

Patient Experience, Quality and Safety Committee

Thursday 15 October 2026, 09:30 - 13:00

Microsoft Teams

Agenda

09:30 - 09:30
0 min

1. PRELIMINARY MATTERS

1.1. Welcome and Apologies

PEQS_Agenda_15Oct26 FINAL.pdf (3 pages)

1.2. Declarations of Interest

PEQS_1.2_Board Members Declaration Of Interests Aug26.pdf (3 pages)

1.3. Chair's Report

09:30 - 09:30
0 min

2. CONSENT AGENDA BUSINESS

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

The Chair will ask if there are any items from the Consent Agenda (Item 7) that Committee Members wish to bring forward to the main agenda.

09:30 - 09:30
0 min

3. ESCALATED ITEMS

3.1. Children's Neurodiversity Services

PEQS_3.1_CYP ND.pdf (9 pages)

09:30 - 09:30
0 min

4. ITEMS FOR APPROVAL / RATIFICATION / ASSURANCE

4.1. Minutes of the previous meeting: 04 August 2026

PEQS_4.1_Minutes 2026-08-04 PEQS unconfirmed.pdf (16 pages)

4.2. Committee Action Log

To Follow

PEQS_4.2_PEQS Action Log Oct26.pdf (1 pages)

4.3. Integrated Quality Report

PEQS_4.3_Integrated Quality Report Q2 Oct 2026.pdf (24 pages)

PEQS_4.3a_PTHB PSOW letter.pdf (14 pages)

4.4. People Experience Framework

PEQS_4.4_PE Framework.pdf (2 pages)

PEQS_4.4a_DRAFT V1.1 People's Experience Policy July 2026.pdf (40 pages)

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4.5. Patient Experience

4.5.1. Primary Care

 PEQS_4.5_Patient Experience in Primary Care.pdf (17 pages)

4.5.2. General Dental Services

 PEQS_4.5b_GDS Quality & Safety Report 151026.pdf (8 pages)

4.6. Medicines Management Annual Report

 PEQS_4.6_Medicines Management and Pharmacy Annual Report 2025-26 Cover Paper.pdf (2 pages)

 PEQS_4.6a_Medicines Management and Pharmacy Annual Report 2025-26.pdf (15 pages)

4.7. Annual Reports

4.7.1. Medical Devices

 PEQS_4.7a_Medical Devices Annual Report 25_26.pdf (25 pages)

4.7.2. Point of Care Testing

 PEQS_4.7b_POCT Annual Report 25_26.pdf (27 pages)

4.8. Transition of Care update

 PEQS_4.8_Transition of Care Progress Update October 2026.pdf (7 pages)

4.9. Monitoring ongoing improvement and barriers to implementation re WHC 37 Infected Blood Inquiry (Blood Transfusions)

4.10. Patient Experience in Commissioning Framework (Routemap/progress report)

To Follow

 PEQS_4.10_Patient Experience and Commissioning Framework October 2026.pdf (8 pages)

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

0 min

There are no items for discussion

There are no items for discussion

09:30 - 09:30 6. CONSENT AGENDA

0 min

6.1. Internal Audit Reports:

6.1.1. Learning Disabilities Eligibility Assessment and Care Co-ordination processes

 PEQS_6.1_2526.26 Learning Disabilities Final Internal Audit Report.pdf (10 pages)

6.2. Joint Commissioning Committee highlight report from the Quality, Safety and Outcomes Sub-Committee 24 August 2026

 PEQS_6.2_QSOC Highlight Report 24 August 2026.pdf (12 pages)

6.3. Clinical Audit Annual Closure Report 2025/26

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6.4. Work Programme

 PEQS_6.5_PEQS Work Programme Oct26.pdf (1 pages)

6.5. Glossary

 PEQS_6.6_PTHB Glossary.pdf (7 pages)

09:30 - 09:30
0 min

7. OTHER MATTERS

7.1. Any Other Urgent Business

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

7.3. Committee reflections

7.4. Date of the Next Meeting: 04 February 2027

7.5. Confidential Items

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

7.6. Welcome and Apologies

7.7. Declarations of Interest

7.8. Minutes of the In-Committee meeting held on 04 August 2026

7.9. Sexual Health Test and Post update



AGENDA

Time	Item	Title	Attached/Or al	Presenter
	1	PRELIMINARY MATTERS		
09.30	1.1	Welcome and apologies	Verbal	Chair
	1.2	Declarations of interest	Verbal	All
	1.3	Chair’s Report	Verbal	Chair
	2	CONSENT AGENDA BUSINESS		
The Chair will ask if there are any items from the Consent Agenda (Item 7) that Committee Members wish to bring forward to the main agenda.				
	3	ESCALATED ITEMS		
09.35 30 mins	3.1	Children’s Neurodiversity Services Purpose: Assurance	Attached	Executive Director of Planning, Performance and Commissioning
	4	ITEMS FOR APPROVAL / RATIFICATION / ASSURANCE		
10.05 5 mins	4.1	Minutes of previous meeting: • 04 August 2026 Purpose: Approval	Attached	Chair
10.10 5 mins	4.2	Committee Action Log Purpose: Approval	Attached	Chair
10.15 25 mins	4.3	Integrated Quality Report including: • PSOW letter • More on harm reviews (action from August meeting) Purpose: Assurance	Attached	Executive Director of Nursing, Quality, Women and Family Health
10.40 15 mins	4.4	People Experience Framework Purpose: Approval	Attached	Executive Director Nursing, Quality, Women and Family Health
10.55	COMFORT BREAK (10 minutes)			
11.05 30	4.5	Patient Experience: A. Primary Care B. General Dental Services Purpose: Assurance	Attached	Executive Director of Primary Care, Community and Mental Health
11.35 15 mins	4.6	Medicines Management Annual Report Purpose: Approval	Attached	Executive Medical Director / Acting Deputy Chief Executive
11.50 25 mins	4.7	Annual Reports: A. Medical Devices B. Point of Care Testing Purpose: Approval	Attached	Executive Director of Allied Health Professions, Health Sciences and Digital

12.15 15 mins	4.8	Transition of Care update Purpose: Assurance	Attached	Executive Director of Nursing, Quality, Women and Family Health
12.30 5 mins	4.9	Monitoring ongoing improvement and barriers to implementation re WHC 37 Infected Blood Inquiry (Blood Transfusions) Purpose: Assurance	Verbal	Executive Medical Director / Acting Deputy Chief Executive
12.35 20 mins	4.10	Patient Experience in Commissioning Framework (Routemap/progress report) Purpose: Assurance	Attached	Executive Director of Nursing, Quality, Women and Family Health
	5	ITEMS FOR DISCUSSION		
		<i>There are no items for discussion</i>		
	6	CONSENT AGENDA		
	6.1	Audit Reports: Internal Audit: Learning Disabilities Eligibility Assessment and Care Co-ordination processes Purpose: Information	Attached	Director of Corporate Governance
	6.2	Joint Commissioning Committee highlight report from the Quality, Safety and Outcomes Sub-Committee 24.08.2026 Purpose: Assurance	Attached	Executive Director of Nursing, Quality, Women and Family Health
	6.3	Clinical Audit Annual Closure Report 2025/26 Purpose: Assurance	Attached	Executive Medical Director / Acting Deputy Chief Executive
	6.5	Work programme Purpose: Information	Attached	Director of Corporate Governance
	6.6	Glossary Purpose: Information	Attached	Director of Corporate Governance
	7	OTHER MATTERS		
12.55	7.1	Any Other Urgent Business	Verbal	Chair
	7.2	Items to be brought to the attention of the Board and/or other Committees	Verbal	Chair
	7.3	Committee Reflections	Verbal	Chair
	7.4	Date of the next meeting: 04 February 2027		
7.5 The Chair, with advice from the Director of Corporate Governance, has determined that the following items include confidential or commercially sensitive information which is not in the public interest to discuss in an open meeting at this time. The Committee is asked to take this advice into account when considering the following motion to exclude the public from this part of the meeting:				

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

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

13.00	7.6	Welcome and Apologies	Verbal	Chair
	7.7	Declaration of Interest	Verbal	Chair
	7.8	Minutes of the In-Committee Meeting held on the 04 August 2026 Purpose: Approval	Attached	Chair
13.05 5 mins	7.9	Sexual Health Test and Post update Purpose: Assurance	Verbal	Executive Director of Public Health
13.10	Close			

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

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

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

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

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POWYS TEACHING HEALTH BOARD - REGISTER OF DECLARATION OF INTERESTS 2026-27							Updated: August 2026
Position	Name	Interest Category	Interest Situation	Relevant Dates from	Relevant Dates to	Description of Declaration	Comment
INDEPENDENT MEMBERS							
PTHB Chair	Carl Cooper	Indirect Interests	Loyalty Interests	02-Feb-25	Current	Sole Trader, Mandy Williams Consulting, The Wellbeing Coach	NIL
		Indirect Interests	Loyalty Interests	02-Apr-25	Current	Family member is an employee of Cardiff & Value University Health Board (non Director).	NIL
Vice Chair	Rhiannon Beaumont-Wood	Indirect Interests	Outside Employment	Jun-23	Current	Director and Owner of RBW Executive and Professional Coaching	NIL
		Non Financial professional interests	Loyalty Interests	01-Jan-08	Current	Royal College of Nursing	NIL
		Indirect Interests	Outside Employment	07-Apr-23	31-May-26	Dorset ICB (NHS Dorset) Non-Executive Member	NIL
		Indirect Interests	Outside Employment	01-Mar-24	31-Mar-27	Registrant Council Member - Nursing and Midwifery Council (NMC)	Renumerated as per Registrant Council Member Terms and Conditions
Independent Member (General)	Rhobert Lewis	Non Financial professional interests	Outside Employment	17-Nov-21	Current	Chair NPTC Group of Colleges	NIL
		Indirect Interests	Outside Employment	01-Jan-20	Current	External member Cross-party STEMM Group Welsh Government	NIL
Independent Member (Trade Union)	Cathie Poynton	NIL	NIL	NIL	NIL	NIL	NIL
Independent Member (finance)	Stephen Elliot	Non Financial professional interests	Loyalty Interests	17-Apr-24	Current	Honorary Fellow and Lifetime Member of Healthcare Financial Management Association	NIL
		Non Financial professional interests	Outside Employment	17-Apr-24	Current	Spouse Directorship of Oshi's World Private Limited Company and a Trustee of Oshi's World Charity	NIL
Independent Member (General)	Ronnie Alexander	Indirect Interests	Outside Employment	2012	Current	Partner Director of RA and CJ Consulting Limited	Dividend Payment only
		Indirect Interests	Outside Employment	Mar-21	Current to Dec-27	Independent Monitoring Authority (IMA) – Non Executive Director	Remunerated
		Indirect Interests	Shareholdings and other ownership interests	2012	Current	Director of RA and CJ Consulting Limited	Dividend Payment only
Independent Member (University)	Simon Wright	Non Financial professional interests	Loyalty Interests	01-Mar-15	28-Feb-29	Personal: Senior Professional Fellow, Cardiff University-Various Healthcare Programmes	Honoury Role
		Indirect Interests	Loyalty Interests	18-Jun-25	Current	Sister: Senior Operational Manager, Milestone Trust, Bristol	Salaried Employment
		Indirect Interests	Loyalty Interests	18-Jun-25	Current	Spouse: District Nurse, Cardiff and Vale UHB	Salaried Employment
		Non Financial professional interests	Loyalty Interests	02-Jan-20	Current	Labour Party member	NIL
		Financial Interests	Outside Employment	09-Feb-26	Current	Head of Partner Engagement for JS Group working with HE sector	Salaried Employment
Independent Member (Third Sector)	Jennifer Owen Adams	Non Financial professional interests	Loyalty Interests	01-Jun-16	10-Jun-27	Member (not a NED) of Glas Cymru the holding company of Dwr Cymru/Welsh Water	NIL
		Non Financial professional interests	Loyalty Interests	01-Sep-24	01-Jun-28	Coopted Member of PAVO	NIL
		Non Financial professional interests	Loyalty Interests	01-Apr-24	01-Apr-27	Chair Public Services Board Scrutiny Committee	NIL
Patterson,Liz 13/10/2026 09:48:47		Non Financial professional interests	Loyalty Interests	01-Jun-10	Current	Member of Community Speed Watch Group	NIL
				01-Jan-19	Current	Member of Society Genealogists	
				08-May-22	Current	Associate Member of the Association of Genealogists and Registered Archivists	
		Financial Interests	Shareholdings and other ownership interests	01-Jun-03 01-Jun-22 01-Jun-88	Current	Sole Trader/Owner of Celebratory Gifts Heraldic Names Sole Trader/Owner:CTW Genealogy Research and Owner:Property in the County of Powys	NIL

Independent Member (Local Authority)	Christopher Walsh	Non Financial professional interests	Loyalty Interests	01-Jul-22 05-May-22 10-Aug-95 22-May-17 25-Sep-17 01-Jun-10	Current	Elected Member Powys County Council •Trustee/Chair: Brecon University Scholarship Fund •Brecon Town Council Elected Member •Governor of Priory Church in Wales School •Member Brecon Beacons National Park Authority SDF & Grant Advisory Panel •Member of the Community Speed Watch Group	NIL
		Non Financial professional interests	Loyalty Interests	01-Jan-86 31-Mar-88	Current	•Member of Royal College of Nursing •Registered Member of Nursing and Midwifery Council	NIL
		Non Financial professional interests	Loyalty Interests	01-Dec-88	Current	Labour Party member	NIL
Independent Member (Capital)	Michael Giannasi	Indirect Interests	Loyalty Interests	2019	Jul-26	Chair of the Board of Social Care Wales (Welsh Government Sponsored Body).	Remunerated
Independent Member	Ian Thomas	Non Financial professional interests	Loyalty Interests	01-Jun-26	Current	Trustee of a UK Charity - Family Fund that provides financial support to families with disabled and seriously ill children	NIL
		Indirect Interests	Outside Employment	01-Apr-23	31-Mar-24	Previous work as an associate for HICO Consultancy	Self Employed
		Non Financial professional interests	Outside Employment	10-May-26	Current	Sit as an NED on the charity's subsidiary company - Family Fund Business Services.	NIL
EXECUTIVE MEMBERS							
Chief Executive Officer	Hayley Thomas	NIL	NIL	NIL	NIL	NIL	NIL
Executive Director of Finance, Capital and Support Services (Acting CEO 13 Jul 26 -	Pete Hopgood	Non Financial Interests	Loyalty Interests	18-Jun-18	Current	Partner is Finance Manager working in SBUHB	Not Relevant
Deputy Director of Finance (Acting Executive Director of Finance 13 Jul 26 -	Hywel Pullen	Indirect Interests	Loyalty Interests	01-Feb-23	Current	A relation has a share in the ownership of St Joseph's Hospital and also works at the Hospital	NIL
		Indirect Interests	Loyalty Interests	01-Feb-23	Current	A relation works as a consultant at Aneurin Bevan UHB and is currently a clinical director and the south-east regional lead for orthopaedics.	NIL
		Indirect Interests	Loyalty Interests	01-Feb-23	Current	A relation works in a clinical role at CTM UHB and St Joseph's Hospital.	NIL
		Non Financial professional interests	Outside Employment	01-May-25	Current	I volunteer as the Treasurer of the Monmouth Churches Together Housing Group	NIL
		Non Financial professional interests	Outside Employment	01-Apr-25	Current	I am the Vice President of Cymru CIPFA Wales, the regional branch of the Chartered Institute of Public Finance and Accountancy (CIPFA)	NIL
Executive Director of Allied Health Professions, Health Science and Digital	Claire Madsen	Financial Interests	Outside Employment	07-Jan-19	01-Apr-28	Occasional Lecturer for University of West of England.	Hourly rate
		Non Financial professional interests	Loyalty Interests	01-Apr-26	01-Mar-28	Member of the The Chartered Society of Physiotherapy	NIL
Executive Medical Director (Acting Deputy Chief Executive 13 Jul 26 -	Kate Wright	NIL	NIL	NIL	NIL	NIL	NIL
Executive Director of People and Culture and Transformation	Debra Wood Lawson	Indirect Interests	Outside Employment	01-Nov-24	01-Nov-27	Non Executive Board Director - Cadarn Housing Group Limited (Powys is a zonal partner)	Remunerated
			Outside Employment	01-Oct-24	Current	Relative employee and training in Aneurin Bevan Univeristy Health Board (non Director)	NIL

Executive Director of Public Health	Mererid Bowley	Non-Financial professional Interest	Loyalty Interest	14-May-25	Current	Member of Faculty of Public Health	Previously declared on annual Declaration of Interest form issued by corporate team since commencement of role. (Transferring recording of declaration on to ESR from this date).
		Financial Interest	Shareholdings and other Ownership interests	14-May-25	Current	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-Financial professional Interest	Outside Employment	01-Nov-23	Current	Self - School Governor – Langynwyd primary school (Bridgend)	Not remunerated
		Indirect Interests	Outside Employment	01-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	01-Jun-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	01-May-25	Current	Partner - Associate for Practice Solutions	
Executive Director of Planning, Performance & Commissioning	Nicola Johnson	Nil	NIL	NIL	NIL	NIL	NIL
Executive Director of Primary, Community Care and Mental Health	Elaine Lorton	Financial Interests	Outside Employment	01-Apr-24	Current	Independent Member – ateb - housing Association	Remunerated
		Non Financial professional interests	Outside Employment	01-Nov-19	Current	Chair of the Board - West Wales Care and Repair	Voluntary
		Indirect Interests	Outside Employment	02-Jun-25	Current	Family Member is an employee of Hywel Dda University Health Board (non Director)	NIL
		Indirect Interests	Outside Employment	01-Aug-23	15-May-26	Family Member employee of Aneurin Bevan Univeristy Health Board (non Director)	NIL
Executive Director of Nursing, Quality, Women and Family Health	Paul Hooton	Non Financial Professional Interests	Loyalty Interests	2018	Current	Member of the Royal College of Nursing	25/10/2025 Started with PTHB October 2025

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Agenda item: 3.1

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE		15 OCTOBER 2026
Subject:	Integrated Quality & Performance Framework – CYP Neurodevelopmental Services Escalation Oversight Group	
Approved and presented by:	Nicola Johnson, Executive Director of Planning, Performance and Commissioning	
Prepared by:	Deputy Director of Performance Commissioning Executive Director for Nursing, Quality, Women and Family Health Director of Midwifery, Women and Family Health Head of Children Public Health Nursing and Paediatric Services	
Other Committees and meetings considered at:	<u>Executive Committee</u> 02 October 2024; 13 November 2024; 11 December 2024; 5 February 2025; 19 March 2025 and 23 April 2025; 23 July 2025; 15 October 2025; 04 February 2026; 15 April 2026, 17 June 2026. <u>Patient Experience, Quality and Safety Committee</u> 07 Nov 2024, 11 Feb 2025; 29 April 2025; 31 July 2025, 23 October 2025; 05 February 2026, 30 April 2026, 04 August 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) was established. The purpose of this paper is to provide the Patient Experience, Quality and Safety Committee with an update on current progress and to take assurance from the approach undertaken resulting in Executive Committee’s decision to de-escalate the service to Level 1: normal performance monitoring arrangements.		
RECOMMENDATION(S):		
The Patient Experience, Quality and Safety Committee is asked to: Take ASSURANCE that the implementation of the IQPF Escalation Oversight mechanism has provided robust oversight of the quality		

improvement and risk mitigation work being undertaken within Neurodevelopmental Services.

- Take **ASSURANCE** from the ongoing monitoring and evaluation mechanisms in place as part of IQPF, **NOTING** Executive Committee's decision to de-escalate the service to Level 1: normal performance monitoring arrangements.

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

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

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

The aim of the EOG is to:

- Provide assurance to the Health Board on the provision of safe and high-quality care to the population we serve.
- Support an ethos of continuous quality improvement, listening, learning, and acting, seeking continual improvement in communication and openness within and across Health Board to enable positive outcomes and shared learning.

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

Progress to date

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

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

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

Level 2a (Exception)	• Failure to achieve / maintain delivery in more than 1 key deliverable / area of performance. • Sustained deterioration on 1 or more domain. This can include: • Failure to deliver on an NHS Performance Framework target or local target trajectory. • A deviation or departure from the normal or expected course of action signifying specific condition or event that requires attention or further action to address the deviation. • Failure of quality standard. • Where SPC methodology notes variance of concern.
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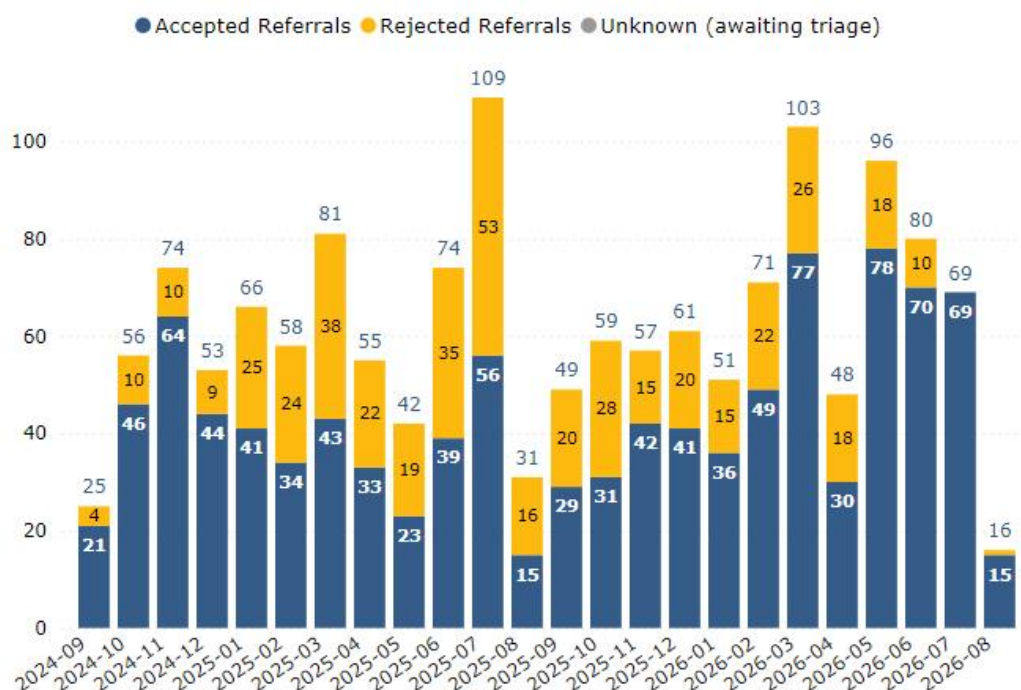
The most recent meeting of the CYP Neurodevelopmental Service EOG was held on the 28 July 2026. Work has continued outside of the formal EOG meetings between the service and the performance team with the current progress noted:

- Performance
 - Waiting List - Total of 845 CYP waiting for a first appointment on 31 August 2026. Noted that there had been 6 breaches > 104 weeks

(including movement from out of area, and agree to back date to original referral date following new information).

- Referrals – Noted that data quality has improved with unknowns now rectified:

Referrals by Month



- Open pathways – 516 patients who have had their first assessment and remain in the diagnostic/clinical element at the 31 August 2026. The number of open pathways had increased since December 2025. There is significant validation work being undertaken in relation to open pathways:
 - Data anomalies (including duplicate open pathways) now understood and being rectified, e.g. re-opening a previous referral for the same child due to more information – currently creates 2 x referrals on the system and if one is open all are open.
 - A local system oversight that when a member of staff has finished and removed their name from WCCIS as the case holder, the system has defaulted back to the “ND Team” as key worker – reflecting the waiting list label - this needs to be actively over-ridden and case re-assigned to another practitioner
 - Historic cases within this number that can be closed and have not been – currently being expedited through ND Panel to support the governance of closure
 - All require actions and will take some time to complete – anticipating significant reduction in this number within the coming weeks.

- Taking current clinical demand (active caseload – open pathways) with the waiting demand for assessment, the current demand is detailed below. The capacity within the service to manage total demand was noted with the increased referral acceptance and increase in open pathways having the potential to destabilise service provision within current capacity and therefore adversely impact the performance recovery trajectory:

Snapshot date	Caseload	RTA (waiting demand)	Total demand
August 2026	516	845	1361

- The service have identified the following focused actions:
 - Recruitment as a priority has been commenced – however, this will require training and time to embed new workforce.
 - Wider actions to enhance assessments by the CAMHs team – this can be increased to 22 clinics per month.
 - Performance management of individual staff members with targeted support.
 - Director to review Paediatric workload (prioritisation) with a view to increase panels as paediatrician is core panel member.
 - Commissioned additional 36 pathways with external provider – local service providing oversight.
 - Review of impending funding under NDIP with a spend plan.
 - Detailed review of demand/capacity to ensure 'internal waiting list' is not building up.
 - New substantive Team Leader has commenced in role, with a further secondment of a Band 8a Senior Nurse role supporting across ND and Community Paediatrics.
 - NDIP monies have been secured for 26/27 and the bid included support for a temporary fixed term Clinical Psychologist which the service are currently expediting. There is also some funds for additional commissioned pathways both of which will advance our current position.
- Risks identified:
 - Some turnover from fixed term and secondment roles, with the recruitment for substantive establishment (as per the agreed business case) almost complete, there is some ongoing training requirements.
 - Required increase in diagnostician oversight of diagnostic outcomes. 1.0wte clinical psychologist remains an outstanding requirement for the service.
 - Cost pressure with implementation of Validated tools (£23k–included within Business Case).

- Referral demand may reduce in the long term: review of service to ensure that post diagnostic support instigated when demand reduction allows and identified of excess resource managed through organisational change.
- Integrated Quality and Performance Assessment Framework (IQPAF)
As part of the EOG process, an IQPAF self-assessment tool has been developed to be used for a self-assessment of service maturity, seeking to answer three key questions:
 - a. How safe and effective are services?
 - b. How person centred are services?
 - c. How well led and effectively managed are services?

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

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

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

- a. Safe and Effective Care – Proposed move from amber/green to green maturity on basis of implementation of redesigned whole system pathway, strengthened MDT diagnostic delivery, referral and triage processes which have resulted in achieving 0>104 weeks. Quality assurance mechanisms strengthened. Completeness and reliability of diagnostic coding and reporting improved. Ongoing assurance through continued workforce training, supervision and standardisation of evidence based assessment practice, implementation of SPOA and SPACE model, recurrent workforce arrangements.
- b. Quality of Patient and Family Experience – Proposed move from amber to amber/green maturity with evidence detailed to support this assessment. Aim to move to green in Q2 with proposed actions outlined.
- c. Quality of Leadership and Management – Proposed move from amber/green to green maturity on the basis of strategic approach to workforce planning and evidence of well-established plans to meet

clinical requirements in the future, well-developed in house training programmes, NDIP report evidences that leadership and management arrangements have supported both operational recovery and wider service transformation, governance has been strengthened through escalation arrangements, redesigned clinical model has enabled a more flexible and needs led approach to appointment sequencing and clinician deployment.

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

The service has previously undertaken an assessment review in April 2025 which was presented to PEQs. A further assessment review has been undertaken by the service and presented to EOG on the 01 April 2026 and subsequently to the Executive Committee and PEQs. An updated assessment was presented to the EOG meeting on the 28 July 2026 where the following was noted:

- The service has transitioned from recovery to a more stable, quality-led model.
- Governance arrangements are now well established, with clear escalation and reporting routes.
- The approved business case (February 2026) supports a recurrent workforce model, with recruitment ongoing to strengthen capacity.
- The service demonstrates alignment with Welsh Government standards and NICE guidance, with MDT-based assessment and decision-making embedded.
- Key areas for continued development include data quality, reporting consistency, triage data capture, and post-diagnostic support.

NEXT STEPS:

Monitoring will continue as per the Integrated Quality and Performance Framework.

IMPACT ASSESSMENT

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

QUALITY:

	No impact	Negative	Positive	Both
Safe			X	
Timely			X	
Effective			X	
Efficient			X	
Equitable			X	
Person Centred			X	
Workforce			X	
Leadership			X	
Culture			X	
Information			X	

Learn, Improve, Research			X	
Whole Systems Approach			X	
EQUALITY:				
	No impact	Negative	Positive	Both
Age	X			
Disability	X			
Gender reassignment	X			
Marriage / civil partnership	X			
Pregnancy / maternity	X			
Race	X			
Religion or Belief	X			
Gender	X			
Sexual Orientation	X			
Welsh Language	X			
Socio-economic status	X			
Social exclusion	X			
Carers	X			
RISK ASSESSMENT:				
	Very Low (0-3)	Low (4-8)	Moderate (9-12)	High (15-25)
Clinical	X			
Financial	X			
Corporate	X			
Operational	X			
Reputational	X			

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WALES

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Addysgu Powys
Powys Teaching
Health Board

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE

UNCONFIRMED MINUTES OF THE MEETING HELD ON 04 AUGUST 2026 at 09:30 VIA MICROSOFT TEAMS

MEMBERS		
Rhiannon Beaumont Wood	RBW	PTHB Vice-Chair (Chair)
Mick Giannasi	MG	Independent Member (General)
Jennifer Owen Adams	JOA	Independent Member (Third Sector)
Simon Wright	SW	Independent Member
IN ATTENDANCE		
Amie Bain	AB	Advanced Pharmacist (13.02 – 13.10)
Helen Bushell	HB	Director of Corporate Governance / Board Secretary
Carl Cooper	CC	Chair of PTHB Board (observing)
Amanda Edwards	AE	Assistant Director of Improvement and Innovation
Nilufa Hossain	NL	Assistant Medical Director
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
Lynda Matthias	LM	Head of Professional Practice and Standards (observing)
Chris Moss	CMo	Assistant Director Performance and Commissioning (10.57 – 10.19)
Paul Hooton	PHo	Executive Director of Nursing, Quality, Women and Family Health
Hywel Pullen	HP	Acting Director of Finance (observing)
Liz Patterson	LP	Head of Corporate Governance
Heidi Sinclair	HS	Head of Quality and Safety (12:50 – 13.10)
Aime Symes	AS	Director of Midwifery, Women and Family Health
Gareth Thomas	GT	Consultant Practitioner in Infection Prevention and Control (observing and presenting Item 4.5)
Jayne Wheeler-Sexton	JWS	Assistant Director of Nursing
Katie Blackburn	KB	Llais (Observing)
APOLOGIES FOR ABSENCE:		
Nicola Johnson	NJ	Executive Director Planning, Performance and Commissioning
Kate Wright	KW	Executive Medical Director / Acting Deputy Chief Executive

Hayley Thomas	HT	Chief Executive
Ian Thomas	IA	Independent Member (General)

1. PRELIMINARY MATTERS

1.1 WELCOME AND APOLOGIES (PEQS/26/28)

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

1.2 DECLARATIONS OF INTEREST (PEQS/26/29)

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

1.3 PATIENT STORY (PEQS/26/30)

PHo introduced the patient story of an experience of a colonoscopy at Brecon Hospital.

EL noted the patient story provided a positive experience regarding the quality of the colonoscopy service, highlighting the professionalism, compassion and personalised care provided by staff throughout the patient journey. It was recognised that, while performance and waiting times remain a focus, the experience demonstrated the Health Board's commitment to delivering a positive patient experience during what can be an uncomfortable procedure. Thanks were expressed to the teams involved, and assurance was given that efforts would continue to reduce waiting times while maintaining high standards of care.

Independent Members asked the following questions for assurance:

How can the learning of this positive patient experience be used as an example of good practice and shared more widely across the organisation to support service improvement?

PHo agreed that the patient experience provided a strong example of "what good looks like" and confirmed that the themes highlighted, including communication, empathy, holistic care, and clear information for patients, would be explored further. It was agreed to consider how these learning points could be shared across the organisation to promote and reinforce good practice.

2. CONSENT AGENDA BUSINESS (PEQS/26/31)

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

MG requested that item **6.1c Audit Wales Report** be considered in light of the following concerns raised within the report:

- Assurance arrangements for commissioned services.
- Management of complaints relating to commissioned providers.
- Availability of quality intelligence to support effective scrutiny.

MG observed that these were not isolated findings but longstanding issues that had been discussed regularly at PEQS, Board and other committees, and which were also reflected in several papers on the current agenda. MG suggested that the Committee should formally note the Audit Wales conclusions as external validation of concerns it had already identified and emphasised the need for a clear strategic response, particularly in relation to commissioned services assurance and complaints oversight.

HB advised that

- The Audit Wales actions would continue to be monitored through Audit and Risk Committee.
- Future PEQS papers should reference and incorporate relevant Audit Wales findings where appropriate.
- The Quality Management System work provided an example of how the recommendations could be reflected and progressed through the Committee.

PHo added that work was underway to develop a Quality and Patient Safety Framework for commissioned services, aligned to the Quality Management System. The Committee's ongoing concerns regarding assurance arrangements were acknowledged and PHo committed to bringing a paper to the next PEQS meeting setting out the proposed approach the planned approach and timescales for strengthening assurance arrangements for commissioned services, with explicit reference to the Audit Wales recommendations.

Action: Executive Director of Nursing, Quality, Women and Family Health

The Committee noted the Audit Wales findings and agreed that future PEQS papers should reference relevant Audit Wales recommendations where appropriate.

MG requested that item **6.1b Internal Audit Mortality Reviews** be considered as this had been received by the Audit, Risk and Assurance Committee who had referred this to PEQS to consider the following outstanding concerns:

- Learning from deaths processes.
- Management and scrutiny of Medical Examiner findings.
- The impact of staffing pressures on these arrangements.
- Assurance regarding deaths involving Powys patients receiving commissioned services.

MG requested that the report be considered at a future meeting with immediate assurance sought on the following matters:

- Whether the backlog of Medical Examiner reports caused by staff sickness had been cleared.
- Whether adequate staffing arrangements were now in place.
- Whether reports were now being processed in real time.

NH confirmed the backlog of Medical Examiner reports had been completely cleared. The backlog had arisen due to significant and unplanned staff absence and additional staff had been put in place to support the process and prevent a recurrence.

HB confirmed that the Internal Audit report would be considered in conjunction with the scheduled Medical Examiner Annual Report at the next meeting of PEQS.

Action: Executive Medical Director

3. ESCALATED ITEMS

3.1 CHILDREN'S NEURODIVERSITY SERVICES (PEQS/26/32)

CMo joined 09.57

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

- In October 2024, Executive Committee escalated Children and Young People (CYP) and Neurodevelopmental Services to Level 3 within the Integrated

Quality and Performance Framework and established an Escalation Oversight Group (EOG).

- The EOG, chaired by the Executive Director of Planning, Performance and Commissioning, has continued to oversee progress and monitor improvement actions.
- In July 2025, Executive Committee approved de-escalation to Level 2A, recognising progress but concluding that the service was not yet ready for full de-escalation.
- The most recent EOG meeting held on 28 July 2026 reviewed waiting list performance, open pathways, referral demand, key improvement actions and current risks.
- Updated Integrated Quality Performance Assessment Framework (IQPAF) and Conditions for Sustainability assessments were considered by the EOG.
- Assessment findings indicated continued service improvement and a transition from a recovery-focused approach to a more stable, quality-led model.
- Future sustainability assessments will align with new Welsh Government standards due to be introduced later in the year.
- The EOG recognised the significant progress made and agreed to recommend a review of the current escalation status to Executive Committee.
- A further update, including any recommendation on escalation status, will be reported to the Committee in October 2026.

Independent Members asked the following questions for assurance:

What assurance can be given that improvements will be sustained, and the service will not return to escalation?

AS advised sustainability will be monitored through Directorate Performance Reviews, senior management oversight and assessment against existing and future Welsh Government standards. The service now has stronger governance, leadership and performance arrangements in place to identify and manage risks before they become unmanageable.

How can a positive maturity assessment be reconciled with the continued pressures on the service?

CM noted the maturity assessment reflects improvements in governance, oversight and workforce planning, which were the issues that had led to escalation. While demand and capacity pressures remain, the service now has systems and processes in place to identify and respond to these pressures. De-escalation and long-term sustainability are related but distinct considerations.

What progress has been made on workforce capacity and referral management?

AS advised that a Clinical Psychologist post is being piloted through temporary funding to demonstrate its value and support a future case for permanent investment. Referral acceptance rates have increased because referral criteria are now better understood, resulting in more complete and appropriate referrals being submitted.

The Committee:

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

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

CMo left 10.19

4. ITEMS FOR APPROVAL RATIFICATION / ASSURANCE

4.1 MINUTES OF PREVIOUS MEETING (PEQS/26/33)

The minutes of the meeting held on 30 April 2026 were **CONFIRMED** as an accurate record.

4.2 COMMITTEE ACTION LOG (PEQS/26/34)

HB presented the action log noting the following updates:

- PEQS/25/88 (a trajectory of improvement relating to incident closure be provided in the Integrated Quality Report) was agreed for closure
- PEQS/25/66 (patient experience/dental quality) – the Chair’s Forum has not met yet, so a change request was made for this to come to October PEQS
- PEQS/25/12 (clinical audit programme) – a change request was made for this to come to October PEQS
- PEQS/25/118b (increased harm review information for commissioned services) – a change request was made for this to come to October PEQS

Independent Members asked the following questions for assurance:

Why is the action relating to commissioned services being deferred again?

PHo acknowledged the Committee’s concerns and explained that developing a quality and patient safety framework for commissioned services is particularly challenging as no national framework currently exists in Wales. The Health Board commissions services across both Wales and England, each with different reporting and quality requirements, requiring PTHB to develop its own approach. While significant work is underway to investigate concerns, complaints and incidents, the longer-term aim is to establish a proactive framework that provides assurance directly from commissioned providers. A paper setting out the proposed approach, milestones and expected trajectory will be brought back to the Committee to provide greater clarity and assurance on progress.

Action: Executive Director of Nursing, Quality, Women and Family Health
(cross reference action PEQS/26/31a above)

The Committee:

- **CLOSED** PEQS/25/88
- **APPROVED** the date change request for PEQS/25/66 and PEQS/25/12, and
- **APPROVED** the date change request for PEQS/25/118b noting this would be the subject of a standalone report to PEQS in October 2026.

4.3 DUTY OF QUALITY ANNUAL REPORT 2025/26 (PEQS/26/35)

AS presented the Annual Duty of Quality Report which demonstrated that quality had remained firmly embedded across both directly provided and commissioned services, supported by strengthened governance arrangements and enhanced use of quality intelligence. It highlighted the Health Board’s strong commitment to learning and improvement, showing how feedback, concerns, incidents and reviews had been translated into practice, policy, training and service delivery. The report also showcased tangible quality improvements across a range of services, supported by overwhelmingly positive patient feedback, while recognising areas requiring further development and setting out clear priorities for 2026/27. Overall, it provided assurance that quality had remained central to decision-making across the Health Board and recommended approval by the Board.

Independent Members asked the following questions for assurance:

How does the Health Board know whether the 45,000 patient feedback responses received represent an appropriate level of engagement?

AS advised the 45,000 responses reflected multiple feedback sources. Benchmarking against national patient experience measures showed that the Health Board was performing at the expected level, achieving a response rate of approximately 8.4 against a national target of 7.5. This placed Powys around the middle of Welsh health boards and provided assurance that patient engagement levels were appropriate.

The Committee:

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

4.4 SAFEGUARDING ANNUAL REPORT 2025/26 (PEQS/26/36)

JWS presented the Safeguarding Annual Report 2025/26 which provided assurance that safeguarding arrangements across the Health Board remained effective, well governed and continued to strengthen during the year. Increased safeguarding activity reflected growing staff awareness and confidence in raising concerns. Key achievements included completion of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) audit actions, strengthened governance arrangements, implementation of a multi-agency safeguarding supervision model, and progress in delivering Corporate Parenting commitments. The report also identified areas requiring further attention, including safeguarding training compliance, MCA and DoLS arrangements, evaluation of improvement activity and organisational resilience. Priorities for 2026/27 were set to support continued improvement and assurance.

Independent Members asked the following questions for assurance:

What formal opportunities are there to learn from safeguarding incidents and reviews, and can an example be provided?

JWS advised all safeguarding reviews across the Mid and West Wales region were considered through the governance arrangements of the Mid and West Wales Safeguarding Board. Each review generated an improvement plan against which the Health Board assessed its own practice and provided assurance on actions taken. Learning was overseen through the Health Board's Practice Improvement Group and Strategic Safeguarding Group, ensuring lessons were embedded across the organisation. The Health Board also reviewed learning from national reviews, including the North Wales Child Practice Review (Foden Review), and implemented improvement plans in response to Welsh Government requirements.

What assurance can be given that vulnerable adults are being safeguarded consistently, given lower engagement with adult services and lower Level 3 training compliance?

JWS advised the increase in safeguarding referrals and activity through the Safeguarding Hub indicated growing staff awareness, confidence and reporting of concerns relating to adults at risk. However, it was acknowledged that engagement and assurance relating to adult safeguarding were not as strong as for children's services. Improving adult safeguarding arrangements and increasing Level 3 safeguarding training compliance remained key priorities, with targeted engagement underway with service leads and progress being monitored through established governance arrangements.

What improvement is expected by the time next year's annual report is presented?

JWS advised a targeted approach to improving Level 3 safeguarding training compliance had been implemented, with monthly engagement with service leads and exploration of more flexible training delivery methods. Early improvements had already been seen, and the expectation was that compliance rates would increase into the 70% range by Quarter 4, providing stronger assurance in next year's report.

How is assurance provided to the Mid and West Wales Safeguarding Board, and will the Annual Report be shared with them?

JWS confirmed the Annual Report could be shared with the Mid and West Wales Safeguarding Board, although this was not routinely requested. Assurance was formally provided through an annual self-assessment process completed by partner organisations, including the Health Board, which contributed to the Board's annual report and overall regional assurance framework.

The Committee:

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

4.5 INFECTION PREVENTION AND CONTROL (IPC) ANNUAL REPORT 2025/26 (PEQS/26/37)

GT presented the report which advised that all actions within the IPC Improvement Plan had been completed, MRSA bacteraemia rates remained at zero, and overall bacteraemia trends continued to improve. While C. difficile cases had increased, hospital-onset cases had reduced by 50%, reflecting the effectiveness of IPC measures. Strong performance was also demonstrated through improved decontamination assurance, high audit compliance scores, and training compliance exceeding targets. Robust governance arrangements with commissioned organisations were in place, and strategic priorities had been established to further reduce healthcare-associated infections and strengthen assurance during the coming year.

Independent Members asked the following questions for assurance:

How significant was the lack of access to pharmacy data for measuring secondary care antimicrobial consumption, and could anything be done to address it?

GT explained that this was not considered to have a material impact. Further clarification would be sought from the Antimicrobial Stewardship Pharmacist and provided outside the meeting.

Why had community-onset C. difficile cases increased while hospital-onset cases had reduced?

GT explained that there was no evidence of the problem shifting from hospital to community settings. Some patients acquired C. difficile without any contact with healthcare services. All cases underwent post-infection review, and a wider increase in community rates was being seen across Wales and the UK, with national work underway to understand the trend.

What learning had been identified from outbreaks such as norovirus, and how was the risk being mitigated?

GT noted that issues had been identified in relation to patient flow and information provided during transfers, particularly during winter periods. More robust transfer documentation and closer working with transfer coordinators had been introduced to reduce the risk of future outbreaks.

The Committee:

- Took **ASSURANCE** from the contents of the Infection Prevention and Control Annual Report 2025/26 that appropriate systems, governance arrangements and controls are in place to support the prevention and management of healthcare associated infections across the Health Board.

4.6 INTEGRATED QUALITY REPORT (PEQS/26/38)

PHo introduced AS who presented the report noting the Quarter 1 report was the first to use the Health Board's revised, more triangulated reporting approach, bringing together incidents, concerns and patient experience to provide a more comprehensive understanding of quality and safety. The report highlighted that the key themes identified in Quarter 4 remained consistent, providing confidence that the right priorities were being identified and improvement efforts focused appropriately. Significant progress had been made in embedding the Listening to People framework, reducing historic backlogs, strengthening incident management and organisational learning processes, and maintaining positive patient experience feedback. Overall, the report demonstrated increasing organisational maturity in using quality intelligence to drive improvement, with a continued focus on evidencing measurable impact during Quarter 2.

Independent Members asked the following questions for assurance:

What assurance is the Committee being asked to take from the report, particularly in relation to patient experience, given the apparent differences between this report and the patient experience information recently presented to Board?

AS explained that both reports draw on the same underlying patient experience data but from different points in time. The Board report reflected older data from the Beacons dashboard, whereas this report used current information following improvements to the Civica patient experience system. The latest data indicated performance above the national average. It was also noted that delays in the Beacons dashboard can create differences in reported performance, and work would continue with national colleagues to explore opportunities to reduce these time lags.

What will embedding an organisational learning approach look like in practice, and how will learning be translated into improvement?

AS explained a health board-wide organisational learning network had been established, supported by a "theme of the month" approach informed by

intelligence from the report. Learning would be promoted through posters, screensavers, educational resources and staff engagement activities. Network champions from across all staff groups would support implementation and feedback. The approach was intended to address recurring organisational themes and culture change over the longer term, whilst local services would remain responsible for addressing learning from specific incidents. Progress would be monitored through measures demonstrating changes in themes and areas of focus over time.

Are there any staff training and development needs required to ensure the organisational learning programme gains traction and changes behaviours?

AS acknowledged that training and development needs may emerge. However, it was anticipated that the organisational learning network and its champions would help identify these requirements through engagement with staff across the organisation. This approach was expected to provide more meaningful feedback than formal gap analyses alone and would help shape future workforce development priorities.

How can assurance be obtained that harm assessments are robust across both directly provided and commissioned services?

AS committed to providing a fuller explanation in a future report outlining how harm assessment processes operate across the system and providing appropriate assurance regarding their robustness.

Action: Executive Director of Nursing, Quality, Women and Family Health

The Committee:

- **NOTED** progress in embedding the revised Integrated Quality Report structure and principles;
- Took **ASSURANCE** from the triangulated analysis of quality and safety intelligence for Q1, and
- **DISCUSSED** any concerns or lines of enquiry.

4.7 PEOPLE'S EXPERIENCE FRAMEWORK (PEQS/26/39)

PHo introduced the report which presented the near-complete work to embed the Patient Experience National Framework within local policies, procedures and governance processes, ahead of Board consideration in September. Draft policy and SOP documents were provided for comment, as they had not yet completed internal governance approval; members were invited to submit feedback by the end of August so it could be incorporated before consideration by the Policy Committee and subsequent Chair's approval for Board submission.

Independent Members asked the following questions for assurance:

Why was a strategy not developed alongside the People's Experience Framework, and would this be defensible if audited?

AS explained a People's Experience Strategy was initially drafted but found it largely duplicated the national framework. The decision was therefore taken to focus on implementing and embedding the framework through governance structures, policy and SOP arrangements. Strategic oversight is provided through a strategic group and supporting operational groups, and this approach could be explained and defended if challenged.

How does the framework address patient experience within commissioned services, and how much assurance can currently be taken?

PHo outlined how the national framework was designed primarily for organisations providing care rather than commissioning services. While a commissioning perspective has been incorporated where possible, further development is required, particularly in relation to cross-border services. Challenges include limitations in existing systems, such as the inability to identify Powys residents within Welsh Health Board feedback data, and differing arrangements with English providers. Further work is underway through contract management and quality management system developments to strengthen assurance arrangements.

Will the framework capture and promote examples of good patient experience as well as learning from concerns and complaints?

AS confirmed that existing reporting arrangements already capture compliments and positive feedback through the Integrated Quality Report and patient experience reporting. While positive experiences are reported, it was acknowledged that more work is needed to ensure learning from good practice is systematically embedded and used to drive improvement.

The Committee:

- **RECEIVED** the report and took **ASSURANCE** that the NHS (national) Wales People's Experience Framework is being implemented within the Health Board
- **REVIEWED** the draft PTHB People's Experience and Listening Policy providing any feedback ahead of the policy being produced into a final draft
- **AGREED** the final draft policy can be shared via Chair's Action for the Committee to consider recommendation to the Board in September.

4.8 MATERNITY SERVICES (PEQS/26/40)

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

- A national Regulation 28 Prevention of Future Deaths report identified learning for maternity services on informed decision-making, community maternity care, escalation processes, foetal surveillance, emergency responses and equipment assurance.
- PTHB reviewed the findings alongside the All-Wales response and found that the key themes were already supported by established governance, clinical oversight, training and quality assurance arrangements.
- The review identified opportunities for further improvement, particularly around documentation, decision-recording, BadgerNet records, equipment assurance and implementation of the All-Wales Community MEWS (Maternity Early Warning Score) chart.
- The Health Board used the external learning to test systems, identify gaps and strengthen controls, rather than relying solely on existing assurance.
- Assurance was provided that actions are underway, progress is being robustly monitored and learning from national and external intelligence has been translated into local service improvements.

Independent Members asked the following questions for assurance:

What assurance can be given that there are controls in place that are working effectively and preventing the types of failures identified by the coroner, rather than simply relying on the absence of incidents?

AS advised the report focused on governance arrangements rather than outcomes data, although local monitoring, incident tracking and learning processes provide evidence of effectiveness. It was acknowledged that more performance and safety data could have been included to demonstrate the impact of existing controls. Work is ongoing to develop more visible maternity reporting and assurance mechanisms to support committee oversight.

Why is the proportion of women choosing to give birth outside clinical guidance relatively high, and how will improvements in this area be monitored?

AS explained that many women choosing birth outside guidance have relatively low-level risk factors and make informed decisions following discussion of the evidence and risks. A smaller number of women with higher-risk factors also choose this option, requiring robust shared decision-making and documentation processes. Further work is underway with Welsh Risk Pool to strengthen documentation and informed-consent arrangements. Progress will be monitored through governance processes, with continued focus on ensuring informed decision-making is consistently evidenced.

Is a maternity dashboard still planned to provide clearer oversight of performance, risks and outcomes?

AS confirmed a draft maternity dashboard has been developed, incorporating both local and national indicators, and is already used within the service. Further work is needed to agree how the information will be reported through governance structures to provide the committee, Executive Team and Board with clear oversight of maternity performance, risks and trends.

The Committee:

- Took **ASSURANCE**: the Health Board has reviewed findings of the Regulation 28 report and considered the relevance of the learning to local maternity services.
- **NOTED** the All-Wales response and the actions taken nationally and locally to strengthen assurance in the areas identified by the Coroner.
- **DISCUSSED** and/or scrutinise the assessment and seek assurance regarding any concern, remaining gaps, risks and improvement opportunities.

4.9 TRANSITION OF CARE UPDATE (PEQS/26/41)

PHo introduced AS who presented the progress report outlining that progress continued to be made and that governance arrangements were well established. While some aspects of operational delivery remained variable, the areas requiring improvement were understood, mitigation plans were in place, and a risk-based approach was being taken to prioritise resources and support sustainable implementation of the programme.

Independent Members asked the following questions for assurance:

How close is this service to being placed into local escalation?

PHo advised that escalation was not currently considered to be necessary. Significant progress had been made in establishing robust governance, oversight and control arrangements, and the programme was considered to be on the right trajectory. The focus was now on embedding service delivery improvements and cultural change. However, the position would continue to be monitored through

Quarter 3 and Quarter 4, and escalation would be reconsidered if the necessary grip, control and service delivery improvements were not achieved.

How could the Committee gain greater assurance that the Transition Programme was improving outcomes and experiences for young people, rather than simply demonstrating progress against governance and programme management arrangements?

PHo acknowledged that while governance and programme delivery measures were being tracked, the impact on young people's experience was less evident. Existing indicators relating to patient and family experience were in place, but further outcome measures could be developed. Consideration would be given as to how baseline measures and key indicators could be strengthened to better demonstrate progress and impact. A risk-based approach was being taken, prioritising those young people closest to transition into adult services, and that information on targets, objectives and milestones could be presented more clearly in future reports to support assurance.

Action: Executive Director of Nursing, Quality, Women and Family Health

The Committee **RECEIVED** the report and took **ASSURANCE** that an action plan is in place, and progress is largely on track.

4.10 SIX-MONTHLY UPDATE ON ANTIMICROBIAL STEWARDSHIP (PEQS/26/42)

NH introduced AB who presented the report which highlighted strong progress in antimicrobial stewardship across Powys Teaching Health Board, with national Welsh Health Circular targets already being met or on track to be met in three of the four key measures. Continued improvement has been supported by dedicated antimicrobial pharmacy leadership, demonstrating the value of a system-wide stewardship approach as prescribing increasingly occurs across a wider range of healthcare settings. While some secondary care antimicrobial data is not yet available due to current system limitations, forthcoming developments, including the EPMA rollout and improved data provision, are expected to enable reporting against these measures in future updates.

Independent Members asked the following questions for assurance:

What contributed to the significant improvement in antimicrobial prescribing performance between Quarter 3 and Quarter 4 of 2024/25?

AB explained the improvement coincided with the appointment of the dedicated antimicrobial stewardship pharmacist role with success attributed to ongoing engagement with contracted providers, relationship-building, education, and continued support to improve prescribing practices across the system.

Does the growth in community-based and independent prescribing present future challenges for antimicrobial stewardship?

AB noted that as prescribing increasingly takes place outside traditional GP settings, monitoring and benchmarking activity becomes more challenging, particularly in community pharmacy settings where defined patient populations are less clear. Continued system-wide leadership and engagement with providers will be important to maintain oversight and support safe prescribing.

What actions are being taken to address these future challenges?

AB advised work is already underway to strengthen antimicrobial stewardship across community settings, including the provision of dedicated stewardship education for community pharmacy prescribers through the Education Academy. While challenges remain, these initiatives are intended to support continued improvement and oversight.

The Committee:

1. **NOTED** three of the four goals are being achieved by the Health Board and its partners and took **ASSURANCE** plans are in place with both managed and contracted services to achieve goal four (70% of total antibiotic usage from the 'access' group).
2. **NOTED** the requirement of strengthened antimicrobial stewardship leadership across the system to provide ongoing assurance, following the recent inclusion of other services in the reported data (e.g. community pharmacy independent prescribers and out-of-hours GP services).

4.11 NURSE STAFFING LEVELS (PEQS/26/43)

PHo introduced JWS who presented the report which presented the outcome of the 2025/26 inpatient ward establishment reviews undertaken across mental health and physical health wards in accordance with the Nurse Staffing Levels (Wales) Act 2016. Using a structured and triangulated review process, the assessment concluded that current nursing establishments remained appropriately aligned to patient need and demand, with no requirement to increase or reduce staffing levels. The review also noted improved workforce stability and identified wider system pressures for further consideration through existing operational, workforce and service planning arrangements.

HB advised that this report had previously gone directly to Board but there were elements of workforce matters that were of relevance to the People and Culture Committee. The governance route for this paper would be reviewed.

Action: Director of Corporate Governance

Independent Members asked the following questions for assurance:

How does the review capture frontline staff experience, wellbeing and workforce sustainability, and will future reviews better reflect staff perspectives to identify pressures before they affect retention, sickness or patient care?

JWS and PHo advised the review identified several workforce and sustainability issues that require further consideration outside the scope of the establishment review. While ward manager feedback, ward visits and staff experiences informed the assessment, it was recognised that the review tool requires further development. Future reviews will consider how staff experience and wellbeing can be more formally incorporated, alongside existing staff feedback mechanisms. The review process already went beyond a traditional establishment review by engaging directly with clinical environments and ward teams. Further work will be undertaken to strengthen the approach and ensure workforce experience informs future assessments more comprehensively.

LM added that national work is underway to further develop staffing reviews in Section 25A areas, including all Powys services. Staff wellbeing and workforce experience are already considered through the triangulation of quality indicators, professional judgement and acuity measures. Additional work is being led through

community hospitals to refine the review methodology, with the aim of incorporating learning from across Wales and providing a further update within the next six months.

Given the increasing acuity of patients, patient flow challenges and delayed discharges identified in the report, how confident can the Health Board be in maintaining safe staffing levels if these wider system pressures are not addressed?

PHo advised that the review provides assurance that current nursing and healthcare support worker establishments are appropriate to meet patient acuity and demand. The principal challenges relate not to staffing numbers, but to wider system pressures, including delayed discharges, patient flow, access to therapies and the availability of onward care. Maintaining safe staffing therefore depends on ensuring staff have the skills, competencies and support required to manage increasingly complex patients, alongside effective collaboration across health, social care and other partner services. The key issue is sustaining workforce capability and system integration, rather than increasing establishment numbers.

How can assurance be provided that pressure damage performance is positive when an earlier report showed a high volume of pressure damage incidents, and what is the correlation between these two reporting measures?

AS advised the pressure damage trend in the patient experience report shows the total number of incidents reported and does not distinguish between avoidable and unavoidable harm, severity levels, or incidents acquired outside Powys. This report provides that additional analysis and context. There is a need for improved triangulation of information to better understand harm, avoidable harm, and the basis for assessing performance as positive, as the incident reporting data alone does not provide that assurance.

The Committee:

- Took **ASSURANCE** that inpatient wards are operating within safe staffing parameters in line with Nurse Staffing Levels (Wales) Act 2016
- **NOTED** the key themes, risks, and system pressures impacting sustainability of safe staffing (non-nursing factors) identified through establishment reviews
- **NOTED** the system-wide pressures impacting sustainability of safe staffing (non-nursing factors)
- **RECOMMENDED** the paper to the Board for its September meeting.

4.12 QUALITY MANAGEMENT SYSTEM (PEQS/26/44)

PHo introduced HS who gave a presentation which outlined the development of a Quality Management System (QMS) in response to Welsh Government requirements under the Health and Social Care (Quality and Engagement) (Wales) Act. The programme will strengthen the integration of quality, governance, performance and risk management arrangements, supported by phased implementation, maturity assessment and ongoing assurance reporting.

RBW made the following observations:

- A systematic approach to quality management beyond regulatory compliance was supported
- There was a need to distinguish between quality assurance and quality control
 - It was important to provide frontline teams with meaningful real-time data

- There was a current reliance on lagging data and a need to improve quality intelligence
- Successful implementation will require significant cultural change alongside process improvements

Independent Members asked the following questions for assurance:

How will the Quality Management System bring existing governance, reporting and learning arrangements together to demonstrate measurable improvements in outcomes, rather than creating an additional layer of governance?

HS noted the key challenge will be identifying activities that add limited value and ensuring the Quality Management System streamlines, rather than duplicates, existing arrangements. The planned maturity assessment and gap analysis will help determine what should change, while workstreams will focus on outcomes, organisational learning and cultural change to demonstrate measurable improvements over time.

The Committee took **ASSURANCE** an approach has been set out to develop a Quality Management System (QMS) for the Health Board. A further report will be provided to the October Committee.

5. ITEMS FOR DISCUSSION

There were no items for discussion

6. CONSENT AGENDA (PEQS/26/45)

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

- **FOR INFORMATION:** Internal Audit Reports on:
 - Mattresses (Follow-up)
 - Mortality Reviews (Reasonable Assurance)
- **FOR ASSURANCE:** Joint Commissioning Committee highlight report from the Quality, Safety and Outcomes Sub-Committee 27 April and 29 June 2026
- **FOR ASSURANCE:** Committee Governance Action Plan
- **FOR INFORMATION:** Board Out and About Programme
- **FOR ASSURANCE:** ePMA update
- **FOR ASSURANCE:** Committee Risk Register
- **FOR INFORMATION:** Committee Work Programme

7. OTHER MATTERS

7.1 ANY OTHER URGENT BUSINESS (PEQS/26/46)

There were no items of any other business.

7.2 ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND/OR OTHER COMMITTEES (PEQS/26/47)

It was noted that the Chair would provide the usual update to Board including detail on the escalated service, together with a little more detail on commissioned services and the quality management system.

7.3 COMMITTEE REFLECTION (PEQS/26/48)

The following reflections were provided by members:

- RBW noted the importance of focusing scrutiny on impact, outcomes and future actions rather than activity alone, and highlighted the need to maintain an appropriate balance of committee business across Executive portfolios.

- JOA commended the significant progress made across patient experience, quality and safety, recognising the quality of scrutiny and the contributions of staff and committee members; noting that while improvement is evident, sustaining progress remains fragile and will require continued focus and deliberate action; and suggested stronger alignment between committee work and the Better Together Transformation Programme as it develops.
- MG praised the quality and honesty of papers and the openness and transparency shown by officers during discussions, identified recurring themes relating to demonstrating impact, strengthening commissioned services assurance, and evidencing patient benefit from governance improvements, and suggested a more structured approach to these themes to support more focused scrutiny and manageable agendas.
- PH commended the expertise, professionalism and assurance provided by teams presenting to the committee and reflected on the substantial progress made within the Directorate while acknowledging that further improvement is still required.

7.4 DATE OF NEXT MEETING (PEQS/26/49)

The date of the next meeting is scheduled on 15 October 2026 via Microsoft Teams.
Meeting closed 13:22.

7.5 CONFIDENTIAL MATTERS

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

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Bwrdd Iechyd
Addysgu Powys
Powys Teaching
Health Board

Agenda item: 4.3

PATIENT EXPERIENCE & QUALITY COMMITTEE		15 OCTOBER 2026
Subject:	Integrated Quality Report: Quarter 2 2026/27	
Approved and presented by:	Paul Hooton, Executive Director Nursing, Quality, Women & Family Health	
Prepared by:	Director of Midwifery, Women & Family Health Interim Head of Quality & Safety	
Other Committees and meetings considered at:	Executive Committee 01 October 2026 – who supported the paper to the Committee.	
PURPOSE:		
To provide an overview of quality and safety for Quarter 2, including progress against priorities identified in Quarter 1.		
RECOMMENDATION(S):		
That the Patient Experience, Quality and Safety Committee:		
- Take ASSURANCE that the available Q2 intelligence has been triangulated to identify principal quality & safety themes, noting some limitations with partial September data, developing commissioned services intelligence and current quality & safety team capacity, and DISCUSS any concerns of key lines of enquiry, recognising current Quality & Safety Team capacity pressures.		
Approve/Take Assurance	Discuss	Note
Y	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	Y	
7. Put Digital First	N	
8. Transforming in Partnership	Y	

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EXECUTIVE SUMMARY:

This report provides an overview of quality, safety and patient experience during Q2 2026/27 (noting September data is part-month due to committee reporting dates). Overall, quality and safety indicators remain stable, with no significant deterioration in incident harm profiles, claims activity, Duty of Candour triggers or Early Warning Notifications. Most incidents continue to be assessed as no or low harm, and all residual Putting Things Right cases have now been closed.

The Listening to People (LTP) framework continues to embed across services, with increasing focus on use of Early Resolution approaches supporting more timely management of concerns. Through monitoring of Patient Experience, most respondents rated their experience positively, with feedback consistently highlighting staff kindness, compassion and professionalism; however, several themes require further attention.

Medical Examiner scrutiny and wider intelligence sources continue to identify learning opportunities relating to communication, care coordination, access to services and end-of-life care.

Triangulated intelligence confirms that the priorities identified in Q1 remain unchanged: communication and engagement, access and timeliness, clinical decision-making, care coordination and operational pressures. While organisational understanding of these themes continues to strengthen, progress in translating intelligence into measurable improvement has been limited by developing organisational learning structures and ongoing capacity pressures within the Quality & Safety Team.

Overall, assurance can be taken that quality and safety systems remain stable, the range of intelligence included within the IQR has broadened during Q2, and provides a consistent indication of the current priority areas, although further development of commissioned-services and other assurance intelligence is required. The focus for Q3 will be on strengthening organisational learning arrangements, developing the Quality Management System and considering how measurable impact from improvement activity can be demonstrated.

1. INTELLIGENCE

This section summarises Quarter 2 quality and safety intelligence and includes data for concerns, incidents, early warning notifications, Duty of Candour, claims, redress and inquests and peoples experience. It highlights key themes, trends and emerging signals to support risk identification, organisational learning and improvement.

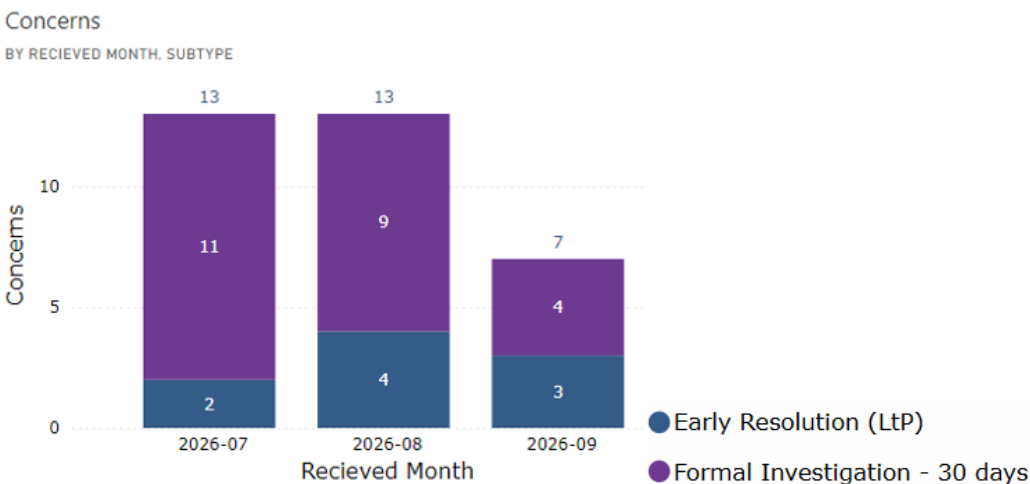
1.1 Listening to People

During Q2, the Listening to People framework has continued to embed across services. The focus has moved from implementation to consistency of practice, particularly in relation to early resolution, quality of listening conversations and timely escalation where concerns cannot be resolved within the early resolution timeframe. Ongoing engagement with services and governance leads has supported improved understanding of the framework and greater consistency in how concerns are managed locally.

1.1.1 Concerns activity Quarter 2

A total of 33 concerns were received during Q2, with activity remaining stable in July and August (13 concerns each month). September has recorded 7 concerns to date; **however, it should be noted that this does not represent a full month's data due to the timing of the report required at Committee.** Overall, 73% (24) of concerns were managed through the Formal Investigation (30-day) process and 27% (9) through the Listening to People Early Resolution pathway. Interpretation of Q2 performance should be with caution, as September data remains incomplete and reporting arrangements continue to be refined. Further review of the data is underway to confirm the position regarding use of the Early Resolution pathway and trajectory towards the Welsh Government expectation of 40% Early Resolution by year end.

Graph 1: Concerns received in Q2 *Data pulled 21/09/26



The most frequent concerns reported via complaints and enquiries were relating to:

- Clinical Treatment/Assessment (16),
- Communication Issues (including language) (6)
- Attitude and Behaviour (5)

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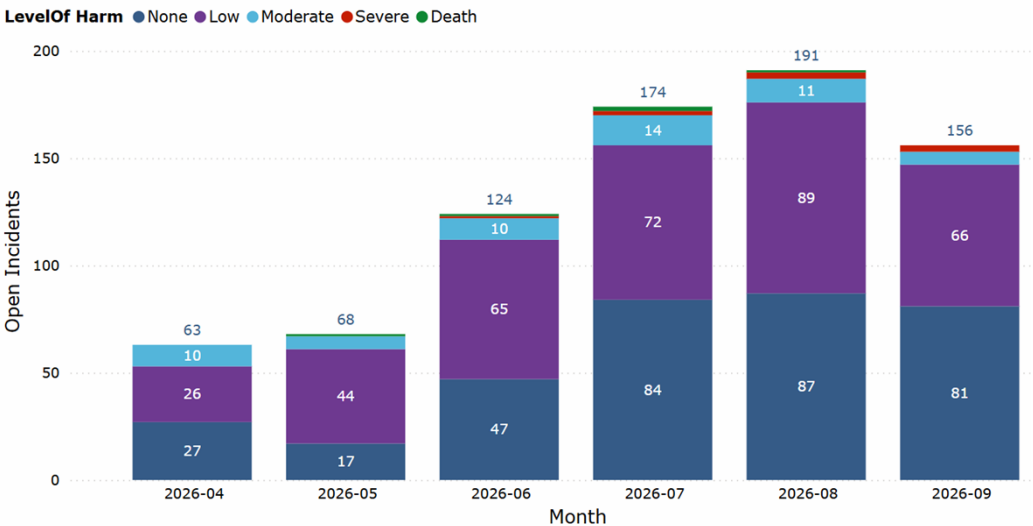
1.2 Incident Reporting

1.2.1 Open Incidents by Level of Harm

The number of open incidents in Q2 increased from 174 in July to 191 in August. It should be noted that September data is based on a partial reporting month and is therefore not directly comparable with previous months. Across all three months, the majority of open incidents were categorised as no harm or low harm, accounting for over 90% of the total caseload. Open incidents associated with moderate, severe, or death-related harm remained low in number throughout the period.

Whilst a number of higher-harm incidents remain open, these are subject to ongoing investigation. As investigations are completed, final harm classifications may be revised accordingly. Overall, the profile of open incidents remains stable, with no significant shift in harm severity identified during Q2.

Graph 2: Open incidents with level of harm April – Sept 2026



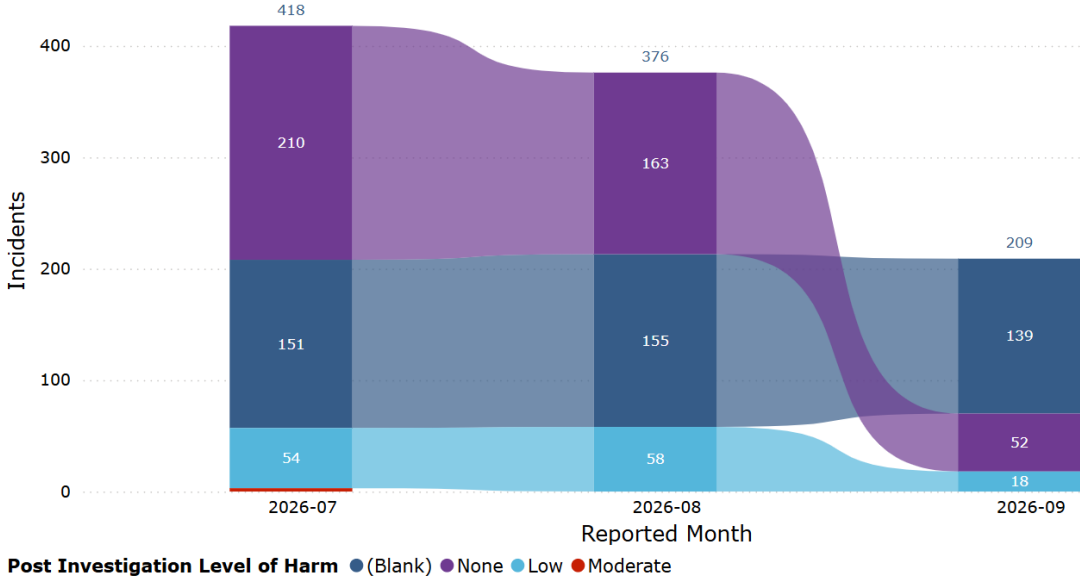
1.2.2 Post-Investigation Level of Harm

Total reported incidents reduced from 418 in July to 376 in August. The majority of incidents with a completed investigation were categorised as No Harm (210 in July; 163 in August) or Low Harm (54 in July; 58 in August), indicating that most reported incidents did not result in significant patient harm. A smaller number of completed investigations were graded as Moderate Harm. The completed investigations available at the reporting date do not indicate an increase in recorded harm severity; however, this position may change as outstanding investigations are concluded.

A significant proportion of incidents are recorded within the blank (unclassified) post-investigation harm category (151 in July; 155 in August; 139 in September). These cases predominantly represent incidents where investigations remain in progress, and a final post-investigation harm assessment will be entered when the investigation is completed.

September data currently shows 209 incidents; however, this reflects an incomplete reporting month and is therefore not directly comparable with previous months. The higher proportion of unclassified (Blank) incidents is consistent with investigations and reviews still being underway at the time of reporting.

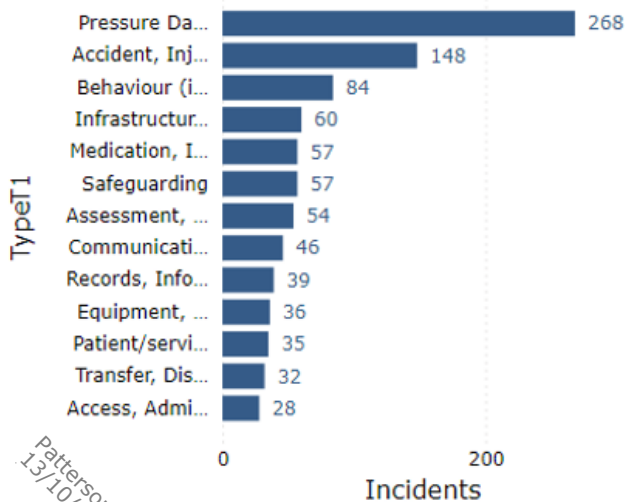
Graph 3: Post investigation level of harm reported in Q2



1.2.3 Incidents by Classification

Graph 4 shows type and number of incidents reported in Q2. Incident reporting remained broadly consistent with Q1. Pressure/Moisture Damage remained the most reported category, rising slightly from 263 to 268 incidents, while Accidents and Injuries reduced from 158 to 148. Reductions were also seen in Behaviour-related, Safeguarding, Medication and Infrastructure incidents, while Assessment-related incidents increased from 31 to 54.

Graph 4: Number and type of incidents reported in Q2



1.2.4 Pressure/Moisture Damage

Pressure Damage remains the most frequently reported incident category within PTHB; however, this reflects the broad range of conditions captured within the classification rather than a high volume of avoidable pressure ulcers. The category includes pressure ulcers present on admission, pressure ulcers acquired during care, moisture-associated skin damage (MASD), and device-related pressure damage, including damage identified in patients admitted from their own homes, care homes, community settings and other healthcare providers. The profile of the Powys population, which includes a significant proportion of frail older people, patients with complex needs, chronic illness and those approaching end of life, contributes to an increased risk of skin deterioration and pressure-related injury. Robust governance arrangements are in place, with all Grade 3, Grade 4, unstageable and deep tissue pressure damage cases subject to review through the Pressure Damage Learning Panel, while Grade 2 and below are reviewed locally to identify opportunities for learning and improvement. Consistent with national definitions of avoidability, the majority of cases reviewed are assessed as unavoidable, reflecting the presence of appropriate risk assessment, preventative interventions and ongoing care management.

Furthermore, where learning from the Pressure Damage Panel is identified, this is progressed and noted within section 2.2 – Translating Intelligence into Improvement.

1.3 Early Warning Notifications and Nationally Reportable Incidents

One Early Warning Notification and one Nationally Reportable Incident was reported in Q2. To protect confidentiality and avoid potential identification of individual cases, no further detail is included in this report.

1.4 Duty of Candour

In Q2, only one incident triggered Duty of Candour. To protect confidentiality and avoid potential identification of individual cases, no further detail is included in this report. Monitoring continues to ensure compliance with statutory requirements and to support learning from incidents where harm thresholds are met.

1.5 Claims, Redress & Inquests

The current claims, redress and inquests position remained stable during Q2. No new no new redress, clinical negligence, personal injury or GMPI claims were recorded during the reporting period, while existing cases continue through the relevant legal and governance processes. This indicator should be interpreted as a lagging measure rather than evidence of current care quality in isolation. One new inquest was recorded, and existing cases continue to be managed through established governance and legal processes.

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Table 1: Current position for claims, redress and inquests

Category	Current Position	Q2 Activity
Redress	14 open cases	No new cases in Q2
Clinical Negligence	8 confirmed cases	No new cases in Q2
Personal Injury	5 confirmed cases	No new cases in Q2
GMPI Claims	6 confirmed cases	No new cases in Q2
Inquests	21 confirmed cases	1 new case in Q2

1.6 People's Experience

During Q2, the People's Experience Framework continued to provide the strategic approach for listening to and learning from patients, families and carers. This section brings together feedback, compliments and survey intelligence to provide a consolidated view of experience themes and performance during the quarter.

1.6.1 Data Completeness and Reporting Limitations

Interpretation of Quarter 2 People's Experience data should be undertaken with caution. A proportion of patient experience intelligence is dependent on national data flows and externally sourced SMS survey responses. Data from commissioned providers is subject to submission and processing timelines through Digital Health and Care Wales (DHCW) before becoming available within local reporting systems. As a result, some Quarter 2 responses had not been received at the time of reporting and the current dataset should be considered incomplete. Work continues with data and performance colleagues to better understand reporting flows, identify opportunities to improve data completeness and strengthen the timeliness of patient experience intelligence available to the Health Board.

1.6.2 Civica Feedback

Patient feedback collected through all 92 surveys through Civica and wider engagement activity during Q2 provides important insight into patient experience across services.

Overall, feedback remains positive, with a high proportion of responses indicating satisfaction with care received, reflected in over 1200 comments recorded during the period. Table 2 demonstrates the total number of responses received into Civica for all types of active surveys and number of contacts via SMS. The number of responses currently available is lower than reported in Quarter 1. However, caution should be exercised when interpreting this position as there are known delays in the receipt and processing of externally sourced SMS survey responses. Organisations external to NHS Wales which will include many of our commissioned services, are required to submit planned care activity data to DHCW by the 20th of the following month i.e. data for July will be submitted by 20th August. DHCW then process the data and make it available to PTHB, approximately one week later causing delay in evidence of responses in Civica. This is often reflected in the national Beacon's dashboard showing a drop in responses, which when retrospectively adjusted demonstrates an improved picture. This also generates some conflict in reporting between the IQR and other

reports across the organisation, particularly where data is provided based on the national dashboard.

Table 2: Total survey responses. *Data correct as of 23/09/2026*

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
Sep-26	17	7	11	240	114	126	0	532	0
Aug-26	27	8	20	443	182	261	1	989	0
Jul-26	26	8	20	611	239	372	0	1138	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 3: Record your compliments responses. *Data correct as of 23/09/2026*

Month	Surveys			Responses			
	Number of Surveys with New Responses	Surveys with New Targeted Responses	Surveys with New Passive Responses	Total New Responses	# of New Targeted Responses	# of New Passive Responses	# of Responses in Welsh
Sep-26	1	0	1	2	0	2	0
Aug-26	1	0	1	24	0	24	0
Jul-26	1	0	1	41	0	41	0

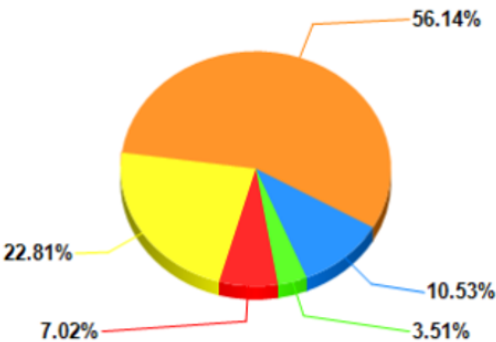
‘Record your compliments’ are compliments and feedback received via cards, letters or verbal comments which are actively recorded through CIVICA and are outlined in Table 3, identifying that 67 compliments were received during the reporting period. This is lower than the position reported in Quarter 1; however, interpretation should be undertaken with caution as the data remains dependent on manual recording by services and is affected by delays in receipt of externally sourced survey data. Discussions with local teams to encourage the recording of compliments continue to ensure we are providing a balanced and measured view of patient experience.

1.6.3 People’s Experience Survey

Graph 6: Overall experience score in PES. *Data correct as of 23/09/2026*

“How would you rate your overall experience”

Available Answers	Responses	Score (%)
Very poor	6	10.53%
Poor	2	3.51%
Neither good nor poor	4	7.02%
Good	13	22.81%
Very good	32	56.14%
Total	57	100%



Analysis of the feedback currently available from the national People’s Experience Survey (PES) indicates that most respondents reported a positive experience of care, with just under 80% rating their experience as either "Very Good" or "Good". Fewer

responses are currently available than were reported in Quarter 1. However, the current dataset is incomplete at the time of reporting due to known delays in receipt and processing of externally sourced SMS survey responses. Further responses are expected to become available through routine national reporting cycles and therefore Quarter 2 response volumes should be interpreted with caution.

Top positive themes from the PES were:

- **Staff kindness, compassion and professionalism** - the most frequent theme where patients repeatedly describe staff as friendly, caring and professional.
- **Community hospitals are highly valued** - many comments reflected appreciation of local care, continuity and care closer to home.
- **Feeling listened to** - patients consistently refer to being heard, having time to ask questions, receiving clear explanations and staff taking concerns seriously
- **Quality of specialist care** - patients expressed confidence in clinicians where assessments were thorough, treatment plans were personalised, expertise was evident and time was given during appointments
- **Cleanliness, food and ward environment** - many positive inpatient comments highlighted clean wards, good food, comfortable surroundings, feeling safe and welcoming atmosphere.

Key concerns raised were:

- **Physiotherapy and rehabilitation provision** The most common concern within otherwise positive inpatient feedback relates to lack of, infrequent or delays to physiotherapy and rehabilitation
- **Communication and follow-up delays** Several poorer ratings relate not to the appointment experience itself, but to what happened afterwards with delays to follow up care, responses, poor communication and unclear plans
- **Access, capacity and bed availability** A recurring concern relates to lack of community hospital beds, delayed transfers, challenges securing local placements, perceived reductions in community services
- **Delays in urgent and out-of-hours care pathways** – relating to NHS 111, delays in call backs, difficulties navigating services and transfer delays
- **Concerns about senior medical communication** – poor comments often focused on feeling ignored, lack of involvement, not feeling listened to and receiving unclear answers from senior clinicians

1.7 Medical Examiner

The Medical Examiner Service continues to provide independent scrutiny of deaths and supports organisational learning through the identification of concerns, positive practice and opportunities for improvement.

In Q2 PTHB received 10 referrals (*data correct as at 24/09/26*) relating to Powys residents showing a slight reduction to the average of six reports per month received in Q3/Q4 of 2025/26. The majority of cases related to care provided by other Health

Boards or involved nursing, residential or care homes, with cases appropriately referred to the relevant organisations for review.

Performance remained broadly stable with the average time death to receipt of clinical records improved from 2.0 to 1.3 days, moving closer to the All-Wales average of 1.0 day. The period from Medical Examiner scrutiny to receipt for the Medical Certificate of Cause of Death remained at 2.0 days, in line with the All-Wales average.

Themes identified through scrutiny panels included completion of DNACPR documentation, communication with families and end of life planning, delays in care packages and planned treatment, availability of community nursing support, discharge shortly before death and late notifications of deaths to the Medical Examiner Service.

Feedback from Next of Kin also highlighted examples of compassionate care and excellent support from community hospitals, district nursing and palliative care teams, care homes and ambulance services.

Key priorities for the next reporting period include:

- Services to continue improvement of timely notification of deaths and submission of clinical records
- Strengthen communication with families throughout the Medical Examiner process
- Share learning relating to end-of-life planning, discharge, community support and DNACPR documentation
- Ensure concerns relating to other Health Boards, care homes or partner organisations are referred and followed up appropriately
- Continue to use feedback from next of kin, including compliments, to support learning and improvement
- Embed themes from Medical Examiner scrutiny within clinical governance and quality-improvement arrangements

Overall, assurance can be taken that the Medical Examiner Service continues to provide independent scrutiny and identify issues for referral, review and organisational learning, whilst maintaining expected operational performance during Quarter 2.

1.8 Development of Quality Intelligence

The Intelligence section continues to mature as the Health Board strengthens its approach to the triangulation and analysis of quality and safety information. During Q2, reporting continued to draw on a broad range of intelligence sources, including patient experience, concerns and complaints, incidents and Medical Examiner feedback, supporting a more comprehensive understanding of quality, safety and organisational risk.

Further progress is being made in bringing together intelligence from Bereavement Services, Health Inspectorate Wales inspections, external reviews, audits and other

assurance activities. This will strengthen the identification of emerging themes, organisational learning opportunities and areas for quality improvement.

Capacity and resilience constraints within the Quality & Safety Team continue to affect the pace at which intelligence, organisational learning and assurance developments can be progressed. Work is being prioritised according to risk and statutory requirement.

2. TRIANGULATION

2.1 Refined Thematic Analysis

Triangulation of Quarter 2 intelligence demonstrates continued consistency across quality, safety and experience sources, confirming that the organisational priorities identified in Quarter 1 remain appropriate. The existing themes continue to relate to communication, access and timeliness of care, clinical decision-making, care coordination and operational pressures, with Q2 intelligence further highlighting the need to monitor communication across care transitions and access to rehabilitation, community support and delayed care pathways.

- **Communication and patient engagement** remains prominent across complaints, patient feedback and Medical Examiner scrutiny, particularly in relation to responsiveness, involvement in decision-making, communication with families, end-of-life discussions and DNACPR documentation. Q2 intelligence reinforces the importance of communication with patients and families during care transitions, including discharge, follow-up and end-of-life care. Positive feedback continues to recognise staff compassion and professionalism, providing a foundation for improvement.
- **Access to care and timeliness** issues remain evident through concerns about assessment, treatment, follow-up, rehabilitation, bed availability and community support, reflecting ongoing system pressures across the patient pathway. Quarter 2 intelligence particularly highlights access to rehabilitation, community support and delayed care pathways as areas for continued monitoring.
- **Clinical decision-making, documentation and risk assessment** continue to feature across intelligence sources. Although Duty of Candour activity, Early Warning Notifications and higher-harm incidents remain low, opportunities remain to strengthen consistency in assessment, documentation and risk management.
- **Care coordination and continuity** themes are reflected in feedback on delayed community support, rehabilitation, discharge planning and coordination between organisations, reinforcing the need for sustained focus on transitions of care.
- **Operational and system pressures** continue to underpin many issues, including bed availability, rehabilitation capacity, service responsiveness and sustained reporting of pressure damage, accidents and assessment-related incidents. However, no significant deterioration in harm profiles or claims activity has been identified during the quarter.

2.2 Translating Intelligence into Improvement

Q2 has focused on further refining the Health Board's understanding of the key themes emerging from triangulated intelligence. Learning from concerns, incidents, patient experience and Medical Examiner scrutiny continues to inform local improvement activity; however, progress in translating intelligence into organisation-wide improvement has been limited by the absence of fully developed structures and mechanisms to consistently share, monitor and evaluate learning across the organisation.

Initial scoping work has commenced to strengthen organisational learning arrangements through the development of the Quality Management System, thematic learning approaches and enhanced governance structures. Whilst this provides an important foundation for future improvement, these arrangements remain at an early stage of development and require further embedding before intelligence can be routinely translated into coordinated organisational action. Capacity and resilience pressures within the Quality & Safety Team have also continued to limit the pace of progress.

Whilst plans for the Elevate Network, and internal, organisational wide learning Network have been developed and are ready to launch, this has been delayed whilst the Quality & Safety Team have prioritised work based on risk and statutory requirement. That said, learning across the organisation is taking place in a number of key areas which are shared here.

2.2.1 Pressure Damage

Pressure damage remains the most frequently reported incident category within PTHB. However, the overall volume of reports should not be interpreted in isolation as an increase in avoidable or serious harm. The category captures pressure damage across inpatient and community settings, including damage present on admission, healthcare-acquired pressure damage, moisture-associated skin damage and device-related damage.

During Q2, the Professional Head of Nursing for Community Services Group completed a review of Q1 2026/27 improvement activity and outcomes. The review brought together findings from pressure damage scrutiny, root cause analysis and learning arising from Coroner processes and was presented to the Community Services Group Executive Quality and Safety Assurance Meeting. This provided additional assurance that learning is being considered systematically and translated into focused improvement activity.

Increased reporting, particularly of Grade 1 pressure damage, can be a positive indicator of a well-engaged workforce and a strengthening safety culture. It suggests that staff are identifying early signs of skin deterioration, recording these promptly and initiating preventative action before damage progresses. More frequent reporting of low-level damage therefore supports earlier intervention, stronger scrutiny and

improved visibility of risk, rather than necessarily indicating deterioration in the quality of care.

It is important to distinguish this activity from incidents involving more serious harm. Grade 1 pressure damage reflects early, non-blanching skin changes where the skin remains intact, whereas Grade 3, Grade 4, unstageable and deep tissue pressure damage represent substantially greater tissue injury and require formal multidisciplinary review. All higher-grade cases continue to be reviewed through established Pressure Damage Learning Panel arrangements, with consideration of avoidability, clinical context, contributing factors, care delivery and opportunities for organisational learning. Grade 1 and Grade 2 incidents are reviewed locally, with escalation where concerns or recurring themes are identified.

During Q2, improvement activity continued to focus on timely risk assessment and reassessment, anticipatory equipment provision, moisture-damage prevention, grading accuracy, documentation and completion of investigations. Acquired and inherited pressure damage are also being considered separately, enabling more meaningful analysis of care-related harm and supporting targeted improvement.

Overall, assurance can be taken from the increased staff engagement in early identification and reporting, strengthened scrutiny through professional and multidisciplinary review, and clearer differentiation between low-level indicators of skin deterioration and pressure damage resulting in serious harm. While it remains too early to attribute changes in incident volumes directly to improvement interventions, the Health Board is demonstrating a more mature approach to identifying risk, reviewing harm and translating learning into preventative action.

2.2.2 Inpatient Falls

Falls prevention continues to represent one of the strongest examples of how quality intelligence, organisational learning and improvement activity can be translated into measurable outcomes. During Q2, the Professional Head of Nursing for Community Services Group undertook a four-year review of improvement activity, outcomes, RCA and Coroner learning for inpatient falls. The review identified that over the last four years, inpatient falls have been subject to sustained governance focus, including focused review processes, falls huddles, thematic learning, policy review, audit and ward-led quality improvement activity. Learning from Datix reports, incident investigations, Coroner learning and local review processes is routinely shared through established governance arrangements, supporting continual refinement of preventative measures and clinical practice.

The programme has evolved beyond incident reporting alone and now provides a structured governance and assurance framework, incorporating multidisciplinary review, executive oversight and organisational learning. All reported falls are reviewed, contributing factors identified and learning disseminated through ward teams and governance structures. This has strengthened the organisation's ability to identify recurring themes and implement targeted prevention strategies.

There is evidence that this organisational focus has been associated with sustained improvement in outcomes. Between 2024/25 and 2025/26, the total number of inpatient falls reduced from 462 to 356, representing a 22.9% reduction. During the same period, the standardised falls rate reduced from 9.52 to 7.65 falls per 1,000 occupied bed days, a reduction of 19.6%. Quarter 1 2026/27 performance has remained positive, with a reported falls rate of 5.8 falls per 1,000 occupied bed days and 100% of reported falls reviewed and closed through Datix processes.

Whilst these improvements are encouraging, falls data must continue to be interpreted alongside patient acuity, occupancy, recurrent fallers and rehabilitation activity. Assurance cannot therefore be taken from incident numbers alone. However, current intelligence suggests that strengthened governance, systematic learning, focused review processes and ward-led improvement activity are contributing to improved outcomes and more consistent organisational oversight.

Current priorities include improving completion of post-fall multifactorial risk assessments, strengthening debrief and documentation processes, and sustaining the governance and learning arrangements that have supported recent improvement.

2.2.3 Sepsis

Sepsis has been identified as an important organisational learning priority, informed by incident review, quality intelligence and wider discussions regarding the recognition and management of deterioration across community and inpatient settings. In response, the Health Board has undertaken a substantial programme of work to strengthen its approach to sepsis recognition, assessment and treatment, reflecting both the unique nature of Powys services and the complexity of providing care across community hospitals, community settings and mental health services.

A dedicated multidisciplinary Sepsis Group has now been established and reports formally through Infection Prevention and Control governance arrangements. The group brings together expertise from across clinical services, governance, pharmacy, education and the Welsh Ambulance Services NHS Trust, creating a coordinated organisational approach to sepsis improvement. This represents a significant step forward in strengthening organisational oversight, consistency of practice and shared learning in relation to deteriorating patients.

The work undertaken to date has delivered a number of important foundations for future improvement. During Q2, the Health Board implemented both the 'Care of the Deteriorating Patient in Hospital Settings policy' and the 'Care of the Deteriorating Patient in Community Settings' policy, providing a more consistent framework for recognising and responding to patient deterioration. Alongside this, work has continued to develop an organisational sepsis policy that reflects the specific context of Powys services and is intended to support more consistent recognition, escalation and management of sepsis across all care settings.

Organisational learning has also identified the need to strengthen clinical capability in areas including cannulation, timely antibiotic administration and care of deteriorating patients within non-physical health environments. As a result, targeted workforce development and service improvement initiatives are being progressed, including work to support alternative approaches to antibiotic administration where cannulation is not feasible and further development of sepsis management arrangements within mental health settings.

Whilst it remains too early to demonstrate measurable impact on patient outcomes, the programme represents a significant organisational milestone. The Health Board can demonstrate that learning has been translated into tangible system improvements through the establishment of dedicated governance arrangements, implementation of new deterioration policies, development of a Powys-specific sepsis improvement programme and strengthened multidisciplinary working across organisational boundaries. These developments have created the foundations necessary to support future improvement in the recognition and management of sepsis. As the programme matures, future reporting will focus on demonstrating the impact of these interventions through audit, compliance, clinical outcome measures and organisational learning indicators.

2.3 Evidence of Impact

Evidence of measurable impact remains variable across the organisational priorities. In some areas, including inpatient falls, there are measurable outcome improvements alongside evidence of strengthened governance and systematic learning. In other areas, including pressure damage, sepsis, People’s Experience and wider thematic organisational learning, the Health Board can demonstrate improvements in systems, oversight and capability, but it remains too early to evidence consistent impact on outcomes.

Whilst some positive indicators are evident, including increased use of the Listening to People Early Resolution pathway, sustained positive patient feedback regarding staff compassion and professionalism, and stable safety indicators with no significant deterioration in incident harm profiles, Duty of Candour activity or claims activity, it is too early to attribute these trends to organisational learning initiatives.

Demonstrating impact remains a key area for development and will require stronger mechanisms to share learning, oversee actions and monitor outcomes over time.

3. COMPLIANCE

3.1 Listening to People

The Listening to People (LTP) framework continues to be embedded across the Health Board following implementation on 1 April 2026. National development of the reporting dataset and performance dashboard remains ongoing, with the Quality & Safety Team actively contributing to this work. Local reporting arrangements will be

aligned to the agreed national approach to ensure consistency and comparability of data. This is anticipated to be ready for implementation in Q3.

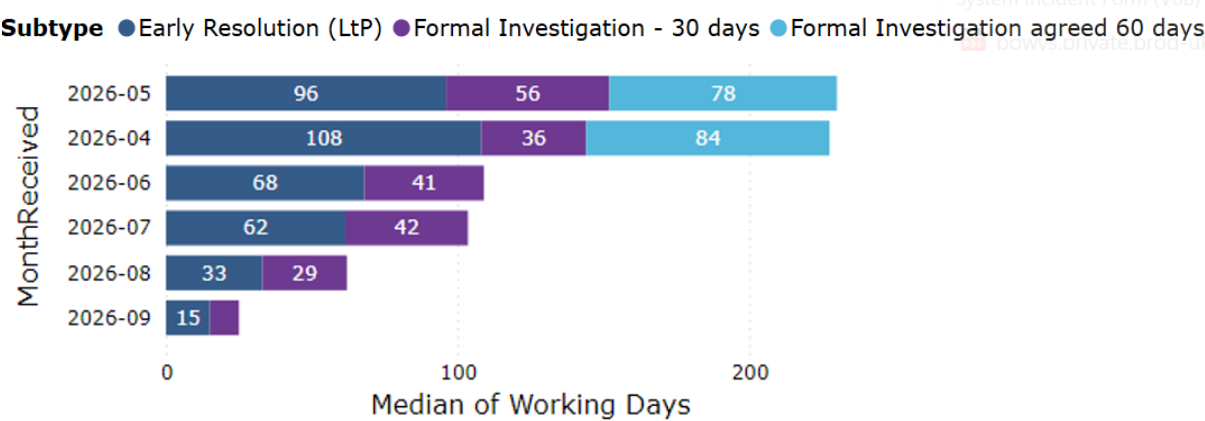
Feedback has been requested from NHS Wales Performance & Improvement on whether there is anything missing from the guidance and if there is anything incorrect or requiring clarification. This is due to be submitted by end of September and will be developed by NHS P&I for future reviews of the framework. Recommendations will include clarity on commissioned services, independent contractors, such as GP, dental and pharmacy services.

Whilst national reporting arrangements continue to develop, early local intelligence has been extracted to provide assurance regarding implementation. Initial indicators suggest the framework has been embedded safely, with services continuing to adapt to new processes and ways of working. Regular engagement has been maintained with Clinical Governance Leads across all service groups, providing oversight, support and opportunities to share learning and address emerging issues.

The Health Board will continue to monitor implementation closely during Q3 as processes mature and the framework becomes further embedded within routine practice.

3.1.1 Early Performance indicators:

Graph 7: Median Working Days from Receipt to Final Response



Early performance data indicates that the Health Board is not yet consistently achieving the 10-working-day Early Resolution target. However, since implementation of the Listening to People framework in April 2026, month-on-month improvement has been demonstrated, with reducing resolution times reflecting increasing familiarity with the framework and greater use of early resolution approaches. Whilst assurance cannot yet be taken that the target is being met consistently, the overall trajectory is positive and suggests continued progress as the framework becomes further embedded.

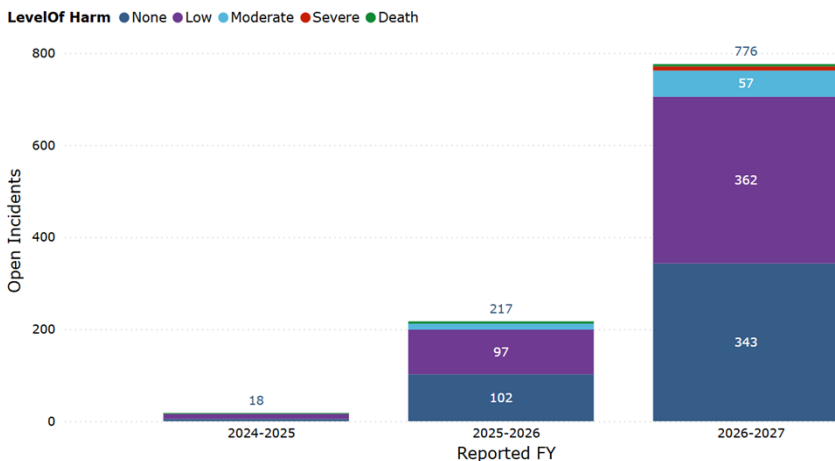
3.2 PTR (Residual Cases)

By the end of Q2, all residual PTR cases had been concluded, with no PTR cases remaining open. This represents sustained progress from the 21 open cases reported at the end of Q4 and the 4 cases remaining at the end of Q1. The position reflects the continued commitment and collaborative effort of the Quality & Safety Team and service-level teams in reviewing, progressing and resolving historic concerns, and provides assurance that the PTR backlog has now been addressed.

3.3 Incident Compliance

Open Incidents by Financial Year

Graph 8: Number of open incidents and level of harm reported by FY



At the end of Q2 2026/27 (noting September data is based on a partial reporting month), there were 776 open incidents, compared with 217 open incidents from 2025/26 and 18 open incidents from 2024/25. The low number of incidents remaining open from previous financial years demonstrates sustained progress in addressing the historical backlog, with legacy cases now representing a small proportion of the overall open caseload.

The current open caseload is predominantly comprised of incidents categorised as No Harm (343; 44%) and Low Harm (362; 47%), accounting for over 90% of all open incidents. A smaller proportion are categorised as Moderate Harm (57; 7%), with very few incidents graded as Severe Harm or Death.

The high proportion of incidents recorded as No Harm should be interpreted with caution, as many of these incidents remain under investigation and have not yet

received a final post-investigation harm assessment. As investigations are completed, harm classifications may be revised accordingly.

3.4 Claims / Redress Compliance

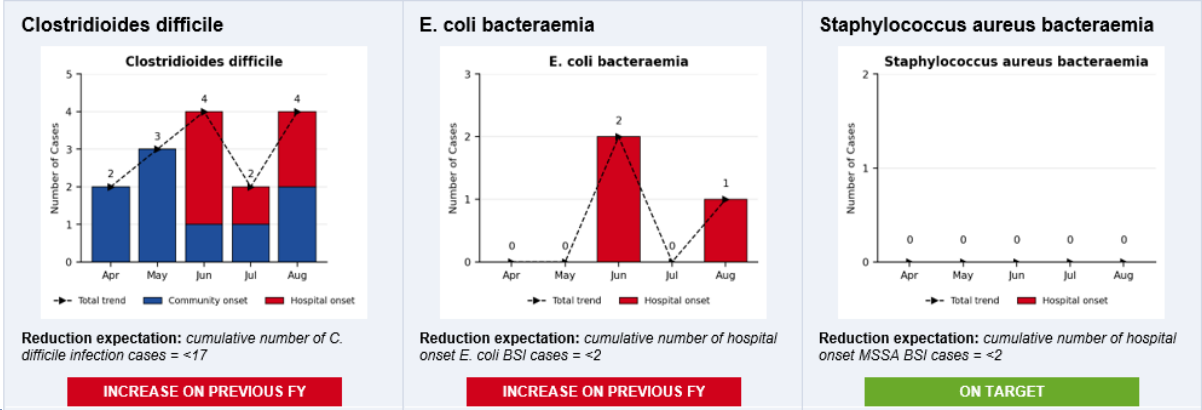
Performance has been maintained at the expected Health Board standard, providing assurance on robustness of current process. Good relations with Welsh Risk Pool continue, providing assurance and oversight, alongside opportunities for improved learning and shared learning from areas across Wales.

4. INFECTION PREVENTION & CONTROL (IP&C)

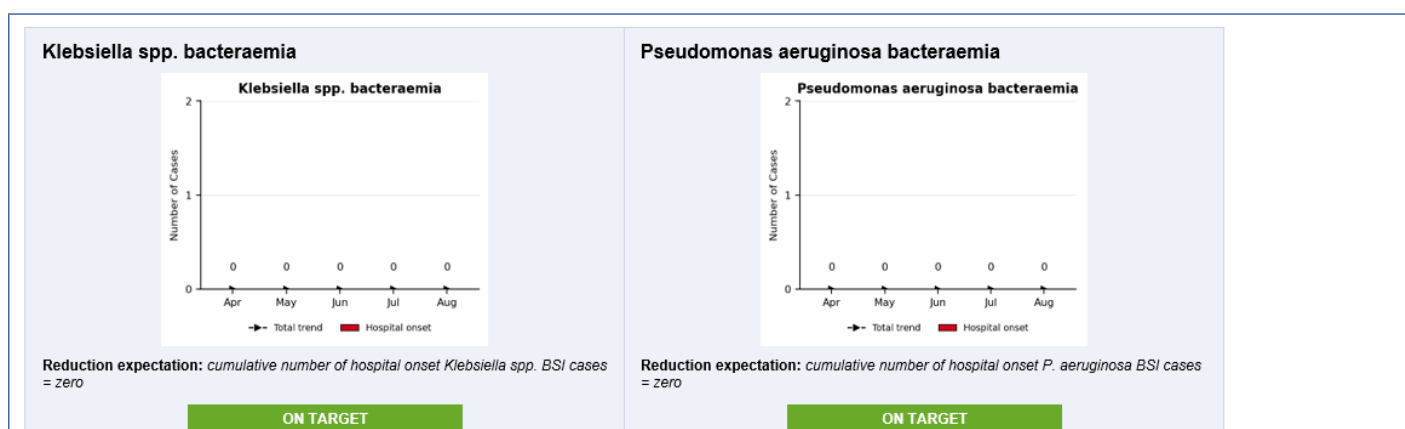
4.1 Surveillance Summary

Surveillance of organisms subject to mandatory Welsh Government reporting indicates a generally positive position for Q2 2026/27, noting that the full quarter dataset is not yet available due to reporting timelines.

The cumulative number of *Clostridioides difficile* infection (CDI) cases remains within the expected reduction target of fewer than 17 cases, with 15 cases reported to date. While hospital-onset CDI cases have increased slightly during 2026, performance remains within the anticipated range. Hospital-onset *Escherichia coli* bloodstream infections (BSIs) exceed the expected threshold of fewer than two cases. No hospital-onset cases of *Klebsiella* spp., *Pseudomonas aeruginosa* or *Staphylococcus aureus* bacteraemia were reported during the quarter, maintaining performance within reduction expectations.



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4.2 Audit, Compliance & Training

All CDI cases in Wales undergo Whole Genome Sequencing (WGS) to identify potential transmission events. Sequencing results for recent cases were distinct, confirming no evidence of transmission within Powys healthcare settings.

Recent Post Infection Reviews identified opportunities to strengthen the early recognition and management of CDI. Key learning included the need for earlier stool sampling in patients with persistent diarrhoea, prompt isolation while infectious causes are being excluded, and enhanced consideration of previous CDI, recent antimicrobial exposure and other risk factors during clinical assessment.

Whilst IPC measures were consistently implemented and effective, opportunities were identified to support earlier clinical escalation and treatment. In response, targeted education has been delivered to clinical teams on CDI risk factors, red flags, timely specimen collection and isolation requirements, including a dedicated teaching session led by the Consultant Microbiologist and Infection Control Doctor. Fidaxomicin is also now available as ward stock to reduce delays in the treatment of recurrent infection.

The CDI Policy is scheduled for review in Q3 and provides an opportunity to embed learning from Post Infection Reviews. Collectively, these actions are intended to improve early recognition, expedite diagnosis and treatment, and further strengthen infection prevention and control practice across the organisation.

4.2.1 Audit

Compliance with IPC audit programmes continues to improve. IPC Compact Audit compliance increased to 95.0% from 94.6% in Q1, whilst IPC Observational Audit compliance improved from 96.2% to 96.9%.

4.2.2 IPC Level 1 and 2 Training

Training compliance remains strong, with both IPC Level 1 and Level 2 training exceeding the organisational target of 85%.

4.3 Laboratory Results Process

All inpatient areas across Powys have now transitioned to Welsh laboratories for sample processing and testing. This has improved consistency in requesting, sampling, processing and reporting practices, mitigated risks associated with previous ICE pathology system issues and strengthened the consistency of external reporting. Work is ongoing to transition maternity services fully to Welsh laboratory provision.

4.5 Policy Development

Policy development progressed during the quarter. The new Clinically Significant Antimicrobial Resistant Organisms (CSARO) Policy and revised MRSA Policy have both been approved, ratified and implemented.

4.6 National Infection Prevention and Control Manual (NIPCM)

Following updates to transmission-based precautions within the NIPCM and the subsequent Welsh Health Circular, a programme of staff drop-in sessions was delivered to support understanding and implementation of the revised guidance. In addition, colleagues from Health and Safety and Occupational Health supported the development of an exemplar risk assessment to assist staff in applying the changes as services prepare for the autumn and winter period.

5. INSPECTIONS & FRAMEWORK IMPLEMENTATIONS

5.1 Health Inspectorate Wales Inspections

During Q2, Tawe Ward, Ystradgynlais Community Hospital underwent an unannounced Healthcare Inspectorate Wales (HIW) inspection. Inspectors provided highly positive feedback, highlighting significant improvement since the previous inspection, particularly in relation to compassionate care, patient and family involvement, care planning, ward environment, staff engagement and leadership. Positive feedback was also received from patients and families regarding the quality of care provided.

One immediate assurance issue was identified relating to organisational compliance with oxygen safety training requirements and low compliance with Basic Life Support and Immediate Life Support training. HIW recognised that these concerns related to wider organisational assurance arrangements rather than the quality of care delivered on the ward. An Immediate Improvement Plan was submitted and is being monitored through established governance arrangements.

Overall, the inspection provided positive assurance regarding the quality and safety of care, with inspectors acknowledging the commitment of staff and the progress made since previous inspections.

5.2 People's Experience Framework

Further progress has been made during Q2 in implementing and embedding the NHS Wales People's Experience Framework across the Health Board. Building on the position reported in Q1, governance, leadership and reporting arrangements have been strengthened, with People's Experience intelligence incorporated within the

Integrated Quality Report to support a more triangulated view of quality, safety and experience. During the quarter, the People's Experience Policy and Standard Operating Procedure were developed and progressed through the Health Board's governance processes, providing a consistent organisational approach to capturing, understanding and responding to people's experiences. Focus is now on embedding the framework across services, strengthening consistency of application, supporting organisational learning and improvement, and developing evidence of impact through routine monitoring and reporting arrangements. The foundations required to support the framework are now in place, with Q3 focusing on embedding, maturity and demonstrating impact on the experiences of patients, service users, families and carers.

5.3 Bereavement Framework

The Bereavement Service continues to progress implementation of the National Bereavement Framework and National Bereavement Care Pathway. Feedback from Welsh Government recognised positive progress in pregnancy and baby-loss support, the Grief First Aider network within the Health Board, family-feedback arrangements and development of the Bereavement Services Codebook, which will be used to measure feedback from Bereavement Questionnaires. The Health Board's overall implementation rating remains Amber, reflecting continued progress alongside capacity pressures and delays in some areas.

Work has continued to strengthen care after death arrangements, including development of the Care After Death Guideline and the ongoing provision of bereavement packs, practical guidance, support information and explanations of death-certification and Medical Examiner process. Progress has also been made in developing pregnancy and baby-loss pathways, supported by Bereavement Champion Midwives.

The Grief First Aider network continues to provide support to bereaved colleagues, with nine trained staff meeting regularly to share learning and maintain consistency. Feedback from staff accessing the network has been positive.

Engagement with community, voluntary and faith organisations continue. Mapping provision to better understand how services meet the needs of those with protected characteristics and those living in rural communities has commenced. This work will inform the planned relaunch of the Bereavement Stakeholder Group and future service development.

Overall, assurance can be taken that implementation continues to progress. However, continued oversights required in relation to capacity, stakeholder mobilisation, workforce resilience and the formal embedding of pathways and governance arrangements.

5.4 Public Services Ombudsman for Wales (PSOW) Annual Letter

The Public Services Ombudsman for Wales Annual Letter 2025/26 has been received. It highlights rising complaint volumes across Welsh public services and identifies key themes, including clinical care, waiting-list management, complaint handling, communication and compliance with Duty of Candour requirements. The Health Board will review the data provided in the letter and consider any organisational learning from Ombudsman investigations and public interest reports. A separate report will be developed to consider the findings, recommendations and any required actions.

6. CONTRACT QUALITY PERFORMANCE REVIEW

6.1 Quality Assurance

The Health Board continues to maintain established contract, quality and performance monitoring arrangements with commissioned providers across Wales and England. Routine quality assurance meetings continue to take place with commissioned organisations, supporting oversight of quality, safety, performance, risks, incidents, complaints, patient experience and emerging concerns relevant to Powys residents. The Health Board recognises that strengthening commissioned-services assurance remains a key organisational priority. Whilst existing governance arrangements provide oversight of identified concerns and quality issues, further work is required to develop a more systematic and integrated approach to quality intelligence, organisational learning and assurance across commissioned services.

In support of this, dedicated resource has been assigned to the development of the Health Board's Quality Management System (QMS). This work includes a specific focus on commissioned-services assurance and is intended to strengthen the triangulation of quality, safety, patient experience, performance and contractual intelligence. The programme of work is being supported through collaboration between Quality & Safety, Planning, Performance and Commissioning colleagues, working with partner organisations to develop and implement a broader framework for commissioned-services quality assurance and oversight.

This work remains at an early stage; however, it represents a significant opportunity to strengthen organisational assurance and improve visibility of quality and safety across commissioned care pathways. Progress will continue to be reported through future iterations of the Integrated Quality Report.

6.2 Commissioning Concerns Monitoring

The Health Board continues to monitor concerns, complaints, incidents and patient experience intelligence relating to commissioned services through established governance arrangements. Information from a range of sources, including concerns, patient feedback, contract monitoring processes and quality review meetings, is used to identify emerging themes and support discussions with commissioned providers.

Work is ongoing to strengthen the consistency, completeness and timeliness of intelligence available from commissioned organisations. This includes consideration of how quality and patient experience information can be incorporated more

systematically into the developing commissioned-services assurance framework and wider Quality Management System programme.

Whilst challenges remain in obtaining consistent intelligence across all commissioned providers and care settings, there is a clear programme of work in place to improve assurance arrangements and strengthen organisational understanding of quality and safety within commissioned services. Progress against this work will continue to be monitored through existing governance structures and reported to Executive Committee and PEQS as appropriate.

7. CONCLUSION

Q2 intelligence indicates a broadly stable quality and safety position, subject to the limitations arising from incomplete September data, outstanding incident investigations and developing commissioned-services intelligence. Triangulation continues to identify consistent priorities relating to communication and engagement, access and timeliness, clinical decision-making, care coordination and operational pressures.

The report demonstrates different levels of maturity across improvement activity. Measurable outcome improvement is evident in inpatient falls, while pressure-damage work demonstrates strengthened scrutiny, learning and interpretation of harm. The sepsis programme represents a significant improvement in organisational infrastructure and capability, although impact on clinical outcomes is not yet available.

Progress in translating learning consistently across the organisation remains constrained by Quality & Safety Team capacity and the delayed launch of the ELEVATE Network. Assurance can nevertheless be taken that the Health Board is increasingly able to identify its principal quality priorities, translate selected areas of intelligence into improvement activity and distinguish between demonstrated impact and anticipated benefit. Further work is required to strengthen commissioned-services assurance, organisational learning arrangements and systematic measurement of outcomes.

NEXT STEPS:

- **Continue to embed** the Listening to People, People's Experience and Bereavement Frameworks across the Health Board.
- **Strengthen organisational learning** through the use of triangulated intelligence to inform priorities and improvement activity.
- **Progress improvement activity** on a risk-based basis, recognising current Quality & Safety Team capacity and resilience pressures.

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					

Ask for: Complaints Standards



01656 641150



Caseinfo@ombudsman.wales

Date: 17 September 2026

Mr Carl Cooper
Chair
Powys Teaching Health Board

By email only

Dear Carl

Annual Letter 2025-26

Our role

As the Public Services Ombudsman for Wales, we independently consider complaints about public services and investigate alleged breaches of the councillor Code of Conduct. We also set complaints handling standards for public bodies, drive continuous learning from complaints and undertake investigations into public services on our own initiative.

Purpose of this Annual Letter

This letter provides an update on our work for this period, and highlights key trends in Welsh health and public service complaints. It details performance specific to your organisation and outlines the positive actions we would like you to take.

Overview - a record-breaking year

This letter, as always, coincides with the publication of our Annual Report, which holds special significance this year as we mark our 20th anniversary. We closed our busiest year on record where the office received 4,507 duly made complaints across its public services and Code of Conduct remits — 27% more than last year, 47% more than 3 years ago, and 3 times as many as 20 years ago.

To meet this demand, we closed a record number of complaints, 29% more than last year and 43% more compared with 3 years ago. We intervened in 568 of complaints that we closed.

Patterson, Liz
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Finding swift resolutions to complaints, where possible, remains important to us and benefits all parties involved. This year, 85% of our interventions included an element of Early Resolution, a process we hope has proved valuable to both your organisation and to complainants.

Despite the increased volume of cases, our case handling times remained efficient. Initial assessments and Early Resolutions were completed within 4 weeks - well ahead of our 6 week target. Additionally we maintained a downward trend in our average investigation time which was 54 weeks this year from 64 weeks in 2023-24.

Overview of health board complaints

During 2025-26, we received 1,351 complaints about health boards marking a significant 42% increase from the previous year. Clinical treatment in hospitals remains the most frequent source of concern. Additionally, complaint handling accounted for approximately 14% of complaints. While this represents a positive decline from 18% 2 years ago, specific concerns in this area are detailed below.

We intervened in 22% of health board complaints that we closed – compared to 27% last year.

Performance specific to your organisation

During 2025-26, we received 31 complaints about your organisation and closed 28 complaints (some of which may have been carried over from the previous year).

We intervened in 25% of the complaints we closed about your organisation.

We made 9 new recommendations to your organisation in the cases closed this year.

There were 10 recommendations that fell due during this period. Your organisation complied with 70% of these within the agreed timescales.

Detailed data on the complaints we handled about your organisation in this period can be found in the appendices below.

Improving compliance with our recommendations

We always take time to ensure that recommendations and timescales are agreed with public bodies before finalising them. Therefore we expect agreed deadlines to be met. Timely compliance is not, however, as high as it should be; with only 69% of our recommendations across Wales complied with on time as at 31 March 2026. Promptly delivering agreements to resolve injustice or hardship for individuals, and implementing systemic learning on time, is vital to build and maintain public trust in both our office and your organisation.

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13/10/2025
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We recognise that unexpected challenges arise that make deadlines difficult to meet. In response to feedback from public bodies, we have adapted our approach moving forward: if you request a reasonable extension on or before the original deadline, and you meet that new date, it will be recorded as complied with on time. We hope this is a welcome adjustment that will help demonstrate a more accurate compliance rate over the coming years.

Supporting improvement of public services – key themes and our own initiative work

When an investigation reveals serious systemic risks that may affect many individuals, or offer wider sector lessons, we publish a public interest report. We published 9 such reports during this period, the vast majority concerning health boards. If you have not already done so, I encourage you to read these reports for their valuable insights - [here](#).

Tragically, we have seen some instances of both individual shortcomings and wider systemic failures causing injustice to citizens in Wales. Key themes in this period have included: poor waiting list management (including inappropriate removal of patients from waiting lists); poor prescribing practice failures where we have seen communication and process breakdown between medical and pharmacy teams; and delays and clinical failures in urgent cancer referrals and ophthalmology.

We have also seen concerning complaint handling failures. Some health board complaint investigations have shown a lack of curiosity, objectivity and rigour which are essential to robust and thorough complaint investigation. In addition, we have seen failures to remain open and transparent with service users who have experienced harm, falling short of duty of candour requirements.

I strongly encourage all health boards and trusts to read the 5 public interest reports and recommendations issued during this period, and to use these insights to proactively strengthen your own complaint handling practices where appropriate.

We continue to expand the use of our own initiative powers. These allow us to investigate emerging issues proactively, addressing administrative failings before they multiply.

This year we issued a follow up report on public bodies' compliance with our previously published report on carers. You will recall I shared my original report with you given your role in identifying, assessing and supporting carers, especially during hospital discharge, and working collaboratively with others as part of an integrated system. Our follow up report can be found [here](#).

Patterson, Liz
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Ongoing own initiative investigations

As at March 2026, we were conducting a further 4 own initiative investigations which focus, among other things, on:

- potential maladministration and service failure in health care
- how social landlords deal with complaints about disrepair and damp and mould.

We expect to complete this work later in 2026, and will determine then if the findings warrant publication in the public interest.

Our Complaints Standards Work

By the end of March 2026, all local authorities, health boards and 21 housing associations in Wales were operating under our model complaints policy. During 2025-26, we initiated the transition for the remaining housing associations and we expect them to be fully compliant by the end of September 2026.

Organisations that are already compliant, or will be shortly, account for 85% of new complaints about public services which we receive.

Our free complaint handling training remains highly requested; we delivered 58 sessions to public bodies across Wales this year, bringing our total since 2020 to over 600 sessions and 10,000 participants.

More broadly we expect to publish the data on complaints handled by local authorities in Wales during 2024-25 and 2025-26 in the Autumn.

Action we would like your organisation to take

To build on findings from this period, can I ask that your organisation takes the following actions:

- Present this Annual Letter and associated data to the Board at the next available opportunity and notify me of the planned meeting dates.
- Review the data in this letter, alongside your own data to better understand your performance, identify trends, and review your compliance with recommendations made by my office.
- Read the reports highlighted in this letter to extract relevant learning for your own Authority.

Patterson, L. J.
13/10/2026 09:48:47

- Provide my office with a copy of your Annual Report for 2025-26 on the Duty of Candour and Quality.
- Inform me of the outcome of your considerations and proposed action plan at the earliest opportunity.

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

Yours sincerely

Michelle Morris
Public Services Ombudsman

Cc. H Thomas
L Mathias

Patterson, Liz
13/10/2026 09:48:47

Information Sheet

Glossary of terms a guide to some of the terms used within our Annual Letters and Appendices.

Appendix A shows the number of complaints we received for all health boards in 2025-26. These complaints are contextualised by the population of each authority.

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

Appendix C shows intervention rates for all health boards in 2025-26. An intervention is categorised by either an upheld complaint (either public interest or non-public interest), an early resolution, or a voluntary settlement.

Appendix D shows outcomes of the complaints we closed for the Health Board in 2025-26. This table shows both the volume, and the proportion that each outcome represents for the Health Board.

Appendix E shows the compliance performance of each health board.

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Annual Letters - Glossary of terms

Term	Definition
Complaints received	The number of duly made complaints we receive about a Public Body.
Duly made complaint	A complaint about public services is duly made when: - the organisation is within our jurisdiction and - the organisation has replied or had the opportunity to reply and - the events complained about happened less than a year ago, or the complainant became aware of them less than a year ago (unless there was a good reason the complainant could not complain sooner) and - the complainant is entitled to bring a complaint and - we have the details we need e.g. name, contact details, organisation being complained about, we can understand the complaint. A complaint about a local councillor is duly made when: - we have the details we need e.g. name and contact details of the complainant, the name of the councillor and the Local Authority they are a member of - we have a signed declaration from the complainant and any third parties whose evidence has been submitted.
Early Resolution	A matter which is closed without investigation because there is an obvious solution and the body agrees to carry out action to resolve the matter. The body must give us evidence that it has taken action within the timeframe agreed.
Intervention	Cases which we have closed and we have either: - Upheld the complaint after investigation. - Resolved the complaint by way of Voluntary Settlement. - Resolved the complaint by way of Early resolution.

Patterson, Liz
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Voluntary Settlement	A matter which has progressed to investigation stage but closed without the investigation being completed because we agree that action which the body has voluntarily suggested it will take is appropriate to resolve the matter. The body must give us evidence that it has taken action within the timeframe agreed.
Uphold	A matter we have closed after investigation and where we found that something went wrong.
% of interventions	The number of public service complaints we closed that involved Early Resolution/Voluntary Settlement and those which we upheld following an investigation, divided by the total number of duly made public service complaints we closed in the reporting period.
Upheld %	The proportion of the complaints in which we intervened that we upheld in the reporting period, shown as a percentage.
Cases Closed	The number of complaints we closed during the reporting period. This may be different from the number we received because there may be some complaints we received in the previous reporting period but which we closed in this reporting period.
Recommendation	These are actions which we ask bodies to take within agreed timescales when we find something has gone wrong. These may be actions to help the individual complainant or systemic actions to help improve services for all service users. We can make recommendations as part of an Early Resolution, Voluntary Settlement or when upholding a complaint following investigation. When we make recommendations, organisations must provide evidence to us that they have complied.
Recommendations made	The number of recommendations we made to bodies during the reporting period. (1 April 2025 to 31 March 2026)
Recommendations falling due	The number of recommendations which needed to be complied with within the reporting period (1 April 2025 to 31 March 2026). Some recommendations will have been made in the previous reporting period but fell due within this reporting period.

Recommendations complied with in line with agreed target date %	The number of recommendations which were complied with by the agreed timescale as set out in Early Resolution, Voluntary Settlement or Investigation report (applicable for those falling due in 2025-26).
Population	Population is included to provide context, based upon the size of an organisation. However, it is recognised that complaints can be made by people who are not included in the population figure, for example, residents from outside the health board or local authority area, or non-contract holders. • For local authorities, population refers to the estimated total number of people living in the local authority area. The figures are taken from the StatsWales.¹ • For housing associations, population refers to the total stock at social rent, shown in units. This includes general needs stock, sheltered stock, other supported stock and extra care stock with non self-contained bedsits, hostels and shared housing. This figure is taken from StatsWales.² • For health boards, population refers to the estimated total number of people living in the health board area. The figures are taken from StatsWales.³

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¹ [Population estimates by local authority, year, sex and age | StatsWales](#)

² [Social landlord housing stock, including social and non social housing | StatsWales](#)

³ [Population estimates by local health boards, year, sex and age | StatsWales](#)

Appendix A – Complaints received (overview)

Health Board	Complaints Received	Population	Received per 1,000 residents
Aneurin Bevan University Health Board	263	601,686	0.44
Betsi Cadwaladr University Health Board	283	697,115	0.41
Cardiff and Vale University Health Board	230	519,662	0.44
Cwm Taf Morgannwg University Health Board	173	449,346	0.39
Hywel Dda University Health Board	172	389,160	0.44
Powys Teaching Health Board	31	135,059	0.23
Swansea Bay University Health Board	199	394,553	0.50
Welsh Ambulance Services University NHS Trust	37	-	-
Total	1388	3,186,581	0.44

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Appendix B – Complaints received (by organisation)

Powys Teaching Health Board	Complaints Received	% share
Admissions/discharge and transfer procedures	1	3%
Adult Mental Health	1	3%
Ambulance Services	0	
Appointment procedures (including outpatients)	2	6%
Care Homes	0	
Child and Adolescent Mental Health	2	6%
Clinical treatment in hospital	11	35%
Clinical treatment outside hospital; Dentist	0	
Clinical treatment outside hospital; GP	1	3%
Clinical treatment outside hospital; Other	1	3%
Clinical treatment outside hospital; Physiotherapist	1	3%
Complaints Handling	0	
Confidentiality	0	
Continuing care	3	10%
De-Registration	0	
Disclosure of personal information / data loss	0	
Finance and Taxation	0	
Funding	0	
Gender Identity Funding	0	
Health	5	16%
Housing	0	
Independent Health Care providers	0	
Medical records/standards of record-keeping	0	
Medication; Prescription dispensing	0	
Non-medical services	0	
Nosocomial (Framework)	0	
Other	0	
Other miscellaneous	0	
Out of Hours GP care	0	
Patient list issues	2	6%
Poor/No communication or failure to provide information	0	
Prisoner Care	0	
Recruitment and appointment procedures	0	
Referral to treatment time	1	3%
Rudeness/inconsiderate behaviour/staff attitude	0	
Services for vulnerable adults (eg with learning difficulties. or with mental health issues)	0	
Various Other	0	
Whistle-blowing	0	
Total	31	

Appendix C – Cases with PSOW intervention (overview)

Health Board	No. of interventions	No. of closures	% of interventions
Aneurin Bevan University Health Board	64	254	25%
Betsi Cadwaladr University Health Board	57	272	21%
Cardiff and Vale University Health Board	38	216	18%
Cwm Taf Morgannwg University Health Board	32	172	19%
Hywel Dda University Health Board	43	160	27%
Powys Teaching Health Board	7	28	25%
Swansea Bay University Health Board	49	195	25%
Welsh Ambulance Services University NHS Trust	8	36	22%
Total	298	1333	22%

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Appendix D – Complaint outcomes (by organisation)

Powys Teaching Health Board		% Share
Complaint investigation discontinued (with early resolution at assessment stages)	0	
Complaint investigation discontinued (without settlement)	0	
Decision not to investigate complaint	12	43%
Early resolution	7	25%
Matter out of jurisdiction	2	7%
Non-public interest report issued: complaint not upheld	0	
Non-public interest report issued: complaint not upheld with early resolution at assessment stage	0	
Non-public interest report issued: complaint upheld	0	
Non-public interest report issued: complaint upheld with early resolution at assessment stage	0	
Premature	7	25%
Public interest report issued: complaint upheld	0	
Public Interest report issued: complaint upheld with early resolution at assessment stage	0	
Special Interest Report	0	
Voluntary settlement	0	
Total	28	

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Appendix E – Compliance performance comparison

Health Board	Number of recommendations made on complaints closed in 2025-26	Number of recommendations falling due in 2025-26	% of recommendations, complied with in line with agreed target date
Aneurin Bevan University Health Board	175	142	70%
Betsi Cadwaladr University Health Board	157	137	61%
Cardiff and Vale University Health Board	86	92	71%
Cwm Taf Morgannwg University Health Board	94	93	72%
Hywel Dda University Health Board	118	118	81%
Powys Teaching Health Board	9	10	70%
Swansea Bay University Health Board	143	144	60%
Welsh Ambulance Services University NHS Trust	23	36	83%



GIG
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NHS
WALES

Bwrdd Iechyd
Addysgu Powys
Powys Teaching
Health Board

Agenda item: 4.4

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE		15 OCTOBER 2026	
Subject:	People’s Experience Framework – September 2026		
Approved and presented by:	Paul Hooton, Executive Director of Nursing, Quality, Women and Family Health		
Prepared by:	People’s Experience Lead		
Other Committees and meetings considered at:	Executive Committee 01 October 2026 – who recommended the paper to the Committee.		
PURPOSE:			
The purpose of this report is to present the Patient Experience, Quality and Safety Committee with the Peoples Experience Framework for review and request recommendation of the policy to the PTHB Board. The policy is based on the national framework, has been reviewed by the Executive Committee and now presented to PEQS for scrutiny and consideration of recommendation to the PTHB Board. The policy is a Board retained approval. The basis of policy has been implemented since April 2026 as per the ongoing commitment to the national framework. The focus has now moved to embedding and maturing the framework across the organisation. A supporting standard operating procedures is in place and will be reviewed as required following policy review and anticipated approval. This report does not cover the routine reporting on Patient Experience, which is reported through the Integrated Quality Report (IQR).			
RECOMMENDATION(S):			
The Patient Experience, Quality and Safety Committee is asked to: - REVIEW the draft Peoples Experience Framework and RECOMMEND to Board that the framework be approved, and - NOTE that the next phase of activity will focus on embedding, maturing and evidencing impact through routine monitoring and reporting.			
Approve/Take Assurance		Discuss	Note

Y	N	N
---	---	---

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:

1. Focus on Wellbeing	Y	
2. Provide Early Help and Support	Y	
3. Tackle the Big Four	N	
4. Enable Joined up Care	Y	
5. Develop Workforce Futures	N	
6. Promote Innovative Environments	N	
7. Put Digital First	N	
8. Transforming in Partnership	N	

EXECUTIVE SUMMARY:

The People's Experience Policy and Standard Operating Procedure were developed to support the implementation of the NHS Wales National People's Experience Framework, launched by Welsh Government in April 2025. Following the appointment of the People's Experience Lead in June 2025, work commenced to establish a consistent organisational approach to capturing, understanding and responding to people's experiences across Powys Teaching Health Board.

The policy was developed through a structured review of the national framework, existing Health Board processes, and current mechanisms for capturing feedback and experience data. Drafts were considered through the People's Experience governance structure, with oversight provided by the People's Experience Strategic Group (PESG). The policy was ratified by PESG in August 2026 before progressing through the Health Board's formal policy approval process in September.

The final policy reflects the principles, expectations and requirements set out within the NHS Wales National People's Experience Framework, ensuring alignment with national guidance and establishing clear responsibilities, governance arrangements, and processes for using people's experience to drive learning, improvement and assurance across the organisation.

NEXT STEPS:

Continue to embed and mature the People's Experience Framework, with quarterly assurance updates provided through the IQR.

IMPACT ASSESSMENT – FORMS PART OF THE POLICY DEVELOPMENT PROCESS

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People's Experience and Listening Policy

Document Reference No:	If a new policy then leave blank, Corporate Governance team will assign the reference
Version No:	1 or incremental from previous version
Publication Date:	To be completed by Corporate Governance Team. (This is the date published on Corporate Governance SharePoint dd/mm/yyyy)
Review Date:	3 months prior to expiry date dd/mm/yyyy
Expiry Date:	3 years after approved date dd/mm/yyyy
Author:	People's Experience Lead
Document Owner:	People's Experience Lead
Accountable Executive:	Executive Director of Nursing, Quality, Woman and Family Health
Approved By:	Name of approving Group
Approved Date:	Date policy approved dd/mm/yyyy
Document Type	Policy
Scope:	PTHB Wide

Powys Teach Health Board is the operational name of Powys Teaching Local Health Board

To ensure that you are always using the latest version of this corporate policy, please refer to the version on the Corporate Governance SharePoint site

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Associated Policies and Written Control Documents

You may wish to list here other policies or written control documents that should be read in conjunction with your policy or may be affected

<i>by material changes to your policy.</i>
• People’s Experience Standard Operating Procedure
• PEP 001 Concerns Policy & Procedures • NHS Wales Listening to People Framework (2026) Welsh Government • People’s Experience Framework (WHC/2024/015): guidance for NHS Wales (2025) Welsh Government

Version Control

Version	Summary of Changes/Amendments	Publication Date
1		
2		
3		
4		
5		
6		

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1.0 Scope

This policy applies to all services provided or delivered by Powys Teaching Health Board.

This includes:

Directly Managed Services

- Community Hospitals
- Community Nursing
- Mental Health Services
- Therapies
- Dental Services
- Public Health Functions
- Specialist Nursing Services
- Women's health/sexual health services
- Maternity services
- Children's Services
- Palliative Care Services

Individuals Covered

This policy applies to:

- Employees
- Students
- Volunteers
- Contractors
- Agency workers
- Independent practitioners
- Board Members

The policy also applies to feedback received from:

- Patients
- Service users
- Carers
- Families
- Visitors
- Advocates
- Community groups
- Members of the public
- Partner organisations

The principles apply equally regardless of age, disability, ethnicity, sexual

orientation, religion, gender identity, Welsh language preference or communication needs.

2.0 Policy Statement

Powys Teaching Health Board is committed to delivering person-centred services that are safe, effective, timely, equitable and responsive to the needs of the people and communities it serves.

The Health Board recognises that people's experiences are a critical indicator of healthcare quality and are equally important to clinical outcomes and patient safety. Every interaction between an individual and the Health Board contributes to their overall experience and provides valuable information that can be used to improve services.

The Health Board will establish and maintain an integrated system for collecting, responding to, analysing and learning from:

- People's experience feedback
- Concerns and complaints
- Patient safety incidents
- Compliments
- Patient and staff stories
- Engagement activities
- Lived experience contributions
- Patient Reported Experience Measures (PREMs)
- Patient Reported Outcome Measures (PROMs)
- Citizen voice and advocacy feedback

The Health Board is committed to ensuring that all individuals, including patients, service users, families, carers, advocates, staff and communities, are listened to and treated with dignity, compassion and respect.

This policy supports compliance with:

- Health and Social Care (Quality and Engagement) (Wales) Act 2020
- NHS Duty of Candour
- NHS Wales Duty of Quality
- Listening to People Guidance 2026
- NHS Wales Concerns, Complaints and Redress Regulations
- Health and Care Quality Standards Wales
- Equality Act 2010
- Welsh Language Standards

The Health Board will demonstrate transparency and accountability through robust reporting systems and by publicly evidencing how feedback and concerns have informed service improvement through a "You Said, We Did" approach.

The Health Board will embed co-production by working with people, carers, families, communities, staff and relevant partners as equal contributors in the planning, design, delivery, evaluation and improvement of services. Lived experience and professional knowledge will be recognised as having equal value.

The Health Board will support Value Based Healthcare by considering people's experiences and outcomes alongside quality, safety, equity, activity and resource information. This will help ensure that decisions and improvement activity focus on the outcomes and experiences that matter most to people while making responsible use of available resources.

3.0 Purpose

The purpose of this policy is to establish a consistent, organisation-wide framework for gathering, responding to and learning from experiences and concerns.

The policy seeks to:

Promote Person-Centred Care

Ensure that people using Health Board services are active partners in service planning, delivery, evaluation and redesign.

Improve Quality

Support the Duty of Quality by ensuring experience information is used alongside safety, effectiveness and outcomes data to improve healthcare delivery.

Improve Safety

Ensure concerns, complaints and incidents are identified, investigated and acted upon promptly to prevent recurrence and reduce harm.

Strengthen Public Confidence

Demonstrate openness, honesty and accountability by responding compassionately and transparently when people raise concerns.

Support Organisational Learning

Create systems that enable learning from all feedback, including positive feedback, concerns, incidents, compliments and lived experiences.

Meet Statutory Obligations

Provide a framework through which the Health Board can fulfil its legal obligations under Welsh Government legislation and NHS Wales guidance.

Reduce Health Inequalities

Ensure the voices of seldom-heard and marginalised communities are actively sought and used to inform service development.

Drive Continuous Improvement

Use quality improvement methodologies and performance monitoring systems to evidence improvements resulting from feedback and experience data.

Promote Co-production

Ensure people and communities are involved from the outset as equal partners in identifying priorities, designing solutions, testing changes and evaluating their impact.

Support Value Based Healthcare

Use PREMs, PROMs, lived experience and co-produced insight alongside outcomes and resource information to support shared decision-making and improve the outcomes and experiences that matter most to people.

4.0 Legislative and Strategic Context

This policy supports compliance with:

- Health and Social Care (Quality and Engagement) (Wales) Act 2020
- Duty of Quality
- Duty of Candour
- Equality Act 2010
- Welsh Language Standards
- NHS Wales Concerns Regulations
- Public Services Ombudsman for Wales arrangements
- Health and Care Quality Standards

The policy also supports delivery of the Health Board's strategic objectives relating to quality, safety, patient experience, engagement and continuous improvement.

The policy also supports the principles of Value Based Healthcare and the co-productive approach described within the NHS Wales People's Experience Framework.

5.0 Definitions

For the purpose of this policy:

- **People's Experience** is the sum of all interactions that individuals have with services, shaped by organisational culture, staff behaviours and systems.
- **Feedback** includes comments, suggestions, concerns, compliments, survey responses and stories shared by patients, families, carers, communities and staff.
- **PREMs** are Patient Reported Experience Measures.
- **PROMs** are Patient Reported Outcome Measures.
- **Concerns** include complaints, patient safety incidents and issues that may require investigation or redress.
- **Lived Experience** refers to the knowledge and insight gained through personal experience of health and care services.
- **Co-production** means people, carers, families, communities, staff and relevant partners working together as equal contributors throughout the design, delivery, improvement and evaluation of services, with lived experience and professional knowledge equally valued.
- **Value Based Healthcare (VBHC)** is an approach that uses information about outcomes, experience and resources to support shared decision-making and improve the outcomes and experiences that matter most to people. Within this policy, VBHC is supported through PREMs, PROMs, lived experience, co-production and quality improvement.

6.0 Policy Principles

The Health Board adopts the following principles as the foundation for all experience and concerns activity.

People First

The needs, preferences and experiences of people must actively inform service delivery and decision-making.

Individuals should be treated as equal partners and experts in their own experiences.

Compassion

All interactions relating to feedback, concerns and complaints must demonstrate:

- Kindness
- Empathy
- Respect
- Dignity
- Understanding

Staff must recognise that people often raise concerns during periods of distress, anxiety, grief or vulnerability.

Listening

The Health Board commits to actively listening to people and ensuring that every concern, complaint or item of feedback receives appropriate consideration.

People must have the opportunity to explain:

- What happened
- How it affected them
- What matters most to them
- Their preferred outcome

Accessibility

People must be able to provide feedback in a way that suits their needs.

This includes:

- Welsh language provision
- Interpretation services
- Easy Read formats
- British Sign Language
- Digital and non-digital methods
- Advocacy support

Early Resolution

Where possible, issues should be resolved quickly and locally through discussion and action before escalation becomes necessary.

Learning

Every concern, incident, compliment and experience represents an opportunity for learning and improvement.

The focus should be on understanding systems and improving services rather than apportioning blame.

Equality and Inclusion

Feedback systems must be designed to encourage participation from all communities, particularly those that are underserved, vulnerable or seldom heard.

Transparency

The Health Board will be open about:

- What people tell us
- What actions have been taken
- What improvements have been made
- What learning has occurred

Accountability

Individuals at all levels of the organisation are accountable for ensuring feedback is acted upon and learning is implemented.

Continuous Improvement

Experience data must be routinely triangulated with the following to ensure a comprehensive understanding of quality and performance.:

- Incident reports
- Complaints
- Clinical outcomes
- PROMs
- PREMs
- Equality data
- Staff experience measures

Co-production

People and communities must be involved early enough to influence priorities and decisions, with accessible and meaningful opportunities to contribute throughout planning, design, testing, implementation and evaluation.

Value Based Healthcare

Decisions should be informed by what matters to people and by a balanced understanding of experience, outcomes, quality, safety, equity and resource use.

7.0 Governance and Accountability

Board Accountability

The Board retains overall responsibility for ensuring that effective systems are in place to gather, understand, respond to and learn from people's experiences, concerns, complaints, incidents, compliments and feedback.

The Board shall:

- Promote a culture of openness, listening and continuous learning.
- Receive assurance that statutory duties are being met.
- Monitor organisational performance against key indicators.
- Ensure appropriate resources are available.
- Consider patient stories and lived experiences as part of governance arrangements.
- Review evidence demonstrating improvements arising from feedback.
- Ensure compliance with Duty of Quality and Duty of Candour requirements.

The Board shall receive regular reports demonstrating:

- People's experience performance.
- Complaint themes and trends.
- Incident themes.
- Equality analysis.
- Learning outcomes.
- Organisational improvement actions.

Executive Leadership

The Executive Director of Nursing, Quality, Woman and Family Health shall act as the Executive Lead for this policy.

Responsibilities include:

- Strategic leadership.
- Board assurance.
- Regulatory compliance.
- Oversight of organisational performance.
- Promotion of person-centred culture.
- Integration of experience data into quality systems.

Quality, Safety and Experience Committee

The Committee shall:

- Scrutinise performance.
- Monitor implementation of learning actions.
- Review serious concerns and emerging risks.
- Receive patient stories and lived experience evidence.
- Provide assurance to the Board.

Operational Leadership

Directorates and Service Managers shall:

- Promote local ownership of feedback.
- Review experience data regularly.
- Ensure concerns are managed appropriately.
- Monitor local improvement plans.
- Ensure staff understand their responsibilities.

8.0 Collecting People's Experience

Strategic Approach

The Health Board adopts an "Always On" approach to experience collection.

People should be able to provide feedback:

- When they want.
- Where they want.
- How they want.

Experience collection shall not be limited to annual surveys.

Methods for Collecting Feedback

Digital Feedback

The Health Board will utilise:

- QR Codes
- Mobile applications
- SMS systems
- Electronic surveys
- Website forms

Face-to-Face Feedback

Staff should encourage people to share experiences directly during care interactions.

Paper Feedback

Paper surveys and feedback forms shall remain available across all services.

Telephone Feedback

Individuals must have telephone access where digital methods are not suitable.

Community Engagement

Feedback may also be collected through:

- Community meetings
- Engagement events
- Focus groups
- Voluntary sector partnerships
- Citizen panels

Core Experience Questions

All local surveys shall include, as a minimum:

- Overall experience rating.
- Positive experience comments.
- Areas for improvement.
- Preferred language information.

PREMs and PROMs

The Health Board will support the systematic use of:

Patient Reported Experience Measures

Used to understand:

- Communication
- Dignity
- Respect
- Involvement
- Care quality

Patient Reported Outcome Measures

Used to understand:

- Health outcomes
- Functional outcomes
- Quality of life improvements

9.0 Listening to People Process

Principles as a provider

The Health Board adopts the four principles of Listening to People:

- *Principle 1* - Listen actively and compassionately.

- *Principle 2* - Investigate fairly and proportionately.
- *Principle 3* - Learn and improve.
- *Principle 4* - Demonstrate leadership and accountability.

Single Point of Access

The Health Board shall maintain a clearly advertised central point for raising concerns.

Access routes shall include:

- Telephone
- Email
- Website
- Written correspondence
- Face-to-face contact

Acknowledgement

All concerns shall be acknowledged within five working days.

Acknowledgement will include:

- Named contact.
- Advocacy information.
- Listening discussion offer.
- Explanation of next steps.

Listening Discussion

A listening discussion must be offered for all concerns relating to care received within Powys and delivered by PTHB services.

The discussion should:

- Establish the nature of concerns.
- Explore desired outcomes.
- Identify support needs.
- Confirm communication preferences.
- Consider opportunities for early resolution.

Advocacy

Advocacy support shall be actively offered.

This includes signposting to:

- Llais

- Independent advocacy services
- Interpretation services

10. Complaints and Concerns Management

Early Resolution

Where appropriate, concerns should be resolved during Stage 1.

Actions may include:

- Explanation.
- Apology.
- Immediate corrective action.
- Service intervention.
- Clinical review.

The target is completion within ten working days of acknowledgement.

Formal Investigation

Where concerns cannot be resolved early, Stage 2 investigation shall commence.

Investigations must be:

- Proportionate.
- Fair.
- Evidence-based.
- Person-centred.
- Timely.

Investigation Standards

Investigations shall:

- Review records.
- Obtain staff statements.
- Seek expert opinion where required.
- Examine contributory factors.
- Consider human factors.
- Consider equality issues.

Communication During Investigation

Individuals shall receive:

- Regular updates.
- Revised timescales where required.
- Accessible communications.
- Opportunities to ask questions.

Investigation Outcomes

Responses must include:

- Summary of concerns.
- Investigation methodology.
- Findings.
- Learning identified.
- Actions being taken.
- Ombudsman information.

11. Duty of Candour

The Health Board is committed to openness and honesty when care may have contributed to moderate harm, severe harm or death.

Where the Duty of Candour applies:

- Individuals will be informed promptly.
- A meaningful apology will be provided.
- Ongoing communication will occur.
- Investigations will be undertaken.
- Support will be offered.

The provision of an apology does not constitute admission of liability.

All Duty of Candour activity shall be monitored through established governance processes.

12. Compliments Management

The Health Board recognises compliments as valuable experience information.

Collection

Compliments may be received through:

- Cards
- Letters
- Email
- Social media
- Verbal feedback

Recording

All compliments shall be recorded on appropriate systems.

Recognition

Compliments should be:

- Shared with teams.
- Included in governance reporting.
- Used in staff recognition programmes.

Learning

Compliments should be analysed to identify:

Positive behaviours.
Best practice.
Innovation.
Service strengths.

13. Patient Stories and Lived Experience

Purpose

Stories provide insight that quantitative data alone cannot offer.

Patient and staff narratives:

- Humanise quality information.
- Identify improvement opportunities.
- Enhance understanding of service impact.

Collection

Stories may be collected through:

- Interviews.
- Digital stories.
- Written narratives.
- Listening events.

Use of Stories

Stories shall be used to:

- Inform Board discussions.
- Support staff education.
- Highlight improvement opportunities.
- Promote organisational learning.

Lived Experience Groups

The Health Board shall maintain mechanisms enabling communities to influence:

- Service design.
- Service delivery.
- Evaluation.
- Strategic planning.

Co-production

Where experience evidence is used to redesign or improve a service, people affected by the service should be involved as equal partners from the outset. Services must be clear about the scope of influence, provide accessible ways to participate, record how people shaped decisions and explain what changed or why a suggested change could not be made.

Co-produced activity should be proportionate to the scale and impact of the work and should actively include people and communities whose voices are less often heard.

14. Equality, Diversity and Inclusion

The Health Board will monitor whether experience varies according to protected characteristics.

This includes:

- Age
- Disability
- Race
- Sex
- Religion
- Sexual orientation
- Gender reassignment
- Welsh language preference
- Objectives
- Reduce inequalities.
- Improve accessibility.
- Understand differing experiences.
- Target improvements appropriately.

Equality monitoring questions should accompany relevant surveys and feedback mechanisms.

15. Analysis and Triangulation

Integrated Quality Intelligence

People's experience information shall be analysed alongside:

- Clinical outcomes.
- Incident data.
- Complaints.
- Claims.
- Staff experience.
- Equality monitoring.
- PROMs.
- PREMs.

Thematic Analysis

Data shall be reviewed to identify:

- Emerging risks.
- Themes.
- Trends.
- Service strengths.
- Opportunities for improvement.

Integrated intelligence should be used to understand relationships between

people's experiences, outcomes, inequalities, quality, safety and resource use, supporting Value Based Healthcare decisions and identifying where co-produced improvement would add greatest value.

Escalation

Emerging concerns shall be escalated through:

- Directorate governance meetings.
- Quality committees.
- Executive review processes.

16. Quality Improvement and Learning

Learning Framework

All feedback shall contribute to organisational learning.

Services must demonstrate:

What was learned.
What was changed.
How improvement was measured.

Improvement Methodology

Services should utilise recognised quality improvement approaches including:

- PDSA cycles
- Lean methodology
- Model for Improvement
- Human Factors approaches

Co-production and Improvement

Services should work with the Quality Improvement Team and the people affected by the service to co-design, test, implement and evaluate changes. People, carers, families, communities and staff should be involved as equal partners, with agreed aims and success measures reflecting what matters to them.

Value Based Healthcare

Improvement activity should consider whether changes have improved outcomes, experience, quality, safety, access or equity and whether available resources are being used responsibly. PREMs and PROMs should be used where appropriate alongside qualitative feedback and operational measures.

"You Said, We Did" evidence should, where applicable, describe:

- You said: the experience, feedback or issue identified.
- We designed together: how people and staff co-produced the proposed solution.
- We did: the change implemented.
- We tested: the quality improvement method and measures used.
- The difference made: the impact and learning identified.
- Value achieved: how the change affected outcomes, experience, quality, safety, equity or resource use and whether it delivered benefits that matter to people.

"You Said, We Did" (Appendix 2)

Evidence of improvement shall be communicated to:

- Patients.
- Communities.
- Staff.
- Stakeholders.

17. Reporting & Assurance

Quarterly reports shall include:

- Survey results.
- Complaints performance.
- Compliment themes.
- Incidents.
- Duty of Candour activity.
- Equality analysis.
- Improvement actions.

Annual reporting shall include:

- Duty of Quality reporting.
- Listening to People reporting.
- Duty of Candour reporting.
- Experience improvement outcomes.

Evidence of co-production and how people have influenced service planning, redesign and evaluation.

Evidence of Value Based Healthcare, including how experience, outcomes and resource information have informed decisions and improvement.

18. Roles & Responsibilities

Board

The Board has overall strategic accountability for ensuring effective arrangements are in place to understand and improve people's experience.

Chief Executive

Overall accountability for compliance.

Executive Lead

The designated Executive Director is accountable for implementation of this policy and for providing assurance to the Board.

Directors and Managers

Directors and managers are responsible for ensuring local implementation, operational monitoring performance and delivering improvement actions.

Support co-production and shared decision-making appropriate to their role.

Consider what matters to people when designing or improving services. Directors and managers must ensure that co-production is considered in service planning and improvement, and that experience and outcomes are considered alongside quality, safety, equity and resource information.

All Staff

All staff have a responsibility to:

- Encourage feedback
- Listen to people respectfully

- Respond appropriately to feedback and concerns
- Escalate issues when required
- Participate in learning and improvement activities

Patient Experience/Concerns Team

- Coordinate experience programmes.
- Support analysis.
- Publish reports.
- Facilitate learning.
- Manage complaints.
- Coordinate investigations.
- Support Listening Discussions.
- Monitor compliance.

19. Performance Indicators, Reporting and Assurance

The Health Board will maintain an integrated reporting framework for people's experience.

The Health Board will monitor:

Experience Measures

- Experience survey response rates.
- Overall experience score.
- Friends and family style indicators.

Concerns Measures

- Acknowledgement within 5 days.
- Listening Discussions offered.
- Early Resolution rates.
- Investigation timescales.

Quality Measures

- Learning actions completed.
- Repeat concerns.
- Duty of Candour compliance.
- Quality improvement outcomes.

Equality Measures

- Feedback from seldom-heard groups.
- Demographic representation.

- Experience variation analysis.

Reporting Measures

- Timely Board reports.
- Public reporting compliance.
- You Said We Did publications.

Co-production and involving people as equal partners.

Value Based Healthcare, shared decision-making and use of PREMs and PROMs.

Co-production Measures

Evidence that people and communities have influenced service design, improvement and evaluation.

Evidence that feedback loops have been closed with participants and communities.

Value Based Healthcare Measures

Evidence that PREMs, PROMs and lived experience have been considered alongside outcomes and resource information.

Evidence that improvement activity has delivered outcomes and experiences that matter to people.

Reports will include:

- Experience data
- Complaints and concerns
- Patient safety incidents
- Compliments
- Equality analysis
- Learning outcomes
- Improvement actions

Regular reports will be presented through governance structures and to the Board.

Public reporting will be undertaken through annual quality reporting and other statutory reporting requirements.

20. Operational and Training Implications

Staff will receive training appropriate to their role, including:

- Effective communication
- Compassionate listening
- Complaint handling
- Equality and inclusion
- Duty of Candour
- Investigation skills
- Quality improvement methodologies

21. Information Governance

Information collected under this policy will be managed in accordance with data protection legislation, confidentiality requirements and records management standards.

22. Implementation, Monitoring, Audit and Review

Compliance with this policy will be monitored through:

- Internal audit
- Governance reporting
- Performance indicators
- Self-assessment against the People's Experience Framework
- External assurance processes

This policy will be reviewed every three years or sooner where changes in legislation, guidance or organisational requirements occur.

23. Appendices

Appendix 1.
Reporting Governance Structure



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People's Experience and Listening
Policy



Appendix 2.

You Said, We Did



24. References and Bibliography

Please include any relevant references and bibliography.

- NHS Wales Listening to People Framework (2026) Welsh Government
- People's Experience Framework (WHC/2024/015): guidance for NHS Wales (2025) Welsh Government
- The Duty of Candour Statutory Guidance (2023) Welsh Government
- National framework for the delivery of bereavement care (2021) Welsh Government
- IGP 020 Data Protection and Confidentiality Policy
- IGP 013 Information Governance Incident Reporting: Standards Operational Procedure
- Data Protection legislation (UK GDPR, Data Protection Act 2018 and Data (Use and Access) Act (DUAA))

25. Equality Impact Assessment

EIA is not optional, it is embedded in Equality legislation and therefore all policies must undergo an impact assessment as part of development and/or review.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/mitigation	Action taken
Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	Positive impact. The policy ensures experiences of children, young people, adults and older people are captured and acted upon. Age-related barriers to feedback can be identified through equality monitoring. No adverse impact identified.	Ensure age-appropriate feedback mechanisms are available, including child-friendly and accessible formats.	Make reference to where the mitigation is included in the document, as appropriate Sections 6, 8 and 14 require accessible feedback methods and monitoring of experience by protected characteristics.
Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	Significant positive impact. The policy promotes accessible communication, advocacy, Easy Read formats, interpretation support, BSL provision and alternative methods of engagement. This supports people with physical, sensory, cognitive and mental health disabilities.	Continue monitoring feedback from disabled people and address barriers identified through equality analysis.	Sections 6, 9 and 14 include accessibility requirements, advocacy support and equality monitoring.

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/mitigation	Action taken
People of different genders: Consider men, women, people undergoing gender reassignment NB Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender	Positive impact. The policy applies equally regardless of gender and gender identity and supports equitable access to providing feedback, raising concerns and participating in service improvement.	Monitor experience data by gender and gender identity where appropriate and lawful.	Make reference to where the mitigation is included in the document, as appropriate Equality and inclusion principles set out in Sections 6 and 14.
People who are married or who have a civil partner.	Neutral to positive impact. The policy does not disadvantage people who are married or in civil partnerships and provides equal access to feedback and concerns processes.	No further mitigation required.	Policy applies equally to all individuals accessing services.

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/mitigation	Action taken
Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.	Positive impact. The policy supports women who are pregnant, on maternity leave or breastfeeding to provide feedback and raise concerns regarding care experiences. The focus on accessibility and person-centred care supports this group.	Ensure maternity service users are actively included in experience collection activities.	Make reference to where the mitigation is included in the document, as appropriate Sections 2, 3, 6 and 8 support equitable access and participation.
People of a minority race, nationality, colour, culture or ethnic origin including non- English speakers, gypsies/travellers, migrant workers	Significant positive impact. The policy promotes interpretation services, accessible communication and inclusion of seldom-heard groups. Equality monitoring supports identification of any disparities in experience.	Maintain translation services and targeted engagement with minority ethnic communities.	Sections 6, 9 and 14 promote inclusive access, interpretation support and equality monitoring.
People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	Positive impact. The policy promotes dignity, respect and person-centred care and enables people to express experiences relevant to their beliefs or faith needs.	Ensure feedback mechanisms remain culturally sensitive.	Policy principles contained in Sections 2 and 6.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/mitigation	Action taken
People who are attracted to other people of: - the opposite sex (heterosexual); - the same sex (lesbian or gay); - both sexes (bisexual)	Positive impact. The policy promotes equitable access to feedback, concerns processes and service improvement regardless of sexual orientation. It supports identification of differential experiences where equality monitoring is undertaken.	Continue monitoring inclusivity of feedback processes.	Make reference to where the mitigation is included in the document, as appropriate Equality monitoring requirements detailed in Section 14.
People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language	Significant positive impact. The policy explicitly recognises Welsh language preferences and access to services in Welsh. Feedback can be provided through preferred communication channels and language choice.	Continue compliance with Welsh Language Standards and monitor Welsh language experience data.	Sections 2, 6, 8, 9 and 14 reference Welsh language provision and monitoring.
People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	Positive impact. Multiple feedback channels (digital, telephone, face-to-face and paper) reduce barriers associated with poverty, digital exclusion or deprivation.	Continue provision of non-digital feedback routes and targeted engagement with disadvantaged communities.	Sections 6 and 8 provide multiple accessible methods of engagement.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/mitigation	Action taken
People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities. This also may include wifi poverty, travel poverty and fuel poverty.	Positive impact. The policy supports people across Powys, including rural communities, through multiple access routes and community engagement mechanisms.	Continue reviewing accessibility for individuals affected by transport, digital and geographical barriers.	Make reference to where the mitigation is included in the document, as appropriate Sections 8, 9 and 14 support diverse engagement methods and equality analysis.
Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	Positive impact for carers, advocates, people experiencing social exclusion, people with communication needs, vulnerable groups and seldom-heard communities. The policy seeks to reduce inequalities by ensuring all voices can be heard.	Regularly analyse participation data to identify underrepresented groups and implement targeted engagement.	Sections 3, 6, 8, 9 and 14 specifically reference seldom-heard, vulnerable and marginalised groups.

How will the strategy, policy, plan, procedure and/or service impact on the health and well-being of our population and help address inequalities in health?

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Questions in this section relate to the impact on the overall health of individual people and on the impact on our population. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
People being able to access the service offered: Consider access for those living in areas of deprivation and/or those experiencing health inequalities Well-being Goal - A more equal Wales	Strong positive impact. The policy improves opportunities for people to provide feedback, raise concerns and influence service improvement regardless of location, disability, language or protected characteristic.	Continue monitoring demographic participation and representation.	Sections 6, 8, 9 and 14 include accessibility measures, equality monitoring and targeted engagement.

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or non-prescribed drugs plus access to services that support disease prevention (eg immunisation and vaccination, falls prevention). Also consider impact on access to supportive services including smoking cessation services, weight management services etc Well-being Goal – A healthier Wales	Indirect positive impact. Improved listening, experience collection and service improvement can enhance quality of care, patient confidence and access to preventative and support services.	Ensure learning from feedback is incorporated into prevention and health promotion initiatives.	Sections 15 and 16 require analysis, learning and quality improvement.

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions Well-being Goal – A prosperous Wales	Positive impact. The policy supports a culture where staff and service users are listened to and improvements are made in response to concerns and feedback. No negative impact anticipated.	Monitor staff feedback themes where relevant.	Sections 13, 15 and 16 support organisational learning and staff experience considerations.

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient Wales	Positive impact. Feedback mechanisms may identify environmental barriers, accessibility concerns and issues affecting patient, visitor or staff experiences.	Ensure environmental concerns identified through feedback are tracked and addressed.	Sections 15 and 16 require thematic analysis and quality improvement actions.

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
People in terms of social and community influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities	Significant positive impact. The policy promotes community involvement, citizen voice, lived experience and partnership working, strengthening community engagement and belonging.	Continue engagement with communities and underrepresented groups.	Sections 8, 13 and 14 support community engagement and lived experience involvement.
People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross domestic product; economic development; biological diversity; climate Well-being Goal – A globally responsible Wales	Limited direct impact. However, improved service quality, engagement and efficient resolution of concerns may contribute to more effective use of resources and sustainable service improvement.	Continue using feedback to inform service redesign and effectiveness.	Quality improvement and governance arrangements outlined in Sections 15, 16 and 17.

Overall EIA Conclusion

The assessment identifies a positive equality impact. The policy is specifically intended to increase inclusion, accessibility,

participation and equitable access to feedback and concerns processes. No adverse impacts have been identified. The policy contains appropriate mitigation through accessibility requirements, equality monitoring, advocacy provision, Welsh language support, multiple feedback channels and targeted engagement with seldom-heard groups. Ongoing monitoring through equality analysis and reporting arrangements will ensure any emerging inequalities are identified and addressed.

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Patient Experience, Quality and Safety Committee on 01 October 2026		Agenda Item 4.5a
Subject:	Patient Experience in Primary Care	
Approved and Presented by:	Elaine Lorton, Executive Director of Primary Community Care & Mental Health	
Prepared by:	Assistant Director of Primary Care	
Purpose:	Primary Care Services play a vital role in helping people access the right care, at the right time, and as close to home as possible. This report brings together information from General Medical Services (GMS), General Dental Services (GDS), Out of Hours (OOH) services and Wales General Ophthalmic Services (WGOS) to provide an overview of people's experiences of Primary Care independent contractor services across Powys.	
Recommendations:	The PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE is asked to: Take ASSURANCE from the arrangements in place for monitoring quality & safety in Primary Care services.	
Executive Summary:	People's experience of Primary Care services in Powys remains positive overall, with ongoing work focused on improving access, reducing inequalities and ensuring patient feedback continues to shape service improvement. The report highlights what patients tell us about their care, how people are accessing services, and where improvements are being made to support better experiences and outcomes. Patient feedback, service activity, concerns, compliments, independent reviews and quality assurance processes are used to understand what matters most to people and to inform ongoing improvement. Most patients report positive experiences of Primary Care services, feeling listened to, respected and involved in decisions about their care. Feedback consistently highlights compassionate staff, professional care and good communication across GP, Out of Hours, Dental and Optometry services. Patients are increasingly choosing digital services, with continued growth in NHS Wales App usage alongside traditional access routes. Areas for improvement include access to appointments, and waiting times remain the most common themes identified through patient feedback. Demand for NHS dental services continues to exceed available capacity, with access remaining a key concern for patients. Travel, location of services and routine access continue to affect the experience of some patients, particularly in rural communities Patient experience is monitored through multiple sources including surveys, concerns, compliments, NHS App data, Llais feedback, HIW reports and service activity information. Feedback is reviewed through established governance and monitoring processes to support continuous improvement in access, quality and people's experiences	

Introduction

- Multiple data sources are used to build a comprehensive picture of patient experience across Primary Care contractors
- This includes service capacity, access arrangements, and patient experience.
- The Primary Care Department undertakes a pivotal role in reviewing and monitoring qualitative and quantitative information sources to obtain assurance around patient experience.

GMS

- Access Standards
- Escalation Framework
- NHS App usage
- Patient contact activity
- Patient Surveys & Civica
- External intelligence e.g. HIW, Llais and RCGP Reports
- Additional Capacity and Workforce Funding
- Unified Contract Assurance Framework

OOH

- Activity and patient dispositions
- Shift fill
- SMS Surveys;
- Friends & Family Test;
- Patient Engagement Group reviews
- Concerns and Compliments
- Safeguarding flagging

GDS

- Dental Access Portal Data
- Dental Helpline Statistics
- Urgent NHS 111 pathway data
- Quality & Safety and Concerns Data
- External Intelligence e.g. NHSBSA Patient Surveys, Civica
HIW reporting, eDen performance data
- Dentally for Community Dental Services data

WGOS

- Activity
- Service provision
- PREMS

Supporting improvements to access and patient experience:

Cluster

Projects and initiatives linked to workforce, new roles, skills development and digital deployed across Powys support access and improve the patient experience

- Pharmacy Frailty Professionals
- MSK First Contact Practitioners
- Digital Access
- Stroke Prevention
- Community Pharmacy Skills Development
- Dental Frailty Nurse
- Dispensing Optician role and skills development

Evaluation of these initiatives and the impact to patient care and experience influence future longevity.

Primary and Community Care Academy

Deliver training to contractors which supports the patient experience

- Improves access and inclusion through British Sign Language interpretation, Welsh language, learning disability, health inequalities and veteran-friendly practice training.
- Strengthens communication by developing staff skills in sign posting, including listening, effective telephone approaches, interpersonal communication and managing difficult conversations.
- Helps patients navigate care through care navigation, diabetes education and improved signposting for patients and families affected by cancer.
- Promotes dignity, safety and compassion through safeguarding, chaperoning, Mental Health First Aid and Medical Examiner process training.
- Supports responsive care by helping staff recognise vulnerability, urgent situations, distress and escalating behaviour, enabling an appropriate and supportive response

Access Standards Information on physical, remote and digital access to services (includes a core and voluntary component)

- 100% practices achieve Access Standards compliance
- PTHB Access Forum meets quarterly and supports continuous monitoring and improvement of patient access and experience - achieving contractual compliance does not necessarily mean all patients feel they can access services whenever they need to, highlighting the importance of ongoing improvement and patient feedback
- The Forum Reviews Access Standards compliance; Practice Escalation Status; Activity & Demand Data; Patient Experience; Complaints & Feedback ; Good Practice & Improvement
- The Access Forum membership includes GP Practices; PTHB; LMC & Llais

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

Unified Contract Assurance Framework brings together governance, quality, compliance and practice intelligence to provide assurance that GP practices are delivering safe, effective and accessible services for patients.

Practice Escalation Framework: provides an early warning system for capacity pressures that may impact patient access and experience.

- Fewer practices are now reporting at Level 4, reflecting a clearer and more consistent understanding of the escalation criteria.
- Escalation levels are regularly monitored, with the Primary Care Department proactively supporting Practices where concerns emerge and alerting/liaising with Llais where appropriate.

NHS Wales App: supporting increased digital access, offering appointment booking, repeat prescription ordering, and access to healthcare information

- Digital access is becoming more popular, freeing up other access routes(e.g. telephone) as practices continue to provide a range of access options to ensure services remain accessible to all patients

Month Year	Distinct Logins	Appointment Bookings	Repeat Prescription Orders
July 2026	12,599	504	9,422
July 2025	8,812	351	6,829
July 2024	4,909	58	3,317

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General Medical Services: Patient Contact Activity

- Patient contact activity is populated direct from GP clinical systems into the national Primary Care Information Portal
- Patient demand remains high, with activity increasingly moving towards digital channels, however continuing to provide multiple access routes to meet the diverse needs of patients
- A snap shot of April activity comparison for 2025 and 2026 evidences increasing use of digital channels, improved telephone performance, and stable appointment activity across practices.
 - Appointment levels remained substantial, with 70,076 appointments in April 2026 compared to 68,752 in April 2025
 - A reduction in abandoned calls suggesting improved call handling.
 - Text messaging increased
 - Digital requests increased
 - Prescription activity increasing

Month	Total calls	Calls abandoned	Prescription items issued	Admin comms	Total text messages sent & received	Total digital requests submitted	Total appointments	Appointments seen	DNAs
Apr-25	97,760	7,925	283,432	53,387	47,737	31,114	68,752	65,357	3,395
Apr-26	80,524	5,523	294,233	52,477	74,253	45,600	70,076	65,474	4,602

- Telephone activity reduced between April 2025 and April 2026, while text messaging and digital requests increased significantly.
- The shift towards digital access routes does not necessarily indicate reduced demand, but rather a change in how patients contact and interact with practices.
- While digital access continues to grow, it does not meet the needs of all patients, and practices continue to offer a range of access routes, including telephone, face-to-face and online services.

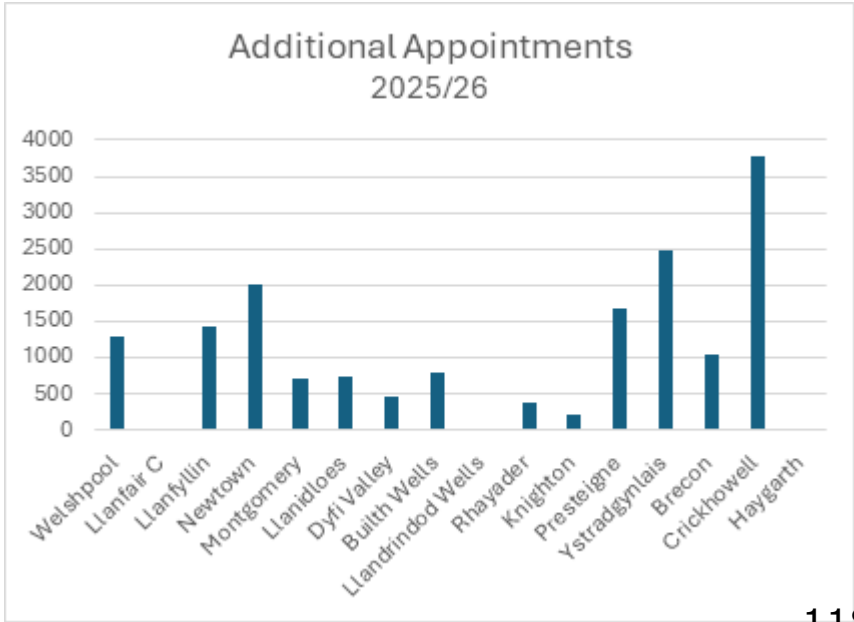
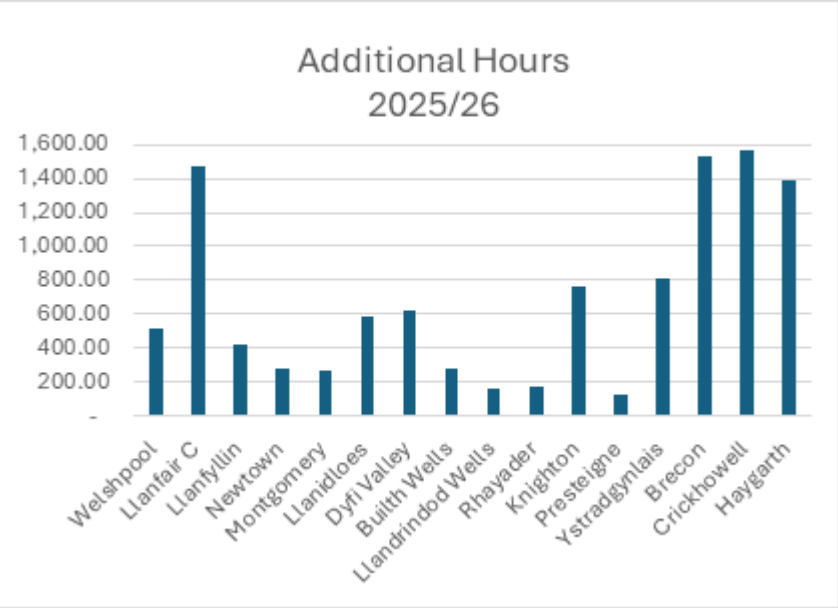
National initiatives following contract negotiations help support patient access and experience:

Additional Capacity 2025/26:

- Since 1 April 2022, national Additional Capacity funding has been available on a 50% match-funding basis, enabling GP practices to take on extra clinical and administrative resource.
- 2025/26 funding enabled **10,950 additional hours** (both clinical and non-clinical), resulting in over **16,960 extra appointments**.

Workforce Fund 2026/27:

- Introduced as part of the 2025/26 GMS Contract, to strengthen workforce capacity and improve patient access to primary care services (replaced Additional Capacity fund).
- The funding supports the delivery of the Community by Design programme and has enabled practices to invest in a wider multidisciplinary team.
- This additional capacity is helping practices respond to increasing patient demand, improve access to the most appropriate healthcare professional, reduce pressures on existing teams, offer better care navigation to support an improvement in patient experience
- The impact of this investment will be evaluated through Community by Design



- The National Patient Experience Survey (NPES) provides direct insight into patient experience and perception of access
- Practices have a mandatory obligation to undertake the survey, a minimum of 25 completed surveys per 1000 registered patients

- Patient experience across Powys GP practices was overall very positive.
 - 71.1% of respondents rated their experience between 8-10 out of 10
 - 90.4% rating it 6/10 or higher.
 - A small proportion of respondents (9.6%) rated their experience 5/10 or lower, highlighting areas where practices should continue to improve

- Patient survey findings are reviewed alongside other access measures to support service improvement and enhance patient experience.

- Practices reflect on the survey results and develop action plans to aspire to improve

- The National Patient Experience Surveys are currently underway for the 2026/27 Access Standards

2025/2026 NPES Survey results: What Patients Told Us

- 67% Always felt listened to
- 66% Always felt well cared for
- 65% Felt involved in decisions
- 76% Felt waiting times were about right
- Friendly, helpful staff
- Professional and caring teams
- Good continuity of care
- Main improvement area: appointment availability, waiting times and telephone access

Civica Patient Feedback

- Surveys completed: -
 - 25/26: 12 (+11 incomplete responses)
 - 26/27 to date: 7 (+3 incomplete responses)
- Provides an additional source of patient experience intelligence from people using primary care services.
- Themes are reviewed alongside survey findings, concerns, compliments and Llais insights.
- Whilst responses are mixed and numbers remain relatively low, feedback is shared with practices to help them identify areas of good practice and opportunities for improvement.
- Patient feedback from Civica contributes to discussions through patient experience and quality governance arrangements.

HIW, Llais and RCGP Reports provide independent feedback on patient experience and service quality

Llais Reports

- Reports following practice visits provide valuable patient insight, helping to assure that access arrangements are not only contractually compliant but are meeting patients' needs and expectations, providing a more complete picture of how patients experience access to primary care services.

Newtown Locality Engagement Report - April 2025 suggested areas for further discussion:

- Mental Health services
- Patient Feedback channels.
- Communication between services.
- Accessibility including demand.

Powys Engagement Report - Presteigne Public Forum - March 2025

- Access to GP Services
- Communication and Coordination between primary and secondary care
- Women's Health
- Mental Health
- Cross-border issues
- Practices review identified themes, consider any learning opportunities, and implement appropriate actions to improve access, communication and the overall patient experience.

HIW Inspection and Reports

- Four HIW reports were received during the reporting period
 - Dyfi Valley Health, Machynlleth 10.11.2025
 - Wylcwm Street, Knighton 23.02.2026
 - Presteigne Medical Centre 12.02.2026
 - Llanfyllin Medical Centre 10.03.2026
- These inspection reports found that patients were generally positive about the care received, staff professionalism and access arrangements.
- Practices have developed action plans to address the findings, and progress will be monitored through the UCAF process.

RCGP Reports

- External assurance is also provided by RCGP reports with two recent reviews for the following Practices:
 - Llanfyllin March 2025
 - Wylcwm Street Surgery July 2026

'Listening to People' (Putting things Right)

- All GP practice websites have recently been updated to improve visibility and awareness to patients
- Learning from patient feedback is used alongside other intelligence sources to support service improvement and assurance activities
- Feedback helps identify themes relating to patient access, communication and overall experience.
- Practice Mid-Year Access Reports includes details of complaints and concerns log that record any issues relating to access

PTHB Datix recorded concerns:

- 2025/26 : 3
- 26/27 to date = 2

Inclusion and Health Equity

- Inclusion Health is a new requirement for GMS
- Practices maintain Inclusion health registers and share intelligence at cluster level to
 - identify vulnerable patients (inc. earlier identification),
 - understand unmet need
 - improve access to appropriate services and better coordinated care
 - work collaboratively to improve access and outcomes for patients for those most at risk of poor health.
- Assurance that this is being addressed will feature in the upcoming UCAF process and data will be available from the 2026-27 cycle.
- This process will support reduced health inequalities and support a more equitable patient experience

Practice	25/26 Concerns relating to Access Issues	Rate per 1,000 registered patients
Dyfi Valley	14	2.07
Haygarth	9	1.04
Llandrindod	<5	0.28
Llanfyllin	<5	0.26
Montgomery	<5	0.12
Newtown	11	0.81
Brecon	<5	0.46
Crickhowell	6	0.48
Welshpool	<5	0.18

- Practices with '0' access concerns in this period are not listed
- Where concerns are less than 5, it is identified as <5 to protect confidentiality

Accessible Communication Standards

- Practices have a requirement to support patients by ensuring that patients can access information and services in a way that meets their communication needs.
 - Identifying and recording communication needs
 - Providing information in accessible formats where required
 - Supporting people with sensory loss, learning disabilities or communication difficulties
 - Promoting the Active Offer and access to Welsh language services
 - Making reasonable adjustments to improve access to care

Patient Access:

- 38,263 patients accessed NHS dental treatment in 2025/26
- 10,257 patients have accessed NHS dental treatment between April and August 2026
- The Dental Access Portal (DAP) provides a fair and transparent mechanism for allocating routine NHS dental places

Pt/DAP Stats	2025/26	2026/27*
Patients Treated	38,263	10,257
Awaiting Offer on DAP	5,426	5,110
Patient Offers Sent	2,269	3,943

*2026/27 data is to 31/08/26

- The number of patients awaiting a service offer from the DAP has reduced from 5,423 at 31/03/26 to 5,110 as at 11/09/26.
- Approximately 23% of offers made to patients receive no response, highlighting an ongoing opportunity to improve patient engagement and utilisation of available NHS dental capacity. Ongoing discussions taking place with Comms Team
- A significant number of patients have successfully accessed care during the reporting periods with an increase in patient offers in 2026/27 due to the new contract regulations
- Demand continues to exceed available NHS capacity within Powys, despite increased patient offers and ongoing recovery of routine access

Patient Offer Outcomes

(*2026/27 data is at 11 Sep 2026)

Outcome	2025/26	2026/27*
Accepted Offer	1,444	2,851
Declined Offer	342	134
No Response	798	907

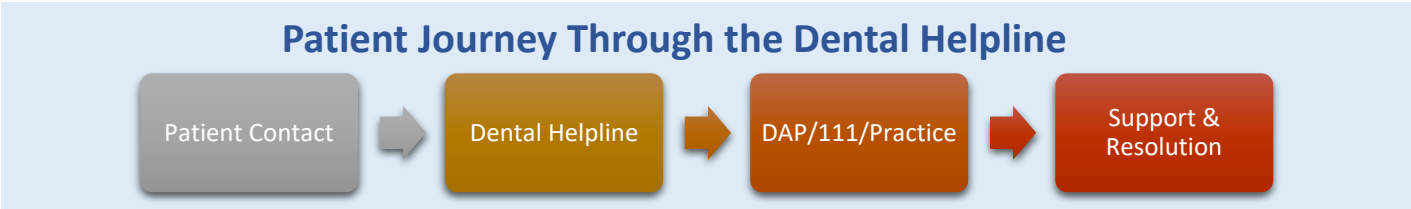
Dental Helpline:

- Patients seeking NHS Dental care have a single point of contact via the Dental Helpline
- Patients are supported to navigate routine and urgent dental access pathways, including the Dental Access Portal (DAP) and NHS 111
- Helpline activity provides valuable insight into patient concerns and emerging access pressures across PTHB NHS Dental Services

Patient Contacts & Outcomes

(*2026/27 data is at 10 Sep 2026)

Call Outcome	2025/26	2026/27*
Dental Helpline Contacts	3,603	1,907
Directed to 111	555	268
Calls related to Concerns	148	42
DAP Related Calls	1,822	886
Other	1,078	711



Top Reasons for Dental Helpline Contact:

- Access to NHS Dentists
- Waiting List and DAP Enquiries
- Dental Pain & Urgent Care
- Practice Closures/Service Changes
- Referral & Orthodontic Queries

Key Patient Experience Themes

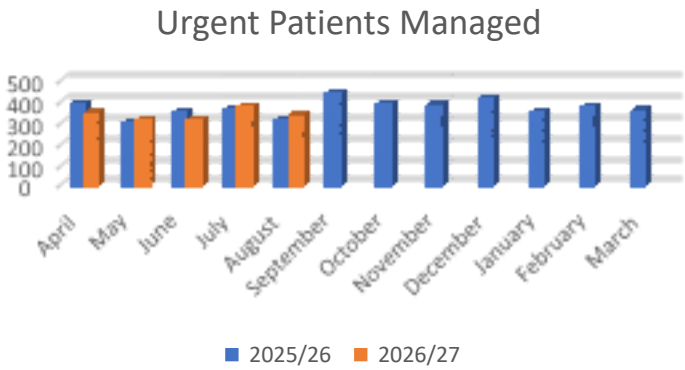
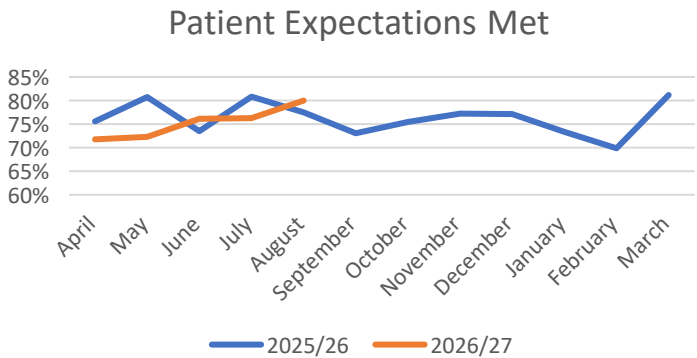
- Growing frustration regarding access
- Increased demand following practice changes
- Higher demand for DAP support
- Continued pressure on urgent care pathways

Urgent access pathway:

- Patient’s experience within the urgent dental pathway has remained positive during 25/26 and 26/27 to date, with patient expectations met for circa 75% of patients.
- Whilst the 2026/27 year-to-date average remains comparable with 2025/26, patient expectations improved from 72% in April 2026 to 80% in August 2026
- Travel distance and appointment location continue to be the most common factors affecting patient experience

Urgent Care Stats	2025/26	2026/27*
Urgent Patients Managed	4,406	1,669
Patient Experience Met	76%	75%

*2026/27 data is as of 31st August



Expectations Met	Expectations not met	Mitigated Outcomes
• The patient was offered and booked an appointment, with no subsequent notification that the appointment was not attended	• The patient did not proceed with the offered appointment • The patient could not be contacted or declined the appointment • The patient was redirected to an alternative care pathway	• The patient initially accepted the appointment but did not subsequently book • NHS 111 or out of hours advice was provided • The patient already had access to an NHS dentist and was directed back to their own practice

Patient expectation criteria used:

Concerns:

- All practices are aware of the new ‘Listening to People’ act that came into force on 1st April 2026
- Formal concerns continue to be driven primarily by access to NHS dental services, rather than clinical quality.
- Concern levels during 2026/27 are expected to exceed previous years, reflecting ongoing access challenges across Powys
- Themes Identified:
 - Access to NHS Services
 - Practice closure and contract changes
 - Waiting times for routine treatment
 - Access to ongoing care following practice closure
 - Referral and orthodontic pathway enquiries

PTHB Quality & Safety Data	2025/26	2026/27*
Enquiries/Complaints	72	27
Compliments	1	0

*2026/27 data as of 11th September

Patient Survey:

- Completed annually by the NHS Business Service Authority (NHSBSA)
- 2025/26 Survey results: 433 responses - 421 related to routine care and 22 related to urgent care
- Themes conveyed a positive experience when accessing NHS dental services

NHSBSA Survey Data	2025/26
Staff Helpful	96%
Staff Respectful	97%
Happy to Travel	88%
Convenient Appointment	95%
Involved in Care Decisions	96%

- Also 95% patients understood the importance of attending future appointments (to support reduced risk and prevention) within the recommended timeframe

Patient Access:

- Access pathways in place for vulnerable, complex and high-needs patients, including a sedation service.
- Patients who experience barriers to access in PTHB clinics are supported through domiciliary provision and specialist dental care.
- Severely frail housebound patients are supported by a dedicated Frailty Dental Nurse via a Cluster project, improving patient experience and access to services.
- A significant proportion of activity relates to continuing care and treatment pathways, supporting patients with complex, additional or long-term dental needs to receive care they require closer to home.
- Cancellations and non-attendance remain a challenge, however many patients supported by the service face additional health, social, mobility or accessibility barriers, highlighting the importance of flexible and patient centred approaches to care.

Appointment Outcomes:

Outcome	2025/26 Total	2026/27 Total (as of 31 st Aug 26)
Completed Routine Appointments	13,564	5,473
Completed Emergency Appointments	2,957	1,024
Cancelled	8,028	4,088
Did Not Attend	1,366	585
Other	10	4
Total	25,925	11,174

Shropdoc:

- 85% cases managed and closed by Shropdoc (2025/26), enabling a good patient experience
- Shift fill rates for OOH bases across the county are consistently covered supporting excellent patient access - 98-100% cover
- Safeguarding flagging in place with PTHB Safeguarding team and General Practice. All at-risk patients are notified to Shropdoc
- Patient experience is informed through SMS Surveys; Friends & Family Test; Concerns and Compliments
- Patient experience, feedback and outcomes are systematically considered in service monitoring, quality improvement and decision-making
- Patient Engagement Group in place as a structured approach to patient experience reporting and quality improvement
 - Review themes from surveys, complaints, concerns and compliments – quarterly
 - Analyse patient stories and feedback
 - Routinely review poor patient feedback
 - Identify opportunities for service improvement
 - Improve engagement with seldom-heard groups
 - Promote learning from patient experience
- In addition, clinical governance reviews, incidents and learning reviews consider the patient journey and outcomes
- Patient experience remains positive, with low levels of complaints and concerns consistent with previous years and indicating no emerging quality issues.
- Compliments recognise compassionate, professional and effective care

Concerns:

- 6 concerns received during 2025/26
 - NHS 111 delays and access
 - Cross-border access issue
 - Communication and patient expectations
 - Concerns following patient deterioration
 - Verification of Expected Death procedure

SMS Survey Responses:

- Positive feedback consistently highlighted kindness, professionalism and reassurance
- Compassionate and caring staff
- Professional clinical care
- Patients felt listened to
- Effective communication and reassurance

Compliments:

- 13 received during 2025/26
- “Outstanding experience”
 - “Kind, helpful and patient”
 - “Professional and reassuring staff”

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SBUHB:

- Patient surveys are undertaken, and evidence of service user experience is used to drive improvement.
- No patient concerns regarding access to OOH services were reported in 25/26 and have not been to date for 2026/27.

PTHB OOH Concerns:

- During 2025/26, PTHB received no concerns relating to GMS OOH services from either Shropdoc or Swansea Bay

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Patient Access and Experience

- Patients accessing optometry services, including sight testing and Low Vision Services, are invited to complete a standard national questionnaire following their appointment to provide insight and support quality improvement.
- Responses are collected centrally and reported through NHS Wales patient experience reporting systems.
- Questions focus on waiting times, communication, involvement in care, dignity and respect, and overall experience
- All practices are aware of the new Listening to People process that came into force on 1st April 2026

Powys-specific results

- 2025/26 is the first time PTHB has received Optometry results reported separately at Health Board level
- Previously, patient experience data was not available in a format that enabled analysis of Powys responses
- Although response numbers are currently low (12 in total), Health Board-level reporting provides an important baseline for understanding patient experience and for monitoring trends over time.

Sight tests (11 responses)

- 91% very good overall experience
- 100% felt well cared for
- 100% treated with dignity and respect

Key Themes

- Friendly, welcoming and caring staff
- Professional and efficient service
- Thorough assessments and clear explanations
- Timely access to appointments
- No significant negative feedback reported

Low Vision Service (1 response)

- 100% Very good overall experience
- Felt well cared for
- Treated with dignity and respect
- Involved in decisions about care
- Information was easy to understand
- "I was treated with the utmost care and consideration"

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE on 15 October 2026		Agenda Item 4.5b
Subject:	Quality & Safety in General Dental Services	
Approved and Presented by:	Elaine Lorton, Director of Primary, Community Care & Mental Health	
Prepared by:	Assistant Director of Primary Care & Associate Dental Director	
Purpose:	To provide assurance that robust systems and clinical governance arrangements are in place to monitor quality and safety across General Dental Services in Powys.	
Recommendations:	The PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE is asked to: Take ASSURANCE from the arrangements in place for monitoring quality & safety in General Dental services (GDS).	
Executive Summary:	A comprehensive range of regulatory, clinical, contractual and patient-experience information supports the identification, monitoring and escalation of quality and safety concerns regarding the delivery of general dental services (GDS) across PTHB. This paper provides assurance on the processes used and a current status update. Key monitoring and assurance processes undertaken by the GDS Monitoring Group include - General Dental Council registration and Dental Performer List compliance - Healthcare Inspectorate Wales intelligence sharing - PTHB Quality and Safety Team oversight of concerns, clinical incidents, 'Listening to People' and Duty of Candour - Contractor Quality Assurance Scheme and clinical governance self-audit - Annual and Mid year Contract Reviews, including practice inspections and document checks - NHS Business Services Authority Clinical Record Card Reviews - NHSBSA and CIVICA Patient Satisfaction Surveys - PTHB Dental Helpline patient feedback and soft intelligence - PTHB Medicines Management Team monitoring of dental prescribing Escalation processes are in place proportionate to issues identified.	

Overview of Quality & Safety Monitoring Processes:

The GDS Monitoring group meets monthly to

- Oversee quality, safety and contractual performance within contractual and regulatory requirements
- Ensure dental services are delivered within the Welsh Government GDS financial allocation
- Review intelligence from multiple assurance sources
- Consider and escalate concerns through established PTHB governance arrangements

Group membership includes clinical, contractual, finance and Quality & Safety representation.



Robust regulatory oversight: Assurance is in place to ensure all dental professionals delivering NHS services in Powys remain appropriately registered, qualified and subject to professional regulation.

General Dental Council (GDC)

- All Dentists and Dental Care Professionals must maintain GDC registration as a mandatory requirement for practice
- Annual renewal and CPD requirements support ongoing professional competence
- Five-year revalidation cycle provides assurance that practitioners remain fit to practise
- Intelligence regarding fitness to practise concerns is shared with Health Boards where appropriate

Workforce Assurance

- Powys has adopted the Welsh Dental Directors Group Interim Management Process (IMP) for Overseas Registration Examination (ORE) qualified dentists
- The process provides structured supervision, support and monitoring to ensure safe integration into NHS dental practice
- Progress is reviewed through established governance arrangements and linked to performer oversight processes
- Supports workforce sustainability whilst maintaining patient safety and quality standards

Dental Performers List (DPL)

- NHS dentists must be included on a Welsh Dental Performers List in addition to GDC registration
- Inclusion requires enhanced DBS checks, references and regulatory declarations
- Annual validation exercises ensure performer records remain accurate
- NWSSP data cleansing exercises support ongoing list accuracy
- Performer concerns are reviewed through established quality and safety governance arrangements and escalated to the Medical Director where appropriate
- Concerns are managed in accordance with the national Framework for the Management of Performance Concerns
- Proportionate escalation processes support patient safety whilst ensuring fairness to practitioners

Current Status:

- Information redacted as identifiable.

Intelligence Led Monitoring: A range of national and local intelligence sources are used to identify emerging quality, safety, performance and probity concerns, enabling the Health Board to respond proportionately and at an early stage where concerns are identified

NHS Business Services Authority (NHSBSA) Activity Monitoring

- Activity data collected for all NHS treatments
- Monitoring undertaken at contract, practice and performer level
- Benchmarking against local and national comparators
- Trend analysis used to identify unusual treatment patterns

Clinical Policy Advisor (CPA) Support

- NHSBSA CPAs provide expert interpretation of activity information
- Targeted reviews, both immediate and routine are commissioned by PTHB where concerns or anomalies are identified (may arise from referrals, complaints, unusual activity patterns or emerging intelligence)
- Immediate Assurance Reports provide rapid assurance regarding specific treatment patterns, performers or contracts
- Findings and outcome support informed decision making through the GDS Monitoring Group

Clinical Record Card Reviews (CRRs)

- Include detailed review of patient records, radiographs and supporting evidence
- Assess clinical quality, record keeping and treatment appropriateness
- Provides assurance regarding both quality and probity
- Recommendations and actions reviewed through the GDS Monitoring Group

Self-Audit Reports

- Contractors complete self-audits to support monitoring and assurance
- Findings help identify areas requiring improvement or additional support

Current Status:

- During 2025/26, five Clinical Record Card Reviews were undertaken by NHSBSA
 - Four reviews were completed and reviewed through established governance arrangements
 - One review was not completed as the contract terminated before the required records were provided
 - One completed review resulted in a recommendation for a repeat Clinical Record Card review, which is anticipated to take place later during 2026/27
- No practices have been subject to a Clinical Record Card Review during 2026/27 to date

Patient Experience & External Intelligence:

Patient & External Assurance Sources:

Patient feedback and independent external intelligence provide valuable assurance regarding the quality and safety of services.

Patient Satisfaction Surveys

- NHSBSA patient satisfaction surveys provide independent feedback from service users
- Results help identify strengths, trends and opportunities for improvement
- Feedback supports constructive discussions with contractors

Powys Dental Helpline

- Offers support and signposting for patients
- Provides valuable soft intelligence regarding access and patient experience
- Can identify emerging concerns before formal complaints arise

Health Inspectorate Wales (HIW)

- HIW inspections provide independent scrutiny of dental practices
- Intelligence is shared with Health Boards where practices provide both NHS and private services
- Inspections include assessment of premises, governance and patient safety arrangements

Quality & Safety Intelligence

- Input from the PTHB Quality & Safety Team
- Review of concerns, incidents and 'Listening to People' information
- Duty of Candour intelligence considered where applicable
- Emerging themes are triangulated with other assurance sources to identify risks and inform improvement activity

Current Status:

- One practice currently designated as a Service of Concern by HIW regarding private dentistry.
- During 2025/26, 72 Formal Enquiries/Complaints received through the Quality & Safety Team. So far in 2026/27, 29 formal enquiries/complaints have been received as of 9th September.
- 2025/26: 3,605 Dental Helpline contacts. 2026/27: 1,893 Dental Helpline contacts as of 9th September.
- Formal concerns and complaints continue to be driven primarily by access to NHS dental services, rather than concerns regarding clinical quality. Key themes include difficulty securing NHS dental care, lengthy waiting times, the impact of practice closures, access to urgent treatment, and communication regarding referral and allocation processes. A smaller number of concerns relate to treatment outcomes, referral delays and the needs of vulnerable patients.
- In 2025/26 there were 443 responses to the NHSBSA patient surveys with 421 responses relating to routine general dental care, and 22 responses for urgent care. 87% of patients were happy with the distance travelled. Further analysis of patient experience is included in the Patient Experience in Primary Care report, being presented to PECS 15/10/26.

Quality Governance Framework: Quality assurance is achieved through a combination of self-assessment, independent review, contractual oversight and continuous improvement processes. Findings from all assurance activities are reviewed through the GDS Monitoring Group and escalated where required.

Quality Assurance Scheme (QAS)

- Annual self-assessment completed by all NHS dental contractors – mandatory requirement
- Reviews infection prevention and control, safeguarding, health & safety, workforce training and clinical governance
- Supports early identification of compliance gaps and improvement opportunities
- Action plan and follow-up monitoring in place

Contract Review & Validation

- Mid-year and annual contract reviews undertaken with all contractors
- Validation of evidence submitted through the Quality Assurance Scheme
- Reviews workforce, governance arrangements, activity performance and quality indicators

Learning & Improvement

- Action plans developed where improvement opportunities are identified
- Progress monitored through established governance arrangements
- Learning shared locally and through all-Wales dental quality and safety networks
- Attendance at national dental quality and safety meetings ensures awareness of emerging risks, best practice and policy developments

Duty of Candour

- Contractors are required to comply with Duty of Candour requirements where thresholds are met
- Compliance and governance arrangements are monitored through quality assurance processes
- Intelligence from incidents and patient feedback informs continuous improvement activity
- Validation of evidence submitted through the Quality Assurance Scheme

Current Status:

- 2025/26: 100% of QAS completed - 5 practices were subject to routine action plans , requiring further assurance. All areas resolved/completed by 3/03/26
- 100% Annual contract reviews completed for 2025/26
- There were no instances of Duty of Candour in 2025/26, and none have been reported so far in 2026/27

Escalation processes: Concerns are reviewed on a case-by-case basis and managed proportionately according to the level of risk identified. Established governance processes ensure appropriate oversight and escalation where required, initially through the GDS monitoring Group

Area of Concern	Potential Response
Performer Concerns	● Performer List Review Process/GDC
Probity Concerns	● Counter Fraud Referral /GDC
Regulatory Issues	● GDC / HIW Liaison
Performance Concerns	● Enhanced Oversight
Clinical Quality Concerns	● Record Card Review / Action Plan
Patient Complaints	● Investigation & Monitoring

● Routine Management ● Enhanced Oversight ● Formal Escalation

Next Steps:

- Continue monthly oversight through the GDS Monitoring Group
- Maintain established quality, safety and governance assurance arrangements
- Monitor active performer, regulatory and contract-related matters through established escalation processes
- Progress the anticipated repeat Clinical Record Card Review and monitor any subsequent recommendations
- Continue implementation of the IMP process to support safe workforce development and sustainability

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Agenda item: 4.6

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE		15 OCTOBER 2026	
Subject:	Medicines Management and Pharmacy Annual Report		
Approved and presented by:	Kate Wright, Executive Medical Director		
Prepared by:	Chief Pharmacist		
Other Committees and meetings considered at:	Executive Committee 01 October 2026 who supported the paper to the Committee.		
PURPOSE:			
To present the Medicines Management and Pharmacy annual report, summarising the team’s contribution during 2025/26 and the main priorities and risks for 2026/27.			
RECOMMENDATION(S):			
The Patient Experience, Quality and Safety Committee is asked to:			
• RECEIVE the 2025/26 Medicines Management and Pharmacy Annual Report and take ASSURANCE from the governance and improvement work evidenced in the annual report; and • NOTE the risks and priorities requiring continued oversight.			
Approve/Take Assurance		Discuss	Note
Y		N	Y
ALIGNMENT WITH THE HEALTH BOARD’S WELLBEING OBJECTIVES:			
Joined up care, workforce, digital first and partnership		Y	Clinical care across Powys, development of pharmacy roles and joint digital medicines work
EXECUTIVE SUMMARY:			
The Medicines Management and Pharmacy Team supports patients across Powys, from hospital wards and care homes to general practice, community pharmacy and specialist services commissioned in Wales and England. The team delivered £2.7m of prescribing efficiencies in 25/26, recorded 566 clinical interventions on our community hospital wards and supported all 40 care homes across Powys. Enhanced coordination of supply supported 39,019 adult influenza vaccinations delivered by general practice and community pharmacy (9.5% increase on 2024/25). Two of our clinical pharmacists qualified as independent prescribers with clear plans to use this qualification to support safe medical care in our			

community

services.

Total and broad-spectrum antibiotic prescribing fell drastically, though appropriate use of WHO Access antibiotics (66.2%) remains below the 70% target and will be a priority area for work on antimicrobial stewardship in 2026/27. Established safety and prescribing oversight provides assurance about our medicines management arrangements, while outcomes of our new electronic prescribing system will be a focus of the teams work over then next year. Priorities for 2026/27 include electronic prescribing, mental health pharmacy development, continued antimicrobial improvement and managing workforce, storage and cross-border risks.

NEXT STEPS:

In 2026/27, we will support safe use of electronic prescribing and medicines administration, then extend patient self-administration beyond the first two wards as the system becomes embedded. We will establish the funded mental health pharmacy roles and help qualified prescribers use their skills in clinical services. Intervention and incident data will guide further prescribing education and safety work, while we progress Blueteq to strengthen oversight of high-cost treatment through commissioned providers. We will track outcomes and financial delivery, and report progress and material risks through established governance routes

The Chief Pharmacist will monitor delivery and escalate material risks through established governance routes. The annual report is attached.

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Medicines Management and Pharmacy Annual Report 2025-26

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Medicines Management and Pharmacy Annual Report 2025-26
Author: Jonathan Boyd, Chief Pharmacist
Date: September 2026

1 Chief Pharmacist overview

Medicines Management and Pharmacy supports patients throughout Powys, connecting care in our community hospitals, general practices, community pharmacies and social care services with specialist treatment delivered by providers in Wales and England. This report describes our contribution during 25/26 and the priorities for 26/27.

The year combined essential clinical care and medicines supply with improvements in prescribing, vaccination and professional practice. The team delivered £2.7m of prescribing efficiencies, supporting the financial sustainability of services and continued access to treatment. Coordinated influenza vaccine supply supported 39,019 adult vaccinations delivered by general practice and community pharmacy, approximately 9.5% more than in 24/25. Reported antibiotic prescribing also reduced markedly demonstrating improved practice, although some targets remain for the current year.

Clinical pharmacy colleagues recorded 566 prescribing interventions, where pharmacists identified and resolved potential prescribing issues, helping to improve patient safety and the quality of prescribing. Recurring themes were used to inform guidance and educational events. Medicines management support reached all 40 care homes in Powys, through visits or remote advice. Pharmacy technicians contributed to national work on self-administration of medicines, while two clinical pharmacists qualified as independent prescribers. Funding approved for dedicated mental health pharmacy posts provides a basis for further service development in 26/27.

Established arrangements for clinical review, incident investigation, prescribing oversight and stock management provide assurance about the processes supporting safe medicines use. Continuing challenges include workforce capacity, medicines storage temperatures in extreme heat and inconsistent discharge information from English providers. Digital development offers opportunities to improve access to medicines information, with benefits requiring further research and evaluation as systems are widely implemented across services.

The Board is invited to note the team's contribution and the priorities set out in section 7. Sustaining improvements will depend on effective partnership working, appropriate workforce capacity and continued attention to emerging risks and outcomes.

I would like to thank colleagues across the team and our partner services. Their expertise, practical support and commitment make an essential contribution to patient care across our large rural county.

Jonathan Boyd
Chief Pharmacist

2 Our team and responsibilities

2.1 The service across Powys

The Medicines Management Team's responsibilities include direct clinical care, medicines governance, support to primary care, oversight of community pharmacy services and scrutiny of medicines used by commissioned providers. These functions connect care within Powys with the specialist services residents access elsewhere.

Clinical pharmacy support reaches all community hospital sites and community teams. Cover is organised around patient need, combining visits with remote advice and close working relationships with local colleagues. The frequency and nature of on-site support vary between services. Electronic prescribing is a key development to strengthen access to medicines information across this dispersed service.

Function	Contribution to care
Clinical pharmacy and medicines management nursing	Medication histories, prescribing review, safe administration, discharge planning, incident investigation and staff education
Primary care medicines optimisation and dietetics	Practice support, prescribing analysis, education and appropriate use of medicines and nutritional products
Community pharmacy services	Commissioning, contractor support, access and service assurance
Medicines supply and vaccination	Ordering, distribution, storage, temperature monitoring and waste reduction
Formulary and high-cost medicines	Evidence review, treatment access, commissioned medicines oversight and commercial arrangements
Governance, development and digital medicines	Medicines safety, controlled drugs, medical gases, prescribing competence, digital systems and workforce development

2.2 Workforce and resources

Recruiting, retaining and developing our workforce is essential to sustaining pharmacy services across Powys and delivering improvements in care. Workforce developments include expanding our professional roles and progressing work to establish additional specialist mental health pharmacy capacity.

The workforce profile provides current service context, rather than a year-end position. Whole-time equivalent (WTE) expresses staffing in full-time posts.

Staff group	Core staff	Core WTE	Establishment WTE
Pharmacists	13	11.70	13.10
Pharmacy technicians	15	13.96	15.36
Assistant technical officers	4	2.40	2.45
Medicines management nurses	2	0.90	0.90
Dietitian	1	0.80	0.80
Administration and data	3	2.40	2.94
Total	38	32.16	35.55

The profile identifies approximately 1 WTE of temporary cover. The difference between core staffing and establishment illustrates the importance of timely recruitment processes, retention of staff and appropriate future workforce planning.

2.3 Working with partners

The team works closely with clinical and operational services, Public Health, primary care contractors, Powys County Council, Health Education and Improvement Wales (HEIW) and provider pharmacy teams in Wales and England. This includes resolving individual medicines problems, supporting contractual assurance and developing shared policies and training. National representation brings Powys experience into work focussing on antimicrobial stewardship, community pharmacy, digital prescribing and patient independence.

3 Safer medicines and reliable services

3.1 Governance and assurance

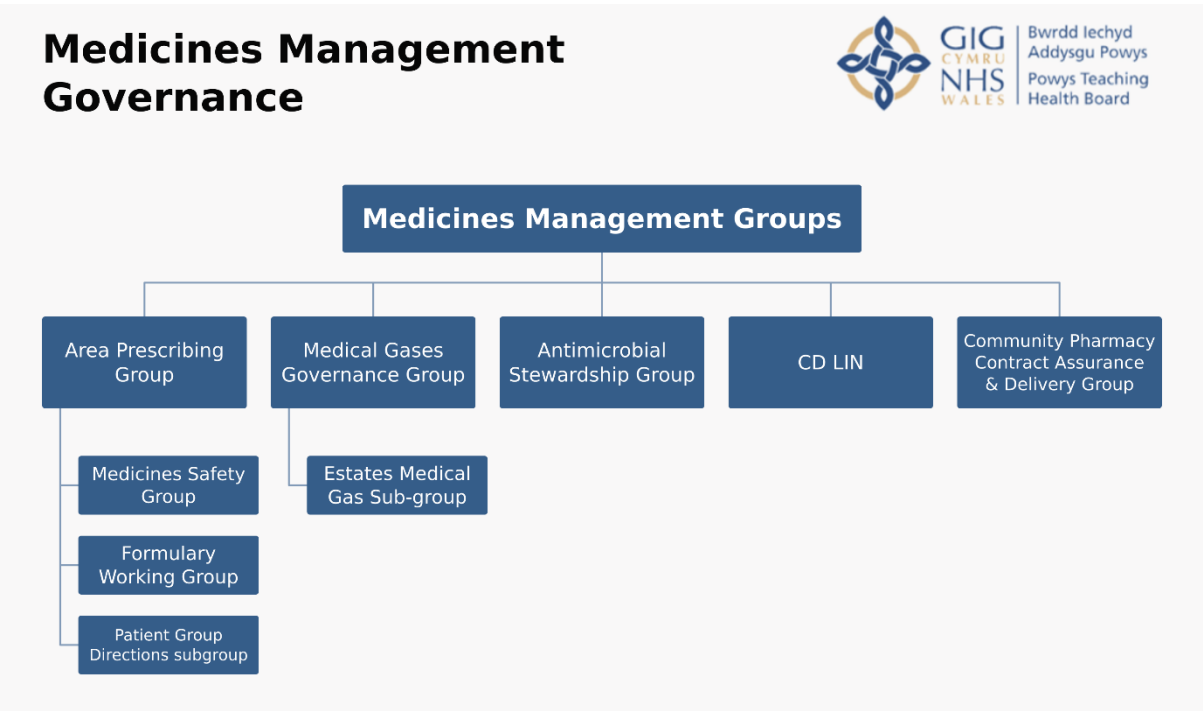
The Chief Pharmacist provides professional leadership for medicines across the health board. The Area Prescribing Group (APG), supported by specialist subgroups, reviews medicines policy, prescribing and safety. This work supports the clinical governance and assurance information presented to executives and the Board.

The Formulary Working Group considers all applications for medicines, appliances and devices, including new uses of existing products. It brings together clinical evidence, patient experience, safety, cost-effectiveness and place in treatment pathways. Recommendations and formulary changes are reported to APG for ratification.

The Medicines Safety Group reviews incidents, national alerts and improvement work. The Medication Safety Officer connects local services with the national safety network and promotes reporting of suspected adverse drug reactions through the Yellow Card scheme. Pharmacy also

contributes to controlled drug oversight, the Controlled Drugs Local Intelligence Network, medical gases governance and evidence reviews for individual treatment funding decisions.

Community pharmacy contract assurance and delivery arrangements support oversight of contractor services. Alongside this, pharmaceutical needs assessment work informs planning for access to community pharmacy across Powys.



3.3 Vaccination and temperature monitoring

The Medicines Management Team supported vaccination programmes during 25/26 by coordinating supply, protecting stock quality and reducing avoidable waste. Working with Public Health, vaccination services, general practice and community pharmacy, the team helped match vaccine availability to local demand.

Central procurement supported the seasonal influenza programme. Preparatory work included supply arrangements, allocation of health board stock, contractor communication and vaccine refrigerator audits. Contractors provided positive feedback on ordering, supply and communication.

Provisional figures show 39,019 adult influenza vaccinations, an increase of 3,372 (9.5%) compared with 24/25. These figures reflect delivery by vaccination providers, supported by coordinated supply arrangements.

Adult influenza vaccinations	24/25	25/26
Community pharmacy	3,866	4,287
General practice	31,781	34,732
Total	35,647	39,019

Regular reviews of orders, stock levels and expiry dates also supported COVID-19 and school influenza programmes. With School Nursing Services, the team improved forecasting and ordering, reviewed stock and supported redistribution of surplus vaccines. Reported school influenza vaccine wastage fell from approximately £35,000 in 23/24 to £2,394 in 25/26, a substantial reduction over two years.

Data loggers continuously monitor medicines refrigerator temperatures, while thermometers monitor ambient storage conditions. When temperatures fall outside the required range, pharmacy colleagues assess stock suitability, advise services and investigate causes. Learning from these incidents informs procedures and training to help prevent recurrence.

The Pharmacy Stores Team reported that an external cold chain audit identified no significant concerns about our vaccine storage, handling or temperature monitoring. Improvement actions focused on stock reconciliation and enhanced data collection, with work continuing to ensure colleagues throughout the health board are familiar with best practice cold chain storage.

Limited storage capacity and high ambient temperatures in parts of the estate remain operational challenges especially throughout the summer months. Priorities include progressing audit actions, strengthening stock and wastage information, and developing electronic vaccine ordering to improve the completeness and traceability of requests.

3.4 Antimicrobial stewardship

Antimicrobial stewardship supports effective infection treatment while reducing unnecessary antibiotic use and helping preserve antibiotics for the future. During 25/26, our dedicated

antimicrobial stewardship pharmacist worked with general practice and community hospitals to review prescribing, provide clinical advice and support improvements in practice.

The improvement plan first initiated in 2024 was judged complete and replaced by an ongoing health board workplan, overseen by the Antimicrobial Stewardship Group. Prescribing data informs targeted practice support through audit, feedback and clinical education. Community hospital work included reviews against local online guidance, feedback to ward teams and regular antimicrobial ward stock reviews.

The March 2026 update showed reductions in total and broad-spectrum prescribing, although the target for antibiotics in the World Health Organization's Access category remains unmet.

Primary care prescribing measure	Reported position
Total antibiotic prescribing	8.6% lower in Q4 25/26 than the Q4 19/20 baseline
Broad-spectrum 4C antibiotics: co-amoxiclav, cephalosporins, fluoroquinolones and clindamycin	15.4% lower in Q4 25/26 than Q4 24/25
Antibiotics prescribed from the Access category	66.2%, against a target of 70%

Percentage reductions are calculated from the reported prescribing values. The Access measure expanded during 25/26 to include wider primary care prescribing, including out-of-hours and pharmacy independent prescribing services, limiting direct comparison with earlier years.

The team has developed local guidance and patient information, and delivered education through induction, preceptorship, professional training and general practice protected learning time events. Penicillin allergy de-labelling work progressed across primary care and community hospitals, aiming to remove inaccurate allergy records following appropriate assessment and support suitable antibiotic choices. Participation in Welsh antimicrobial groups enabled Powys to contribute to national improvement work.

Priorities for 26/27 are to sustain these prescribing improvements, address unwarranted variation across practices and improve performance against the national Access target. Further work will establish the reach and outcomes of penicillin allergy de-labelling and use audit findings to guide targeted support.

3.5 Authorised medicines use and medical gases

The team supports timely treatment through Patient Group Directions (PGDs) and medicines protocols. PGDs enable authorised healthcare professionals to supply or administer specified medicines to defined groups of patients without an individual prescription, within agreed conditions.

During 25/26, the team developed or reviewed 66 PGDs and nine medicines protocols. The portfolio comprises 69 PGDs within health board services and a further 28 in community pharmacies.

Multidisciplinary development and oversight through the PGD Sub-Group support consistent practice, with documents published on the health board website.

Review of the PGD framework proposed clearer responsibility for service leads to audit use in their clinical areas. The proposed change supports local accountability for staff authorisation, competence, record keeping and use of current documents. Pharmacy colleagues also contributed to preparations for Vaccine Group Directions, developing local governance arrangements, guidance and implementation plans.

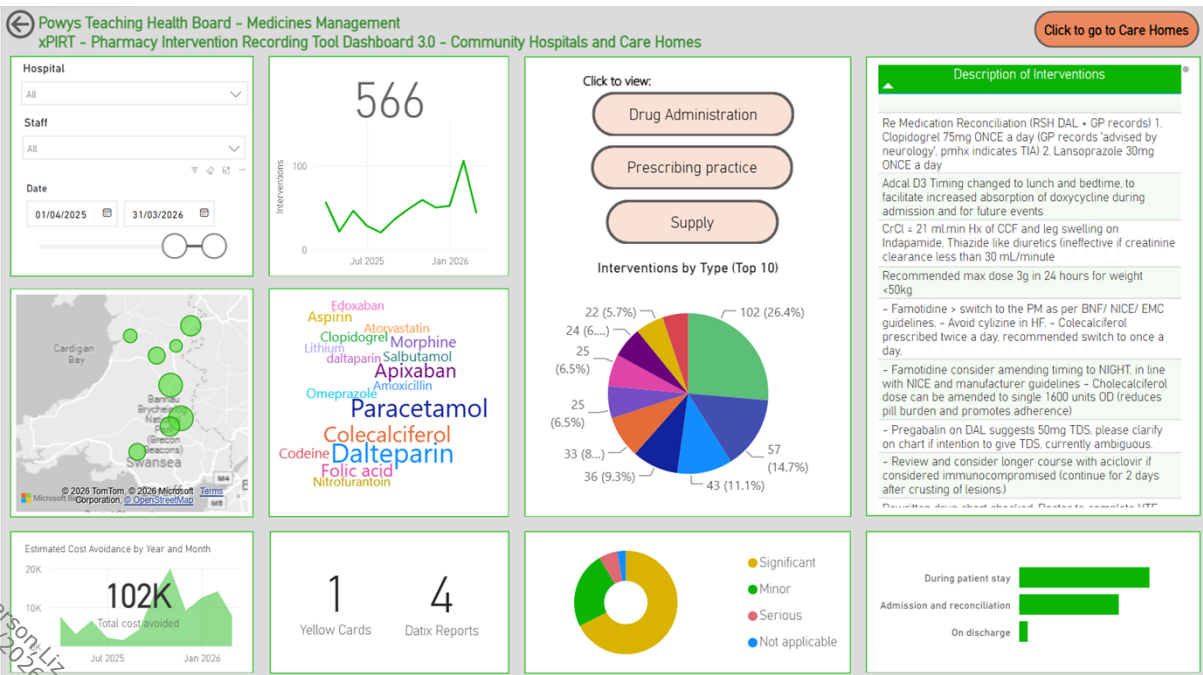
Pharmacy contributes to medical gases oversight and a dedicated working group reviewing cylinder management throughout the health board. This work brings together safety, staff training and procurement considerations, with opportunities to improve purchasing, reduce unnecessary stockholdings and limit rental costs and emergency orders.

Priorities for 26/27 are to progress the revised PGD framework through approval and implementation, support Vaccine Group Directions where applicable, and improve medical gas cylinder management. Financial benefits from cylinder changes will be reported as delivery is evidenced.

4 Care and access across Powys

4.1 Clinical pharmacy and safer transfers of care

Clinical pharmacy teams work alongside hospital and community colleagues to support safe medicines use from admission through to discharge. Pharmacists, pharmacy technicians, medicines management nurses and assistant technical officers check medication histories, review prescriptions, support safe administration, coordinate supplies and help patients and carers understand treatment. Medicines reconciliation, checking that medicine lists are accurate when patients move between services, is central to this work.



During 25/26, the team recorded 566 clinical interventions through the Pharmacy Intervention Reporting Tool. Power BI analysis identified recurring prescribing issues and informed education and improvement work.

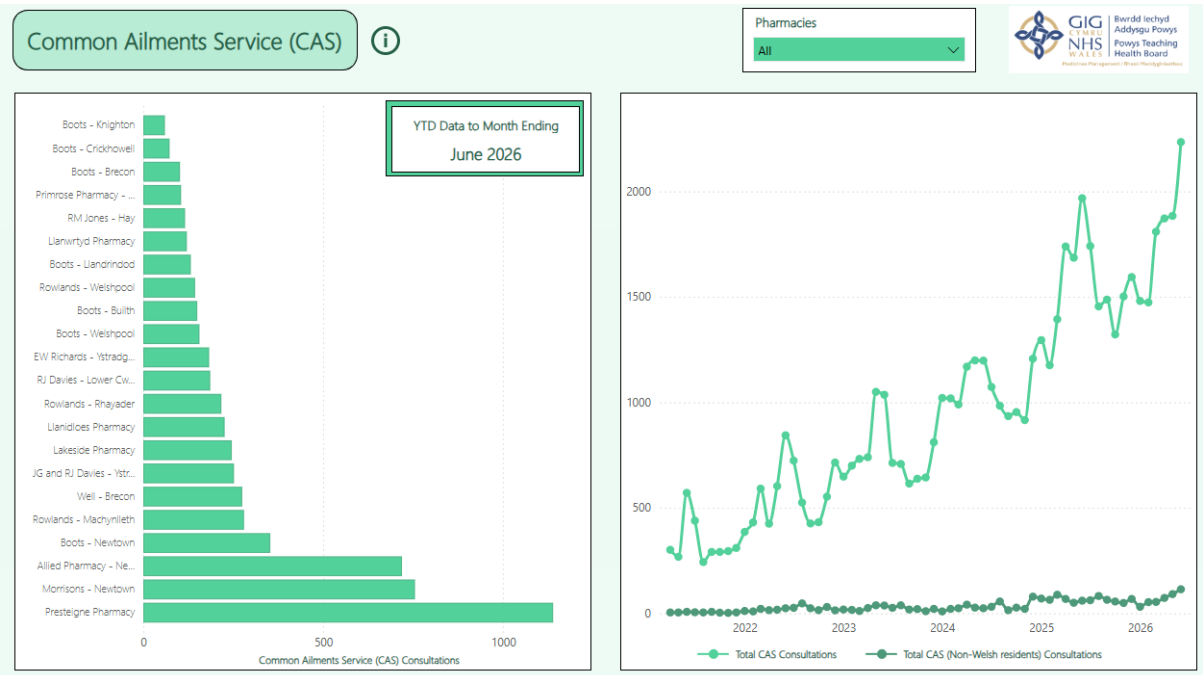
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Common interventions concerned anticoagulant choice and dosing, prevention of blood clots, paracetamol doses appropriate to patients' weight, and vitamin D replacement following fractures. Repeated queries about dalteparin informed development of revised guidance on preventing blood clots and a planned change to enoxaparin. Ward and departmental findings were shared with clinical teams to support learning and consistent prescribing.

Priorities are to strengthen evaluation of clinical interventions, progress prescribing guidance informed by recurring issues, and improve discharge information sharing with commissioned providers.

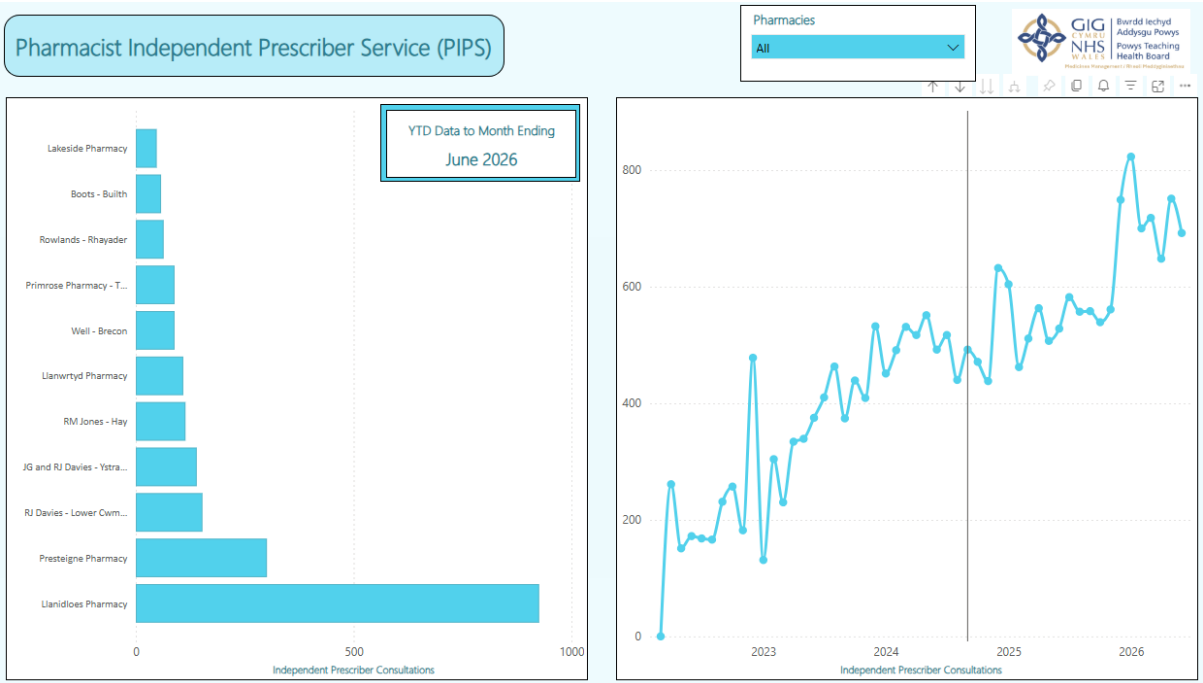
4.2 Community pharmacy and general practice

Community pharmacies offer advice and treatment close to home across a dispersed population. The Medicines Management Team supports contractors to advertise and deliver services, monitors provision and challenges poor delivery. This combines commissioning and assurance with practical help to resolve local service problems.



The Common Ailments Service and Pharmacist Independent Prescribing Service remain central to this work. They provide routes to assessment and treatment for conditions that might otherwise require a general practice appointment. Community pharmacies also contribute to contraception, smoking cessation, emergency medicines supply, vaccination and harm reduction.

Monitoring individual services alongside a combined measure of common ailments, independent prescribing, smoking cessation and contraception consultations supports a broader understanding of activity. This is important where a change in the type of consultation affects individual service counts. The team also reinforces the purpose of emergency medicines supply, including challenging use where routine arrangements should meet patients' needs.



In general practice, prescribing surveillance supported targeted discussions about costly branded and unlicensed products and opportunities for better-value treatment. Pharmacy colleagues contributed to contract assurance and sustainability discussions, using prescribing indicators to support engagement. Antimicrobial and dietetic education formed an engaging part of GP protected learning time during 25/26.

The forward programme includes continued contractor support, clearer evaluation of access and delivery, and review of 56-day prescribing, including in dispensing practices. Improving continuity of care remains a shared priority with primary care colleagues.

4.3 Supporting patients to manage their medicines

Self-administration supports suitable patients to retain responsibility for their medicines during a hospital stay. Pharmacy colleagues work with ward teams to assess suitability, provide nursing education and agree the level of support required. The programme builds on earlier work in Powys and aims to help patients maintain familiar routines and prepare for discharge.

Powys pharmacy technician leadership contributed to development of the All Wales self-administration of medicines framework, published in March 2026. This included leadership of the Education and Training Sub-Group, working with multidisciplinary colleagues and HEIW on practical

training materials. The work brings local experience into a consistent approach to assessment and staff preparation across Wales.

Further local development will focus on appropriate access, staff training and alignment with electronic prescribing. Patient experience and participation will be important measures of whether the programme is supporting independence in practice.

4.4 Care homes and domiciliary care

All 40 of our care homes in Powys received medicines management support through a face-to-face visit or remote advice during the reporting period. The team supported medicines processes and worked with social care colleagues on incidents and concerns, directing help according to need.

Closer working with the Complex Care Team supported medicines management in nursing homes with health board-commissioned beds. At Cottage View, the team contributed to review of the Medication Administration Policy and access to medicines training for care staff.

Work with HEIW on assessor training for domiciliary care providers supported development of a consistent approach to medicines assessment and practice. These contributions extend pharmacy expertise beyond hospitals and general practice into the services supporting people in their own homes and residential care.

5 Value and financial stewardship

5.1 Medicines expenditure and efficiency

The team delivered £2.7m of prescribing efficiencies in 25/26 through a programme covering primary care prescribing, commissioned secondary care medicines and medicines supplied within PTHB services. The work combined review of prescribing choices, procurement, formulary decisions and scrutiny of high-cost treatments.

General practice prescribing is a major component of medicines expenditure, alongside treatment funded through commissioned providers and medicines used within PTHB. Price changes, shortages and increasing demand for treatment continued to create pressure. Improving value helps sustain access to effective medicines, including treatments recommended through NICE technology appraisals and All Wales Medicines Strategy Group (AWMSG) advice. Savings are pursued alongside clinical suitability, safety and continuity of treatment.

5.2 Better-value prescribing and procurement

Prescribing decision-support systems provided information and alternative treatment suggestions within general practice prescribing workflows. The team reported £52,008 from ScriptSwitch and £291,121 from OptimiseRx, totalling £343,129 in software-reported savings. These contributions sit within the wider efficiency programme.

Targeted prescribing analysis and practice engagement complemented these systems, identifying opportunities to review expensive branded or unlicensed products. Dietetic input supported appropriate prescribing of nutritional products and education for primary care colleagues.

A multidisciplinary review of wound care products brought together tissue viability, district nursing, podiatry and pharmacy. The work included a wider product range, guidance on use and movement towards online ordering with direct delivery. Further development of procurement arrangements and implementation audit remains necessary to assess consistency and value across services.

5.3 High-cost medicines and treatment access

The High-Cost Drugs Team works with provider pharmacy teams and national commissioning colleagues to support appropriate treatment, use of best-value biological medicines and recovery of eligible rebates. This is particularly important for Powys residents receiving specialist care outside the health board.

The team's pharmacist and pharmacy technician contributed to implementation of Blueteq, a system supporting authorisation and oversight of high-cost medicines. Work with the All Wales Therapeutics and Toxicology Centre included form development, testing and engagement with Welsh and English providers. The programme supports clearer records of treatment eligibility and commissioning decisions, alongside improved financial oversight.

Continued local implementation forms part of the national programme, for which AWMSG identifies the end of March 2027 as the full-rollout milestone. Progress requires coordinated work across provider pathways and clear arrangements for monitoring use.

Pharmacy also provides evidence reviews and clinical advice to the Individual Patient Funding Request panel. Written reviews of medicines cases support consideration of clinical benefit and value in individual circumstances, while pharmacist membership contributes to the panel's wider decision-making.

5.4 Prescribing performance and sustainability

The National Prescribing Indicators for 2025 to 2028 provide a framework for comparing prescribing and targeting improvement. They cover analgesics, antimicrobial stewardship, respiratory prescribing and sodium-glucose cotransporter-2 inhibitors, alongside safety and efficiency measures. National reports and dashboards support comparison across health boards, clusters and practices.

Locally, prescribing information informs practice discussions, education and targeted support. The antimicrobial results in section 3.4 illustrate progress alongside an outstanding target. Continued attention to variation is necessary across the wider prescribing programme.

Inhaler prescribing and medical gases also offer opportunities to reduce environmental impact where clinically appropriate. Work in these areas must consider treatment effectiveness, patient needs and practical implementation. Environmental benefits and financial savings require separate measurement.

6 Developing the service

6.1 Electronic prescribing and medicines administration

Pharmacy professionals made a substantial contribution to preparation and roll out of electronic prescribing and medicines administration (ePMA) during 25/26. Their work connected system configuration and clinical safety with the practical requirements of prescribing, administration and medicines supply across wards in Powys.

Pharmacy staff contributed to medicines configuration, validation, testing and planning changes in ward practice, working with supplying hospital pharmacies and colleagues using the same system elsewhere.

Electronic prescribing is intended to improve access to medicines information and remove paper-chart rewriting. Evaluation will need to monitor effect on errors, staff time and medicines administration using baseline information and implementation experience. Continued pharmacy involvement is essential to safe adoption and effective day-to-day use of the system.

6.2 Prescribing capability and professional development

Two PTHB clinical pharmacists qualified as independent prescribers during 25/26, strengthening the clinical skills available within the service. All seven students in the 25/26 V300 independent prescribing cohort passed their examinations, with results confirmed in August. These achievements support the development of prescribing capability across professional groups.

A pharmacy technician also completed peer vaccinator training for the autumn/winter 25/26 programme, extending the team's contribution to staff vaccination. Pharmacy colleagues continued to support multidisciplinary education and national professional networks, including antimicrobial stewardship and medicines self-administration.

The team continued work with HEIW on prescribing competency assurance and appraisal. This connects professional development with service requirements and the support clinicians need to prescribe safely within their competence.

Subsequent progress during 26/27 has strengthened these arrangements. The PTHB Non-Medical Prescribing Lead contributes to the national group developing prescribing appraisal across professions and care settings. By August 2026, three PTHB independent prescribers had been nominated and matched with three appraisers for the HEIW pilot.

Local arrangements require annual competency self-assessment and submission of a scope of prescribing practice, supported by continuing professional development and evidence maintained in a portfolio. Implementation work includes following up outstanding submissions and preparing for prescribing appraisal every three years.

An August 2026 register update recorded 48 independent non-medical prescribers and 46 community nurse prescribing practitioners employed by PTHB, alongside 24 independent prescribers in commissioned services. The workforce spans nursing, allied health professions, community

pharmacy and optometry, demonstrating the breadth of prescribing development supported across Powys.

For 26/27, five applicants were identified for independent prescribing training and four community staff nurses for community nurse prescribing training. Expressions of interest are considered through the newly established Advanced Skills Board, linking training opportunities to professional readiness and service need.

A continuing priority is to support qualified pharmacist prescribers to use their skills within provider services. Defined scopes of practice, mentorship, appropriate policies and clear expectations within clinical roles will support the transition from qualification to sustained prescribing practice.

6.3 Mental health pharmacy and digital primary care

Funding was approved in January 2026 for a lead pharmacist and senior pharmacy technician in mental health services. These roles are intended to strengthen medicines governance and clinical support across care settings.

The team also worked with Digital Health and Care Wales to help dispensing practices consider the Electronic Prescription Service. This engagement supports preparation for changes in prescription handling and communication between practices and community pharmacies. Deployment and its effect on services will be assessed through the continuing digital programme.

7 Delivery and priorities

7.1 Progress against previous commitments

Commitment	Progress during 25/26
Develop electronic prescribing	Pharmacy-led preparation, medicines configuration, workflow mapping, testing and clinical safety input
Expand pharmacist prescribing	Two clinical pharmacists qualified; support for use of prescribing skills planned for 26/27
Improve antimicrobial and environmental performance	Lower reported total and broad-spectrum antibiotic prescribing; Access target remains unmet; environmental work continues
Strengthen mental health and medical gases oversight	Mental health pharmacy funding approved and cylinder-management review progressed
Support self-administration	Contribution to the national framework and training development, building on the local programme

7.2 Priorities for 26/27

Priority	Focus for delivery
Implement and evaluate digital medicines systems	Support safe ePMA use, assess benefits and progress electronic prescribing in outpatient clinics
Strengthen clinical capacity and prescribing	Establish mental health pharmacy roles, support prescribers into practice and maintain coverage across Powys
Improve medicines safety and continuity	Act on administration themes, storage risks and discharge information
Sustain prescribing improvement and financial oversight	Address indicator gaps, deliver appropriate efficiencies and progress Blueteq implementation with providers
Support independence and care closer to home	Develop self-administration, sustain care home support and strengthen contractor service delivery

7.3 Matters requiring continued oversight

Workforce capacity, medicines storage conditions and information sharing across care boundaries require continuing executive and Board attention. Recruitment, professional development and flexible cover support service resilience. Temperature monitoring, stock assessment and operational improvements address storage risks. Engagement with commissioned providers remains necessary to improve the reliability of cross border discharge information.

The emphasis for 26/27 is to sustain day-to-day services while demonstrating the results of improvement work. Clinical outcomes, patient experience, prescribing performance and financial delivery will inform decisions about where further support or escalation is needed.

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Powys Teaching
Health Board

Agenda item: 4.7a

PATIENT EXPERIENCE, QUALITY & SAFETY COMMITTEE

Date of Meeting:
15 OCTOBER 2026

Subject:	Medical Device Annual Report 2025-2026
Approved and presented by:	Claire Madsen, Executive Director for Allied Health Professions, Health Sciences and Digital
Prepared by:	Medical Devices Manager
Other Committees and meetings considered at:	This report has been considered at Executive Committee on the 01 October 2026

PURPOSE:

This paper has been prepared for information and approval. It provides an overview of the Medical Device Service, its background to the organisation and its ambitions for 2026 - 2027. The report sets out how the service has performed over the past year, with highlights of the key achievements and a review of the challenges and risks.

RECOMMENDATION(S):

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

- take reasonable **ASSURANCE** from the progress described in the report,
- **NOTE** the residual assurance gaps identified, and
- **NOTE** the 2026/27 priorities intended to strengthen governance, resilience, compliance and patient safety.

Approve/Take Assurance	Discuss	Information
✓	x	✓

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:

1. Focus on Wellbeing	✓	
2. Provide Early Help and Support	✓	
3. Tackle the Big Four	✓	
4. Enable Joined up Care	✓	
5. Develop Workforce Futures	✓	
6. Promote Innovative Environments	✓	
7. Put Digital First	✓	
8. Transforming in Partnership	✓	

EXECUTIVE SUMMARY:

This paper provides the Patient Experience, Quality & Safety Committee with an annual overview of the Medical Devices Service, including performance during 2025/26, key achievements, residual assurance gaps and the priorities for 2026/27. Overall, reasonable assurance can be provided that the Health Board's arrangements for the governance, management and oversight of medical devices continue to support safe and effective use across clinical services.

During 2025/26, the service has demonstrated measurable progress in governance, medical device safety oversight, contract management, digital asset management, procurement controls, sustainability and organisational learning. Key achievements include improved performance under the new main maintenance contract, Year 1 contract savings, recovery of inappropriate charges, income generation from equipment disposal, successful implementation of new defibrillators, strengthened collaborative audit activity with Infection Prevention and Control, and £510,930 Welsh Government end-of-year equipment investment.

The areas where full assurance cannot yet be provided are clearly understood and relate principally to workforce training and competency recording, mattress management following the Limited Assurance audit outcome, capacity within the Medical Devices Team, consistent compliance with approved procurement and acquisition processes, and continued reliance on manual processes for some contract data flows. These matters are reflected in the residual risk profile and are being managed through established governance routes and the 2026/27 priorities.

The 2026/27 priorities are focused on consolidation, assurance closure and governance maturity. Particular emphasis will be given to the revised Medical Device Policy, the development of a Medical Devices Governance Framework, strengthened clinical governance arrangements, improved digital assurance through Microsoft 365 technologies, enhanced asset and training visibility, and continued progress on sustainability, resilience and value for money. These actions provide a clear direction of travel and support a more robust assurance position for services, senior managers, the Board, regulators and auditors.

The following provides a summary of progress made against the key priorities set out in 24/25 Annual Report for 25/26:

Key Priority for 2025/26	Progress Update	Status
Environmental & Sustainability	• Medical Devices Team fully engaged with ISO 14001 accreditation activities. • Adaptation workshop delivered jointly with the Environmental & Sustainability Team. • Medical Devices Hub implemented to support NHS Wales' net zero carbon ambition by 2030.	Completed for 2025/26. Continues as a priority for 2026/27.

Business Continuity	• Business Impact Assessment completed.	Completed for 2025/26. Continues as a priority for 2026/27.
Information and Communication Technology (ICT)	• Medical Device Audit process digitalised and embedded into routine practice. • Digitalisation of additional documentation and processes commenced.	Completed for 2025/26. Further developments continue as a priority for 2026/27.
e-Quip Asset Management System	• Data import process embedded for the primary maintenance contract provider. • Validation exercises completed to ensure data integrity and system assurance.	Completed for 2025/26. Further developments continue as a priority for 2026/27.
Contracts	• Hub model fully embedded. • Savings achieved through changes to the plinth and physiotherapy equipment contract. • Additional supplier charges appropriately challenged and credit received. • Increased focus on contract performance through KPI monitoring.	Completed for 2025/26. Further developments continue as a priority for 2026/27.
PTHB Preceptorship Study Day	• Medical Devices Manager delivered a presentation at the Preceptorship Study Day. • Feedback was positive, resulting in an invitation to contribute to future events.	Completed.
Bariatric Equipment	• Following submission of a Situation, Background, Assessment and Recommendation Report (SBAR) by the Medical Devices Manager, approval was secured to progress with purchase of equipment for three designated bariatric units. • A Task and Finish Group was established to oversee implementation.	Completed for 2025/26. Further developments continue as a priority for 2026/27.
Wheelchair Provision and Maintenance	• Task and Finish Group established to lead a Health Board-wide wheelchair replacement programme.	Completed for 2025/26. Further developments continue as a priority for 2026/27.

Future Annual Reports	• Separate reporting arrangements introduced for Point of Care Testing and Medical Devices to provide greater clarity and focus.	Completed.
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DETAILED BACKGROUND AND ASSESSMENT:

A detailed background and assessment have been provided in the main Annual Report document below.

NEXT STEPS:

The Health Board will progress the 2026/27 priorities as a programme of consolidation, assurance closure and governance maturity. The immediate focus will be on strengthening clinical governance, closing known assurance gaps, improving workforce competency assurance, completing mattress management improvement actions, embedding digital and asset management improvements, and maintaining progress on sustainability, resilience and value for money. Progress will continue to be monitored through the relevant governance routes and escalated where residual risks cannot be mitigated within existing capacity.

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POWYS TEACHING HEALTH BOARD
MEDICAL DEVICES ANNUAL REPORT
1st April 2025 - 31st March 2026

Patterson Liz
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Background

Powys Teaching Health Boards (PTHB) Medical Devices Service ensures practicable steps are taken to make sure all risks associated with the acquisition, management and use of medical devices are minimised to protect and safeguard the interest of service users, carers, and staff. Medical Devices and equipment represent a substantial health board asset and have a significant impact on patient care.

The term “medical devices” covers a broad range of products and can be defined as; *“an instrument, apparatus, appliance, material, or healthcare product, (except medicines) used for, or by a patient or service user”*. The associated consumables are not the responsibility of the Medical Device Team, these sit as the responsibility of the operational service groups.

Powys Teaching Health Board must ensure that medical devices and equipment meet appropriate standards of safety, quality, and performance, complying with all the relevant directives set out by the MHRA. It is the responsibility of the organisation and all employees to contribute to the provision of safe and secure use of all medical devices for service users, carers, and staff.

Introduction

This Annual Report describes the Health Board’s Medical Device activities undertaken, for the Financial Year commencing the 1st of April 2025 to 31st of March 2026.

The report covers the following activities that PTHB has undertaken during this period, to make improvements to the Health Board’s Medical Device Service provision:

- Governance Arrangements
- Risk Assessment and Management
- Partnership Working
- Environment and Sustainability
- Assurance
- Key Priorities for April 2026 to March 2027

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Governance Arrangements

Medical Device Team

The overall responsibility for Medical Devices sits with the Chief Executive.

The Chief Executive has delegated the responsibility and leadership for Medical Devices to the Executive Director of Allied Health Professions, Health Science and Digital, who has delegated its management to the Deputy Director of Allied Health Professions and Health Science.

This role is supported by a full-time Medical Device Manager, and part-time Senior Administrator. The administrator role is a shared resource with the Point of Care Testing Service. The Medical Device Manager takes responsibility for ensuring that PTHB is compliant with all aspects of Medical Device management and works in collaboration with internal and external service leads, Welsh Government, other NHS organisations and external multiagency partners, to help facilitate a comprehensive integrated approach across the organisation.

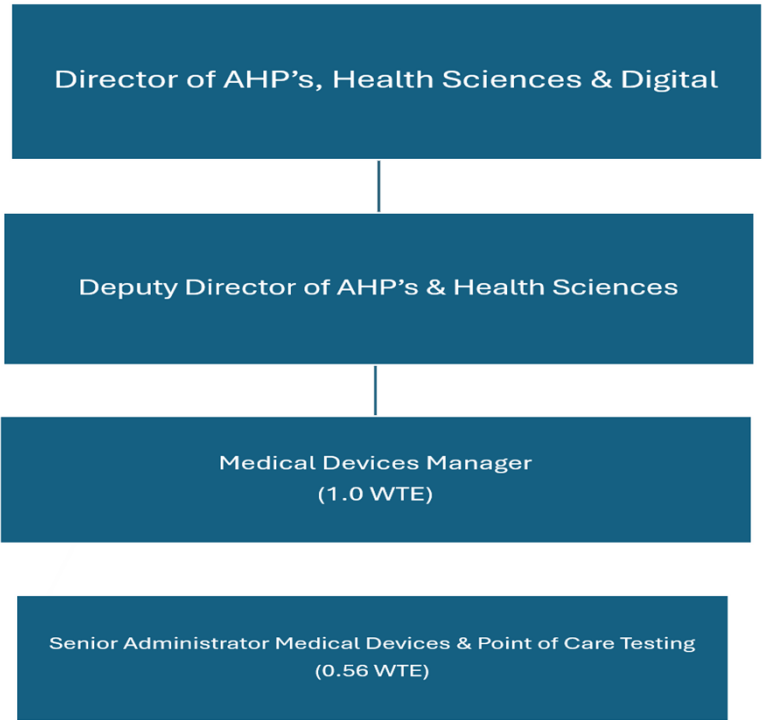
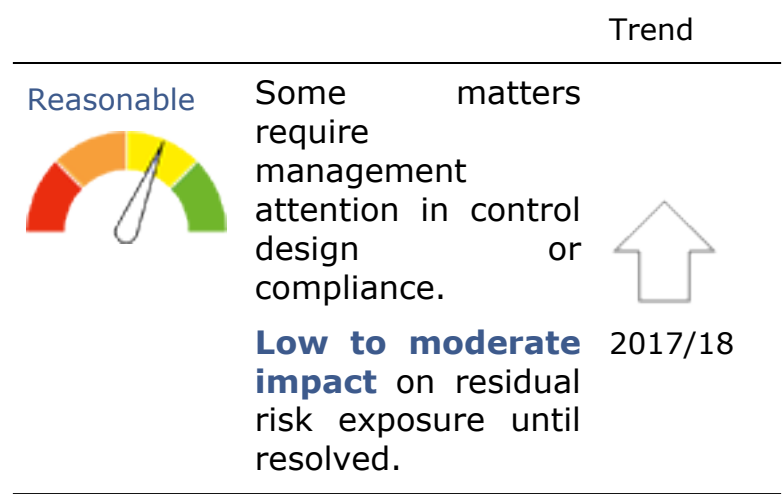


Diagram 1 – Medical Devices Management Structure

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Medical Equipment and Devices Internal Audit, October 2021

An Internal Audit was carried out in July 2021 with the final report being issued in October 2021. The overall rating of Reasonable Assurance was awarded, a significant improvement on previous audits. Reasonable Assurance reflects the fact that a policy and procedures are in place, but improvements are required in some areas to ensure that controls are being consistently complied with. The key matters requiring management attention have been outlined in an action plan and regularly reviewed and updated through the Medical Device and Point of Care Testing Group. Compliance against the recommendations is also formally reported through internal audit monitoring processes led by the Corporate Governance Team.



		development to ensure contract requirements are accurate from the outset.
Staff Training	9	Increased training availability delivered through Clinical Education.
Electrical Infrastructure	9	Close working with Estates and ongoing awareness raising regarding electrical safety.
Acquisition of Medical Devices	12	Robust processes continue to be implemented and embedded throughout the lifecycle of medical devices.

The highest-scoring risk remains the **Acquisition of Medical Devices** (score 12), reflecting the importance of maintaining effective controls throughout the medical device lifecycle. Mitigating actions continue to focus on implementing and embedding robust processes to support safe and compliant acquisition, management, and disposal of medical devices.

Risks relating to **Capacity within the Medical Device Team, Contract Monitoring, Staff Training, and Electrical Infrastructure** each score 9. Mitigations included temporary staff redeployment to maintain key service delivery, strengthened contract monitoring and specification development, increased access to training through Clinical Education, and close collaboration with Estates to promote and maintain electrical safety standards.

Overall, mitigation measures remain focused on strengthening governance, improving staff capability, ensuring contractual compliance, and maintaining safe infrastructure to support the effective management of medical devices across the organisation.

Incidents

Incidents are reported into the Medical Device and Point of Care Testing Group, where key themes and trends are also identified. Learning from incidents is a key contributor to continuous quality improvement. The Medical Device Manager is automatically notified of any related incidents, although this relies on accuracy of reporting. Through the Medical Device and Point of Care Testing Group, awareness has been raised of the importance in selecting correct categories when reporting an incident into Datix. This is to ensure incidents are not missed by relevant personnel in order for appropriate actions and learning to be achieved. Collaboration with key services, including Medicines Management and Estates, has taken place to continue this improvement work.

During this reporting period, there have been a total of 40 incidents reported, 18 less than the previous year. These fall into subcategories as listed below. Analysis of these figures does not show any trends or themes of concern relating to specific equipment type or service.

To reinforce the learning from incidents, the Medical Devices Team ensure they themselves report any incidents or concerns identified through audits and day to day activities. Learning from incidents is a key contributor to continuous quality improvement and is always a priority for the team.

Category	Quantity
Failure of Medical Device	9
Other	4
Medical Device User Error	6
Accidental Damage/Loss	7
Sterility expired	1
Wrong device used	1
Lack of Availability of Medical Device	3
Poorly Maintained Device	4
Expired Equipment/Device	5

Table 2 – Incidents Reported by Category (*Data Source: Datix*)

To improve incident reporting and learning, engagement with Datix Administrator has taken place to review how Medical Device and Point of Care Testing incidents are recorded. The outcome, as of October 2025, Medical Device and Point of Care Testing incidents will be reported separately, Datix reporting options have been amended to support this.

Medical Devices Audit

Specific months have been set for completion of the medical devices audit, these are January and June. Having set months has had a positive impact on the number of services completing the audit. The audit covers key areas of medical device management. For example, maintenance; asset tracking; storage; training; infection control and decontamination. Transferring the audit tool into MS Forms has also resulted in an increase in uptake. Audit outcomes are reported and monitored through the Medical Device and Point of Care Testing Group. The Medical Device Team provide support to teams who are identified through their audit process that improvements are required. Further improvements are being implemented to support services with increasing their uptake further. During this reporting period, audit outcomes were overall positive, with a few areas identified as requiring some additional support from the Medical Device Team. The number and types of queries received from services by the team during each audit month suggested the audit was having a positive impact. Audit outcomes are shared with Medical Device and Point of Care Testing Group to ensure learning is shared widely.

Medical Device Training

The Management of Medical Devices policy requires operational managers to ensure that staff are suitably trained and competent to use all medical devices and equipment depending on their role, and to document evidence of training taking place which must be recorded on the Electronic Staff Record (ESR).

The Medical Equipment and Devices Internal Audit, October 2021 gave Limited Assurance in terms of staff training and therefore for staff that are expected to operate and use medical devices.

As reported in the Annual Report for 2024/2025, high risk items would be the focus but would be dependent on resource and capacity but once embedded the model will be rolled out across all service areas and devices, where applicable. Collaborative work between Medical Devices and Clinical Education has identified what immediate actions were required to achieve this.

It is pleasing to report on progress which has included implementation of infusion pump and syringe driver training delivered by the Clinical Education Team and training in how to use a defibrillator (model specific) provided by the Resuscitation Officer during Basic Life Support (BSL) Training. Whilst there have been significant improvements in training provision and record keeping, the health board cannot be assured that all staff are currently both trained and competent in the use of devices they are expected to operate.

Support and engagement from the Clinical Education Team in progressing training in these key areas has been key to successful implementation of training that was not previously in place.

Medical Devices Regulations (MDR)

Following the UK's departure from the EU, changes to medical device regulations are expected to introduce new requirements for health institutions that manufacture or modify medical devices. During 2025/26, the Medical Device Manager participated in a HEIW-led national MDR group to assess organisational readiness and support an all-Wales approach. Welsh Health Boards completed a preparedness assessment, which was reported to Welsh Government, while awaiting further guidance from the MHRA.

Partnership Working

Medical Devices Replacement Programme

The Medical Devices Replacement Programme is regularly discussed at the Medical Device and Point of Care Testing Group.

A pilot has commenced in theatre and endoscopy, a service with high value equipment. Validation of key items of equipment has been undertaken which will enable progression to the next phase of populating equipment age and value. This will support with identifying expected replacement dates and estimated costs. Once the pilot is complete and the model evaluated, the approach will be rolled out across other high value equipment areas, for example, dental and outpatients.

The Medical Device Manager has close links with Capital Control Group to ensure any opportunity for funding is secured and allocated through a fair prioritisation process. Prior to medical equipment requests for Capital Funding being presented to the Capital Control Group, they go through the Capital Funding Prioritisation Group where a formal evaluation process takes place. Prioritisation in this way supports the Capital Control Group in allocating funding accordingly.

During the Financial Year 2025/2026, the health board was successful in obtaining end of year monies from Welsh Government which enabled £510,930 of equipment to be purchased across the organisation. This includes essential equipment for ophthalmology and ENT clinics, theatre and endoscopy procedures, audiology clinics, ECG machines and ultrasound machines for Cardiology clinics and bladder scanners. This funding is essential to support replacement of key items of equipment required to deliver services across the health board. The prioritisation process is key to maximising the opportunities made available through end of year funding.

Having the prioritised list of equipment impacts on the health board's ability to meet the timeframes imposed by Welsh Government and is essential for the process and being able to deliver within the Financial Year.

Links have continued to be strengthened with Charitable Fund and League of Friends colleagues. This has led to vast improvements, particularly in relation to the governance arrangements to support the correct acquisition of equipment purchased through these routes and also raised awareness of funding options available to service leads.

Clinical Education

The Medical Devices Manager and representatives from the Clinical Education Team continue to strengthen relationships. This is key to developing a robust training programme for all staff expected to operate and be responsible for medical devices and equipment.

Community Equipment Contract and Medical Devices

The Medical Devices Manager has worked closely with the Head of Therapies and the Strategic Commissioning Manager in Powys County Council to identify medical devices which are suitable for distribution via the Community Equipment Service. These items include nebulisers, suction machines and cough assists and are now available for clinicians to prescribe for patients. Issuing medical devices in this way will ensure that the Health Board is assured that those items are readily available for patients, ensuring a prompt response when requests are made. Additional assurance is also achieved in terms of tracking, maintenance and servicing. These key relationships continue to strengthen, enabling improved assurance processes, reporting on activity and compliance into the Medical Device and Point of Care Testing Group on a quarterly basis.

NWSSP Procurement

NWSSP Procurement colleagues continue to be actively engaged in medical device procurement, ensuring access to multiple suppliers, robust supply chain options, and the application of All-Wales contracts where appropriate to support best value. Strong relationships are in place with both purchasing and maintenance teams.

Environment & Sustainability

The Medical Device Team and the Environment and Sustainability Team work very closely. Collaboratively, improvements have been put in place to support the acquisition and disposal of medical devices, ensuring environmental and sustainability factors are

always considered. A Climate Adaptation workshop was held in January 2026, led by the Environment & Sustainability Team, with an outcome of specific recommendations for Medical Devices which are being monitored and progressed within the team. This will become a priority for 2026/2027.

The new main maintenance contract provider has been a key enabler to implement a hub model for equipment repairs and acceptance testing. This process has been implemented to support the health board in minimising its carbon footprint in line with the NHS Wales aim of net zero carbon by 2030. The first 12 months have proven successful in reducing the amount of travel engineers undertake. A Key Performance Indicator is in place to monitor actions taken by the maintenance provider to support local de-carbonisation. It was the aim of the health board to implement this model with previous provider; however, this proved a challenge and wasn't successful.

The Health Board is part of an all-Wales contract with an online auction company. This company collects and disposes of equipment that is no longer required by the Health Board. In 2025, a new provider was awarded the contract following a NWSSP Procurement-led tender process. The new contract has been in place since 1st August 2025 and has generated income totalling £48,750 during this period. Income for April to July 2025/26, from the previous provider amounted to £20,885. An annual income exceeding **£69,000**. It must be noted that this total includes non-medical equipment. This process not only provides income generation for the Health Board but also ensures items are disposed of in a responsible way. The Medical Device Manager is certified Carbon Literate, along with other members of the AHP and Health Science Directorate.

All Wales Medical Equipment Managers Group (AWMEMG)

The Medical Device Manager has been a member of the All-Wales Medical Equipment Managers Group since 2020, when COVID planning commenced. Being a member of this group has provided a significant support network, particularly as the group is largely made up of senior and experienced Medical Engineers. The group has representation on UK Network Group from which regular updates are given. Health Boards formally report into the AWMEMG in the form of a SPORT report (Successes, Priorities, Opportunities, Risks & Threats). The group submits a formal collaborative report to the Welsh Scientific Advisory Committee (WSAC).

Assurance

Medical Device Alerts

Collaborative working between the Quality and Safety Team and Medical Device Team, along with Service Groups has seen vast improvements in the way the Health Board manages and responds to Medical Device Alerts. A review of alerts management and implementation of new processes has enabled prompt engagement with key stakeholders to ensure action is taken as quickly as possible. Processes have also been strengthened between the Health Board and NHS Wales Shared Services Partnership (NWSSP) Procurement, this supports the way in which alerts are managed and provides additional assurance that any impacted products are identified, and appropriate action taken.

Internal Audit - Mattresses

Following a disappointing mattress audit in December 2023, an improvement plan was put in place. To obtain assurance that improvements are being made an Internal Audit by NWSSP was commissioned. An audit brief was agreed by Executive Director of Allied Health Professionals, Health Sciences and Digital Services on 20th March 2025. Field work took place during April-June 2025 with a Final Report published in July 2025. The audit outcome was disappointingly Limited Assurance. Collaborative working with service leads, infection control and suppliers to ensure improvements are made is in place with an external re-audit to be undertaken during 26/27.

Internal Audit – Contract Management

NWSSP Internal Audit of Contract Management audit brief agreed by Executive Director of Finance, Capital and Support Services in October 2024. Field work undertaken in February – May 2025 with an Assurance Opinion of Advisory. The Final Audit Report was presented to Audit Committee in June 2025.

Contracts

Contract management remains a key function of the Medical Device Team. Following challenges experienced under the previous medical device maintenance contract, including service quality concerns and inappropriate charges, the Health Board retendered the contract and appointed a new provider from 1 April 2025.

The first year of the new contract has delivered significant improvements in compliance, service quality, reporting against key performance indicators, communication, and overall contract performance. The introduction of a hub-based repair model has also reduced travel requirements, delivering both financial and environmental benefits.

Compared to the previous contract, the Health Board achieved savings of **£10,264** during the first year. Additional savings have been realised through contract scrutiny and optimisation activities, including the recovery of **£32,425** in inappropriate charges identified under the previous contract and a further **£1,500** annual saving through revised maintenance arrangements for plinths and physiotherapy equipment.

Whilst improved engagement from procurement and finance colleagues has strengthened contract management processes, limited capacity within the Medical Devices Team continues to impact the ability to undertake more comprehensive contract monitoring and development activities.

e-Quip Asset Management System

Following a lengthy project implementation phase the system is now embedded. Robust processes have been implemented to support the success of the system. It is essential that service groups adhere to these processes and ensure they are compliant with all elements of medical device management. Validation exercises continue to be undertaken, in conjunction with services to ensure processes continue to be embedded. As previously referenced, a pilot in Theatre & Endoscopy includes key staff having access to the system to support with replacement planning.

The new main maintenance provider uses e-Quip as their Asset Management System. This is a significant benefit to the health board as data imports are efficient and enables the health boards e-Quip system to receive regular updates, providing a more accurate inventory than with previous provider. It must be noted that manual processes are currently still in place for other contract providers. This will become a priority for 26/27 now the model is in place.

Complaints & Patient Feedback

The service is pleased to report there have been no complaints reported in relation to medical devices during the reporting period.

Lessons & Good Practice

Medical Devices receives quarterly reports from all service areas, which are reviewed and used to formulate lessons learnt and good practice for sharing across the Health Board. In addition to these formal reports, ad hoc sharing of good practice is also something the team encourage. There have been a few occasions during this period where issues that have arisen have been escalated through internal processes due to the severity. These have been responded to promptly by service leads and remedial action put in place immediately.

SharePoint Site Development Update

Significant work has been undertaken to ensure that all relevant documentation and guidance is now available on the SharePoint site. This enhancement provides staff with streamlined access to procedures, policies, and other essential, up-to-date resources.

Ongoing improvements include the progressive upload of medical device User Manuals, further supporting clinical teams in their day-to-day operations. Looking ahead to 2026/27, this initiative will be expanded with the transition from static Word-based documents to interactive, live Microsoft Forms where appropriate. This will enable more efficient data and information collection from clinical areas, enhancing both usability and responsiveness.

Feedback from services has recognised that the Medical Devices page within SharePoint is difficult to navigate to as it currently sits within the professional standards element of Therapies and Health Science. With support from the Digital Team, improvements will be made in 26/27.

Freedom of Information Requests

During 2025/2026 there were eight Freedom of Information requests made with regards to Medical Devices. Of these, two breached the timeframe for replies because of either collation of information from other areas and/or limited capacity within the team to respond in a timely manner. These requests can often be very time consuming for the team in gathering information as often liaison with several departments is required.

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Month of Request	Request Subject	Requestor Type	Time taken (working days)
April	Cardiopulmonary Exercise Testing Systems	Company	1 Day
June	Routine replacement of patient monitors	Company	5 Days
June	Elastomeric Infusion Devices	Company	3 Days
September	Weighing Devices	Company	6 Days
October	Bronchoscopy Service	Company	8 Days
November	LIO Platform (not medical device)	Company	1 Day
January	Implanted Ports	Company	2 Days
March	Reverse Osmosis Units	Company	1 Day

Table 5 – Freedom of Information requests made during 2025/2026 (Data Source: Medical Device Team)

Priorities 2026/27

The priorities for 2026/27 represent the next phase of service development. The focus in recent years has been on strengthening governance, embedding core systems and addressing historic audit recommendations. The focus for 2026/27 will be on consolidating these improvements, increasing clinical governance maturity, strengthening organisational resilience and maximising the benefits of digital technologies, collaborative working and sustainable procurement.

Further detail on each priority is provided below; however, the following table summarises the key priorities for 2026/27 and the quality domains they support.

Key Priority	Purpose/Outcome	Timescale	Health & Care Quality Standards – Quality Domains
Clinical Governance & Medical Device Policy Review	Review and streamline CDP002, introduce SOPs and establish regular Clinical Governance Meetings.	Throughout 2026/27	Safe, Effective,
Better Together	Strengthen collaborative working and service integration across the Health Board.	Throughout 2026/27 and ongoing	Person centred, efficient, Timely

Incident Management & Datix	Improve incident reporting, learning and governance oversight through revised Datix reporting and regular review.	Throughout 2026/27	Safe, effective
Environment & Sustainability	Support ISO 14001 accreditation and embed environmental objectives within Medical Device services.	Throughout 2026/27	Safe, efficient, effective
SharePoint Site Development	Improve accessibility of Medical Device information and increase use of interactive digital forms.	Throughout 2026/27	Efficient, Timely
Business Continuity	Complete Business Impact Analysis and strengthen resilience planning for service continuity.	Quarter 4 2026/2027 and ongoing	Safe, efficient
ICT & Digitalisation	Digitise key Medical Device processes including EDOF and MDF3 forms to improve efficiency.	Throughout 2026/27	Efficient, Timely
e-Quip Asset Management System	- Continue embedding system use, validation exercises and asset management compliance. - Continue to progress to automated data input into e-Quip for all other contracts managed by MD Team. - Medical Device Team to participate in User Group and Training sessions provided by e-Quip supplier.	Throughout 2026/27	Efficient, Safe, Effective
Contracts Management	Maximise contract performance, improve repair pathways and identify cost saving opportunities.	Throughout 2026/27	Effective, efficient, safe
PTHB Preceptorship Study Day	Raise awareness of Medical Device Management and user responsibilities amongst newly registered staff.	April 2026	Person centred
Bariatric Equipment Provision	Implement permanent bariatric equipment solution to improve patient flow and reduce admission delays.	End of Q2 2026/27	Equitable, safe, person centred

Wheelchair Provision & Maintenance	Establish clear arrangements for wheelchair provision, governance and maintenance.	End of Q2 2026/27 for purchase. End of Q4 for maintenance	Safe, person centred
Bed and Mattress Audit	Undertake external audit and improve assurance regarding mattress management and compliance.	Audit to take place by Q3	Safe

Clinical Governance and Medical Device Policy

The 2026/27 review of the Medical Device Policy (*CDP 002 Policy for the Management of Medical Devices and Equipment*) will introduce a more structured approach to medical device governance. The revised policy will sit as the top tier, setting out the strategic, legislative and regulatory requirements for medical device management, including organisational accountability, compliance, risk management, training, procurement, asset management, incident reporting and assurance.

This will be supported by a second-tier Medical Devices Governance Framework, which will translate policy requirements into a whole-system model for how medical devices are managed, monitored and assured across the organisation. The framework will bring together responsibilities, reporting routes, lifecycle controls, escalation processes, asset recording, training requirements and assurance mechanisms into a single integrated and auditable structure.

This approach will move medical device management away from a collection of procedures and towards a clearer governance model. It will improve standardisation, strengthen accountability, support better asset utilisation, enable continuous monitoring of compliance, and provide the Board with stronger assurance that medical devices are safe, compliant, appropriately maintained and used only by competent staff.

For PTHB, this will create a more defensible governance structure capable of supporting traditional equipment, community-based services, virtual wards, digitally connected technologies and third-party providers. It will also align medical device management more clearly with the Health Board's wider quality, safety, digital and governance arrangements.

The revised structure will be supported by Standard Operating Procedures, process maps and guidance for specific parts of the medical device lifecycle, alongside regular Clinical Governance Meetings to review incidents, risks, audit findings, compliance, maintenance indicators, asset register integrity, training, workforce issues and improvement priorities. Whilst this reset is underway, the Medical Device and Point of

Care Testing Group has been put on hold to allow the new arrangements to be developed and implemented coherently.

Better Together

The Medical Devices Team is committed to supporting the Better Together programme through the procurement of medical devices and equipment that align with service delivery changes. This includes ensuring all procurement and financial requirements are met, facilitating the efficient transition, transfer, or disposal of equipment, and maintaining compliance with all relevant governance and regulatory requirements throughout the process.

Incident Management and Datix

Following engagement with the Datix Administrator, 2026/27 will see improved incident reporting and learning. Medical Device and Point of Care Testing incidents will be reported separately, Datix reporting options have been amended to support this. Incidents will be regularly reviewed by Medical Device Manager as well as reporting/escalating into the Team Clinical Governance Group.

Environment and Sustainability

The Medical Device Team are committed to supporting the health board with ISO 14001 Environmental Management Systems accreditation. The standard provides a framework for organisations to manage and improve their environmental performance. An action plan will be developed to monitor progress for relevant areas against the standard within the team. The Medical Device Manager will continue to represent the team on the health board Environment and Sustainability Group.

SharePoint Site Development Update

Feedback from services has recognised that the Medical Devices page within SharePoint is difficult to navigate to as it currently sits within the professional standards element of Therapies and Health Science. With support from the Digital Team, improvements will be made in 26/27. This will be in conjunction with ongoing improvements to site content, to include the progressive upload of medical device User Manuals, further supporting clinical teams in their day-to-day operations. This initiative will be expanded with the transition from static Word-based documents to interactive, live Microsoft Forms where appropriate. This will enable more efficient data and information collection from clinical areas, enhancing both usability and responsiveness.

Business Continuity

In line with the scheduled review of the Corporate Business Continuity Plan and keeping in line with the Business Continuity Management Policy, completion of a High-Level Business Impact Analysis will be undertaken in May/June 2026. Given the single points of dependency within the Medical Device Team, there remains ongoing challenges during times of absence. Whilst cross cover with the Point of Care Manager is possible to some degree, there will always be limitations in technical and expert knowledge.

Information Communication and Technology (ICT) & Digitisation

The proposed Medical Devices Governance Framework will be digitally enabled through existing Microsoft 365 technologies, particularly Power BI, Power Automate, SharePoint

and Microsoft Lists. This will help move assurance from manual, retrospective reporting towards more real-time monitoring, automated compliance reporting and earlier identification of emerging risks.

Integrated dashboards will support oversight of key indicators including asset register accuracy, maintenance compliance, training and competency compliance, MHRA alert management, incident actions and replacement planning. Automated workflows will provide reminders, escalations and action tracking, reducing administrative burden and reliance on manual oversight.

The framework will also strengthen workforce assurance by linking devices to training and competency requirements, providing visibility of compliance at individual, service and organisational level and enabling managers to address gaps proactively.

Overall, this approach will create a single source of truth for medical device governance data, improving efficiency, strengthening compliance monitoring and providing more robust assurance to services, senior managers, the Board, regulators and auditors.

e-Quip Asset Management System

e-Quip Asset Management System is used by the Health Board to manage medical devices. Following a lengthy project implementation phase the system is now embedded. Robust processes have been implemented to support the success of the system. It is essential that service groups adhere to these processes and ensure they are compliant with all elements of medical devices management. Validation exercises continue to be undertaken, in conjunction with services to ensure processes continue to be embedded. As previously referenced, a pilot in Theatre & Endoscopy includes key staff having access to the system to support with replacement planning.

The new main maintenance provider uses e-Quip as their Asset Management System. This is a significant benefit to the health board as data imports are efficient and enables the health boards e-Quip system to receive regular updates, providing a more accurate inventory than with previous provider. It must be noted that manual processes are currently still in place for other contract providers. This will become a priority for 26/27 now the model is in place.

Further improvements to reporting and governance may be achieved through the implementation of the e-Quip training module, enabling the accurate recording and monitoring of staff training and competency against specific medical devices. In addition, attendance at the e-Quip User Group and Training Event in November 2026 will provide Medical Device Representatives with an opportunity to further develop their knowledge and expertise, supporting the effective utilisation of the system and the continued enhancement of governance processes. Financial support is required for this attendance as it is not a free event.

Contracts

The Medical Devices Team will continue to work collaboratively with the primary maintenance provider to further develop and optimise maintenance and repair processes, ensuring efficiencies are realised wherever possible. Through effective contract management and regular performance reviews, the team will monitor

compliance with agreed Key Performance Indicators (KPIs), Service Level Agreements (SLAs) and contractual obligations to ensure the delivery of a high-quality, responsive and cost-effective service.

A key priority will be the continuous improvement of repair pathways, working closely with clinical services, manufacturers and maintenance providers to reduce equipment downtime, improve turnaround times and enhance the availability of medical devices across the Health Board. Opportunities to streamline processes, remove duplication and improve communication will be actively pursued to support operational efficiency and service resilience.

The team will also identify and implement sustainable cost-saving opportunities through robust contract management, repair-versus-replacement evaluations, standardisation initiatives and procurement efficiencies. Performance, operational and financial data will be regularly reviewed to support informed decision-making, drive continuous improvement and ensure that resources are utilised effectively. This approach will maximise value from existing contracts, support the delivery of financial savings and maintain the highest standards of equipment reliability, compliance and patient safety.

PTHB Preceptorship Study Day

The Medical Device Manager will be engaging with the PTHB Preceptorship Study Day in April 2026 to promote awareness of medical device management. This engagement will be invaluable in ensuring users of equipment are aware of their responsibilities, ensuring both patient and staff safety is not compromised.

Bariatric Equipment

The health board has experienced challenges with access to bariatric equipment for inpatient wards. This has sometimes led to delayed admissions as suitable equipment has not been available in time to accept patients. The Medical Device Manager has engaged with the Assistant Director for Community Service Group and Head of Nursing. Initially the response to an SBAR was that a formal rental arrangement would be the preferred option to ensure such equipment could be accessed in a timely manner. However, this decision has been reviewed with the plan to purchase a suite of equipment for identified sites then being the preferred option. NHS Wales Shared Services Partnership Procurement Services (NWSSP) are now engaged and specifications agreed. It is anticipated this formal arrangement will be in place by the end of Q2 of Financial Year 2026/2027.

Wheelchair Provision and Maintenance

Reports from some service areas have identified that some sites have a lack of wheelchair provision which has impacted on patient experience and increased risks to patient safety. For example, lack of wheelchair availability has prevented attendance at an outpatient appointment. A review of wheelchair provision has identified a gap in responsibility, management and maintenance service. A Task and Finish Group has progressed this work during 25/26 and will be a priority for the team in 2026/2027, in conjunction with support services, therapy and nursing colleagues.

Mattress Audit – External

Drive DeVillbis are the current maintenance and product provider for beds and mattresses and have agreed to undertake an audit of beds, mattresses, couches and cots. The Medical Device Manager will lead on the co-ordination of the audit in conjunction with service leads. Further to the Internal Audit outcome of mattresses of Limited and the last audit undertaken by Drive DeVillbis which did not prove favourable, it is anticipated there will be significant improvement in the outcome of this audit, in particular mattress management.

Conclusion

During 2025/26, the Medical Devices Service has continued to demonstrate measurable progress across governance, compliance, contract management, digital systems, sustainability and financial stewardship. Significant progress has been made in addressing previous audit findings, strengthening organisational controls and improving the Health Board’s ability to support the safe use of medical devices across clinical services.

The overall assurance position is one of reasonable assurance. Full assurance cannot yet be provided in a small number of areas, particularly workforce competency assurance, mattress management, procurement compliance, service capacity and the remaining reliance on manual data flows. These areas are well understood, reflected in the residual risk profile and aligned to the 2026/27 improvement priorities. The direction of travel for 2026/27 is clear: consolidation of progress, closure of known assurance gaps, stronger clinical governance, improved digital maturity, enhanced resilience and continued delivery of safe, effective, sustainable and value-based medical device management.

Impact Assessment
Not required

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Health Board

Agenda item: 4.7b

PATIENT EXPERIENCE, QUALITY & SAFETY COMMITTEE		DATE: 15 OCTOBER 2026	
Subject:		Point of Care Testing Annual Report 2025-2026	
Approved and presented by:		Claire Madsen, Executive Director for Allied Health Professions, Health Sciences and Digital	
Prepared by:		Point of Care Testing Coordinator	
Other Committees and meetings considered at:		Executive Committee on the 01 st October 2026 – who supported the paper to the Committee.	
PURPOSE:			
This paper is presented for approval and assurance. It provides an annual overview of the Point of Care Testing (POCT) Service, summarising progress during 2025/26, key achievements, principal risks, residual assurance gaps and the priorities for 2026/27. The report supports the Committee in taking a balanced view of service maturity, governance, quality assurance, workforce resilience, digital readiness and patient safety.			
RECOMMENDATION(S):			
The Patient Experience, Quality & Safety Committee is asked to:			
• RECEIVE the 2025/26 Point of Care Testing Annual Report, • Take reasonable ASSURANCE from the progress described, NOTING the residual assurance gaps relating to workforce resilience, governance maturity and national connectivity dependencies, and • NOTE the 2026/27 priorities to strengthen compliance, resilience, digital assurance and patient safety.			
Approve/Take Assurance		Discuss	Information
✓		x	✓

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:

1. Focus on Wellbeing	✓
2. Provide Early Help and Support	✓
3. Tackle the Big Four	✓
4. Enable Joined up Care	✓
5. Develop Workforce Futures	✓
6. Promote Innovative Environments	✓
7. Put Digital First	✓
8. Transforming in Partnership	✓

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Executive Summary

During 2025/26, the Powys Teaching Health Board Point of Care Testing (POCT) Service made significant progress in maturity, resilience and strategic contribution. The report provides reasonable assurance that the core foundations required for safe and effective POCT delivery are now in place, with strengthened arrangements for governance, quality assurance, workforce sustainability, digital readiness and service development. Key improvements include the establishment of a permanent Band 7 POCT Coordinator role, recruitment to Band 4 Associate Practitioner support, implementation of the Nova Biomedical glucose monitoring platform, embedding of Blood Gas and INR External Quality Assessment, and progress with WPOCT readiness.

The service is increasingly positioned not only as a governance and quality assurance function, but as a strategic diagnostic enabler of the Health Board's Better Together ambitions. In a large rural county with no acute hospital or pathology laboratory within its boundaries, POCT provides an important mechanism for bringing diagnostic testing closer to patients, supporting earlier clinical decision-making, reducing unnecessary travel, improving patient flow and enabling more care to be delivered through primary care, community hospitals, urgent care, virtual models and neighbourhood-based services.

Assurance is strongest where arrangements are embedded, measurable and supported by digital oversight. This includes established quality management processes, improved service maturity, enhanced operator controls, strengthened incident learning, embedded EQA participation and the growing contribution of POCT to pathway redesign, antimicrobial stewardship, Primary Care development and diagnostics closer to home. The maturity assessment provides further evidence of progress, with the overall score improving from 1.9 (Developing) to 3.4 (Established) during the reporting period.

Residual assurance gaps remain in workforce resilience, completion of the governance, audit and KPI framework, Primary Care assurance and national connectivity dependencies. These gaps are recognised, mitigating actions are in place, and continued executive oversight will be required during 2026/27 to ensure POCT can safely support the scale of transformation required through Better Together. Overall, the report demonstrates that POCT is moving from a primarily technical and service-governance function towards a strategic diagnostic capability, with future value dependent on safe expansion, robust assurance, digital connectivity and active alignment with Better Together priorities.

During 2025/26, the Powys Teaching Health Board Point of Care Testing (POCT) Service made significant progress in maturity, resilience and strategic contribution. The report provides reasonable assurance that the core foundations required for safe and effective POCT delivery are now in place, with strengthened arrangements for governance, quality assurance, workforce sustainability, digital readiness and service development. Key improvements include the establishment of a permanent Band 7 POCT Coordinator role, recruitment to Band 4 Associate Practitioner support, implementation of the Nova Biomedical glucose monitoring platform, embedding of Blood Gas and INR External Quality Assessment, and progress with WPOCT readiness.

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The following table summarises progress against the key priorities agreed for 2025/26:

Key Priority for 2025/26	Progress Update	Status
WPOCT Device Connectivity	- Continued rollout of WPOCT connectivity across POCT services. - Progress made with device integration planning and implementation. - Delays encountered due to supplier and IT capacity issues, resulting in revised timescales.	Partially completed for 2025/26. Implementation continues into 2026/27 following approved timescale extension.
Clinical Pathway Development & Governance	- POCT services expanded to support clinical pathway development and service transformation. - Governance arrangements strengthened through increased	Completed for 2025/26. Further development remains a priority for 2026/27 .

	oversight of POCT activities. • POCT continues to support sustainable, value-based care closer to home.	
Quality Assurance (IQC & EQA Monitoring)	• Monitoring of Internal Quality Control (IQC) and External Quality Assessment (EQA) programmes embedded. • Regular performance review and assurance processes established. • Quality monitoring provides assurance of safe and effective POCT service delivery.	Completed for 2025/26. Embedded into routine practice.
Primary Care POCT Model	• Progress made towards developing a sustainable model for working with Primary Care. • Engagement undertaken to identify opportunities to support community-based diagnostics. • Full implementation delayed due to wider service and stakeholder dependencies.	Partially completed for 2025/26. Continues as a priority for 2026/27 .
POCT Governance, Audit & KPI Framework	• Initial work commenced to review and strengthen governance arrangements. • Development of quality assurance compliance framework, audit programme and KPI reporting initiated. • Work delayed due to service capacity pressures and competing priorities.	Not completed in 2025/26. Action formally carried forward to 2026/27 .
Training & Competency Management	• Training compliance monitored throughout the year. • Collaborative working strengthened with suppliers and clinical education teams. • Support provided to ensure staff competency and safe POCT practice.	Completed for 2025/26. Continues as business-as-usual activity.
Identification of New POCT Opportunities	• Further opportunities for POCT identified across PTHB services. • Opportunities assessed to support improved access, patient experience and clinical pathways. • Service development	Completed for 2025/26. Further opportunities will continue to be explored in 2026/27 .

	discussions initiated where appropriate.	
Primary & Community Care POCT Opportunities	• Opportunities identified to expand POCT within primary and community care settings. • Engagement undertaken to understand potential benefits and implementation requirements.	Completed for 2025/26. Supports continued service development in 2026/27 .
Future Annual Reports	• Separate reporting arrangements established for Point of Care Testing and Medical Devices. • Improved visibility of POCT achievements, risks and priorities.	Completed.

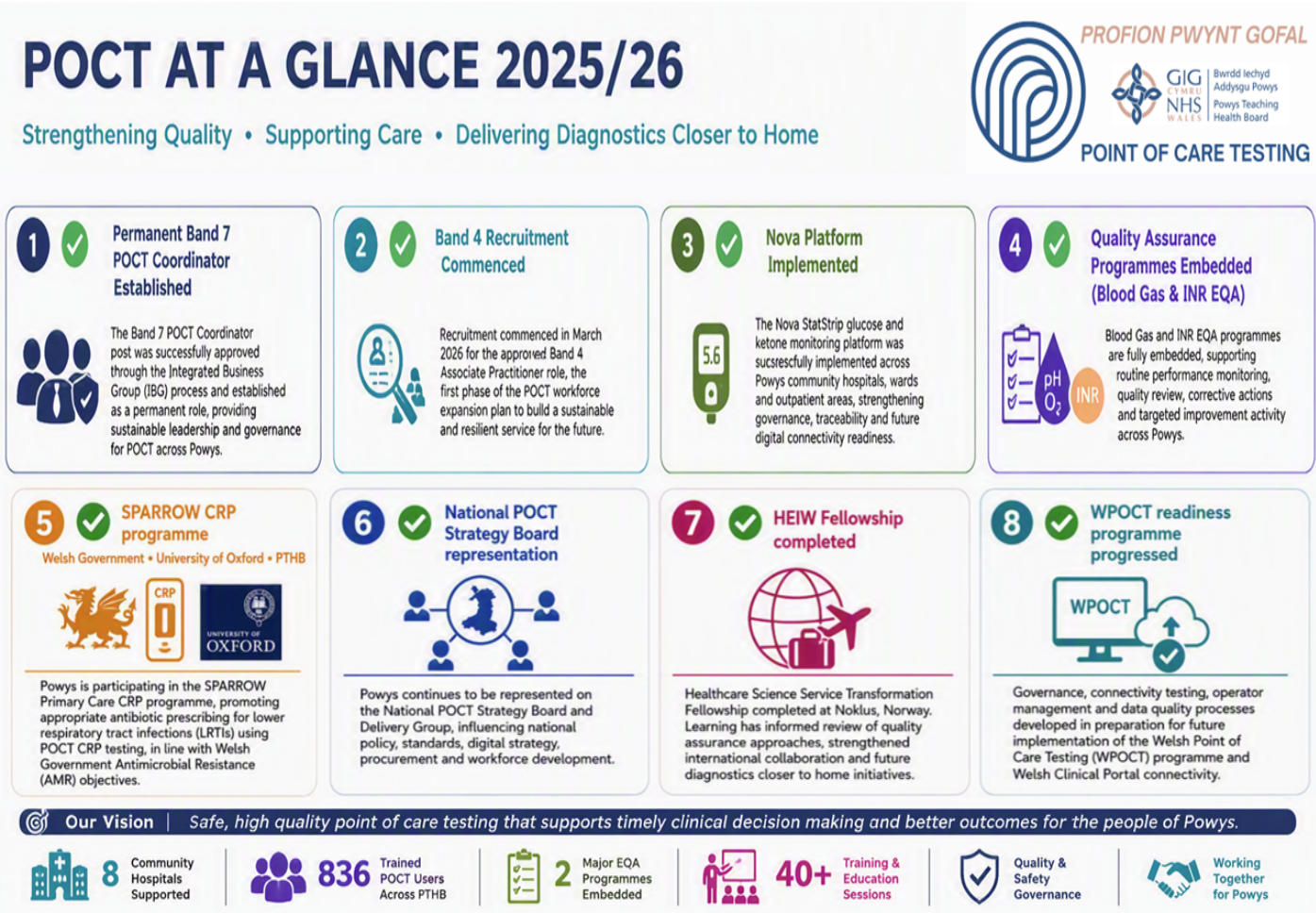


Figure 1 POCT At a Glance 2025/26

NEXT STEPS:

The Health Board will progress the 2026/27 POCT priorities through a focused programme of governance, assurance and service improvement. Priorities include

completing connectivity implementation, strengthening governance, closing assurance gaps, embedding audit and KPI reporting, developing Primary and Community Care POCT models, and maintaining IQC, EQA and training compliance.

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Background

Point of Care Testing (POCT) refers to diagnostic testing performed near or at the site of patient care, enabling clinical decisions to be made more rapidly than would otherwise be possible through traditional laboratory testing pathways.

POCT is particularly important in Powys because of:

- Large geographical distances.
- An ageing population.
- Limited acute hospital provision within county boundaries.
- No laboratories within county boundaries.
- Ambitions to provide care closer to home.
- National diagnostics transformation priorities.

The POCT Service provides the scientific, technical and governance framework required to ensure testing is safe, effective, quality assured and compliant with recognised standards. During 2025/26, the service provided oversight for 286 POCT devices across PTHB: 217 glucose/ketone devices, 59 INR devices, 6 blood gas analysers and 4 urinalysis devices.

Within this context, POCT should be understood as a key enabler of Better Together. Its value lies not only in the management of devices and testing processes, but in providing the quality-assured diagnostic capability that allows clinical teams to make decisions earlier, closer to the patient and within more integrated models of care.

Governance Arrangements

The Chief Executive retains overall responsibility for POCT, with executive accountability delegated through the Executive Director for Allied Health Professions, Health Sciences and Digital and operational/professional oversight through the Deputy Director of Therapies and Health Sciences.

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POCT SERVICE REACH / GROWTH SINCE 2024/2025

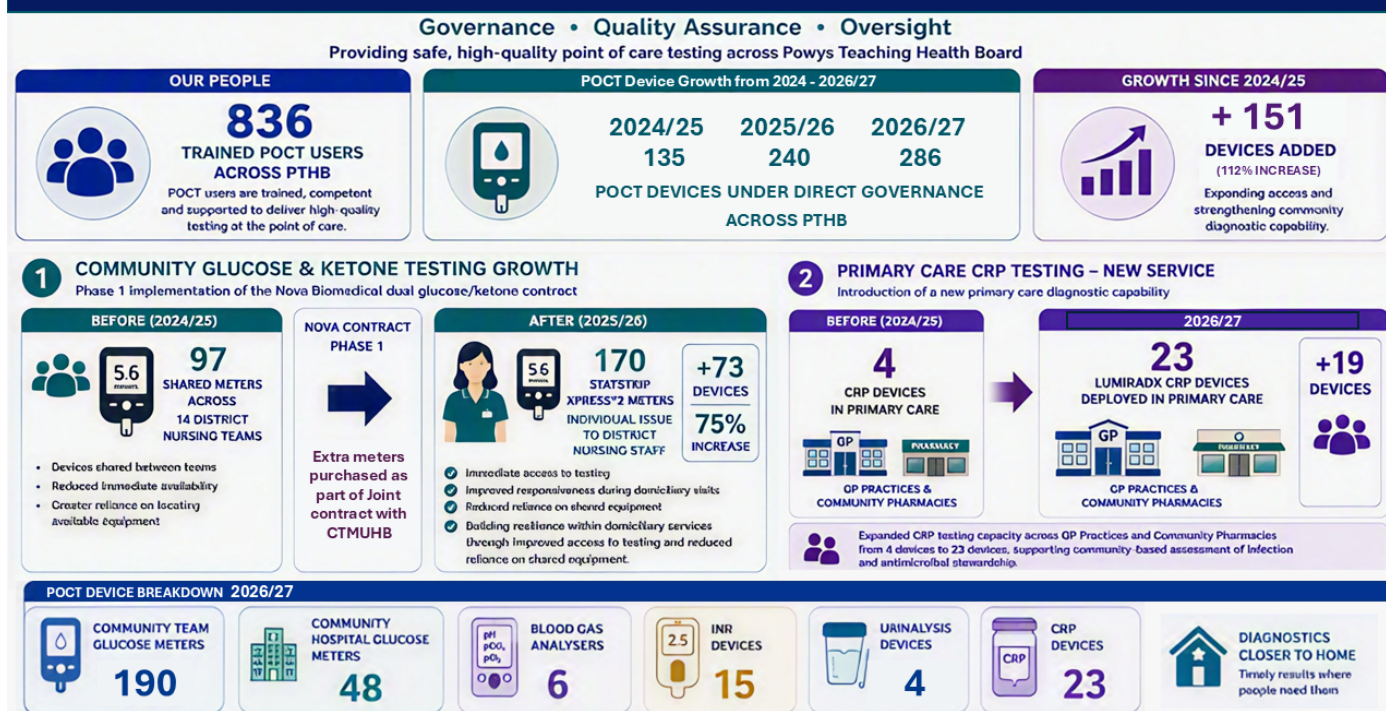


Figure 2 Service Growth since 2024

During 2025/26, the POCT Service provided governance, quality assurance and oversight for 286 POCT devices and 836 trained users across Powys Teaching Health Board.

The role encompasses:

- Governance oversight.
- Quality assurance.
- Risk management.
- Device verification and implementation.
- Training and competency management.
- Incident investigation and learning.
- National strategy implementation.
- Clinical pathway development.
- Digital connectivity and data oversight.

The service engages through Medical Devices governance arrangements and maintains links with clinical services, pathology partners, suppliers, DHCW, Welsh Government and national POCT groups to oversee quality, patient safety, workforce competency, compliance and service development.

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POCT Service Structure

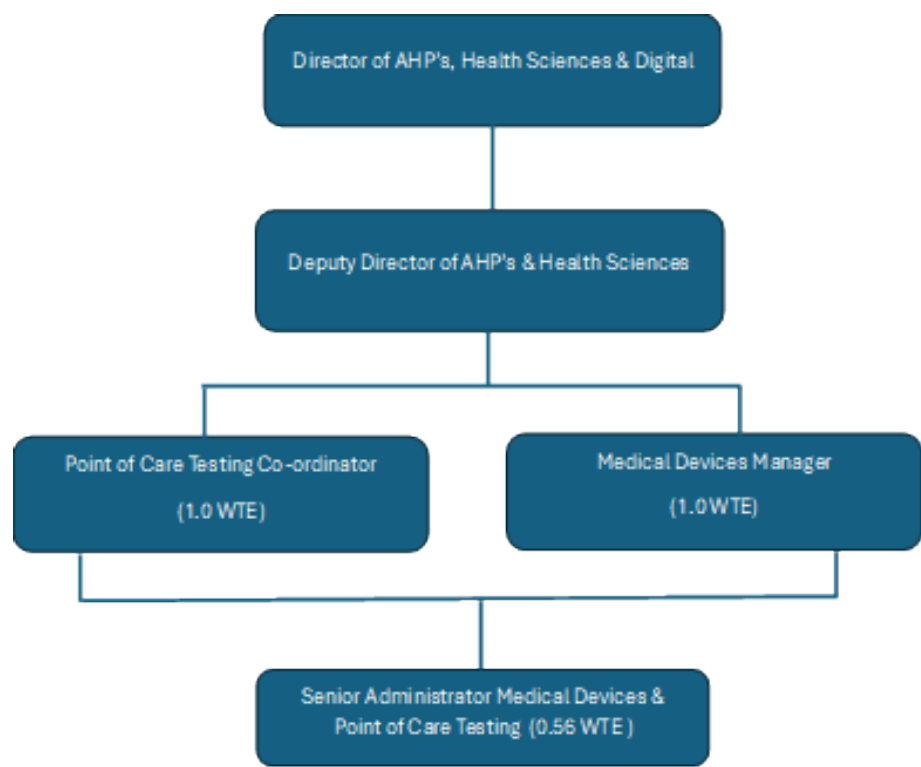


Figure 3 POCT Service Structure 2025/26

Workforce Development

2025/26 was a significant year for workforce sustainability. The fixed-term POCT Coordinator role became a substantive Band 7 position, and recruitment commenced for Band 4 Associate Practitioner support, improving resilience and reducing reliance on a single-post model.

This represents a significant milestone in the development of a more resilient and sustainable POCT service.

Strategic Alignment with PTHB IMTP 2024-29

POCT contributed to IMTP and Better Together priorities by improving access to diagnostics, strengthening clinical governance, supporting care closer to home and increasing digital maturity through local delivery and participation in national programmes. The service increasingly provides the scientific, technical, governance and digital foundations required to support pathway redesign, urgent care, primary and community care development, virtual models of care and more sustainable diagnostic provision across Powys.

IMTP Priority	POCT Contribution
Primary & Community Care	Development of CRP testing pathways, INR governance and support for diagnostics closer to home.
Planned Care	Glucose monitoring services, pathway support and improved diagnostic governance.
Urgent Care	Participation in Urgent Care and Minor Injury Unit workstreams, supporting timely clinical decision-making.
Digital First	Poccelerator (WPOCT) readiness activity, data quality improvement and preparation for Welsh Clinical Portal connectivity.
Workforce Futures	Establishment of the permanent Band 7 role and recruitment of the Band 4 Associate Practitioner role.
Quality & Safety	Enhanced quality assurance, governance oversight, EQA participation and competency management.

Table 1 POCT Alignment with PTHB IMTP 2024-29

POCT C-Reactive Protein (CRP) Testing in Primary Care

During 2025/26, the POCT Service supported the SPARROW Programme, a collaboration with Welsh Government, the University of Oxford, Welsh Health Boards and Primary Care stakeholders to develop CRP testing in Primary Care. The programme supports antimicrobial stewardship by improving diagnostic certainty for suspected lower respiratory tract infections and reducing unnecessary antibiotic prescribing. It also demonstrates how POCT can enable Better Together ambitions by supporting earlier intervention, more confident decision-making in community settings and a shift towards diagnostics closer to home.

Quality Management System

During 2025/26, the POCT Quality Management System continued to mature, providing the framework for monitoring quality, competency, governance, compliance, risk and assurance across the Health Board's POCT estate.

The service developed in line with ISO 15189 principles and recognised POCT best practice, supported by specialist scientific advice and peer review through the Service Level Agreement with Aneurin Bevan University Health Board. Workforce capacity remains a constraint but will be partly mitigated through additional support staff in 2026/27.

Accreditation and Compliance

PTHB does not currently hold standalone POCT accreditation; however, governance and quality systems continue to develop in alignment with recognised standards, regulatory requirements and best practice.

Risk Assessment and Management

The POCT risk profile during 2025/26 centred on workforce capacity, governance and assurance, clinical engagement, and training and competency. Risks were monitored through established governance arrangements, with mitigations focused on permanent staffing, specialist support through the ABUHB SLA, strengthened oversight, and improved training and digital monitoring.

Risk Theme	Risk Score (2025/26)	Mitigation
POCT Service Capacity and Sustainability	4	Permanent POCT Co-ordinator appointed, ABUHB Service Level Agreement maintained for specialist support, recruitment of additional POCT support staff approved, and development of a POCT strategy and work programme commenced.
Governance, Assurance and Clinical Engagement	6	Continued oversight through the Medical Devices and POCT Group, attendance monitoring, engagement with service leads and governance teams, implementation of remote oversight capabilities, and review of governance arrangements to strengthen assurance.
Training and Competency Management	2	Supplier-led training programmes established, collaboration with Clinical Education strengthened, competency monitoring processes developed through collaboration with Digital Team, and additional training resources introduced to support compliance.

Table 2 Summary of POCT Risk Register 2025/26

Future Risk Management Priorities

Risk priorities for 2026/27 are to strengthen workforce resilience, implement the revised POCT policy and governance framework, progress WPOCT connectivity, introduce enhanced audit and assurance, automate risk/action tracking and improve patient identification data quality.

Incidents

Six POCT-related Datix incidents were reported during 2025/26. All were reviewed by the POCT Service, with themes informing training, governance, business continuity and digital traceability improvements.

The main themes were operator access and authorisation, competency and procedural compliance, emergency workflow, quality control, patient identification and consumable storage.

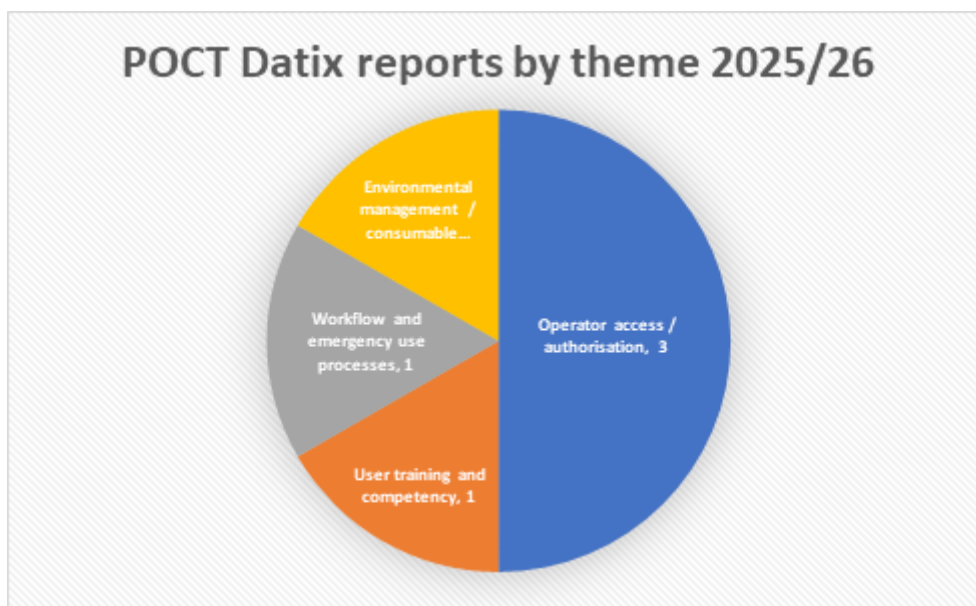


Figure 4 POCT Incidents Reported by Theme (Data Source: Datix)

Most incidents related to human factors, process compliance and local operational challenges rather than device analytical failure, providing assurance on device performance while highlighting the need for continued user support and governance oversight.

Learning and Improvement

From 2026/27, Medical Device and POCT incidents will be reported separately, with revised categorisation to improve trend analysis, learning and visibility of POCT-specific risks.

Training and Competency

Training and competency remained central to POCT safety during 2025/26, with 836 active trained users across blood glucose, INR and blood gas testing. The service worked with Clinical Education, suppliers and clinical teams to support implementation training, refresher activity, competency monitoring and user support.

Implementation of the Nova Biomedical glucose monitoring platform created a significant training requirement across community hospitals, outpatient departments and community services. Enhanced operator controls now restrict device access to authorised, competent users and reinforce traceability through the "Never Share Your Barcode" message.

Targeted Quality Improvement Through Training

Quality assurance data also drove targeted improvement. Following poor i-STAT EQA performance in the Pan Powys Respiratory Team, the POCT Service undertook root cause review, education and standardisation of practice, resulting in improved understanding and performance.

Future Development

During 2026/27, the focus will be on embedding the POCT Training Database, automating competency monitoring, expanding local training capacity with Clinical Education and the POCT team, and using dashboards to strengthen assurance.

The continued development of sustainable training and competency systems remains essential to safe, consistent and compliant POCT delivery across Powys.

Quality Assurance

Quality assurance arrangements matured during 2025/26, with EQA, IQC, device connectivity and targeted improvement increasingly embedded into routine governance and assurance processes.

Blood Gas and INR EQA programmes achieved 95% satisfactory performance. Unsatisfactory returns were limited, followed up and used to inform targeted support and monitoring.

Internal Quality Control (IQC)

IQC monitoring was strengthened through implementation of NovaNet, connecting 48 glucose monitoring devices across community hospital sites and enabling remote monitoring, operator management, auditability and IQC lockout where quality requirements are not met.

A risk-based review of glucose IQC led to an approved SBAR to move selected services from daily to weekly IQC, maintaining assurance while reducing unnecessary consumable use and releasing clinical time.

The change is expected to maintain patient safety, improve efficiency, support sustainability and deliver estimated recurrent efficiencies of approximately £21,500 per annum.

Overall, the quality assurance arrangements established during 2025/26 provide increasing assurance that POCT services are delivered safely, consistently and in line with recognised standards.

POCT Connectivity and Digital Strategy

Digital connectivity remained a major strategic priority during 2025/26 and is central to POCT's ability to support Better Together at scale. Although national supplier and technical challenges delayed full WPOCT implementation, local readiness work progressed and positioned PTHB to move forward when national dependencies allow. Connected POCT systems will be critical to ensuring that results generated closer to home are visible, traceable, auditable and clinically usable across pathways.

NovaNet connected 47 glucose monitoring devices and provided remote monitoring, operator management, quality control visibility, auditability and traceability. Remote

interrogation of NovaNet data supported investigation of five of the six reported POCT incidents, demonstrating the governance value of connected systems.

Patient Identification and Result Traceability

Preparation for WPOCT included work with the Clinical Digital Team to strengthen patient identification, NHS Number usage and result traceability ahead of Welsh Clinical Portal integration.

Future Digital Development

Digital priorities for 2026/27 are WPOCT implementation, automated compliance reporting, digital audit, performance dashboards, competency monitoring and integration of Microsoft 365 tools into governance and assurance processes.

Partnership Working, Contracts and Procurement

Partnership working supported POCT development during 2025/26, including specialist support through the ABUHB SLA, collaboration with Clinical Education, Medicines Management, Respiratory Services, Urgent Care, DHCW, suppliers, Primary Care, Welsh Government, the University of Oxford and national POCT networks.

National POCT Activity

PTHB maintained representation on national POCT strategy, delivery, INR, connectivity, procurement and workforce workstreams, ensuring Powys remained aligned with and able to influence NHS Wales developments.

Contract Management and Financial Stewardship

Contract and procurement activity demonstrated effective financial stewardship. Roche CoaguChek reconciliation identified an historic overpayment of approximately £30,000 for recovery, while work continued with Finance, ABUHB, Cwm Taf Morgannwg UHB and Nova Biomedical to strengthen invoicing and reconciliation for the glucose monitoring contract.

Research and Innovation

Learning from the HEIW Noklus fellowship, WEQAS conference and professional development activity informed IQC optimisation, quality management development and future innovation proposals, including a rural POCT D-Dimer pilot funding application.

Environment and Sustainability

The POCT Service remains committed to supporting Powys Teaching Health Board's environmental sustainability objectives and recognises the important role healthcare

services play in reducing waste, improving resource efficiency and supporting sustainable working practices.

Whilst patient safety and quality assurance requirements remain the primary consideration in all POCT activities, opportunities to reduce environmental impact are routinely considered during service planning, procurement activities and implementation projects.

Examples of activity undertaken during 2025/26 included:

- Consideration of sustainability principles during implementation of new POCT technologies and service developments including developing economical device installation route plans.
- Increased use of virtual meetings and remote engagement where appropriate, reducing unnecessary travel across the geographically dispersed Health Board.
- Participation in wider Health Board Environment and Sustainability discussions.
- Review of quality assurance processes to identify opportunities to reduce unnecessary consumable usage without compromising patient safety or regulatory compliance.
- Increased use of digital systems and electronic records to reduce reliance on paper-based processes.

Supporting Diagnostics Closer to Home

The POCT Service continues to support the Health Board's ambition to deliver care closer to home through the development and governance of community-based diagnostic services.

By enabling testing to be undertaken closer to the patient, POCT can contribute to:

- Reduced patient travel.
- Earlier clinical decision-making.
- More efficient use of healthcare resources.
- Improved access to diagnostics within rural communities.

These benefits support both the sustainability agenda and wider strategic objectives relating to equitable access to healthcare services across Powys.

Future Priorities

During 2026/27 the POCT Service will continue to explore opportunities to strengthen sustainability and environmental performance through:

- Further digitisation of governance processes.
- Reduction in paper-based documentation.
- Review of consumable usage and wastage.
- Exploration of sustainable procurement opportunities and holding suppliers accountable.
- Continued application of value-based healthcare principles to quality assurance and service delivery.
- Use of digital technologies to reduce unnecessary travel and administrative burden.

The service will continue to ensure that sustainability considerations are incorporated into future POCT developments whilst maintaining the highest standards of quality, governance and patient safety.

Digital Communications and Information Management

Digital transformation continues to be a key enabler for the future development of the POCT Service. During 2025/26, work commenced to modernise communication, information management and governance processes through increased use of Microsoft 365 technologies and digital solutions.

Historically, many POCT processes have relied on static documents, manual record keeping and email-based communication. As the service has expanded, opportunities have been identified to improve efficiency, accessibility and governance through greater use of digital tools.

Digital Forms and Information Collection

The transition from static Word-based documents to interactive Microsoft Forms and other Microsoft 365 solutions commenced during 2025/26.

This approach is intended to:

- Improve the efficiency of information collection.
- Reduce administrative burden.
- Improve data quality and consistency.
- Support automation of routine processes.
- Provide more responsive and user-friendly systems for clinical services.

The increased use of digital forms will also support future governance and assurance activities by providing improved visibility of compliance, audit and training information.

POCT Information Hub

Feedback received from service users highlighted that POCT information can currently be difficult to locate, as POCT resources are hosted within the wider Therapies and Health Sciences webpages.

In response, discussions commenced with the Digital Team during 2025/26 to improve accessibility and visibility of POCT information.

Work is now underway to develop a dedicated POCT digital presence that will provide users with easier access to:

- Policies and governance documents.
- Standard Operating Procedures.
- User guides and training materials.
- Quality assurance information.
- Forms and audit tools.
- Service updates and communications.
- Contact details and support information.

The aim is to create a single location where users can quickly access the information required to safely undertake POCT activities.

Microsoft 365 and Process Automation

The planned expansion of the POCT workforce will enable greater focus on digital transformation activities during 2026/27.

A key objective will be to replace manual and paper-based processes with digital solutions using Microsoft 365 technologies.

These technologies will support more efficient management of governance, training, quality assurance and audit processes, whilst reducing reliance on spreadsheets and manual administration.

Future Digital Development

A major area of future development will be the creation of a dedicated POCT governance platform that supports real-time oversight and assurance activities.

Planned developments include:

- Automated compliance monitoring.
- Digital audit programmes.
- Training and competency dashboards.
- Quality assurance reporting.
- Automated reminders and action tracking.
- Performance monitoring tools.
- Risk management solutions.

Development of these systems will support the creation of a more proactive, data-driven approach to governance and provide improved assurance to managers, governance groups and the Health Board.

POCT Risk Register Development

As part of the wider digital transformation programme, discussions are focussing on developing an automated Medical Devices & POCT Risk Register using Microsoft 365 technologies.

The proposed solution will include:

- Centralised risk management.
- Automated action assignment.
- Named action ownership.
- Review date monitoring.
- Automated reminders and escalation workflows.
- Audit trails.
- Dashboard reporting.
- Real-time visibility of risk status and mitigation actions.

The system will reduce reliance on manually maintained records whilst strengthening governance, accountability and assurance arrangements. This work is planned for 2026/27 when capacity within POCT allows.

Looking Forward

The continued development of digital systems forms an important component of the POCT Service's long-term strategy. By improving access to information, automating routine processes and enhancing governance oversight, digital transformation will support the delivery of a more efficient, resilient and sustainable POCT service for the population of Powys.

Freedom of Information Requests

No Freedom of Information (FOI) requests relating specifically to Point of Care Testing were received by Powys Teaching Health Board during the 2025/26 reporting period.

Service Identity and Maturity

To support objective assessment of service development and provide a measurable framework for continuous improvement, the POCT Service undertook a self-assessment against a bespoke POCT Maturity Framework developed specifically for Powys Teaching Health Board. The framework evaluates the maturity of the service across eight domains considered critical to the safe, effective and sustainable delivery of POCT services.

The assessment compares the position of the service at 31st March 2025 and 31st March 2026, demonstrating the progress achieved during the reporting period.

Maturity Scale

Score	Description
1	Initial - Ad hoc, reactive processes
2	Developing - Some structure, limited consistency
3	Established - Standardised processes, consistent delivery
4	Advanced - Integrated systems, proactive improvement
5	Optimised - Continuous innovation, system-wide excellence

POCT Service Maturity Assessment

Domain	March 2025	March 2026	Change
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Governance & Leadership	2	4	▲ +2
Workforce Competency	2	3	▲ +1
Technology & Infrastructure	2	3	▲ +1
Quality & Safety	2	4	▲ +2
Data & Performance Monitoring	1	2	▲ +1
Patient-Centred Care	2	3	▲ +1
Sustainability & Innovation	2	4	▲ +2
Strategic Influence & Partnerships	2	4	▲ +2

The maturity assessment demonstrates substantial progress across all assessed domains during 2025/26, with the overall maturity score increasing from 1.9 (Developing) to 3.4 (Established).

The greatest improvements were observed in:

- Governance & Leadership.
- Quality & Safety.
- Sustainability & Innovation.
- Strategic Influence & Partnerships.

This reflects the successful transition of the POCT Service from a developing governance function towards a more established, strategically focused service supporting diagnostics, quality assurance, workforce development and clinical governance across Powys Teaching Health Board.

Participation in the SPARROW CRP programme supported exploration of community-based diagnostic pathways and demonstrated the potential for POCT to support earlier clinical decision-making and more appropriate antibiotic prescribing within Primary Care.

The assessment also identifies priorities for future development, particularly in relation to digital transformation, performance monitoring and automation of governance processes, which will form key areas of focus during 2026/27.

Assurance Summary

The information presented in this report demonstrates continued progress in the development and maturity of the Point of Care Testing (POCT) Service during 2025/26. The service has strengthened its contribution to clinical governance, diagnostic transformation and the Health Board's ambition to deliver safe, effective care closer to home. It also provides reasonable assurance that POCT is increasingly positioned as a strategic enabler of Better Together by supporting timely diagnostics, pathway redesign, digital readiness, workforce capability and community-based models of care.

During the year, several key milestones were achieved, including the permanent establishment of the Band 7 POCT Co-ordinator role, progression of the approved

workforce model through recruitment of a Band 4 Associate Practitioner, and successful implementation of the Nova Biomedical glucose monitoring platform. Quality assurance arrangements continued to mature, with Blood Gas and INR External Quality Assessment programmes becoming fully embedded and achieving 95% satisfactory performance. The Quality Management System has also been strengthened, while readiness activities for the Welsh Point of Care Testing programme and future digital connectivity requirements have progressed.

The service has increased its operational and strategic impact through connection of 48 glucose monitoring devices to the NovaNet middleware platform, enhanced participation in national POCT programmes, completion of the HEIW Healthcare Science Service Transformation Fellowship, and delivery of service improvement initiatives supporting quality, sustainability and value-based healthcare. These include an evidence-based IQC optimisation programme projected to deliver recurrent efficiencies of approximately £21,500 per annum. In addition, contract reconciliation activity identified around £30,000 available for recovery, demonstrating effective financial stewardship.

Service maturity has shown significant improvement during the reporting period, with the overall maturity assessment score increasing from 1.9 (Developing) to 3.4 (Established). This reflects the continued evolution of POCT from a developing governance function to an established and strategically important component of the Health Board's diagnostic and clinical governance infrastructure.

The Health Board can take reasonable assurance that core governance, quality assurance, training and competency arrangements are in place to support the safe and effective use of POCT. This assurance is strongest where processes are embedded, measurable and supported by digital oversight; it is more limited where arrangements remain dependent on national connectivity timelines, local engagement, workforce capacity or further development of audit and KPI reporting.

While some assurance gaps remain in relation to workforce resilience, further governance development and national dependencies linked to connectivity programmes, mitigating actions are in place and are being actively progressed. Overall, the service is demonstrably stronger than at the start of the reporting period and continues to move towards a more resilient, digitally enabled and strategically aligned model. As POCT becomes increasingly embedded within diagnostic pathways, it is well positioned to support safer, timelier clinical decision-making and contribute to the Health Board's long-term ambition of delivering sustainable, high-quality care closer to home.

Overall assessment: The report is suitable for Executive Committee consideration, subject to continued oversight of the residual assurance gaps described above. The principal areas requiring sustained focus during 2026/27 are completion of the governance, audit and KPI framework; implementation of the revised POCT policy; delivery of WPOCT connectivity dependencies; strengthening of Primary Care POCT assurance; and embedding the expanded workforce model to reduce single points of failure.

Priorities for 2026/27

The 2026/27 priorities represent the next phase of POCT service development and are framed around the service's role as a strategic enabler of Better Together. Having established core governance arrangements, strengthened quality assurance and improved workforce sustainability, the focus will move from service establishment to demonstrable system impact, supported by clear ownership, measurable milestones, routine reporting and escalation of delivery risks.

Clinical Governance and Policy Development

A key priority for 2026/27 will be the review and update of the Management of Point of Care Testing Policy (CDP 015). The revised policy will provide a more comprehensive governance framework for POCT across Powys Teaching Health Board, clearly defining organisational responsibilities, quality assurance requirements, training and competency expectations, incident management arrangements and assurance processes.

As the understanding, utilisation and demand for POCT continue to increase across the Health Board, there is also a need to strengthen governance arrangements relating to the evaluation, selection and introduction of new POCT technologies. The unique nature of healthcare delivery in Powys means that device selection decisions must consider not only clinical requirements, but also rurality, workforce capability, connectivity, sustainability, quality assurance requirements and long-term support arrangements.

During 2026/27, the POCT Service will therefore work with key stakeholders to develop a collaborative approval process for POCT device selection, ensuring future investment decisions are clinically appropriate, evidence-based and aligned with organisational priorities.

This work will support the continued development of the POCT Quality Management System and ensure local governance arrangements remain aligned with national standards, regulatory requirements and emerging best practice.

POCT Connectivity and Digital Transformation

The implementation of the Welsh Point of Care Testing (WPOCT) programme will remain a major priority during 2026/27. Building on the substantial preparatory work completed during 2025/26, the service will continue to work with Digital Health and Care Wales (DHCW), suppliers and national stakeholders to progress connectivity and support future integration of POCT results into the Welsh Clinical Portal.

Alongside connectivity developments, the service will continue to explore opportunities to utilise Microsoft 365 technologies, including Power BI, Power Apps, SharePoint and Power Automate, to improve governance, automate assurance processes and reduce administrative burden.

Primary Care Development

The POCT Service will continue to support the SPARROW CRP Programme and associated antimicrobial stewardship initiatives. Particular focus will be placed on

establishing sustainable governance and quality assurance arrangements for CRP testing within Primary Care, supporting implementation activities and evaluating opportunities for wider adoption of POCT-supported clinical pathways.

The Welsh Government-funded Band 4 Associate Practitioner role will provide additional capacity to support implementation, training, quality assurance and engagement within Primary Care settings, addressing a previously unmet IMTP priority.

Audit, Assurance and Quality Improvement

Further development of the audit and assurance framework will be a significant area of focus during 2026/27. Planned activities include the introduction of routine audit programmes, enhanced monitoring of patient identification practices and development of key performance indicators to support more proactive governance oversight.

The service will also support an NHS Wales Shared Services Partnership (NWSSP) Internal Audit review of Primary Care POCT quality assurance arrangements, using the findings to further strengthen governance and assurance processes.

Workforce Development and Resilience

Following recruitment of additional workforce capacity, priority will be given to embedding the revised workforce model, strengthening resilience and reducing reliance on single points of dependency within the service.

Development of training systems, competency monitoring arrangements and local education provision will continue, supported by strong collaboration with Clinical Education colleagues and external partners.

Asset Management and Value-Based Healthcare

The service will continue to apply value-based healthcare principles to POCT delivery through review of device utilisation, appropriateness of equipment deployment and opportunities to improve efficiency.

Planned work includes audits of device utilisation, assessment of fleet requirements and continued evaluation of quality assurance practices to ensure a proportionate and evidence-based approach is adopted whilst maintaining patient safety and governance standards.

Diagnostics Closer to Home

The POCT Service will continue to explore opportunities to support diagnostics closer to home by contributing to pathway redesign initiatives, community-based diagnostic models and service transformation programmes.

Through participation in Better Together, Primary Care development programmes and national POCT initiatives, the service will support delivery of the Health Board's wider ambitions to improve access to diagnostics, reduce unnecessary travel and enable earlier clinical decision-making for patients across Powys.

Collectively, these priorities will support the continued maturation of the POCT Service, strengthen governance and assurance arrangements, and position the service to play an increasingly important role in the delivery of safe, effective and sustainable healthcare across Powys.

Better Together

The POCT Service should be regarded as a strategic enabler of the Better Together Programme. Its core contribution is to provide safe, quality-assured and digitally connected diagnostic capability that supports more care to be delivered closer to home, enables earlier decision-making and strengthens integrated pathways across primary, community, urgent and planned care.

This means that POCT is not simply a technical support function; it is part of the enabling infrastructure required to deliver future models of care. Through involvement in multidisciplinary discussions and pathway development work, the service will continue to identify where POCT can support demand management, reduce delays in diagnosis, improve patient flow and enable clinicians to make safe decisions outside traditional hospital settings.

During 2026/27, the POCT Service will support Better Together by:

- Enabling diagnostics closer to home through safe deployment of POCT in appropriate primary, community and urgent care settings.
- Providing scientific, technical and governance expertise to pathway redesign projects.
- Supporting urgent care, virtual care and community service models with timely diagnostic information.
- Supporting implementation of clinically appropriate POCT technologies where there is clear pathway, patient and system value.
- Ensuring governance, quality assurance, workforce competency, connectivity and sustainability requirements are embedded into future service developments from the outset.

This approach will ensure POCT remains aligned with wider organisational transformation objectives and is actively used to support sustainable healthcare delivery, improved patient experience and better outcomes for the population of Powys.

Business Continuity

Business continuity arrangements remain an important consideration for the POCT Service due to the specialist nature of the role and the reliance on a relatively small workforce structure.

During 2025/26, the service continued to manage business continuity risks through prioritisation of essential activities, close collaboration with colleagues within the Medical Devices Service and utilisation of specialist support arrangements through the Service Level Agreement with Aneurin Bevan University Health Board.

Whilst the permanent establishment of the Band 7 POCT Coordinator role and recruitment of additional support staff will improve resilience, there remains a degree of dependency on specialist knowledge and expertise within the service.

In line with the Health Board's Business Continuity Management Policy, a review of the POCT Business Impact Assessment will be undertaken during 2026/27. This work will assess the impact of service disruption, identify critical activities and ensure appropriate contingency arrangements remain in place.

Key areas of focus will include:

- Workforce resilience.
- Continuity of quality assurance programmes.
- Maintenance of training and competency processes.
- Support for critical POCT services.
- Connectivity and digital system dependencies.
- Management of supplier and contractor risks.

The continued development of the workforce model is expected to further strengthen business continuity arrangements and reduce reliance on single points of failure within the service.

Key Achievements 2025/26

- Permanent Band 7 POCT Coordinator role established.
- 2 x Band 4 Associate Practitioner recruitment commenced.
- Nova Biomedical glucose monitoring platform implemented.
- Blood Gas and INR EQA programmes embedded.
- WPOCT readiness programme progressed.
- HEIW Healthcare Science Service Transformation Fellowship completed.
- Support provided to the SPARROW CRP Programme in collaboration with Welsh Government and the University of Oxford.
- National POCT Strategy Board representation maintained.
- IQC optimisation proposal approved with estimated annual efficiencies of £21,500.
- Roche contract reconciliation identified approximately £30,000 available for recovery against future invoices.
- POCT Service Maturity Score improved from 1.9 (Developing) to 3.4 (Established).

Conclusion

The 2025/26 reporting period was one of significant progress, consolidation and maturation for the Powys Teaching Health Board Point of Care Testing Service. The service now has a stronger platform for governance, quality assurance and strategic development, and is increasingly positioned as a key enabler of Better Together ambitions.

Major achievements included securing the permanent Band 7 POCT Coordinator role, commencing recruitment for additional workforce capacity, embedding quality

assurance programmes, implementing the Nova Biomedical glucose monitoring platform and strengthening governance arrangements across the Health Board.

The service increased its contribution to organisational priorities through diagnostics transformation, digital readiness, antimicrobial stewardship and the development of diagnostics closer to home. Participation in national and international programmes strengthened the profile of Powys within the wider POCT community and supported alignment with emerging best practice.

The maturity assessment undertaken during the reporting period demonstrated measurable improvement across all assessed domains, reflecting the successful evolution of the service from a developing governance function towards an established and strategically important component of the Health Board's diagnostic, quality and clinical governance infrastructure.

Residual challenges remain in relation to digital connectivity, workforce resilience, Primary Care assurance and expansion of governance, audit and KPI arrangements. These are understood, have identified mitigating actions and require continued executive oversight during 2026/27.

The progress achieved during 2025/26 provides a strong foundation for future development and positions POCT to support improved patient outcomes, strengthened governance and sustainable healthcare delivery across Powys. Its future strategic value will be realised through safe expansion, digital connectivity, robust assurance and active alignment with Better Together priorities, ensuring POCT supports the Health Board’s ambition to deliver more integrated, timely and accessible care closer to home.

Impact Assessment
Not required

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Health Board

Agenda item: 4.8

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE		15 OCTOBER 2026	
Subject:	Transition and Handover from Childrens to Adult Services – 2026/27 Implementation Plan Update		
Approved and presented by:	Paul Hooton, Executive Director of Nursing / Director of Midwifery, Women and Family Health		
Prepared by:	Head of Children’s Nursing and Paediatric Services		
Other Committees and meetings considered at:	Executive Committee 01 October 2026 – whop supported the paper to the Committee.		
PURPOSE:			
To provide a quarterly update of the 2026/27 Transition and Handover from Childrens to Adult Services implementation plan.			
RECOMMENDATION(S):			
The Patient Experience, Quality and Safety Committee is asked to: • RECEIVE the report take ASSURANCE that an action plan is in place and progress is largely on track.			
Approve/Take Assurance		Discuss	Note
Y		Y	N

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

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EXECUTIVE SUMMARY:

The Transition and Handover Programme is well established at a strategic and governance level, with strong alignment to national guidance.

However, operational delivery is variable, with key areas including THP completion, Named Worker allocation, joint working with adult services, and outcome monitoring REQUIRING FURTHER FOCUS.

Targeted mitigation actions are in place, with the next phase focused on standardisation, strengthening accountability, improving data and monitoring, and ensuring consistent, seamless transitions for all young people.

PURPOSE:

This briefing provides an update on delivery against the Transition and Handover Monitoring and Review Plan (2026–2027), aligned to Welsh Government Transition & Handover Guidance (2022).

It sets out:

- Areas on track for compliance
- Areas slipping or at risk
- Mitigation actions to support recovery
- Key priorities for the next reporting period

STRATEGIC CONTEXT

The Transition and Handover Plan (THP) programme is a statutory and quality requirement, requiring:

- Early identification (age 13–14)
- Named worker for each young person
- Co-produced Transition & Handover Plans
- Joint working with adult services
- Monitoring of outcomes at 6 and 12 months post-transition

Delivery is overseen through Director-led governance arrangements and aligned to existing quality and performance frameworks.

DELIVERY OVERVIEW

Progress is positive in establishing governance, structures and policy alignment, with early implementation activity underway.

However, operational consistency and system embedding remain variable, with several elements partially implemented or at risk due to workforce capacity, digital limitations, and cross-system dependencies.

4. AREAS ON TRACK

4.1 Governance and Accountability – ON TRACK

Status:

- Designated senior leadership and oversight structures in place
- Programme governance aligned to Board and quality structures

Evidence:

- Requirement for clear governance, accountability, and reporting mechanisms established

Impact:

- Provides clear accountability for delivery and escalation
- Enables structured programme monitoring

4.2 Policy Alignment and Programme Framework – ON TRACK

Status:

- Transition model aligned to Welsh Government guidance
- Clear framework established (THP, Named Worker, Rising-16 review)

Evidence:

- Defined national requirements including THP, Named Worker, and structured reviews

Impact:

- Ensures compliance with national standards
- Provides a consistent model for implementation across services

4.3 Early Identification Processes – IMPROVED

Status:

- Identification at ages 13–14 recognised and embedded in policy
- Implementation variable across services

Evidence:

- Requirement for early identification at age 13–14

Impact:

- Early planning improving in some areas
- Inconsistent application limits system-wide impact

5 AREAS REQUIRING CONTINUED FOCUS

5.1 Named Worker Allocation – PROGRESSING

Planned Position:

- All young people have a clearly identified Named Worker

Current Position:

- Allocation inconsistent across services and pathways
- A triage process is required for all those that have open health pathways at age 14 for consideration of need to commence a managed transition pathway

Evidence:

- Quarterly reports from WCCIS identifying all young people age 14+
- Requirement for Named Worker pre- and post-handover
- Triage records

Key Issues:

- Workforce capacity pressures
- Lack of clarity in some pathways regarding responsibility

5.2 Transition & Handover Plans (THPs) – IN DEVELOPMENT

Planned Position:

- All transitioning young people have a co-produced, standardised THP

Current Position:

- THP completion and quality variable
- Identified workstreams (ready, steady, Go) commencing to monitor progress and service improvements identified
- Limited consistency in co-production with CYP and families starting to improve

Evidence:

- Requirement for standardised THP for every young person

Key Issues:

- Lack of standardised templates fully embedded – in development
- Digital/system limitations – some barriers with change to Rio
- Variation in practice across teams

5.3 Joint Working with Adult Services – **IN DEVELOPMENT**

Planned Position:

- Rising-16 reviews and joint planning embedded

Current Position:

- Inconsistent engagement with adult services
- Lack of consistency in establishing timely and quality of joint reviews

Evidence:

- Requirement for joint reviews and shared accountability

Key Issues:

- MCA assessment process to be embedded
- Cross-organisational coordination challenges
- Capacity pressures within children's/adult services

5.4 Continuity of Care (No Gaps) – **FOCUSED WORK NOT STARTED YET**

Planned Position:

- Seamless transfer with no disruption to care

Current Position:

- Risk of gaps during transition period in some pathways

Evidence:

- Requirement for no delays or gaps in care provision

Key Issues:

- Unclear accountability at point of transfer
- Scheduling and service capacity challenges

5.5 Monitoring, Outcomes and PREMs – **NOT STARTED YET**

Planned Position:

- Collection of feedback at 6 and 12 months post-transition

Current Position:

- Monitoring processes not yet fully implemented
- Limited evidence of outcome tracking

Evidence:

- Requirement to capture PREMs and evaluate outcomes

Key Issues:

- Lack of systematic data collection processes
- Digital and reporting limitations

5.6 Digital Systems and Documentation – WORKING WITH WCCIS

Planned Position:

- Digitally accessible, shared THP and integrated systems

Current Position:

- Systems not yet fully interoperable or consistently used

Evidence:

- Requirement for integrated digital systems and documentation

Key Issues:

- IT system limitations (e.g. WCCIS/RIO integration)
- Variability in documentation practice

6. Mitigation Actions

6.1 Workforce and Accountability

- Clarify Named Worker responsibilities across all pathways
- Escalate workforce risks through governance structures
- Align workforce planning with transition requirements

6.2 Standardisation of THPs

- Introduce a standardised THP template across services
- Strengthen expectations for co-production with CYP and families
- Embed compliance through governance and audit

6.3 Strengthening Joint Working

- Formalise expectations for Rising-16 reviews
- Improve engagement with adult services through structured pathways
- Establish clear accountability for handover

6.4 Improving Continuity of Care

- Define accountability at each stage of transition
- Strengthen tracking of individual transitions
- Introduce escalation processes where delays occur

6.5 Monitoring and Evaluation

- Develop and implement PREMs collection process
- Establish routine monitoring at 6 and 12 months
- Align reporting with quality and performance governance

6.6 Digital and Systems

- Work with digital teams to improve access to shared records

- Strengthen use of WCCIS and consistent documentation standards
- Develop interim solutions where system limitations exist

7. Priorities for Next Reporting Period – Ongoing – progress made – will take some time to embed

Priority 1 – Achieve THP Compliance

- Ensure all eligible young people have a completed THP
- Improve consistency and quality of plans

Priority 2 – Strengthen Named Worker Model

- Achieve full coverage across all services
- Clarify roles and accountability

Priority 3 – Embed Joint Working with Adult Services

- Ensure all Rising-16 reviews are completed
- Improve coordination and shared planning

Priority 4 – Establish Monitoring and Outcomes Framework

- Implement PREMs collection
- Introduce routine outcome tracking

Priority 5 – Reduce Risk of Care Gaps

- Strengthen oversight of transitions
- Ensure continuity of care is consistently achieved

Powys Teaching Health Board (PTHB) Children & Young People's Transition and Handover Monitoring and Review Plan (2026-2027)									
Summary Delivery vs Plan							Calculations		
Delivery against Plan		RAG Status Definition	%	Comments					
% of activities on track		GREEN: On time or within 1 week of date - you know it will be on time	32%						
% of activities at risk of delay		AMBER: 1-3 weeks or there is a risk it might be late	20%						
% of activities which are late or confirmed as being late		RED: More than 3 weeks late or you definitely know its going to be late	8%	Note these 2 issues related to timeliness WCCIS developments / Rio					
% of activities which are complete		Blue: Activity is complete	40%						
Ref	Work Activities		Lead	Actionees	RAG Status	Plan Start	Plan Finish	Progress	
1.0	GOVERNANCE - Health Boards and Trusts should have a clear accountability and delivery mechanism in place for ensuring implementation of the transition and handover guidance across all healthcare settings which report to the Board.								
1.01	Approve and publish PTHB Transition & Handover SOP for PTHB provider services		RM/CD		A	Feb-26	Apr-26	Had several revisions - going to Policies and Procedures group for ratification October	
1.02	Engage with paediatric and adult team re SOP		RM/CD		B	May-26	Jun-26		
1.03	Implementation of SOP		RM/CD		A	Jun-26	Aug-26	Implementation now commencing	
1.04	Establish an Operational Group (MDT) to support implementation and delivery		RM/CD		B	May-26	Jun-26		
1.05	Establish Transition Oversight Group (post T&F)		AS		B	Feb-26	Apr-26	Terms of Reference in draft form. Meetings to be established.	
1.06	Embed quarterly & annual reporting into IQPR/PEQS		AS		B	May-26?		Report quarterly IQPG meetings W&C and then to Execs and Board	
1.07	Define escalation pathways for transition risks		RM/CD		B	Apr-26	Jun-26	To be included as part of the SOP	
1.08	Design and agree family facing transition information pack		RM/CD		A	May-26	Jun-26	Quarter 3 for completion and implementation	
1.09	Issue family facing transition information pack		RM/CD		A	Jun-26	Aug-26	To be developed within "Ready" task and finish group -	
1.10									
2.0	TRANSITION AND HANDOVER SENIOR LEAD - Have you designated a T&H Senior Lead with accountability for ensuring implementation and quality of the transition and handover guidance across all primary, secondary tertiary and community services.								
2.01	Identify Senior Lead for Transition in Delivered Childrens Services PTHB		SD		B		Feb-26		
2.02	Identify Senior Lead for Transition in Childrens Commissioned services		SD		B		Feb-26		
2.03									
3.0	Transition and Hand Over Plan and Rising 16 - Every child and young person transferring from children to adult services should have a documented transition and handover plan or equivalent.								
3.01	Design and implementation of a digital dashboard for Transition		RM/CD/KL		A	Mar-26	Jun-26	Have met with digital services and plans in place to develop a Transition referral on WCCIS - some challenges with developments needed and moves over to Rio	
3.02	Highlighting children reaching 14+ and identifying the most appropriately placed professional to open the Transition Referral		RM/CD		B	Jun-26	Jul-26	Transition referrals opened for all children 14+ triage required to determine which of those children are likely to require a transition to adult services process	
3.03	Adopt WO THP (e.g. with Ready Steady Go/Hello) across all services		RM/CD		A	Jun-26	Sep-26	Plan to place in Forms on WCCIS - ?Rio awaiting confirmation to start	
4.0	Key Worker - Are there Transition and Handover Named workers identified and appointed from the NHS body's childrens or adult services to support the transition and handover of healthcare for every child and young person.								
4.01	To establish most appropriately placed professional to be the key worker. (as above 3.02)		RM/CD		B		Jun-26	SOP to establish the most appropriately placed keyworker and to be involved on WCCIS so the key worker can be clearly identified.	
4.02	Ensure electronic records system can identify and report on key workers for those children in Transition		RM/CD		G		Sep-26	Have already met with WCCIS - system ready for use	
4.03									
4.04									
5.0	Monitoring - What monitoring arrangements are in place for your health board or trust.								
5.01	Transition Oversight Group		AS		B	Apr-26		Terms of Reference in draft form. Meetings to be established.	
5.02	Transition Operational Group to be formulated		CD/RM		G	Oct-26		Terms of Reference to be formulated and to ensure we have adequate representation from adult services	
6.0	Mechanism to Capture - Health Boards and Trusts should have a mechanism to capture the child and young person / family / carer impression of the transition and handover process after 6 months and 12 months to help inform future service provision. In addition, a mechanism to capture how many people have made a representation under Putting Things Right.								
6.01	Design/launch 6- & 12-month post Transition PREMs (interim if needed)		RM/CD		G	Aug-26	Dec-26		
6.02	Patient Reported Experience Measures (PREM) Evaluation (Oversight Group)		AS		G	Jan-27	Dec-26		
6.03	To adopt Ready Steady Go 6 and 12 month feedback.		RM/CD		G	Jun-26	Mar-27		
7.0	Audit - How often do you monitor and review in relation to quality and effectiveness, patient satisfaction and activity?								
7.01	Deliver mandatory Transition & THP training across Childrens and young persons services and audit the number receiving training.		RM/CD		A	Jun-26	Aug-26	Training to be planned for Q 3	
7.02	Yearly notes audit for childrens services.		RM/CD	Operational Group	G	Apr-27	Mar-27		
7.03									
7.04									
8.0	Evaluation and Project Closure								
8.01									
8.02									
8.03									
8.04									
8.05									

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Patient Experience, Quality and Safety Committee on 15 October 2026		Agenda Item 4.10
Subject:	Patient Experience and Commissioning Framework	
Approved and Presented by:	Paul Hooton, Executive Director of Nursing, Quality, Womens and Family Health	
Prepared by:	Head of Quality and Safety	
Purpose:	The purpose of this paper is to provide an update on the approach to strengthening the process for obtaining patient experience feedback and data in relation to concerns, incidents, and experience, from commissioned organisations providing care for Powys residents. This also addresses the recommendations of the Structured Assessment Audit Wales Report from February 2026.	
Recommendations:	The Patient, Experience, Quality and Safety Committee is asked to: RECEIVE the paper and provide any comment on the approach set out to strengthening the process for obtaining patient experience feedback and data in relation to concerns, incidents, and experience, from commissioned organisations providing care for Powys residents.	
Executive Summary:	The organisation has previously identified challenges regarding the Health Board's ability to obtain sufficient assurance over the quality, safety and experience of care delivered through commissioned services. These challenges were reinforced by the Audit Wales Structured Assessment Report (February 2026), which identified weaknesses in assurance arrangements, oversight of complaints and the availability of quality intelligence relating to commissioned providers. Whilst Powys Teaching Health Board commissions services from a wide range of providers across Wales and England, there is currently no single, integrated source of intelligence to triangulate patient experience, complaints, incidents, provider quality intelligence and regulatory concerns. This creates a risk that emerging quality or safety issues affecting Powys residents may not be identified, escalated or acted upon at the earliest opportunity. The Integrated Quality and Performance Framework (IQPF), aligned to the emerging Quality Management System (QMS) and Target Operating Model (TOM), is intended to address this assurance gap through a consistent approach to the collection, triangulation and oversight of commissioned service intelligence. The framework will provide earlier visibility of emerging concerns, support proactive risk identification, strengthen governance oversight and organisational learning, and enhance assurance that Powys residents receive safe, effective and person-centred care regardless of where that care is delivered. Executive Committee has supported the development and implementation of the framework as a key component of strengthening assurance, oversight and governance of commissioned services.	



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd
Addysgu Powys
Powys Teaching
Health Board

Patient Experience and Commissioning Framework

OUR INTEGRATED DOMAINS



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Why Change?

Why Change?

Strengthening Assurance for Commissioned Services

- Audit Wales recommendation February 2026
- Fragmented intelligence
- No single view of quality, safety and experience

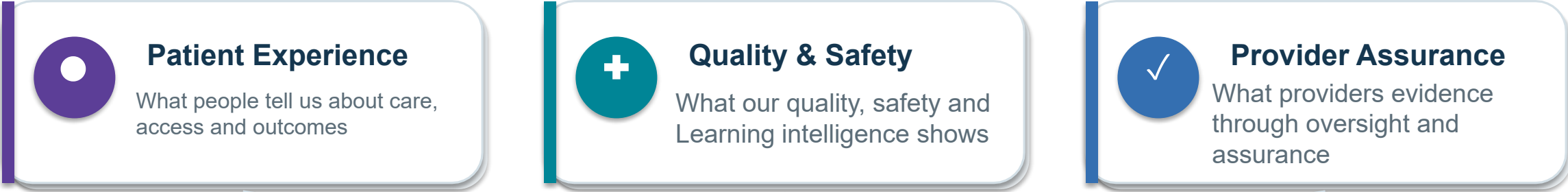
Current State

- Intelligence held across multiple systems and teams
- Limited triangulation of complaints, incidents and quality intelligence
- No single view of quality and experience for Powys residents receiving commissioned care
- Risk that emerging concerns are detected too late

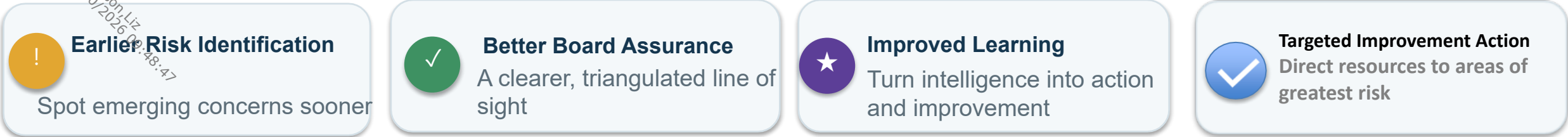


WHAT GOOD LOOKS LIKE

Three lenses brought together into one clear view of quality



SO WHAT?



One dashboard • multiple sources • a shared understanding of quality

The Proposal

Commissioned Services Assurance Framework

- Aligned to the Health Boards IQPF
 - Built around:
 - 👤 Patient Experience Intelligence
 - Quality & Safety Intelligence
 - 📊 Provider Performance Assurance
 - ⚠️ Governance & Escalation Assurance
 - ⚖️ Regulatory & External Intelligence
- Examples:
- Healthcare Inspectorate Wales
 - Care Quality Commission
 - Coroner notifications
 - Audit findings

Delivered through phased implementation plan during 2027/28:

A consistent approach to oversight, scrutiny and learning

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Response to Audit Wales Findings

Audit Wales Finding	Planned Response
Assurance arrangements for commissioned services	Development of an integrated commissioned services assurance model aligned to the QMS and IQPF
Management of complaints relating to commissioned providers	Strengthened patient experience intelligence and thematic reporting
Availability of quality intelligence	Triangulation of quality, safety, performance and patient experience data
Governance oversight	Formal reporting and escalation through established governance arrangements
Limited triangulation of	Integrated dashboard combining experience, quality, safety and provider assurance information

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Next Steps

Deliverables

- **Phase 1**
 - Framework design
 - Data mapping
 - Governance approval
- **Phase 2**
 - Dashboard development
 - Test reporting arrangements
- **Phase 3**
 - Full implementation and reporting through PEQS



How will we know it's working?

Measure	Current State	Future State
Commissioned service complaints reviewed	Variable	100% thematic review
Quality intelligence dashboard	Not available	Implemented
Triangulated reports to PEQS	Limited	Quarterly
Escalated provider concerns tracked	Variable	Formal oversight process

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Learning Disabilities Eligibility Assessment & Care Co-ordination Processes Final Internal Audit Report 2025/26

Powys Teaching Health Board



Substantial Assurance

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Appendix A 9

Review Reference

Fieldwork

Executive Sign Off

Audit Committee

Executive Lead

Audit Team

PTH-2526-26

May - July 2026

August 2026

October 2026

Elaine Lorton, Executive Director of Primary, Community Care and Mental Health.

Ian Virgil, Head of Internal Audit

Ken Hughes, Audit Manager

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Partneriaeth
Cydwasaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services
Partnership
Audit and Assurance Services



Executive Summary

Purpose

Our review of the Learning Disability service was completed in line with the 2025/26 Internal Audit Plan for Powys Teaching Health Board (the 'Health Board') and focussed on the robustness and documentation of the eligibility assessment and care co-ordination processes.

Overview

The Community Adult Learning Disability Team is a multi-disciplinary team that provides healthcare services to adults over the age of 18 with a learning disability. The multi-disciplinary team includes nurses, health care assistants and specialist consultants in Epilepsy, Physiotherapy, Occupational Therapy, Speech and Language Therapy, Psychiatry and Psychology. The department of Health makes a clear distinction between Learning Disability and Learning Difficulty. For an individual to be classed as having a Learning Disability they must have significant impairment of intellectual functioning. A learning difficulty such as dyslexia, ADHD or Dyspraxia does not affect general intellect, and these needs are met through mainstream services. To ensure patients are eligible for the Learning Disability service they must meet the eligibility criteria. Assessment is a key element of the teams work to ensure that referrals to the team meet the eligibility criteria. A care co-ordinator must then be allocated for all eligible patients who will Work collaboratively with the patient and Mental Health Service Providers with a view to agreeing outcomes which those Mental Health Services are designed to achieve.

We have concluded **substantial** assurance on this area. The following matters require management attention:

- There was no up to date terms of reference in place for MDT meetings.
- The quality of MDT meeting notes needs to be improved to ensure they clearly include all salient information regarding the initial assessment including the outcome and rationale for acceptance or rejection by the LD service.

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:

- The Dementia Pathway SOP that is due to replace the out-of-date Adult Intellectual Disabilities Operational Framework has been in draft since February 2026 and had not been approved at the time of our audit in July 2026.

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 eligibility criteria and assessment and care co-ordination processes are adequately documented.		-	Substantial
2	A record is kept of all referrals to the service, the outcome of their assessment and any appeals or challenges to the outcome.		-	Substantial
3	The assessment process for each referral is properly documented and the rationale for acceptance or rejection is clearly recorded.		1, 2	Reasonable
4	A care co-ordinator is identified for all eligible patients, and an appropriate Care and Treatment Plan (CTP) is put in place and reviewed regularly.		-	Substantial
5	The assessment and allocation of services and care co-ordination for eligible patients is appropriate and is undertaken within reasonable timescales.		-	Substantial
6	Mechanisms are in place for recording and monitoring the level of service delivery and outcomes and reporting these upwards through the Service Group and Health Board to provide appropriate assurance.			Substantial

Management Actions

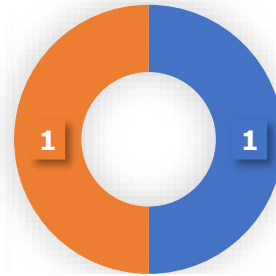


High Priority



Medium Priority

Themes



■ Governance

■ Information, Data
Quality & Data
Accuracy

Risk Types

Legal & Regulatory Non-Compliance

Quality or Safety Issues

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Findings & Agreed Action Plan

Objective 1: The eligibility criteria and assessment and care co-ordination processes are adequately documented.

Substantial

Overview / Summary of Observations

The eligibility criteria is clearly documented and requires all patients to have a diagnosed Learning Disability to be eligible for the service. The eligibility criteria is contained within the Adult Intellectual Disabilities Operational Framework. This was due for review in August 2023. A new Standard Operational Policy covering the eligibility process has now been drawn up. This is dated February 2026, but we note it was still in draft and had not been approved at the time of our audit. The process for checking eligibility has also been documented in an easy to follow 'flow chart'.

The PTHB SharePoint site has a dedicated Learning Disabilities page. This had a section for Learning Disability Documents & Resources which included the Learning Disability Referral Criteria, Referral Form and a list of some 74 Learning Disability Champions covering the Health Board together with their contact details. The PTHB website has a dedicated Learning Disability page and provides information on who may or may not be eligible for LD services, and signposts users to make an enquiry to the LD team via the e-mail link provided if they think someone may be eligible.

In summary, the eligibility criteria and assessment process has been adequately documented. A new Standard Operational Policy has been drawn up to replace the out-of-date Operational Framework, and the eligibility criteria and supporting documentation such as standard referral forms are readily available to all PTHB staff.

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Objective 2: A record is kept of all referrals to the service, the outcome of their assessment and any appeals or challenges to the outcome.

Substantial

Overview / Summary of Observations

Referrals can be made by a variety of routes, for example self-referral by the patient or their carer, from mainstream healthcare services, via Social Services or from the patient's GP. There is a standard referral form which is available on the Learning Disabilities SharePoint page. However, we were informed that some referrals are made verbally over the telephone or are brought up during the fortnightly MDT meetings. GP's tend to make referrals by letter rather than using the standard referral form.

When referrals are received basic checks are carried out to ensure all the necessary details have been received including the patients consent to the referral. The referral details are then entered into the WCCIS (system). Any referral documentation such as the standard referral form, GP referral letter or e-mail is uploaded to the Referral section of WCCIS. The case is then scheduled for discussion at the next fortnightly Multi-Disciplinary Team (MDT) meeting. The outcome of each assessment should then be recorded in the MDT minutes.

Eligibility for the service is considered at the fortnightly MDT meetings and there are three possible outcomes, i.e. referral accepted, decision pending as further information required or rejected. The main eligibility criteria is the diagnosis of an existing 'Learning Disability'. If there is an existing Learning Disability diagnosis the patient is accepted as eligible for the service. If it is possible they may have an undiagnosed Learning Disability the referral is put on hold and further information is gathered which could take between 4 weeks (for eligibility screening) up to 14 weeks if a psychological assessment is required. The patient may also be assessed as not eligible for the LD service. In this case they may be signposted to other relevant services.

A sample of 10 referrals was selected for testing to ensure that the details were promptly recorded in WCCIS prior to the referral being considered at the next available MDT meeting. In each case, the referral had been made promptly recorded on the system and had been scheduled for the next available MDT for initial assessment. Of the ten referrals tested, three had been rejected, all of which had been signposted to other NHS services and none of the decisions had been challenged.

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Overview / Summary of Observations

As noted previously, to qualify for the LD service referrals must have a suspected Learning Disability or a Learning Disability diagnosis before the age of 18 in accordance with the documented eligibility criteria.

All referrals are initially recorded on the WCCIS system and are scheduled to be discussed at the next fortnightly Multi-Disciplinary Team (MDT) meeting. Meeting notes are kept for all MDT meetings. The meeting notes from 15 MDT meetings were reviewed and it was noted that meetings were attended by a wide variety of different staff and the number of attendees in attendance varied significantly. We were informed that MDT meetings were initially covered by a terms of reference, but this could not be located during the audit.

The MDT assessment meeting notes were reviewed for a sample of referrals to ensure the assessments had been undertaken promptly, in a fair and robust manner, the rationale for the outcome of the assessment was clear, and the outcome had been accurately recorded in the minutes matching the outcome recorded in the WCCIS system. Whilst all referrals were considered promptly at the next scheduled MDT meeting, the meeting notes did not always record the outcome of the discussion or the rationale for accepting or rejecting each referral.

Key Findings		Risk & Impact	Agreed Management Action
1	MDT Terms of Reference A review of the meeting notes from 15 MDT meetings showed that 22 different staff had attended the meetings. The average number of meetings attended by each attendee was 8/15. The lowest attendance was six and the highest number of attendees was 16, and the average number of attendees was 12. The meetings had been chaired by five different attendees, although we note that all were suitably experienced staff. We were informed that a terms of reference had previously been drawn up for the group, but this could not be located at the time of our audit. An up-to-date terms of reference is important to ensure the group's remit is clear and valid, and decisions are made by an appropriate number of suitably qualified and experienced members of the group. Patterson, Liz 13/10/2026 09:48:47	The group's remit is unclear. Decisions may be made without staff with the necessary knowledge and experience being present.	Agreed Action: A new terms of reference will be drawn up for the group that sets out the remit of the group, membership, roles and responsibilities and quorum for making decisions.
		Medium Priority	Expected Evidence of Implementation: An updated and approved terms of reference is in place.
	Theme: Governance		Officer: Head of Nursing Learning Disabilities Target Implementation Date: 30 th September 2026
		Control Design	

2	MDT Meeting Notes / Minutes The MDT meeting notes from the initial review for ten referrals were reviewed. Although the WCCIS system shows that five referrals were accepted, three were rejected, one assessment was ongoing and one referral was under 18, this was not always accurately reflected in the MDT meeting minutes. For 5/10 referrals, there was insufficient detail in the MDT minutes and the rationale for acceptance / rejection was not adequately recorded.	The MDT minutes do not accurately reflect decisions made during meetings and action taken.	Agreed Action: The quality of the MDT minutes and requirements for future meetings will be reviewed to ensure that they provide a comprehensive record of the MDT meeting for all future referrals considered.
			Expected Evidence of Implementation: Improved quality of MDT Meeting Notes / Minutes that accurately reflect the decisions taken during MDT meetings, the outcome of discussions and the rationale for acceptance or rejection.
		Medium Priority	Officer: Head of Nursing Learning Disabilities Target Implementation Date: 30 th September 2026
	Theme: Information, Data Quality & Data Accuracy	Control Operation	

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Objective 4: A care co-ordinator is identified for all eligible patients, and an appropriate Care and Treatment Plan (CTP) is put in place and reviewed regularly

Substantial

Overview / Summary of Observations

Care Co-ordination is a statutory role under the Mental Health (Wales) Measure 2010 and the Mental Health (Care Co-ordination and Care and Treatment Planning) (Wales) Regulations 2011. It applies to individuals receiving secondary mental health services and requires a designated Care Co-ordinator to oversee and manage their care. The Care Co-ordinator is responsible for:

- Working collaboratively with the service user, their family/carers (where appropriate), and relevant service providers to agree care outcomes;
- Developing and maintaining a Care and Treatment Plan (CTP);
- Ensuring the CTP is regularly reviewed and updated;
- Promoting effective co-ordination of services involved in the person's care; and
- Maintaining contact with the individual and, where appropriate, their family or carers.

The legislation places a duty on the relevant Mental Health Service Provider (Local Health Board or Local Authority) to appoint a Care Co-ordinator as soon as reasonably practicable and normally within 14 days of a person being accepted into secondary mental health services. In summary, the Care Co-ordinator acts as the lead professional responsible for ensuring that mental health care is planned, coordinated, reviewed, and delivered effectively to meet the individual's needs.

Testing was undertaken on a sample of five referrals to ascertain whether a care co-ordinator had been allocated and a care and treatment plan drawn up. Whilst all had been allocated a care co-ordinator, a care and treatment plan had only been drawn up for one of the five clients reviewed. However, a CTP is not always required, and we were informed that this is determined using a CPT screening tool as part of the assessment process.

Objective 5: The assessment and allocation of services and care co-ordination for eligible patients is appropriate and is undertaken within reasonable timescales.

Substantial

Overview / Summary of Observations

Once a referral has been accepted by the LD service the client is offered an assessment and diagnostic appointment to determine the services they will need. The assessment process for people with learning disabilities should incorporate reasonable adjustments to maximise participation and outcomes, in line with the Equality Act 2010. Prior to assessment, informed consent must be obtained. If there are concerns about the person's capacity, a capacity assessment should be completed, ensuring the individual is fully informed about the assessment process in accordance with the Mental Capacity Act 2005.

For our sample selected for review, assessments had been carried out within reasonable timescales and appropriate services had been allocated by the LD team.

Objective 6: Mechanisms are in place for recording and monitoring the level of service delivery and outcomes and reporting these upwards through the Service Group and Health Board to provide appropriate assurance.

Substantial

Overview / Summary of Observations

The Learning Disability Service has various reporting requirements internally and to the Welsh Government.

A quarterly Safeguarding Strategic Service Group Exception Report is prepared for the Director of Nursing and Board members. This report demonstrates the Learning Disability Service Groups compliance with National Safeguarding Quality priorities.

A range of Learning Disability metrics are also collated monthly. These include targets where appropriate and are submitted to the NHS Executives. Review of the June 2026 Return identified that only about half of the metrics for June had been completed, although all figures had been included for previous months. We were informed that the team could not complete the figures due to missing information from Primary Care, but the issue preventing the information being received has now been resolved.

A quarterly Reporting Template is also completed that reports Learning Disability Health Check progress. This reports on the number of individuals within the PTHB are that are on GP Learning Disability registers, and the number offered a health check and the take up of health checks. It also provides metrics on the accuracy of LD registers, the number of HB staff that have received specific LD training and the use of funding and interventions. The report also highlights the services key achievements for each quarter. We were informed that the Welsh Government has now stopped funding this work. However, progress on the health checks and Health Equality Framework are reported via the Learning Disability matrix.

A Quality Assurance (Quals) report is also produced monthly that provides data in areas such as compliments, referrals, assessment outcomes, staff sickness and vacancies. This is a new internal report which is submitted to LD services monthly.

The Welsh Government required all Health Boards to provide details of all patients with a learning disability as at the 8th April 2026 who are occupying a hospital bed together with details of their length of stay, whether discharge/ transfer planning is underway and if there are any barriers to progress. This is requested annually. Powys had two inpatients at the 2026 census date.

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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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Joint Commissioning Committee

Highlight Report from the Quality, Safety and Outcomes Sub-Committee

Dyddiad y Cyfarfod / Date of Meeting	22/09/2026
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Gareth Mitchell, Corporate Governance Manager, NWJCC
Cyflwynydd yr Adroddiad / Report Presenter	Aaron Fowler, Committee Secretary, NWJCC
Noddwr yr Adroddiad / Report Sponsor	Carole Bell, Director of Nursing and Quality, NWJCC

Pwrpas yr Adroddiad / Report Purpose	For Assurance
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Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Health Boards	Various	Noted
Senior Leadership Team (SLT)	16/09/2026	Noted

1. SITUATION/BACKGROUND

This report had been prepared to provide NWJCC Joint Committee (JC) Members with a summary of the key issues considered by the Quality, Safety and Outcomes (QSOC) Sub-Committee at its public meeting on 24 August 2026.

Key highlights from the meeting are reported in **Section 2**.

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2. HIGHLIGHT REPORT

(Links to reports highlighted – [August 2026](#))

Status	Update
Alert / Escalate	Joint Accreditation Committee of the International Society for Cellular Therapy ISCT and the European Group for Blood and Marrow Transplant EBMT (JACIE) Accreditation Risks – Members noted the continued critical risk relating to JACIE certification for Bone Marrow Transplant and CAR-T services. The Committee noted the action plan submitted by Cardiff and Vale University Health Board and the work underway to understand mitigating actions and future planning implications through the Integrated Medium-Term Plan (IMTP) and clinical review processes.
Advise	Reports from each of the Directors of Commissioning were received. The following items were discussed. <u>Director of Commissioning for Specialised Services</u> - Members discussed quality, safety and outcome risks across the specialised services portfolio, including JACIE accreditation risk which is highlighted above. Cardiac Surgery – Cardiac surgical services had been escalated to Level 2, with an initial action plan received and further detail requested to address gaps in data, reporting and assurance. Plastic Surgery and Paediatric Endoscopy – Members noted ongoing waiting list and service sustainability pressures in plastic surgery services in South and North Wales, as well as an emerging risk in paediatric gastroenterology relating mainly to endoscopy waiting lists. Further work was being undertaken to understand the pathways and ensure that patients were prioritised appropriately. - Members noted that thrombectomy remained on the organisational risk register and that further consideration would take place through the Joint Committee. <u>Welsh Kidney Network (WKN) Report</u> - Members received assurance on four nationally reportable incidents that had closed through the Quality and Patient Safety process. - The Committee noted one risk scored at 16 relating to renal dialysis capacity. Members also noted the forthcoming October Renal Network Conference and that information would be shared with Lay Members should they wish to attend. <u>WKN: Welsh Language Patient Story - Chronic Renal Disease and Home Dialysis</u> - The Committee welcomed the open and transparent approach taken by the network, including the sharing of learning across Wales. Members also received a follow-up update on the

Status	Update
	previous Welsh language patient story, noting assurance on patient travel times, transport performance, patient experience at Neath Port Talbot dialysis site and mechanisms for patients to raise concerns. <u>Director of Commissioning for Ambulance Services and National Programmes</u> - Members noted improvement in ambulance handover hours, while recognising that performance remained above commissioned capacity. - Updates were received on NHS 111 digital developments. Non-Emergency Patient Transport Services (NEPTS) and WAST Call-Taking Processes – Members requested further assurance on non-emergency patient transport cancellations, quality and equity implications, and WAST call-taking processes, including algorithms, modelling and the framework in place. - Members noted an emerging issue relating to adult critical care transfer service vehicle availability, with work underway with the provider to seek assurance on delivery. - NWJCC and Police colleagues were progressing an 18-month programme to streamline SARC commissioning across Wales, covering the future service model, specification, finance, governance and performance arrangements. Major Trauma Network - The Committee noted that interim overnight coordination arrangements remained in place, supported by EMRTS, while discussions continued with WAST and the network to agree a sustainable 24-hour model. The issue would be kept under review and escalated if the risk increased or a long-term solution was not identified. <u>Director of Commissioning for MHLDVG</u> - Members noted the position regarding St Andrew’s Healthcare, independent sector performance improvement plans and the positive de-escalation of Caswell Clinic from Level 3 to Level 2. The Committee received assurance that patient safety risks and issues within commissioned services were being managed and monitored. <u>Incident and Concerns Report</u> - Members noted 14 new nationally reportable incidents, three early warning notifications and 16 new complaints, with no new referrals to the Ombudsman. Further work was requested to strengthen the presentation of outcomes, learning and wider sharing of Regulation 28 learning across health boards.
Assure	The Committee received the QSOC Sub-Committee's assigned risks from the <u>NWJCC Operational Risk Register</u> as of 31 July 2026. The Committee noted that the risk picture remains stagnant, with a number of long-standing risks that had not moved for a considerable period. AF confirmed that this has been reflected at JC. A <u>Consolidated Neurosciences Risk Report</u> was also included for noting.

Status	Update
	The Escalation Trajectories Report was received and is attached at Appendix 1. The Committee received assurance regarding services currently in escalation. Members noted that one services was in escalation level 3 and that detail had been considered through the relevant Director reports. An update on auditory implant services will be included in the next report to provide further assurance on staff morale. The Regulator Report (Healthcare Inspectorate Wales (HIW)/Care Quality Commission (CQC) was received. The Committee received assurance that the report would be considered as part of the forthcoming QSOC development session to strengthen how regulatory information is presented and used to support assurance. All Wales Individual Patient Funding (IPFR) Report The Committee noted that the deep dive was underway and that a review of the IPFR form would be undertaken in due course.
Inform	Patient Story – QSOC received a patient story relating to specialist spinal rehabilitation. Members welcomed the strongly positive account of person-centred, coordinated and compassionate care, recognising the role of the multidisciplinary team, specialist expertise, continuity of care and psychological support in achieving positive outcomes. QSOC Development Day – Members noted that the development day agenda had been updated and would include an item on EQIA and prioritisation. Forward Plan of Business – The Committee reviewed and noted the 2026–27 Forward Plan of Business.
Appendices	Appendix 1 - Escalation Trajectories.

3. ASSESSMENT

Objectives / Strategy	
Dolen i Amcan (au) Strategol CBC Link to JCC Strategic Objectives(s)	Maximise Value
	Ensure Quality; Reduce Duplication; Improve Equity & Population Health; Facilitate Integration
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	A Resilient Wales
	A Healthier Wales
Dolen i Hwyluswyr Ansawdd	Leadership

(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality (Duty of Quality Statutory Guidance (gov.wales))	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 Have you undertaken a Quality Impact Assessment Screening?	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: This is a summary of the latest meeting of the JCC
Cydraddoldeb Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? / Equality Have you undertaken an Equality Impact Assessment Screening?	Yes: ☒	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please include rationale below: This is a summary of the latest meeting of the JCC
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Joint Committee as a result of the activity outlined in this report.	
Effaith Adnoddau (Pobl /Ariannol) / Resource Impact (People / Financial)	Yes (Include further detail below)	
	The performance of the services will be used to develop the Plan and identify the areas where resources may be required.	

4. RECOMMENDATIONS

The Joint Commissioning Committee is asked to:

- **Note** the highlights outlined in Section 2 of this report; and
- **Receive** the **report** as assurance

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Director Lead: Melanie Wilkey
Commissioning Lead: Krysta Hallewell
Commissioning Team: Neuro-Sciences

Date of Escalation Meetings: 05/08/2026
Date Last Reviewed by Quality & Patient Safety
Committee: 24/08/2026

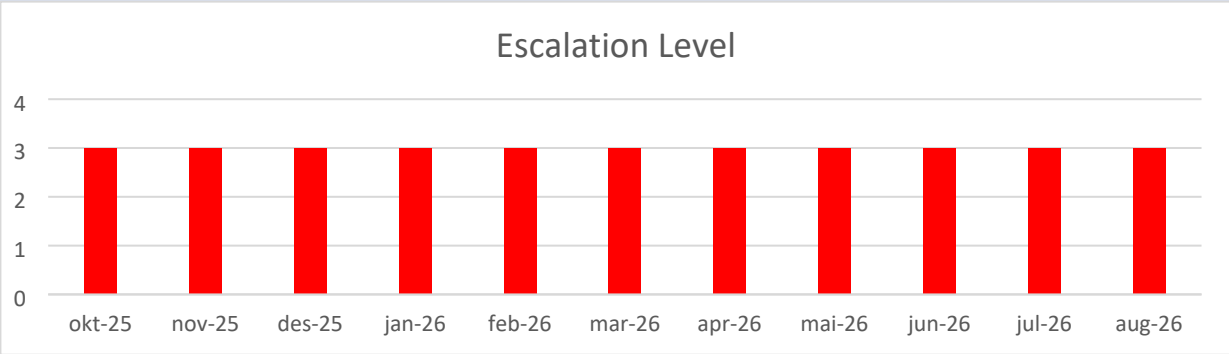
Service in Escalation:
Specialist Auditory Implant Device Service

Current Escalation
Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ August 26
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
October 2025	3

Rationale for Escalation Status: Due to insufficient progress against agreed improvement actions monitored through the quarterly Service Performance Management meetings since January 2024, and continued underperformance against the RTT position relative to the specific ministerial target for this patient cohort, the Neurosciences, Long Term Conditions and Rare Conditions Commissioning Team recommends escalation to **Level 3 – Escalated Measures**.

The service now requires significant and sustained improvement, with Executive-level oversight and intervention necessary to address performance risks and secure recovery against agreed standards.

Background Information:

The escalation of the Cardiff and Vale Specialist Auditory Implant Device Service to Level 3 of the NWJCC Escalation Framework was initiated in October 2025 and endorsed by the NWJCC Senior Leadership Team.

The NWJCC assurance and confidence rating remains Low. A formal escalation letter was issued to Cardiff and Vale UHB on 6 October 2025. However, delays in confirming a named Executive Lead and Health Board availability resulted in a postponement of the initial escalation meeting.

The first formal escalation meeting was subsequently held on 22 January 2026.

Action (NWJCC Lead: Director of Commissioning):	Action Due Date	Completion Date
Escalation endorsed by SLT	Oct 25	Oct 25
Escalation letter sent to CVUHB	Oct 25	Oct 25
Escalation meeting to discuss detail and progress against action plan (every 4 weeks)	Ongoing	Ongoing

Issues/Risks:

February 2026 Update – Commissioning and provider teams to jointly clarify: Historic and current commissioning expectations for CT scans, where clinical interpretation of scans should take place and whether pathway changes created unintended delays.

April 2026 update the pre-surgical CT scan pathway remains an open action. Progress has been made on the Long Term Agreement (LTA), and the service will share the draft in due course. The service has highlighted the impact of additional activity undertaken to reduce backlog pressures, noting a decline in staff morale. There is a recognised risk that ongoing pressures on staff wellbeing may contribute to increased sickness absence. Escalation meeting planned for the 16th April has been moved to the 28th April at the request of the service.

June 2026 – There has been significant progress in addressing the 52 week waits in the service and there are no patients currently at 52 weeks working towards a 36 week target. Work ongoing with the review and rebasing of the LTA. The pre surgical scan pathway is still an open action with an SOP in draft. An operational

manager has been moved into the service for support but there are still some concerns around stress wellbeing with the service being stretched due to increased activity to reduce the longest waiters.

August 2026 – Escalation meeting held 5th August. The service has addressed the longest waiters and by August will be working to a 36-week target. The service are modelling against the BCUHB service and have the data and optimal pathways and are in the process of arranging a visit. The SOP for pre surgical scan pathway has been embedded into Audiology service operating procedure. At present the service do not feel they can meet a 26-week target. Sickness has decreased and the morale of the team has improved. There continues to be ongoing discussions around LTA and sustainability of the service

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Director Lead: Sue O'Leary
Commissioning Lead: Sue O'Leary
Commissioning Team: Mental Health

Date of Escalation Meetings: 03/08/2026
Date Last Reviewed by Quality & Patient Safety Committee: 24/08/26

Service in Escalation:
Caswell

Current Escalation Level 2

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	August 2026
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:

Month	Escalation Level
okt-25	3
nov-25	3
des-25	3
jan-26	3
feb-26	3
mar-26	3
apr-26	3
mai-26	3
jun-26	3
jul-26	3
aug-26	2

Escalation History:

Date	Escalation Level
January 25	3

Rationale for Escalation Status: The service has been placed under formal escalation due to sustained concerns relating to safety and quality within the facility. A site visit by NWJCC representatives in July 2025 identified significant safety and quality concerns. These were reported to the JC in September 2025, which commissioned a full-service review.

The review, undertaken between 15 September and 3 October 2025, assessed compliance with recognised Medium Secure Unit standards and included patient-level review. It identified serious safety and quality issues requiring urgent action.

Similar concerns had been raised in a 2022 NCCU review and were echoed in a June 2025 independent report on Swansea Bay University Health Board’s Mental Health and Learning Disability services, which highlighted compromised care standards and weaknesses in leadership and oversight.

The findings indicate systemic governance and safety risks requiring immediate improvement action and strengthened executive oversight.

Background Information:
The escalation of the Caswell Clinic Service to Level 3 of the NWJCC Escalation Framework was initiated and endorsed by the NWJCC Senior Leadership Team in October 2025, following significant safety and governance concerns.

Following engagement with the Swansea Bay Executive Team, the service was placed in Level 3 escalation, with weekly improvement meetings established with Caswell senior leaders and monthly oversight meetings with the Health Board Executive. A detailed improvement plan aligned to recognised standards was developed, with a number of urgent actions identified. Admissions were paused pending assurance that immediate safety risks had been addressed.

Action (NWJCC Lead- Director of Mental Health AC)	Action Due Date	Completion Date
In Committee update to JCC members	October 2025	October 2025
Letter to SBUHB Executive team	October 2025	October 2025
JCC to meet with Caswell SLT on a weekly basis	Complete	Complete

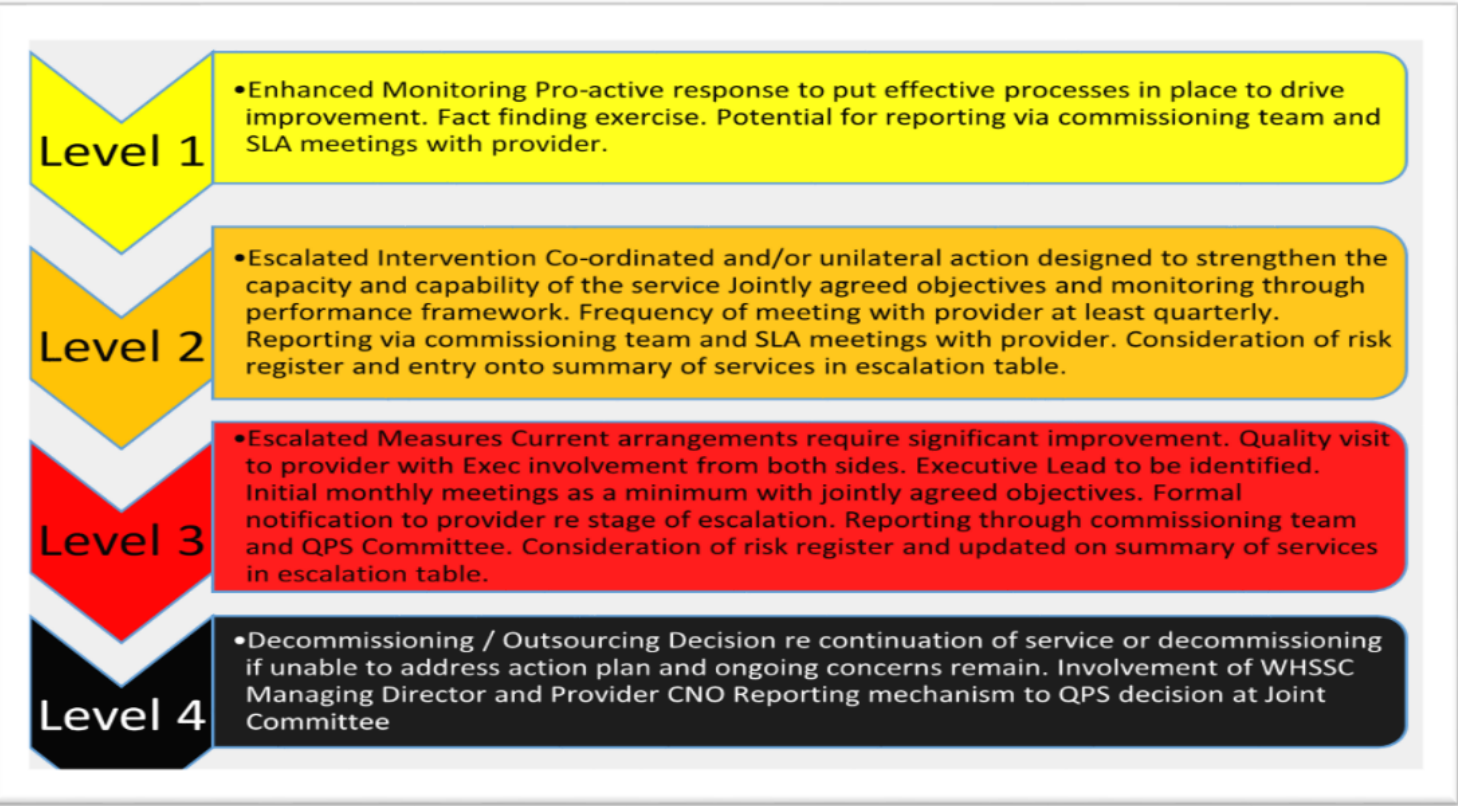
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August 2026 Update Admissions were suspended in September 2025 due to significant staff and patient safety concerns. Immediate risk mitigation actions were implemented over a three-month period. Assurance was received in January 2026, and admissions recommenced on 9 January 2026. Robust oversight remains in place, including: Weekly meetings between MHLDVG and Caswell senior leadership to monitor delivery of the action plan, with independent verification of completed actions. Fortnightly meetings between the MHLDVG Director and Swansea Bay Executive Team to seek further assurance and address delivery risks. Whilst the service has been de-escalated to Level 2 (see below) the JCC continues to meet with Caswell on a fortnightly basis to continue ongoing assurance processes. Issues/Risks: The service remains in Level 3 escalation. Decisions regarding de-escalation will be taken jointly by the MHLDVG and NWJCC Nursing and Quality teams once sustained improvement and compliance are demonstrated. Caswell Clinic remain in Level 3 escalation. Discussions have been held within JCC to establish what needs to be done in order to reduce the level of escalation in the future. Caswell Clinic have been asked to complete the evidence section of the MHLDVG action plan. This will give the JCC a description of what the service has done in order to resolve or mitigate the issues raised at the time of the initial review. Once that has been received by the MHLDVG division, each action will be reviewed against the evidence supplied with a view to understanding what level of progress has been made and what the ongoing escalation level will be. The current series of meetings between the MHLDVG and SBUHB have been suspended and will be rearranged following receipt of the updated action plan from the service in order to ensure that the ongoing meetings are relevant, with the appropriate personnel, and discuss relevant points of the action plan”. June 2026 – Following receipt of a consolidated report in late April 2026 evidencing significant progress against the original review findings, commissioning, quality safety and medical teams have undertaken a detailed assessment to identify the remaining actions required for de-escalation to level 2 monitoring. More integrated oversight arrangements are in place, via monthly escalation meetings from April 2026, with ongoing engagement with the service to support delivery. A clear set of outstanding actions are in place with the health board, with a commitment to review and sign off evidence on a rolling basis. August 2026 – Following an escalation meeting with the service the JCC recognised the considerable progress that has been made by staff across Caswell Clinic and SBUHB in addressing the issues identified within the Improvement plan since late 2025. It also acknowledges the work undertaken across the service to strengthen quality, safety and operational arrangements. A review undertaken in July by colleagues from the NWJCC Quality & Safety, Medical and Mental Health teams, working in collaboration with SBUHB and Caswell Clinic teams, confirmed that all immediate concerns have now been mitigated and that most actions within the de-escalation plan have been achieved. Continued focus will be required to ensure that these improvements are sustained and fully embedded across the service. Several areas will remain subject to ongoing monitoring in line with level 2 escalation and assurance to support the maintenance of progress achieved to date and to ensure that improvements continue to be embedded. The JCC will continue to work with the service to support and assure further improvement in care planning, clinical risk assessments and the wider governance programme.	Suspension for new admissions to the clinic	Complete	Complete
	JCC to meet with Caswell SLT on a fortnightly basis	Ongoing	Complete
	Clinic reopen to admissions	January 2026	January 2026
	JCC to meet with Caswell on a fortnightly basis to continue ongoing assurance processes	August 2026	Ongoing
	Letter to SBUHB exec team informing of de-escalation to Level 2	August 2026	Complete

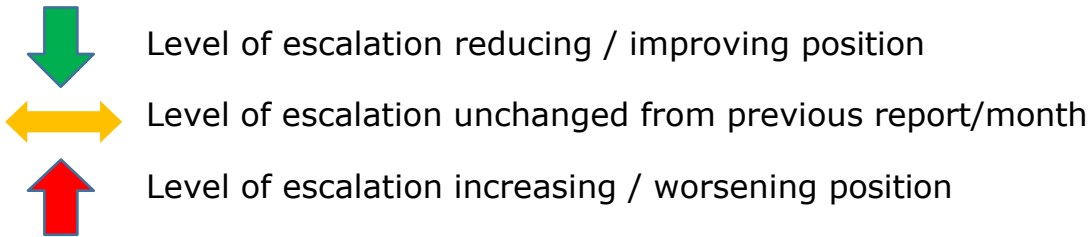
Level 1 ENHANCED MONITORING	Any quality or performance concern will be reviewed by the Commissioning Team. Enhanced monitoring is a pro-active response to put effective processes in place to drive improvement. It is an initial fact finding exercise which should ideally be led by the provider and closely 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.

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Level 4 DECOMMISSIONING/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.
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SERVICES IN ESCALATION





GIG
CYMRU
NHS
WALES

Bwrdd Iechyd
Addysgu Powys
Powys Teaching
Health Board

Agenda item: 6.3

EXECUTIVE COMMITTEE		15 OCTOBER 2026	
Subject:	Closure Report for the 2025-2026 Clinical Audit Programme		
Approved and presented by:	Kate Wright, Executive Medical Director		
Prepared by:	Prepared by the individual services and collated by Safety and Quality Improvement Manager		
Other Committees and meetings considered at:	Executive Committee 16 September 2026 – who supported the paper to the Committee.		
PURPOSE:			
The purpose of this paper is to provide a closure report for the 2025-2026 clinical audit plan.			
RECOMMENDATION(S):			
The Committee is asked to: Take ASSURANCE the clinical audit programme 2025/26 has been monitored and progress reported.			
Approve/Take Assurance		Discuss	Note
Y		N	N

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

EXECUTIVE SUMMARY:

This paper presents the closure report for the PTHB clinical audit programme for 2025-26. A total of 180 audits were included in the original program from the following services in the organisation.

Women and Children's service	40
Mental Health and LD services	40
Infection Prevention Control	4
Medical Directorate	5 medicines management and 1 corporate
Unscheduled Care	8
Dentistry	6
Therapies and Diagnostics	22
Theatre Services	54

HEADING:

Changes to the audit programme and to reporting

Following encouragement by the Medical Director to adopt a more focussed approach to audit, a number of services undertook a mid-year review of their audit plans. The surgery and endoscopy team decided to remove 18 of their planned audits which covered areas recently audited and replace them with two new, and more impactful, audits.

Instead of *ad hoc* audits the Medicines management team has decided that the "4C" antibiotic prescribing in primary care will be monitored and addressed where necessary with individual practices according to their quarterly performance as tracked on the medicines management prescribing indicator dashboard and that community hospital antimicrobial prescribing will be monitored prospectively using bespoke EPMA dashboards following the implementation of this system across wards which is currently underway.

Also to note is that the IPC (infection prevention and control) audit programme is now subject to established governance arrangements through the IPC Committee each quarter, with reporting subsequently feeding into the IQR and into PEQS.

Additionally, the annual IPC report is presented at PEQS each July and provides assurance regarding IPC activity, outcomes and associated audits. To prevent unnecessary duplication of reporting, IPC audits will not be listed on future clinical audit programmes.

The unscheduled care team noted that the majority of audits are now undertaken using MS Forms and Business Intelligence (BI) tools, reducing printing costs while improving data accuracy and reporting capability. The team also notes that the "Was Not Brought" (WNB) audit is now undertaken as a separate process,

aligned to the development of MIU 011 relating to children on the Child Protection Register (CPR) or Looked After Children (LAC) who are referred onward from Powys MIUs. This ensures enhanced oversight and assurance in this high-risk cohort.

Spotlighting selected achievements from the 2025/26 audit programme.

The Community Dentistry Service has encouraged patient feedback by promoting the ongoing use of CIVICA systems and providing a selection of methods both traditional and digital for patients to provide feedback.

The service's Consent to Treatment Audit strengthened the documentation of Risks, benefits, and treatment alternatives, whilst also improve the recording of reasons for unwise patient decisions and the justification for antibiotic prescribing.

An audit on the compliance with ACORN and Fluoride Application improved data accuracy, maintaining strong compliance in Fluoride varnish application and ACORN completion. This work supports the maintenance of high preventative care standards while improving data quality and system alignment.

The dental service also undertook a Local Anaesthetic Audit reviewing cases where the patient had discomfort. The audit promoted clinical effectiveness by encouraging appropriate use of nerve blocks and the clinically appropriate use of Lignospan and Articaine where clinically appropriate.

The Unscheduled Care team wish to highlight that documentation audit has been separated into adult and paediatric cohorts to provide more targeted insight and support focused service improvement. Patient satisfaction audits are now reviewed on a monthly basis at Team Leader meetings to identify trends and inform local quality improvement actions.

Furthermore, the mattress audit has been updated to include servicing requirements, strengthening governance and equipment oversight, whilst highlight reports have been established to support clear escalation of key findings, areas of concern, and actions for improvement.

Colleagues across the Mental Health services, would like to highlight that audits over the past year have particularly supported improvement in inpatient safety and quality. This includes learning from audits focused on ligature and environmental risk assessments, WARRN risk assessments, care planning quality, and medicines management, all of which have informed local action plans, strengthened assurance, and contributed to ongoing quality improvement at ward and service level.

The surgery and endoscopy service would like to highlight their audit work in support of the introduction of the electronic traceability of endoscopes that enhances patient safety by providing a complete digital audit trail of scope use and it's decontamination cycle, reducing reliance on paper records, and supporting compliance with WHTM 01-06.

Further audit has also allowed for the implementation of new guidelines and inclusion criteria to be expanded. PTHB now offer general anaesthetics to patients with a BMI of up to 40, and 1 year post myocardial infarction patients. This will be monitored by clinical audit

Audiology. During October and November 2025 all Adult Hearing Rehabilitation Services in Wales took part in the National Audit against the new version 3 of the Quality Standards for Adult Hearing Rehabilitation Audiology (2025). The audiology audit is unique in that it is the only National Clinical Audit which is carried out by auditors external to the Health Board.

The compliance targets for the 2025 audit were 80% for each individual standard and an overall target of 85%. The Powys Adult Hearing Rehabilitation Service met the 80% target in all nine individual standards, whilst also meeting the overall target of 85%.

Discussion and dissemination of audits

Unscheduled care colleagues take audit highlight reports to be reviewed during the monthly MIU Team Leads meetings, with key findings subsequently reported through Quality & Safety reports to ensure wider organisational oversight.

The Therapies and Health Sciences team hold a T&HS Audit Feedback session which is held quarterly, whilst also having a bi-monthly T&S Quality, Patient Experience and Audit session for services to feedback and share any learning

Nursing Audit reports come through CSG QSPE meeting with highlights being then taken through DMT. Recognising that we need to consider an annual audit reporting mechanism, quarterly reviews will be implemented with ward nursing for example to ensure that information is accessible on outcomes/quality improvements and escalation of risk.

Audit findings within Mental Health are routinely reported through ward governance meetings, QUAILS and SMT. Learning is shared with multidisciplinary teams, fed into improvement plans where required, and escalated through nursing and medical leadership routes to ensure visibility and assurance at service and corporate level.

The Theatre and Endoscopy Service. Theatre staff share audit feedback at

TOG and Departmental team meetings or at departmental audit days. Whilst for Endoscopy audit feedback is shared with EUAG and at Departmental team meetings and Departmental audit days.

Patterson, Liz
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IMPACT ASSESSMENT

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

QUALITY:

	No impact	Negative	Positive	Both	
Safe			✓		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	✓				
Financial	✓				
Corporate	✓				
Operational	✓				
Reputational	✓				

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.

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Appendix A
Draft Clinical Audit Plan 2025/26

Community Services Group					
Surgery and Endoscopy					
Driver	Audit Title	End Date	Service	Lead	Status
Local Audits for Service Improvement	Staff Survey	Quarter 4	Theatre and Endoscopy	Theatre / Endoscopy Lead	Completed awaiting final report
Service Evaluation	Hand hygiene Audits	Quarter 4	Theatre and Endoscopy	Theatre / Endoscopy Lead	Completed, note now via MEG system
Service Evaluation	Legal and ethical audit	Quarter 1	Theatre	Theatre Lead	Removed
Service Evaluation	Data protection and GDPR	Quarter 1	Theatre	Theatre Lead	Removed
Service Evaluation	Management/Human Resources	Quarter 1	Theatre	Theatre Lead	Removed
Service Evaluation	Education	Quarter 1	Theatre	Theatre Lead	Removed
	Environmental Audit Process Improvement Tool (PIT) Infection Control Brecon	Quarter 2	Theatre	Theatre Lead	Completed
	Environmental Audit Process Improvement Tool (PIT) Infection Control Llandrindod	Quarter 2	Theatre	Theatre Lead	Completed
Service Evaluation	Five Steps to Safer Surgery	Quarter 1	Theatre	Theatre Lead	Removed
Service Evaluation	Managing Perioperative Normothermia	Quarter 1	Theatre	Theatre Lead	Removed
Service Evaluation	Medical devices audit	Quarter 1 Quarter 4	Theatre	Theatre Lead	Completed Both quarters
	Radiation Audit	Annual	Theatre	Senior Clinician Theatre/Endoscopy Planned care / Theatre team leader	Quarter 2 Completed
Service Evaluation	Risk Management (Organisational and Environmental)	Quarter 2	Theatre	Theatre Lead	Assessed elsewhere
Service Evaluation	Decontamination	Quarter 2	Theatre	Theatre Lead	audit now called Cairn Technology Peracetic acid

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					monitoring Completed
Service Evaluation	Specimen Management	Quarter 2	Theatre	Theatre Lead	Removed
Service Evaluation	Tourniquets	Quarter 2	Theatre	Theatre Lead	Removed
Service Evaluation	Use and Handling of Surgical Instruments	Quarter 2	Theatre	Theatre Lead	Removed
Service Evaluation	Preoperative care for Patients with Dementia	Quarter 2	Theatre	Theatre Lead	Removed
Service Evaluation	Anaesthesia	Quarter 3	Theatre	Theatre Lead	Removed
Local Audits for Service Improvement	Surgical record keeping audit & consent	Quarter 3	Theatre	Theatre Lead	Completed
	Mattress Audit	Quarterly	Endoscopy	Senior Clinician Theatre/Endoscopy Planned care	Quarter 4 Completed
Service Evaluation	Post anaesthetic Care	Quarter 3	Theatre	Theatre Lead	Removed
Service Evaluation	Surgical patient story	Quarter 4	Theatre	Theatre Lead	TBC Awaiting Corporate Patient Experience Lead to complete
Service Evaluation	Accountable Items, Swab, Instrument and Sharps Count	Quarter 4	Theatre	Theatre Lead	Completed
Service Evaluation	Infection Control	Quarter 4	Theatre	IPC	Completed – see note in text.
Service Evaluation	NEWS audit	Quarter 4	Theatre	Quality & safety lead Clinician/Planned care manager	Completed
Service Evaluation	Foreign body aspiration during intubation, advanced airway management or ventilation	Quarter 4	Theatre	Planned care manager	Completed
Service Evaluation	Individual endoscopists KPIs	Quarter 1 Quarter 3	Endoscopy	Endoscopy Clinical Lead	Quarter 1 Completed Quarter 3 Completed
Service Evaluation	Electrosurgery	Quarter 3	Theatre	Theatre Lead	Removed
Service Evaluation	Fluid Management	Quarter 3	Theatre	Theatre Lead	Removed
Service Evaluation	Surgical patient story	Quarter 4	Theatre	Theatre Lead	TBC Awaiting Corporate Patient

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					Experience Lead to complete
Service Evaluation	Pre assessment and Specific Day Case Requirements	Quarter 4	Theatre	Theatre Lead	Removed
Service Evaluation	Audit of prosthesis verification data	Quarter 4	Theatre	Theatre Lead	Removed
Service Evaluation	Intraoperative Care	Quarter 4	Theatre	Theatre Lead	Removed
Service Evaluation	Gastric ulcers rescoped within 12 weeks	Quarter 2 Quarter 4	Endoscopy	Endoscopy coordinator & Data/ Audit Support	Quarter 2 Completed Quarter 4 Completed
Service Evaluation	Post colonoscopy colorectal cancer rate	Quarter 4	Endoscopy	Endoscopy Clinical lead	Completed
Service Evaluation	Patient satisfaction survey	Quarter 4	Endoscopy	Data/ Audit Support	Completed
Service Evaluation	Patient story	Quarter 1 Quarter 3	Endoscopy	Endoscopy Coordinator	Quarter 1 Completed Quarter 3 Awaiting Corporate Patient Experience Lead to complete
Service Evaluation	Endoscopist satisfaction survey	Quarter 4	Endoscopy	Endoscopy Coordinator	Completed
Service Evaluation	Vetting and validation of endoscopy referrals	Quarter 4	Endoscopy	Clinical lead Endoscopy	Delayed
Service Evaluation	Gastric ulcers rescoped within 12 weeks	Quarter 2 Quarter 4	Endoscopy	Endoscopy coordinator & Data/ Audit Support	Quarter 2 Completed Quarter 4 Completed
Welsh Government National Audit Programme	Bowel Screening Wales User Experience Survey Results	Quarter 4	Endoscopy	Bowel Screening Wales	Completed
Local Audits for Service Improvement	Record Keeping/Consent	Quarter 3	Endoscopy	Endoscopy Coordinator	Completed
Service Evaluation	Annual planning & productivity report	Quarter 3	Endoscopy	Planned Care Manager	Completed
Service Evaluation	Scope traceability	Quarter 4	Endoscopy	Endoscopy Coordinator	Completed
Service Evaluation	8 Day Readmissions & 30 Day Mortality Report	Annual	Endoscopy	Senior Clinician Theatre/Endoscopy Planned care	NEW Quarter 4 Completed

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Local Audits for Service Improvement	Inclusion/exclusion criteria audit	Quarter 2 Quarter 4	Endoscopy	Endoscopy Coordinator	Removed
Local Audits for Service Improvement	Bowel Screening Wales pathology reporting audit	Quarter 3	Endoscopy	Business Support Manager Planned Care	Completed
Local Audits for Service Improvement	Pain / Comfort Audit	Quarter 2 Quarter 4	Endoscopy	Endoscopy Coordinator	Quarter 2 Completed Quarter 4 Completed
Local Audits for Service Improvement	Single cancer pathway process	Quarter 4	Endoscopy	Planned care manager	Completed
Local Audits for Service Improvement	Audit of open access referrals into our service	Quarter 4	Endoscopy	Planned care manager	Completed
Local Audits for Service Improvement	Audit for Endoscopy Screening assessment	Quarter 4	Endoscopy	Planned care manager	Completed
Local Audits for Service Improvement	PGD 0083C (Supply of Moviprep for Bowel Screening)	6 months prior to expiry of PGD operational from 11/06/25 - 10-06-28	Endoscopy	Endoscopy Coordinator	NEW Quarter 1 Completed Next due Quarter 1 2028
Local Audits for Service Improvement	PGD 0149A (Administration of Adrenaline in Endoscopy)	6 months prior to expiry of PGD operational from 01/08/25 - 12-06-28	Endoscopy	Endoscopy Coordinator	NEW Quarter 2 Completed Next due Quarter 1 2028

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Therapies and Health Science

Driver	Audit Title	End Date	Service	Lead	Status
Audits performed for accreditation schemes	Compliance with Standard operating procedures	Quarter 3	Radiography	Head of Radiography	Completed
Audits performed for accreditation schemes	Pregnancy Status	Quarter 3	Radiography	Head of Radiography	Completed
Audits performed for accreditation schemes	Correct use of radiographic markers	Quarter 3	Radiography	Head of Radiography	Completed
Audits performed for accreditation schemes	Non Medical Referrals (NMR) Audit of NMR compliance	Quarter 3	Radiography	Head of Radiography	Completed
Audits performed for accreditation schemes	Reject analysis	Quarter 3	Radiography	Head of Radiography	Completed
Audits performed for accreditation schemes	Radiographer commenting audit	Quarter 3	Radiography	Head of Radiography	Completed
Audits performed for accreditation schemes	QA plain film and NOUS / Midwife Sonography	Quarter 3	Radiography	Head of Radiography	Completed
Local Audits for Service Improvement	QA reporting Audit	Quarter 3	Radiography	Head of Radiography	Completed
Audits performed for accreditation schemes	Monthly Clinispet/Clinel Wipes Audit	Quarter 3	Radiography	Head of Radiography	Completed
Audits performed for accreditation schemes	Sonography Service Audit		Radiography	Clinical Governance Lead for Sonography	Completed
Audits performed for accreditation schemes	Reporting Radiography Service Audit	Quarter 3	Radiography	Head of Radiography	Completed
Other National Audit & Service Evaluation	The Sentinel Stroke National Audit Programme	Quarter 4	All AHPs	Consultant Therapist for Stroke	Ongoing data reporting

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Audits performed for accreditation schemes	Red Dot	Quarter 4	Radiography	Head of Radiography	Completed
Local Audits for service improvement	Therapy Outcome Measures Audit	Quarter 4	Speech and Language Therapy	Head of Speech and Language Therapy	Completed
Local Audits for service improvement	Correct use of radiographic markers	Quarter 4	Radiography	Head of Radiography	Completed
Local Audits for service improvement	MIU NMR Audit for appropriate referrals	Quarter 1	Radiography	Head of Radiography	Completed
Other National Audits	National Diabetes Foot Care Audit	TBC National	Podiatry	Head of Podiatry	Ongoing data reporting
Other National Audits	Parkinsons AHP	TBC National	Therapies & Health Sciences	SLT	Ongoing data reporting
National Programme Audit	Adult Audiology Standards	TBC National	Audiology	Professional Head of Audiology	Completed
Service Evaluation	RCOT proforma on 'focusing on occupation' and 'your professional rationale'	Quarter 4	OT	Professional Head of OT	Completed
Service Evaluation	MSK Transformation Business Case	Quarter 1	Physio	Professional Head of Physio / Consultant MSK	Completed – Reported to Diagnostic and Planned Care Board

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Community Dentistry					
Driver	Audit Title	End Date	Service	Lead	Status
Local Audits for Service Improvement	Patient Experience Audit	May 2025	Community Dentistry	Tesni Jones	Completed
Other National Audit	WHTM01-05	Sept 2025	Community Dentistry	Rachael Anwyl	Completed
Local Audits for Service Improvement	Written Consent to treatment audit	Dec 2025	Community Dentistry	Lloyd Bovensiepen	Completed
Local Audits for Service Improvement	Compliance with Acorn and Fluoride Application for GDS patients	Sept 2025	Community Dentistry	Evelyn Gough	Completed
Local Audits for Service Improvement	Antimicrobial Stewardship	Jan 2026	Community Dentistry	Lloyd Bovensiepen	Completed
Local Audits for Service Improvement	Patient engagement and outcomes of treatment visits	Feb 2026	Community Dentistry	TBC	Completed
Local Audits for Service Improvement	Radiography grading - Annual subjective image quality ratings of dental radiographs in the Community Dental Service	Continuous yearly run chart	Community Dentistry	Warren Tolley/ Catherine Adams	Completed

Unscheduled Care					
Driver	Audit Title	End Date	Service	Lead	Status
Local Audits for Service Improvement	Missed Fractures Audit	Quarter 4 2025	Unscheduled Care	Senior Manager	Rolled over to 2026
Local Audits for Service Improvement	Mattress audit	Quarter 4 2025	Unscheduled Care	Senior Manager	Rolled over to 2026
Local Audits for Service Improvement	Hand Hygiene Audit	Quarter 4 2025	Unscheduled Care	Senior Manager	Rolled over to 2026
Local Audits for Service Improvement	Primary Care Attenders		Unscheduled Care	Senior Manager	Removed as now reported in business intelligence report.

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Local Audits for Service Improvement	Paramedic/downgrade ambulance audit.		Unscheduled Care	Senior Manager	Removed as now reported in business intelligence report.
Local Audits for Service Improvement	PGD Audit	Quarter 4 2025	Unscheduled Care	Senior Manager	Rolled over to 2026
Local Audits for Service Improvement	Paeds under five audit – scrutiny of every attender under five	Quarter 4 2025	Unscheduled Care	Senior Manager	Added to Audit schedule in February 2026
Local Audits for Service Improvement	Ask & Act – Audit tool for RE Enquiry for Domestic Abuse in MIU	Quarter 4 2025	Unscheduled Care	Senior Manager	Incorporated into Routine enquiry audit

Medical Directorate					
Medicines Management					
Driver	Audit Title	End Date	Service	Lead	Status
Local Audits for Service Improvement	4C antimicrobial prescribing in primary care.	Quarter 3 2025/26	The Antimicrobial Stewardship (AMS) Pharmacist recruited October 2024 will take the lead on this audit moving forward.	Chief Pharmacist Emlyn Pritchard/Amie Bain	Completed
Local Audits for Service Improvement	"Start Smart then Focus" audit for antimicrobial prescribing in community hospitals	Quarter 4 2025/6		Amie Bain	Completed
Local Audits for Service Improvement	Community Pharmacy Rota Services The aim of this audit is to establish how much current rota services are used for their intended purpose.	Quarter 3 2025/26		Chief Pharmacist Emlyn Pritchard/Gail Brown	Completed
Local Audits for Service Improvement	Blueteq assurance audit	Quarter 4 2025/26		Chief Pharmacist Claire Jones	Completed

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	A random sample of 10 patients will be selected and their clinical notes will be checked to ensure that they meet the criteria for treatment.				
Local Audits for Service Improvement	Controlled Drugs Management in clinical areas across PTHB.	Quarter 4 2025/26		Controlled Drugs Accountable Officer Jayne Price/Internal Audit	Completed

Corporate Functions					
Resuscitation					
Driver	Audit Title	End Date	Service	Lead	Status
Other National Audit	Completion of DNACPR	Q4 2025	Resuscitation	Resuscitation Officer	Delayed
Infection Prevention and Control					
Local Audits for Service Improvement	Organisational IPS Environmental Audit	Q4 2025	IPC Staff	IPC Lead	Completed – see note in text on IPC.
Local Audits for Service Improvement	IPS Environmental Audit (More frequent/smaller)	Quarterly	IPC Staff	IPC Lead	Completed – see note in text on IPC.
Local Audits for Service Improvement	Mental Health Ward Environmental Audit	Q4 2025	Ward Staff	IPC Lead	Completed – see note in text on IPC.
Local Audits for Service Improvement	Hand Hygiene	Quarterly	Ward Staff	IPC Lead	Completed – see note

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					in text on IPC.

Mental Health and Learning Disabilities					
Mental Health					
Driver	Audit Title	End Date	Service	Lead	Status
Audits in response to Identified Risk	Audit of Environmental Ligature Risk Assessment	Quarter 2	All Mental Health Units	Senior Nurse - Inpatient Matron role	Completed
Audits in response to Identified Risk	Audit of WARRN risk assessments		All Mental Health Units	Consultant Nurse/Governance Lead	Completed
Audits in response to Identified Risk	Audit of Security Risk Assessment		All Mental Health and LD Units	Head of MH Operations	Completed
Local Audits for Service Improvement	Audit of Care and Treatment plans		All Mental Health Units	CTP Lead/Governance Lead	Completed
National Programme Audit	NCISH Suicide audit		All Mental Health Units	Suicide and SH Prevention Lead	Completed
National Programme Audit	National review of schizophrenia audit		All Mental Health Units	Clinical Director MH&LD	Completed
Local Audits for Service Improvement	Inpatient Physical health monitoring audits	Quarter 2	Ward units	Clinical Director MH&LD	Completed
Local Audits for Service Improvement	RCP/NICE quality standards for inpatient care	Quarter 2	Ward units	Senior Nurse - Inpatient Matron role	Completed
Local Audits for Service Improvement	Medicine management audit	Quarter 2	All Mental Health & LD Units	Service Managers and Ward Managers	Completed

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Local Audits for Service Improvement	Hand hygiene/Matress audits	Quarter 2	Ward units	Ward Managers	Completed
Local Audits for Service Improvement	Record Keeping	Quarter 2	All Mental Health Units	Team Leads/Ward Managers/IG	Completed
Local Audits for Service Improvement	DNAs	Quarter 2	All Mental Health Units	Business and Performance Manager	Completed
Local Audits for Service Improvement	Multi-factorial Falls Risk Assessment Audit (Inpatients)	Quarter 2	Ward units	Service Managers and Ward Managers	Completed
Local Audits for Service Improvement	Welsh Language Active Offer Audits		All Mental Health & LD Units	TBC	Completed
Local Audits for Service Improvement	WNB		CAMHS	CAMHS Operational Lead	Completed
Local Audits for Service Improvement	Early Intervention in Psychosis	Quarter 3	CAMHS	CAMHS Operational Lead	Completed
Local Audits for Service Improvement	Outcome Measure Audit	Quarter 3	CAMHS	CAMHS Operational Lead	Completed
Local Audits for Service Improvement	LPMHSS Pathway Audit	Quarter 3	Community Based	Service Manager LPMHSS/Psychology	Completed
Local Audits for Service Improvement	Policy Audit		All Mental Health & LD Units	CPAG	Completed
Local Audits for Service Improvement	Community Medical Caseload and Admin	Quarter 2	All Mental Health Units	Clinical Director MH&LD	Completed
Local Audits for Service Improvement	S117 Audit	Quarter 2	All Mental Health Units	Head of MH Operations	Completed
Local Audits for Service Improvement	MH Act Compliance	Quarter 3	All Mental Health Units	HoMH Nursing	Completed
Local Audits for Service Improvement	Adult & Older Adult CMHT MDT Audit	Quarter 3	Community Based	Head of MH Operations	Completed
Local Audits for Service Improvement	Epilepsy audit	Quarter 2	All LD	Head of LD	Completed
Local Audits for Service Improvement	Liaison data audit	Quarter 2	All LD	Head of LD	Completed
Local Audits for Service Improvement	Champion training audit	Quarter 2	All LD	Head of LD	Completed
Local Audits for Service Improvement	Anti-psychotic and physical health audit	Quarter 3	All Mental Health & LD Units	Consultant Psychiatrist/Head of SOAD	Completed
Local Audits for Service Improvement	H&S audit doors/alarms/ radio functions	Quarter 2	Ward Based	Service Managers and Ward Managers	Completed

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Local Audits for Service Improvement	Medical Devices audit	Quarter 2	All Mental Health & LD Units	Service Managers and Team Managers	Completed
Local Audits for Service Improvement	Environmental audit/ cleanliness/risks	Quarter 2	All Mental Health & LD Units	Service Managers and Team Managers	Completed
Local Audits for Service Improvement	Fire risk audit drills/points/equipment	Quarter 2	All Mental Health & LD Units	Service Managers and Team Managers	Completed
Audits in response to Identified Risk	Therapeutic observations audit	Quarter 3	All Mental Health & LD Units	Service Managers and Ward Managers	Completed
Audits in response to Identified Risk	WCCIS and V4 MHM forms audit	Quarter 3	All Mental Health & LD Units	Service Managers and Ward Managers	Completed
Audits in response to Identified Risk	Advocacy audit	Quarter 3	All Mental Health & LD Units	Head of LD	Completed
Audits in response to Identified Risk	Discharge letters audit from in-patient services.	Quarter 3	All Mental Health & LD Units	Clinical Director MH&LD	Completed
Audits in response to Identified Risk	Escorting patients off hospital grounds	Quarter 3	All Mental Health & LD Units	Service Managers and Ward Managers	Completed
Audits in response to Identified Risk	Educational audit	Quarter 3	All Mental Health & LD Units	Service Managers and Team Managers	Completed
Audits in response to Identified Risk	CRHTT audit of CTP/WARRN & 72 hour f2f assessments	Quarter 3	All Mental Health & LD Units	Service Managers and Team Managers	Completed
Audits in response to Identified Risk	Older adult CMHT discharge audit	Quarter 3	All Mental Health & LD Units	Service Managers and Team Managers	Completed
Audits in response to Identified Risk	s136 audit	Quarter 3	All Mental Health & LD Units	Clinical Director MH&LD	Completed

Women and Children's Service

Midwifery

Driver	Audit Title	End Date	Service	Lead	Status
Local Audit for Service Improvement	All Wales Handheld Maternity Records	July 2025	Maternity	Clinical Supervisor for Midwives	Completed

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Service evaluation	Maternity Triage Process Review	October 2025	Maternity	MatNeo Champion	Completed
Local Audit following change to policy or procedure	VTE Guideline	November 2025	Maternity	Clinical Supervisors for Midwives	Completed
Local Audit following change to policy or procedure	Spontaneous Rupture of Membranes Guideline	April 2025	Maternity	Consultant Midwife	Completed
Local Audit for Service Improvement	Perinatal Mental Health Birth Management Planning	December 2025	Maternity	Perinatal Mental Health	Completed
Local Audit for Service Improvement	Intrapartum Transfers from Powys to DGH (<i>Business as usual</i>)	June 2025	Maternity	Consultant Midwife	Completed
Local Audit for Service Improvement	Clinical Information Sharing Caseload (<i>Business as usual</i>)	March 2026	Maternity	Clinical Supervisors/Consultant Midwife	Completed

Children's Nursing Leadership Team

Local Audit for Service Improvement	Transition	6 monthly	Children's Services	SD	Delayed
Local Audit for Service Improvement	Children's Continuing Care	Q4	Children's Services	SD	Delayed

Children's Public Health nursing (Health Visiting & Flying Start)

Local Audit for Service Improvement	Routine Enquiry (Quarterly)	Q3	Generic HV& Flying Start	WD/Delegate	Completed
Local Audit for Service Improvement	Record Keeping	Record Keeping	Generic HV& Flying Start	WD/Delegate	Completed

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Local Audit for Service Improvement	Was Not Brought	Monthly	Generic HV& Flying Start	WD/Delegate	Completed monthly
Local Audit for Service Improvement	Welsh Levels of Care	Quarterly	Generic HV& Flying Start	WD/Delegate	Completed
Local Audit for Service Improvement	Implementation of Guideline: Health Visiting Caseload cleanse	6monthly	Generic HV& Flying Start	WD/Delegate	Completed for August 25 and February 26
Local Audit for Service Improvement	Cypris Data Compliance	6 monthly	Generic HV& Flying Start	WD/Delegate	Completed

School Nursing and Immunisation Team

Local Audit for Service Improvement	Was Not Brought	Monthly	School Nursing/Imms	WD/Delegate	Completed
Local Audit for Service Improvement	Flu Immunisation Uptake	Following programme	Immunisation Team	WD/Delegate	Completed
Local Audit for Service Improvement	DTP MenACWY Imms Uptake	Following programme	Immunisation Team	WD/Delegate	Completed
Local Audit for Service Improvement	HPV Immunisation uptake	Following programme	Immunisation Team	WD/Delegate	Completed
Local Audit for Service Improvement	E-Consent	Following each Imms programme	Immunisation Team	WD/Delegate	Completed
Local Audit for Service Improvement	Level 1 Continence Delivery	Quarterly	School Nursing	WD/Delegate	Completed
Local Audit for Service Improvement	Record Keeping	Q4	SN/Imms	WD/Delegate	In progress

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Local Audit for Service Improvement	Handwashing	Q4	SN/Imms	WD/Delegate	Completed
Local Audit for Service Improvement	ANTT (Immunisation nurses)	Q4	Immunisation team	WD/Delegate	Completed
Local Audit for Service Improvement	Safeguarding Caseloads	Quarterly	School Nursing Team	WD/Delegate	Completed

Community Paediatrics					
National Audit	National Audiology Audit	Q3	Comm Paeds	RL	Completed
Local Audit for Service Improvement	ADHD Medications	Q2	Comm Paeds	RL	Delayed
Local Audit for Service Improvement	Downs Syndrome Audit	Q4	Comm Paeds	IP	Delayed
Local Audit for Service Improvement	CPIP +Register review	Q4	Comm Paeds	LA/RL	Delayed
Local Audit for Service Improvement	Record Keeping	Q3	Comm Paeds	SD/LA	Delayed

Children's Community Nursing					
Local Audit for Service Improvement	Was not brought	Monthly	CCNS	CD/Delegate	Completed Monthly
Local Audit for Service Improvement	Record keeping	Quarter 4	CCNS	CD/Delegate	SOAP training needs to be updated. Record keeping audit to be completed.

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Local Audit for Service Improvement	ANTT	Quarter 4	CCNS	CD/Delegate	Hand hygiene completed every 6 months. All Mandatory training completed for ANTT. Awaiting MEG training for future audits.
Local Audit for Service Improvement	Paediatric Continence	Quarter 4	CCNS	CD/Delegate	Audit completed July 25. Caseload management completed May 26.
Local Audit for Service Improvement	Paediatric Epilepsy	Quarter 4	CCNS	CD/Delegate	Service contributes to the epilepsy12 audit.

Neuro Development Team					
Local Audit for Service Improvement	Introduction of caseload management	Monthly	ND	CD/Delegate	Quarterly audits completed
Local Audit for Service Improvement	Average length of open assessment pathways	Monthly	ND	CD/Delegate	Monitored by SD monthly.
Local Audit for Service Improvement	Record Keeping	Quarterly	ND	CD/Delegate	Quarterly audit completed on record keeping. Noted that SOAP training needs to be updated.
Local Audit for Service Improvement	Was Not Brought	Monthly	ND	CD/Delegate	Monthly WNB audit completed.

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Audit Driver Key:

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

Progress Key:

	Progress
	On Track/Completed
	Indicates audit Rolled Forward from 2024/25 Programme
	Not undertaken due to lack of capacity
	Cancelled as being no longer required

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Patient Experience, Quality and Safety Committee 2026-27					
Theme	Item Title	April 30/04/2026	August 04/08/2026	October 15/10/2026	February 04/02/2027
Governance	Minutes of previous meeting	✓	✓	✓	✓
Governance	Declaration of Interests	✓	✓	✓	✓
Governance	Action Log	✓	✓	✓	✓
Governance	Committee Risk Register	✓	✓	✓	✓
Governance	Annual Work Programme	✓			
Governance	Board Out and About Programme	☒	✓		✓
Governance	Committee Work Programme (updated through year)		✓	✓	✓
Governance	Items to be brought to the attention of the Board and/or other Committees	✓	✓	✓	✓
Governance	Annual Assessment of Committee Effectiveness				✓
Governance	Committee Governance Action Plan		✓		✓
Governance	Committee Annual Report	✓			
Governance	Review of Terms of Reference PEQS				✓
Governance	Review of Terms of Reference Power of Discharge Group				✓
	Chairs Report (update on PoDGp, out and abouts and aob relating to PEQS)			✓	✓
Quality	Integrated Quality Report to include:	✓	✓	✓	✓
Quality	PSOW Annual Letter (within IQR - when received)			✓	
Quality	Integrated Quality and Performance Framework (timing to be confirmed)				
Quality	Maternity Services reporting	✓	✓	☒	✓
Safeguarding	Safeguarding Annual Report		✓		
	PHW Test and Post incident	✓			
Research, Development and Improvement	Quality based improvement / learning		☒	☒	✓
Research, Development and Improvement	Research, Development and Innovation			☒	✓
Patient Experience	Patient Experience Framework	✓		✓	
Patient Experience	Patient Story		✓		✓
Primary Care	Patient Experience in Primary Care		☒	✓	
Primary Care	Primary Care - dental quality			✓	
MH Compliance	MH Power of Discharge Annual Report including MH compliance with legislation and update				✓
Clinical Audit	Annual Programme Clinical Audit	✓			
Clinical Audit	Clinical Audit Annual Closure Report			✓	
Clinical Audit	In year Progress Report Clinical Audit			☒	
Audit Reports	Any Internal Audit/Wales Audit reports received - for information	✓	✓	✓	✓
Medicines Management	Annual Report of Accountable Officer for Controlled Drugs				✓
Annual Reports	Medicines Management Annual Report			✓	
	Duty of Quality Annual Report		✓		
	Annual Report Medical Devices and Point of Care Testing			✓	
	Transition of Care Annual Report/update		✓	✓	
	Nurse Staffing Levels		✓		
Infection Prevention and Control	Chief Nursing Officer IPC statement	✓			
Infection Prevention and Control	IPC Annual Report		✓		✓
	Mortality Annual report (including follow up to Internal Audit on Medical Examiner)			☒	✓
Other	Corporate Parenting Charter update			☒	✓
	Staff experience of ND Services in escalation (post escalation)				
	JCC Quality Safety and Outcomes Sub-Committee Highlight Report (as held)	✓	✓	✓	✓
	EPMA update		✓		
	Monitoring ongoing improvement and barriers to implementation re WHC 37 Infected Blood Inquiry (Blood Transfusions)			✓	
	Six-monthly update on Antimicrobial stewardship		✓		✓
	Monitoring Report Mental Health Services post escalation	☒			
	Quality Management System		✓	☒	✓
	Patient Experience in Commissioning Framework			✓	
Escalated Items:					
	Civica (Patient Experience - see above)	✓	✓		
	Neurodiversity (referred from D&P Oct 2024)	✓	✓	✓	✓
In Committee					
	Report on suicides	✓			
	Transition of Care Report (to each meeting until agreed can be bi-annual)	✓	In main meeting	In main meeting	✓
	PHW Test and Post Sexual Health Service Incident	✓			
KEY	HSE update				
Added to draft agenda					
Date to be confirmed					
Item deferred					
Item brought forward					
Item not taken subsequent to work programme review					



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd
Addysgu Powys
Powys Teaching
Health Board

Powys Teaching Health Board Glossary (Last updated August 26)

Acronym	
AD ECP	Associate Director of Estates, Capital & Property
ACEO	Acting Chief Executive Officer
ADoF	Acting Director of Finance
ADCEO / EMD	Acting Deputy Chief Executive / Executive Medical Director
CEO	Chief Executive Officer
DCEO / ED FC&SS	Deputy Chief Executive Officer / Executive Director of Finance, Capital & Support Services
DCG	Director of Corporate Governance
D I&T	Director of Improvement & Transformation
E MD	Executive Medical Director
ED PH	Executive Director of Public Health
ED PC&T	Executive Director of People, Culture & Transformation
ED PP&C	Executive Director of Planning, Performance and Commissioning
ED AHPHS&D	Executive Director of Allied Health Professions, Health Sciences and Digital
ED NQW&FH	Executive Director of Nursing, Quality, Women and Family Health
ED PCCMH	Executive Director of Primary Care, Community & Mental Health
ABUHB	Aneurin Bevan University Health Board
AFC	Agenda for Change
A&E	Accident and Emergency
AGW	The Auditor General for Wales
AHPs	Allied Health Professionals
ALN	Additional Learning Needs
ANP	Advanced Nurse Practitioner
AO	Accountable Officer
AQS	Annual Quality Statement/Report
ARAC	Audit, Risk and Assurance Committee
ASM	Accelerated Sustainable Model
AR	Audit Recommendations
AF	Audit Findings
APB	Area Planning Board
AGS	Annual Governance Statement
BAF	Board Assurance Framework

BCUHB	Betsi Cadwaladr University Health Board
BMA	British Medical Association
CAHPO	Chief Allied Health Professionals Officer
CAAP	Clinical Associate in Applied Psychology
CAMHS	Child and Adolescent Mental Health Services
CCN	Childrens Community Nursing
COC	Continuity of Care
CDO	Chief Dental Officer
CEMT	Chief Executive Management Team
CHC	Continuing Health Care
CIW	Care Inspectorate for Wales
CLIP	Collaborative Learning in Practice
CNO	Chief Nursing Officer
CPCF	Community Pharmacy Contractual Framework
CPD	Continued Professional Development
CPR	Child Practice Review
CRR	Corporate Risk Register
CSP	Clinical Service Plan
CTMUHB	Cwm Taf Morgannwg University Health Board
CV	Curriculum Vitae
CVUHB	Cardiff and Vale University Health Board
CWMPAS	Mid and West Wales Regional Safeguarding Adults Board
CYSUR	Mid and West Wales Regional Safeguarding Children Board
CTC	Care Transfer Co-ordinator
CCOMG	Complex Care Operational Management Group
DATIX	Incident Management System
DAP	Dental Access Portal
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/Pathway of Care Delays
D2RA	Discharge to Recover and Assess
DST	Decision Support Tool
DOI	Declaration of Interest
EASC	Emergency Ambulance Services Committee
EOG	Executive Oversight Group

EOY	End of Year
EMRTS	Emergency Medical Retrieval & Transfer Service
EPMA	Electronic Prescribing and Medicines Administration
ESR	Electronic Staff Record
EMI	Elderly Mentally Infirm
FBC	Full Business Case
FOI	Freedom of Information
FFT	Friends and Family Test
FTE	Full Time Equivalent
F&P	Finance and Performance Committee
GDS	General Dental Services
GIRFT	Getting It Right First Time
GLP-1	Glucagon Like Peptide
GMC	General Medical Council
GMS	General Medical Services
GP	General Practitioner
GNCC	General Nursing Complex Care Team
G&H	Gifts and Hospitality
H&S	Health and Safety
HCA	Health Care Assistant
HCS	Health and Care Standards
HCSW	Health Care Support Worker
HDUHB	Hywel Dda University Health Board
HEIW	Health Education and Improvement Wales
HIA	Health Impact Assessment
HIW	Healthcare Inspectorate Wales
HP	Health Protection
HPF	Healthcare Professionals Forum
IBG	Investment Benefit Group
ICB	Integrated Care Board
ICF	Integrated Care Funding
ICU	Intensive Care Unit
IEN	Internationally Educated Nurse
IG	Information Governance
IM	Independent Members
IMTP	Integrated Medium-Term Plan
IPFR	Individual Patient Funding Request
IP&C	Infection Prevention and Control
IOPF	Integrated Quality Performance Framework
IOPG	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
KSF	Knowledge and Skills Framework
LoF	League of Friends
LA	Local Authority
LHB	Learning Health Board
LMC	Local Medical Committee
LPF	Local Partnership Forum
LPMHSS	Local Primary Mental Health Support Services
LRF	Local Resilience Forum
LTA	Long Term Agreement
LTCs	Long-Term Conditions
NDR	National Data Resource Platform
NICE	National Institute for Health and Care Excellence
MAC	Mindfulness, Acceptance and Compassion Team
MD	Ministerial Direction
MD's	Minimum Data Set
MDTs	Multi-Disciplinary Teams
MAP	Medical Associate Practitioner
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
NWSSP	NHS Wales Shared Services Partnership
JCC	NHS Wales Joint Commissioning Committee
NHSE	National Health Service England
NHS	National Health Service
NHSWE	NHS Wales Executive

NICE	National Institute of Health and Clinical Excellence
NRI	Nationally Reportable Incidents
NWSSP	NHS Wales Shared Services Partnership
NNA	Nursing Needs Assessment
OBC	Outline Business Case
OCP	Organisational Change Process
ODEC	Organisational Development, Engagement and Communications
OOC	Out of County
OOH	Out of Hours
ORS	Opinion Research Services
OSCE	Objective Structured Clinical Examination
OT	Occupational Therapy
PA	Physician Associate
PADR	Personal Appraisal Development Review
PAVO	Powys Association of Voluntary Organisations
PET CT	Positron Emission Tomography Computed Tomography
PCC	Powys County Council
PALS	Patient Advice and Liaison Service
PEQS	Patient Experience, Quality and Safety Committee
PREM	Patient-Reported Experience Measure
PROM	Patient-Reported Outcome Measure
PCMW	Primary Care Model for Wales
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
QOF	Quality and Outcomes Framework
RaTS	Remuneration and Terms of Service Committee
DDRB	Review Body on Doctors' and Dentists' Remuneration
RCN	Royal College of Nursing
REES	Race Equality Employment Standard
RIIC	Research, Innovation & Improvement Coordination

RIF	Regional Investment Fund
RISP	Radiology Information System Procurement
RJAH	The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
RN	Registered Nurse
RPB	Regional Partnership Board
RTT	Referral to Treatment
RTS	Routemap To Sustainability
RAMI	Risk Adjusted Mortality Index
RMF	Risk Management Framework
RHCW	Rural Health and Care Wales
Q1 Q2 Q3 Q4	Quarter 1 (April, May, June), Quarter 2 (July, August, September), Quarter 3 (October, November, December), Quarter 4 (January, February, March)
QSEG	Quality, Safety and Experience Group
SAR	Subject Access Request
SAS	Specialty and Specialist
SBAR	Situation, Background, Assessment, Recommendation
SBUHB	Swansea Bay University Health Board
SDEC	Same Day Emergency Care
SLA	Service Level Agreement
SOC	Strategy Outline Case
SOP	Standard Operating Procedure
SaTH	The Shrewsbury and Telford Hospital NHS Trust
SPB	Strategic Programme Board
SRO	Senior Responsible Owner
SPPP	Social Partnership and Public Procurement (Wales) Act 2023
RJC	South East Wales Regional Joint Committee
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

WCVA	Wales Council for Voluntary Action
WESB	Wales Employment and Skills Board
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
WLGA	Welsh Local Government Association
WNCR	Welsh Nursing Care Record
WNHSC	Welsh NHS Confederation
WRES	Workforce Race Equality Standard
WTE	Whole Time Equivalent
WVT	Wye Valley NHS Trust
WCD	Written Controlled Document
YTD	Year to Date

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