all Powys commissioned providers with 70.1% of pathways waiting under 26 weeks for treatment, 113 wait over 52 and of these 4 pathways wait between 77 and 104 weeks for Ophthalmology and respiratory medicine. WVT is the only English provider to consistently report special cause improvement for all key wait bands.
- **The Shrewsbury & Telford Hospital NHS Trust (SATH)** reports a more challenged position with all key wait bands reporting special cause concern e.g., the total numbers of waiters in these bands is increasing. The key challenged specialties for long waiting pathways in SATH are Ophthalmology and Oral Surgery which make up 24 of the total 27 pathways between 77 and 104 weeks.
- **The Robert Jones and Agnes Hunt Orthopaedic Hospital (RJAH)** remains the most challenged English provider for long waits the SPC chart (right) shows a growing trend of very long waiters and with all key wait bands are reporting special cause concern. Historically RJAH has always been challenged by complex spinal pathways but in March of the 40 total breaches 16 are for Knee & Sports Injuries, 12 are complex spinal, 10 reported for Arthroplasty pathways, and 2 in upper/lower limb. The longest wait for a complex spinal pathway awaiting specialist unit was reported by the provider at 307 weeks.

- Work ongoing with NHSE providers, primarily RJAH, SaTH and WVT, re PTHB Commissioning Intentions 2025/26, commissioning to NHS Wales treatment targets.

~~Cancer~~

- ~~Cancer performance remains poor against the 62 day targets in both English and Welsh commissioned services.~~

~~Urgent and Emergency Care (latest position April 2025)~~

~~Welsh Emergency Access (A&E) providers~~

- ~~Powys residents have seen a slight increase to 66.3% for those waiting under 4 hrs in Welsh units.~~
- ~~Number of patients reported waiting over 12 hrs was 124 for April 2025~~

~~English Emergency Access (A&E) providers~~

- ~~It should be noted that the English information is not complete, Shrewsbury and Telford NHS Trust data has not been available consistently from Q1 2024/25.~~
- ~~PTHB residents attending English emergency units see the longest wait with 47.4% reported in March as waiting less than 4hrs in their units.~~
- ~~Of the reported health board 140 patients were reported waiting over 12hrs (predominately Wye Valley NHS Trust).~~

~~Data Quality~~

- ~~Information on emergency department waits can be delayed especially from English providers, this results in retrospective updates of performance which will be noticeable between reporting month although minor.~~

Update including impact of actions to date on current risk score:

Improved performance experienced within NHS England commissioned service providers; expected improvement in NHS Wales expected following issue of additional planned care monies in 2025/26, and national procurement process for outpatients and treatments.

Continued inequity of access for PTHB residents accessing NHSW services in comparison with NHSE.

SRR 004	There is a risk that the Health Board is unable to respond to the demand for provided services	
Current Risk Score: **16**	**Risk rating detail:** (likelihood x impact) Current: L4 x I4 = 16 Inherent: L4 x I4 = 16 Target: L3 x I4 = 12	**Risk Category:** Performance and Service Sustainability **Boards Risk Appetite:** **Open**
Executive Lead: Executive Director of Primary Care, Community and Mental Health (PCCMH)		**Assuring Committee:** Patient Experience, Quality & Safety Committee
Latest review date: October ~~July~~ 2025 **Added to register:** July 2024 **Link to Strategic Priorities and Wellbeing Objectives:**		**Cause of risk:** • Increase in demand, inequality of access, complexity of patient needs, or failure to respond to demand pressures. **Risk materialising would result in:** • Poorer outcomes and experience for the citizens of Powys • Increased system pressure across urgent and emergency care pathways. • Reduced efficiency in patient flow and bed utilisation • Inability to meet national performance targets and ministerial priorities.

Several SPs and WBO 4 and 8				
Controls (What has been implemented to manage the risk?)		**Sources of Assurance**	**Level of Assurance**	**Highest Assurance provided to:**
4.1	For Planned Care Services - Regular review of demand pressures by looking at referral levels into services. Reviewing all in-reach SLA with partner organisations to achieve a more sustainable offer. Maximising insourcing offer to ensure optimal performance standards are achieved. Implement as many Optimisation frameworks and 5 Goals for Planned Care as appropriate for a community-based provider	• Referral data into services from commissioning data sets and supplementary reports received from commissioned providers Best practice guidance from GIRFT and Welsh Government / NHS Exec	Reasonable	Finance & Performance
4.2	For Urgent & Emergency Services – Regular review of demand pressure by reviewing attendance rates and emergency inpatient volumes	Attendance data into services from commissioning data sets and supplementary reports received from commissioned providers	Reasonable	Finance & Performance
4.3	All services - using demand data to plan to provide the correct level of services provision for all services provided in county	Demand, activity and financial information from commissioning datasets used to inform contract plans	Reasonable	Finance & Performance
4.4	Reviewing where services do not meet clinical and operational standards	Various data sources including operational & performance data.	Reasonable	Finance & Performance
4.5	Constantly reviewing staffing level and the amount of agency staff being used. Additional control procedures in place to the reliance on agency staff (particularly	Various workforce and financial reports recording agency usage at ward and service level	Reasonable	Finance & Performance

	higher cost agency providers) and deliver expected cessation.			
4.6	Improving the outcomes and experience data capture to inform future planning	Various data sources including operational & performance data. Qualitative information from PROMS & PREMS reporting, clinical audit, regulatory inspections	Reasonable	Finance & Performance
4.7	Development and implementation of integrated system coordination mechanisms—including the Integrated Flow Hub, daily discharge huddles, Trusted Assessment processes, and the expansion of Powys DigiFLO—to enhance system resilience and operational efficiency. This control supports delivery of the PTHB Six Goals for Urgent and Emergency Care, contributes to the NHS Wales People's Experience Framework, and enables a shift toward a prevention-based, value-driven model of care.	Task & Finish Group reports, baseline assessment against National SPoA Framework, operational data (Package of Care Delays, PoCD), pilot evaluations and implementation monitoring reports	Reasonable	Finance & Performance

Mitigating Actions (What more will we do?)

Action	Lead	Action update	Deadline	Action on Target
<u>Planned Care</u> ▪ Continue series of regular meetings with service providers ▪ Monitor and manage delivery against performance improvement trajectories for our own services. ▪ Medinet contract extended to offer Powys residents experiencing long waits in commissioned service	Executive Director PCCMH	Performance Trajectories being routinely monitored and managed.	September 2026	On track

providers in NHS Wales to be treated in Powys. Work being progressed to issue a tender for insourced provision in 2025/26. Ongoing scrutiny and oversight through CQPR meetings with escalation through Integrated Performance Report.				
<u>General Service Sustainability & Future Models of Care</u> The health board is currently reviewing models of care as part of its five-year plan but also in response the staffing and financial challenges. ▪ A number of service reviews are being undertaken with several 'cases for change' having been approved by the Health Board and stakeholders.	Executive Director PCCMH	Overall case for change now available for second phase engagement, with options development completed and available for future engagement and consultation. Further work ongoing to develop and implement service change that falls below threshold for consultation.	April 2026	On track
There are some performance indicators that continue to fail the operational standard e.g. Neuro-developmental target. The Health Board will develop a suite of indicator sub-sets to determine if any improvement is being made towards achievement of the overall target.	Executive Director PCCMH	A number of sub-indicator performance targets have been identified. These have been built into the IQPR and actions in train to further reduce risk	December 2025	On track
Operationalise and expand integrated system coordination mechanisms—including the Integrated Flow Hub, daily	Executive Director PCCMH	Flow Hub: model scoped, and roles identified; launch planned for December 2025.	March 2026	On Track

discharge huddles, Trusted Assessment processes, and DigiFLO rollout—to mitigate delays, improve patient flow, and support timely discharge across the system.		PoCD: Daily tracking and escalation in place; overall delays reduced, recognising seasonal variation. Daily 'huddle' to review patients in place. DigiFlo: Implemented on community hospital wards, expansion into MH has been progressed. Trusted Assessment: Pilot completed in collaboration with PCC with early findings indicating positive impact.		

Additional information:

~~**Rationale for current score:**~~

~~**Planned Care**~~

- ~~NHS Wales Ministerial standards~~
- ~~Whilst services generally perform well against access targets, the fragility of some of the in-reach SLAs creates inherent operational risk to delivery.~~

~~**Inpatient Beds**~~

- ~~At present capacity is part staffed by continued reliance upon agency staff. This is not a sustainable or affordable model.~~
- ~~On any given day, over 40% of our beds can be occupied by patients that are clinically optimised and ready for discharge. They are delayed due to a lack of capacity in onward parts of the pathway. Elongated lengths of stay can have a detrimental impact to the long term needs for patients, and an increase to overall rehabilitation needs~~

~~**Primary Care**~~

- ~~There are some recruitment challenges for staffing in primary care.~~
- ~~Dental access and capacity required does not currently meet demand.~~

~~**Minor Injury Units**~~

- ~~Powys MIUs continue to performance well, in May (latest validated available) reported 100% compliance against 4 hour target and no patients waiting longer than 12 hours.~~

~~**Mental Health**~~

~~Elements of the service are currently in internal performance and scrutiny escalation~~

Rationale for Current Score: Mitigation actions are ongoing, but some underlying challenges remain, so the current risk score remains unchanged at this review. Collaborative efforts through the *Better Together* programme are expected to provide further support in addressing this strategic risk alongside mitigating actions listed above.

Decontamination

Final Internal Audit Report

2025/26

Powys Teaching Health Board

Reasonable Assurance

Contents

Review Reference	PTH-2526-23
Fieldwork	September – November 2025
Executive Sign Off	16th December 2025
Audit Committee	13th January 2026
Executive Lead	Paul Hooton, Executive Director of Nursing, Quality, Women and Family Health
Audit Team	Ian Virgill, Head of Internal Audit
	Warren Alexander, Audit Manager

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Executive Summary

Purpose

Our review of Decontamination arrangements was completed in line with the 2025/26 Internal Audit plan for Powys Teaching Health Board (the 'Health Board').

Decontamination refers to a series of procedures such as cleaning, disinfection, and sterilisation. These procedures are designed to eliminate or neutralise contaminants, thereby preventing infectious agents or other harmful substances from reaching a vulnerable body site in amounts sufficient to cause infection or other adverse effects.

The Health Board has a legal duty under several regulations, including the Health and Safety at Work Act (1974), to ensure that the decontamination of all reusable medical devices follows recognised guidelines. Additionally, the Health Board must comply with the Welsh Health Circular WHC/2015/050, which outlines the standards for decontamination practices in healthcare organisations. Other relevant publications include the Medical Device Regulations (2002) and the Welsh Health Technical Memoranda (WHTM), which provide technical guidance for the decontamination of reusable surgical instruments, endoscopes, and other critical devices.

Regulations mandate that the Health Board ensures compliance with current national standards, legislation, and recognised guidance documents. Systems must be in place to ensure that reusable medical devices and items of patient care equipment are appropriately decontaminated prior to use and that the risks associated with decontamination processes are effectively managed.

Processes apply equally to equipment that is owned, rented or on loan. These processes should protect, as far as reasonably practical, the health, safety and welfare of staff, patients and individuals who are involved in inspection, service, repair or transportation of medical devices or equipment.

Overview

We have concluded **reasonable** assurance on this area. The matters requiring management attention include:

- Improvements to governance arrangements – clarification of attendance requirements and ensuring consistency in record-keeping.
- A decontamination risk register needs to be developed and monitored.
- All staff training should be brought up to date and kept up to date going forward.
- Omissions or anomalies in the Endoscopy weekly water testing monitoring spreadsheet should be investigated and resolved.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

Scope & Assurance Summary

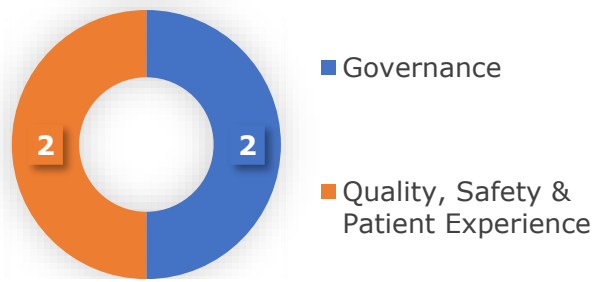
Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	Governance arrangements are in place to ensure oversight of decontamination matters including the monitoring of decontamination 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**

Management Actions

0 High Priority

4 Medium Priority

Themes



Risk Types

Public Perception & Reputational Risk

Legal & Regulatory Non-Compliance

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Findings & Agreed Action Plan

Objective 1: Governance arrangements are in place to ensure oversight of decontamination matters including the monitoring of decontamination risks.	**Reasonable**

Overview / Summary of Observations

The following groups are in place in relation to decontamination:

- Decontamination Safety Group: This meets bi-annually and includes representatives from Cwm Taf Morgannwg University Health Board (CTMUHB) Sterilisation and Decontamination Unit, which undertakes sterilisation on behalf of the Health Board. Between meetings, issues would be picked up by the Head of Infection Prevention and Control or via the All Wales Decontamination and Sterilisation Advisory Group.
- Infection Prevention and Control & Decontamination Committee: Most operational responsibility for decontamination is undertaken by this committee, including oversight of the Decontamination Safety Group. It meets quarterly and is attended by representatives from across the Health Board.

Both meetings are formally structured, generally have appropriate governance arrangements in place and cover appropriate matters. However, we found a small number of inconsistencies in adherence to documented attendance requirements and shortcomings in the keeping of records.

The Decontamination Safety Group Terms of Reference states that its function includes monitoring decontamination issues and updating a decontamination risk register, and the group has had discussion regarding the best way for this to occur. However, this has not currently progressed further, and no completed decontamination risk register has been presented and discussed at either of the above groups.

An annual report is presented to the Patient Experience, Quality and Safety (PEQS) Committee which reviews decontamination activities during the previous year and planned activities going forward.

	Key Findings	Risk & Impact	Agreed Management Action
1	**Governance arrangements** Decontamination Safety Group. • While this is attended by a core group of staff and the meetings are quorate, records of meetings from December 2024 and July 2025 indicated that several staff members listed in the Terms of Reference as required attendees were not in attendance. • The Terms of Reference is scheduled for review by December 2025. Infection Prevention and Control & Decontamination Committee. • While this is attended regularly by a core group of staff and the meetings are quorate, records of five meetings which took place between May 2024 and August 2025 indicated	Safety compromised or reputational damage due to inadequate governance of decontamination.	**Agreed Action:** • The Terms of Reference for the Decontamination Safety Group and the Infection Prevention and Control & Decontamination Committee will be reviewed to ensure that they are appropriate, attendance at meetings will be matched with the Terms of Reference to evidence compliance and staff will be reminded of their responsibility to attend where necessary. • The action log will be used to record decisions taken at meetings. • SharePoint folders will be periodically reviewed to identify errors or inconsistencies such as duplicate documents.

	that there were a large number of staff who attended less frequently, and it was difficult to match attendance against the requirements set out in the Terms of Reference. • Audio recordings of the meetings are retained, but decisions taken at the meetings are not recorded in the action logs. • A recording was available for one meeting for which a concise attendance list had not been produced. • Meeting papers are retained in individual SharePoint folders, one of which included duplicate versions of the agenda, and another included duplicate versions of the action log.		**Expected Evidence of Implementation:** • Copies of the reviewed and updated Terms of Reference for the Decontamination Safety Group and the Infection Prevention and Control & Decontamination Committee. Copies of minutes confirming that attendance at meetings is matched with the Terms of Reference . • Copy of the action log recording decisions taken at meetings. • There are no duplicate documents in the SharePoint folders.
		Medium Priority	**Officer:** Gareth Thomas – Head of Infection Prevention and Control
	Theme: Governance	Control Operation	**Target Implementation Date:** 31/01/2026
2	**Decontamination risk register** The Decontamination Safety Group Terms of Reference states that its function includes monitoring decontamination issues and updating a decontamination risk register. Furthermore, the group has discussed this and it was agreed that one risk register would be used, which would include relevant risks from CTMUHB. However, this has not currently progressed further, and no completed decontamination risk register has been presented and discussed at either the Decontamination Safety Group or the Infection Prevention and Control & Decontamination Committee.	Safety compromised if decontamination risk is not managed appropriately.	**Agreed Action:** A decontamination risk register will be developed and regularly presented and discussed.
			Expected Evidence of Implementation: Copy of the decontamination risk register and minutes of the Decontamination Safety Group confirming it has been regularly presented and discussed.
		Medium Priority	**Officer:** Gareth Thomas – Head of Infection Prevention and Control & Alex Smith – Specialist Practitioner IPC/Decontamination
	Theme: Governance	Control Operation	**Target Implementation Date:** 31/01/2026

Objective 2: Accessible Decontamination policies and procedures are in place at both a Health Board and localised level that reflect relevant national guidance.	**Substantial**

Overview / Summary of Observations

The Health Board has two policies in place which cover decontamination:

- TEP 070 Decontamination and Storage and Use of Flexible Reuseable Endoscopes which was issued August 2025 and has review date August 2028.
- IPC 004 Decontamination of reusable medical and surgical devices policy which was issued October 2025 and has review date September 2028.

Both were issued following appropriate review and approval, are detailed and comprehensive and cover relevant areas such as roles and responsibilities, procedures, storage, traceability, repair and maintenance and training. They are available on the Health Board's policies intranet site which is accessible by all staff.

In addition, Endoscopy has developed a detailed suite of action cards which set out guidance relating to decontamination.

The Health Board keeps up to date with relevant guidance via participation in various national groups including the All Wales Decontamination and Sterilisation Advisory Group, All Wales Decontamination Forum, Institute of Decontamination Sciences and the All Wales Ultrasound Decontamination Governance Group.

Objective 3: Roles and responsibilities of staff in relation to decontamination have been clearly defined and training resources are adequate.	**Reasonable**

Overview / Summary of Observations

Both of the Health Board's policies in relation to decontamination set out detailed and comprehensive information regarding the roles and responsibilities for each grade of staff involved in decontamination processes. Both are available on the Health Board's policies intranet site which is accessible by all staff.

Key staff have attended relevant training at Eastwood Park, which is a specialised training provider for decontamination across the NHS.

An Authorised Person (Decontamination) within the PTHB Estates Team has been appointed for three years from December 2023 following a formal assessment by the Senior Decontamination Engineer, NWSSP Specialist Estates Services who is responsible for oversight of decontamination across NHS Wales.

The Health Board participates in various national groups including the All Wales Decontamination and Sterilisation Advisory Group, following which updates are provided via the Infection Prevention and Control & Decontamination Committee.

There was good representation from the Health Board at the All Wales Decontamination Forum in June 2025.

Appropriate training is also in place for the main body of staff, although the records indicated some gaps in completion or instances where it was not up to date.

	Key Findings	Risk & Impact	Agreed Management Action
3	**Training** The Training Matrix included a number of unfilled cells highlighted in yellow, although this was partly due to training in progress or new starters. Similarly, Tristel and Trophon training records for annual refresher training in relation to ultrasound probes used in Radiology and Maternity indicated some outstanding training, although we were informed that this had been partly impacted by IT issues accessing online training.	Safety may be compromised if decontamination is not carried out appropriately.	**Agreed Action:** All staff training will be brought up to date and kept up to date going forward. **Expected Evidence of Implementation:** Records confirming that all staff training is up to date.
		Medium Priority	**Officer:** Alex Smith – Specialist Practitioner IPC/Decontamination
	Theme: Quality, Safety & Patient Experience	Control Operation	**Target Implementation Date:** 31/01/2026

Objective 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**

Overview / Summary of Observations

The decontamination arrangements at the Health Board can be summarised as follows:

- CTMUHB Sterilisation and Decontamination Unit undertakes the majority of sterilisation on behalf of the Health Board. Any issues arising are reported to the Infection Prevention and Control & Decontamination Committee within PTHB. An example of this was recorded in the meeting of October 2024, whereby a decontamination incident relating to the Air Handling Unit at the Sterilisation and Decontamination Unit had malfunctioned and sample levels far exceeded the acceptable limit. It was reported that affected equipment had to be reprocessed, including 300+ packs belonging to the Health Board, but the issue had been identified prior to any risk of exposure to patients.
- Historically, dental decontamination has been undertaken using a desktop process, which we have been informed is compliant. However, in June 2025, a trial commenced where decontamination is undertaken by Hywel Dda University Health Board which would be a 'gold standard' process.
- Endoscopy decontamination is undertaken in-house in Brecon, with a second site at Llandrindod having been decommissioned. Record-keeping and monitoring arrangements have been covered under objective 5.

An update on decontamination arrangements is included in the Infection Prevention and Control & Decontamination Committee with verbal updates having initially been provided during the period under review and subsequently formal PowerPoint presentations have been provided.

The Equipment and Devices Order Form includes a section which requires cleaning and decontamination be addressed.

Objective 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.	**Reasonable**

Overview / Summary of Observations

Recording and monitoring arrangements at the Health Board can be summarised as follows.

- The sterilisation duties undertaken by CTMUHB on behalf of the Health Board are covered by the bi-annual Decontamination Safety Group which is attended by representatives of CTMUHB. Between these meetings, issues are addressed by the Head of Infection Prevention and Control, or via the All Wales Decontamination and Sterilisation Advisory Group.
- A dental decontamination trial commenced in June 2025 where decontamination is undertaken by Hywel Dda University Health Board which, although presently in its early stages, is covered by the Infection Prevention and Control & Decontamination Committee and it is understood will be subject to ongoing monitoring.
- Endoscopy is the only area where decontamination is undertaken in-house by the Health Board, which occurs in Brecon. A manual traceability system had previously been in place, but this was replaced by a new electronic system, 'Health Edge' in February 2025. This offers full traceability via use of a barcode system which records each step of the decontamination process and has built-in safeguards to prevent steps from being omitted. Weekly water testing is also undertaken which forms part of the Health Board's Endoscopy validation process and is recorded in a spreadsheet. However, while review of this spreadsheet confirms that results are generally being recorded and monitored weekly as required, we noted a small number of omissions or anomalies which are detailed in the Key Finding below.

Relevant audit activity has occurred which has included the following:

- An annual review of Flexible Endoscope Decontamination Facilities was undertaken by the Decontamination Engineer, NWSSP Specialist Estates Services which was detailed and comprehensive. It provided Amber/Green assurance and its findings, which have been actioned by the Health Board, will be followed up at the next annual review.
- An Endoscopy Decontamination Audit was undertaken by the Specialist Practitioner, Infection Prevention & Control (Decontamination) using an Infection Prevention Society template. It only identified a small number of issues which have since been resolved.
- Endoscope traceability audits of the Health Edge system have been undertaken in May and September 2025 by the Theatre & Endoscopy Co-Ordinator, with a further audit scheduled for January 2026.
- A Cleaning of Ultrasound Probe Process audit template is ready to be used for an audit of decontamination of ultrasound probes / transducers which is planned and an audit template for the Trophon machine high level disinfection equipment for ultrasound probes in radiology and maternity is also ready for use. Both appear well structured and fit for purpose.

Key Findings		Risk & Impact	Agreed Management Action
4	**Endoscopy weekly water testing** Endoscopy weekly water testing is undertaken which forms part of the Health Board's Endoscopy validation process, which is recorded in a spreadsheet. However, while review of the spreadsheet confirms that results are generally being recorded and monitored weekly as required, we noted that no result was recorded for one machine for week commencing 14 April 2025 and no follow up was included to a comment querying this anomaly. Furthermore, no results were recorded in the spreadsheet for the two preceding weeks to it being provided to us.	Safety may be compromised if Endoscopy water quality issues are not promptly identified.	**Agreed Action:** Endoscopy weekly water testing results will be promptly recorded in the monitoring spreadsheet, and any omissions or anomalies will be promptly investigated and resolved.
			Expected Evidence of Implementation: Copy of the spreadsheet confirming that there are no omissions or anomalies in the Endoscopy weekly water testing.
		Medium Priority	**Officer:** Gareth Thomas – Head of Infection Prevention and Control
	Theme: Quality, Safety & Patient Experience	Control Operation	**Target Implementation Date:** 31/12/2025

Appendix A

Assurance Opinion

 **Substantial**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
 **Reasonable**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
 **Limited**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
 **Unsatisfactory**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
 **Advisory**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership]

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The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of the Powys Teaching Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Continuing Healthcare

Final Internal Audit Report

2025/26

Powys Teaching Health Board

Reasonable Assurance

Contents

Review Reference	PTH-2526-10
Fieldwork	August – September 2025
Executive Sign Off	October 2025
Audit Committee	January 2026
Executive Lead	Elaine Lorton, Executive Director of Primary Community Care and Mental Health
Audit Team	Ian Virgil, Head of Internal Audit
	Lucy Jugessur, Deputy Head of Internal Audit

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Executive Summary

Purpose

The overall purpose of this audit was to review recent changes and future plans around continuing healthcare to address the current level of cases and costs and to provide assurance on the efficacy and timeliness of placement reviews.

Between May 2024 and May 2025 there has been a 27.6% increase in the number of CHC cases supported by the Health Board contributing to a continually challenging financial position.

Continuing Healthcare (CHC) is a package of care arranged and funded by the NHS for individuals who have been assessed as having a primary health need due to disability, accident or illness. There is a Continuing NHS Healthcare National Framework for Implementation in Wales. This was published in July 2021 and implemented in April 2022. The document sets out the arrangements for the effective, efficient and equitable delivery of CHC in Wales.

The Health Board is required to have processes in place to assess and approve applications in line with Continuing NHS Healthcare: The National Framework for Implementation in Wales. Once approved, recipients are recorded in the All-Wales National Complex Care Database (NCCD) used for monitoring and financial forecasting purposes.

The Health Board has recently procured additional external support, linked to its current escalation status, which includes coverage of CHC. The scope of our audit, and the associated assurance provided, is therefore restricted to the specific objectives detailed below and does not cover the wider CHC processes.

Overview

We have concluded **reasonable** assurance on this area. The significant matters requiring management attention include:

- The existing procedure document is outdated and the new version, currently in draft and under review, does not include references to related procedures.
- Patient placement review documentation can be slow to be filed and the file structure lacks coherence and convention.
- The Complex Care Improvement Plan is not reported on in its entirety.

Full details of matters arising are detailed within the Findings & Agreed Action Plan. The following opportunities for enhancement have been identified that do not impact the overall opinion and are highlighted for management information:

- A brief overview/procedure document describing operation of the electronic system used to obtain authorisation of CHC claims and reviews should be created, and this should be referenced by the general CHC procedure document.
- An action log should be implemented and used as a master, consolidated record of all actions arising from placement reviews. The log should include action details, owner, target completion dates and current status. A record should also be maintained of the date that actions are either completed, sanctioned as complete by the Scrutiny panel, or both.

Scope & Assurance Summary

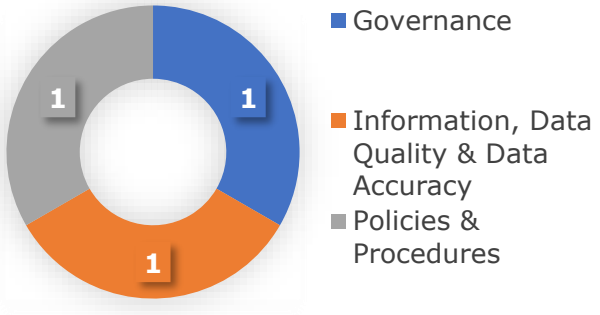
	Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)	Related Findings	Assurance
1	The Health Board's new electronic system for managing the process of authorising CHC claims is in line with the Health Board's scheme of delegation and ensures compliance with the CHC National framework guidance.	-	**Substantial**
2	CHC placement reviews, including those for complex and / or high-cost care are completed at the required times and are adequately assessed, with required actions undertaken from the review outcome, as outlined in the CHC National Framework.	1, 2	**Reasonable**
3	The Health Board has improvement plans in place to address the current level of CHC cases and associated costs. Progress towards delivery of the plans is effectively monitored and regularly reported within the Health Board.	3	**Reasonable**

Management Actions

3

Medium Priority

Themes



Risk Types

Financial Loss

Findings & Agreed Action Plan

Objective 1: The Health Board's new electronic system for managing the process of authorising CHC claims is in line with the Health Board's scheme of delegation and ensures compliance with the CHC National framework guidance	**Substantial**

Overview / Summary of Observations

New applications for CHC and reviews completed on existing patient packages are subject to scrutiny via two panel reviews: "Scrutiny Panel" and "Resource panel". The Scrutiny panel reviews the patient's background, needs and details of the package placement, submitted via either an initial application or, for patients already receiving CHC, a review. If approved by the Scrutiny panel and the package necessitates new or changed cost, then the package is further reviewed at Resource Panel. If both panels approve the package, the cost of delivery will then require approval as per the Scheme of Delegation. This is obtained via the new electronic "system".

Packages requiring cost approval are added to an Excel spreadsheet. This spreadsheet is linked to the Health Board's Scheme of Delegation using automated formulae and via this link, the spreadsheet auto-populates the appropriate cost signatory.

When package details and the cost signatory have been populated, the spreadsheet is circulated between all cost signatories via an email chain until the appropriate approval has been obtained.

The spreadsheet's link to the Scheme of Delegation is maintained by the Finance department who realign the spreadsheet formulae in the event of any change. This ensures that the appropriate approval per the most up to date version of the Scheme of Delegation is always obtained.

The National Framework Guidance does not stipulate any requirements for obtaining approval over cost of a package and so, there is no risk of non-compliance with that framework in this respect.

The new email system was implemented in January 2025, replacing the previous method of obtaining cost approval via face-to-face meetings. Since its introduction, the CHC team have reported administrative time savings however, our analysis has not been able to quantify this, and we noted that approval times could still vary considerably between 0 days and 10 weeks. Despite this variation, there is no impact on patient package commencement which is critical as, per the National Framework Guidance "CHC packages provided for patients must not be delayed due to administrative processes".

At implementation, there was little training or guidance issued for recipients of the email and attached file and this resulted in some early issues bedding the process in. This was however resolved by the CHC team in time, although we note there continues to be an absence of documented explanatory guidance. Whilst a minor observation, it is suggested that for good practice and to avoid any ambiguity around the process arising with future recipients, a guidance document in the form of a sub-process be created and added to the CHC Team's procedural guidance pack.

Our review concluded that the new electronic system both aligned with the Health Board's Scheme of Delegation and ensured compliance with the National Framework Guidance and therefore, there are no key observations raised against this objective.

Objective 2: There is a process to implement, schedule and track CHC placement reviews, ensuring they are conducted at the required intervals as per the CHC National Framework.	**Reasonable**

Overview / Summary of Observations

When a new package is agreed, key details including review dates are added to the National Complex Care Database (NCCD). Whilst the NCCD could be considered a legacy system for its limited functionality, it does provide ability for caseworkers in the CHC team to review upcoming and overdue package review dates, and this feature is used to schedule patient reviews.

The CHC team have an internally mandated target compliance rate of 85% of reviews to be completed "on-time". In this sense, an on-time review is one that is completed before or, within one month after, the target review date. Per the National Framework Guidance, placement reviews must be conducted (at minimum) after three and twelve months from commencement and 12 monthly thereafter.

As part of our review, we sample tested all placement reviews for the 20 patients receiving the most expensive care packages. This testing showed that 18 of 21 (86%) of reviews between January 2024 and August 2025 had been completed on time or early, exceeding the Team's internal target. Of the three reviews completed late, one remained outstanding at the time of testing and was 10 weeks overdue but, this review was responsibility of the District Nursing Team and the CHC Team were proactively following this up. Comparing 2024 against 2025, we noted a slight decrease in reviews being completed on or before target from 91% to 86% but, acknowledge that over that same period caseload per caseworker had increased by 45% from an average of 49 patients per caseworker in 2024 to 71 in 2025.

To provide assurance that reviews were compliant with the assessment criteria described by the National Framework Guidance, we also considered the documentation completed for all reviews in the sample (55). Our testing on this revealed that every review can, and usually did, result in completion and generation of many documents, but critically, all included a complete Nursing Needs Assessment (NNA). Whilst the format of this document differed depending on the type of presentation a patient displayed, the NNA is structured and was completed in such a way to ensure compliance with all areas of consideration required for CHC as stipulated by the National Framework Guidance. This includes specific sections for:

- Capture of patient capacity and consent;
- An overview assessment describing the patient's background, needs and any changes in their presentation;
- A detailed assessment against each of the 12 care domains;
- A summary description of each of the four key indicators;
- A conclusion and recommendation for ongoing provision of care; and
- A list of actions required to further tailor care or ensure the placement provider (care home) standards were of appropriate standard.

Whilst all patient records reviewed in our sample testing contained documentation to support that a full and thorough review had been conducted, identifying required documentation was a challenge. As noted, every review can result in completion and generation of many documents, and we found that digital copies of these held in patient files lacked convention both in terms of naming and filing structure. This meant that sourcing and identifying documents relating to a specific review was time consuming and difficult including for the CHC team. This is discussed in more detail below in key finding 1.

All actions recorded as part of a review are thoroughly documented on the NNA and these are discussed by the Scrutiny panel to ensure appropriateness. The CHC team maintain a record of actions discussed and approved by the Scrutiny panel in meeting minutes and have a method in place for ensuring these are followed up to completion. There is not however a master file that provides a consolidated list of all

actions in a single place, and this makes getting an overview of status for individual actions challenging. Therefore, we suggest, in order to improve transparency and aid action tracking that a file of this type is created and the CHC team maintain this going forward.

The overall process for scheduling and conducting reviews and also for following up on actions arising from reviews is well embedded with review timeline compliance above the CHC teams target and this was substantiated by our sample testing. However, during our review we noted that the general CHC procedure document describing the standard CHC process was out of date and currently under review. This is discussed more fully below in key finding 2.

	Key Findings	Risk & Impact	Agreed Management Action
1	**Patient Placement Review Documentation Storage** As part of our testing, we checked to ensure every recorded review could be substantiated with appropriate documentation. Whilst all records reviewed as part of our sample did have the appropriate documents, these were challenging and time consuming to identify, including for the CHC team as: • Files were named inconsistently, lacking convention and description of the document • Files lacked structure and order and were stored in folders containing sometimes dozens of documents In addition, several of the files requested within the sample had not been typed in digital format and were only available in hand-written hard copy. This included several documents that had been originally created several weeks before the audit review commenced.	Risk of non-compliance with National Framework Guidance and loss of patient background and history in event of caseworker change in CHC team	**Agreed Action:** The CHC team will design and implement a file management process and ensure consistency of use across the team. The process will include: • A time target for typing up and storing documents electronically to patient files; • A file naming convention including: document title, patient reference and date; and • A file management structure within SharePoint for storing patient files. **Expected Evidence of Implementation:** New file management process in place and being utilised.
		Medium Priority	**Officer:** Assistant Director Complex Care **Target Implementation Date:** March 31st 2026
	Theme: Information, Data Quality & Data Accuracy	Control Design	

Key Findings		Risk & Impact	Agreed Management Action
2	**CHC General Procedure Document** The currently documented procedure describing the general CHC procedure was created in 2015 and last reviewed in 2018. This document was due to be reviewed in 2019, but no review has been documented, and our work has shown that the procedure described does not now accurately reflect the actual procedures employed. The CHC team are well represented at the All-Wales CHC Management Group and so are appropriately positioned to monitor and implement any change to the National Framework Guidance. Whilst this mitigates risk of actual process not aligning with current guidance, any changes are not reflected in procedural documentation. The CHC team have however drafted a new procedure document, and this is currently under review. We have reviewed this document and note that it does not contain reference to other related procedures, several of which are new. Whilst care must be taken to avoid duplication or repetition between procedural documentation, including references in a procedure to related guidance can help to ensure holistic capture of the full end to end process.	Operating without a documented, approved procedure could lead to incorrect or inconsistent process exposing the Health Board to regulatory censure and denying patients of care to which they are entitled.	**Agreed Action:** The procedure document currently in draft will be updated to include, where appropriate, references to other related and newly created CHC procedures. Review and approval of the draft will then be expedited and the final version circulated to all members of the CHC team for awareness.
			Expected Evidence of Implementation: An updated procedure document containing appropriate references is available on the Health Board's SharePoint site
		Medium Priority	**Officer:** Assistant Director Complex Care **Target Implementation Date:** November 30th 2025
	Theme: Policies & Procedures	Control Design	

Objective 3: The Health Board has improvement plans in place to address the current level of CHC cases and associated costs. Progress towards delivery of the plans is effectively monitored and regularly reported within the Health Board	**Reasonable**

Overview / Summary of Observations

The CHC team have a master plan covering the period January 2024 to April 2026 – the "Complex Care Improvement Plan 2024 – 2026". This plan was authored by the Assistant Director of Continuing Healthcare who also retains responsibility for operational delivery of the areas of focus detailed by the plan.

In total, there are 16 focus areas detailed by the plan covering a range of considerations and team operations including:

- Team and departmental Governance structure (2)
- The patient review process and review timeline compliance (2)
- Enhancement of digital capability (1)
- Design, documentation and delivery of new and updated Standard Operating Procedures (SOPs) (6)
- Reporting (1)
- Placement and partner relationships (2)
- Legislative and framework changes (2)

The plan includes descriptions of work and targeted benefits for each area of focus as well as target completion dates. Each focus area is also RAG (Red/Amber/Green) rated denoting progress toward completion and highlighting risks to completing the work and/or achieving the targeted benefit.

Whilst the plan document provides a succinct overview of improvement works undertaken by the department, there is no evidence that the plan has been packaged as an overall programme of work, submitted for review, scrutiny and approval by committee or, that reports on progress are delivered at programme level.

As at August 2025, workstreams listed in the Improvement Plan are described with the following statuses:

- 7 – Complete
- 1 – Complete – Ongoing action
- 6 – In progress
- 2 – In Progress – At risk

Key Findings		Risk & Impact	Agreed Management Action
3	**Formalise Plan Governance** The CHC team have a master improvement plan – the "Complex Care Improvement Plan 2024 – 2026". This plan effectively summarises activity and workstreams ongoing or complete across 16 different areas of focus. The planning document is maintained with narrative highlighting updates and key risks to achieving targeted objectives however, it is not presented in fulness to the Performance and Delivery Committee, and this may inhibit transparency over the full breadth and scope of work being undertaken by the team. Committee updates instead are formatted in such a way to provide a narrative update on key areas of focus within the plan. Whilst this narrative focus is appropriate for committee papers, the lack of summary provided on the full plan may inhibit the committee's view of the full scope and breadth of work being undertaken by the team and therefore limit the assurance being provided.	Lack of governance may result in activity unaligned with strategic objectives and risk left unmitigated jeopardising achievement of objectives	**Agreed Action:** To provide perspective on the scale of improvement works undertaken, tighten governance and provide greater assurance, the Improvement Plan will be summarised with a dashboard presented at every committee meeting. The "Programme dashboard" will include the summary built into the plan illustrating: • Number of workstreams completed • Number of workstreams in progress • Number of workstreams at risk Narrative will then be provided on key achievements for the period and, where risks have been highlighted, what actions are being implemented to mitigate. **Expected Evidence of Implementation:** Dashboard reporting available on committee meeting papers.
		Medium Priority	**Officer:** Assistant Director Complex Care **Target Implementation Date:** December 31st 2025
	Theme: Governance	Control Operation	

Appendix A

Assurance Opinion

 **Substantial**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
 **Reasonable**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
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 **Advisory**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
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Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership]

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Mental Health and Learning Disability Triage and Assessment Process

Final Internal Audit Report

2025/26

Powys Teaching Health Board

Reasonable Assurance

Contents

Review Reference	PTH-2526-11
Fieldwork	August - November 2025
Executive Sign Off	29th December 2025
Audit Committee	January 2026
Executive Lead	Elaine Lorton, Executive Director of Primary Care, Community & Mental Health
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

To review the project management and implementation of Phase 1 of the new Single Point of Access (SPOA) Triage and Assessment Model for Mental Health & Learning Disabilities (MH & LD) Services in Powys Teaching Health Board (the 'Health Board').

Overview

The Health Board's 'Six Goals' Programme within Urgent Care, approved a bid from MH & LD services in June 2023 for temporary funding to introduce Community Mental Health Triage Practitioners and move to a SPOA for MH & LD, which would include '111 press 2 for Mental Health'.

The SPOA service went live in September 2024, and a Business Case was then submitted to the Health Board's Investment Benefit Group in December 2024 to secure recurrent funding for the SPOA service to continue owing to the temporary 'Six Goals' funding ending in March 2025. The recurrent funding was approved by the Health Board's Executive Committee.

A project was established to support the introduction of SPOA, which involves two key phases.

- Phase 1, which consisted of implementing a Triage team, incorporating previous Mental Health referrals administration hub forming a Single Point of Access for MH & LD, physically located and integrated with the '111 press 2 service'.
- Phase 2, which relates to the implementation of an Assessment Team into the MH & LD SPOA service and its alignment with the 'Better Together Community Model Re-design Programme'.

We note that only Phase 1 has been implemented so far, and project work relating to Phase 2 was ongoing during the time of our audit.

We have concluded **reasonable** assurance on this area. The matters requiring management attention include:

- The absence of formal governance arrangements for the SPOA Service.
- Finalisation and formal approval of the SPOA Standard Operating Procedure.
- Reporting interface issues between the Welsh Community Care Information System (WCCIS) system and Power BI.
- The absence of reporting arrangements for SPOA Service demand, capacity, and performance management data to the MH & LD Directorate senior management team.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

The following opportunity for enhancement has been identified that does not impact the overall opinion and is highlighted for management information:

- Inclusion of compliance timescales for each of the Colgate Triage Categories within the main body of the SPOA Standard Operating Procedure.

Scope & Assurance Summary

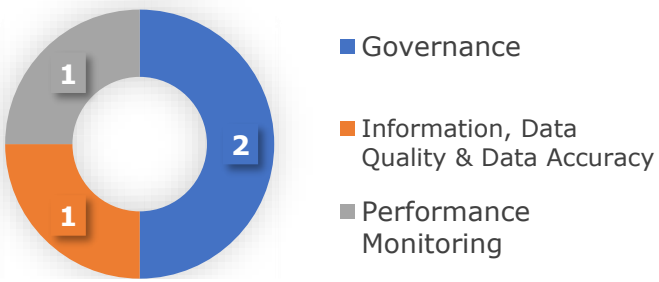
	Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)	Related Findings	Assurance
1	Effective project management arrangements are in place for the development and implementation of the Model, including a project group, project plan and risk register	-	**Substantial**
2	The project has received the required Health Board approval and provision of funding	-	**Substantial**
3	Phase 1 of the project covering the triage team and SPOA service has been effectively implemented with an appropriate structure and staffing establishment is in place	1	**Reasonable**
4	The triage team and SPOA service are operating effectively with a Standard Operating Procedure (SOP) in place that clearly defines the pathway from access through to triage and stages of service delivery	2,3	**Reasonable**
5	Robust mechanisms are in place for recording, monitoring and reporting the levels of demand and capacity in order to provide effective oversight and determine if the service is delivering the anticipated benefits	4	**Limited**

Management Actions

2 High Priority

2 Medium Priority

Themes



Risk Types

Legal & Regulatory Non-Compliance

Findings & Agreed Action Plan

Objective 1: Effective project management arrangements are in place for the development and implementation of the Model, including a project group, project plan and risk register.	Substantial

Overview / Summary of Observations

The inception and implementation of Phase 1 of the SPOA/111 Press 2 Service was supported by a robust and well documented project management methodology and approach that included a Project Group, Project plan and Project risk register.

Project Group meetings were regularly held, were quorate and well attended by membership, and were satisfactorily documented within workstream decision and action logs that were subject to ongoing monitoring. This enabled project milestones to be completed in accordance with project plan timescales. Project issues that were identified were appropriately documented within the workstream decision and action logs and recorded on the risk register which was subject to regular review and update.

Periodic progress reporting during Phase 1 of the project was provided to the Mental Health Transformation Programme Board and Executive Committee.

Objective 2: The project has received the required Health Board approval and provision of funding.	Substantial

Overview / Summary of Observations

An Investment Business Case (IBC) was created to secure a future and recurrent funding commitment by the Health Board to the SPOA/111 Press 2 Service following temporary 'Six Goals for Unscheduled Care' funding that was made available from Welsh Government to establish the new triage and assessment model. This temporary funding stream ended on March 31st, 2025.

The SPOA/111 Press 2 Phase 1 Investment Business Case (IBC) was fully costed to determine its funding requirements and stated justification and option appraisals to support and substantiate the requested recurrent funding from the Health Board, to ensure the continuity and growth of the Service. The IBC also clearly outlined the anticipated outcomes and benefits of the project, including helping to reduce Directorate variable nursing pay, and specifically that of the dependency and usage of specialist mental health nursing agency staff.

The IBC was scheduled to go to the Investment Business Group (IBG) in December 2024, but that meeting was stood down. Given the urgency for approval, IBG Chair's Action was applied that enabled submission to the Executive Team for consideration and approval during its meeting on January 8th, 2025.

We note that the IBG has no delegated authority to approve, they make recommendations to the Executive Committee who then consider the IBG's recommendations and will approve the Investment Business Case and then advise the IBG accordingly.

Executive Committee sponsorship and approval of the IBC was granted on 8th January 2025.

Objective 3: Phase 1 of the project covering the triage team and SPOA service has been effectively implemented with an appropriate structure and staffing establishment is in place.	Reasonable

Overview / Summary of Observations

Phase 1 of the SPOA project was successfully implemented, and the service went live in September 2024.

The service has an appropriate structure in place supported by an adequate staffing establishment which currently allows for effective service delivery. As previously noted, the current establishment is fully funded on a recurring basis. However, management have highlighted that in due course SPOA Service referral demand may rise which would require an increase in the staffing complement.

Whilst the current establishment is fully funded, we note that the service is still reliant on a level of agency usage due to delays in appointing to full establishment levels and covering sickness and other absence.

However, there is currently no formal governance structure and arrangements in place for the SPOA Service that interfaces with the MH & LD Directorate management and wider Health Board governance apparatus.

	Key Findings	Risk & Impact	Agreed Management Action
1	**SPOA Service Governance** Currently there is no governance structure and arrangements in place that enables the SPOA Service to report governance related matters to the MH & LD Directorate Team meetings. Current reporting undertaken is only that of quality & safety related issues, and these appear to be reported on a very infrequent basis to the Adult Mental Health Putting Things Right (PTR) meeting. As such, the Directorate and wider Health Board governance apparatus may not have effective oversight of the service and may not be formally receiving any key governance issues arising that may require scrutiny and action at a higher level. Patterson,Liz 30/01/2026 15:02:31	Patients accessing the SPOA service may not receive appropriate and timely triage and assessment.	**Agreed Action:** An Operational Delivery Group will be established for the SPOA which will formalise operational governance arrangements for the service. It will report into MH&LD SMT via the Service Quality Improvement and Development (SQID) workstream and align to the deliverables identified in the Transformation Workstream reporting progress to the Better Together Project Board. The SPOA will also formalise the reporting of Quality & Safety related governance into the QUAILS meeting, which is an SMT workstream, this will be on a monthly basis. **Expected Evidence of Implementation:** Terms of Reference for SPOA – Operational Delivery Group(ODG). Standing Agenda and minutes of ODG. Report for SQID / Report for QUAILS. Transformation Programme Board standing agenda item and minutes.
		High Priority	**Officer:** Lauraine Hamer – Interim Head of Operations. Marielle Restall – Interim Service Manager 111#2/SPOA. **Target Implementation Date:** 01/02/26
	Theme: Governance	Control Design	

Objective 4: The triage team and SPOA service are operating effectively with a Standard Operating Procedure (SOP) in place that clearly defines the pathway from access through to triage and stages of service delivery.	Reasonable

Overview / Summary of Observations

The SPOA Service has a draft SOP that outlines in a clear, comprehensive and logical format the referral and triage criteria and processes, and these are underpinned by referral and triage pathways that explain the processes in detail. The SOP also includes a copy of the Colgate Triage Guidelines and Tool which are the formal requirements relating to the triage process undertaken by SPOA nurse assessors to determine further assessment and action.

However, compliance timescales for each of the Colgate Triage Categories A to F are not directly stated within the SOP but are included within two Appendices. For ease of reference, it would be useful to include a summary of the Colgate Triage criteria and required triage timescales for each into the body of the SOP.

We can confirm that all SPOA Team members have access to the SOP and are conversant with its content, and there are no other procedures in place relating to the direct running of the SPOA Service and of its referral pathway management processes in place.

Prior to the operational commencement of the SPOA Service a range of awareness exercises were undertaken with key user groups and stakeholders to ensure that they were fully appraised of the Service's existence and also methods of user referral. These included Police, Ambulance, Local Authority, Public Health Wales, Armed and Ex-Forces, Third Sector representatives and Powys Regional Partnership Board (RPB). GP Cluster Group meetings in Powys were also informed of the Service and its referral pathways.

We undertook testing of a sample of 30 referrals into the SPOA Service between the period of April to July 2025 and sought to confirm the following:

- Triage undertaken was in accordance with the classification criteria stated in the Colgate Triage Categories A to G and notes on Welsh Community Care Information System (WCCIS) patient records recorded justifications for the Categories allocated.
- Colgate Scale Triage referral receipt dates to triage timescales were being complied with in accordance with Categories A to G.

Our testing was only undertaken in relation to the referral and triage pathway, as the assessment and onward referral pathways stages were being formalised and finalised as part of the Phase 2 project relating to the SPOA Service which was ongoing at the time of the audit and therefore outside of the current audit scope.

All 30 sampled referrals were triaged in accordance with the classification criteria and priority timescales stated in the Colgate Triage Categories A to G, and the supporting narrative and audit trail within WCCIS patient records documented this in all cases.

However, issues were identified relating to the interfacing of WCCIS and Power BI reporting output.

Key Findings		Risk & Impact	Agreed Management Action
2	**Draft SPOA Service Standard Operating Procedure (SOP)** The SPOA Service SOP is currently in draft format and was scheduled to be submitted to the Clinical Policy Advisory Group (CPAG) in November 2025 for review/approval. However, it was deferred as it was decided that additional information was required to be added to the SOP regarding the Service's relationships and risks in respect of other Mental Health Service's respective SOPs. We note that at time of our audit, the draft SOP is planned to be submitted to a CPAG meeting in early 2026 for further consideration.	Patient referral, access and delivery pathways are fully documented and are complied with.	**Agreed Action:** The SPOA Service draft SOP will be updated to reflect the Service's relationships with other Mental Health Service's respective SOPs as soon as is practicable. This action has been completed; SOP has been reviewed and updated to reflect current operational arrangements and is currently out to comments for wider service. A timescale for submission to the MH&LD Clincal Policy Advisory Group (CPAG) for approval will be confirmed once the SOP is updated. Following this, submission to SMT for approval. **Expected Evidence of Implementation:** Finalised SOP has been scheduled for approval at January CPAG and ratified SOP will be produced as evidence. SMT minutes will reflect decision re approval.
		Medium Priority	**Officer:** Marielle Restall – Interim Service Manager 111#2/SPOA **Target Implementation Date:** 20/01/26
	Theme: Governance	Control Design	
3	**Reporting interface issues between Welsh Community Care Information System (WCCIS) system and SPOA Service Power BI reports** Whilst we can confirm that all sampled referrals were being triaged in accordance with the prescribed timescales, a number of referral to triage timescales stated on the Power BI report that was used for our sampling were erroneous. Initial investigations suggested that this is due to interface issues between WCCIS and Power BI whereby the triage form used by SPOA assessors is not shown as being closed down at the since time on the Power BI report as it was on WCCIS, despite the triage being undertaken in an efficient manner as documented on the WCCIS patient notes audit trail. Additionally, several referrals on the Power BI report stated incorrect Colgate Triage Categories, and this appears to be a	Patients accessing the SPOA service may not receive appropriate and timely triage and assessment.	**Agreed Action:** Liaison will be undertaken between SPOA management and the WCCIS Systems Team to ensure that future Power BI reporting accurately reflects content on WCCIS, and any interface reporting glitches are identified and remedied. Meeting with WCCIS and BI/IT staff has been scheduled to address discuss issues highlighted and to understand underlying reasons for the noted discrepancies. Based on these discussions an Action Plan will be put into place to rectify and improve data quality

	glitch whereby they are correctly reflected on WCCIS patient notes but are not being pulled through via Power BI accurately. These issues will need to be addressed to ensure that future Power BI reporting accurately reflects content on WCCIS, as in due course Mental Health Directorate Management, as well as Health Board senior management may request the provision of reports, the content of which is at risk of being inaccurate.		**Expected Evidence of Implementation:** Notes of meetings scheduled to discuss identified issues. Action Plan with objectives and timescales. Testing of BI dashboards following implementation with screenshots to evidence desired outcomes.
		Medium Priority	**Officer:** Lauraine Hamer, Marielle Restall. **Target Implementation Date:** 01/03/26
	Theme: Information, Data Quality & Data Accuracy	Control Operation	

Objective 5: Robust mechanisms are in place for recording, monitoring and reporting the levels of demand and capacity in order to provide effective oversight and determine if the service is delivering the anticipated benefits.	Limited

Overview / Summary of Observations

The SPOA Service is supported by the Welsh Community Care Information System (WCCIS) that retains the patient referral data obtained from self-referrals via 111 Press 2 function and direct clinical referrals from GPs/clinicians/EMS and other referring agencies.

This system captures patient clinical triage assessment notes and dates/times of referral, the subsequent onward actions, and provides an audit activity trail linked to the assessor undertaking the triage. The information on WCCIS can be utilised via Power BI to provide a wide suite of dashboards and reports covering referral activity and referral demand and capacity. WEBEX, the digital telephony system used by the triage assessors timestamps the call wait and duration times and this information feeds into WCCIS to support the audit trail and triage performance data.

However, at the time of our review there was no reporting of SPOA activity and no KPIs were in place. We are therefore unable to provide any assurance that the performance of the service, and associated delivery of the anticipated SPOA benefits, are subject to effective oversight.

As part of our review, we were able to confirm that there is ongoing and active management being undertaken within the SPOA Service to reduce its use and subsequent expenditure on specialist agency nursing staff, which was one of the anticipated benefits of the service. Agency nurse usage reports are produced by Finance and Workforce and are sent out monthly to the Executive Director of Primary, Community Care & Mental Health. There is also a variable pay meeting held once a month within the MH & LD Directorate which reviews SPOA agency nursing expenditure.

There has been a trend of reduced agency nursing staff usage over the period September 2024 to November 2025, with exception based periodic spikes that are attributable to sickness and seasonal staffing requirements. The fall in agency nursing usage has been most noticeable during the 2025/26 financial year to date.

Key Findings		Risk & Impact	Agreed Management Action
4	**<u>Recording, Monitoring and Reporting of SPOA Service Demand and Capacity</u>** At the time of our review there was no reporting of SPOA Service demand, capacity, triage call timescales and performance management data to Directorate senior management. We were informed by service management that no-one within the Health Board has requested any activity reports or any other performance information since the Service became operational in September 2024. SPOA Service management are also unclear what senior management would specifically want in the way of reports that could be provided by the Service. Additionally, no KPIs are in place for the SPOA Service, and we were informed that Health	The anticipated benefits of the project may not be delivered.	**Agreed Action:** SPOA Service management will prepare for regular reporting of its demand, capacity, triage call timescales and performance management activity data to SQID which reports to MH & LD Directorate senior management. Improved data and reporting capacity has been highlighted as a service requirement as part of the WCCIS Replacement tendering process, it is recognised that additional work will need to be carried out to ensure that configuration of the new system delivers anticipated outcomes in terms of demand, capacity and activity reporting. There have been National conversations about development of KPIS for consistency purposes across Health Boards and MH&LD proposal to the National Strategic Programme Board for Mental

	Board senior management have not to date asked for any to be introduced. Furthermore, there is no functionality within Power BI to produce reports on agency nursing activity, or the recording of data attributable to agency nursing usage as this information is held on the financial ledgers and not on WCCIS. There is no interface between Power BI to the financial ledgers that would facilitate production of reports/dashboard to show reduction of agency spend. As such, it is unclear if Health Board senior management and Health Board Groups/Committees are being formally appraised of the SPOA Service achieving the anticipated outcomes and benefits detailed within the IBC.		Health has included testing as part of being a 'demonstrator' pilot area which will build in measures for evaluation as well as performance monitoring for Wales. Full performance reporting is planned for the next stage of roll out and it is the assessment part of transformation that is seeking to eradicate community variable pay. Demand and capacity modelling has been undertaken utilising available data for the purposes of planning future services as part of Better Together of which the SPOA Triage and Assessment Service is within the accelerated design scope. The wider benefits of the SPOA for access to services, equitability and consistency of triage is already recognised. However, it is acknowledged that national and local workstreams could be brought together more seamlessly into one governance structure and the service will work towards this. Financial monitoring of other variable pay and private providers is undertaken by MH&LD SMT but in consideration of the key finding of monitoring impact the of SPOA specifically against IBC, MH&LD Senior Management will take advice from colleagues in the Performance and Commissioning on how to overcome the challenge of lack of functionality within Power BI to interface with financial ledgers. Resulting actions will form part of the work of the aforementioned ODG and reporting through the strengthened governance arrangements as previously described. **Expected Evidence of Implementation:** Highlight Report to Better Together Project Board. Copy of identified KPIs and ODG Action Plan. SQID Minutes. SMT Minutes.
		High Priority	**Officer:** Louisa Kerr – Assistant Director. Lauraine Hamer – Interim Head of MH Operations.
	Theme: Performance Monitoring	Control Operation	**Target Implementation Date:** 01/02/26

Patterson,Liz
30/01/2026 15:02:31

Appendix A

Assurance Opinion

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EXTERNAL • QUALITY • ASSESSMENT

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership]

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 7.2

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE	**DATE 05 FEBRUARY 2026**
Subject:	**Corporate Parenting Promises**
Approved and presented by:	Paul Hooton Executive Director of Nursing, Quality, Women and Family Health
Prepared by:	Jayne Wheeler Sexton Assistant Director of Nursing
Other Committees and meetings considered at:	Executive Committee - 07 January 2026 who approved the promises. PTHB Strategic Safeguarding Group

PURPOSE:

To inform the Patient Experience, Quality and Safety Committee (PEQS) of the set of Corporate Parenting Promises which have been developed and shared with Welsh Government following the Health Board signing the Corporate Parenting Charter in 2025

To inform the PEQS Committee on the development of a Corporate Parenting Task and Finish Group which will further develop the Promises, undertake an assessment exercise against the Promises, use the results to develop and implement an improvement plan and monitor and evaluate impact. Improvement work will be in coproduction with care experienced children.

RECOMMENDATION(S):

The Committee is asked to

1) **RECEIVE** the report and take **ASSURANCE** Corporate Parenting Promises are in place (Appendix 1).

Approve/Take Assurance	Discuss	Note
Y	N	Y

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	
2. Provide Early Help and Support	Y	
3. Tackle the Big Four	N	
4. Enable Joined up Care	Y	
5. Develop Workforce Futures	N	

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

EXECUTIVE SUMMARY:

Corporate Parenting Charter

The Corporate Parenting Charter Corporate parenting Charter | GOV.WALES is a set of **Principles** and **Promises** developed by Welsh Government in collaboration with care-experienced children and young people, to support and strengthen public bodies in their role as Corporate Parents.

The Charter aligns to the United Nations Convention on the Rights of the Child (UNCRC), reflects the Wellbeing of Future Generations (Wales) Act 2015 and the Social Services and Well-being (Wales) Act 2014 Part 6 Code of Practice (Looked After and Accommodated Children).

At the official public launch of the Corporate Parenting Charter on 22 September 2023, both the First Minister and the Permanent Secretary signed the Charter on behalf of Welsh Ministers and Welsh Government respectively.

Powys Teaching Health Board signed the Corporate Parenting Charter in 2025 making a clear public commitment to become "corporate parents" and deliver on the relevant principles outlined in the 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.

The Corporate Parenting role extends from strategic senior leaders to all employees across the health board

Welsh Government are asking Public Bodies to share their Pledges and how they align to the Principles within the Charter (not all Principles apply to Health).

Powys Teaching Health Board's Pledge is a set of **8 Promises to Care Experienced Children** of how we will take care of them and support the health board to meet the Corporate Parenting Principles (Appendix 1)

Our Promises are built upon the principle of **Nothing about you, without you**

APPENDIX 1

Powys Teaching Health Board Corporate Parenting Promises to Care Experience Children

1. 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.

2. 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

3. 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.

4. 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.

5. 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.

6. 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.

7. 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

8. Our Vision

We want every child and young person who has experienced care to feel:

❖ Healthy – feeling good in body and mind

❖ Heard – because what you say matters

❖ Safe – in your home and community

❖ Supported – by people who care about you

❖ Excited – about your future

NEXT STEPS:

- Corporate Parenting Promises Task and Finish Group established to undertake an assessment against the Promises, use the results to 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

IMPACT ASSESSMENT -NOT REQUIRED FOR THIS REPORT

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 7.3

PATIENT EXPERIENCE QUALTIY AND SAFETY COMMITTEE	**DATE 05 FEBRUARY 2026**
Subject:	**Mental Capacity Act 2005 Deprivation of Liberty Safeguards NWSSP Limited Assurance Audit Action Plan Update**
Approved and presented by:	Executive Director of Nursing, Quality, Women and Family Health
Prepared by:	Assistant Director of Nursing Mental Capacity Senior Practitioner - Safeguarding
Other Committees and meetings considered at:	Executive Committee 21 January 2026

PURPOSE:

To update the PEQS Committee on the progress made against the matters arising following an NHS Internal MCA DoLS limited assurance audit report in January 2025.

RECOMMENDATION(S):

The Committee is asked to:

1) **NOTE** and take **ASSURANCE** on the progress made against the internal audit management actuions.

Approve/Take Assurance	Discuss	Note
Y	N	Y

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

EXECUTIVE SUMMARY:

In January 2025, an NWSSP internal audit on MCA DoLS returned a **limited assurance** report which made 3 high priority and 3 medium priority actions (Appendix 1)

In response to the audit and a previous MCA gap analysis undertaken, a business case to support the development of a Supervisory Body was presented and approved at PTHB Executive Committee in May 2025, which enabled the identified improvement work to commence.

The audit recommendations were translated into an action plan and operationalised through the MCA Operational Group which reports to the Strategic Safeguarding Group.

Significant progress has been made against all 6 actions, with all fully completed. Work is continuing to consolidate and build up the improvements already achieved. A follow up NWSSP MCA DoLS audit commenced in January 2026 and will report during Q4 2026.

MCA DoLS Action Plan Progress Update

Recommendation		Priority	Agreed Management Action	Update
1	The DoLS policy should be reviewed and brought up to date as necessary with a date of the next review noted in line with any appropriate Health Board guidance on Policy documentation maintenance. The updated policy should include reporting requirements, including frequency, content, to whom, and format (spreadsheet, table, dashboard etc).	Medium	PTHB DoLS policy requires updating.	**Completed** Re-write completed of a DoLS Practice Guidance, consultation completed
2	The Health Board has effective arrangements in place for providing training to nursing staff on the wards relating to DoLS processes. However, there is currently no on-going cycle of DoLS training in place that is directed towards the Managing Authority responsibilities. This gap in training is linked to the current lack of a DoLS co-ordinator post within the Health Board. Once the DoLS co-ordinator post is in place, training on the DoLS Managing Authority responsibilities should be developed along with a plan for on-going delivery.	Medium	A business case is required for the role of DoLS co-ordinator. A training needs analysis will be undertaken to determine required cycle of training. Identified training to be offered to the Managing Authority.	**Completed** Business case agreed May 25 Task & Finish group initiated to undertake the training needs analysis of MCA DoLS. Training delivered with ongoing training plan Audit process in place via MEG
3	Action First are commissioned to provide BIA assessments when the demand rises above a level that can be managed by the Health Board staff.	Medium	Safeguarding Team to ensure they have a process to maintain evidence of correct qualifications from external assessors. To ensure that	**Completed**

	The Health Board DoLS team should create a process to ensure that any staff provided by Action First are fully qualified and that any certification requirements for the role are up to date.		procurement amend the contract as required.	Process implemented following Procurement advice.
4	There remains a gap in the provision of a dedicated DoLS Supervisory Body role within PTHB, that provides oversight and co-ordination of the process and decision-making required. This is a gap that has been identified to PTHB Executive team The Health Board should ensure that arrangements are put in place as soon as possible to allow for the on-going provision of the DoLS Supervisory Body Role.	High	A business case is required for the role of DoLS co-ordinator, administration and Best Interest Assessors. Depending on outcome of business case, recruitment into positions will be required.	**Completed** Business case agreed May 25 Positions recruited to 2 x Best Interest assessors. DoLS Coordinator SLA for DoLS administration from PCC completed Interim positions in place while recruitment was underway
5	Delays are currently being experienced in obtaining timely sign-off of DoLS applications. The DoLS Signatories element of the process is reliant on senior staff agreeing to be part of a DoLS Signatory rota which is challenging to maintain due to being additional to normal duties. The DoLS Co-ordinator role would help to reduce this pressure and ensure timely scrutiny and sign-off of DoLS applications. The Health Board must ensure that all DoLS applications are reviewed and signed off in a timely manner.	High	A business case is required for the role of DoLS co-ordinator This role will include to sign off the applications and review the current signatories process and manage the signatory's rota.	**Completed** Signatories increased DoLS co-ordinator in post and undertaking a scrutiny, quality assurance and streamlining of processes role.
6	Management reports should be developed to record ongoing performance against the target dates. These should then be reported to an appropriate group and / or Committee with actions identified to improve performance where required. The case tracker spreadsheet could be developed to track and monitor progress on a case-by-case basis to confirm whether the target dates are being achieved and facilitate qualitative reporting, not just quantitative. Ideally a shared system should be used to enable all authorised users at least read access to live case data	High	A case tracker spreadsheet will be updated and accessible in real time for PTHB Supervisory Body. A Dols Co-ordinator role will need to be in place to provide the challenge and scrutiny. Performance will be reported into PTHB Strategic Safeguarding Group. .	**Completed** A case tracker spreadsheet has been updated and accessible to PTHB Supervisory Body in real time. DoLS co-ordinator role recruited. Performance reported into PTHB Strategic Safeguarding Group and MCA Operational group KPI's and data requirements have been identified and agreed between PCC and PTHB

NEXT STEPS:

- Work with NWSSP to support completion of the follow up MCA DoLS audit which commenced in January 2026
- Consolidate the improvements made and continue to develop and drive MCA DoLS forward within the Health Board
- Continue to mature data sets to ensure they effectively capture the impact of the changes implemented

Appendix 1
Internal Audit report - MCA DoLS (January 2025).

IMPACT ASSESSMENT - NOT REQUIRED

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

Agenda item: 7.4

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE	**05 February 2026**
Subject:	**Antimicrobial Stewardship Report**
Approved and presented by:	Kate Wright, Executive Medical Director
Prepared by:	Chief Pharmacist Antimicrobial Stewardship Pharmacist
Other Committees and meetings considered at:	Executive Committee - 21 January 2026

PURPOSE:

The paper is designed to provide relevant assurances to the organisation that relevant structures are in place supported by appropriate monitoring and reporting. The AMS Group will continue to meet quarterly to discuss and update the AMS workplan (incorporating all goals listed in this paper), reporting any concerns and assurances to the IP&C Committee.

RECOMMENDATION(S):

The Committee is asked to:

- **RECEIVE** the report taking **ASSURANCE** the organisation has appropriate structures and reporting in place with regards to Antimicrobial Stewardship.

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, including telecare to provide specialist support to clinicians and patients, is integrated into the AMS workplan, as is partnership working with other providers with respect to development of care closer to home (at home intravenous antibiotic service development).
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	

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 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	NAP Target 4a 2024-9 WHC TUA(PC)/2025 NPI 2025-8
1b	Reduce overall antimicrobial consumption in secondary care by 5% against 2019/20 baseline by 2029/30 ***NB: PTHB are 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

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 (figure 1):

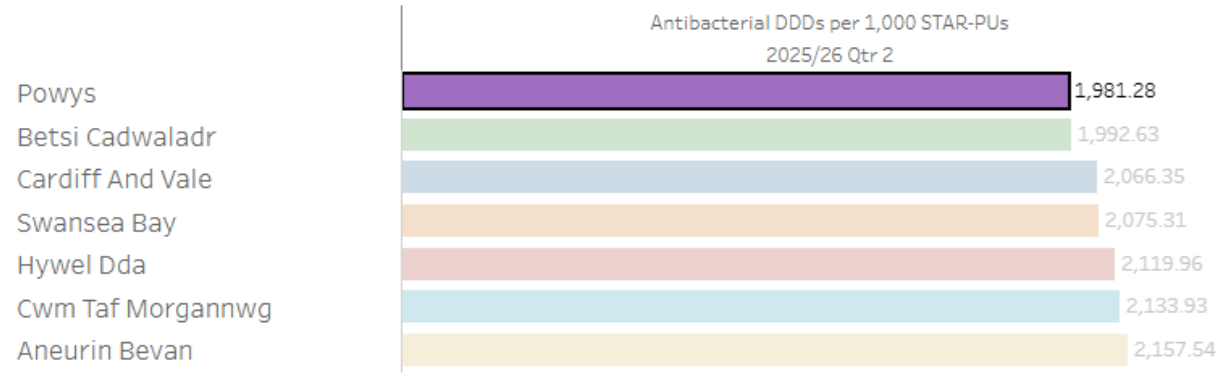


Figure 1: Total antimicrobial use across Welsh Health Boards for Q2 2025/6. Source: SPIRA

Despite its comparatively low usage, PTHB were previously the only Health Board to actually *increase* antimicrobial usage rather than decreasing it. Significant progress has been made in this area over the last 6 months, however, with PTHB **currently achieving the target** of 10% reduction in the latest quarter (figure 2):

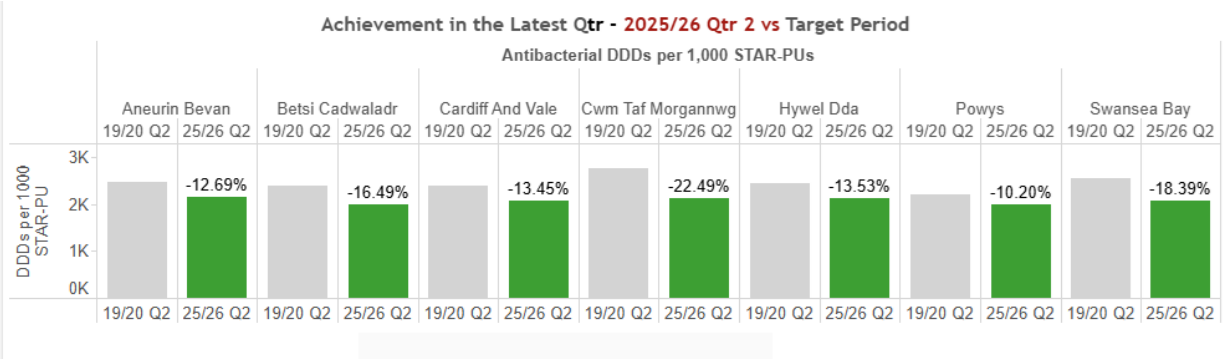


Figure 2: Progress against WHC reduction target of 10% for total antimicrobials in primary care in Q2 2025/6. Source: SPIRA

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.

Previously PTHB had been an outlier in Wales in their consistent high usage of these agents. Significant progress has been made on this measure in the last 12 months, however, and following a targeted programme of work (including GP education sessions, audit and feedback and specialist clinical support) PTHB are no longer the highest users of 4C antibiotics and are **currently achieving the target** to reduce in number (figure 3):

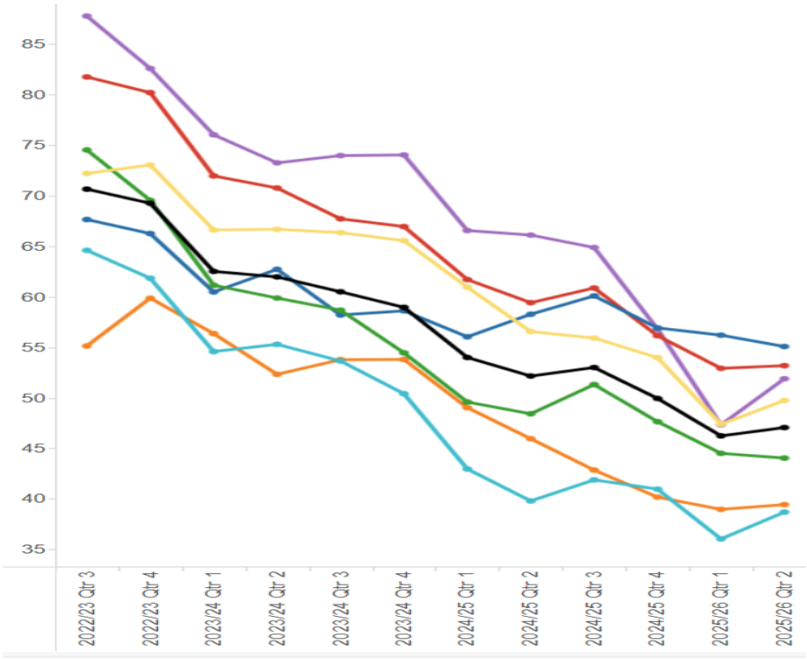


Figure 3: 4C antimicrobial use over time. PTHB is shown in purple. Source: SPIRA

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 were historically the least adherent to these recommendations but following a targeted programme of work between the medicines management team and GP practices (including targeted education and incentive schemes), have shown significant improvements and are no longer an outlier in Wales (figure 4):

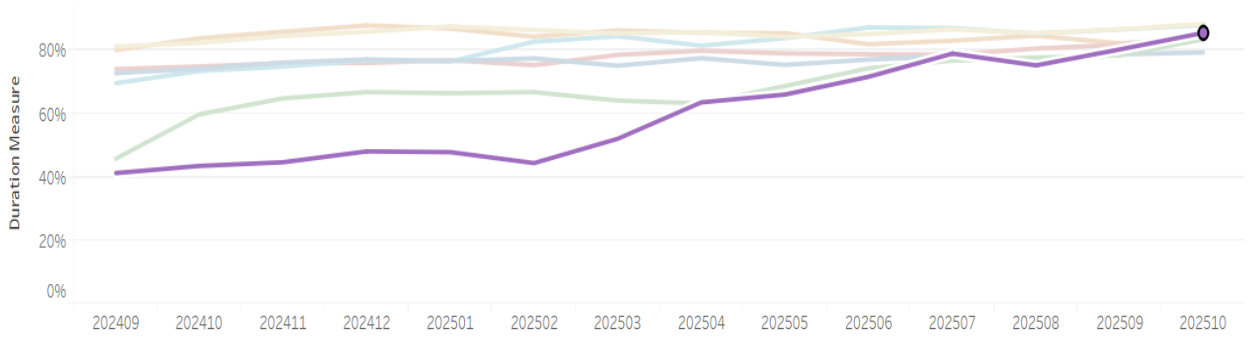


Figure 4: Percentage of RTI antibiotics prescribed as recommended 5 day courses (compared to 7 day courses). Powys is in purple. Source: SPIRA

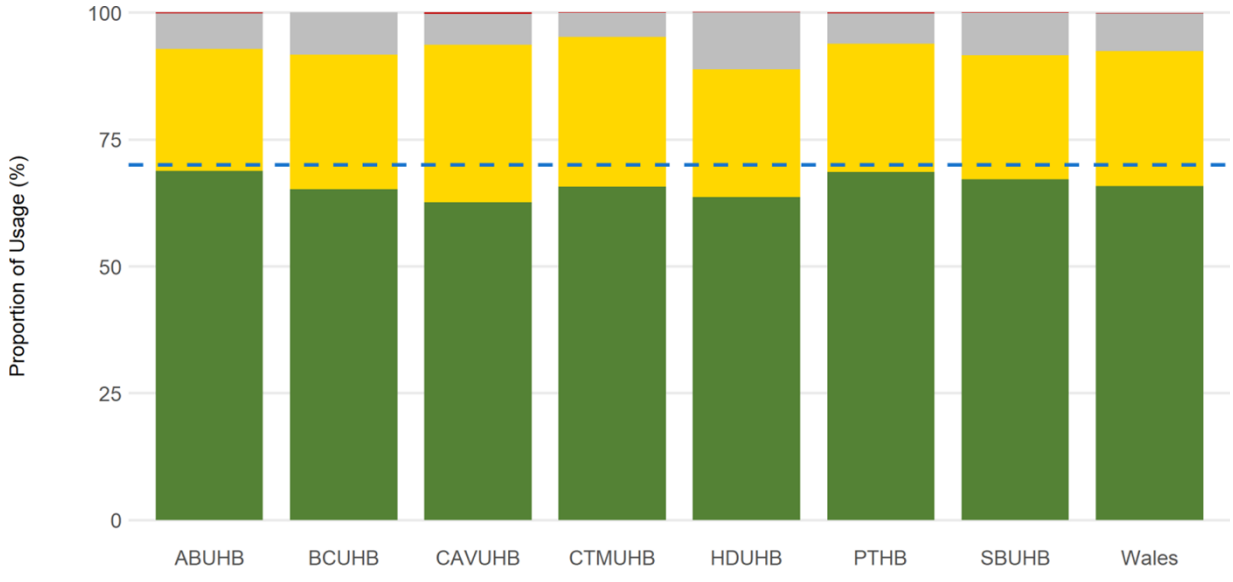
Powys is **currently achieving the target** of 75% of RTI antibiotics being prescribed as 5-day courses. The rate of optimal prescribing of the individual antibiotics measured as part of this target in October 2025 are shown below:

Antibiotic	**Target**	**Actual**
Amoxicillin 500mg capsules	75%	85.6%
Doxycycline 100mg capsules	75%	67.9%
Clarithromycin 500mg tablets	75%	65.8%
Combined RTI antibiotics	**75%**	**76.7%**

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, measured across all PTHB primary carte prescribing - including GP in hours, GP out of hours, Independent Prescribers, and the community pharmacy Common Ailments Service (Sore Throat and UTI schemes).

By the end of 2024/25 PTHB achieved **68.6%** access antimicrobial usage, which is a reduction from the 70.4% previously reported at the end of 2023/4. Like all Health Boards across Wales, PTHB are **currently NOT achieving** this target (figure 5):



	ABUHB	BCUHB	CAVUHB	CTMUHB	HDUHB	PTHB	SBUHB	Wales
Reserve	0.2	0.0	0.3	0.1	0.1	0.2	0.1	0.1
Other	7.0	8.3	6.0	4.7	11.2	5.9	8.3	7.4
Watch	24.0	26.5	31.1	29.5	25.2	25.3	24.5	26.6
Access	68.8	65.2	62.6	65.7	63.6	68.6	67.1	65.8

Figure 5: Comparison of All-Wales antimicrobial access category prescribing rate in primary care. Dotted lines represent the 70% target. Source: PHW HARP Team 2025

Plans are in place to address this, including:

- The delivery of a primary-care penicillin allergy delabelling project (to enable the wider use of access antibiotics)
- Further education sessions and targeted reviewed of practices prescribing higher volumes of 'watch' and 'reserve' antibiotics in primary care (such as lymecycline and co-amoxiclav).
- Increased clinical support being delivered by the AMS pharmacist to individual clinical staff across all settings (nurses, pharmacists, Drs) to promote prudent and preferred use of 'access' antibiotics.
- Working with digital teams to develop AMS into clinical systems such as electronic prescribing and digital clinical support, to increase use of recommended 'access' antibiotics.

NEXT STEPS:
The AMS Group continue to meet quarterly to discuss and update the AMS workplan (incorporating all goals listed above), reporting any concerns and assurances to the IP&C Committee. Actions for clinical areas are cascaded accordingly (e.g. community hospital ward managers), and the group has representation from across the system (e.g. dental, pharmacy, medical, primary care and inpatient areas).

IMPACT ASSESSMENT
Not required

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	06/10/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Gareth Mitchell, Corporate Governance Manager, 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 Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Health Boards		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 (QSO) Sub-Committee at its public meeting on 6 October 2025.

Key highlights from the meeting are reported in Section 2.

2. HIGHLIGHT REPORT

(Links to reports highlighted - October 2025 - NHS Wales Joint Commissioning Committee).

Status	Update
Alert / Escalate	
Advise	Reports from each of the Directors of Commissioning were received. The following items were discussed and referred to the Joint Committee for noting.: Director of Commissioning for Specialised Services • The significant risk in relation to the Blood and Marrow Transplantation (BMT) and Chimeric Antigen Receptor T-cell Therapy (CAR-T) services delivered by Cardiff and Vale University Health Board (CVUHB); and the linked service at Swansea Bay University Health Board (SBUHB). While the service currently holds Joint Accreditation Committee of the European BMT Society (JACIE) accreditation, existing facilities do not meet the standards required. A JACIE inspection had taken place, and the final report was awaited. • Significant risks reported across the Specialist Services portfolio including plastic surgery outreach clinics and PET-CT for prostate cancer. • An overview of progress within the Phase 2 review of Cardiac Commissioning. This included confirmation that a demand and capacity review for the programme had commenced and that an inaugural Project Delivery Board was scheduled during October to oversee this work. • Escalation Trajectories for specialist services in escalation are attached as **Appendix 1** for information. Director of Commissioning for Ambulance Services/111 Report • The implementation of phase two of the ambulance response model was discussed. This included confirmation that traditional Amber and Green Categories would be replaced with Orange (time-sensitive), Yellow (assess-and-respond), and Blue (non-emergency transport) to better reflect clinical need. Enhanced clinical screening would also ensure that patients with conditions like stroke or ST-Segment Elevation Myocardial Infarction received timely and appropriate care, while the Red category continued to target life-threatening emergencies. This phase aimed to improve resource use, reduce unnecessary hospital conveyance, and deliver better clinical outcomes. Plans were in place to deliver a 'go live' date in early December 2025. • Non-Emergency Patient Transport Service (NEPTS) is facing increased demand pressure. This was contributing to

Status	Update
	increased travel distances, rising provider costs, and inefficiencies at the interface between Health Boards and the ambulance service. Assurance and working groups had been set up to co-ordinate and drive improvements in this area. • An update was given in relating to the EMRTS Judicial Review claim. It was acknowledged that an application had been made by the claimant to the Court of Appeal to determine whether the appeal had sufficient grounds to proceed. • The 111 service remained challenging. Further work had been undertaken on call handling capacity, and a 111 Re-roster Project Board had been established to support this. Clinical call-back performance, however, was reported to have improved. Members discussed capacity issues within the NEPTS service and the ongoing work to develop a dashboard to identify performance issues including to track the number of bookings/cancelations in real time with a need for updates to be shared at a future meeting on this important piece of work. Director of Commissioning for MHLDVG Report • A recent visit to Rampton High Secure Hospital had identified significant improvements in patient care. • Significant issues have been identified following a review of the Caswell Clinic would require immediate action and close monitoring thereafter. A meeting had taken place with the SBUHB Executive Team to escalate identified concerns. An official report and action plan had been commissioned and would be shared with SBUHB for action as a matter of urgency. Any impact on escalation levels at the Caswell Clinic would be reported at the next Committee meeting. • Urgent repairs required at the Uned Gobaith Perinatal Inpatient Mental Health Unit at Tonna Hospital. Committee members noted that plans were being formulated to secure alternative capacity for patients given the necessity of a temporary 6-week closure of the unit to complete the required maintenance work. The Incident and Concerns Report highlighted 7 new incidents reported for the period spanning July-August and 6 new complaints, four had been closed and two remain open.
Assure	The JCC Risk Register - QSO risks were received. The Committee received an update about the risks allocated to it from the NWJCC Operational Risk Register (ORR) as at the 31 August 2025. Members **noted:**

Status	Update
	• Twenty risks (scoring 15/25 or over) were recorded within the ORR, eleven of which were assigned to the Committee for assurance and review. • Two new risks were added to the ORR since the previous update, two risks had been de-escalated, and one risk had been closed. The Regulator Report (Healthcare Inspectorate Wales (HIW) / Care Quality Commission (CQC) was received. An update on regulatory activity was provided. Members noted updates from HIW and the CQC and acknowledged ongoing collaboration with HIW to improve reporting and assurance processes. Members highlighted the need for future reports to provide greater specificity in relation to areas of concern raised by regulators.
Inform	**Patient Story – Cystic Fibrosis (CF)** A CF patient shared her story and personal experiences of the care received from NHS Wales, illustrating the benefits of shared decision-making and patient engagement. The story included a trial drug that had dramatically changed the patient's quality of life to the extent that she had successfully completed a cross-Atlantic rowing challenge, the first person with CF ever to do so. All Wales Individual Patient Funding (IPFR) Report The IPFR report would be a standing item at all future QSO meetings. It was agreed that outcome data would be added into the report, going forward. Financial elements of IPFR would continue to be reported to the Planning, Performance and Finance Sub-Committee as part of the NWJCC Finance Report. NWJCC Policy Group Report As per the NWJCC governance arrangements, the NWJCC Policy Group Report was received and noted at the meeting (this was a 6-monthly scheduled report). 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 would still be presented as a separate agenda item at the QSO meeting to fully capture work undertaken across the Network. The report was noted at the meeting and members discussed the use of outcome data for service planning, the national system used to track patient journeys and transplant decisions and the effectiveness of kidney

Status	Update
	transplants in terms of survival rates as well as wider economic benefits.
Appendices	None.

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 Asesiad o'r Effaith ar Ansawdd? /* **Quality**	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: This is a summary of the

Have you undertaken a Quality Impact Assessment Screening?		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 IMTP and identify the areas where resources may be required.	

4. RECOMMENDATIONS

The Health Board is asked to:

- **Note** the highlights outlined in Section 3 of this report.

Executive Director Lead: Melanie Wilkey
Commissioning Lead: Amy Lewis
Commissioning Team: Women and Children

Date of Escalation Meetings: 10/10/23, 19/12/23, 16/05/24,25/11/24, 15/01/25, 18/03/25, 20/05/25, 01/07/25
Date Last Reviewed by Quality & Patient Safety Committee: 04/08/25

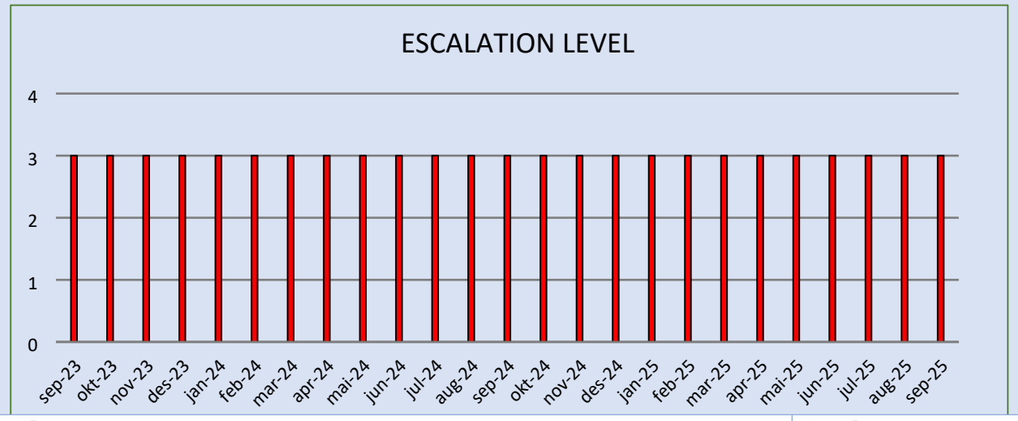
Service in Escalation:
Neonatal Intensive Care Unit

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ September 2025
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
September 2023	**3**

Rationale for Escalation Status:

High levels of cot closures reported across all three levels of care, blood stream infection rates and progress implementing the new cot configuration.

Background Information:

There are currently two risks on the CRAF relating to Neonatal services at Cardiff and Vale UHB, lack of cot availability due to workforce and the service being a negative outlier status for blood stream infections, on the National Neonatal Audit Programme (NNAP). Limited progress has also been made against implementing the workforce required to support the cot configuration.

NWJCC assurance and confidence level in developments:

Low / Medium – First draft of an action plan has been received however further detail has been requested. The mitigations required to support safe staffing levels and improvements against infection rates requires a robust workforce plan which has a medium to long term lead time for completion. Escalation status being discussed at executive level within the JCC.

The Paediatric and Neonatal Escalation Reset Meeting is to take place on the 18th **of** September where an overview of the service will be discussed to gain an understanding from the health boards perspective of where they feel they are in the process, rather than discussing actions and objectives. The overarching objectives for the service are in the development phase and when agreed within the commissioning team they will be shared with the health board for comments and then presented at the reset meeting, to ensure they are agreed

Actions:

Action	NWJCC Lead	Action Due Date	Completion Date
Working with C&V UHB executive team to develop a plan to implement new baseline as all other HBs are in a position to go live	Director of Planning	16th August 2024	See comment in development section
Re-set meeting to discuss and agree actions/objectives in collaboration with the health board	Senior Planning Manager	18th September 2024	18th September 2024
Escalation meeting to discuss detail and progress against action plan (every 6 weeks)	Head of Commissioning	-	4th November 2025

collaboratively. New executive leads for both organisations will be agreed as part of this process to ensure all are in agreement.

Actions/Objectives agreed on the 18**th of** September in collaboration with the health board. Monthly escalation meetings to re-commence on the 25**th of** November to monitor progress.
Working with C&V UHB executive team to develop a plan to implement new baseline as all other HBs are in a position to go live – Phase 1 implementation paper to be taken to management group on 28th November to recommend a way forward to progress with the implementation of the new baseline.

15th January escalation meeting. Health board presented their progress against the agreed actions/objectives. Progress acknowledged. JCC to assess progress report against the objectives. Decision made service to remain at escalation level 3 as more data required ensuring that the improved position is sustained prior to considering de-escalation.
Conversations ongoing regarding implementing phase 1, both internally in the JCC and with the health board. If phase 1 is not implemented as previously agreed by Joint Committee, then there will need to be appropriate communication to all the health boards to advise. The commencing of Phase 2 has been delayed due to the OCP process.

18th March escalation meeting. Health Board presented their progress against the agreed actions/objectives. Progress acknowledged. JCC to assess progress report against the objectives. The escalation level was discussed in the W&C commissioning team meeting on 19th March. The team agreed that the service should remain at escalation level 3.

20th May escalation meeting. Health Board presented their progress against the agreed actions/objectives. Progress acknowledged. JCC to assess progress report against the objectives. Executive Director lead agreed to progress finance conversations around funding. The escalation level was discussed in the W&C commissioning team meeting on 21st May. The team agreed that the service should remain at escalation level 3.
The delay in implementation by the Health Board of the Phase 1 revised cot configuration and agreement on next steps is currently with the Senior Leadership Team. A paper to provide an update to Joint Committee on Phase 1 implementation is in development. Phase 2 under discussion due to delays with the implementation of Phase 1.

1st July escalation meeting held. Health Board presented their progress against the agreed actions/objectives. Progress acknowledged. JCC to assess progress report against the objectives. Executive Director lead agreed to progress finance conversations around funding, as meeting not yet taken place. The escalation level was discussed during the meeting and there was agreement that the service should remain at escalation level 3.

The delay in implementation by the Health Board of the Phase 1 revised cot configuration and agreement on next steps is currently with the Senior Leadership Team. A paper to provide an update to Joint Committee on Phase 1 implementation has been written and is with the Director of Commissioning for Specialised Services. Phase 2 under discussion due to delays with the implementation of Phase 1. 2nd September update – The escalation meeting scheduled for the 23rd of September has been stood down. This is for the JCC to work through the funding matters internally. An internal workshop to discuss Phase 1 progression and the funding matters has been arranged for the 22nd of October 2025. The next scheduled escalation meeting is the 4th **of** November. The service remains at escalation level 3.	

Issues/Risks:
March 24 - The service have not submitted an action plan despite being in escalation since Sept 23, they are unable to increase their cot numbers based on the new cot configuration and reported that they cannot safely deliver on the cots that they are currently commissioned, no progress made with exec to exec meeting, possibility that outsourcing from the service may be required, the service remains at escalation level 3 but if there are no improvements increasing the escalation will be considered.
May 24 - Through quarterly assurance meetings with all neonatal units in the South & West of Wales it has been reported that there has been increased pressure across the network for cot availability
July 24 – Temporary closure of Princess of Wales (PoW) Maternity and Neonatal unit for essential maintenance work from September to December. JCC currently commission 4 High Dependency (HD) cots within the PoW and Prince Charles Hospital (PCH) sites within CTMUHB. PCH are able to flex their cot base from 15 cots to 19 to provide HD capacity and Special Care based on clinical need. Consultation and communication with all stakeholders is underway alongside Maternity users who this will impact upon. Swansea Bay University Health Board and Cardiff and Vale have been asked to support the delivery of maternity care based on demand and demographics of the planned maternity users. Work is currently underway within CMTUHB to gain the appropriate data and demographics of the women currently booked to birth during this period. The Welsh Ambulance Service and the Neonatal network are working with CMTUHB to ensure safe delivery and appropriate preparation of pathways to enable safe transfer and clear guidance for the maternity users and clinical teams. Ongoing weekly project meetings have been put in place, NWJCC have been invited to attend these. Updates from these will be shared within the NWJCC to understand the impact this will have on current commissioned cots. An early warning notification has gone to Welsh Government.

Executive Director Lead: Melanie Wilkey
Commissioning Lead: Emma King
Commissioning Team: Cardiac

Date of Escalation Meetings:
Date Last Reviewed by Quality & Patient Safety Committee: 04/08/25

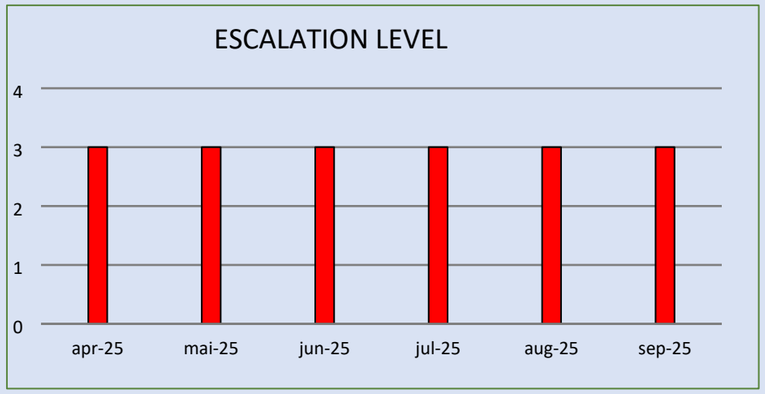
Service in Escalation:
Bariatrics

Current Level	Escalation
3	

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ September 2025
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
April 2025	**3**

Rationale for Escalation Status :

Update April 2025 – The process for the escalation of the Salford obesity surgery service to Level 3 of the NWJCC Escalation Framework was initiated in December 2024 and endorsed by the NWJCC Senior Leadership Team in January 2025. The service has been subject to formal escalation arrangements due to our long-standing concerns with the obesity surgery waiting list and activity levels.

Background Information:

The process for the escalation of the Salford obesity surgery service to Level 3 of the NWJCC Escalation Framework was initiated in December 2024 and endorsed by the NWJCC Senior Leadership Team in January 2025.

NWJCC assurance and confidence level in developments:

Low - A letter was sent to Salford in February informing them of the escalation and process (no response has yet been received). A chasing communication was sent by the Director of Commissioning for Specialised Services in April 2025. An escalation meeting will be arranged with the Salford service as soon as a response has been received from Salford.

September 2025 Update – Correspondence was received from Salford on 25th September 2025 to serve notice of 6 months on the contract for bariatric services. Work will progress to look at alternative commissioning options and ensuring patients currently on the waiting list are not adversely affected by this change.

Actions:

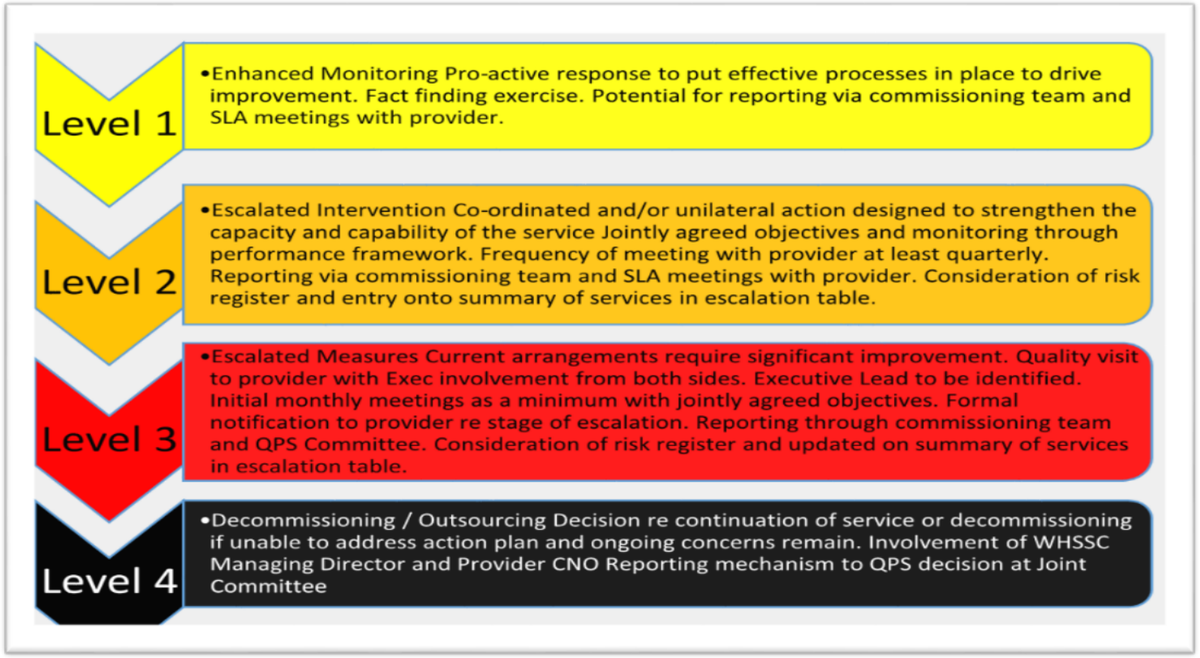
Action	NWJCC Lead	Action Due Date	Completion Date
Escalation endorsed by SLT	Director of Commissioning	Jan 25	Jan 25
Escalation letter sent to Salford	Director of Commissioning	Feb 25	Feb 25
Follow up email sent to Salford	Director of Commissioning	April 25	April 25
Head of Commissioning for Cardiac has contacted the Commissioning Lead for Obesity Services (Greater Manchester ICB) in NHSE	Head of Commissioning	July 25	July 25
SBUHB to provide service for 15 patients from this catchment area	Head of Commissioning	March 26	March 26
A follow up letter has been sent to Salford requesting an urgent response to the escalation letter	Director of	September 25	September 25

		Commissioning		

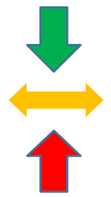
Issues/Risks:
September 25 – Notice served by Salford requires alternative provision to be sought before 1st April 2026.

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.
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

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 7.6

Patient Experience, Quality and Safety Committee	**Date: 05 February 2025**
Subject:	**Committee Effectiveness: Continuous Development Plan 2025-26**
Approved and presented by:	Helen Bushell, Director of Corporate Governance
Prepared by:	Deputy Board Secretary
Other Committees and meetings considered at:	Committee Effectiveness report and plan have been considered at earlier Committee meetings in 2025.
Appendices:	Appendix A – PEQS Continuous Development Plan 2025-26

PURPOSE:

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

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

RECOMMENDATION(S):

The Committee is asked to:

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

Approve/Take Assurance	Discuss	Note
x		

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	A commitment to good governance and robust corporate systems are a key enabler of all of our wellbeing objectives.
2. Provide Early Help and Support	Y	
3. Tackle the Big Four	Y	
4. Enable Joined up Care	Y	

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

COMMITTEE EFFECTIVENESS

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

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

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

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

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

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

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

NEXT STEPS:

The Corporate Governance Team will continue to monitor actions still under implementation as of February 2026 and will consider how these are fed into the continuous development processes for 2026/27.

Appendix A – PEQS Continuous Development Plan 2025-26

Committee Effectiveness: Continuous Development Plan 2025–2026

Patient Experience, Quality and Safety Committee

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

Theme	Action	Owner	Timeline	Status	Comments
Membership	Review and confirm committee membership	DCG / PTHB Chair	Q1	Complete	New Committee Membership confirmed as of May 2025
Assurance to Board (Quality Assurance: QMS)	Develop a standardised reporting template for clear upwards assurance	Governance Team	Q2	Complete	Alert, Advice, Assurance, Inform (AAAI) Reports have been introduced for all Committees for reporting to the Board from March 2025 (having been piloted during 2024/25). This template will be reviewed and matured in readiness for September Board.
Organisational Learning (Quality Learning: QMS)	Schedule opportunity to actively consider evidence of learning and improvement in each Committee	Governance Team	Q3	Underway	Integrated into review of Committee Work programme for 2026-27 as in development as of Q4.

Committee Agenda Focus (Quality Planning: QMS)	Apply risk-based approach to planning agendas, prioritising high-risk/high-impact items	DCG/Committee Chairs	Q1	Complete	Prioritisation is undertaken as part of the agenda setting process, this is aligned to SRR, CRR, ORR and BAF process.
Training & Induction	Develop induction information and training needs analysis for each Committee	Governance Team	Q4	Complete	ARAC induction pilot held in September 2025, further schedule to be considered for 2026/27.
Integration of Risk	Incorporate risk lens in committee discussions and papers	Governance Team	Ongoing	Underway	Committee risk register a core agenda item at every committee. Review of Committee Paper template underway with consideration of how to best integrate risk appetite levels into cover reports.

Committee-Specific Action Plan

Patient Experience, Quality and Safety Committee

Theme	Action	Owner	Timeline	Status	Comment
Patient Voice	Formalise patient experience as a substantive, consistent agenda item	Governance Team/Chair of Committee	Q2	Complete	Patient Experience stories received in April and July 2025 and scheduled for February 2026. Items also received in regards to Civica and Dental quality throughout the year. Patient experience will continue to be consistently brought forward as part of the 2026/27 work programme, which is currently under development.
Organisational learning	Strengthen feedthrough from incident reviews/actions taken to Committee. (Quality Learning: QMS)	EDoNQW&FH	Q3	Underway	High level learning themes are embedded into the Integrated Quality Report on a quarterly basis. More work is required to systematically capture and report learning from an organisational perspective. This action will continue into 2026/27.

Patient Experience, Quality and Safety Committee 2025-26

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

KEY

Added to draft agenda
Date to be confirmed
Item deferred
Item brought forward
Going to Board
Due to Committee
Find Exec Cttee date
transferred to another committee
Date/Item to be confirmed

Powys Teaching Health Board Glossary (Last updated Decemberjanuar 26)

Acronym	
ADoECP	Associate Director of Estates, Capital & Property
CEO	Chief Executive Officer
DCG	Director of Corporate Governance
DIT	Director of Improvement & Transformation
EMD	Executive Medical Director
ED PH	Executive Director of Public Health
ED P&C	Executive Director of People and Culture
ED PP&C	Executive Director of Planning, Performance and Commissioning
ED FCSS	Executive Director of Finance, Capital & Support Services
ED AHPHSD	Executive Director of Allied Health Professions, Health Sciences and Digital
ED NQW&FH	Executive Director of Nursing, Quality, Women and Family Health
EDPCCMH	Executive Director of Primary Care, Community & Mental Health
ABUHB	Aneurin Bevan University Health Board
AFC	Agenda for Change
AGW	The Auditor General for Wales
AHPs	Allied Health Professionals
ALN	Additional Learning Needs
AO	Accountable Officer
ARAC	Audit, Risk and Assurance Committee
ASM	Accelerated Sustainable Model
AR	Audit Recommendations
APB	Area Planning Board
BAF	Board Assurance Framework
BCUHB	Betsi Cadwaladr University Health Board
BMA	British Medical Association
CAAP	Clinical associate in applied psychology
CAMHS	Child and Adolescent Mental Health Services
CCN	Childrens Community Nursing
CEMT	Chief Executive Management Team
CHC	Continuing Health Care
CIW	Care Inspectorate for Wales
CLIP	Collaborative Learning in Practice

CNO	Chief Nursing Officer
CPD	Continued Professional Development
CPR	Child Practice Review
CRR	Corporate Risk Register
CSP	Clinical Service Plan
CTMUHB	Cwm Taff Morgannwg University Health Board
CV	Curriculum Vitae
CVUHB	Cardiff and Vale University Health Board
CWMPAS	Mid and West Wales Regional Safeguarding Adults Board
CYSUR	Mid and West Wales Regional Safeguarding Children Board
CTC	Care Transfer Co-ordinator
CCOMG	Complex Care Operational Management Group
DATIX	Incident Management System
D&P	Delivery and Performance Committee
DCG	Delivery Co-ordination Group
DGH	District General Hospital
DHCW	Digital Health and Care Wales
DNA	Did not Attend
DNACPR	Do Not Attempt Cardio-Pulmonary Resuscitation
DPA	Data Protection Act
DToC	Delayed Transfer of Care
D2RA	Discharge to Recover and Assess
DST	Decision Support Tool
EASC	Emergency Ambulance Services Committee
EOG	Executive Oversight Group
EOY	End of Year
EMRTS	Emergency Medical Retrieval & Transfer Service
EPMA	Electronic Prescribing and Medicines Administration
ESR	Electronic Staff Record
EMI	Elderly Mentally Infirm
FBC	Full Business Case
FOI	Freedom of Information
FFT	Friends and Family Test
FTE	Full Time Equivalent
F&P	Finance and Performance Committee
GDS	General Dental Services
GIRFT	Getting It Right First Time
GMC	General Medical Council
GMS	General Medical Services
GP	General Practitioner

GNCC	General Nursing Complex Care Team
H&S	Health and Safety
HCA	Health Care Assistant
HCS	Health and Care Standards
HCSW	Health Care Support Worker
HDUHB	Hywel Dda University Health Board
HEIW	Health Education and Improvement Wales
HIW	Healthcare Inspectorate Wales
HP	Health Protection
HPF	Healthcare Professionals Forum
ICF	Integrated Care Funding
IEN	Internationally Educated Nurse
IG	Information Governance
IM	Independent Members
IMTP	Integrated Medium Term Plan
IP&C	Infection Prevention and Control
IQPF	Integrated Quality Performance Framework
IQPG	Integrated Quality & Performance Group
IQPR	Integrated Quality Performance Report
IT	Information Technology
JAG	Joint Advisory Group (on Gastrointestinal Endoscopy)
JCC	Joint Commissioning Committee
JD	Job Description
JET	Joint Executive Team
JIPCA	Joint Inspection of Child Protection Arrangements
JLT	Joint Leadership Team (PTHB and PCC)
JR	Judicial Review
KPI	Key Performance Indicator
LoF	League of Friends
LA	Local Authority
LHB	Learning Health Board
LMC	Local Medical Committee
LPF	Local Partnership Forum
LRF	Local Resilience Forum
LTA	Long Term Agreement
MAC	Mindfulness, Acceptance and Compassion Team
MD	Ministerial Direction
MDTs	Multi-Disciplinary Teams
MEG	Medical E-Governance System

MEG	Main Expenditure Group
MH	Mental Health
MHD	Mental Health & Learning Disability
MIU	Minor Injury Unit
MOU	Memorandum of Understanding
MOA	Memorandum of Agreement
MSK	Musculoskeletal
MV	Mass Vaccination
NHSE	National Health Service England
NHS	National Health Service
NHSWE	NHS Wales Executive
NICE	National Institute of Health and Clinical Excellence
NRI	Nationally Reportable Incidents
NWSSP	NHS Wales Shared Services Partnership
NNA	Nursing Needs Assessment
OBC	Outline Business Case
OCP	Organisational Change Process
OOC	Out of County
OOH	Out of Hours
OSCE	Objective Structured Clinical Examination
OT	Occupational Therapy
PA	Physician Associate
PADR	Personal Appraisal Development Review
PAVO	Powys Association of Voluntary Organisations
PCC	Powys County Council
PEQS	Patient Experience, Quality and Safety Committee
PHE	Public Health England
PHW	Public Health Wales
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
RIIC	Research, Innovation & Improvement Coordination
RIF	Regional Investment Fund

RISP	Radiology Information System Procurement
RJAH	Robert Jones and Agnes Hunt
RN	Registered Nurse
RPB	Regional Partnership Board
RTT	Referral to Treatment
RTS	Routemap To Sustainability
Q1 Q2 Q3 Q4	Quarter 1 (April, May, June), Quarter 2 (July, August, September), Quarter 3 (October, November, December), Quarter 4 (January, February, March)
QSEG	Quality, Safety and Experience Group
SAR	Subject Access Request
SAS	Specialty and Specialist
SBAR	Situation, Background, Assessment, Recommendation
SBUHB	Swansea Bay University Health Board
SDEC	Same Day Emergency Care
SLA	Service Level Agreement
SOC	Strategy Outline Case
SOP	Standard Operating Procedure
SaTH	Shrewsbury and Telford Hospital NHS Trust
SPB	Strategic Programme Board
SRO	Senior Responsible Owner
TaODEC	Tactical Organisation Development, Engagement and Communication
TI	Targeted Intervention
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 Trust
YTD	Year to Date