Patient Experience, Quality and Safety Committee

Thu 30 April 2026, 09:30 - 12:30

Microsoft Teams

Agenda

09:30 - 09:30
0 min

1. PRELIMINARY MATTERS

PEQS_Agenda_30Apr26 FINAL.pdf (3 pages)

1.1. Welcome and Apologies

1.2. Declarations of Interest

PEQS_1.2_Register of Interests Feb 2026_Board Members Declaration Of Interests summary 2025-26.pdf (3 pages)

09:30 - 09:30
0 min

2. CONSENT AGENDA BUSINESS

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

09:30 - 09:30
0 min

3. ITEMS FOR APPROVAL / DECISION / RATIFICATION

3.1. Minutes of the previous meeting: 05 February 2026

PEQS_3.1_Minutes 2026-02-05 PEQS unconfirmed.pdf (15 pages)

3.2. Committee Action Log

To Follow

3.3. Committee Annual Work Programme 2026/27

PEQS_3.3_Work Programme 2026-27.pdf (1 pages)

3.4. Committee Annual Report 2025/26

PEQS_3.4_PEQS Committee Annual Report 2025-26 cover.pdf (13 pages)

09:30 - 09:30
0 min

4. ESCALATED ITEMS

4.1. Children's Neurodiversity Services

PEQS_4.1_Neurodevelopmental Services.pdf (8 pages)
PEQS_4.1a_Appendix 1 Conditions for Sustainability.pdf (8 pages)

4.2. Peoples Experience Framework

PEQS_4.2_Patient Experience Framework exception report Apr26.pdf (7 pages)

09:30 - 09:30
0 min

5. ITEMS FOR ASSURANCE

5.1. Integrated Quality Report

PEQS_5.1_Integrated Quality Paper Apr26.pdf (18 pages)

5.2. National Assurance Assessment of Maternity and Neonatal Services in Wales

PEQS_5.2_Maternity Assurance Report.pdf (11 pages)

5.3. Board Out and About Programme

5.4. Annual Clinical Audit Programme 2026/27

PEQS_5.4_Clinical Audit Programme 2026-2027 Report.pdf (2 pages)
PEQS_5.4a_Clinical Audit Programme 2026-2027 Appendix A.pdf (21 pages)

5.5. Monitoring Report of Mental Health Service post escalation

PEQS_5.5_April 2026 Post de-escalation experienc final.pdf (11 pages)

5.6. Quality Statement - Infection Prevention and Control

PEQS_5.6_IPC Quality Statement Committee paper.pdf (7 pages)

5.7. PHW Test and Post Sexual Health Service incident

5.8. Committee Risk Register

PEQS_5.8_Committee Risk Register Cover.pdf (2 pages)
PEQS_5.8a_Appendix A - Committee Risk Register.pdf (16 pages)

09:30 - 09:30
0 min

6. ITEMS FOR DISCUSSION

There are no items for discussion

09:30 - 09:30
0 min

7. CONSENT AGENDA

7.1. Internal Audit Reports:

7.1.1. Clinical Supervision

PEQS_7.1a_Clinical Supervision Final Internal Audit Report.pdf (8 pages)

7.1.2. Deprivation of Liberty Standards

PEQS_7.1b_DoLS Follow-up Final Internal Audit report.pdf (8 pages)

7.2. Joint Commissioning Committee highlight report from the Quality, Safety and Outcomes Sub-Committee 15 December 2025

PEQS_7.2_JCC_QSOC Highlight Report 15 December 2025.pdf (17 pages)

7.3. Glossary

PEQS_7.3_Powys Teaching Health Board Glossary.pdf (6 pages)

09:30 - 09:30

8. OTHER MATTERS

0 min

8.1. Any Other Urgent Business

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

8.3. Committee reflections

8.4. Date of the Next Meeting: 04 August 2026

8.5. Confidential Items

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

8.6. Welcome and Apologies

8.7. Declarations of Interest

8.8. Minutes of the In-Committee meeting held on 05 February 2026

09:30 - 09:30
0 min

9. IN-COMMITTEE ESCALATED ITEMS

9.1. Transition of Care Update and Action Plan

09:30 - 09:30
0 min

10. ITEMS FOR ASSURANCE

10.1. Health and Safety Executive Notice - Felindre Ward

10.2. Report on Suicides

10.3. PHW Test and Post Sexual Health Incident

POWYS TEACHING HEALTH BOARD
PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE

THURSDAY 30 APRIL 2026
09:30 – 13:00
VIA MICROSOFT TEAMS

AGENDA				
Time	**Item**	**Title**	**Attached/Oral**	**Presenter**
	1	**PRELIMINARY MATTERS**		
09.30	1.1	Welcome and apologies	Verbal	Chair
	1.2	Declarations of interest	Verbal	All
	2	**CONSENT AGENDA BUSINESS**		
The Chair will ask if there are any items from the Consent Agenda (Item 7) that Committee Members wish to bring forward to the main agenda.				
	3	**ITEMS FOR APPROVAL / DECISION / RATIFICATION**		
09.35	3.1	Minutes of previous meeting: • 05 February 2026	Attached	Chair
	3.2	Committee Action Log	Attached	Chair
	3.3	Committee Annual Work Programme 2026/27	Attached	Chair
	3.4	Committee Annual Report 2025/26	Attached	Chair
	4	**ESCALATED ITEMS**		
09.50	4.1	Children's Neurodiversity Services	Attached	Executive Director of Planning, Performance and Commissioning
10.05	4.2	People Experience Framework update	Verbal	Executive Director of Nursing, Quality, Women and Family Health
	5	**ITEMS FOR ASSURANCE**		
10.15	5.1	Integrated Quality Report	Attached	Executive Director of Nursing, Quality, Women and Family Health
10.45	5.2	National Assurance Assessment of Maternity and Neonatal Services in Wales	Attached	Executive Director of Nursing, Quality, Women and Family Health
11.05	**COMFORT BREAK (10 minutes)**			
11.15	5.3	Board Out and About Programme	Presentation	Director of Corporate Governance / Board Secretary
11.25	5.4	Annual Clinical Audit Programme 2026/27	Attached	Executive Medical Director
11.35	5.5	Monitoring Report of Mental Health Service post escalation	Attached	Executive Director of Primary, Community Care and MH
11.55	5.6	Quality Statement – Infection Prevention and Control	Attached	Executive Director of Nursing, Quality, Women and Family Health

12.00	5.7	PHW Test and Post Sexual Health Service Incident	Verbal	Executive Director of Public Health
12.05	5.8	Committee Risk Register	Attached	Director of Corporate Governance
	6	**ITEMS FOR DISCUSSION**		
		There are no items for discussion		
	7	**CONSENT AGENDA**		
	7.1	Internal Audit Reports: • Clinical Supervision *(Reasonable Assurance)* • Deprivation of Liberty Standards follow-up audit *(all actions implemented)* **Purpose**: Information	Attached	Director of Corporate Governance
	7.2	Joint Commissioning Committee highlight report from the Quality, Safety and Outcomes Sub-Committee 15 December 2025 **Purpose:** Assurance	Attached	Executive Director of Nursing, Quality, Women and Family Health
	7.3	Glossary **Purpose**: Information	Attached	Director of Corporate Governance
	8	**OTHER MATTERS**		
12.10	8.1	Any Other Urgent Business	Oral	Chair
	8.2	Items to be brought to the attention of the Board and/or other Committees	Verbal	Chair
	8.3	Committee Reflections	Verbal	Chair
	8.4	Date of the next meeting: 04 August 2026		

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

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

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

12.15	8.6	Welcome and Apologies	Verbal	Chair
	8.7	Declaration of Interest	Verbal	Chair
	8.8	Minutes of the In-Committee Meeting held on the 05 February 2026	Attached	Chair
	9	**IN-COMMITTEE ESCALATED ITEMS**		
12.20	9.1	Transition of Care Update and Action Plan	Attached	Executive Director of Nursing, Quality,

				Women and Family Health
	10	**ITEMS FOR ASSURANCE**		
12.35	10.1	Health and Safety Executive Notice – Felindre Ward	Attached	Executive Director of Primary, Community Care and MH
12.40	10.2	Report on suicides	Attached	Executive Director of Primary, Community Care and MH
12.55	10.3	PHW Test and Post Sexual Health Service Incident	Attached	Executive Director of Public Health
13.00	Close			

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

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

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

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

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

Updated: February 2026

Position	Name	Interest Category	Interest Situation	Relevant Dates from	Relevant Dates to	Description of Declaration	Comment	Date Returned
INDEPENDENT MEMBERS								
PTHB Chair	**Carl Cooper**	Indirect Interests	Loyalty Interests	2018	Ongoing	Sole Trader, Mandy Williams, Consulting	Nil	29/05/2025
		Indirect Interests	Loyalty Interests	2025	Ongoing	Family member is an employee of Cardiff & Value University Health Board (non Director).	Nil	
Vice Chair	**Kirsty Williams**	Non Finanical personal interests	Loyalty Interests	Feb-25	Current	Co Director of Samaritans Powys	None	22/04/2025. Left the Health Board on 30 September 2025
		Non Finanical personal interests	Loyalty Interests	Nov-22	Current	Director of ILEP Ltd a subsiduary of Cardiff University	None	
		Indirect Interests	Outside Employment	Feb-24	Ongoing	Commissioner for South Wales Fire and Rescue	Ministerial Appointment	
		Non Finanical personal interests	Loyalty Interests	2024	Current	Vice Chair of Brecknock YFC Board of Management	NIL	
Vice Chair	**Rhiannon Beaumont-Wood**	Non Financial professional interests	Outside Employment	Jun-23	Ongoing	Director and Owner of RBW Executive and Professional Coaching	None	16/02/2026
		Non Finanical personal interests	Loyalty Interests	May-23	Ongoing	Non-Executive Member Dorset ICB (In the process of forming a cluster with Dorset ICB, Somerset ICB, Bath, East Somerset, Swindon and Wiltshire ICB)	Renumerated as per Non-Executive Member, Terms and Conditions	
		Non Finanical personal interests	Loyalty Interests	Jun-24	Ongoing	Registrant Council Member - Nursing and Midwifery Countil (NMC)	Renumerated as per Registrant Council Member Terms and Conditions	
Independent Member (General)	**Rhobert Lewis**	Non Financial professional interests	Outside Employment	Nov-21	Current	Chair NPTC Group of Colleges	NIL	30/05/2025
		Indirect Interests	Outside Employment	Nov-21	Current	External member Cross-party STEMM Group Welsh Government	NIL	
Independent Member (Trade Union)	**Cathie Poynton**	NIL	NIL	NIL	NIL	NIL	NIL	01/05/2025
Independent Member (finance)	**Stephen Elliot**	Non Financial professional interests	Outside Employment	04/02/2024	Current	Spouse Directorship of Oshi's World Private Limited Company and a Trustee of Oshi's World Charity	NIL	17/04/2025
Independent Member (General)	**Ronnie Alexander**	Indirect Interests	Outside Employment	01/10/2018	Current	Lay Observer to HEIW Participation in ARCPs and Pharmacy Advisory Board	Small half-day or daily payment dependant on booking availability	15/05/2025
		Indirect Interests	Outside Employment	2012	Current	Director of RA and CJ Consulting Limited	Dividend Payment only	
		Indirect Interests	Outside Employment	2017	Current	Member of Finance, Risk and Audit Committee Hafod/Hendre Housing Association	Remunerated	
		Indirect Interests	Outside Employment	Mar-21	Current to Dec-27	Independent Monitoring Authority (IMA) – Non Executive Director	Remunerated	
		Indirect Interests	Shareholdings and other ownership interests	2012	Current	Director of RA and CJ Consulting Limited	Dividend Payment only	
Independent Member (University)	**Simon Wright**	Financial Interests	Outside Employment	2015	Current	Personal: Academic Registrar, Cardiff University-Various Healthcare Programmes	Salaried Employment	09/02/2026
		Indirect Interests	Loyalty Interests	2001	Current	Sister: Senior Operational Manager, Milestone Trust, Bristol	Salaried Employment	
		Indirect Interests	Loyalty Interests	2021	Current	Spouse: District Nurse, Cardiff and Vale UHB	Salaried Employment	
		Non Financial professional interests	Loyalty Interests	02-Jan-20	Ongoing	Labour Party member	NIL	
		Financial Interests	Outside Employment	09-Feb-26	Current	Head of Partner Engagement for JS Group working with HE sector	Salaried Employment	
Independent Member (Third Sector)	**Jennifer Owen Adams**	Non Financial professional interests	Loyalty Interests	Jun-16	Ongoing	Member (not a NED) of Glas Cymru the holding company of Dwr Cymru/Welsh Water	None	31/01/2026
		Non Financial professional interests	Loyalty Interests	07.02.2025	09.02.2028	PAVO-Vice Chair	None	
		Non Financial professional interests	Loyalty Interests	01.09.2024	01.06.2028	Coopted Member of PAVO	None	
		Non Financial professional interests	Loyalty Interests	Jul-05	Ongoing	Chair Public Services Board Scrutiny Committee	None	
		Financial interests	Outside Employment		Ongoing	Part time work (every other Saturday) with an outside employment	Salaried Employment	

		Non Financial professional interests	Loyalty Interests	2013	Ongoing	Brother - Senior Manager Freedom Leisure (Lead responsibility for Swansea and South Powys).	NIL	
Independent Member (Local Authority)	**Christopher Walsh**	Non Financial professional interests	Loyalty Interests			Member of Community Speed Watch Group Member of Society Genealogists Associate Member of the Association of Genealogists and Registered Archivists	NIL	19/06/2025
		Financial Interests	Shareholdings and other ownership interests		Ongoing	Sole Trader/Owner of Celebratory Gifts Heraldic Names Sole Trader/Owner:CTW Genealogy Research and Owner:Property in the County of Powys	NIL	
		Non Financial professional interests	Loyalty Interests		Ongoing	Elected Member Powys County Council •Trustee/Chair: Brecon University Scholarship Fund •Brecon Town Council Elected Member •Governor of Priory Church in Wales School •Member Brecon Beacons National Park Authority SDF & Grant Advisory Panel	NIL	
		Non Financial professional interests	Loyalty Interests		Ongoing	•Member of Royal College of Nursing •Registered Member of Nursing and Midwifery Council	NIL	
		Non Financial professional interests	Loyalty Interests		Ongoing	Labour Party member	NIL	
Independent Member (Capital)	**Michael Giannasi**	Indirect Interests	Loyalty Interests	2019	Current	Chair of the Board of Social Care Wales (Welsh Government Sponsored Body).	Remunerated	01/04/2025
Independent Member	**Ian Thomas**	Non Financial Personal Interests	Outside Employment	Apr-23	01/03/2024	Worked with a team of consultants as an independent associate in the past. I worked alongside HICO from April	NIL	09/04/2025
EXECUTIVE MEMBERS								
Chief Executive Officer	**Hayley Thomas**	NIL	NIL	NIL	NIL	NIL	NIL	30/05/2025
Executive Director of Finance, Capital and Support Services	**Pete Hopgood**	Non Financial Interests	Loyalty Interests	18/06/2018	Ongoing	Partner is Finance Manager working in SBUHB	Not Relevant	22/05/2025
Executive Director of Allied Health Professions, Health Science and Digital	**Claire Madsen**	Financial Interests	Outside Employment	07-Jan-19	Current	Occasional Lecturer for University of West of England.	Hourly rate	02/06/2025
		Non Financial professional interests	Loyalty Interests	10-Jun-05	Current	Member of the The Chartered Society of Physiotherapy	NIL	
Executive Director of Nursing, Quality, Women and Family Health	**Claire Roche**	Non Financial Professional Interests	Outside Employment	2018	Current	Member of the Royal College of Nursing	NIL	10/06/2025
		Non Financial Professional Interests	Outside Employment	1994	Current	Member of the Royal College of Midwifery	NIL	Left the Health Board on 10 October 2025
Executive Medical Director	**Kate Wright**	Non-Finanical professional Interest	Outside Employment	01-Aug-91	Current	Member of the British Medical Association	NIL	10/06/2025
Executive Director of People and Culture	**Debra Wood Lawson**	Indirect Interests	Outside Employment	01-Nov-24	Current	Non Executive Board Director - Cadarn Housing Group Limited (Powys is a zonal partner)	Remunerated	29/05/2025
			Outside Employment	01-Sep-25	Current	Relative employee and training in Aneurin Bevan Univeristy Health Board (non Director)	NIL	
Executive Director of Public Health	**Mererid Bowley**	Non-Finanical professional Interest	Loyalty Interest	NIL	NIL	Member of Faculty of Public Health	Previously declared on annual Declaration of Interest form issued by corporate team since commencement of role. (Transferring recording of declaration on to ESR from this date).	14/05/2025
		Financial Interest	Shareholdings and other Ownership interests	NIL	NIL	Husband works for Mitie Engineering who hold contracts/work with some NHS bodies/organisations. Shares held by husband and myself and Mitie Company	Previously annually since start of employment through completion of declarations of interest form issued by corporate team annually.	
Director of Corporate Governance/ Board Secretary	**Helen Bushell**	Non-Finanical professional Interest	Outside Employment	Nov-21	Current	Self - School Governor – Langynwyd primary school (Bridgend)	Not remunerated	18/06/2025
		Indirect Interests	Outside Employment	Aug-16	Current	Partner is the Chair of a Housing Association who provide social housing across a large geographical area (including Powys).	Remunerated part time role, 2-4 days per month	
		Indirect Interests	Outside Employment	Jul-24	Oct-24	Partner is listed on the Bank for PTHB - working occasionally for the organisation by dual agreement.	Paid per hour/day of work	

		Indirect Interests	Outside Employment	Sep-22	Current	Partner - Public Appointment - Youth Work strategy and implementation Board - Oct 22 - Sept 24	Remunerated 2-4 days per month	
Director of Strategic Improvement and Transformation	**Lucie Cornish**	Nil	Nil	Nil	Nil	Nil	Nil	13/11/2024
Executive Director of Planning, Performance & Commissioning	**Nicola Johnson**	Nil	Nil	Nil	Nil	Nil	Nil	30/05/2025
Executive Director of Primary, Community Care and Mental Health	**Elaine Lorton**	Financial Interests	Outside Employment	Apr-24	Current	Independent Member – ateb - housing Association	Remunerated	30/05/2025
		Non Financial professional interests	Outside Employment	Nov-19	Current	Chair of the Board - Wet Wales Care and Repair	Voluntary	
		Indirect Interests	Outside Employment	Mar-23	Current	Family Member is an employee of Hywel Dda University Health Board (non Director)	Nil	
		Indirect Interests	Outside Employment	Sep-23	Current	Family Member employee of Aneurin Bevan Univeristy Health Board (non Director)	Nil	

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE

UNCONFIRMED MINUTES OF THE MEETING HELD ON 05 FEBRUARY 2026 at 09:15 VIA MICROSOFT TEAMS

MEMBERS		
Simon Wright	SW	Independent Member (Chair)
Mick Giannasi	MG	Independent Member (General)
Jennifer Owen Adams	JOA	Independent Member (Third Sector)
Ian Thomas	IA	Independent Member (General)
Chris Walsh	CW	Independent Member (Local Authority)
IN ATTENDANCE		
Jonathan Boyd	JB	Chief Pharmacist (11.38 – 11.57)
Helen Bushell	HB	Director of Corporate Governance / Board Secretary
Carl Cooper	CC	Chair of PTHB Board (observing)
Amanda Edwards	AE	Assistant Director Innovation and Improvement (09.15 – 11.57)
Jayne Laurence	JWS	Assistant Director Primary Care (11.15 – 11.35)
Elaine Lorton	EL	Executive Director of Primary Care, Community and Mental Health
Claire Madsen	CM	Executive Director of Allied Health Professionals, Health Sciences and Digital
Chris Moss	CMo	Assistant Director Performance and Commissioning (09.35 – 09.50)
Paul Hooton	PHo	Executive Director of Nursing, Quality, Women and Family Health
Liz Patterson	LP	Head of Corporate Governance
Heidi Sinclair	HS	Head Of Quality and Safety (09.15 – 10.36)
Aime Symes	AS	Director of Midwifery, Women and Family Health
Kate Wright	KW	Executive Medical Director
APOLOGIES FOR ABSENCE:		
Nicola Johnson	NJ	Executive Director Planning, Performance and Commissioning
Hayley Thomas	HT	Chief Executive

1. PRELIMINARY MATTERS

1.1 WELCOME AND APOLOGIES (PEQS/25/81)

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

1.2 DECLARATIONS OF INTEREST (PEQS/25/82)

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

1.3 PATIENT STORY (PEQS/25/83)

PHo introduced the Mr Brown's Story, a story of his experience of his care after a stroke, and his wife, an Occupational Therapist with the Health Board who explained her role as a family member in his rehabilitation journey.

CM observed that the story underscored the crucial importance of communication, person-centred care, and meaningful family involvement during rehabilitation. Although it was helpful that Mrs Brown happened to be an occupational therapist, giving her additional insight into Mr Brown's rehabilitation, it remained essential in all cases to involve families, and, where appropriate, friends, throughout the journey. Rehabilitation was often challenging, lengthy, and emotionally demanding, and people needed consistent support and encouragement from those around them.

Such life-changing events affected entire families, not only the individual receiving care, and everyone needed to understand what was happening and feel supported. Rehabilitation was frequently a family experience rather than an individual one, and services needed to bring the whole family along on that journey. Mr and Mrs Brown had illustrated this particularly well through their openness and the clarity with which they described their experiences. Thanks were expressed to both Mr and Mrs Brown for their candour and for explaining their journey so eloquently.

2. CONSENT AGENDA BUSINESS

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

MG requested that item 7.4 Six monthly update on antimicrobial resistance be brought forward to the main agenda.

SW advised that this item would be taken directly after item 5.4.

3. ITEMS FOR APPROVAL / DECISION / RATIFICATION

3.1 MINUTES OF PREVIOUS MEETING (PEQS/25/84)

The minutes of the meeting held on 23 October 2025 were **CONFIRMED** as an accurate record.

SW invited EL to give an update on JAG accreditation which had been scheduled for November 2025 as a matter arising from the July 2025 minutes.

EL advised that the service had engaged with JAG accreditors in November 2025 who had asked for a longer period to elapse to be able to assess revised management arrangements. JAG accreditation would now take place in Quarter 1 2026/27. It was confirmed that the Finance and Performance Committee are monitoring this matter.

3.2 COMMITTEE ACTION LOG (PEQS/25/85)

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

- PEQS/25/14 (Staff experience of Mental Health and Learning Disability Services in escalation) – request to defer to April 2026, agreed with Chair due to agenda pressure.
- PEQS/25/62b – benchmarking waiting times for ND Services- request to defer to April 2026
- PEQS/25/63 – Implementation plan for Patient Experience Framework – to be considered under item 4.2

Two items had been transferred to other Committees or Fora:

- PEQS/25/65b – Board to be given an opportunity to reflect on the balance of the organisation as a commissioner or provider – to be transferred to Board Development
- PEQS/25/66 – Chairs Forum to reflect on most appropriate reporting approach for dental services monitoring – to be transferred to the Chairs Forum.

The remaining actions were either not due or completed.

The change of date requests were accepted.

Independent Members asked the following questions for assurance:
In relation to action PEQS/25/08 the Chief Executive took an action to assess the number of actions remaining open to PEQS. Is a full update available?
HB advised that this matter had been discussed with the Chief Executive and there was a recognition that with good intent short timeframes are given but unexpected events occur and, in some cases, more realistic timeframes would be appropriate.

What is the rationale for not reporting PEQS/25/65b and 66 back to Committee. Might this result in these actions slipping?
HB advised that these two actions have been moved to the work programmes for Board Development and the Chairs' Forum. Audit Wales has previously challenged the organisation to be clear about whether transferred actions must come back for further reporting. As a result, the Governance team is now being explicit about whether follow-up is needed.

At January Board a query was raised in relation to a previous question raised in this Committee relating to quality assuring or dip sampling Power of Discharge Group decisions. To date this has not been answered. Please may this be added to the Committee work programme?
HB advised that a meeting has been arranged to discuss the Power of Discharge Group and an update will be brought to Committee.
Action: Director of Corporate Governance/Board Secretary and Executive Director Primary, Community Care and Mental Health

4. ESCALATED ITEMS

4.1 CHILDREN'S NEURODIVERSITY SERVICES (PEQS/25/86)

CMo joined 09.35

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

- Significant progress made, noting a 40% reduction in the total waiting list between February 2025 and January 2026.
- Despite this, open pathway counters increased by 54%, meaning the overall caseload has only reduced by 8.8% when both waiting lists and open pathways are considered.
- The team is monitoring demand and capacity closely, working with services to understand and manage this balance.
- A business case for continued investment has been completed and submitted to the Investment and Benefits Group; additional work was requested and is now progressing to Executive Committee this month.
- De-escalation of the service remains an ambition, but depends on:
  - Progress of the business case
  - Updated self-assessments against the Integrated Quality Performance Assessment Framework
  - Review of conditions for sustainability

- Continued focus on demand and capacity modelling
- Updated self-assessments are expected to be submitted to the next Escalation Oversight Group (EOG) this month, with recommendations to follow for both this committee and the Executive Committee relating to de-escalation of this service.

Independent Members asked the following questions for assurance:
Will metrics be included in the self-assessment tool, and if so, are they national metrics so benchmarking against other services can take place?
CMo advised that metrics are included and that the Integrated Quality and Performance Framework: Assessment Framework and Conditions for Sustainability Assessment would be provided to Committee Members.
Action: Assistant Director of Performance and Commissioning

AS added that external support had been sought to assist in identifying the metrics to enable accurate benchmarking.

Why was the business case for sustainable funding, submitted to the Executive in August 2025, not due to be considered until February 2026, given the urgency and priority of the service?
AS explained that although the business case was submitted in August, amendments were requested because the paper was lengthy and difficult to follow. The team then became aware that changes to Regional Integration Funding (RIF) were expected from March 2026. Rather than submitting a case that would require further revisions, resubmission was delayed until clarity on the funding position was available. The revised paper, now incorporating the updated RIF funding context, will be considered in February 2026.

How will assurance be maintained during the sustainability phase when the January EOG meeting was cancelled, and will the cancelled meeting be rearranged?
CMo advised although the January EOG meeting had to be cancelled due to apologies, informal assurance activity continued. During the interim period, ongoing discussions took place between relevant leads regarding the Integrated Quality Pathway, sustainability conditions, and progress updates. These discussions ensured that the updates were prepared for the brought forward February EOG meeting and onward reporting to the Executive Committee and this Committee.

What will happen once the RIF funding ended in March 2026, given that service improvements remained fragile?
AS advised that the revised business case explicitly accounted for the imminent conclusion of RIF funding. The new case was designed to secure ongoing support through a stepped approach. The urgency had increased significantly once it became clear that RIF funding would change in the coming financial year, which was why the business case was being prioritised in February 2026.

What is the plan to address the long-standing capacity gap in the Psychology team, particularly regarding diagnostic oversight linked to sustainability?
AS confirmed that the business case included a new psychologist post to provide the required diagnostic oversight and support. Subject to approval and funding, the team were confident that recruitment would be successful and that the gap could be addressed soon.

The Committee:

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

CMo left 10.13

4.2 PEOPLE'S EXPERIENCE FRAMEWORK UPDATE (PEQS/25/87)

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

- Welsh Government (WG) launched the national People's Experience Framework in April 2025.
- Powys appointed its first People's Experience Lead in June 2025, marking the first year of implementation.
- Work has strengthened experience capture systems, especially via the National Survey and Civica.
- Internal Civica users doubled in six months, improving feedback quality and consistency.
- A system-wide self-assessment was completed, showing overall maturity as 'developing'.
- Strengths included good person-centred care and positive staff engagement, though practice remained variable.
- Governance strengthened with clear executive oversight and quarterly reporting through the Integrated Quality Report (IQR).
- Feedback trends: strong compassion and care quality, but issues with operational pressures, communication and flow.
- A draft People's Experience Strategy has been developed, aligned to the framework and duty of quality.
- Consultation will run March–May, with approvals expected July–September, and solid foundations are now in place despite slight delays.

Independent Members asked the following questions for assurance:
How does the People's Experience Framework ensure that Powys' predominantly rural population is being accurately represented? How is the survey methodology and the questions within it weighted or adapted to capture the experience of rurality, and how can the Board be confident that responses reflected the local geographical context?
AS explained that there were limitations in the Civica system because many survey questions were nationally scripted and could not be adjusted locally, which restricted how rural factors could be reflected. There are also challenges in distinguishing between experiences delivered in Powys versus those delivered out of county, although national work was underway to address this. The richer rural context was often better captured through patient stories and local service-level engagement rather than formal survey tools. Further development was needed, and feedback was invited during the upcoming strategy consultation, and the wider issue of triangulating multiple data methodologies was recognised. Twice-yearly thematic reviews were proposed to bring together all intelligence sources and improve organisational learning.

To what extent does the organisation's digital capability enable or hinder progress in developing the patient experience agenda? Do digital limitations require additional pressure or investment to improve systems and help accelerate progress?
AS explained that digital capability had improved, particularly through increasing the number of system users and strengthening local ownership at ward, matron and service-lead levels. Some capacity challenges arose from the small size of the quality and safety team. Work is ongoing to enhance digital triangulation using Power BI, linking Datix and Civica, and that the team planned to visit Betsi Cadwalladr University Health Board to review their "gold-star" approach. Digital improvement was a priority, and members were assured that further progress was expected.

Does the Patient Experience Framework cover Powys patients who received services out of county or across the border, particularly for commissioned services?
AS confirmed that the strategy did cover out-of-county care, although further development was needed. Work is underway with commissioned providers to secure Powys-specific patient experience data.

How is external feedback being incorporated into triangulation, and is a clear matrix being developed to present a coherent picture of concerns?
AS confirmed that work was underway to strengthen triangulation, including combining Datix and Civica data via Power BI. Plans were in place for twice-yearly thematic reviews to bring together intelligence from incidents, claims and patient experience.

The paper noted that practice varied depending on local leadership and capacity. What level of leadership was being referred to, strategic, ward manager, or clinician, and what actions were being taken to address this?
AS explained that the reference to local leadership included ward managers, matrons and heads of service. Capacity challenges existed linked to the small quality and safety team and emphasised the need for patient experience to remain a high priority across services. The organisation was working to ensure it stayed high on local agendas.

Did feedback from Welsh-speaking patients differ from English-speaking patients, and was this accounted for in survey questions and context?
AS acknowledged this was an important consideration and noted it should be treated similarly to rurality, ensuring cultural and linguistic context was captured. This point will be taken back to the team for further action.

HB advised that the action log item had intentionally been kept open because it remained rated as a red risk, and assurance was given that the action would be updated and presented appropriately for the next iteration.

In relation to escalation, the original issue escalated by the committee to the Board related specifically to Civica and the organisation's ability to mobilise and implement it. Over time, this escalation had gradually become associated with the wider People's Experience agenda. However, the escalated item was always Civica itself, rather than the full framework. To ensure clarity, it is proposed that for the April Committee meeting a focused paper will be brought setting out the original escalation point, describing the current position against that issue, and providing a clear recommendation on whether the escalation could now be closed. Alongside this, the organisation would continue its ongoing work on the People's Experience Framework, separate from the original escalation. This approach aligned with the discussion at the Board the previous week and supported the

need for a clear understanding of what had initially been escalated and how progress should be assessed.

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

SW drew attention to the request for a greater understanding of how commissioned services will be incorporated into the overall approach to patient experience, and a need for the Strategy to explicitly include commissioned services.

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

The Committee:

- **RECEIVED** the report updating on progress in developing the PTHB Peoples Experience Framework **NOTED** the later than anticipated timescale to finalise the Framework;
- Took **ASSURANCE** that People's Experience is appropriately monitored and reported and that continued actions are in place to further develop People's Experience implementation, monitoring, and reporting.

5.ITEMS FOR ASSURANCE

5.1 INTEGRATED QUALITY REPORT (PEQS/25/88)

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

- The Once for Wales Datix Risk Register rollout had stalled due to technical issues; interim governance arrangements are operating while a solution is sought.
- Concerns (Putting Things Right (PTR)) performance dipped, with reduced 30-day compliance, although mean response times improved; work continues to strengthen internal processes and prepare for the introduction of the Listening to People Regulations in April 2026.
- Incident management improved significantly, with historic incidents closed, better monthly closure rates, and stronger oversight, though timeliness for nationally reportable incidents still requires improvement.
- People's experience, Infection Prevention and Control, bereavement services and commissioned services all showed generally stable or positive indicators, with continued work to strengthen data quality, triangulation and reporting.

Independent Members asked the following questions for assurance:

Why are Duty of Candour notifications decreasing, and is this genuinely a positive trend?

AS explained that during early implementation, staff tended to over-report Duty of Candour cases while they were still learning the process. Subsequent organisation-wide training improved staff confidence in applying the correct criteria. The reduction therefore reflected more accurate, appropriate reporting, not reluctance to speak up. Current levels are considered appropriate and safe, with no evidence of under-reporting.

What is causing capacity issues affecting incident closures, and what is the expected trajectory for improvement?

AS advised capacity pressures arose from seasonal leave, sickness, winter pressures, and inconsistent attendance at investigation panels. Some issues are organisation-wide, including higher incident volumes in certain clinical areas. A definitive trajectory could not be confirmed during the meeting, but an update would be provided to Members once data was reviewed.

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

What are "no value" incidents, and does the terminology risk being misinterpreted?

AS clarified, that "no value" refers to incidents where harm level or financial impact has not yet been assessed, not that the incident lacks importance. It was acknowledged the

terminology could be misleading and committed to reviewing the language to avoid negative perceptions, particularly for the public. She confirmed that learning is still captured, even where harm or cost is low or absent.

Why were so many Civica responses (approx. 400) "unmatched" to services, and is this a systemic issue?
AS advised unmatched responses likely related to patients who accessed multiple services, making attribution unclear. Ongoing discussions were taking place with Civica to improve data mapping. This was a national system limitation, not unique to Powys, and better triangulation across datasets should improve service-level attribution.

What control does Powys have over the Datix risk module and why are there technical issues?
HB explained that Datix is a nationally procured system with limited local control. Current issues relate specifically to the risk management module, which does not allow controls to be entered, rendering it unusable. Powys is reliant on national teams and the vendor for fixes. In the meantime, the organisation has reverted to excel-based risk systems, with Audit, Risk and Assurance Committee (ARAC) kept informed.

Are themes such as clinical treatment, attitudes and behaviour linked to Powys staff or commissioned providers, and how is learning shared?
AS advised work was underway to identify whether these concerns relate to in-county or commissioned services. The need for triangulation across incidents, complaints and survey feedback to obtain a full picture was emphasised. Once themes are fully understood, learning will be shared with relevant services, and action plans monitored to prevent recurrence.

SW noted that this paper related to an action PEQS/25/64a (incident closure) and this action had now been closed.

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

5.2 MATERNITY ASSURANCE REPORT (PEQS/25/89)

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

- Strong assurance on maternity service safety and quality: services are being actively monitored, improved and governed effectively, with no immediate safety concerns identified.
- Positive national assessment feedback: Powys has fully engaged with national maternity assurance processes. Early feedback highlights a committed workforce, strong leadership, good accessibility and safe practice. The final All-Wales report is expected shortly.
- Strengthened local governance: A new Quality Improvement Forum now integrates learning from incidents, complaints, national programmes and user feedback into a single prioritised improvement plan, significantly improving oversight.
- Progress across national improvement programmes:
  - *Maternity and Neonatal Safety Improvement Programme:* Good progress across safety priorities, but sustainability is at risk pending confirmation of national funding beyond March.

- *Midwifery Unit Self Assessment:* Work on midwifery-led care has strengthened informed choice and staff confidence, gaining national recognition and selection for international presentation.
- Workforce and digital improvements underway: Leadership and culture have been strengthened, with a redesigned midwife on-call model launching next week. Digital capability will be significantly enhanced with BadgerNet going live on 02 March, improving safety, audit and cross-border continuity of care.

Independent Members asked the following questions for assurance:
What issues have been escalated to WG regarding BadgerNet, and how confident can we be that these problems will be resolved?
AS explained that the main risks relate to system interoperability, particularly between BadgerNet and two key systems: WCCIS (demographic and child health systems) and Viewpoint (ultrasound imaging). The inability of these systems to interface smoothly creates duplication and a small risk of error, and in the case of Viewpoint, can affect the availability of scan information for clinicians in other hospitals. These issues have been formally escalated to WG through national digital groups. Integration work has been prioritised for the next phase after April, although no funding has yet been secured. Despite this, the overall benefits of BadgerNet significantly outweigh the risks, and Powys will continue implementation while temporary workarounds are used.

What contingency plans are in place if BadgerNet or other digital systems fail, given maternity services are high-risk?
CM assured the Committee that whilst digital systems always carry a degree of failure risk, whether due to software issues or power outages, Powys is strengthening business continuity planning. Internal audit has been commissioned to test these plans, with a focus on high-risk services such as maternity. BadgerNet has a responsive support model, and national groups are coordinating risk management across Wales.

Will BadgerNet improve visibility of quality and safety in commissioned maternity services, where Powys has traditionally had limited oversight?
AS confirmed that BadgerNet will significantly enhance Powys' visibility of quality and safety information for women receiving care in neighbouring Welsh and English hospitals. Two English providers already use BadgerNet, and all Welsh providers are due to be live by April. This will support the development of a more comprehensive maternity dashboard and improve oversight of high-risk pathways.

What lessons are being learned from issues with the Viewpoint system, and how are risks being mitigated before integration is complete?
AS described Viewpoint integration as the most significant risk because ultrasound data does not yet flow automatically into BadgerNet. This can limit the information available to external obstetric teams. Mitigation consists of enhanced training, manual data transfer and close monitoring, though these measures have limitations. CM added that Viewpoint (part of the RISP radiology programme) is being rolled out across Wales but is progressing slowly due to vendor workload. Full interoperability will take time, but interim safety measures will continue until all systems stabilise.

Are Band 7 midwives being properly supported through the leadership redesign, and how are morale, training needs, sickness and retention being monitored?

AS confirmed that the Band 7 redesign addresses longstanding structural issues, ensuring that specialist roles, such as digital midwife, bereavement midwife and practice development midwife, are properly established within the service. Band 7 staff are being supported through structured training, engagement and partnership with trade unions and workforce colleagues. Change can create uncertainty, but morale and cultural impact are being actively monitored. Staff understand the need for the redesign and that the process is being implemented within governance and budget parameters.

Have women and service users been involved in shaping the Band 7 changes and wider service improvements?
AS explained that maternity services aim for strong co-production, but engagement can be challenging due to the voluntary nature of service-user roles in Wales. Powys continues to engage women through existing mechanisms such as Better Together events and will seek user input where appropriate, while avoiding overloading service users with multiple concurrent consultations.

SW noted that this item had been subject to an action PEQS/25/65a and given the issues with BadgerNet concluded it would be appropriate to keep this action open.

The Committee:

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

5.3 PATIENT EXPERIENCE IN PRIMARY CARE (PEQS/25/90)

JL joined the meeting 11.15

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

- Comprehensive monitoring systems are in place covering opening hours, contact activity, access standards, escalation levels, patient feedback, digital usage, and external inspection findings.
- Activity levels are extremely high, with April–October data showing ~651,000 calls, 1.9 million prescriptions and 250,000+ digital requests, demonstrating significant and sustained demand on Powys practices.
- Practices fully utilise national additional capacity funding, enabling over 17,200 extra appointments in 2024–25 and supporting clinical and administrative workforce needs.
- Access and escalation monitoring show mixed pressures, with four practices at Level 4 escalation (one recently reassessed to Level 3), but 100% compliance with national access standards across all Powys practices.
- Patient and system feedback is actively gathered and used, including ~4,500 patient survey responses, Civica feedback, NHS App uptake data, and HIW reports, allowing tailored follow-up with practices where concerns are identified.

Independent Members asked the following questions for assurance:

Is the digital inequity affecting Powys patients, because English providers are not integrated into the NHS Wales App, being formally monitored and managed from a governance perspective?
HB confirmed that this issue has been raised repeatedly across multiple forums and is recognised as a significant cross-border concern. Digital oversight sits with the ARAC, and the intention is to draw all related risks and actions together in one organisational position. Work is ongoing between digital leads, and Powys continues to escalate the issue nationally. A new UK Parliament cross-border inquiry may also provide a route to influence. The Committee agreed to formally refer this concern to ARAC for oversight and action.
Action: Executive Director of Allied Health Professions, Health Science and Digital

Why do the three-year appointment activity figures appear to show a decrease in practice contacts? Was this expected, and how will this be explored further?
EL acknowledged that the trend was noted and understood, though not unexpected. Historically, Powys has delivered the highest number of appointments per head in Wales, but appointment numbers alone do not reflect quality or effectiveness. Changes such as improved triage, use of wider services, and strengthened signposting mean patients may be directed to other appropriate providers (e.g., pharmacy), reducing appointment volume. JL added that trained reception teams now signpost more effectively, meaning fewer GP appointments may be needed. The Health Board will continue to review the trend with practices to understand the underlying factors.

The Committee:

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

JL left the meeting 11.35

5.4 ANNUAL REPORT OF ACCOUNTABLE OFFICER FOR CONTROLLED DRUGS (PEQS/25/91)

JB joined the meeting 11.35

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

- Powys has a mature and strengthening governance framework for the safe and lawful management of controlled drugs, with clear accountability and system-wide oversight.
- The Controlled Drugs Local Intelligence Network (CDLIN) meets quarterly with police, regulators, substance misuse services, local authority partners and counter-fraud, enabling early identification and coordinated management of risks.
- Incident reporting has risen significantly, particularly from community pharmacies, reflecting better awareness and a supportive reporting culture. Enhanced tools (e.g., QR-code reporting) have enabled easier and more transparent reporting.
- Prescribing data shows sustained reduction in opioid burden and robust monitoring of increases in drugs like gabapentin and ADHD medications. The team investigates contextual factors to understand and manage risk, rather than treating increases as unexplained.
- Delays in controlled drug destruction have reduced dramatically (from ~60% to 18%), supported by a stable, trained pool of authorised witnesses. The main remaining area for improvement is increasing reporting from care homes, with targeted engagement already underway.

Independent Members asked the following questions for assurance:

Are rises in ADHD prescribing tracked against national trends, and can we link local increases to wider UK patterns, including the impact of private diagnosis?
JB explained that Powys has strong primary care prescribing data and can compare its trends with other health boards and GP practices across Wales and England. ADHD prescribing is increasing, largely due to previously unmet need now being addressed through Powys' own clinic. However, the bigger concern is the rise in private online diagnoses and prescribing, much of which is invisible within NHS data. Work is underway with other health boards and cross-border partners to understand where prescriptions are generated, where they are dispensed, and how many relate to Powys patients. The Committee will be kept updated as the national picture develops.

Does reporting from "care homes" cover the full spectrum of care settings, from domiciliary care through to nursing homes, and is stratified data available for these?
JB confirmed that reporting covers the full range of providers, including domiciliary care, private care homes, nursing homes, and homes managed by the Health Board. The complexity of the sector was acknowledged, together with the challenges it creates for consistent reporting. Many incidents involving domiciliary care are picked up through safeguarding teams, and there is a strong working relationship with them.

How is incident reporting being strengthened?
JB advised that improving reporting is fundamentally about culture and relationships rather than policy alone. The aim is to foster a learning, not blaming, approach. Plans are in place to develop learning and education events that share incident themes and learning across all relevant providers, helping them understand the benefits of reporting and how information is used to improve safety. However, many providers operate with very tight margins, making engagement challenging.

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

7.4 SIX MONTHLY UPDATE ON ANTIMICROBIAL RESISTENCE (PEQS/25/92)

JB presented the report and drew attention to the following areas:
- Strong antimicrobial stewardship governance is in place, led by a well-established multidisciplinary group. Recruitment of a highly skilled pharmacist has significantly strengthened engagement and driven measurable improvements across Powys.
- Marked improvements have been achieved across all three national primary-care antimicrobial stewardship measures.
  - Overall antibiotic use has reduced by the required 10% national target.
  - Use of broad-spectrum "high-risk" antibiotics has fallen, with Powys no longer the highest user in Wales.
- Prescribing quality has improved, with adherence to recommended 5-day course lengths rising from the lowest compliance position nationally to meeting the 75% NICE-aligned target.
- Work remains to improve use of "Access" antibiotics (e.g., amoxicillin, flucloxacillin). A credible improvement plan is in place, including a structured penicillin allergy de-labelling programme to increase safe use of first-line antimicrobials.
- Secondary care data limitations persist because Powys does not operate an acute hospital. However, risks are mitigated through:

- Six-monthly community hospital antimicrobial audits,
- Annual point-prevalence surveys,
- Strong ward-based pharmacy presence. Together, these provide sufficient insight to identify risks, outliers and improvement needs, which are then addressed through targeted stewardship actions.

Independent Members asked the following questions for assurance:
The paper shows strong improvement in primary care antimicrobial stewardship, but there appears to be a gap in secondary care consumption data. How significant is this gap, can it be resolved, and how are we monitoring secondary care prescribing in the meantime?
JB explained that the gap in secondary care antimicrobial consumption data arises because Powys does not operate an acute district general hospital and therefore relies on other health boards' pharmacy supply data, which is not formally reported. This makes accurate consumption monitoring difficult, but it is recognised nationally as a system limitation rather than a Powys governance failure. To mitigate this, Powys carries out six-monthly antimicrobial audits in community hospitals, participates in annual point-prevalence surveys coordinated by Public Health Wales, and benefits from a strong pharmacy ward presence ensuring good oversight of prescribing, adherence to guidance and reduction of waste. These processes provide sufficient insight to identify risks and outliers, and stewardship actions are targeted accordingly.

The Committee **RECEIVED** the report and took **ASSURANCE** the organisation has appropriate structures and reporting in place with regards to Antimicrobial Stewardship.

JL and AE left 11.55

5.5 TERMS OF REFERENCE REVIEW (PEQS/25/93)

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

- Standing Orders require an annual review of Committee Terms of Reference
- Significant changes were made to the Terms of Reference last year and therefore only minor changes are proposed this year, including administrative changes
- There is one substantive change proposed in relation to accurate reference to the People's Experience Framework

Independent Members had no questions or any proposed amendments to the Committee Terms of Reference.

The Committee

- **ENDORSED** the proposed amendments to the Terms of Reference;
- **IDENTIFIED** no further potential amendments; and
- **AGREED** that the Chair of the Committee and Director of Corporate Governance will finalise the revised Terms of Reference for presentation to the Board in May 2026 for approval.

5.6 COMMITTEE RISK REGISTER (PEQS/25/94)

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

- Two strategic risks remain within the committee's remit, both relating to demand pressures, one for commissioned services and one for provider services.
- The Committee receives updated risks in the same format as the Board, with changes highlighted in red; these risks were last reviewed alongside the Board Assurance Framework in November 2025.
- Due to the nature of these high-level risks, significant monthly movement is limited, but the Committee is encouraged to scrutinise any area where further assurance is required.

- Risk 003 (commissioned services demand) contains several controls currently offering only limited assurance. Work will continue into the next planning cycle to strengthen these controls, recognising that some depend on external partners.
- All risks will undergo a full annual review at year-end, aligned with the Board's strategic risk register and risk appetite, to ensure controls and assurances remain appropriate for the new financial year.

Independent Members asked the following questions for assurance:

Should the materialising risk description explicitly reference reputational risk, given that poor outcomes, citizen experience and performance challenges could negatively affect public perception?

HB explained that reputational risk is already captured within the Health Board's separate strategic risk on public confidence and reputational damage (Strategic Risk 12) which sits under the oversight of another Committee.

Should the minutes note the detailed Board discussion on waiting time, particularly the levers available for reducing long waits with English providers and improving RTT data, so it does not appear that the Committee failed to scrutinise SR003?

HB agreed and confirmed that the Committee referred to the earlier Board discussion reflecting scrutiny had been undertaken elsewhere.

The length of wait for spinal surgery is shown as 200 weeks, but in a recent Board it was given as 300 weeks. Can the wait time be clarified?

HB undertook to check which figure was correct and update the relevant documents and minutes accordingly.

Action: Director of Corporate Governance / Board Secretary

HB confirmed that Appendix A Committee Risk Register should be properly titled February 2026.

The Committee

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

6. ITEMS FOR DISCUSSION

There were no items for discussion

7. CONSENT AGENDA (PEQS/25/95)

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

- **FOR INFORMATION:** Internal Audit Reports on:
  - Decontamination (Reasonable Assurance)
  - Continuing Health Care (Reasonable Assurance)
  - MH and LD Triage and Assessment Process (Reasonable Assurance)
- **FOR ASSURANCE:** Corporate Parenting Charter update
- **FOR ASSURANCE:** Update on implementation of management actions for DoLS Internal Audit Report
- **FOR ASSURANCE:** Joint Commissioning Committee highlight report from the Quality, Safety and Outcomes Sub-Committee 06 October 2025
- **FOR ASSURANCE:** Committee Governance Action Plan
- **FOR ASSURANCE:** Work Programme

8. OTHER MATTERS

8.1 ANY OTHER URGENT BUSINESS (PEQS/25/97)

There were no items of any other business.

8.2 ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND/OR OTHER COMMITTEES (PEQS/25/98)
It was noted that the Chair would provide updates on those items escalated to Board, together with the actions taken to address the backlog in incident closure. One item had been identified for referral to ARAC: digital inequity in the NHS Wales app.
8.3 COMMITTEE REFLECTION (PEQS/25/99)
The following summary of business and reflections were provided by members: • SW thanked colleagues for their concise introductions to papers • HB noted that no external colleagues were in attendance • CC observed there had been excellent paper presentation, high quality information provided, incisive scrutiny and effective chairing
8.4 DATE OF NEXT MEETING (PEQS/25/100)
The date of the next meeting is scheduled on 05 February 2025 via Microsoft Teams. *Meeting closed 12.09.*
8.5. CONFIDENTIAL MATTERS
The following motion was passed: ***"Representatives of the press and other members of the public shall be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest"***

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	✓			
	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				✓
Clincial Audit	Annual Programme Clinical Audit	✓			
Clincial Audit	Progress Report Clinical Audit			✓	
Audit Reports	Any Internal Audit/Wales Audit reports received - for information	✓	✓	✓	✓
Medicines Management	Annual Report of Accountable Officer for Controlled Drugs				✓
Annual Reports	Medicines Management Annual Report			✓	
	Duty of Quality Annual Report		✓		
	Annual Report Medical Devices and Point of Care Testing			✓	
	Transition of Care Annual Report		✓		
Infection Prevention and Control	Chief Nursing Officer IPC statement	✓			
Infection Prevention and Control	IPC Annual Report		✓		
Other	Corporate Parenting Charter update			✓	✓
	Staff experience of ND Services in escalation (post escalation)				
	JCC Quality Safety and Outcomes Sub-Committee Hightlight Report (as held)	✓	✓	✓	✓
	EPMA update		✓		
	Monitoring ongoing improvement and barriers to implementation re WHC 37 Infected Blood Inquiry (Blood Transfusions)		✓		
	Six-monthly update on Antimicrobrial resistance		✓		✓
	Monitoring Report Mental Health Services post escalation	✓			
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)	✓	✓	✓	✓
	PHW Test and Post Sexual Health Service Incident	✓			

KEY
Added to draft agenda
Date to be confirmed
Item deferred
Item brought forward

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda Item: 3.4

Patient Experience, Quality and Safety Committee	**Date of Meeting: 29 April 2025**
Subject:	**PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE ANNUAL REPORT TO THE BOARD**
Approved and Presented by:	Helen Bushell, Director of Corporate Governance / Board Secretary
Prepared by:	Head of Corporate Governance
Other Committees and meetings considered at:	N/A

PURPOSE:

The purpose of this report is to provide the Patient Experience, Quality and Safety Committee Report for 2024/25.

RECOMMENDATION(S):

It is recommended that the Patient Experience, Quality and Safety Committee :

- **CONSIDER** the Patient Experience, Quality and Safety Committee Annual Report for 2024/25 summarising the key areas of business activity undertaken;
- **RECOMMEND** the report to the Board for the 21 May 2025 meeting.

Approval/Ratification/Decision	Discussion	Information
X		

Contents

1. Introduction

The Patient Experience, Quality and Safety Committee has been established by the Board in order to provide advice and assurance to the Board on the effectiveness of arrangements in place for securing the achievement of the Board's aims and objectives, in accordance with the standards of good governance determined for the NHS in Wales.
This report summarises the key areas of business activity undertaken by the Patient Experience, Quality and Safety Committee ('the Committee') over the past year and highlights some of the key issues which the Committee intend to give further consideration to over the next 12 months.

2. Roles and Responsibilities

The Terms of Reference for the Committee were agreed by the Board in September 2021 and revised in May 2025. The purpose of the Committee is to:

- provide accurate, evidence based (where possible) and timely advice to the Board and its committees in respect of the development of the following matters, consistent with the Board's overall strategic direction
    a. Citizen Experience; and
    b. Quality and Safety of directly provided and commissioned services.

- Committee will seek assurances:
    a) The robustness of the Board's Clinical Quality Framework;
    b) the experience of patients, citizens and carers ensuring continuous learning;
    c) the provision of high quality, safe and effective healthcare within directly provided and commissioned services;
    d) the effectiveness of arrangements in place to support Improvement and Innovation and
    e) compliance with mental health legislation, including the Mental Health Act 1983 (amended 2007) and the Mental Capacity Act 2005.

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

- Safe
- Effective

- Timely
- Person Centred
- Efficient
- Equitable

The Committee is responsible for providing advice to the Board and Committees on:

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

B. Seek assurance that arrangements for capturing the **experience of patients, citizens and carers** are sufficient, effective and robust, including:
    - the delivery of the Patient Experience Framework;
    - patient experience in primary care; and
    - the implementation of Putting Things Right regulations (to include patient safety incidents, complaints, compliments, clinical negligence claims and inquests) reporting trends, with particular emphasis on ensuring that lessons are learned.

C. Seek assurance that arrangements for **the provision of high quality, safe and effective healthcare** are sufficient, effective and robust, including:
    - the systems and processes in place to ensure efficient, effective, timely, dignified and safe delivery of directly provided services;
    - the commissioning assurance arrangements in place to ensure efficient, effective, timely, dignified and safe delivery of commissioned services;
    - the arrangements in place to undertake, review and act on clinical audit activity which responds to national and local priorities;
    - the recommendations made by internal and external review bodies, ensuring where appropriate, that action is taken in response;

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

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

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

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

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

The committee annually review their terms of reference and report any changes to the Board for ratification.

2.1 Membership of the Committee

The membership of the Committee during 2025/26 was:

Name	Role	Attendance
Kirsty Williams (to 30/09/2026)	Chair	2/2
Simon Wright	Interim Chair from 01/10/2025	2/4
Mick Giannasi	Independent Member (from 09/06/2025)	3/3
Jennifer Owen Adams	Independent Member	4/4
Ian Thomas	Independent Member	3/4
Chris Walsh	Independent Member (from 09/06/2025)	2/3

2.2 Others in Attendance

During 2025/26, the following staff attended the Committee:

Name	Role	Attendance
Claire Roche (to 05/10/2025)	Executive Director of Nursing, Quality, Women and Family Health	2/2
Paul Hooton (from 06/10/2025)	Executive Director of Nursing, Quality, Women and Family Health	2/2
Nicola Johnson	Executive Director of Planning, Performance and Commissioning	1/4
Elaine Lorton	Executive Director Primary Care, Community and Mental Health	4/4
Claire Madsen	Executive Director of Allied Health Professions, Health Science and Digital	4/4
Kate Wright	Executive Medical Director	3/4
Helen Bushell	Director of Corporate Governance / Board Secretary	3/4

Where officers were unavailable substitutes attended on their behalf. Other officers attended during the year to present reports which related to their areas of responsibility as required.

The Chief Executive, Hayley Thomas, was also invited to attend every meeting, and attends at least annually, attending twice during the year. The Chair of the Board, Carl Cooper, attended three meetings. The Chair has a standing invite to attend Board Committees.

2.3 Meeting frequency

During 2025/26 the Committee met four times and was quorate on all occasions.

The terms of reference for the Committee require meetings to be held four times a year and otherwise, as the Chair of the Committee deems necessary, consistent with the annual plan of Board and Committee Business.

3. Activity in 2025/26

3.1 Main Areas of Committee Activity 2025/26

ITEMS FOR ASSURANCE	
PATIENT STORIES	
Parents of children accessing neuro-diversity services	April 2025
Maternity Story	July 2025
Mr Brown's stroke story	February 2026
Quality, Safety and Patient Experience	
Integrated Quality Report	At every meeting October 2025 (included Public Services Ombudsman for Wales Annual Letter 2024/25)
Duty of Quality Annual Report 2024/25	July 2025
Infection Prevention and Control Annual Assurance Report	July 2025
Medical Devices and Point of Care Testing Annual Report 2024-25	October 2025
Medicines Management Annual Report	October 2025
Annual Report of Accountable Officer for Controlled Drugs	February 2026
Electronic Prescribing and Medicines Administration system update	July 2025
Patient Experience – dental quality	October 2025

Patient Experience – primary care	February 2026
Maternity Assurance Report	February 2026
Six monthly report on antimicrobial resistance	February 2026
Child Protection / Safeguarding	
Joint Inspection on Child Protection Arrangements – monitoring Health Board actions	April 2025
Annual Safeguarding Report 2024-25	July 2025
Services previously in local escalation	
Maternity Service assurance report	October 2025
Mental Health	
Mental Health Services – staff experience of service in escalation	April 2025
Mental Health Services Act Hospital Managers Power Of Discharge Group Terms of Reference	July 2025
Clinical Audit and Regulatory Reports	
Clinical Audit Annual Programme	April 2025
Clinical Audit Annual Report	July 2025
Clinical Audit Progress Report	October 2025
Monitor implementation of actions regarding Deprivation of Liberty Safeguards Internal Audit Report	July 2025 and February 2026
ITEMS FOR APPROVAL	
There were no items for approval	
ITEMS CONSIDERED IN-COMMITTEE	
Briefing on suicides	April 2025

Report on unexpected deaths	July 2025
Transition of Care - update	February 2026
ESCALATED ITEMS	
Civica – Patient Experience – now called People's Experience Framework	Committee escalated to Board in May 2023. A report was included within the Integrated Quality Report in April and July 2025S, and separate reports on People's Experience Framework received in October 2025 and February 2026
Children's Neuro Developmental Services	Escalated by Executive Committee in October 2024 – Committee advised in November 2024 and monitoring reports received in April 2025, July 2025, October 2025 and February 2026
CORPORATE GOVERNANCE	
Committee Annual Report	April 2025
Committee Annual Work Programme	April 2025
Committee Risk Register	Each meeting
Committee Work Programme	Each meeting
Annual Assessment of Committee Effectiveness	April 2025
Review of Committee Terms of Reference	April 2025
Committee Governance Action Plan	July 2025
ITEMS FOR INFORMATION	
Internal Audit Reports: • Patient Flow and Discharge Management Final Report • Additional Learning Needs Legislation • Cancer Services	 April 2025 April 2025 April 2025

• Pharmacy Stores (Reasonable) • Quality, Safety and Governance (Reasonable Assurance) • Business Continuity Planning (Substantial Assurance) • Risk Management (Reasonable Assurance) • Mattresses Final Report (Limited Assurance) • Duty of Candour • Decontamination (Reasonable Assurance) • Continuing Health Care (Reasonable Assurance) • MH and LD Triage and Assessment Process (Reasonable Assurance)	July 2025 July 2025 July 2025 July 2025 July 2025 October 2025 February 2026 February 2026 February 2026
Audit Wales Report: Cancer Services	April 2025
JCC Quality Patient Safety Committee Chairs Report: • 03 February 2025 • 20 May 2025 • 06 October 2025	 April 2025 July 2025 February 2026
Corporate Parenting Charter update	February 2026
Committee Governance Action Plan	February 2026

3.2 Work programme and action log

The Committee Work Plan ensures that the Committee discharges its responsibilities in a planned manner. It assists with agenda planning and is updated during the year to ensure that the Committee considers any additional items which may arise during the year.

In order to monitor progress and any necessary follow up action, the Committee has an Action Log that captures all agreed actions. This provides an essential element of assurance to the Committee and from the Committee to the Board.

The Committee reported to the Board through a Committee Chair's report, providing an overview of items considered by the Committee and highlighting any cross-committee issues / themes or items needing to be brought to the Board's attention. The Committee Chair's report and confirmed minutes are published on the website.

4. Assurance to the Board

The Committee wishes to assure the Board that on the basis of the work completed by the Committee during 2025/26, there are effective measures in place and there are no outstanding issues that the Committee wishes to bring to the attention of the Board over and above the risks and issues already raised in the Committee Chairs report, noted as Escalated Items or those that are already visible in the corporate risk register.

The Chair of the Committee reports into the Board via a report from Committee Chairs, where any significant issues are brought to the attention of the Board. The reporting template was developed in year and made consistent across all Committees.

5. Committee Effectiveness

During the year the Committee has continued to review and revise its ways of working to optimise a robust governance approach balancing the need reduce pressure on staff where possible, whilst ensuring the Committee fulfils its responsibilities.

The Committee continued to review its effectiveness thorough the year, to ensure effective use of time and ensure it fulfilled its role to provide assurance to the Board.

The key developments/adaptations made this year included the production of a Continuous Development Committee Effectiveness Plan which outlined the following areas of action:

- Review and confirm committee membership – agreed in May 2025 but remain under review as Board membership alters

- Develop a standardised reporting template for clear upwards assurance - Alert, Advice, Assurance, Inform (AAAI) Reports have been introduced for all Committees for reporting to the Board from March 2025
- Schedule opportunity to actively consider evidence of learning and improvement in each Committee – to be progressed
- Apply risk-based approach to planning agendas, prioritising high-risk/high-impact items – undertaken during agenda setting process
- Develop induction information and training needs analysis for each Committee – undertaken for Audit, Risk and Assurance Committee, to be progressed for other Committees
- Incorporate risk lens in committee discussions and papers – to be progressed

Committee effectiveness reviews are undertaken on two year cycle with a detailed qualitative review undertaken in 2024/25 and a facilitated review completed in March 2026, focusing on composition, functioning, assurance, leadership and culture. The outcomes and any agreed development actions will be reported in Q2 2026/27

Planned Activity in 2026/2027

The Committee has developed its annual work programme and is committed to continuing to develop its function and effectiveness as per its terms of reference. The Committee welcomes any feedback from the Board in relation to its annual work programme.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 4.1

EXECUTIVE COMMITTEE	**15 APRIL 2026**
Subject:	**Integrated Quality & Performance Framework – CYP Neurodevelopmental Services Escalation Oversight Group**
Approved and presented by:	Nicola Johnson, Executive Director of Planning, Performance and Commissioning
Prepared by:	Deputy Director of Performance and Commissioning Executive Director for Nursing, Quality, Women and Family Health Director of Midwifery, Women and Family Health Head of Children Public Health Nursing and Paediatric Services
Other Committees and meetings considered at:	Executive Committee 02 October 2024; 13 November 2024; 11 December 2024; 5 February 2025; 19 March 2025 and 23 April 2025; 23 July 2025; 15 October 2025; 04 February 2026; 15 April 2026. Patient Experience, Quality and Safety Committee 07 Nov 2024, 11 Feb 2025; 29 April 2025; 31 July 2025, 23 October 2025; 05 February 2026.

PURPOSE:

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

The purpose of this paper is to provide the Executive Committee with an update on current progress.

RECOMMENDATION(S):

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

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

Approve/Take Assurance	Discuss	Note
Y	Y	N

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

EXECUTIVE SUMMARY

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

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

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

DETAILED BACKGROUND AND ASSESSMENT

Background

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

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

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

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

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

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

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

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

The most recent meeting of the CYP Neurodevelopmental Service EOG was held on the 01 April 2026 with the following progress updated noted:

- Open pathway validation work continues.
- New QA system to be implemented for Panel MDTs.
- Qb (computer based activity that measures attention, activity and impulsivity) has now been approved by Digital Oversight Group – need to move to procurement phase.
- External provider successfully procured for 36 additional assessment pathways through extension of previous contract.
- Business Case was presented to Executive Committee in February 2026, seeking recurrent financial investment to deliver a sustainable, robust service which is compliant with both Welsh Government standards and NICE; and which will deliver timely assessments, pre and post diagnostic

support. It was agreed with one exception; the post of Psychologist was not agreed. Recruitment commenced immediately to facilitate the stability in workforce required to sustain achievements to date.

- Risks identified:
  - Required increase in diagnostician oversight of diagnostic outcomes. 1.0wte clinical psychologist remains an outstanding requirement for the service.
  - Cost pressure with implementation of Validated tools (£23k–included within Business Case).
  - Referral demand may reduce in the long term: review of service to ensure that post diagnostic support instigated when demand reduction allows and identified of excess resource managed through organisational change.
- Performance
  - Waiting List - Total of 823 CYP waiting for a first appointment at the end of March 2026. Over 104 week waits have been managed with no patients waiting >104 weeks at the end of March 2026.
  - Referrals – Noted that the service experiencing an increase in referrals, 73 referrals received in February, with 95% accepted onto the waiting list. Noted that referral rejection rate % has fallen slightly in Q3 and that performance trajectory had assumed 70% referral acceptance rate.
  - Open pathways – 480 patients who have had their first assessment and remain in the diagnostic/clinical element at end of March 2026. Noted that the number of open pathways had increased since December 2025.
  - Taking current clinical demand (active caseload – open pathways) with the waiting demand for assessment, the current demand is detailed below. Waiting times have improved, total waiting list is reducing, however EOG had expressed concern on the capacity within the service to manage total demand 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
30/03/2026	480	823	1303

  - 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.

- 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:

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

  The service has previously completed a baseline assessment in November 2024, with subsequent assessments in March 2025, February 2026 and March 2026 all of which have been presented to and considered by the EOG. At the most recent meeting the following assessment was received:

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

  - Safe and Effective Care
    - Maturity - Moved from Amber in February to Amber/Green in March with reference to the IQPAF criteria.
    - EOG accepted the assessment of the move from Amber to Amber/Green for Maturity and requested the service confirm detailed actions and associated timescales to achieve Green Maturity assessment status.

  - Quality of Patient and Family Experience
    - Results - Moved from Amber in February to Green in March with reference to the IQPAF criteria.
    - Maturity – Amber assessment in March with reference to the IQPAF criteria.

        - EOG accepted the assessment of the move from Amber to Green for Results; and accepted the Amber assessment for Maturity. The service was requested to confirm detailed actions and associated timescales to achieve Green Maturity assessment status.

    - Quality of Leadership and Management
        - Maturity – Moved from Amber in February to Amber/Green in March with reference to the IQPAF criteria.
        - EPG requested the service provide further detail and supporting evidence for further consideration at the next meeting.

- 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 (see Appendix One).

  EOG acknowledged the huge amount of work undertaken and requested that the service provide further detail for consideration at the next meeting, as well as detailed phase 2 action plan for sustainability in order to move towards de-escalation.

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

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

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				

Appendix Two: Conditions for Sustainability Assessment (March 2026)

Area	Description	Success criteria	Service Assessment Feb 2026
Corporate Governance	Effective oversight and scrutiny of service provision consistently being provided by the Directorate / PEQs / Delivery and Performance Committee / Board.	• Submission of clear evidence based information triangulated with qualitative feedback to inform Board oversight and scrutiny. • Service risk registers reviewed and updated on regular basis.	• Service reporting within the Directorate escalating at the following levels 1) ND Service IQP meeting 2) W&C IQP Meeting 3) Corporate IQP • Escalation Oversight Group Presentation Template populated and shared for EOG meetings (frequency has reduced with reduction of escalation level) • Risk register and improvement plan updated monthly or as necessary. • Presentation to Executive Committee and PEQS committee quarterly via performance team.
Leadership (clinical and non-clinical)	Robust oversight of quality and performance of services.	• Leadership is visible. • Create unity of purpose. • Leadership development support in place. • Shared leadership responsibilities. • Empowerment of staff and teams. • Authentic, collective and compassionate leadership. • Active engagement in driving forward service improvement.	• Substantive clinical leadership structure in place (HoN, Consultant Paediatrician), with structured meetings and foundations developed for service delivery and sustainability. • Business case developed for IBG and refined for Execs – agreed Feb 2026 • Interim team leader supported with study leave for Management programme, CLIP programme and ongoing coaching support. • Safeguarding, Management and Clinical supervision provided for all staff. • Professional alignment for AHP within the team who have regular supervision from the relevant professional head of therapies • Programme of work supported by OD colleagues to support current and ongoing needs of the team during a period of transformation and improvement.
Culture and Values	Evidence of culture of improvement.	• Shared sense of pride around performance. • Staff aware of and actively participate in improvement work. • Staff view maintaining quality as part of their job, that they have a stake in continually enhancing their performance and are clear on the performance improvement activity and can explain their role in it. • Psychologically safe working environment is actively supported and maintained.	• Quality & Performance are intrinsic to all reporting mechanisms and discussions. • Clear KPI's to support wider quality targets along with RTA include quality of assessment, management of open pathways, wider support. • Clinical support structure (open forums for discussions, forums to raise concerns or inform change and improvements) in place to support a culture of psychological safety. • Wider MDT Community of learning established with wider colleagues from therapies and CAMHS to ensure effective join up and shared vision • Working with OD colleagues for some targeted areas of work.
Strategic Vision and Collaboration & engagement	Service has clear agreed vision communicated to relevant stakeholders including the public.	• Shared vision, goals, strategies. • Actions being delivered providing confidence that sustainable long term continuous improvement is achievable. • Organisation to promote strong partnerships with both internal and external stakeholders.	• Co-production information service change and development. • Open dialogue with PCC and third sector colleagues. • Collaboration for improvements with PCC colleagues both in Social Care and Education.

Area	Description	Success criteria	Service Assessment Feb 2026
	All stakeholders share understanding of processes and systems seeking to improve and clear on their contribution.	• Supportive structures to ensure involvement of patients, families, public, clinical and non-clinical staff at all levels of the organisation. • Well defined roles and responsibilities. • Clearly agreed and defined outcome measures (quantitative and qualitative).	• Multi Agency Children's Emotional Wellbeing and Neurodevelopmental Single Point of Access (SpoA) for early help and support has been agreed as a trial and supported through Start Well & RIF Funding • Clear vision and strategy in place which will be further supported with substantive workforce structure-alignment with PCC along with standard operating procedures aligned with best practice and evidence-based decision making.

Area	Description	Success criteria	Service Assessment Feb 2026
Quality Management System approach. (refer to PTHB QMS)	Continuous focus on understanding of what a quality service looks like; knowing whether we are delivering the services that our population needs; learning and improving; with leadership for quality owned and driven by the Health Board.	• Quality Planning ○ Understanding population need & design of services, policies, structures, systems to meet those needs. ○ Reflect government strategies and targets. • Quality Control ○ Processes in place to monitor performance in real time & take action when required standards not met. ○ Control processes owned by those directly providing the service with skills and permission to address performance issues within their control. ○ Quantitative and qualitative measures with appropriate escalation measures. • Quality Improvement. ○ Staff provided with right skills to deliver improvement. ○ QI plan and active QI projects in place with evidence that changes are being delivered. ○ Programme Management support in place to deliver the improvement plan with open and transparent reporting with effective Board oversight. • Quality Assurance. ○ Verify that quality control is maintained, and that performance is evaluated. ○ Effective structures, systems and standards to provide clear line of sight across the Health Board to give assurance internally and externally to stakeholders, that desired improvements to services and population outcomes are being achieved and sustained. • Principles: ○ Patient centred care – meet patient and stakeholder requirements. Essential is understanding of current and future needs of patients and public through co-production, consultation and two way communication. ○ Evidence based decision making – decisions based on robust best practice, analysis and evaluation of data and information. ○ Population and stakeholder engagement (see above). ○ Clear vision and purpose (see above). ○ Education and Training. ▪ Formal capability programmes in place to build skills across clinical and non-clinical colleagues. ▪ Build organisational wide skill in application of modern quality improvement methods. ▪ Aligned with culture where improvement work is seamlessly integrated into day to day work.	• Production of a population demand report from PH colleagues to provide insight into prevalence. • Neurodiversity prevalence report v1 Feb 2025 • Service delivery plan aligned to demand and capacity to ensure <104week waits. • Power BI dashboard reviewed and available with current and up to date data to support oversight of service. • Qualitative measures being address within CIVICA and created through co-production. • TNA completed and training plan in place to support service delivery. Significant training has taken place in all key Validated Assessment tools • QI driven transformation with robust structures in place to monitor improvements and outcomes. • Data driven service to ensure compliance, performance and outcome is captured. Information shared within team meetings, directorate meetings, committee and board as required. • Co-production agenda and outcomes in place to ensure all transformation and change is driven and supported by both staff and service users. • SOP revised and implemented based on best practice and evidence-based decision making. • Clear and robust management of concerns, incidents and investigations to ensure triangulation of data and information is evident. • Demand and capacity workforce planning to inform sustainable workforce plan supported by business case for consideration by executive committee. • Business Case presented at Execs and agreed for 26/27 budget amendments enabling the sustainability of the current resource level. Some recruitment needed due to recent leavers from temporary contracts. INTERNAL BUSINESS CASE IBG v1.7.docx

Area	Description	Success criteria	Service Assessment Feb 2026
		○Incident and complaints management. ▪ Effective investigations being conducted on business as usual basis. ▪ Language used in investigation reports is easy to understand for families. ▪ Lessons from clinical incidents must inform delivery of the multi-disciplinary training plan. ▪ Actions arising from serious incident investigation that involve a change in practice must be audited to ensure a change in practice has occurred. ▪ Change in practice arising from a serious incident investigation must be seen within 6 months after the incident occurred. ▪ Ensure that all complaints that meet the serious incident threshold are investigated as such. ▪ Complaints themes and trends to be monitored by the service. ○ Workforce. ▪ Safe and Sustainable workforce. ▪ Demand and capacity workforce planning to inform sustainable workforce plan supported by a business case for consideration by executive committee.	
Integrated Quality & Performance Assessment Framework (IQPAF)	The IQPAF is used effectively at service and Board level to regularly reflect upon and evaluate progress.	• Regular assessments of 'maturity' level for safe and effective care; quality of leadership and management; and quality, safety and patient experience. • Progression of the domains towards maturity with evidence of progress against agreed key metrics.	• IQP meeting with team - monthly • IQPAF assessments of Maturity undertaken within the service and presented to EOG and Executive Committee.
Guidance on the delivery of Neurodevelopmental Services in Wales	Guidance on functions of Neurodevelopmental (ND) services in Wales (inclusive of children who may also have learning disabilities and additional learning needs)	• Standard 1 Access • Standard 2 Referrals – additional information • Standard 3 & 4 Assessment – additional information • Standard 5 Consolidation and Interpretation of findings • Standard 6 Feedback of Assessment • Standard 7 Post assessment considerations • Standard 8 Post assessment interventions	• All 8 Welsh Government standards met within current service delivery model. • Long term improvements ongoing with improved timely access with waiting list reduction • Long term improvements ongoing with future plans to add sensory targeted therapies, to the existing post diagnostic support of family training and support and child/young person medication strategies. Additional sensory support requires resource but will be supported from the team once waiting lists are reduced.
Data Standards - Neurodevelopmental Service Assessments (ASD & ADHD) for Under 18s Impact Assessment	The current data collected through the existing proforma for Children and Young People Neurodevelopment Assessment – Wait Times is inconsistent and unsuitable for publication by Welsh Government. To address this, a revised reporting template has been developed to improve consistency, clarify	• **Completed Impact Assessment** • This impact assessment seeks to confirm whether Health Boards: • Agree with the proposed reporting metrics and definitions outlined in the new proforma. • Can capture the required information within their current systems or identify any changes needed to enable reporting. • **The updated template aims to:**	• The service leads have met with the data team and jointly completed the Impact assessment and submitted – please see below RAG rated impact assessment

Area	Description	Success criteria	Service Assessment Feb 2026
	definitions, and provide a more comprehensive view of pathway demand and waiting times.	• Standardise performance reporting through clearer guidance. • Reflect the full pathway, not just referral and assessment stages. • Support trend analysis and planning through higher-quality data. • Feedback will inform feasibility, readiness, and any system changes required before phased implementation.	

New Reporting Framework

The following indicators and definitions are included in **Phase 1 (April 2026)** of the revised reporting proforma:

Indicator			Definitions	Analyst Comments
1	**Number of referrals received by the Neurodevelopmental Service (see definition) during the month (monthly count)**	1.1 Total	Total number of referrals received by Neurodevelopmental Services each month (1.1). Neurodevelopmental Services include both: • Standalone neurodevelopmental assessment services (include all referrals, not limited to ADHD or ASD) • Neurodevelopmental assessments delivered as part of a wider service (e.g. paediatrics), including any referrals requesting ASD or ADHD assessment or designated as suitable for neurodevelopmental triage Include children and young people up to the day before their 18th birthday.	We currently report on this
	Source of referral	1.2 GP's	Referral Source: Record the number of referrals received from each referral source during the month. The total of all sources should equal the overall referral total (1.1). For referrals from sources other than GP (1.2), Mental Health and Learning Disability Service (1.3), other NHS (1.4), Self-Referral (1.5), Social Services (1.6), Education (1.7), Third Sector (1.8), count these under Other external (1.9)	We currently report on this
		1.3 Mental Health & Learning Disability Services		
		1.4 Other NHS		
		1.5 Self Referral		
		1.6 Social Services		
		1.7 Education		
		1.8 Third Sector		
		1.9 Other external		
5	**Of the referrals that completed triage during the month, how many of these were:**	5.1 **accepted** on to a waiting list for neurodevelopmental assessment	For purposes of reporting: Accepted referral: A referral is "accepted" when triage determines an ADHD or ASD assessment is needed and the child or young person is added to the waiting list. Rejected referral: A referral is "rejected" when triage decides not to add the patient to the ADHD or ASD assessment waiting list. Rejected	The system is capable of recording Triage date, but currently this has not been used. Reporting for this indicator would require that the service initiates use of the capability to record in WPAS
		5.2 **rejected** at triage by the Neurodevelopmental Service		As above

			referrals may still involve offering advice or signposting to other services but should not be excluded from the rejected count.	
6	**Number of patients who are waiting to start an ASD or ADHD assessment**	6.1 Patients waiting up to an including **182 days** (<=25 weeks)	Provide information only on children and young people awaiting an ADHD or ASD neurodevelopmental assessment. **Clock start:** The date the service first receives the referral (written or verbal), regardless of whether further information is needed for triage. **Clock stop:** The date of the first face-to-face or virtual assessment appointment, which may be with the child, young person, or their parent/guardian. A virtual attendance must be a real-time, two-way conversation (e.g. telephone or video call) with a clinician leading the diagnostic assessment. Do not stop the clock for contacts that only provide advice, guidance, or collect information before the assessment begins.	We currently report on this
		6.2 Patients waiting **183 days** and over up to and including **252 days** (26-35 weeks)		
		6.3 Patients waiting **253 days** and over up to and including **364 days** (36-51 weeks)		
		6.4 Patients waiting **365 days** and over up to and including **729 days** (52 weeks - 103 weeks, 1-2 years)		
		6.5 Patients waiting **730 days** and over up to and including **1094 days** (104 - 155 weeks/ 2-3 years)		
		6.6 Patients waiting **1095 days** and over (>=156 weeks/ 3 years)		
8	**Number of patients removed from the waiting list in reporting month (monthly count)**	8.1 Total Removals (all reasons)	• 8.1 Total removals: Record the total number of patients removed from the waiting list for any reason during the reporting month. This includes all removals, such as those who have started assessment, those who declined further assessment, or those transferred to other services • 8.2 Removals due to assessment: Specifically count the patients who were removed from the waiting list because their assessment appointment was attended during the reporting month.	Likely able to do, but need clarification from service and applications on how it is recorded
		8.2 Removals to commence assessment		We currently report on this

READER NOTES

The following indicators and definitions are included in **Phase 2 (September 2026)** of the revised reporting proforma:

Indicator			Definitions	Comments
2	**Number of referrals awaiting triage** *(see definition)* **outcome at month end (month end census snapshot)**		For reporting purposes: • Triage: The process where a clinician reviews a referral (plus any required additional information) to decide if a neurodevelopmental assessment is necessary. • Awaiting triage outcome: Referrals still under review, with no decision yet on whether the child or young person will be accepted (added to the ASD/ADHD assessment waiting list) or rejected. • Completed triage: The referral has been reviewed and a decision made—either the child is placed on the assessment waiting list (clock started) or the referral is rejected.	The system is capable of recording Triage date, but currently this has not been used. Reporting for this indicator would require that the service initiates use of the capability to record in WPAS
3	**Total number of referrals (received in any month) that have completed triage during the reporting month (monthly count)**			As above
4		4.1 Had waited **< and including 28 days** from date of referral	4.1 and 4.2 combined should be equivalent to the total number of referrals that have completed triage in month (Indicator 3) • Clock start: Date the referral (written or verbal) is first received by	As above

	Of referrals that have completed traige during reporting month, how many:	4.2 Had waited **>28 days** from date of referral	the service, regardless of whether further information is needed for triage. • Clock stop: Date triage is completed (see definition in indicator 2/3).	As above
9	**Total number of assessments completed during the reporting month (9.1) (monthly count)**		9.2, 9.3, and 9.4 combined must equal the total number of assessments completed in the month (as reported in 9.1). Clock start: The clock starts on the date of the first assessment appointment, as defined in indicator 5 guidance. Clock stop: The clock stops on the date when both of the following have occurred: (1) the family has received verbal feedback on the assessment outcome (either in person or virtually), and (2) written confirmation of the diagnosis or outcome has been sent to the family. Use the later of these two dates as the clock stop date.	We currently report on this
	Assessments completed during reporting month (monthly count) An assessment is considered completed when a family has received their verbal assessment outcome feedback (this may be face to face or virtual), AND written confirmation has been sent to the family.	9.2 Of total assessments completed, number completed up to and including **84 days** (<=11 weeks)		
		9.3 Of total assessments completed, number completed between **85 days and 168 days** (12-23 weeks)		
		9.4 Of total assessments completed, number that took **169 days or over** > =24 weeks		

READER

NOTES

The following indicators and definitions are included in **Phase 3 (March 2027)** of the revised reporting proforma:

Indicator			Definitions	Analyst comments
7	**Number of patients >18 on the waiting list for assessment at date of reporting**		Number of patients aged > 18 on an under 18's waiting list for ASD or ADHD assessment on the census date (including those in the process of being transitioned to an adult service but not yet removed from the children's waiting list)	Yes, we can report on this
10	**Total number of children and young people given an ADHD or ASD diagnosis folloing a neurodevelopmental assessment in month (10.1) (monthly count)**		10.2, 10.3, 10.4 combined must equal the total number of children given a diagnosis of ASD or ADHD (as reported in 10.1).	Provided that diagnoses are consistently recorded by service staff, we can report on this
	Diagnosis Type Of total number of diagnoses given, how many were…	10.2 ADHD only	• 10.2 ADHD diagnoses: Record the number of patients who were diagnosed solely with ADHD during the reporting month. Do not include patients who were also diagnosed with ASD in this count. • 10.3 ASD diagnoses: Record the number of patients who were diagnosed solely with ASD during the reporting month. Do not include patients who were also diagnosed with ADHD in this count. • 10.4 Combined ASD & ADHD diagnoses: Record the number of patients who were diagnosed with both ASD and ADHD during the reporting month. These patients must not be included in the counts for single conditions (10.2 or 10.3).	As above
		10. 3 ASD only		
		10.4 ASD & ADHD (both conditions)		

11	**Post assessment support and intervention type (monthly count)** Of assessments completed:	11.1 Number of patients discharged with advice or signposting only	Patients may be included 11.2 and 11.3 if they receive both. Reporting Definitions for post assessment outcome type: 11.1 Advice and Signposting Only: Count patients who received advice or were directed to another service outside the HB for support. 11.2 Referral for ADHD Medication Consultation: Count patients referred for an ADHD medication consultation after assessment. 11.3 Referral for Non-Pharmacological Intervention: Count patients referred for non-medication interventions specifically for neurodevelopmental conditions delivered by or commissioned by the health board. Note: Patients may be counted in both 11.2 and 11.3 if they received referrals for both types of intervention within the reporting month.	Would be possible using local reason codes
		11.2 Number of patients referred for ADHD medication consultation		
		11.3 Number of patients referred for a non-pharmacological intervention provided or commissioned by the LHB		

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Agenda item: 4.2

PATIENT EXPERIENCE AND QUALITY COMMITTEE	**30 April 2026**
Subject:	**People's Experience Framework – April 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:	Informal Executive Committee, 22 April 2026

PURPOSE:

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

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

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

This report is presented to PEQS in line with the Committee's role in providing quality and people-experience assurance to the Board. The report also recommends the de-escalation of the capacity concerns related to CIVICA originally escalated by the Committee in 2023.

RECOMMENDATION(S):

The Committee is asked to:

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

Approve/Take Assurance	Discuss	Note
Y	Y	Y/N

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

EXECUTIVE SUMMARY:

1. Situation

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

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

More recently the People's Experience Lead has been supporting the Concerns Team due to staffing and capacity issues.

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

Therefore this report provides:

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

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

2. Current Position

2.1 A draft Powys Teaching Health Board People's Experience Strategy has been developed, aligned to the Welsh Government national People's Experience Framework and the Duty of Quality requirements. This provides the foundation for a consistent, system-wide approach to capturing, analysing and acting on people's experience and fully implementing the framework.

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

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

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

3. Civica

3.1. Capacity for the organisation to roll out the civica system was of concern and in 2023 became an issue that the PEQS committee escalated and reported to the Board.

3.2. People's Experience Lead now managing Civica across the health board. Surveys being used and promoted. Civica now being used as business as usual for feedback and compliments.

3.3. The use and availability of Civica has been increased to allow more staff access to add feedback and survey entries onto Civica but also to provide managers access to real time reports demonstrating their feedback, specific to their services. Through this, wider engagement and awareness of Civica has also increased across services.

3.4. The hierarchy within Civica has been reviewed to ensure services are represented and allows all areas of care to receive feedback from the public.

3.5. Next steps will involve setting up service specific QR codes for the People's Experience Survey to allow patients and the public quicker access

to provide their feedback, aiming to increase the number of responses received.

3.6. Civica and the People's Experience Survey is now feeding data into the IQR Power BI dashboard. Work is also to be undertaken to develop a section specific to compliments received within the organisation.

4. PEF Self-Assessment

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

	Maturity Position - Developing
Strengths	• Clear organisational commitment to person-centred care • Strong values alignment among staff • Feedback mechanisms in place (formal & informal) • Positive staff engagement and local ownership • Evidence of feedback informing improvements • Growing recognition of experience as part of quality & safety
Gaps	• Variable practice across services • Dependent on local leadership & capacity • Limited systematic analysis & triangulation of feedback • Inconsistent reporting of outcomes & learning • Limited organisational assurance • Improvements not consistently measurable or visible
Next Steps	• Strengthen consistency and coordination across services • Embed routine analysis and triangulation of experience data • Improve visibility of impact and outcome measures • Enhance reporting and learning pathways • Strengthen governance & organisational oversight • Progress maturity through systematic and sustainable approaches

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

5. People's Experience Strategy

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

5.2 This is likely to come back to PEQs for final approval in the September report. Committee is asked to note that progress continues as reported, and the formal approval of the Strategy does not impinge on on-going development of this work.

6. PEF Implementation Plan

6.1 The ongoing Implementation Plan (Appendix 1) outlines the actions to be taken and the progress to date with regard to the implementation of the framework. This will be reported in the IQR quarterly updated in future reports.

6.2 The People's Experience Lead is going to receive project management support from the W&C directorate. This support will include a review of current action plans and templates and develop them into smarter actions. Services within the organisation will be required to engage in task and finish groups to allow the People's Experience Lead to regularly monitor and track progress against the PEF.

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

7. People's Choice Awards

7.1. From the end April, patients, relatives and carers will be able to nominate staff and teams for a new People's Choice Award. This award will help us capture, celebrate and learn from positive examples of care and exceptional service, as well as ensure our staff receive thanks from those that matter the most; our patients and their families.

7.2. Nominations will be made available via the PTHB website and social media channels. All staff and teams nominated will receive a certificate of recognition and an award presented to the winner. The award will form part of the current staff appreciation awards on a quarterly basis.

8. Conclusion

8.1 Committee is asked to note the progress within the report and take assurance that implementation of the national Patient Experience Framework is underway and making progress; robust monitoring and reporting systems are now in place for committee to receive regular assurance and oversight of this work.

NEXT STEPS:
1. Consultation of the Patient Experience Strategy is due to launch in May; consultees include staff, patients and stakeholders. **2.** Bring back the PES for PEQs approval in July/August. **3.** Continue with the implementation plan, reporting on progress in the quarterly IQR report to PEQs. **4.** If agreed, confirm to the PTHB Board the de-escalation of the capacity concerns related to CIVICA from the PEQs committee.

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					

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Agenda item: 5.1

PATIENT EXPERIENCE AND QUALITY COMMITTEE	**30 APRIL 2026**
Subject:	**Integrated Quality Report: Quarter**
Approved and presented by:	Paul Hooton, Executive Director Nursing, Quality, Women & Family Health
Prepared by:	Director of Midwifery, Women and Family Health
Other Committees and meetings considered at:	Executive Committee - 15 April 2026 who supported the paper to PEQS.

PURPOSE:

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

RECOMMENDATION(S):

The Committee is asked to:

- **NOTE** the introduction of a revised Integrated Quality Report structure, and provide feedback to support further refinement and development over the coming period.
- **RECEIVE** the report and take **ASSURANCE** that Quality and Safety is appropriately monitored and reported and that continued actions are in place to further develop quality and safety monitoring and reporting.

Approve/Take Assurance	Discuss	Note
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	N	
7. Put Digital First	N	
8. Transforming in Partnership	N	

EXECUTIVE SUMMARY:

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

This report has been prepared following a recommendation in the Audit Wales Structured Assessment report 2025 to review and strengthen the structure of the Integrated Quality Report to improve clarity, insight, and assurance. This report introduces a revised structure to support clearer presentation of quality and safety information. Further refinement will be required as this approach develops. Feedback from Committee members is welcomed to inform any further refinement of the structure to ensure it continues to meet the needs of both internal and public audiences.

The report is structured to separate three key elements: intelligence, triangulation, and assurance. The initial section presents quality and safety intelligence drawn from multiple sources, including incidents, concerns, patient feedback, and other indicators. This is followed by a triangulated analysis, bringing together these sources to identify overarching themes and emerging organisational priorities. The report should be interpreted in the context of relatively small datasets in some areas, and triangulation is used to support a balanced view of performance and risk. A dedicated compliance section then provides assurance against key regulatory and national standards. This approach is intended to improve the visibility of learning, support a more integrated understanding of risk, and strengthen the Health Board's ability to drive targeted improvement.

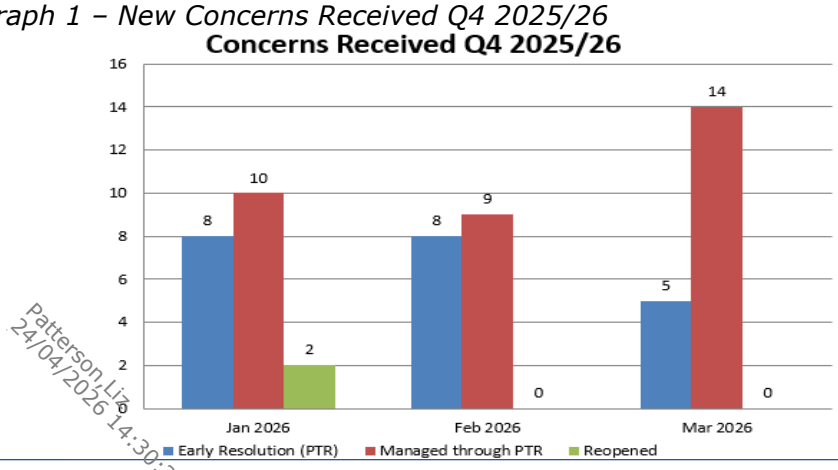
1. INTELLIGENCE

This section presents an overview of quality and safety intelligence for Quarter 4, drawing on data from incidents, concerns, patient experience, Duty of Candour and claims. It focuses on the key themes, trends and signals emerging across these sources to identify emerging risks to inform organisational learning and improvement.

1.1 Putting Things Right (PTR) – Concerns

In Q4 2025/26, **33** formal **21** early resolution concerns and were raised through PTR (*graph 1*).

Graph 1 – New Concerns Received Q4 2025/26



The number of concerns remains relatively low (n= 54 formal concerns), and themes should therefore be interpreted alongside other intelligence sources to ensure a balanced understanding. A review of these, highlights several consistent themes:

- **Communication and Patient Engagement**
  - Clarity, timeliness, and consistency of information
  - Involvement of patients and families in decision-making
- **Access to Care and Timeliness**
  - Delays in assessment, treatment, and follow-up
  - Waiting times across pathways (e.g. neurodevelopmental services)
- **Clinical Decision-Making and Quality of Care**
  - Concerns regarding appropriateness of care
  - Perceived missed opportunities in assessment or treatment
- **Patient Experience and Professionalism**
  - Staff attitude, behaviour, and communication style
  - Emotional impact on patients and families
- **Care Coordination and System Processes**
  - Continuity of care and coordination between services
  - Pathway clarity, handovers, and organisational processes

These themes are consistent with previous reporting and continue to inform targeted quality improvement activity at both service and organisational level. Learning and action is further reported under section 2- Triangulation.

1.2 Incident Reporting

In Q4 2025/26 the following incidents were reported by level of harm:

Table 1: Level of harm Q4

Level of harm	No per Q4
None	599
Low	179
Moderate	4
No value	388
TOTAL	**1170**

A total of 1,170 incidents were reported during the quarter. Whilst this provides a reasonable dataset, interpretation of sub-categories and themes should consider variation in reporting and classification.

Month-by-month incident reporting is outlined in Graph 2. Overall reporting levels remain stable, with the majority of incidents recorded as 'no harm' or 'low harm', consistent with an established reporting culture across the Health Board.

However, a notable proportion of incidents are currently categorised as 'no value'. This is a Datix classification used where a harm level has not been assigned due to partial or incomplete investigation. Harm grading is expected to be completed

at the time of incident entry (mandatory field), with subsequent review at service level to ensure accuracy and amend where required following initial assessment or investigation and when this is incomplete this leads to 'no value' outputs.

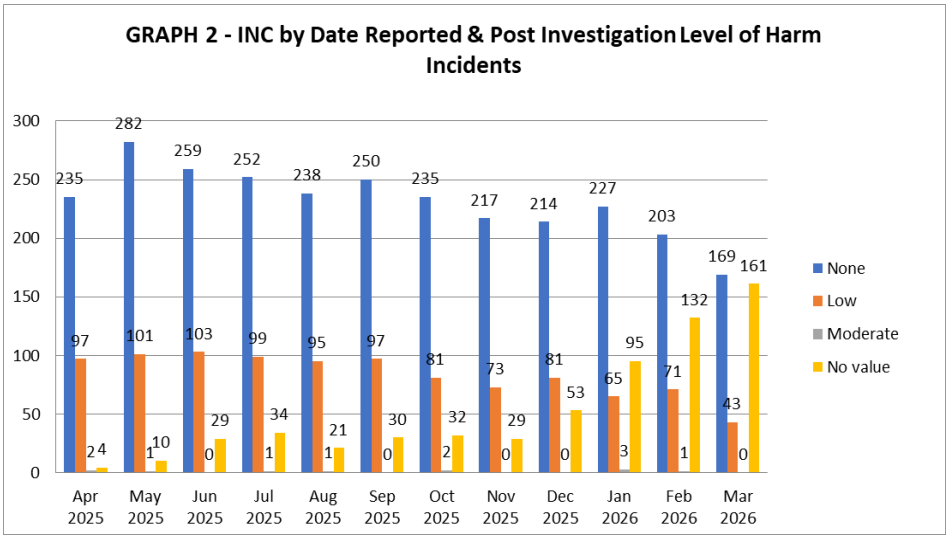
The presence of 'no value' incidents indicates inconsistency in the completion of incident records, which reduces the completeness of harm-based reporting and trend analysis. This is recognised as an area for improvement.

Actions are in place to address this, including:

- Reinforcement of expectations for harm grading at the point of investigation
- Targeted education and training for staff on incident reporting requirements
- Ongoing oversight by the Quality and Safety Team to support data quality and compliance
- Incorporation of this issue within wider learning and improvement work

It is anticipated that these actions will lead to improved data completeness and strengthen the Health Board's ability to derive meaningful learning and assurance from incident reporting.

There was **1** Nationally Reportable Incident (NRI) during Q4. Learning from this has been included in the overall incident learning set out below.



Thematic review of the incidents reported in Q4, identify the following:

- **Skin Integrity and Pressure Damage**
  - High volume of pressure ulcers and moisture-associated skin damage
  - Includes category 2 pressure ulcers and suspected deep tissue injuries

- **Falls and Accidental Injury**
  - Falls (witnessed and unwitnessed)
  - Patients found on the floor

- General accidental injuries

➢ **Violence, Aggression and Behavioural Incidents**
- Patient/service user to staff incidents
- Behavioural escalation and aggression

➢ **Workforce, Capacity and Environmental Factors**
- Lack of suitably trained staff
- Infrastructure and environment-related issues

➢ **Safeguarding and Vulnerability**
- Safeguarding concerns (adult and child)
- Vulnerable individuals requiring additional protection

This report presents themes at an organisational level to complement existing service-level analysis. These themes provide important insight into operational and clinical risks and will be triangulated with other sources of quality intelligence to inform organisational learning and improvement outlined in Section 2 - Triangulation.

1.3 Early Warning Notifications (previously No surprises notifications)

A total of 7 Early Warning Notifications were submitted during Q4 2025/2026. A review of Early Warning Notifications submitted during the period highlights a small number of high-severity incidents, providing important insight into areas of organisational risk.

The most prominent theme relates to mental health crisis presentations, including incidents involving significant risk of harm. These cases emphasise the complexity and acuity of presentations within mental health pathways and the importance of timely and effective crisis response. Safeguarding and the management of vulnerable individuals is also a key theme. These incidents reinforce the need for robust multi-agency working and effective risk assessment and management processes.

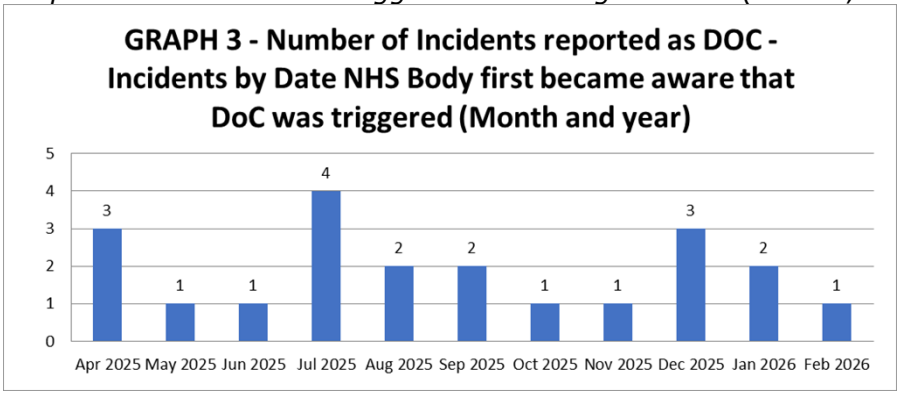
A further issue identified relates to system and access challenges within urgent care pathways, including a reported delay in accessing services due to a technical issue. Whilst an isolated event, this represents a potential patient safety risk and has been escalated and reviewed. Communication and information sharing have also been identified as contributory factors in a number of cases, highlighting the importance of timely escalation and effective coordination across services and partner organisations.

Although the number of notifications is low, the severity and nature of these incidents provide insight into high-severity risks, which are considered alongside wider intelligence to inform organisational learning and wider triangulation of quality and safety intelligence under section 2 - Triangulation.

1.4 Duty of Candour (DoC)

There have been 3 Duty of Candour cases during Q4 2025/26; this is a marked reduction on same period in 2024/25 (19 cases). There was no thematic issue across DoC incidents that were not already identified within incidents.

Graph 3 – Date DoC was triggered in the Organisation (Source; Datix)



1.5 Claims, Redress & Clinical Negligence

Table 2 below identified the current position, including the Q4 specific activity relating to Redress, Clinical Negligence, Personal Injury, GMPI claims and Inquests.

Table 2:

Category	Current Position	Q4 Activity
Redress	13 open cases (June 2021 – March 2026)	Ongoing
Clinical Negligence	8 confirmed cases	1 new case in Q4
Personal Injury	<5 confirmed cases	No new cases in Q4
GMPI Claims	<5 confirmed cases	No new cases in Q4
Inquests	23 confirmed inquests	8 new in Q4

Of these cases, the thematic links include:

- Mental Health related deaths
- Clinical decision making / clinical risk assessment

1.6 People's Experience

Patient engagement activity during the quarter provides insight into patient experience across a range of services. Feedback from engagement relating to temporary service changes has been largely positive, particularly in relation to staff compassion and quality of care. However, a number of operational challenges have been identified, including issues impacting patient flow, discharge processes, and the clarity of information provided to patients.

The use of patient stories continues to be promoted as a key mechanism for capturing lived experience and supporting organisational learning. Whilst engagement remains positive, the volume of stories collected is currently limited.

Work continues to strengthen this approach, including increasing staff capability in digital storytelling and establishing a more structured programme for story collection across services. This is expected to enhance the Health Board's ability to capture meaningful patient insight and support quality improvement.

The People Experience Framework Progress was previously reported and will continue to be reported as a stand alone report.

Patient feedback collected through Civica and wider engagement activity during Quarter 4 provides important insight into patient experience across services. Overall, feedback is generally positive, with a high proportion of responses indicating satisfaction with care received, reflected in over 1,200 compliments recorded during the period. The table below show the total number of responses received into Civica for all types of active surveys and number of contacts via SMS. Note that responses via SMS are delayed by one calendar month, therefore not a true representative of March 2026.

Table 3: Civica Response Data

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
Mar-26	34	7	28	566	179	387	1	852	0
Feb-26	37	8	32	861	422	439	1	2883	0
Jan-26	34	8	29	801	460	341	1	3179	0

Targeted responses are those collected via SMS, IVR and Email. Passive responses are those collected via all other delivery methods such as QR codes and survey links

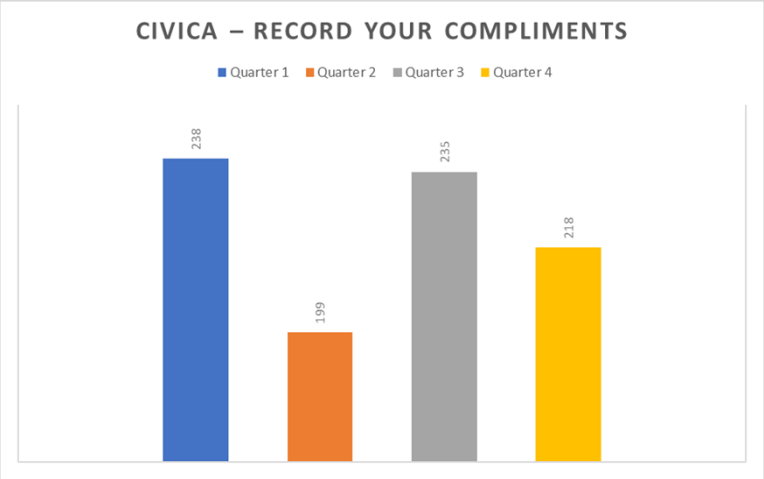
The Heatmap below provides an overview of responses to the PES by service areas, as per the current hierarchy for Q4. The Civica structures and hierarchy for reporting has been reviewed and awaiting implementation by Civica therefore will be more representative of all services within PTHB.

Table 4: PES outcomes

Services	Responses	2 - How would you rate your overall experience?	6 - Were you able to communicate in your preferred language?	7 - Was the time you waited:	8 - Did you feel well cared for?	9 - Were you treated with dignity and respect?	10 - Did you feel that you were listened to?	11 - Were you involved as much as you wanted to be in decisions about your care?	12 - Were things explained to you in a way you could understand?	Overall
		People's Experience Survey (PES)	People's Experience Survey (PES)	People's Experience Survey (PES)	People's Experience Survey (PES)	People's Experience Survey (PES)	People's Experience Survey (PES)	People's Experience Survey (PES)	People's Experience Survey (PES)	
Community: e.g. your home, mobile unit, public place	4	63	100	100	67	78	67	67	78	77
Dental Services	2	25	100	100	0	0	0	0	0	28
Feedback - concerns team only	4	50	100	50	58	92	58	50	67	66
Hospitals and services outside Powys	1	75	100	100	67	67	67	67	67	76
Other services not on a hospital site: e.g. mental health, Glan Irfon	7	86	100	83	83	83	83	83	83	86
PTHB Service Setting	88	83	96	85	90	92	84	79	85	87
Unmapped	444	87	99	84	91	96	91	87	91	91
	Overall	86	98	84	90	95	89	85	90	90
	Benchmarks	85	85	85	85	85	85	85	85	

Compliments are actively recorded through CIVICA and are outlined below, identifying 218 compliments were received in Q4.

Graph 4 – Civica recorded compliments by volume by quarter



Analysis of feedback highlights several consistent themes. Positive feedback frequently relates to staff compassion, professionalism, and the quality of care provided. Areas for improvement are primarily associated with communication and information provision, including clarity of information and patient understanding, alongside aspects of access and service experience. These findings are consistent with themes identified through other sources of intelligence.

Work is ongoing to strengthen the use of Civica as a primary feedback mechanism, improve the consistency of data capture across services, and enhance accessibility of surveys, including alignment with national Accessible Information standards.

Patient feedback from external engagement activity, including Llais, continues to provide complementary insight into local population needs and experiences. These themes will be considered alongside other sources of intelligence to inform

organisational learning and improvement actions, as outlined below in section 2, Triangulation.

2. TRIANGULATION

2.1 Triangulation across incidents, concerns, claims / redress and patient feedback supports a broader understanding of quality and safety across the Health Board, beyond service level. This approach represents a strengthening of previous reporting arrangements, moving beyond individual data sources to identify consistent themes, emerging risks, and system-wide learning.

Learning will be aligned to key thematic issues identified through triangulated intelligence, enabling the development of targeted improvement initiatives, including a focus on patient-centred communication. A programme of professional improvement is being led by the Executive Director of Nursing through newly established, structured forums, supporting the coordination of learning across services and with professional education colleagues.

2.2 The Triangulation of Intelligence

Across all sources, a number of recurring themes are evident. Communication and patient engagement is consistently identified, particularly in relation to the clarity and timeliness of information and involvement of patients and families. Access to care and timeliness also remains a key theme, including delays in assessment, treatment, and response. Clinical decision-making and risk assessment are highlighted across multiple datasets, alongside issues relating to care coordination and continuity across services. In addition, incident reporting identifies specific operational risks, including falls, skin integrity, and workforce or system pressures, whilst higher severity intelligence highlights risks associated with vulnerable individuals and mental health presentations.

This triangulated view demonstrates that different intelligence sources provide complementary insight into quality and safety. Patient feedback and concerns predominantly reflect experience and communication, whilst incidents highlight clinical and operational safety risks, and Early Warning Notifications provide insight into high-severity and low-frequency events. Taken together, this provides a more balanced and reliable assessment of organisational performance and risk.

2.3 Emerging Organisational Priorities

Based on triangulated intelligence, the following priority areas are consistently identified. These themes represent priority areas for focus rather than specific actions. Detailed, measurable actions and trajectories will be developed through a structured improvement plan:

- **Communication and patient engagement** – improving the clarity, consistency and timeliness of information and involvement of patients and families
- **Access to care and timeliness** – reducing delays across pathways, including assessment, treatment and response times

- **Clinical decision-making and risk assessment** – strengthening consistency and quality of clinical judgement and risk management
- **Care coordination and continuity** – improving integration across services and clarity of patient pathways
- **Operational and system pressures** – addressing workforce, environmental and process factors impacting service delivery and patient safety

The next phase of work will translate these priorities into SMART actions, with defined measures, timescales and accountability.

This work represents a development in reporting, strengthening organisational oversight and the ability to identify priority areas for improvement. It is recognised that some datasets are small in volume, particularly concerns and high-severity incidents. Triangulation is therefore used to identify consistent signals across sources, rather than relying on individual data points.

The next phase of this work will focus on refining these themes into a small number of clearly defined organisational priorities, supported by a structured improvement plan. This work is currently underway, with the intention of establishing an agreed set of priorities and associated actions by the end of Quarter 1.

In the interim, the Health Board can take assurance that further work is underway to refine the key areas requiring focus, and that a systematic approach is being established to ensure learning is translated into meaningful and sustained improvement.

Overall, assurance is provided that the Health Board is strengthening its approach to understanding and responding to quality and safety risks through improved use of triangulated intelligence.

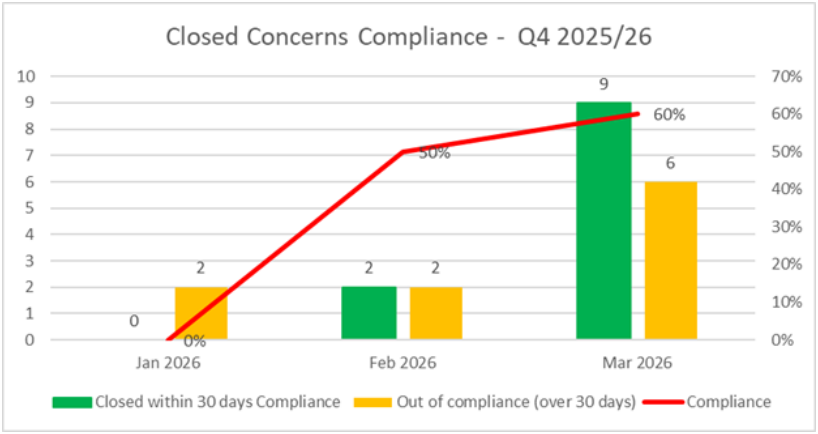
3. COMPLIANCE

This section provides an overview of the Health Board's compliance with key regulatory and national standards across quality and safety. It is presented separately to ensure that assurance regarding performance and governance is clearly demonstrated, whilst maintaining a distinct focus on organisational learning and improvement within the preceding sections.

3.1 Putting Things Right (PTR) – Compliance against Regulation

Under the Putting Things Right (PTR) process, formal concerns are required to be responded to within 30 working days. Performance for Quarter 4 is outlined in Graph 5.

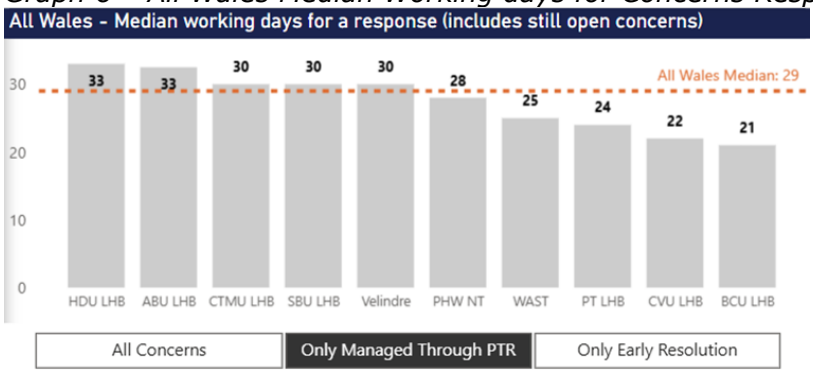
Graph 5 – Concerns compliance response rate (Source: Datix)



Compliance within the quarter reflects the impact of very small numbers. In January, compliance was 0%, with two concerns due within the period. Performance improved progressively through February (50%) and March (60%). Whilst percentage compliance appears variable, this should be interpreted in the context of low volumes, where individual cases can significantly influence reported performance.

Importantly, overall timeliness remains within target, with the Health Board maintaining a mean response time of 24 working days (Graph 6), providing assurance that responses are, on average, being delivered within the required timeframe.

Graph 6 – All Wales Median Working days for Concerns Response (Source: Beacons Dashboard)



A number of challenges have impacted performance during the quarter, including capacity constraints within the Quality and Safety team and delays within the sign-off process. In response, a focused programme of work was undertaken during March to address historic backlog. This has resulted in the closure of all outstanding PTR concerns from 2025, representing a significant improvement in position.

As at 31 March 2026, a total of 21 formal concerns from the 2025/26 reporting period remain open, with only 2 of those from within 2025. With the introduction of the Listening to People Regulations on 1 April 2026, the service has established a clear trajectory to reduce this number to 5 by the end of Quarter 1, with the aim of achieving full clearance of all outstanding PTR concerns by the end of Quarter 2.

The Health Board's progress in eliminating the 2025 backlog is a positive position in the context of national performance. Ongoing monitoring of outstanding cases and compliance will continue through the national Beacons dashboard to ensure sustained improvement and timely resolution of concerns. Continued focus will be placed on maintaining trajectory through robust oversight, clear accountability, and alignment with the new Listening to People framework.

3.2 Listening to People Framework

The Listening to People Regulations were implemented on 1 April 2026. In preparation, significant work was undertaken to ensure that all concerns managed under the previous Putting Things Right arrangements were appropriately recorded and progressed prior to transition.

Work is also underway to develop a Health Board wide Standard Operating Procedure (SoP) to support the consistent implementation of the new regulations. This will set out the end to end process for managing concerns locally, including delegated sign off arrangements, quality assurance processes, and clearly defined roles and responsibilities across service, Quality and Safety, Executive and Board levels. The SoP is scheduled for consultation in early May, with a planned implementation by the end of May 2026.

3.3 Claims, Redress & Clinical Negligence – Compliance

A small number of historic redress cases remain open, with some dating back to 2021. To support timely progression and conclusion of these cases, an ad hoc virtual panel has been established to provide focused oversight and challenge.

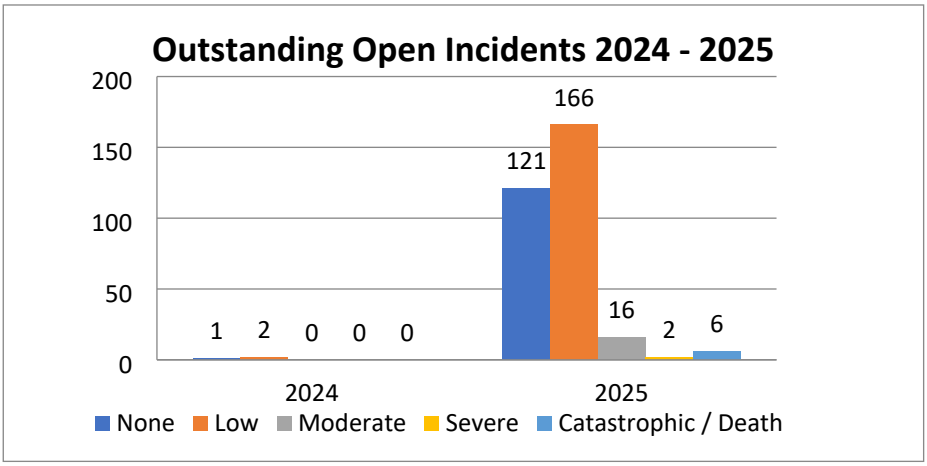
All redress cases continue to be managed through the Learning from Events Review (LFER) process in conjunction with the Welsh Risk Pool. Following a minor and exceptional compliance variance in Quarter 3, performance has now returned to expected standards, providing assurance regarding the robustness of current processes.

3.4 Incident and NRI – Compliance

In Quarter 3, the closure of historic incidents was identified as an area requiring improvement. Significant progress has since been made, with all outstanding moderate and above harm incidents from 2024 now closed.

As demonstrated in Graph 7, only a small number of low and no harm incidents from 2024 remain open, with the residual backlog largely comprising lower-harm cases from 2025. These are being actively progressed, with continued oversight in place to support timely closure and ensure sustained improvement in incident management processes.

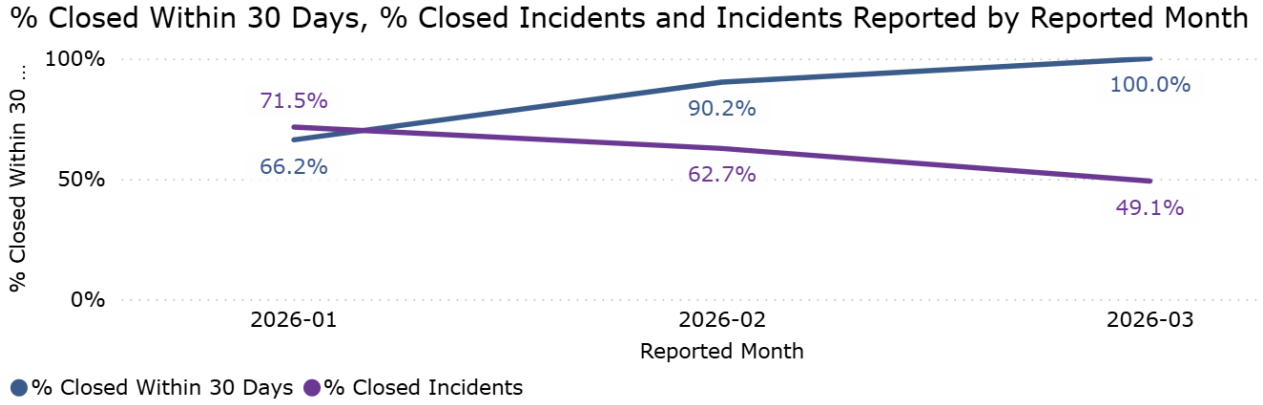
Graph 7: Open Incidents as at 10/4/26 (Source: Datix)



As demonstrated in Graph 8, performance relating to the timeliness of incident closure within 30 days has shown sustained improvement across the quarter, increasing from 66.2% in January to 100% in March. This indicates that where incidents are being progressed, they are being completed within expected timeframes, providing assurance regarding the effectiveness of current processes.

In contrast, the overall proportion of incidents closed has reduced over the same period, from 71.5% in January to 49.1% in March. This reflects ongoing capacity pressures impacting the ability to progress the full volume of incidents requiring review and closure.

Graph 8: performance against 30 day closure



Actions are in place to address this and support recovery of performance, including:

- Targeted oversight of open incidents at service level, with regular review of outstanding cases
- Continued focus on timely progression and closure of newly reported incidents
- Support from the Quality and Safety Team to prioritise higher-risk incidents and provide guidance on investigation processes
- Ongoing monitoring through routine reporting to identify areas requiring additional support

In addition, a wider review of incident and concerns management processes has commenced, with a programme of actions underway to streamline and improve how incidents are communicated, managed and progressed. This includes maximising the functionality of existing systems, such as Datix, to support more effective communication, audit trails, and document management at a local level. This work will be formalised through the development of a Standard Operating Procedure to support consistency and efficiency across the Health Board.

These actions are expected to support improved overall closure rates, whilst maintaining the positive position in relation to timely completion of investigations. Overall, processes are in place, with continued focus required to improve consistency in closure performance.

3.5 Nationally Reportable Incidents

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

- 4 open (2 awaiting sign off)

Improved timeliness of investigations is a focus for 2025/26 as high numbers of investigations remain open for >90 working days with the average completion time of 191 days. This reflects the complexity of a small number of cases rather than systemic delay, however improvement remains required.

4. Infection Prevention and Control (IP&C)

4.1 Inpatient Outbreaks

Five inpatient outbreaks were reported during Q4, associated with seasonal illnesses (influenza-like illness [ILI] and norovirus). All outbreaks were managed in line with Health Board outbreak control policies and procedures. No beds were lost as a result, either due to services operating at full capacity or through IPC risk assessment of admissions, including the safe repatriation of patients to Powys where required.

4.2 Decontamination Audit

An internal audit of decontamination services resulted in overall **reasonable assurance**, with two of the five areas receiving substantial assurance.

4.3 Quality Improvement

Welsh Government published the Quality Statement: Infection Prevention and Control during Q4, which sets clear expectations and standards for NHS organisations to ensure robust systems for preventing and controlling Healthcare Associated Infections (HCAIs). The team have undertaken an initial mapping exercise against the 52 quality attributes, highlighting that many of the essential structures and processes required for a high-quality IPC service is already in place and there is clear evidence of improvement and maturity following the two-year IPC improvement plan. The team will continue to advance the further actions required to align with the statement.

IPC Level 1 & 2 training levels remain >85% across the Health Board

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

The IP&C team continues to focus on improving compliance with Aseptic Non-Touch Technique (ANTT) including gaining bronze accreditation in one service area by May 2026 and use this as a platform for advancing accreditation.

4.4 Hospital Acquired Infection

The team are actively involved and contributing to the national Clostridioides difficile (CDI) improvement programme, with a specific focus on strengthening the integration of patient experience into infection prevention and control practices. A questionnaire has been developed and will be shared via CIVICA with all patients who had a CDI infection during 2025/26 to inform learning.

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

Overall reduction expectations were largely met (outlined below), with many indicators performing at or below the levels achieved in the previous financial year. This demonstrates sustained improvement and consistency across core IPC metrics.

Hospital onset cases of CDI reduced from 38% to 15% in this financial year, that reflects robust IPC measures, strengthened clinical practices and improved surveillance.

However, community-onset cases now account for the majority of total cases, which explains why overall numbers remain higher. This pattern aligns with national trends. To address this, the IPC team is actively engaging with national learning and improvement programmes. In parallel, work is underway to integrate IPC into virtual wards.

Reduction expectation number	Domain	Financial year 2024/25	Financial year 2025/26
E. coli bacteraemia			
1.	A reduction of at least 10% in cases of hospital onset E. coli BSI is expected vs the cases in 2024-2025	2 cases reported	1 case reported **(one less than the previous FY)**
P. aeruginosa bacteraemia			
2.	A reduction of at least 10% in cases of hospital onset Pseudomonas aeruginosa BSI vs the cases in 2024-2025	0 cases reported	0 cases reported **(equivalent to previous FY)**
Klebsiella spp. Bacteraemia			
3.	A reduction of at least 10% in cases of hospital onset Klebsiella spp BSI vs the cases in 2024-2025	0 cases reported	0 cases reported **(equivalent to previous FY)**
Clostridioides difficile			
4.	To reduce the overall burden of C. diff infection by at least 25% against the 2024-25 counts	22 cases reported	26 cases reported **(4 more than in the previous FY). However, hospital onset reduced from 38% in the previous year to 15%.**
Staphylococcus aureus bacteraemia			
5.	MSSA Improvement Goal: A decrease of at least 20% compared to the 2024/25 baseline counts for all Health Boards MRSA Improvement Goal: All Health Boards should have fewer MRSA BSI cases in 2025/26 than in 2024/25	2 cases reported	1 case reported **(1 less than the previous FY)**

5 Health and Social Care Inspections

5.1 Health Inspectorate Wales Inspections

The Health Board continues to respond to actions arising from Health Inspectorate Wales (HIW) inspections and reviews. Previously reported positions indicated good progress against a number of improvement plans, including those relating to Llandrindod Wells Minor Injuries Unit and Ystradgynlais Community Mental Health Team, with the majority of actions either completed or not yet due.

As part of ongoing work to strengthen governance and oversight, a review of the monitoring and reporting arrangements for HIW actions has been initiated. This will ensure there is a consistent and robust approach to tracking progress, providing assurance, and supporting timely completion of all actions across the organisation.

In addition, unannounced inspections undertaken during the period at Maldwyn Ward, Victoria Memorial Hospital and Twymyn Ward, Bro Ddyfi Community Hospital have resulted in further improvement actions. These have been responded to and submitted for Executive assurance, with full reports awaited. Strengthening the oversight and assurance processes for regulatory actions will form part of the wider programme of governance improvement outlined within this report.

6. Bereavement Framework

Work to support the implementation of the National Bereavement Framework (NBF) continues across the Health Board, with a focus on strengthening bereavement pathways, improving support for families, and ensuring services are accessible and inclusive.

Progress to date includes the development of bereavement pathways in collaboration with Maternity Services, alongside the continued provision of bereavement support resources, including out-of-hours information and accessible bereavement packs. Work to enhance inclusivity remains ongoing, including alignment with equality requirements and the development of culturally appropriate support materials.

Engagement with bereaved individuals and families has continued to inform service development, with feedback being used to shape improvements in care and support. In addition, awareness and support initiatives delivered in previous quarters continue to inform current practice.

Further work is planned to build on this foundation, including strengthening engagement activity, enhancing staff capability, and progressing a coordinated approach to bereavement support across services

7. Medical Examiner

We are currently engaged with the NHS Wales Performance and Improvement team to facilitate our external Medical Examiners Audit and expect an update within the next quarter.

We will prepare an associated action plan where improvements are identified and present this in the next quarterly report.

8. Contract Quality Performance Review

8.1 Quality Assurance

The Health Board continues to work with commissioned providers to oversee quality and safety, with established governance arrangements in place through routine contract and quality review meetings.

Recognising the need to further strengthen the consistency and depth of assurance, work is underway to enhance the approach to quality oversight across commissioned services. This includes a joint programme of work between the Quality and Safety and Commissioning Teams, aligned to the Health Board's

annual plan, to develop more robust and meaningful quality metrics and reporting mechanisms.

This work will support improved visibility of provider performance, enable more effective triangulation of intelligence, and strengthen the Health Board's ability to identify risk, assure quality, and drive improvement across commissioned services. Development of these arrangements is in progress and will build on existing governance structures to provide a more consistent and systematic approach to quality assurance.

8.2 Commissioning Concerns Monitoring

Following the changes to planned activity regarding Powys patients provided by NHS England, the Health Board have received 13 concerns which have been managed as enquiries for Q4. This is a reduction on the 33 in Q3.

We have undertaken a review of each case, ensuring it is appropriately classified, and prepared monitoring fields in the Datix system, and advice for those inputting the enquiries to support improved monitoring of these concerns. A refreshed review has identified a total of 66 cases to end of Q4.

Whilst these cases are appearing to reduce in number, it should be noted that the complexity has increased, requiring more detailed responses, and often input from clinicians in commissioned services which is impacting both capacity and response times.

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

9. Conclusion

This report provides an overview of quality and safety across the Health Board, drawing on multiple sources of intelligence to present an integrated understanding of performance and risk. The introduction of a triangulated approach has enabled identification of consistent themes, including communication, access to care, clinical decision-making, care coordination, and operational pressures. These insights provide a strong foundation for organisational learning and support a focused approach to improvement.

Whilst recognising areas where further progress is required, the report presents assurance that relevant processes are in place to monitor performance, respond to risks, and strengthen governance arrangements. Work is underway to translate these insights into a structured programme of improvement, with clearly defined priorities to be established by the end of Quarter 1. Overall, assurance is provided that the Health Board is refining its systematic and effective approach to understanding and improving quality and safety.

IMPACT ASSESSMENT – NOT REQUIRED FOR THIS REPORT

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 5.2

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE	**30 APRIL 2026**
Subject:	**Maternity Services Assurance Report- Local response to the All-Wales Maternity and Neonatal Assurance Assessment**
Approved and presented by:	Paul Hooton, Executive Director of Nursing
Prepared by:	Head of Midwifery, Sexual and Women's Health Director of Midwifery, Women and Family Health
Other Committees and meetings considered at:	Executive Committee – 15 April 2026

PURPOSE:

This paper provides assurance to the Committee on the safety, quality, and effectiveness of maternity services within Powys Teaching Health Board, with specific reference to the findings of the All-Wales Maternity and Neonatal Assurance Assessment (February 2026) – see appendix 1.

It summarises the Health Board's response to the assessment, including progress across key domains: safety and escalation, clinical governance, workforce capability, data and digital systems, and care pathway assurance.

The report also highlights how ongoing engagement with national programmes, including the Maternity and Neonatal Safety Support Programme (MatNeo SSP), alongside local initiatives such as the Quality Improvement Forum and implementation of BadgerNet, are supporting continuous improvement.

The paper is intended to provide assurance that maternity services are appropriately monitored, governed, and strengthened through a structured and coordinated approach aligned to national expectations.

RECOMMENDATION(S):

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

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

Approve/Take Assurance	Discuss	Note
Y	Y	Y

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

EXECUTIVE SUMMARY:

'The Path to Safer Beginnings in Wales' (February 2026) is the publication based on the National Assurance Assessment of Maternity and Neonatal Care and Services. The publication provides a national framework for evaluating the safety, quality, and governance of maternity services across Wales.

Powys Teaching Health Board participated fully in the process through structured self-assessment, executive sign-off, and engagement with the national review team, including direct engagement with clinical teams.

The assessment indicates that maternity services in Powys are operating without immediate safety concerns. Most domains were assessed at maturity levels 2–3, reflecting established systems and a committed workforce. However, assurance is currently limited by variability in governance evidence, workforce experience profile, and the maturity of data systems, which present risks to consistency and sustainability if not addressed.

In response, the service has developed a structured improvement programme focused on safety and escalation, clinical governance, workforce capability, data and digital systems, and care pathway assurance. This is supported by national and local programmes including MatNeo SSP, the Quality Improvement Forum, MNVP development, and implementation and ongoing development of BadgerNet.

POSITION SUMMARY:

1.All Wales Maternity and Neonatal Assurance Assessment:

The Path to Safer Beginnings in Wales, February 2026 provides an evaluation of maternity services across Wales. Whilst the report provides an all-Wales review, Health Boards **will not** receive local reports relevant to their service. Health Boards are asked to translate the national recommendations into local delivery plans, demonstrating alignment with a nationally co-ordinated 3-year improvement plan. Health Boards are also required to provide regular assurance on progress, impact and risk.

Locally, since the publication the service has completed a review of the findings, with benchmarking and gap analysis based on the self-assessment that was undertaken at the time of the review, and the current status.

The Health Board has identified the following priority areas for improvement:

- Safety and escalation
- Clinical governance
- Workforce capability
- Culture, Staff Experience and Wellbeing
- Data and digital systems
- Care pathway assurance

A structured improvement plan has been developed (Appendix 1), aligned to national frameworks, including MatNeo SSP, and supported by local governance structures. This will be monitored through the Women's and Children's Quality Improvement Forum which has clear reporting and escalation mechanisms in place.

The report provides a number of recommendations to be undertaken at a national level and we are awaiting the publication of the nationally co-ordinated 3-year improvement plan. The Health Board is committed to contributing to, and supporting the development of national initiatives and actions and will report on further development as this progresses.

2.Local Implications and Actions:

Safety and escalation
Operational escalation processes have been reviewed to improve clarity and consistency across the service. A revised escalation policy is in development and under consultation, with implementation planned for May 2026. This includes strengthened arrangements for the escalation of commissioned services, both maternity and neonatal, and outlines clear roles and responsibilities, and defined escalation thresholds. This addresses previously identified variability in how service pressures and risks were escalated, particularly in relation to commissioned services, and will provide clearer system-wide visibility of risk and more consistent decision-making.

MatNeo funding has been confirmed for a further 12 months, this specifically funds additional roles, enabling continued delivery of this nationally led programme. The MatNeo programme will deliver:

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

Training on recognition and response to deterioration is delivered through mandatory PROMPT study days in partnership with WAST colleagues. The service continues to perform well in national PROMPT assessment, with an associated improvement plan in place to further strengthen consistency and staff experience.

Clinical governance

Governance arrangements are being strengthened to improve oversight, consistency, and learning from incidents. A revised meeting structure has been established, including a weekly safety meeting and a six-weekly multidisciplinary operational meeting, with development of a patient experience forum in progress. These meetings provide a clear route for escalation of performance and risk, with defined reporting into Women's, Children's and Family Health Quality and Performance meetings, and onward to corporate governance structures.

A multidisciplinary quality assurance process is being developed to strengthen the quality of incident investigation review and sign off and quality of learning. A Learning and Quality Improvement Forum has also been established across maternity, women's, and children's services. This is in its early stages of development but is supporting systematic tracking of incidents, triangulation with complaints and audit findings, and formal closure only where re-audit or review demonstrates sustained improvement.

The development of a paid Maternity and Neonatal Voices Partnership (MNVP) role will facilitate the strengthened voice of the mother, baby and family. The role enables genuine co-production of service improvements and provides a structured mechanism to monitor and evaluate perinatal services in Wales, driving better outcomes and building trust in maternity and neonatal care. The service has developed a job description and function, and will be seeking funding support in coming weeks.

A revised clinical governance SOP will be developed following this work to clearly define expectations, roles, and responsibilities and strengthen consistency across the governance framework. We are being supported by the Quality and Safety Team, and any local systems will fully align with Health Board systems for consistency.

Cross-border governance
Work is ongoing with partner organisations to strengthen oversight of care pathways for Powys residents, including data sharing, escalation processes, and quality assurance. A cross-border working Standard Operating Procedure is in development and will be shared with both local and commissioning partners to support shared ownership, consistency of approach, and accountability across pathways. These will be implemented to enhance the quarterly partnership meetings that are well established with every provider.

The implementation of BadgerNet will further strengthen visibility of care, data quality, and continuity across organisational boundaries, supporting improved assurance for commissioned services and the full patient pathway for Powys birthing people.

Workforce capability
A review of skill mix has confirmed staffing arrangements that support safe care delivery. However, it identified an imbalance in workforce experience, with a significant cohort of newly qualified midwives commencing at a similar time over recent years, increasing pressure on staff supporting preceptorship and consolidation of learning. There have also been limited opportunities for some preceptees to gain full competence, by the nature of limited-service provision within the model of Powys. This has recently been negated through the development of service level agreements with partner Health Board's to enable our midwives to go and work in a local hospital to gain outstanding competence and enhance confidence.

The preceptorship framework is under review, supported by the Royal College of Midwives, to ensure it is robust and aligned to national standards. This will strengthen structured consolidation of learning through the District General Hospital setting alongside the community-based model in Powys, improving consistency and clarity for new starters.

The mandatory training requirements has been revised to ensure alignment with local and national requirements. The compliance dashboard has been refined to focus on core mandatory training, improving data accuracy, ownership, and confidence in reporting. The dashboard will become visible to the board through routine maternity assurance reporting. Monitoring is now strengthened through the six-weekly multidisciplinary operational meeting, with training plans updated and individualised to support sustained compliance above 90 percent by September 2026.

Culture, Staff Experience and Wellbeing
Staff wellbeing, culture, and engagement are supported through established mechanisms including clinical supervision, mandatory training structures, and visible leadership across maternity services.

Feedback mechanisms are in place, including local reporting routes and staff engagement opportunities, however there are flaws in some aspects of the current system, with evidence it is not always being used for its intended purpose. A structured staff feedback framework is being developed to ensure consistent routes for raising concerns, defined response timelines, and clear reporting of themes and resulting actions through governance processes. A key focus is ensuring that staff voice is not only heard but translated into action through governance and quality improvement processes, including alignment with the Learning and Quality Improvement Forum.

Further work will focus on ensuring staff feedback is routinely triangulated with incident, workforce, and quality data, and that resulting actions are tracked to completion and impact.

Data and digital systems.
The implementation of BadgerNet (March 2026) will significantly strengthen clinical oversight, data quality, and audit capability, including across organisational boundaries. Locally, it will standardise documentation, improve continuity of care, and strengthen reliability of maternity data within a single electronic record.

During implementation, there is a recognised risk of variation in data completeness and recording as staff transition to the new system. This is being mitigated through targeted training, system support, and ongoing data validation processes, alongside digital and data colleagues, to ensure consistent system use, high-quality data entry, and effective information flow. This will be supported through a multidisciplinary approach to data validation and interpretation.

During transition, variation in recorded data is expected as systems embed. This will be actively managed through triangulation across clinical, digital, and quality teams to maintain assurance and data integrity. A national maternity dashboard is in development to support consistency across Wales. Locally, assurance dashboards will continue to be developed to ensure timely visibility, maintain oversight, and support responsive improvement activity.

The programme represents an evolving improvement journey rather than a single implementation point and will require sustained clinical leadership to ensure optimisation and ongoing alignment with service needs and regulatory expectations, including NMC record-keeping requirements. Whilst this post is not currently available, it is promoted at a National level and we must explore this opportunity further.

Maternity Care Delivery and Pathway Assurance
Maternity care delivery pathways are aligned with All-Wales national standards and safety requirements and are delivered through Powys' cross-border model of care. Community based midwifery led care is provided locally and high risk obstetric led care is delivered by neighbouring Health Boards.

This model requires strong co-ordination, clear escalation pathways, and consistent clinical standards across organisations, to ensure safe and seamless care for women and babies.

A structured whole-system review of maternity care pathways is currently underway. This is focused on:

- ensuring women receive care in the most appropriate setting
- strengthening clarity and consistency of escalation between services
- reducing unwarranted variation across different provider organisations
- confirming that pathways remain sustainable within the Powys model

This work is not being undertaken in response to a specific safety incident, but reflects the complexity of the cross-border model and the need to ensure continued robustness, consistency, and resilience of pathways over time.

Assurance is currently maintained through established governance arrangements with commissioned providers, including regular quality and performance review meetings. No significant concerns have been identified; however, this review will strengthen oversight, improve consistency, and support shared accountability across organisational boundaries.

CONCLUSION:

The findings of The Path to Safer Beginnings in Wales, have been translated into a structured and prioritised improvement programme, embedded within existing governance systems.

The Health Board has assurance that maternity services are operating safely, supported by established escalation processes, clinical governance structures, and a committed workforce. Areas for strengthening are clearly identified and actively being progressed.

Key enablers, including implementation of BadgerNet, strengthening of governance forums, MNVP development, and continued participation in MatNeo SSP, will further enhance system visibility, consistency, and assurance. Cross-border working and partnership arrangements continue to be strengthened to ensure effective oversight of commissioned care and continuity across pathways for Powys residents.

The Committee can take assurance that no immediate safety concerns have been identified and that systems are in place to identify and respond to risk. However, delivery of the improvement plan is essential to address identified gaps in governance consistency, workforce capability, and data maturity. The Action Plan in Appendix 1 provides clear accountability, delivery milestones, and ongoing assurance of progress.

APPENDIX 1 - All-Wales Maternity and Neonatal Assurance Assessment, Recommendations & Action Plan February 2026

Recommendation	Action	Progress Notes	Date / Status	National Alignment
Enhance Safety and escalation	Evaluate current escalation process	Completed	March 2026	All-Wales Maternity & Neonatal Assurance Assessment; MatNeo SSP; aligns with national early warning standards
	Revise Escalation Policy, consult and ratify	Policy drafted; in consultation	May 2026	
	Secure external funding/recruit to MatNeo roles	Completed	April 2026	
	Deliver MatNeo objectives; final yr programme	Defined action plan in progress	March 2027	
	Review and refine the training modules on deterioration, jointly with WAST colleagues	Not yet started. Due to commence April 26	July 2026	
Strengthen Clinical governance	Revise governance meeting/reporting structures	Completed – new meeting/escalation process	March 2026	All-Wales governance standards; MatNeo SSP guidance
	Triangulation review on quarterly basis	Process in development. Will commence end Q1	July 2026	
	Strengthen Incident Investigation Quality – across all levels of harm	Linking with Q&S team/incident management framework; expand training offer	September 2026	
	Establish Learning & QI Forum	Completed QI database, ToR, meetings established	March 2026	
	Roll out Listening to People Framework	Launched April 26, with support from Q&S team.	April 2026	
	Establish Obstetric need/ develop business case	Not yet started. Due to commence June 2026	August 2026	
	Develop JD for MNVP Lead role	Currently awaiting Job Evaluation – subject to funding confirmation	April 2026	
	Business case to secure funding for MNVP role	Drafted and planned for April 26	April 2026	
Improve Culture and wellbeing	Review working conditions and on-call arrangements - EU directives and staff voices.	OCP completed; new working conditions implemented Feb26. 3/6 month reviews due	September 2026	Strategic Perinatal Workforce Plan: All-Wales guidance on staff engagement and wellbeing aligned with Powys Teaching Health
	Enhance clinical supervision – refresher training and greater oversight and reporting of issues.	Review of role underway. Currently over established for ratio of CSfM:midwives, adjust	August 2026	
	Develop SoP for staff feedback; current local arrangements fragmented	SOP in draft – for wider engagement with workforce; engagement required with Trade Unions	June 2026	

Recommendation	Action	Progress Notes	Date / Status	National Alignment
	Enact the RCM Caring for You Charter – engage with staff through this mechanism	Signed up to C4U charter some time ago, but this has become less used over time. To re-establish	July 2026	Board local workforce and engagement strategies
	Enhance Trade Union Representatives locally, including learning Reps.	Active recruitment and support has seen 2 new faces join these roles.	January 2026	
	Establish Networking with Trade Unions, locally and regionally	Established space and time for engagement with senior leaders. Visible responses when required	January 2026	
Review Workforce capability	Undertake individual skills assessments	Preparing via self-assessment and 1:1's with PDM and Supervision. Review every 12 months	August 2026	Strategic Perinatal Workforce Plan; aligned with Powys Teaching Health Board local workforce strategy
	Review skill-mix/team set-up every 6 months	Review identified action needed – via QI forum	Jan 2026	
	Review training plan in line with National Core Competency Frameworks; ensure full delivery	Review undertaken and training restructured and assigned across the next 12 months.	February 2026	
	Review preceptorship programme and delivery following learning from recent years preceptees	Recent adaptations including service level agreements with neighbouring health boards established to support the current preceptees; translate to wider programme for ongoing success.	August 2026	
	Review Band 7 capacity, roles and gap analysis re: national recs and local provision.	Completed and gaps identified; poor use of time and funding identified	November 2025	
	Develop OCP to transform Band 7 leadership	OCP completed; consultation launch April 2026	April 2026	
Modernise Data and digital systems	Launch BadgerNet digital maternity system	Completed	March 2026	All-Wales digital maternity strategy; alignment with National Maternity and Neonatal Data Standards; Powys local data and governance strategy
	Contribute to national and local development of BadgerNet system	Ongoing throughout the next year	March 2027	
	Develop digital lead midwife role – local demand and national recommendation.	JD completed; business case being drafted	May 2026	
	Develop dashboard, ensuring alignment with Beacon, but considering local demand and intelligence requirements	Review team established and ToR agreed. Likely to be iterative for some time.	December 2026	

Recommendation	Action	Progress Notes	Date / Status	National Alignment
	Develop dashboard / metrics for commissioned services for assurance/performance/pt safety	In draft & wider consultation across commissioned services, with support from commissioning team	March 2027	
Care and Maternity Delivery Pathways	Undertake end-to-end mapping of maternity pathways across Powys and commissioned providers; antenatal, intrapartum, postnatal	Early mapping methods being established with key to identify variation, gaps, duplication and risk	September 2026	Standardisation of pathways and safety standards across Wales; All-Wales Maternity Safety and Governance Framework
	Develop and agree standardised escalation criteria / clinical thresholds with commissioned providers; ensure consistency of decision-making across pathways	To be developed in partnership with commissioned services	December 2026	
	Formalise cross-border governance arrangements; implementation of shared Standard Operating Procedure	Under consult, including defined roles, responsibilities, and escalation routes	October 2026	
	Develop and implement a suite of assurance metrics for maternity pathways	In progress and consultation with all providers	March 2027	
	Introduce multidisciplinary case review of complex or escalated cases to test pathway effectiveness and identify learning	To be developed	November 2026	
	Incorporate service user feedback (via MNVP) into pathway review to ensure pathways reflect lived experience across cross-border care	Dependent on the MNVP role establishment	January 2027	

KEY:

Completed
On-track
Requires Escalation

IMPACT ASSESSMENT – NOT REQUIRED FOR THIS REPORT

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 5.4

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE	**30 APRIL 2026**
Subject:	**Clinical Audit Programme for 2026-27**
Approved and presented by:	Kate Wright, Executive Medical Director
Prepared by:	Safety and Quality Improvement Manager on behalf of the services.
Other Committees and meetings considered at:	Executive Committee - 15 April 2026 who endorsed the programme to the Committee.

PURPOSE:

The purpose of this paper is to present the clinical audit plan for the 2026-2027 clinical audit plan.

RECOMMENDATION(S):

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

- **APPROVE** the 2026-27 Clinical Audit Programme.

Approve/Take Assurance	Discuss	Note
Y	Y	Y

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

EXECUTIVE SUMMARY:

Clinical Audit, the systematic review of actual performance against expected standards, remains an important benchmarking tool in assessing compliance of practice against standards.

It will provide assurance in areas where procedures are inherently high-risk, or where new processes and policies have been introduced. It may also identify areas of concern where quality improvement is be needed.
The services were asked to draft a Clinical Audit Plan incorporating the following:

- High volume basic activities which require a high level of compliance.
- Concerns identified during investigations of Nationally Reportable Incidents or complaints.
- New policies or changes to existing policy / practice to confirm new practice is established safely and effectively.
- The prioritisation of new and repeat clinical audit projects based on recognised clinical risk.
- Clinical audits required to confirm that practice has improved where concern had been raised.
- It was suggested that where audits had been repeated over multiple cycles and had not shown concern and were not mandatory, they could be stood down.

The plan was developed and supported by the Assistant Directors with responsibility for;

- Women and Children's Services
- Community Services Group
- Mental Health and Learning Disabilities Group
- Medicines management
- Primary Care

A copy of the current draft Clinical audit Plan 2026/27 can be found at **Appendix A.**

NATIONAL CLINICAL AUDIT PROGRAMME

Owing to the imminent Senedd elections we have been advised that guidance on the National Clinical Audit Programme is likely to be delayed to August 2026. However, it is highly likely that participation in continuing multi-year audits will still be supported.

IMPACT ASSESSMENT – NOT REQUIRED FOR THIS REPORT

Community Services Group					
Theatre and Endoscopy					
Driver	**Audit Title**	**Start Date**	**Service**	**Lead**	**End Date**
Local Audits for Service Improvement AfPP requirement JAG requirement	Staff Survey	Annual	Theatre / Pre Operative Assessment / Endoscopy	Theatre/Endoscopy Co Ordinator's	Quarter 4
Service Evaluation High volume activity	Hand hygiene/Bare below the elbow via MEG reporting system	Monthly	Theatre / Pre Operative Assessment / Endoscopy	Theatre/Endoscopy Co Ordinator's	Quarter 4
Service Evaluation National alert	Foreign Body Aspiration During Intubation, Advanced Airway Management or Ventilation Audit	Annual	Theatre	Senior Clinician Theatre/Endoscopy Planned care	Quarter 4
Service Evaluation	Environmental Audit Process Improvement Tool (PIT) Infection Control. Brecon and Llandrindod.	Annual	Theatre	Infection Prevention and Control team	Quarter 4
Service Evaluation MDPOCT requirement	Medical Devices Audit	Bi yearly	Theatre	Theatre Co Ordinator	Quarter 1 Quarter 4
Service Evaluation New policy change	NEWS 2	Annual	Theatre	Senior Clinician Theatre/Endoscopy Planned care	Quarter 4
Service Evaluation IRMER requirement	Radiation Audit	Annual	Theatre	Senior Clinician Theatre/Endoscopy Planned care / Theatre team leader	Quarter 2
Service Evaluation AfPP requirement	Surgical Patient Satisfaction audit	Annual	Theatre	Senior Clinician Theatre/Endoscopy Planned care/ Theatre Co Ordinator	Quarter 4

Service Evaluation	Surgical patient story	Annual	Theatre	Corporate Patient Experience Lead	TBC Corporate Patient Experience Lead to complete
Local Audits for Service Improvement AfPP requirement	Consent	Annual	Theatre	Theatre Co Ordinator / Data Audit Support Officer	Quarter 3
Local Audits for Service Improvement AfPP requirement	Theatre record keeping audit	Weekly	Theatre	Theatre Co Ordinator and team	Quarter 4
Service Evaluation AfPP requirement	Swab Instrument and Sharps count observational audit	Monthly alternative sites	Theatre	Scrub practitioners and designated TSW's	Quarter 4
Service Evaluation Incident – new process put in place	Post operative surgical consultant follow up appointments	6 monthly	Theatre	Senior Clinician Theatre/Endoscopy Planned care/ Theatre Co Ordinator /Team leaders	Quarter 2 Quarter 4
Service Evaluation	Local environmental audit via MEG reporting system	Quarterly	Theatre	Senior Clinician Theatre/Endoscopy Planned care/ Theatre Co Ordinator	Quarter 4
Service Evaluation	Mattress Audit via MEG reporting system	Quarterly	Theatre	Senior Clinician Theatre/Endoscopy Planned care	Quarter 4
Service Evaluation AfPP requirement	Theatre Service AfPP review	3 yearly	Theatre	Senior Clinician Theatre/Endoscopy Planned care/ Theatre Co Ordinator /Team leaders	Quarter 4 Next due 2028
Service Evaluation AfPP requirement	Surgical Pathway Observational audit	Annual	Theatre	Theatre Co Ordinator /Team leaders	Quarter 4
Service Evaluation AfPP requirement	8 Day Readmissions & 30-Day Mortality Report	Annual	Theatre	Senior Clinician Theatre/Endoscopy Planned care	Quarter 4

Service Evaluation JAG requirement	Annual planning & productivity report	Annual	Endoscopy	Senior Clinician Theatre/Endoscopy Planned care	Quarter 3
Local Audits for Service Improvement Incident – compliance with policy	Audit of open access referrals into our service	Annual	Endoscopy	Senior Clinician Theatre/Endoscopy Planned care	Quarter 4
Local Audits for Service Improvement Incident – compliance with new process	Bowel Screening Wales pathology reporting audit	Annual	Endoscopy	BSW/ Business Support Manager Planned Care	Quarter 3
Welsh Government National Audit Programme	Bowel Screening Wales User Experience Survey Results	Annual	Endoscopy	Bowel Screening Wales	Quarter 4
Local Audits for Service Improvement JAG requirement	Pain / Comfort Audit	6 monthly	Endoscopy	Endoscopy Coordinator	Quarter 2 Quarter 4
Local Audits for Service Improvement JAG requirement	Consent	Annual	Endoscopy	Endoscopy Coordinator/Data Audit support officer	Quarter 3
Service Evaluation JAG requirement	Decontamination Audit Process Improvement Tool (PIT) Infection Control Brecon	Annual	Endoscopy	Infection Prevention and Control team	Quarter 4
Service Evaluation JAG requirement	Environmental Audit Process Improvement Tool (PIT) Infection Control Brecon	Annual	Endoscopy	Infection Prevention and Control team	Quarter 4
Service Evaluation JAG requirement	Endoscopist satisfaction survey	Annual	Endoscopy	Endoscopy Coordinator	Quarter 4
Local Audits for Service Improvement Incident – compliance with new process	Audit for Endoscopy Screening assessment	Annual	Endoscopy	Senior Clinician Theatre/Endoscopy Planned care	Quarter 4
Service Evaluation JAG requirement	Gastric ulcers rescoped within 12 weeks	6 monthly	Endoscopy	Endoscopy coordinator & Data/ Audit Support	Quarter 2 Quarter 4
Service Evaluation JAG requirement	Individual endoscopists KPIs	6 monthly	Endoscopy	Endoscopy Clinical Lead	Quarter 1 Quarter 3
Service Evaluation MDPOCT requirement	Medical devices audit	Bi yearly	Endoscopy	Endoscopy Coordinator	Quarter 1 Quarter 4

Service Evaluation JAG requirement	Patient satisfaction survey	Annual	Endoscopy	Senior Clinician Theatre/Endoscopy Planned care	Quarter 4
Service Evaluation JAG requirement	Patient story	Bi yearly	Endoscopy	Corporate Patient Experience Lead	Quarter 1 Quarter 3
Service Evaluation JAG requirement	Post colonoscopy colorectal cancer rate (PCCRC) and Post endoscopy upper GI cancer (PEUGIC)	Annual	Endoscopy	Endoscopy Clinical lead	Quarter 2
Local Audits for Service Improvement JAG requirement	Record Keeping	Weekly	Endoscopy	Endoscopy Coordinator and team	Quarter 4
Service Evaluation IHEEM requirement	Scope traceability	Annual	Endoscopy	Endoscopy Coordinator	Quarter 4
Local Audits for Service Improvement Policy change	Single cancer pathway process	Annual	Endoscopy	External audit results sent to Senior Clinician Theatre/Endoscopy Planned care	Quarter 2
Service Evaluation JAG requirement	Vetting and validation of endoscopy referrals	Annual	Endoscopy	Clinical lead Endoscopy	Quarter 4
Service Evaluation IHEEM requirement	Local environmental audit via MEG reporting system	Quarterly	Endoscopy	Endoscopy Co Ordinator	Quarter 4
Service Evaluation	Mattress Audit via MEG reporting system	Quarterly	Endoscopy	Senior Clinician Theatre/Endoscopy Planned care	Quarter 4
Service Evaluation IHEEM requirement	Cairn Technology - Peracetic Acid monitoring	Annual	Endoscopy	Cairn Technology	Quarter 2
Service Evaluation JAG requirement	8 Day Readmissions & 30-Day Mortality Report	Annual	Endoscopy	Senior Clinician Theatre/Endoscopy Planned care	Quarter 4
Local Audits for Service Improvement Policy change	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	Next due Quarter 1 2028
Local Audits for Service Improvement Policy change	PGD 0149A (Administration of Adrenaline in Endoscopy)	6 months prior to expiry of PGD	Endoscopy	Endoscopy Coordinator	

		operational from 01/08/25 - 12-06-28			Next due Quarter 1 2028

Community Services Group					
Therapies and Health Science					
Driver	Audit Title	Start Date	Service	Lead	End Date
Audits performed for accreditation schemes	Compliance with Standard operating procedures	Quarter 1	Radiography	Head of Radiography	Quarter 3
Audits performed for accreditation schemes	Pregnancy Status (multiple audit rounds)	Quarter 1	Radiography	Head of Radiography	Reported Quarterly
Audits performed for accreditation schemes	Correct use of radiographic markers (multiple audit rounds)	Quarter 1	Radiography	Head of Radiography	Reported Quarterly
Audits performed for accreditation schemes	Non Medical Referrals (NMR) Audit of NMR compliance (multiple audit rounds)	Quarter 1	Radiography	Head of Radiography	Reported Quarterly
Audits performed for accreditation schemes	Reject analysis (multiple audit rounds)	Quarter 1	Radiography	Head of Radiography	Reported Quarterly
Audits performed for accreditation schemes	Radiographer commenting audit (multiple audit rounds)	Quarter 1	Radiography	Head of Radiography	Reported Quarterly
Audits performed for accreditation schemes	QA plain film and NOUS / Midwife Sonography (multiple audit rounds)	Quarter 1	Radiography	Head of Radiography	Reported Quarterly
Local Audits for service improvement	QA reporting Audit (multiple audit rounds)	Quarter 1	Radiography	Head of Radiography	Reported Quarterly
Audits performed for accreditation schemes	Monthly Clinispet/Clinel Wipes Audit (multiple audit rounds)	Quarter 1	Radiography	Head of Radiography	Reported Quarterly
Audits performed for accreditation schemes	Sonography Service Audit (multiple audit rounds)	Quarter 1	Radiography	Clinical Governance Lead for Sonography	Reported Quarterly
Audits performed for accreditation schemes	Reporting Radiography Service Audit (multiple audit rounds)	Quarter 1	Radiography	Head of Radiography	Reported Quarterly

Audits performed for accreditation schemes	Compliance with Standard operating procedures (multiple audit rounds)	Quarter 2	Radiography	Head of Radiography	Reported Quarterly
Welsh Government National Audit Programme	Audiology - Tinnitus Standards	Quater 1	Audiology	Senior Audiologist	Quater 3
Local Audits for service improvement	Adult SLT use of introduction of biozoon	Quarter 1	Speech and Language Therapy	Clinical Lead	Quarter 4
Local Audits for service improvement	Change in children's service delivery	Quarter 1	Speech and Language Therapy	Clinical Leads	Quarter 3
Local Audits for Service Improvement	Therapy Outcome Measures Audit	Quarter 1	Speech and Language Therapy	Head of Speech and Language Therapy	Quarter 4
Other National Audits	Transforming MND Care Audit Tool'	Quarter 3	CNRT	MND care coordinator	Quarter 4
Other National Audits	National Respiratory Audit Programme (NRAP)	Quarter 1	Community Respiratory (Pulmonary Rehabilitation)		Quarter 4
Local Audits for service improvement	HCPC Notes audit	Quarter 3	CMATS	Service Lead for FCP/CMATS	Quarter 3
Local audits following change in procedure	Orthopaedic benefits tracker - 35 domains	Each quarter	CMATS	MSK consultant Physio	Each Quarter
Local audits following change in procedure	FCP outcome data	Each quarter	FCP	Service Lead for FCP/CMATS	Each Quarter
Local audit for service improvement	template compliance/documentation audit	Quarter 2	Dietetics	Clinical Team Lead	Quarter 3
Local audit for service improvement	clinical letters audit	Quarter 2	Dietetics	Clinical Team Lead	Quarter 3
Local audit for service improvement	Nutritional screening audit	Quarter 2	Dietetics	Clinical Team Lead	Quarter 3
Other National Audits	National Diabetes Foot Care Audit	TBC National	Podiatry	Head of Podiatry	TBC National
Other National Audits	SNAPP	TBC National	Therapies & Health Sciences	Consultant Therapist - Stroke	TBC National
Other National Audits	Parkinsons AHP	TBC National	Therapies & Health Sciences	SLT	TBC National
Service Evaluation	RCOT proforma on 'focusing on occupation' and 'your professional rationale'	Quarter 1	OT	Professional Head of OT	Quarter 4

Service Evaluation	MSK Transformation Business Case	Quarter 4	Physio	Professional Head of Physio / Consultant MSK	Quarter 1

Community Services Group					
Unscheduled Care					
Driver	Audit Title	Start Date	Service	Lead	End Date
Local Audits for Service Improvement	Differing Diagnosis (previously Missed Fractures Audit)	Monthly	Unscheduled Care	Senior Manager	Quarter 4 2027
Local Audits for Service Improvement	Mattress audit	Monthly	Unscheduled Care	Senior Manager	Quarter 4 2027
Local Audits for Service Improvement	Hand Hygiene Audit	Quarterly Quarter 1	Unscheduled Care	Senior Manager	Quarter 4 2027
Local Audits for Service Improvement	PGD Audit	Annual	Unscheduled Care	Senior Manager	Quarter 4 2027
Local Audits for Service Improvement	Documentation Audit Child Attendances under 18 (Formally knows as Paeds under five audit – scrutiny of every attender under five)	Monthly	Unscheduled Care	Senior Manager	Quarter 4 2027
Local Audits for Service Improvement	Adult Documentation Audit	Monthly	Unscheduled Care	Senior Manager	Quarter 4 2027
Local Audits for Service Improvement	Routine Enquiry Audit	Quarterly Quarter 4	Unscheduled Care	Senior Manager	Quarter 4 2027
Local Audits for Service Improvement	Was Not Brought Audit	Quarterly Quarter 3	Unscheduled Care	Senior Manager	Quarter 3 2027

Local Audits for Service Improvement	Harm & Mortality (Cardiac arrests, major trauma, death in dept) – Report on occurrence and collate annually.	Annual	Unscheduled Care	Senior Manager	Quarter 4 2027
Local Audits for Service Improvement	Patient Feedback – Quarterly paper survey/continuous QR code access.	Quarterly Quarter 4	Unscheduled Care	Senior Manager	Quarter 4 2027

Community Services Group					
Nursing (Ward and Community)					
Driver	Audit Title	Start Date		Lead	End Date
Local Audits for Service Improvement	NEWS 2 Audit – National spreadsheet	Weekly (wards 1 in 9)	Nursing (Wards)	Ward Managers	Quarter 4 2026
Local Audits for Service Improvement	NEWS Audit via MEG	Monthly	Nursing (Wards)	Ward Managers	Quarter 4 2026
Local Audits for Service Improvement	Wristband Audit via MEG	Monthly	Nursing (Wards)	Ward Managers	Quarter 4 2026
Local Audits for Service Improvement	Dols Audit via MEG	Monthly	Nursing (Wards)	Ward Managers	Quarter 4 2026
Local Audits for Service Improvement	Environmental Audit via MEG	Monthly	Nursing (Wards)	Ward Managers	Quarter 4 2026
Local Audits for Service Improvement	Welsh Language Audit via MEG	Monthly	Nursing (Wards)	Ward Managers	Quarter 4 2026
Local Audits for Service Improvement	DNACPR Audit via MEG	Monthly	Nursing (Wards)	Ward Managers	Quarter 4 2026
Local Audits for Service Improvement	Multi-factorial Falls Risk Assessment Audit (Inpatients)	Annual Quarter 4 2026	Nursing (Wards)	Ward Managers	Quarter 4 2027
Local Audits for Service Improvement	Hydration and Nutrition Audit	Quarter 4 2025	Nursing (Wards)	Senior Nurses	Quarter 4 2026

Service Evaluation	Medical Devices Aduit	Biyearly – Jan & June	OPD	Senior Nurse Manager	Q1 & 4 2027

Community Services Group					
Specialist Nursing					
Driver	**Audit Title**	**Start Date**		**Lead**	**End Date**
Other National Audit & Service Evaluation	Parkinson's UK National Audit	2 yearly Data collection 1-5-26 – 30-9-26 Submission 31-10-26	Specialist Nursing – Parkinson's Disease	Parkinson's Disease ANP	Quarter 3 2026
Local Audits for Service Improvement	Pressure Damage Audit	Annual Quarter 1 2026	Specialist Nursing – Tissue Viability Nurse	Senior Nurses	Quarter 1 2027
Local Audits for Service Improvement	Diabetes Ward Audit	Annually	Specialist Nursing - Diabetes	Diabetes Team Lead	Quarter 1 2026
Service Evaluation	Clinic PREM Data	Quarterly	Specialist Nursing - Continence	Continence Service Manager	Quarter 4 2026
Service Evaluation	Prescribing Data	Quarter 1	Specialist Nursing - Continence	Continence Service Manager	Quarter 4 2026
Service Evaluation	Transition Clinic PREM Data	Biannual (New) Quarter 2	Specialist Nursing - Continence	Continence Service Manager	Quarter 4 2025
Service Evaluation	Pad PREM	Biennial 2025	Specialist Nursing - Continence	Continence Service Manager	Quarter 4 2026
Service Evaluation	COBWEB PREM	Biennial 2025	Specialist Nursing - Continence	Continence Service Manager	Quarter 4 2026
Service Evaluation	CIVICA/PREMS clinic data	Monthly	Specialist Nursing – Cardiology	Cardiology Team Lead	Quarter 4 2026

Other National Audit & Service Evaluation	National Audit of Cardiac rehab/PROMS	Annually Completed Aug 2025	Specialist Nursing – Cardiology	Cardiology Team Lead	Quarter 2 2026
Service Evaluation	CROMS data	Monthly	Specialist Nursing – Cardiology	Cardiology Team Lead	Quarter 4 2026
Local Audits for Service Improvement	Quality Assurance Audits for ECHO scans at neighbouring DGH.	Monthly	Specialist Nursing – Cardiology	Cardiology Team Lead	Quarter 4 2026

Community Services Group					
Outpatient Services					
Driver	Audit Title	Start Date		Lead	End Date
Local Audits for Service Improvement	ENT LocSSIPs Audit	Annual – Q1 (June) 2026	OPD	Senior Nurse Manager	Q1 2027
Local Audits for Service Improvement	Pessary LocSSIPs Audit	Annual Q2 (September) 2026	OPD	Senior Nurse Manager	Q2 2027
Local Audits for Service Improvement	Eye Care Health Risk Rating	Annual Q2 (July) 2026	OPD	Senior Nurse Manager	Q2 2027
Local Audits for Service Improvement	Gynaecology LocSSIPS Audit	6 monthly Q1 (June) 2026	OPD	Senior Nurse Manager	Q1 2027
National Ophthalmic Audit	Cataract Outcomes Audit – Pulled from Live Audit Database	Monthly	OPD	Senior Nurse Manager	Q4 2027
Service Evaluation	Colposcopy QA Audit	3 yearly – Completed April 2025	OPD	Cervical Screening Wales	Q1 2028

Service Evaluation	WET AMD Outcomes Audit	Annual Q2 (August) 2026	OPD	Mr Faris Arif	Q2 2027
Service Evaluation	Hand Hygiene Audit	Monthly	OPD	Senior Nurse Manager	Q2 2027
Service Evaluation	Medical Devices Aduit	Biyearly – Jan & June	OPD	Senior Nurse Manager	Q1 & 4 2027
Local Audits for Service Improvement	Staff Survey	Yearly	OPD	Senior Nurse Manager	Q3 2027
Local Audits for Service Improvement	Patient Satisfaction Survey	Monthly	OPD	Senior Nurse Manager	Q4 2027

Primary Care

Primary Care

Driver	Audit Title	Start Date	Service	Lead	End Date
Local Audits for Service Improvement	Audit of Minor Injury Services OR Audit of Lithium Prescribing	TBC	GP Surgery	Practice Manager	Quarter 4
Local Audits for Service Improvement	Audit of diabetes care	TBC	GP Surgery	Practice Manager	Quarter 4

Primary Care

Community Dentistry

Driver	Audit Title	Start Date	Service	Lead	End Date
Local Audits for Service Improvement	Patient Experience Audit	Real-time patient	Community Dentistry	CIVICA – Heidi Thomas	Real-time patient

		feedback throughout the year			feedback throughout the year
Other National Audit	WHTM01-05	Autumn/winter 2026	Community Dentistry	Rachael Anwyl	Autumn/winter 2026
Local Audits for Service Improvement	Clinical notes and written Consent to treatment audit	Dec 2026	Community Dentistry	Lloyd Bovensiepen/Susan Bracegirdle	Dec 2026
Local Audits for Service Improvement	Best Practice prevention – Delivering Better Oral Health	Sept 26	Community Dentistry	Nurse Led - TBC	Oct 26
Local Audits for Service Improvement	Antimicrobial Stewardship	Dec 2026	Community Dentistry	Lloyd Bovensiepen	Jan 2027
Local Audits for Service Improvement	Alignment between planned treatment and delivered treatment in scheduled appointments	June/July 2026	Community Dentistry	TBC	July/Aug 2026
Local Audits for Service Improvement	Time spent on treatment interventions by patient group (Adults, Children, Special Care), Excluding Inhalation Sedation	Autumn 2026	Community Dentistry	TBC	Autumn 2026
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 *Note: All staff undertaking radiographs to continuously undertake radiography self-auditing	Continuous yearly run chart

Women and Children's Service					
Midwifery					
Driver	Audit Title	Start Date	Service	Lead	End Date
NHS Performance & Improvement	NEWTT2 pathway	April 2026 rolling audit	Maternity	Mat Neo Lead	October 2026
Local Audit for Service Improvement	All Wales Handheld Maternity Records / Electronic Patient Record	Rolling	Maternity	Clinical Supervisor for Midwives	October 2026
Service evaluation	Maternity Triage Telephone Calls Process Review	Six monthly rolling audit	Maternity	MatNeo Lead	June 2026
Local Audit for Service Improvement	Perinatal Mental Health Birth Management Planning	Annually	Maternity	Perinatal Mental Health	December 2026
Local Audit for Service Improvement	Intrapartum Transfers from Powys to DGH *(Business as usual)*	Annually	Maternity	Consultant Midwife	May 2026
Local Audit for Service Improvement	Clinical Information Sharing Caseload *(Business as usual)*	Annually	Maternity	Clinical Supervisors/Consultant Midwife	March 2027
Local Audit for Service Improvement	GAP / GROW	Annually	Maternity	Practice Facilitator	Sept 2026
Local Audit for Service Improvement	BFI standards	Annually	Maternity	Infant Feeding Lead Midwife	October 2026
Safeguarding	Was Not Brought (WCCIS)	Rolling monthly	All Services	Lead Advanced Nurse Practitioner	Quarter 4
Safeguarding	Routine Enquiry	Quarterly Q1	PHN	AHoPHN	Quarter 4
National Audit	Down Syndrome Pathway	Annual	Com Paeds	Medical Lead	Quarter 3

National Audit	Quality of Adoption Medicals	TBC	Com Paeds	Medical Lead	Quarter 4
National Reporting	HCWP mandatory contacts compliance	Quarterly	PHN	AHoPHN	Quarter 4
National Reporting	HCWP 2 (School Age Children) Implementation	Bi Annual	PHN	AHoPHN	Quarter 2 Quarter 4
National Reporting	Transition and Handover from Children's to Adult services	Bi Annual	Children's Services/ Adult Services / Mental Health & LD Services	HoS (Children's Services) **With support from** HoS Therapies, HoS CAMHS, HoS LD	Quarter 2 Quarter 4
National Reporting	ALN Compliance	Quarterly from Q3	Children's Services incl Therapies and CAMHS	DECLO	Quarter 4
Service Evaluation	Children's Continuing Care, review following repatriation	Bi-annual Q2	CCNS	HoS	Quarter 2 Quarter 4
Service Evaluation	ND Open Pathways Audit	Quarterly Q1	ND	HoS	Quarter 4
Service Evaluation	Meeting the Health Needs of Children in school		CCNS/ Special Schools	Lead Advanced Nurse Practitioner	Quarter 3
Local Audit for Service Improvement	Caseload Audit to include acuity	Quarterly Q1	Children's Services	Operational Leads & HoS	Quarter 4
Local Audit for Service Improvement	Quality and timeliness of Record Keeping	Rolling Annually	Children's Services	Professional Leads & HoS	Quarter 2
Local Audit for Service Improvement	Environments of Care Audit (clinic venues / bases)	Biannual	HV	AHoPHN/HoS	Quarter 2 Quarter 4

Mental Health and Learning Disabilities					
Mental Health and Learning Disabilities					
Driver	Audit Title	Start Date	Service	Lead	End Date
Local Audits in response to NRI/Identified risk	Audit of Environmental Ligature Risk Assessment	Q1	All MH	Senior Nurse - Inpatient Matron role	Quarterly
Local Audits in response to NRI/Identified risk	Audit of WARRN risk assessments	Q4	All MH	CTP Lead/Governance Lead	2027
Local Audits in response to NRI/Identified risk	Audit of Security Risk Assessment	Q2	All MH&LD	Head of MH Operations	Quarterly
Local Audits for Service Improvement	Audit of Care and Treatment plans	Q4	All MH	CTP Lead/Governance Lead	Q4
Welsh Government National Audit Programme	NCISH Suicide audit	Q2	All MH	Suicide and Self Harm Prevention Lead	Q4
Welsh Government National Audit Programme	National review of schizophrenia audit	Q4	All MH	Clinical Director MH&LD	Q4
Local Audit for Service Improvement	Inpatient Physical health monitoring audits	Q1	Ward Based	Clinical Director MH&LD	Q4
Local Audit for Service Improvement	RCP/NICE quality standards for inpatient care	Q1	Ward Based	Senior Nurse - Inpatient Matron role	Q4
Local Audit for Service Improvement	Medicine management audit	Q1	All MH&LD	Service Managers and Ward Managers	Monthly

Local Audit for Service Improvement	Hand hygiene/Mattress audits	Q1	Ward Based	Ward Managers	Monthly
Local Audit for Service Improvement	Record Keeping	Q1	All MH	Team Leads/Ward Managers/IG	Q4
Local Audit for Service Improvement	Did Not Attend audit.	Q1	All MH	Business and Performance Manager	Q4
Local Audit for Service Improvement	Multi-factorial Falls Risk Assessment Audit (Inpatients)	Q2	Ward Based	Service Managers and Ward Managers	Q4
Local Audit for Service Improvement	Was Not Brought audit	Q4	CAMHS	CAMHS Operational Lead	Quarterly
Local Audit for Service Improvement	Early Intervention in Psychosis audit	Q2	CAMHS	CAMHS Operational Lead	Q4
Local Audit for Service Improvement	Outcome Measure Audit	Q2	CAMHS	CAMHS Operational Lead	Q4
Local Audit for Service Improvement	LPMHSS Pathway Audit	Q2	Psychology	Service Manager LPMHSS/Psychology	Q4
Local Audit for Service Improvement	S117 Audit	Q1	All MH	Head of MH Operations	Q4
Local Audit for Service Improvement	MH Act Compliance	Q2	All MH	HoMH Nursing	Quarterly
Local Audit for Service Improvement	Adult & Older Adult CMHT MDT Audit	Q2	Community Based	Head of MH Operations	Quarterly
Local Audit for Service Improvement	Epilepsy audit	Q1	All LD	Head of LD	Q4
Local Audit for Service Improvement	Liaison data audit	Q1	All LD	Head of LD	Q4
Local Audit for Service Improvement	Champion training audit	Q1	All LD	Head of LD	Q4
Local Audit for Service Improvement	Anti-psychotic and physical health audit	Q2	All MH&LD	Consultant Psychiatrist/Head of SOAD	Q4
Local Audits in response to NRI/Identified risk	Therapeutic observations audit	Q2	All MH&LD	Service Managers and Ward Managers	Quarterly
Local Audits in response to NRI/Identified risk	WCCIS and V4 MHM forms audit	Q2	All MH&LD	Service Managers and Ward Managers	Quarterly

Local Audits in response to NRI/Identified risk	Advocacy audit	Q2	All MH&LD	Head of LD	Quarterly
Local Audits in response to NRI/Identified risk	Discharge letters audit from in-patient services.	Q2	All MH&LD	Clinical Director MH&LD	Q4
Local Audits in response to NRI/Identified risk	Escorting patients off hospital grounds	Q2	All MH&LD	Service Managers and Ward Managers	Quarterly
Local Audits in response to NRI/Identified risk	Educational audit	Q2	All MH&LD	Service Managers and Team Managers	Q4
Local Audits in response to NRI/Identified risk	CRHTT audit of CTP/WARRN & 72 hour f2f assessments	Q2	All MH&LD	Service Managers and Team Managers	Q4
Local Audits in response to NRI/Identified risk	Older adult CMHT discharge audit	Q2	All MH&LD	Service Managers and Team Managers	Q4
Local Audits in response to NRI/Identified risk	s136 audit	Q2	All MH&LD	Clinical Director MH&LD	Q4

Medical Directorate

Medicines Management

Driver	Audit Title	Start Date	Service	Lead	End Date
Local Audit for Service Improvement	ADHD Prescribing Audit (including all-setting dashboard and private prescribing	Q3	Medicines Management / Mental Health Pharmacy	Mental Health Pharmacist	Q4
Local Audits for Service Improvement	GLP-1 Prescribing Audit	Q2	Medicines Management	Emlyn Prichard	Q3
Audits performed for accreditation schemes / Safety & Governance	Medical Gases Site Audit (linked to safety and savings programme)	Q1	Medicines Management / Estates Interface	Jayne Price	Q2
Local Audits for Service Improvement	Medication Storage Audit (PSN055 compliance across hospital and clinic sites)	TBC	Medicines Management	Kath Harries	Q4
Local Audits for Service Improvement	Denosumab Optimisation Audit (biosimilar implementation across care settings)	Q2	Medicines Management	Claire Jones	Q3

Audit Driver Key:

	Driver

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

Progress Key:

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

Subject:	MH&LD Services one year post de-escalation
Approved and Presented by:	Elaine Lorton, Executive Director of Primary Care, Community & Mental Health
Prepared by:	Assistant Director MH&LD, Collaborative of Senior Management and wider Staff Team
Purpose:	To provide an update on the Quality Indicators for which local escalation was instructed in 2024, staff experience one year post de-escalation and additional work contributing to growing maturity as monitored by SMT governance structure.
Recommendations:	The Committee is asked to: • **NOTE** sustained improvement despite ongoing challenges for services • **RECEIVE** the update and take **ASSURANCE** that continuous improvement work is embedded in 'business as usual' as well as ongoing workstreams within a governance framework to ensure relevant focus on key quality and safety indicators.
Executive Summary:	MH&LD Division was the first service to be locally escalated under the IQPAF following a clinical audit and Q&S Service review. Following an intense period of recovery work and development of a continuous improvement plan with ongoing implementation, the Division was de-escalated in October 2024. A paper was submitted to PEQS early 2025 to share experiences of the process and de-escalation. This paper is provided 18 months on to provide an update on performance against key quality and safety indicators a year post de-escalation. Staff feedback has again been sought and is included as part of this report.

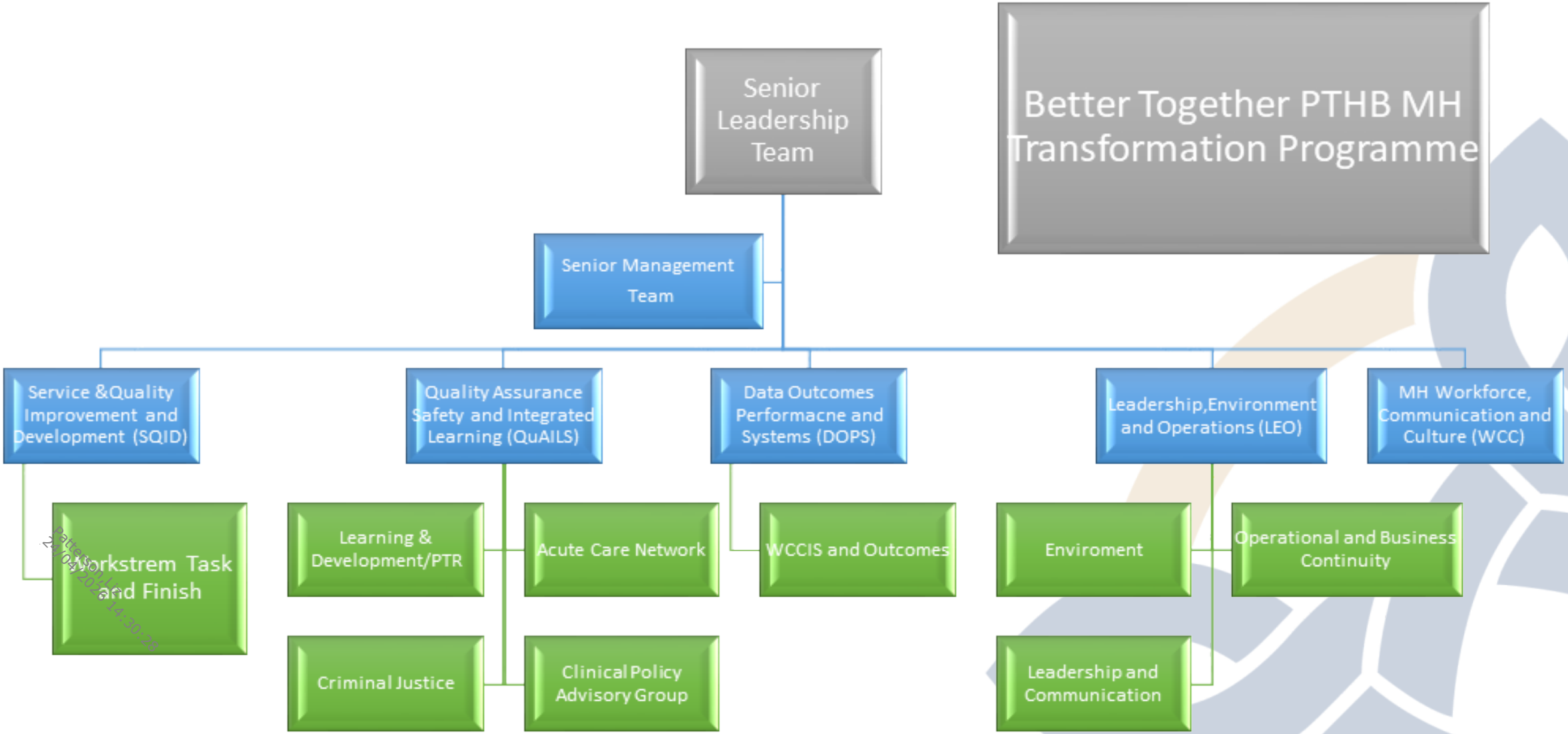
1. Background

- Escalated March 2024 – (MH Service Review 2023 and Clinical Audit Felindre Ward)
- First to be escalated to level 2a under new IQPAF
- Quality and Safety Escalation Indicators
  - Incident management including backlog Datixs and NRI position
  - Clinical Audit Felindre Ward (MDT and Discharge)
  - Clinical Audit Plan
  - Care and Treatment Plan Audit
  - Policy and SOPs
  - PMVA Compliance
  - Training Matrix and Plan
- Maturity Matrix & Conditions of Sustainability
- De-escalated October 2024

2. 2025/26 Improvement Programme included;

- Better Together
- Supportive Assessment
- Governance and Continuous Quality and Safety Improvement Plan
- Financial Context
- Reporting Process
- Key Issues
- Risks
- Continuous Quality and Safety Improvement Plan for 2026/27

MH Governance Structure



3. Continuous Q&S Improvement Plan

Current position

- 110 Datixes in total, 56 of these are in management review.
  - Open: Felindre 31, Clywedog 14 and Tawe 11 highest in community at 33.

  (Nov 2023 over 800 datixes requiring investigation)
- Datix Huddles continue though March 26 QUAILS reported reduced attendance. Reviewed and related to service pressures – being addressed.
- Incident management oversight (QUAILS)
- 36 Policies/Standard Operating Procedures approved since escalation date. 22 of these complete in 2025/26. Further 7 in feedback stage. All marked as clinical priority updated. Active Policy tracker reviewed at QUAILS. New system for wide consultation but in day to day pressures, receiving feedback to contribute to policy review in timely way is challenging.

3. Continuous Q&S Improvement Plan

Current position

- NRIs Currently 9 open.
  - 15 open at 1.4.25 with additional 13 NRIS during 2024/25
  - 19 closed in last year.
  - Themes: Contact with police, physical health co-morbidities, changing age profile, transitions of care between secondary services, record keeping
- 149 staff undertaken full CTP training in 2025, 54 half day training. CTP compliance consistently over 80% but ongoing work to improve to target.
- WARRN and CTP 279 MH&LD staff
- At time of escalation (2024), no CTP audits had been undertaken since 2019. At present 2nd CTP audit completed Feb 2026. Final report to be presented April SMT.
- PMVA Compliance – sustained improvement
- Training matrix – ongoing updating so remains current

Continuous Q&S Improvement Plan ctd

- Clinical Audit response
- Tawe – Improvement from destabilised to highly functioning
- Felindre focus
  - Clinical review and update Felindre SOP
  - Agency reduction
  - Improved sickness rates and staffing position
  - HIW positive reports
  - CCTV and env improvements good for patient safety
  - Wellbeing work
  - More resilience and positive management
- MH Act Assurance Meeting – multi-agency

4. Engagement process

To determine staff views 2 years post escalation

- Email circulation
- Senior Management Team
- Team meetings
- 121s
- Datix Huddles
- Maturity Matrix

5. Staff feedback

- Continue to feel supported by Senior Leadership and Management Team.
- Concern re understanding of challenges for Mental Health Services and how day to day pressures can impact sustaining performance.
- Striving to maintain and improve (competing demands) means going 'above and beyond'.
- Challenged by consistent 'additional asks' including National workstreams.
- Incident legacy (Felindre) and Wellbeing Work.
- Communication and routemap to sustainability change.

6. Senior Management Team feedback

'Kindness continues to be key'

- Challenges of balancing priorities.
- Ongoing benefits of strengthened internal relationships.
- Good governance process but sustaining the position and balancing operational issues remains a challenge.
- Hard to sustain levels of working. Some burnout and low immunity.
- Professional leadership support vs scrutiny.
- Maturity Matrix and Conditions of sustainability embedded.
- Strengths of being solution focussed.
- Supportive assessment feedback assuring.

7. Next Steps

- Business as usual - systemised approach of reviewing and feeding back on performance, compliance and Q&S indicators.
- Ongoing Supportive Assessment Response plan implementations.
- Ongoing and improved communication mechanisms.
- Inpatient Safety Programme.
- Management structure finalisation

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 5.6

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE	**30 APRIL 2026**
Subject:	**Infection Prevention and Control (IPC) Quality Statement**
Approved and presented by:	Paul Hooton – Executive Director of Nursing, Quality, Women and Family Health
Prepared by:	Head of Infection Prevention and Control and Decontamination
Other Committees and meetings considered at:	Executive Committee – 15 April 2026.

PURPOSE:

This paper summarises the recently published IPC Quality Statement and offers assurance to the Committee regarding the Health Boards current level of compliance with the required standards. It outlines the work already underway to align reporting structures to support sustained quality, safety and improvement as it relates to Infection Prevention and Control and Decontamination.

RECOMMENDATION(S):

The Patient Experience, Quality and Safety Committee is asked to, based on the exercise undertaken against the standards within the IPC Quality Statement the Committee:

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

Approve/Take Assurance	Discuss	Note
Y	N	Y

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	
2. Provide Early Help and Support	Y	

3. Tackle the Big Four	Y	
4. Enable Joined up Care	Y	
5. Develop Workforce Futures	Y	
6. Promote Innovative Environments	Y	
7. Put Digital First	Y	
8. Transforming in Partnership	Y	

EXECUTIVE SUMMARY:

This paper presents the Infection Prevention and Control Quality Statement and provides formal assurance regarding compliance and ongoing work with the required standards and regulatory expectations. It outlines the structured approach being taken to validate alignment against each quality attributes and ensure IPC governance, oversight and reporting mechanism demonstrably meet the required framework within the statement.

In June 2023 a two-year IPC Improvement Plan within PTHB delivered a comprehensive programme of work, which strengthened surveillance, audit, training, policy compliance, and Executive oversight. As a result, IPC systems and process have been embedded into business-as-usual practice, significantly improving the Health Boards baseline position.

The IPC team have undertaken an analysis against the standards set out in the IPC Quality Statement to provide validation of current compliance and identify any areas requiring refinement to align with the statement. In parallel, IPC Committee reporting is being mapped directly to each of the quality attributes within the statement to ensure clear traceability to ensure Ward to Board assurance and Board to Ward assurance. Reporting will take place through Service Group Quality and Safety/Assurance meetings, with escalation to the IPC Committee where required. This process strengthens ownership and accountability at service level. It also enables a structured feedback loop that supports comprehensive reporting, shared learning and continuous improvement aligned with the Quality Statement.

HEADING:

Situation

Welsh Government has published the Quality Statement: Infection Prevention and Control, which sets clear expectations and standards for NHS organisations to ensure robust systems for preventing and controlling Healthcare Associated Infections (HCAIs).

The statement reinforces the requirement for organisations to implement a quality management approach to IPC, including planning, assurance, control and improvement, in-line with the Duty of Quality within the Health and Social Care (Quality Engagement) (Wales) Act 2020. The quality statement also reflects the

principles of the Well-being of Future Generations (Wales) Act 2015 by supporting a long-term, preventative approach to health and care and is aligned with the UK 20-year vision for antimicrobial resistance - and the UK 5-year National Action plan (NAP) for antimicrobial resistance.

In line with the national direction the IPC team has undertaken an initial review and mapping exercise against the 52 attributes outlined within the statement. This work provides a baseline understanding of the Health Boards strengths, risks and improvement opportunities.

Background

The IPC Quality Statement outlines expectations that NHS organisations must review their status against each quality attributes and use this assessment to provide assurance regarding the delivery and experience of care for the population.

Delivery of the standards aligns with the NHS Wales Health and Care Quality standards particularly:

- Safe
- Effective
- Timely
- Workforce
- Quality and experience

Each of these domains support a whole-system approach to ensuring healthcare services are safe, high quality and continuously improving.

Within the Health Board, IPC is overseen through a well-established governance structure that provides clear leadership, accountability and operational support. The IPC Committee acts as the central forum for assurance, bringing together key colleagues from across the Health Board.

Historically, reporting into the IPC Committee has been largely service-specific, with individual departments submitting updates directly to the IPC Committee. While this has provided valuable operational insight, it has limited the organisations' ability to identify cross-cutting themes, system level risk and opportunities for shared learning. The Quality statement requires a more integrated, standardised and transparent approach to governance ensuring that IPC performance is visible across all tiers of the Health Board and that improvement is driven through a consistent quality-management framework.

To strengthen governance and assurance, reporting will now be channelled through key operational governance groups including:

- Decontamination safety group
- Antimicrobial stewardship group
- Environmental cleanliness and standards group
- Mental Health quality assurance group
- Water safety and ventilation safety group
- Clinical service group (CSG) quality and safety assurance meetings
- Womens and children's quality assurance meetings
- Midwifery quality assurance meetings

This shift in reporting ensures that each service area reports against a standardised IPC quality framework, aligned with the national standards and overseen by the IPC Committee. It also embeds IPC within the organisation's broader quality and safety structures.

An internal IPC audit completed in March 2024 provided overall **reasonable assurance**, with substantial assurance in three of the five assessed areas. A separate internal audit on decontamination, carried out in December 2025, also resulted in overall **reasonable assurance**, with two of the five areas receiving substantial assurance.

Assessment

The initial mapping exercise against the 52 quality attributes has been completed by the IPC team, highlighting that many of the essential structures and processes required for a high-quality IPC service is already in place and there is clear evidence of improvement and maturity following the two-year IPC improvement plan.

Key findings:

- The Health Board benefits from established IPC governance structures following the Health Boards two-year IPC improvement plan. The Executive Direct of Nursing has oversight of IPC and there is regular reporting into PEQS. These structures provide a solid platform for strengthening Board-level visibility and assurance. The recent shift toward more structure reporting through operational governance groups will enable clearer oversight, more consistent information flow and improved triangulation of risk.
- Strong surveillance and incident management processes – the Health Board has well-established surveillance processes for key organisms and HCAIs, with regular reporting at a national level. Dashboards for monitoring HCAIs are in place.
- Existing specialist operational safety groups are in place to support IPC governance and oversight (i.e., decontamination safety group, water safety group)

- A comprehensive annual IPC audit programme is undertaken across all relevant clinical areas following the Infection Prevention Society audit framework. This provides a consistent nationally recognised methodology for address compliance with key IPC standards. In addition to the annual audits the IPC team undertakes targeted audit programmes focusing in specific risk areas based on surveillance data, incident trends, national guidance and local intelligence. These audits are electronically recorded via the MEG system.
- Dedicated IPC team with expertise and experience to provide advice and oversight across the span of the organisation, as required in the Welsh Governments Code of Practice for Reduction of Healthcare Associated Infections. The team is supported by an Infection Control Doctor/Consultant Microbiologist.
- The implementation of patient experience into IPC, with the IPC team currently working with NHS Wales Performance and Improvement national team to explore ways to incorporate patient experience within IPC assurance processes, specifically in relation to Clostridioides Difficile infections
- Strengthening safe clinical practice through implementation of ANTT (Aseptic Non-Touch Technique) with the IPC team currently working to achieve accreditation with services across the Health Board
- Sustained high levels of IPC level 1 & 2 training are seen across the Health Board (consistently >85%)
- There is strong performance in cleanliness, decontamination and water safety, supported by engaged estates and facilities team. IPC involvement in refurbishment and capital schemes have demonstrated good alignment with Welsh Health Technical Memorandums (WHTMs).
- Incident and outbreak management processes are robust for IPC and consistently applied across the Health Board. Learning from incidents and action plans are shared and updated following outbreaks and incidents and several services have demonstrated strong improvements following outbreaks and audit findings.
- IPC policies are available to staff across the Health Board and meet the standards and requirements as outlined in the Code of Practice.
- An antimicrobial stewardship (AMS) programme is in place, encompassing surveillance of antimicrobial prescribing and interventions to improve optimal use of antibiotics to reduce resistance risk with a dedicated AMS Pharmacist in post to support.

Development areas identified:

- Improved organisations reporting structures to enable theme and trend analysis
- Enhanced integration between operational groups and strategic IPC governance
- Improved data triangulations across operational groups

- Consistency in reporting and assurance across all clinical and non-clinical areas
- Continuing to strengthen workforce awareness that IPC is embedded in everyday practice across all roles

Governance and reporting improvements:

Moving reporting from individual services to operation governance groups will:

- Improve quality of assurance into the IPC Committee
- Enable cross-organisational analysis of risks and trends
- Support alignment with the national quality domains
- Provide clearer escalation routes for IPC risk
- Reduce duplication of reporting

The structure will also enable the IPC Committee to focus more effectively on, amongst others:

- Risks
- Performance themes
- Improvement priorities

The assessment demonstrates that the Health Board is well aligned with the IPC Quality Statement and strong foundations already exist, following the Health Boards two-year IPC improvement plan. The mapping exercise highlights not only areas for further development but also strengths, emerging good practice and a clear Health Board commitment to delivering safe, high-quality care.

NEXT STEPS:

The IPC team have already begun implementing the actions required to align with the IPC Quality statement. The following next steps reflect the work that is actively underway with reporting on progress into the IPC Committee:

1. Finalise governance reporting

- Complete the alignment of all IPC reporting templates to the Quality Statement domains (Safe, Effective, Timely, Workforce, Quality & Experience).
- Formally approve the updated governance flow for operational groups reporting into the IPC Committee.

2. Implement standardised reporting

- Roll out the standardised IPC reporting format to all operational groups (e.g., decontamination, antimicrobial stewardship, environmental cleanliness, water safety, mental health, CSG, maternity/children's services).

3. Address development areas identified in GAP analysis

- Develop a focused action plan to address gaps highlighted in the 52-attribute assessment

4. Strengthen theme and trend analysis

- Begin quarterly thematic analysis reports to aid escalation and organisational learning.

5. Embed patient experience into IPC

- Work with NHS Wales Performance & Improvement teams to implement agreed methods of capturing patient experience in IPC processes, focusing initially on C. difficile.

6. Advance ANTT accreditation

- Finalise the organisational ANTT accreditation roadmap.
- Prioritise directorates or services with the highest procedural risk profile.
- Gain bronze accreditation in one service area by May 2026 and use this as a platform for advancing accreditation.

7. Monitor and Sustain High IPC Training Compliance

- Continue monitoring IPC Level 1 & 2 compliance (>85% baseline) and identify areas falling below target

8. Provide quarterly assurance updates to the Executive team

Provide structured quarterly reports demonstrating:

- Progress against the gap analysis actions
- Service-level and organisational compliance trends
- Key risks, controls, and escalation themes aligned to national quality domains.

9. Reaffirm IPC as 'everyone's business'

Launch a brief organisational communications piece emphasising:

- "IPC is everyone's responsibility"
- Key expectations for managers and clinical leaders
- Availability of IPC support and expertise.

IMPACT ASSESSMENT – NOT REQUIRED FOR THIS REPORT

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 5.8

Patient Experience, Quality and Safety Committee	**Date: 30 April 2026**
Subject:	**Committee Risk Register**
Approved and presented by:	Helen Bushell, Director of Corporate Governance
Prepared by:	Corporate Governance Officer
Other Committees and meetings considered at:	
Appendices :	Appendix A – Committee Risk Register

PURPOSE:

The purpose of the Committee Risk Register is to draw together relevant risks for the Committee from the Strategic Risk Register (SRR), to provide a summary of the significant risks to delivery of the health board's strategic objectives. This copy of the Committee Risk Register is based upon the SRR received by the Board on 25 March 2026.

RECOMMENDATION(S):

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

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

Approve/Take Assurance	Discuss	Note
Y	Y	x

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

COMMITTEE RISK REGISTER

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

This copy of the Committee Risk Register is based upon the received by the Board on 25 March 2026.

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

NEXT STEPS:

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

The next Strategic Risk Register update is due to the Board on 20 May 2026.

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Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Committee Risk Register

Patient Experience, Quality and Safety Committee

30 April 2026

STRATEGIC RISK DASHBOARD – NOVEMBER 2025

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

KEY:

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

RISK HEAT MAP – NOVEMBER 2025

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

SRR 003	There is a risk that the Health Board is unable to respond to the demand for commissioned services	
Current Risk Score: **20**	**Risk rating detail:** (likelihood x impact) Current: L5 x I4 = 20 Inherent: L5 x I4 = 20 Target: L3 x I4 = 12	**Risk Category:** Performance and Service Sustainability **Boards Risk Appetite: Open**
Executive Lead: Executive Director of Planning, Performance & Commissioning		**Assuring Committee:** Patient Experience, Quality & Safety Committee
Latest review date: February 2026 **Added to register:** July 2024 **Link to Strategic Priorities and Wellbeing Objectives:**		**Cause of risk and rationale for current score:** • Increase in demand, inequality of access, complexity of patient needs, or failure to respond to demand pressures • December 2025 position (NHSW) November 2025 (NHSE): • Planned Care NHS Wales – number of patients waiting > 52 weeks improved however only HDUHB and SBUHB compliant for Powys residents. Very long waits (>104 weeks) ~~continue to increase~~ reduced. HDUHB and SBUHB ~~has~~ reported no Powys resident pathways > 104 weeks. Challenges remain with in-reach provision due to capacity fragility and complex diagnostic delays. • Planned Care NHS England: PTHB requested NHSE providers to deliver to NHSW waiting times targets. WVT reporting 66.7% ~~9.4~~% of pathways waiting <26 weeks for treatment, no patients waiting >104 weeks. SATH

SP 11 and WBO 8		reporting more challenged position. No patients >104 weeks but continuing to report patients >52 weeks (178). RJAH remains most challenged provider for long waiters. ~~78~~131 > 104 weeks reported in ~~July~~ November. Very long waits exceed 200 weeks, especially for complex spinal. • The risk relates to the Timely, Equitable, Effective and Patient Experience elements of the Duty of Quality. **Risk materialising could result in:** • Poorer outcomes and experience for the citizens of Powys • Difficulty in balancing performance and financial plan		
Controls (What has been implemented to manage the risk?)		**Sources of Assurance**	**Level of Assurance**	**Highest Assurance provided to:**
3.1	For Planned Care Services - Regular review of demand pressures by looking at referral levels into services	Referral data into services from commissioning data sets and supplementary reports received from commissioned providers. Low assurance currently due to robustness of referral data. Exploring alternative data sources (e.g. activity) whilst working through improved data set for GP referrals. Intention to review further in context of Commissioning	Limited	Executive Director

		Intentions for 2026/27; and SCF implementation plan.		
3.2	For Urgent & Emergency Services – Regular review of demand pressure by reviewing attendance rates and emergency inpatient volumes	Attendance data into services from commissioning data sets and supplementary reports received from commissioned providers Intention to review further in context of Commissioning Intentions for 2026/27 and SCF implementation plan.	Reasonable	Executive Director
3.3	Using demand data to plan to commission sufficient service provision for all services provided out of county, noting the need to agree a balanced finance and performance position as part of the IMTP process	Demand, activity and financial information from commissioning datasets used to inform contract plans Intention to review further in context of Commissioning Intentions for 2026/27 and SCF implementation plan.	Reasonable	Executive Director
3.4	Reviewing where services do not meet clinical and operational standards	Various data sources including operational & performance data. Intention to review further in context of Commissioning Intentions for 2026/27 and SCF implementation plan.	Limited	Executive Director
3.5	Improving the outcomes and experience data capture to inform future reporting on commissioned services to the	Various data sources including operational & performance data. Qualitative information	Limited	Executive Director

	Finance and Performance Committee and Board as well as future planning	from QMS, PROMS & PREMS reporting, concerns, NRIs, clinical audit, regulatory inspections Intention to review further in context of Commissioning Intentions for 2026/27 and SCF implementation plan.		

Mitigating Actions (What more will we do?)				
Action	**Lead**	**Action update**	**Deadline**	**Action on Target**
<u>Planned Care</u> ▪ Continue regular meetings with commissioned service providers. ▪ Secure performance improvement trajectories from providers. ▪ Insourcing contract extended to offer Powys residents experiencing long waits in commissioned service providers in NHS Wales to be treated in Powys. ▪ Ongoing scrutiny and oversight through CQPR meetings with escalation through Integrated Quality and Performance Report. ▪ Continuing to work to obtain robust data for referrals from NHSW and NHSE GPs for Powys residents.	Executive Director of Planning, Performance and Commissioning (supported by DPCCMH)	Performance Trajectories and details on harm reviews for Powys residents requested from commissioned service providers in NHS England and NHS Wales to understand expected performance 2025/26 and to be reviewed and discussed through CQPRMs. Planned Care Insourced provision tender exercise ~~delayed~~ cancelled pending outcome of GIRFT assessment of planned care. Temporary extension of medinet to end of March 2026. ~~Mitigating actions~~	April 2025 and ongoing	~~Delayed (Procurement)~~

▪ GIRFT strategic assessment of planned care. ▪ Commissioning Intentions 2026/27 for NHSW and NHSE providers. ▪ Recommendations from GT review – to be included in SCF implementation plan.		~~put in place to ensure continuity of service provision whilst tender exercise undertaken. Paper presented to Executive Committee for decision.~~ Established Commissioning Oversight and Assurance Group (COAG), chaired by Exec DPPC, to provide a forum for internal oversight and escalation of performance monitoring of commissioned non-specialist services. Additional actions to be taken: ▪ Strategic Commissioning Framework implementation plan for 2026/27 (to reflect outcomes of GIRFT assessment of planned care and GT recommendations). ▪ Refresh of IQPR to include additional detail particularly on quality metrics. ▪ Increased scrutiny on performance through Commissioning Oversight		

		and Assurance Group and planned Commissioned Services Performance Report.		
▪ Cancer	MD (supported by DPPC)	Added to this version of the risk register. Actions to be agreed. Cancer Working Group chaired by Medical Director. CQPRMs and COAG cover all specialties with commissioned providers. Cancer Deep Dive ~~to be~~ presented to F&P Committee October 2025.	TBA	TBC
<u>Urgent and Emergency Care</u> ▪ CQPRMS cover all specialties with commissioned providers including UEC. ▪ Continued work on 6 Goals plan to reduce admissions and secure timely discharge. ▪ Strengthening arrangements for admissions to community beds in NHSE.	DPPC (supported by DPCCMH)	CQPRMS and COAG cover all specialties including urgent and emergency care. Historically had regular meetings (ICAP and Q&S) with Health Boards and WAST to cover performance, patient experience, incidents and resultant investigations, clinical indicators~~. Several~~	April 2025 and ongoing	On track

▪ Continue series of regular meetings with WAST and commissioned service providers. ▪ Continue commissioning of ambulance services in partnership through the Joint Commissiong Committee ▪ Secure performance improvement trajectories and improvement plans from providers. ▪ NHSW and NHSE commissioning intentions 2026/27.		~~recent ICAP meetings have been cancelled.~~ Regular attendance at CCLG and sub- committee structure including Ambulance and 111 Commissioning Group, NEPTS Commissioning Assurance Group. ~~New governance structure developed by the JCC with establishment of Ambulance Services and 111 Collaborative Commissioning Integration Group.~~ Standing agenda item in CQPRMs to review improvement plans, patient experience, and patient harm.		
<u>All indicators</u> There are some performance indicators that continue to fail the operational standard e.g. Single Cancer Pathway, 4 Hour ED waits. The Health Board will develop a suite of indicator sub-sets to determine if any improvement is being made towards achievement of the overall target.	DPPC	Integrated Quality and Performance Framework (IQPF) has been reviewed and refreshed for 2025/26. As part of the IQPF, the Integrated Quality and Performance Report will continue to provide information across the NHS Wales Performance Framework	April 2025 and ongoing	On track

		measures including Cancer and 4 hour ED waits. IPQF annual review planned for March 2026 to inform IQPF refresh for 2026/27.		

Additional information:

Rationale for current score:

Planned Care

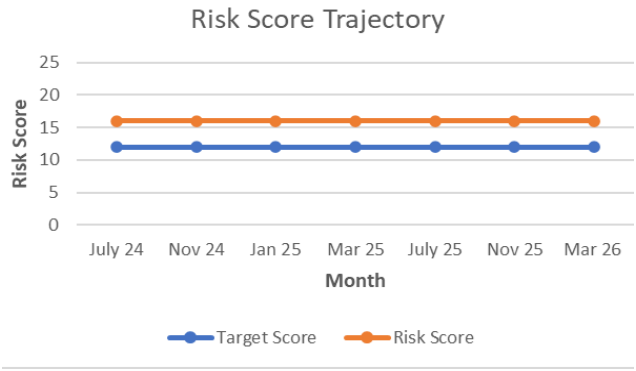
NHS Wales

- Latest validated position to month 8 ~~5~~ as per IQPR month ~~5~~ 8 report presented to Executive Committee. ~~15th October 2025. (April 2025):~~

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

~~Improved~~ Performance being maintained across NHSW and NHSE providers, still challenges in compliance with patients waiting >52 and 104 weeks. ~~performance experienced within NHS England commissioned service providers; expected improvement in NHS Wales expected following issue of additional planned care monies in 2025/26, and national procurement process for outpatients and treatments.~~

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

SRR 004	There is a risk that the Health Board is unable to respond to the demand for provided services	
Current Risk Score: **16**	**Risk rating detail:** (likelihood x impact) Current: L4 x I4 = 16 Inherent: L4 x I4 = 16 Target: L3 x I4 = 12	**Risk Category:** Performance and Service Sustainability **Boards Risk Appetite:** **Open**
Executive Lead: Executive Director of Primary Care, Community and Mental Health (PCCMH)		**Assuring Committee:** Patient Experience, Quality & Safety Committee
Latest review date: February 2026 **Added to register:** July 2024 **Link to Strategic Priorities and Wellbeing Objectives:**		**Cause of risk:** • Increase in demand, inequality of access, complexity of patient needs, or failure to respond to demand pressures. **Risk materialising would result in:** • Poorer outcomes and experience for the citizens of Powys • Increased system pressure across urgent and emergency care pathways. • Reduced efficiency in patient flow and bed utilisation • Inability to meet national performance targets and ministerial priorities.

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

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

Mitigating Actions (What more will we do?)

Action	Lead	Action update	Deadline	Action on Target
<u>Planned Care</u> ▪ Continue series of regular meetings with service providers ▪ Monitor and manage delivery against performance improvement trajectories for our own services. ▪ On track for delivery of national OPD recovery plan and secondary validation of RTT position.	Executive Director PCCMH	Performance Trajectories being routinely monitored and managed. GIRFT review underway	September 2026	On track

▪ Medinet contract extended to offer Powys residents experiencing long waits in commissioned service providers in NHS Wales to be treated in Powys. Work being progressed to issue a tender for insourced provision in 2025/26. Ongoing scrutiny and oversight through CQPR meetings with escalation through Integrated Performance Report. External review of elective care commissioned from GIRFT for Q4 25/26				
<u>General Service Sustainability & Future Models of Care</u> The health board is currently reviewing models of care as part of its five-year plan but also in response the staffing and financial challenges. ▪ A number of service reviews are being undertaken with several 'cases for change' having been approved by the Health Board and stakeholders.	Executive Director PCCMH	Overall case for change now available for second phase engagement, with options development completed and available for future engagement and consultation. Further work ongoing to develop and implement service change that falls below threshold for consultation.	April 2026	On track
There are some performance indicators that continue to fail the operational standard e.g. Neuro-developmental target. The Health Board will develop a suite of indicator sub-sets to determine if any improvement is being made	Executive Director PCCMH	A number of sub-indicator performance targets have been identified. These have been built into the IQPR and actions in train to further reduce risk	~~December 2025~~ April 2026	On track

towards achievement of the overall target.				
Operationalise and expand integrated system coordination mechanisms—including the Integrated Flow Hub, daily discharge huddles, Trusted Assessment processes, and DigiFLO rollout—to mitigate delays, improve patient flow, and support timely discharge across the system.	Executive Director PCCMH	Flow Hub: model scoped, and roles identified; launch planned for December 2025. PoCD: Daily tracking and escalation in place; overall delays reduced, recognising seasonal variation. Daily 'huddle' to review patients in place. DigiFlo: Implemented on community hospital wards, expansion into MH has been progressed. Trusted Assessment: Pilot completed in collaboration with PCC with early findings indicating positive impact.	March 2026	On Track
Additional information:				
Rationale for Current Score: Mitigation actions are ongoing, including further actions relating to planned care but some underlying challenges remain, so the current risk score remains unchanged at this review. Collaborative efforts through the *Better Together* programme are expected to provide further support in addressing this strategic risk alongside mitigating actions listed above.				

Clinical Supervision

Final Internal Audit Report

2025/26

Powys Teaching Health Board

Reasonable Assurance

Contents

Review Reference	PTH-2526-18
Fieldwork	October - December 2025
Executive Sign Off	28 January 2026
Audit Committee	10 March 2026
Executive Lead	Director of Allied Health Professions, Health Science and Digital
Audit Team	Ian Virgil, Head of Internal Audit Lucy Jugessur, Deputy Head of Internal Audit

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GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

Our review of Clinical Supervision was completed in line with the 2025/26 Internal Audit Plan for Powys Teaching Health Board (the 'Health Board').

The Health Board updated their Clinical Supervision and Reflective Practice Policy in May 2025. Our audit focused on the level of compliance with the Health Board's Clinical Supervision Policy across relevant staffing groups, the frequency of supervision meetings and the quality and recording of supervision meetings.

Overview

We have concluded **reasonable** assurance on this area. During the audit we were not provided with access to individuals records to review clinical supervision session notes as management felt this could be interpreted as a breach of trust. Our Testing was therefore undertaken through a survey sent to all Psychology and Therapies staff that should be in receipt of clinical supervision. The findings identified and assurance provided are therefore largely based on the results of the survey responses received.

The significant matters requiring management attention are:

- The frequency of Clinical and Live supervision sessions is not in line with the clinical supervision policy for all supervisees.
- Clinical supervision sessions are not being adequately recorded for all supervisees.
- The take up by clinical supervisors of clinical supervision training courses offered by the Health Board is very low.

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

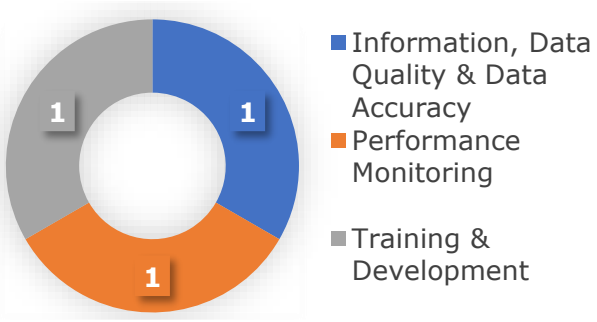
Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	Clinical supervision meetings are held at least quarterly and live supervision annually in line with the Clinical Supervision policy for all relevant clinical staff.	1	**Reasonable**
2	Supervision is adequately recorded and includes clear objectives and outcomes, and the type of supervision (Management Supervision; Clinical Supervision; Professional Supervision) and approach (one to one; triparty; Group; Peer Group) is appropriate.	2	**Reasonable**
3	The frequency and quality of clinical supervision meetings is monitored, and action is taken where issues are identified.	-	**Substantial**
4	Supervisors are adequately trained.	3	**Reasonable**

Management Actions

1	2
High Priority	Medium Priority

Themes



Risk Types

Quality or Safety Issues

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Findings & Agreed Action Plan

Objective 1: Clinical supervision meetings are held at least quarterly and live supervision annually in line with the Clinical Supervision policy for all relevant clinical staff.	**Reasonable**

Overview / Summary of Observations

The clinical supervision policy is up to date and clearly sets out the clinical supervision requirements for all relevant staff. The policy is readily available to all Health Board staff via the PTHB SharePoint site, and awareness of the requirement for clinical supervision is being actively promoted by line managers and clinical supervisors.

At the time of our audit there was no central record of clinical supervision or annual live supervision sessions held or planned. Testing identified that quarterly clinical supervision is being undertaken regularly, and in many cases more often than quarterly, but sessions are timetabled in individual's diaries rather than in a central record which is acceptable given the volume of sessions being undertaken. Testing did however identify that live supervision is not being undertaken annually for all staff, and a small number of Therapies staff were not receiving clinical supervision at least quarterly.

	Key Findings	Risk & Impact	Agreed Management Action
1	**Frequency of Supervision** Not all staff are receiving live supervision annually and clinical supervision quarterly as required by the Clinical Supervision Policy. Testing of a sample of 28 Therapies staff identified that annual live supervision was not being received by 11/28 staff (40%), and 3/28 (10%) were having clinical supervision less frequently than quarterly. Testing of a sample of 30 Psychology staff identified that all were receiving clinical supervision quarterly or more frequently. However, testing of a reduced sample of 17 Psychology staff identified that annual live supervision was not being received by 12/17 staff (70%).	Clinical supervision is not undertaken in accordance with the clinical supervision policy and fails to meet the needs of supervisees.	**Agreed Action:** Awareness sessions for supervisors and supervisees to highlight the benefits of live supervision will be run to ensure all staff have live supervision annually in line with the clinical supervision policy.
			Expected Evidence of Implementation: Increased compliance with the requirements of the clinical supervision policy.
		High Priority	**Officer:** Christopher Hartwright, Head of Psychology. Victoria Deakins, Head of Therapies & Health Sciences
	Theme: Performance Monitoring	Control Operation	**Target Implementation Date:** April 2026

Objective 2: Supervision is adequately recorded and includes clear objectives and outcomes, and the type of supervision (Management Supervision; Clinical Supervision; Professional Supervision) and approach (one to one; triparty; Group; Peer Group) is appropriate.	**Reasonable**

Overview / Summary of Observations

The Clinical Supervision Policy requires sessions to be recorded by the supervisee in a format that includes SMART goals and actions that will be reviewed at future supervision sessions, with a copy being retained by the supervisee on their CPD file. Although not mandatory, the policy includes a template for recording sessions that should be signed off by both the supervisee and supervisor. The policy also recommends that each supervisee has a Clinical Supervision contract with the supervisor and completes a standard Supervision Checklist when setting up sessions. The supervisee must also ensure that each session is recorded in ESR.

As we were not able to access individual's clinical supervision records, compliance with the above requirements was tested via a survey sent out to Psychology and Therapies supervisees. The survey was completed by 30 Psychology supervisees and 28 Therapies supervisees. All staff that responded to the survey were receiving clinical supervision on a one-to-one basis, with some also taking part in group sessions. In most cases responses indicated that goals and actions were being set. However, supervision notes were not being kept by all supervisees. Where notes were being kept, most were not using the template from the Clinical Supervision Policy. There was also limited use of the standard Clinical Supervision contract and checklist, and not all sessions were being recorded on ESR.

As we were not given access to review supervision notes, we were unable to assess if clinical supervision sessions included the setting of clear objectives and outcomes.

	Key Findings	Risk & Impact	Agreed Management Action
2	**Recording of Clinical Supervision Sessions** Our survey identified that: • Only 14/30 Psychology supervisees (47%) and 11/28 Therapies supervisees (40%) had signed the Clinical Supervision contract and completed the checklist as recommended by the Clinical Supervision Policy. • Supervision Notes were being kept by all Psychology supervisees but were not being kept by 8/28 Therapies supervisees (29%). • The recommended template from the clinical supervision policy was only being used by 5/30 Psychology supervisees (17%) and 6/22 Therapies supervisees that keep supervision notes (27%). • Supervision notes were only being signed off by 8/30 Psychology supervisees (27%) and 8/22 Therapies supervisees (36%).	Clinical supervision is not undertaken in accordance with the clinical supervision policy and fails to meet the needs of supervisees.	**Agreed Action:** Awareness sessions will be run for supervisors and staff receiving clinical supervision to help improve compliance with the clinical supervision policy. **Expected Evidence of Implementation:** Increased compliance with the requirements of the clinical supervision policy.

	• Sessions were being recorded in ESR for 25/30 Psychology supervisees (83%) and 18/28 Therapies supervisees (64%).		
		Medium Priority	**Officer:** Christopher Hartwright, Head of Psychology Victoria Deakins, Head of Therapies & Health Sciences **Target Implementation Date:** April 2026
	Theme: Information, Data Quality & Data Accuracy	Control Operation	

Objective 3: The frequency and quality of clinical supervision meetings is monitored, and action is taken where issues are identified. **Substantial**

Overview / Summary of Observations

There is no central record of clinical supervision meetings held or planned, but the frequency of clinical supervision meetings is being monitored by clinical supervisors on an individual basis. We were informed that this is also being done by line managers through the PADR process, although we were unable to verify this.

Testing identified that clinical supervision was being undertaken at least quarterly for most supervisees, and many were receiving supervision more frequently than this. It was also encouraging that overall, 55/58 respondents to our survey were happy that clinical supervision was meeting their development needs and they were happy with the clinical supervision they were receiving.

Many respondents also provided constructive comments about the clinical supervision they were receiving, and these have been shared separately with Senior Management and could be used to further improve the quality of clinical supervision.

Objective 4: Supervisors are adequately trained.	**Reasonable**

Overview / Summary of Observations

Training needs should be identified during supervisor's PADR and feed into the relevant service training plan. The clinical supervision policy requires supervisors to be adequately trained and recommends they undertake a number of training courses that are offered by the Health Board.

A sample of clinical supervisors was selected to ascertain if they had attended any of the clinical supervision training provided by the Health Board as specified in the Clinical Supervision Policy. For the sample tested, the majority of staff with clinical supervision duties had received suitable training outside of the Health Board, but the take up of the Clinical Supervision courses provided by the Health Board was very low. Clinical supervision may be improved by raising awareness of the availability of these courses so more clinical supervisors undertake the specific courses provided by the Health Board.

	Key Findings	Risk & Impact	Agreed Management Action
3	**Clinical Supervisor Training** The Clinical Supervision Policy suggests supervisors can undertake four in-house training courses provided by the Health Board. For the sample of ten supervisors tested, only two had completed one of the four courses on offer. Some supervisors commented that they were not aware of the availability of PTHB training, and that they would find it useful to attend as the courses would provide helpful refresher training.	Supervisors may not be adequately trained.	**Agreed Action:** We will raise awareness of the PTHB training courses through a targeted campaign to encourage a greater take up by staff with clinical supervision responsibilities. **Expected Evidence of Implementation:** Increased numbers of staff attending the training courses.
		Medium Priority	**Officer:** Christopher Hartwright, Head of Psychology Victoria Deakins, Head of Therapies & Health Sciences **Target Implementation Date:** April 2026
	Theme: Training & Development	Control Operation	

Appendix A

Assurance Opinion

 **Substantial**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
 **Reasonable**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
 **Limited**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
 **Unsatisfactory**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
 **Advisory**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership]

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The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

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Public Sector Internal Audit Standards

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Deprivation of Liberties Safeguards Follow-up

Final Internal Audit Report

2025/26

Powys Teaching Health Board

Contents

Review Reference	PTH-2526-21
Fieldwork	January - February 2026
Executive Sign Off	16th February 2026
Audit Committee	March 2026
Executive Lead	Paul Hooton – Executive Director of
Audit Team	Ian Virgill, Head of Internal Audit
	Lucy Jugessur, Deputy Head of Internal Audit

Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

We have completed a follow-up review of the Deprivation of Liberties Safeguards (DoLS).

Our original DoLS audit was reported in December 2024 and identified six issues which resulted in an overall assurance rating of 'Limited Assurance'.

For 2025/26 we have revised our approach to reporting our follow-up audit work to ensure that we comply with the requirements of the new Global Internal Audit standards. As such we will no longer be providing an assurance rating as part of our follow-up reports.

The purpose of this follow up review is therefore to establish if management has now taken corrective measures to fully implement the agreed management actions and address the relevant key findings from our original report.

We note that the Audit, Risk and Assurance Committee has continued to monitor progress in implementing these actions through the internal audit tracker.

Overview

Our follow up review has confirmed that all six agreed actions have been **implemented,** as follows:

Original Priority Rating	Number of agreed actions	Implemented / obsolete (Closed no further action required)	Action Ongoing (Further action required)	Not Implemented / Not due (Further action required)
High	3	3	0	0
Medium	3	3	0	0
Total	**6**	**6**	**0**	**0**

As part of our follow-up review, we met with the Mental Capacity Act and DoLS/LPS Senior Practitioner and the Safeguarding Business Support Manager to establish the progress that has been made with the implementation of the agreed actions. We then obtained and reviewed documentation and evidence to validate the stated position for each of the actions.

As noted above, this has enabled us to confirm that all the agreed management actions have been implemented. The provision of additional staff resources has provided a stable foundation for the ongoing delivery of the Supervisory role, and the development of training for ward staff will further strengthen awareness of the Managing Authority role. Strengthening of the signatory arrangements is aiding timely authorisation of DoLS applications, and the developments around the case tracker and performance reporting are improving oversight.

Whilst implementation of the agreed actions has improved the DoLS position within the Health Board, ongoing work is required to ensure that the future training for ward staff is consistently delivered as planned and the monitoring and reporting of key performance information continues to be developed.

Further detail of the work undertaken by management to implement each of the agreed actions is provided in the table below.

Appendix A: Progress of Agreed Actions

Ref	Previous Finding, Agreed Management Action, Original Responsibility & Timescale	Priority Rating	Current Status & work undertaken
Finding 1	**Policy and process document.** Finding: There is an issue with the October 2022 review date for the Health Board's DoLS policy having passed. Although this was explained at the outset of the audit as initially being due to the UK Government delay and indecision with any potential implementation of the Liberty Protection Safeguards (LPS), which were effectively 'abandoned' in April 2023. Currently, the DoLS policy is unable to reflect updates within its policy until PTHB determine its Supervisory Body Role, following the Local Authority notice that they cannot continue their role of DoLS Co-ordination. This remains an identified gap within PTHB. The Policy should still be formally reviewed and updated where required. We also noted that there is nothing in the Health Board's Policies on the requirements for reporting the DoLS position, though we have confirmed this does happen, and also note that the WG policy does not include reporting either. Agreed Action: Update DoLS Policy. Original Responsibility & Timescale: Jayne Wheeler-Sexton, June 2025	**Medium Priority**	**Action Status: Implemented** The DoLS Policy has been updated and converted into a practice guidance document entitled 'Deprivation of Liberty Safeguards Guidance'. The Guidance was approved by the PTHB MCA Operational & Practice Improvement Group in January 2026. The Guidance is comprehensive and covers all elements of the DoLS process.

Ref	Previous Finding, Agreed Management Action, Original Responsibility & Timescale	Priority Rating	Current Status & work undertaken
Finding 2	**Provision of Training on Managing Authority Responsibilities.** Finding: The Health Board has effective arrangements in place for providing training to nursing staff on the wards relating to DoLS processes. However, there is currently no on-going cycle of DoLS training in place that is directed towards the Managing Authority responsibilities. This gap in training is linked to the current lack of a DoLS co-ordinator post within the Health Board, which is noted under matter arising 4. Agreed Action: A business case will need to be made for the role of DoLS co-ordinator. A training needs analysis will be undertaken to determine required cycle of training. Identified training put into place for the Managing Authority. Original Responsibility & Timescale: Jayne Wheeler-Sexton, March 2025 / July 2025 / September 2025	**Medium Priority**	**Action Status: Implemented** A Business case for the role of DoLS Co-ordinator was developed and approved in May 2025. An analysis of required DoLS training was undertaken by a Task & Finish Group. All PTHB wards have been provided with a training session covering their managing authority responsibilities. A six-monthly rolling programme of training sessions to each ward started in February 2026.

Ref	Previous Finding, Agreed Management Action, Original Responsibility & Timescale	Priority Rating	Current Status & work undertaken
Finding 3	**BIA Contractor Qualification.** Finding: Action First are contracted to the Health Board to provide BIA personnel when the demand rises above a level that can be managed by the Health Board Staff. The Health Board have been unable to confirm what/if any process exists to ensure the Action First staff are fully qualified and currently certified to fulfil the role. Agreed Action: Safeguarding Team to ensure they have a process to maintain evidence of correct qualifications from external assessors. To ensure that procurement amend the contract as required. Original Responsibility & Timescale: Jayne Wheeler-Sexton, February 2025	**Medium Priority**	**Action Status: Implemented** Advice was received from the Procurement service and the qualifications and accreditation for all the current external assessors provided by Action First have been confirmed. A process has also been set-up to ensure that the same information is confirmed for any new external assessors. This will be managed by Safeguarding Administration. Procurement confirmed that the contract does not need to be amended at this stage, but this can be done when the contract is renewed.

Ref	Previous Finding, Agreed Management Action, Original Responsibility & Timescale	Priority Rating	Current Status & work undertaken
Finding 4	**Provision of DoLS Supervisory Body role.** Finding: The DoLS process previously failed to operate correctly when key personnel left the Health Board. The current interim measure has allowed additional administration for PCC to support the DoLS process using Welsh Government grant money. The MCA Senior Practitioner is also stepping outside of her role to undertake some responsibilities required in the DoLS Co-ordination responsibility. However, there remains a gap in the provision of a dedicated DoLS Supervisory Body role within PTHB, that provides oversight and co-ordination of the process and decision-making required. This is a gap that has been identified to PTHB Executive team. Agreed Action: A business case will need to be made for the role of DoLS co-ordinator, administration and Best Interest Assessors. Depending on outcome of business case, recruitment into positions will be required. Original Responsibility & Timescale: Jayne Wheeler-Sexton, March 2025 / June 2025	**High Priority**	**Action Status: Implemented** A Business case which included the roles of DoLS Co-ordinator and Best Interest Assessors, and the provision of administration was developed and approved in May 2025. The full title of the DoLS Co-ordinator role is the 'MCA DoLS Supervisory Body Authorised Signatory and Quality Assurance Practitioner'. There was a delay in recruiting to the role as the initial cycle did not have candidates with the necessary specialist knowledge. Interim arrangements were put in place from October 2025 until the permanent recruitment was completed and the Practitioner commenced in role in January 2025. The Best Interest Assessor posts have now also been recruited into and the individuals have commenced. A Service Level Agreement is now in place between the Health Board and Powys County Council for the provision of an administrative function for the DoLS process until March 2027.

Ref	Previous Finding, Agreed Management Action, Original Responsibility & Timescale	Priority Rating	Current Status & work undertaken
Finding 5	**Authorisation of DoLS Applications.** Finding: Delays are currently being experienced in obtaining timely sign-off of DoLS applications. The DoLS Signatories element of the process is reliant on senior staff agreeing to be part of a DoLS Signatory rota which is challenging to maintain due to being additional to the MCA Senior Practitioners normal duties. The DoLS Co-ordinator role would help to reduce this pressure and ensure timely scrutiny and sign-off of DoLS applications. Agreed Action: A business case will need to be made for the role of DoLS co-ordinator, This role will include to sign off the applications and review the current signatories process and manage the signatory's rota. Original Responsibility & Timescale: Jayne Wheeler-Sexton, March 2025 / June 2025	**High Priority**	**Action Status: Implemented** A Business case which included the role of DoLS Co-ordinator was developed and approved in May 2025. The job description for the permanent MCA DoLS Supervisory Body Authorised Signatory and Quality Assurance Practitioner confirms that the post includes undertaking the role of authorised signatory and also developing and expanding the capacity of DoLS signatories. The work to improve the DoLS signatories process has included increasing the number of signatories on the rota by five which has enabled reduced demand on other signatories and a robust sign-off process is now in place.

Ref	Previous Finding, Agreed Management Action, Original Responsibility & Timescale	Priority Rating	Current Status & work undertaken
Finding 6	**Case tracking.** Finding: The DoLS applications have timescales for completion, being within 28 days for a standard application and 7 days (extendable by 7) for an urgent (unplanned) one. To date the Health Board has not monitored or reported whether or not the target dates have been achieved. The case tracking spreadsheet updated by the DoLS Admin team, is available to PTHB in real time since October 2024 and prior to this the spreadsheet was shared for the purpose of the audit from April 2024. This identifies within that time frame for the standard applications the target date was not achieved in 50% of cases. For urgent applications, 77% were not completed within the 7 day time limit and 68% were not completed within the 14-day extended. We were informed by the MCA Senior Practitioner that the current demand of application's are above what the Health Board can provide with the number of BIA's available and that the procurement of Action First is dependent on WG grant money being available for this. Agreed Action: The case tracker spreadsheet will be updated and accessible in real time for PTHB Supervisory Body. A Dols Co-ordinator role will need to be in place to provide the challenge and scrutiny. Performance will be reported into PTHB Strategic Safeguarding Group. Original Responsibility & Timescale: Jayne Wheeler-Sexton, March 2025 / June 2025 / June 2025	**High Priority**	**Action Status: Implemented** The DoLS Case Tracker spreadsheet has been updated and now comprehensively covers all stages of the DoLS process including request, assessment and authorisation. Completion dates for the key stages of the process are also recorded and tracked. The Case Tracker is available to Health Board and Powys County Council in real time with required information governance in place. Review of a download form the live Case Tracker confirmed that the information recorded is complete and up to date. Information is extracted from the database through a BI report to provide monthly statistics on DoLS performance and this is reported into the Health Board's MCA Operational & Practice Improvement Group. The Group then reports into the Health Board's Safeguarding Strategic Group.

Appendix B

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Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

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Cyd-bwyllgor Comisiynu Joint Commissioning Committee

Joint Commissioning Committee

Highlight Report from the Quality, Safety and Outcomes Sub-Committee

Dyddiad y Cyfarfod / Date of Meeting	27/01/2026
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Helen Tyler, Head of Governance and Risk, NWJCC
Cyflwynydd yr Adroddiad / Report Presenter	Susan Elsmore, Chair of Sub-Committee and Lay Member, NWJCC
Noddwr yr Adroddiad / Report Sponsor	Carole Bell, Director of Nursing and Quality, NWJCC

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Health Boards		Noted

1. SITUATION/BACKGROUND

This report has been prepared to provide NWJCC Joint Committee Members with a summary of the key issues considered by the Quality, Safety and Outcomes (QSO) Sub-Committee at its public meeting on 15 December 2025.

Key highlights from the meeting are reported in Section 2.

2. HIGHLIGHT REPORT

(Links to reports highlighted – December 2025)

Status	Update
Alert / Escalate	Risk Management discussions – Concern was raised over thrombectomy (Risk 88) and the absence of a timeline in relation to the business case from Cardiff and Vale University Health Board (CVUHB) in relation to the provision of a 24/7-hour mechanical thrombectomy service in South Wales. Demand for the service was not as high as expected. As such, the capacity in place between CVUHB and UHB is sufficient to meet the current demand and at present the JCC were commissioning more capacity than was being utilised. This would continue to be flagged as an issue with Medical Directors to ensure that it was clear that access to Thrombectomy services was not solely a commissioning issue. In addition, members discussed the interdependencies within specialised services and acknowledged that articulating this was complex. Members remained concerned about St Andrews as the service remained suspended under the National Framework Agreement. Members also raised concern over the issues identified at the Caswell Clinic which led to this service being placed in Escalation Level 3. Members agreed that keeping the Caswell Clinic closed to new admissions pending satisfactory assurances was the correct approach.
Advise	Reports from each of the Directors of Commissioning were received. The following items were discussed and referred to the Joint Committee for noting. Director of Commissioning for Specialised Services • That the South Wales Specialist Auditory Implant Device Service had been placed in escalation Level 3 due to waiting list concerns. The JCC had met with the provider and received an action plan which seeks to reduce waiting times by the end of Quarter 4. • Obesity Surgery Services Northern Care Alliance NHS Foundation Trust Salford Royal Hospital Obesity Surgery had served notice. The NWJCC will be seeking an alternative provider for North Wales patients. • That the Neonatal service had been de-escalated. CB highlighted the positive impact on data reporting and coroner's inquests' reports following improvements within the service. • The Thrombectomy risk had been discussed under Item 3.1. Challenges persist with plastic surgery outreach in North

Status	Update
	Wales, PET-CT for prostate cancer, Joint Accreditation Committee of the International Society (JACIE) Accreditation for Bone Marrow Transplantation (BMT) and Chimeric Antigen Receptor T-cell (CAR-T) Services (report still pending), and hereditary anaemias. • Cost savings were anticipated when switching providers for enteral feeds in cases of intestinal failure. • Various events had taken place in relation to Service Innovation and Improvement including Paediatric Oncology, All-Wales Posture and Mobility Service and Intestinal Failure. Welsh Kidney Network (WKN) Report Despite a recent change in governance arrangements (and the Network becoming a part of the NWJCC Specialised Services Directorate), the WKN Report would still be presented as a separate agenda item at the QSO meeting to fully capture work undertaken across the Network. • One Nationally Reported Incident (NRI) had been closed in relation to a Catastrophic fistula haemorrhage resulting in the death of the patient at home. Surgical intervention was delayed due to co-morbidities, anaesthetic complexities, and issues with communication and process. RP assured members that learning was being disseminated across Wales with consideration of changing intervention timelines for these rare but high-risk cases. • One new NRI had been reported, also noted as emerging risk 93. RP outlined the early stages of an independent investigation following the brief but sudden closure of the Cardiff transplant programme, which resulted in missed transplant opportunities. An investigation focused on why and how the unit closed. The WKN has been assured that the service was not vulnerable, and immediate measures have been taken to prevent any further occurrences. Regional collaboration with Bristol and the Southwest will be important, but it was premature to draw conclusions before the investigation concluded. Director of Commissioning for Ambulance Services/111 Report • Phase 2 of the updated ambulance performance framework launched on 2 December 2025, after the team had worked with Welsh Ambulance Services Trust (WAST) and partners to assess and mitigate risks. This led to significantly higher conveyance rates in the orange category. • The Handover 45 initiative, aiming to transfer patients within 45 minutes, had improved performance but results vary by Health Board and hospital, highlighting a need for targeted

Status	Update
	support. Each health board had completed a readiness assessment, currently under review by the National Ambulance Handover Taskforce regarding automatic ambulance release at 45 minutes. • The Non-Emergency Patient Transport Services (NEPTS) service in Wales faced ongoing capacity issues, leading to outpatient and discharge transport cancellations. To address this, the Ambulance Services and 111 Commissioning Team were running weekly forums with stakeholders, aiming for strategic integration and improved discharge efficiency under the NEPTS Future Vision (2030). • WAST had continued its efforts to improve 111 call handling capacity, establishing a dedicated 111 Re-roster Project Board. The Ambulance Services and 111 Commissioning Team remain actively involved, providing support for the strategic priorities and direction of the urgent and emergency care system. This included mapping the various clinical assessment services currently available across Wales to identify duplication and develop proposals for greater efficiency. Anticipated winter-related challenges were also being addressed. • Ongoing discussions with WAST were focused on ensuring that the JCC receives timely and updated reports about incidents and concerns, as well as implementing lessons learned from these outcomes. Director of Commissioning for MHLDVG Report • The St Andrews service remained suspended under the National Framework Agreement and was regularly reviewed through the Enhanced Monitoring process of the Framework. The JCC, together with several agencies, continued to hold oversight meetings and met frequently with the provider. Health Boards were encouraged to closely monitor their patients and there were currently six JCC commissioned medium secure placements within the service. There was a significant increase in interest from both local and national media following the CQC's (Care Quality Commission) latest review of the service released on December 12, 2025. The provider had been rated inadequate across several areas. • The September 2025 review of the Caswell Clinic identified safety and quality concerns. As a result, a decision was taken to Escalate the service to Level 3 and suspend new admissions to the unit due to these safety concerns. An action plan was created, and although some progress had been made, there were still unresolved issues concerning environmental risks and staff risk assessment practices. A member of the NWJCC

Status	Update
	team will offer advice and training on risk assessment and AC has arranged for staff from the Unit to visit another medium secure Unit. • Seren Lodge Perinatal Unit at Countess of Chester Hospital was set to open for admissions on 17 December 2025, with a MHLDVG commissioning team visit scheduled for 9 January 2026. The Incident and Concerns Report highlighted • 4 new nationally reportable incidents, 1 DATIX and 1 early warning notification reported to the Commissioning teams over the period 01/09/2025 – 31/11/2025. • Four incidents were closed in this reporting period. • Thirty-six incidents remained open at the time the report was written. • Six new complaints had been received. • No new referrals to the Ombudsman.
Assure	The Committee received the QSO sub-committee's assigned risks from the NWJCC Operational Risk Register as of 30 November 2025. After QSO scrutiny and review, the JCC will receive the November 2025 risk register at its January 2026 meeting. AF highlighted: • Thirteen risks, with a score of 15 or above, have been assigned to QSOC. All these risks were classified as Specialised Services Commissioning Risks. • Between September 2025 and November 2025 two new risks had been added – Risk 91 Hereditary Anaemia and Risk 92 Women and Children Commissioned Services posts. • One risk has been de-escalated (Risk 3 – plastic surgery but this was a risk assigned to the Planning, Performance and Finance sub-committee and had been highlighted due to the link with the patient story); and • A new section addresses emerging risks. Risk 93 concerned service sustainability for the National Transplant Programme, this risk was reported in more detail under Agenda Item 4.2. The Escalation Trajectories Report was received and is attached at **Appendix 1.** Members noted the changes made to the report and commented that these were helpful. The Regulator Report (Healthcare Inspectorate Wales (HIW)/Care Quality Commission (CQC) was received. An update on regulatory activity was provided. No issues of concern had been highlighted within updates reported upon.

Status	Update
Inform	**Patient Story – Breast Reconstruction** A patient shared her story and personal experiences of the care received from Swansea Bay University Health Board Breast Reconstruction Service. The patient provided an account of her experience with risk-reducing breast reconstruction surgery, detailing aspects such as family history, genetic testing, surgical interventions, complications, and both emotional and logistical challenges. These included extended waiting periods, as each procedure required initiating a new process. Members noted the challenging wait times (partially due to the constraints around the COVID-19 outbreak which was unavoidable) as well as pathway challenges. Members were concerned that patients who required second-stage or revision surgeries were placed back at the start of the waiting list, and this often resulted in lengthy delays with no formal time limits for any subsequent surgeries. Members acknowledged the psychological impact this would have on patients. RT highlighted and praised the support, both emotional and physical, the team provided throughout the patient pathway but agreed that extended waiting times were challenging. All Wales Individual Patient Funding (IPFR) Report A request for IPFR updates to include the financial details of approvals. The finance team were undertaking work in this area. IPFR processes were being used to look at small cohort commissioning. Final approval of the All-Wales IPFR policy was anticipated for January 2026, as some Health Boards had yet to present the updated policy to their Boards for approval. The policy was planned to be implemented across Wales in February 2026.
Appendices	

3. ASSESSMENT

Objectives / Strategy	
Dolen i Amcan (au) Strategol CBC **Link to JCC Strategic Objectives(s)**	Maximise Value
	Ensure Quality; Reduce Duplication; Improve Equity & Population Health; Facilitate Integration
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	A Resilient Wales
	A Healthier Wales
Dolen i Hwyluswyr Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / **Link to Enablers of Quality** (Duty of Quality Statutory Guidance (gov.wales))	Leadership
	Culture and Valuing People; Learning, Improvement and Research; Whole-systems Perspective
Dolen i Feysydd Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / **Link to Domains of Quality** (Duty of Quality Statutory Guidance (gov.wales))	Effective
	Efficient; Equitable; Person-centred; Timely; Safe
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *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	Yes: ☒	No: ☒

Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? / **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Outcome for Equality (delete as appropriate): ~~POSITIVE~~/NEUTRAL/~~NEGATIVE~~ Outcome for Welsh Language (delete as appropriate): ~~POSITIVE~~/NEUTRAL/~~NEGATIVE~~	If no, please include rationale below: This is a summary of the latest meeting of the JCC
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Joint Committee as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	Yes (Include further detail below) The performance of the services will be used to develop the IMTP and identify the areas where resources may be required.	

4. RECOMMENDATIONS

The Health Board is asked to:

- **Note** the highlights outlined in Section 3 of this report.

Executive Director Lead: Melanie Wilkey
Commissioning Lead: Amy Lewis
Commissioning Team: Women and Children
Date of last Escalation Meetings: 2/12/25
Date Last Reviewed by Quality Safety, Outcome Committee: 06/10/25

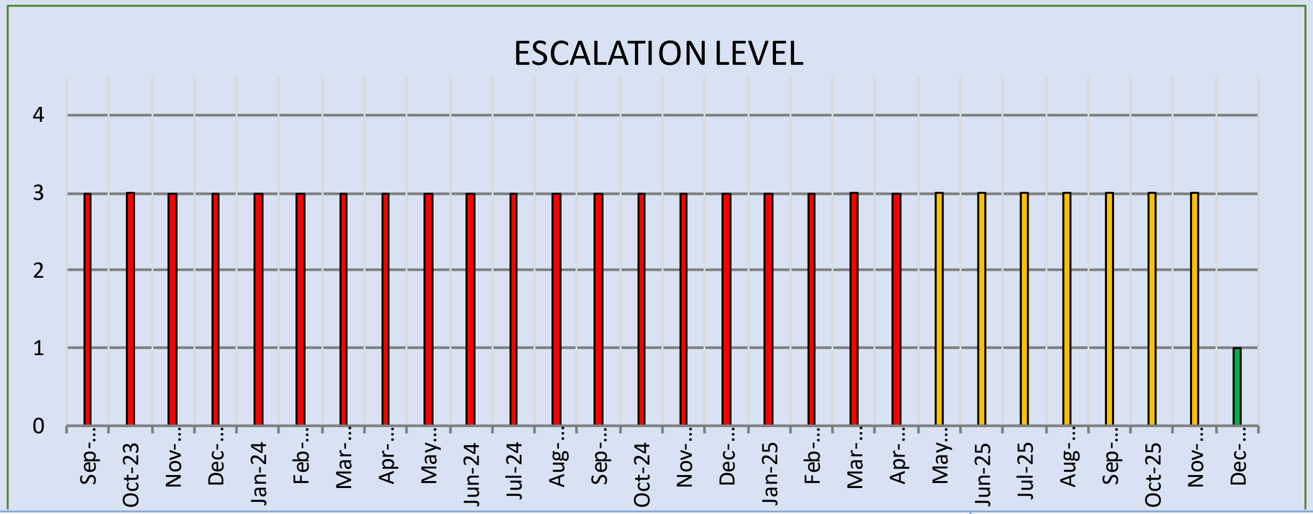
Service in Escalation: Neonatal Intensive Care Unit

Current Escalation Level 1

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↓ December 2025
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
November 2023	**3**

Rationale for Escalation Status:

High levels of cot closures reported across all three levels of care, blood stream infection rates and progress implementing the new cot configuration.

Background Information:

There are currently two risks on the CRAF relating to Neonatal services at Cardiff and Vale UHB, lack of cot availability due to workforce and the service being a negative outlier status for blood stream infections, on the National Neonatal Audit Programme (NNAP). Limited progress has also been made against implementing the workforce required to support the cot configuration.

NWJCC assurance and confidence level in developments:
A Paediatric and Neonatal Escalation Reset Meeting took place on the 18th September 2024 to gain an understanding from the health boards perspective of process made and to identify any outstanding actions. Joint Actions/Objectives and monthly meetings have since been agreed.

15th January and 18th March 20th May 1st July escalation meeting and progress acknowledged. Decision made service to remain at escalation level 3 as more data required ensuring that the improved position is sustained prior to considering de-escalation. Conversations ongoing regarding implementing phase 1, both internally in the JCC and with the health board.

Actions:

Action	NWJCC Lead	Action Due Date	Completion Date
Working with C&V UHB executive team to develop a plan to implement new baseline as all other HBs are in a position to go live	Director of Planning	16th August 2024	See comment in development section
Re-set meeting to discuss and agree actions/objectives in collaboration with the health board	Senior Planning Manager	18th September 2024	18th September 2024
Escalation meeting to discuss detail and progress against action plan (every 6 weeks)	Head of Commissioning	-	2nd December 2025

On 4th September the Cabinet Secretary for Health and Social Care has commissioned an all-Wales assurance assessment of maternity and neonatal services to assess the safety and quality of the services. In addition an internal workshop to discuss Phase 1 progression and funding matters took place on the 22nd October 2025. As a result, a decision was made that the work required to progress the cot configuration assessment as part of the escalation process would be stood down and form part of the National work going forward. An escalation meeting with the service took place on the 2nd December and the dashboard data presented noted that the service was no longer an outlier for neonatal infection nor mortality. As a result the service was de-escalated to level 1 and the Health Board was formally informed on 5/12/25.	
Additional Issues/Risks: May 24 - Through quarterly assurance meetings with all neonatal units in the South & West of Wales it has been reported that there has been increased pressure across the network for cot availability July 24 – Temporary closure of Princess of Wales (PoW) Maternity and Neonatal unit for essential maintenance work from September to December.	

Executive Director Lead: Melanie Wilkey
Commissioning Lead: Emma King
Commissioning Team: Cardiac
Date of Escalation Meetings:
Date Last Reviewed by Quality Safety Outcome Committee: 6/10/25

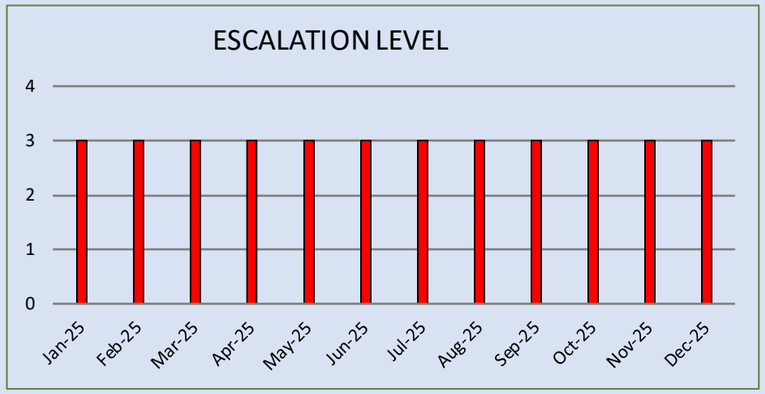
Service in Escalation: Bariatrics

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ December 2025
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
January 2025	**3**

Rationale for Escalation Status :

Update April 2025 – The process for the escalation of the Salford obesity surgery service to Level 3 of the NWJCC Escalation Framework was initiated in December 2024 and endorsed by the NWJCC Senior Leadership Team in January 2025. The service has been subject to formal escalation arrangements due to our long-standing concerns with the obesity surgery waiting list and activity levels.

Background Information:

The process for the escalation of the Salford obesity surgery service to Level 3 of the NWJCC Escalation Framework was initiated in December 2024 and endorsed by the NWJCC Senior Leadership Team in January 2025.

NWJCC assurance and confidence level in developments:

Low - A letter was sent to Salford in February informing them of the escalation and process (with no response being received). A chasing communication was sent by the Director of Commissioning for Specialised Services in April 2025. A follow up letter was sent in September 2025 (from the NWJCC Chief Commissioner) to Salford requesting an urgent response to the escalation letter and confirmation of a named Executive Lead from Salford Royal

Correspondence was received from Salford on 25 September 2025 to serve notice of 6 months on the contract for bariatric services. **Work will progress to look**

Actions:

Action	NWJCC Lead	Action Due Date	Completion Date
Escalation endorsed by SLT	Director of Commissioning	Jan 25	Jan 25
Escalation letter sent to Salford	Director of Commissioning	Feb 25	Feb 25
Follow up email sent to Salford	Director of Commissioning	April 25	April 25
Head of Commissioning for Cardiac has contacted the Commissioning Lead for Obesity Services (Greater Manchester ICB) in NHSE	Head of Commissioning	July 25	July 25

at alternative commissioning options and ensuring patients currently on the waiting list are not adversely affected by this change.	SBUHB to provide service for 15 patients from this catchment area	Head of Commissioning	March 26	March 26
	A follow up letter has been sent to Salford requesting an urgent response to the escalation letter	Director of Commissioning	September 25	September 25
	A letter has been sent to BCUHB informing them of the Salford position.	Director of Commissioning	November 25	November 25
	A formal letter will be sent to the Salford (NCA) requesting a treatment plan for the patients currently on the waiting list; and a further request for the named NCA Executive Lead to continue with NWJCC escalation process.	Director of Commissioning	December 25	December 25
	Explore other commissioning options	Head of Commissioning	December 2025	March 26

Issues/Risks:
September 25 – Notice served by Salford requires alternative provision to be sought before 1st April 2026.

Executive Director Lead: Melanie Wilkey
Commissioning Lead: Krysta Hallewell
Commissioning Team: Neuro sciences

Date of Escalation Meetings: 03/12/25
Date Last Reviewed by Quality Safety Outcome Committee: N/A

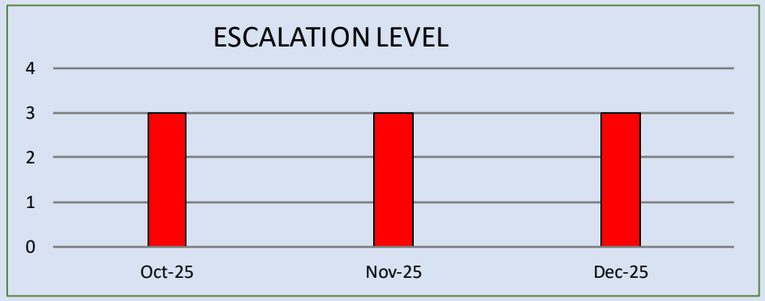
Service in Escalation: Specialist Auditory Implant Device Service

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ December 2025
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
October 2025	**3**

Rationale for Escalation Status : Due to the lack of progress made against the actions monitored through the quarterly Service Performance Management meetings since January 2024, and the RTT position against the specific ministerial target for this patient population, the Neurosciences, Long Term Conditions and Rare Conditions Commissioning Team recommends placing the service into Level 3 - 'Escalated Measures' as the service requires significant action/improvement requiring Executive level input.

Background Information:

The process for 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.

NWJCC assurance and confidence level in developments:

Low - A letter was sent to Cardiff and Vale UHB informing them of the escalation and process. An action plan, trajectory and timescale will be agreed at the initial escalation meeting on the 3rd December 2025.

There has been a delay in arranging the first meeting. The NWJCC wrote to CAVUHB on the 6th October 25, CAVUHB did not confirm their Executive Lead, delays due to CAVUHB availability.

Actions:

Action	NWJCC Lead	Action Due Date	Completion Date
Escalation endorsed by SLT	Director of Commissioning	Oct 25	Oct 25
Escalation letter sent to CVUHB	Director of Commissioning	Oct 25	Oct 25

Issues/Risks:

Executive Director Lead: Adrian Clarke
Commissioning Lead: Joanna Dainton
Commissioning Team: MHLDVG

Date of Escalation Meetings:
JCC/Caswell SLT- 16/10/25, 21/11/25
JCC/SBUHB Exec- 03/10/25, 07/11/25, 20/11/25, 5/12/25
Date Last Reviewed by Quality Safety Outcome Committee: N/A

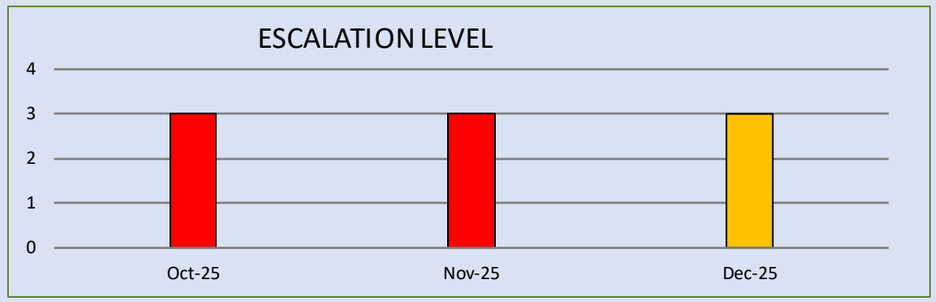
Service in Escalation: Caswell Clinic Medium Secure Unit

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ December 2025
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
October 2025	**3**

Rationale for Escalation Status: Staff and Patient safety issues. Further Quality issues.

A site visit of the facility by NWJCC members in July 2025 identified significant concerns with safety and quality issues. This was reported to the JCC in September 2025 and it was agreed a full service review would be undertaken.
The service review took place between 15th September and 3rd October 2025, assessing service delivery against the recognised quality standards for Medium Secure Units and reviewing individual patients.
The NWJCC review has identified a number of significant safety and quality issues requiring urgent action. Similar issues were identified within a NCCU service review undertaken in November 2022 (1). The NWJCC findings also echo concerns raised within a report produced by an external consultant on the wider Swansea Bay University Health Board Mental Health and Learning Disability Service provision in June 2025 (2) that found provision of safe, effective, respectful, patient centred care was compromised and that performance and leadership structures were not supporting proper oversight of service delivery.

Background Information:

Initial visit to service by Director of Commissioning for MHLDVG and JCC Lay Members raised a number of concerns. Further in-depth review undertaken by JCC MHLDVG review team. Further concerns raised regarding the safety and quality of the service provided at that time. Admissions suspended in order to minimise risk.

Actions:

Action	NWJCC Lead	Action Due Date	Completion Date
Work with SBUHB executive team & Caswell Clinic SLT to develop an action plan to implement mitigating	Director of	8th December	Finalised action plan agreed on 5th

Full report drafted and disseminated to SBUHB Executive team along with Caswell SLT. Service placed in Level 3 Escalation in October 2025 following endorsement by JCC SLT.

NWJCC assurance and confidence level in developments:

Members of the NWJCC met with Swansea Bay Executive Team in early October to share initial concerns, pending production of a full report. In line with the nature of the concerns and NWJCC quality and governance process, the Caswell Service was placed in escalation Level 3. Weekly service improvement meetings will now be held with Caswell Clinic Senior Leadership Team and that monthly meetings will be held with Swansea Bay Health Board Executive Team.

To support the review findings and service improvement, a detailed plan highlighting specific actions required against recognised standards has been produced. Some of these actions require immediate attention and others will be developed over time.
It is recommended that admissions to the unit are paused until the NWJCC and Swansea Bay Executive Board has received reassurance that the urgent safety issues have been resolved.

December 2025-

Final draft of an action plan received; however further detail has been requested. The mitigations required to support a safe service and in order to reopen the service to new admissions has been received from SBUHB via the action plan. Initial focus is on immediate safety concerns with other mitigations for less serious issues following. Escalation level 3 agreed at executive level within the JCC.

actions in order to minimise risks to staff and patients at the service.	Commissioning		December 2025
Weekly escalation meeting with Caswell SLT & JCC DoC and SBUHB Exec lead every fortnight, to discuss and agree progress against actions/objectives	Asst. DoC/DoC	Ongoing	On completion of all actions
Immediate concerns to be addressed by 8th December 2025 followed by review of completed actions by JCC.	Head of Commissioning	8th December 2025	
Suspension for new admissions to the clinic	JCC	Ongoing	Ongoing

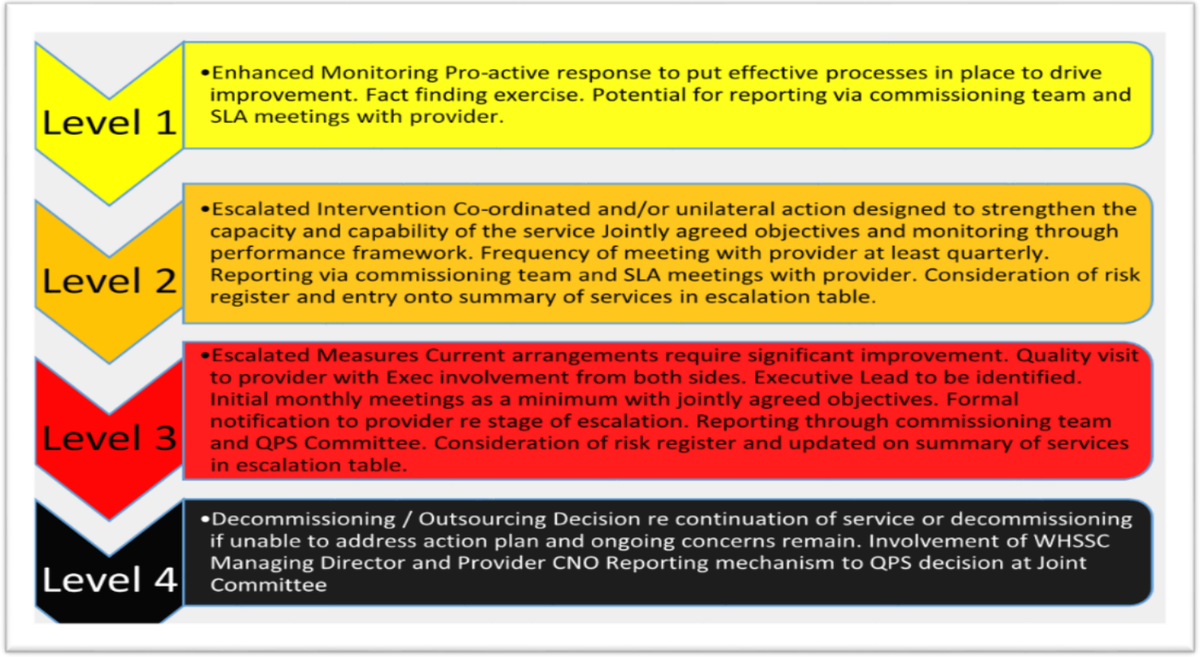
Issues/Risks:

October 25-
Service review raised a number of significant issues that could possibly lead to patient and/or staff safety issues. Following this review, new admissions have been suspended and the service placed in Level 3 escalation.
A number of meetings have been held with JCC and the Service SLT in order to clarify details within the JCC written report and to enable both organisations to come to an agreement on a final action plan which will address immediate, mid- and longer-term issues.

December 25-
Final report and action plan agreed. SBUHB have stated that all immediate concerns that led to admissions being suspended, will have been addressed by 8th December. JCC review team plan to meet with SLT at Caswell clinic on 10th December in order to verify that all mitigating actions are sufficient to reduce identified risks, so that the service can re-open to admissions and escalation level can be reconsidered.

Level 1 ENHANCED MONITORING	Any quality or performance concern will be reviewed by the Commissioning Team. Enhanced monitoring is a pro-active response to put effective processes in place to drive improvement. It is an initial fact finding exercise which should ideally be led by the provider and closely monitored and reviewed by the commissioning team. The enquiry will lead to one of the following possible outcomes: • No further action is required routine monitoring will continue. The concern which raised the indication for inquiry will be logged and referred to during the routine monitoring process to ensure this has not developed any further. • Continued intervention is required at level 1 and a review date agreed. • Escalation to Level 2 if further intervention is required There is the potential for reporting via commissioning team report to Quality Patient Safety Committee and through SLA meetings with provider
Level 2 ESCALATED INTERVENTION	Escalated intervention will be initiated if Level I Enhanced Monitoring identifies the need for further investigation/intervention. There should be a Co-ordinated and/or unilateral action designed to strengthen the capacity and capability of the service. At this stage there should be jointly agreed objectives between the provider and commissioner and monitored through the relevant commissioning team. Frequency of meeting with provider should be at least quarterly and possible interventions will include • Provider performance meetings • Triangulation of data with other quality indicators • Advice from external advisors • Monitoring of any action plans A risk assessment should be undertaken and logged on the Commissioning Team Risk Register. Where appropriate the risk will be included on the JCC Risk Management Framework. Reporting is via commissioning team report to Quality Patient Safety Committee report and SLA meetings with provider. The investigation will lead to on to the following possible outcomes: • Action plan and monitoring are completed within the allocated timeframe, evidence of progress and assurance the concern has been addressed. De-escalation to Level 1 for ongoing monitoring. • If the action plan is not adhered to and further concerns are raised by the Commissioning team or by the provider team or further concerns are identified it may be necessary to move to Level 3 Escalated Measures
Level 3 ESCALATED MEASURES	Where there is evidence that the Action Plan developed following Level 2 has failed to meet the required outcomes or a serious concern is identified a service will be placed in escalated Level 3. At this stage the quality of the service requires significant action/improvement and will require Executive input. In addition to routine reporting through QPS a formal paper will be considered by the JCC Corporate Directors Group (CDG) and an Executive Lead nominated. Formal notification will be sent to the provider re the Level of escalation and a request made for an Executive lead from the provider to be identified. An initial meeting will be set up as soon as possible dependant on the severity of the concern. Meetings should take place at least monthly thereafter or more frequently if determined necessary with jointly agreed objectives. Provider representation will depend on the nature of the issue, but the meetings should ideally comprise of the following personnel as a minimum: • Chair (JCC Executive Lead) • Associate Medical Director - Commissioning Team • Senior Planning Lead – Commissioning Team • JCC Head of Quality • Executive Lead from provider Health Board/Trust • Clinical representative from provider Health Board/Trust • Management representative from provider Health Board/Trust An agreed agenda should be shared prior to the meeting with a request for evidence as necessary. At the conclusion of the meeting a clear timeline for agreed actions will be identified for future monitoring and confirmed in writing if appropriate. Reporting will be through commissioning team to QPS Committee. Consideration of entry on the risk register and summary of services in escalation table for Chairs report to Joint Committee. Consideration to involve and have a discussion with Welsh Government may be considered appropriate at this stage. If there is ongoing concern relating patient care and safety with no clear progress, then further escalation will be required to Level 4. On the other hand, if progress is made through the escalation Level 3 evidence of this should be presented to CDG/QPS and a formal decision made with the provider to de-escalate to Level 2.

Level 4 **DECOMISSIONING/OUTSOURCING**	Where services have been unable to meet specific targets or demonstrate evidence of improvement a number of actions need to be considered at this stage. This stage will require notification and involvement of the JCC Managing Director and CEO from the provider organisation. Both Quality Patient Safety Committee and Joint Committee should be cited on the level of escalation. The following areas will need to be considered, and the most appropriate sanction applied to help resolve the issue: 1. De-commissioning of the service 2. Outsourcing from an alternative provider. This may be permanent or temporary 3. Contractual realignment to take into account the potential need to maintain and agree an alternative provider. Involvement with Welsh Government and the Community Health Council is critical at this stage as often there are political drivers and levers that need to be considered and articulated as part of the decision making. Moving in and out of escalation and between Levels In addition to the Levels described above the process has introduced a traffic light guide within each level. The purpose of this is to help demonstrate the direction of travel within the level. It sets out an approach to help identify progress within the level and lays out the steps required for movement either upwards (escalation) or downwards (de-escalation) through the level. At every stage a red, amber or green colour will be applied to the level to illustrate whether more or less intervention is in place. Red being a higher level of intervention moving down to green. It will also help determine the easing of the escalated measures described and inform movement within the stages of escalation. As the evidence and understanding of the risks from a provider and commissioner become evident decisions can be made to reduce the level of intervention or there may be a need to reintroduce intervention should conditions worsen and trigger the re-introduction of measures if progress is unacceptable. In this way organisations will be able to understand what is being asked of them, progress will be easily identified, and it will help avoid any confusion. It will also help in the reporting to provide assurance that action is being taken to meet the agreed timescales.



SERVICES IN ESCALATION

Level of escalation reducing / improving position

Level of escalation unchanged from previous report/month

Level of escalation increasing / worsening position

Powys Teaching Health Board Glossary (Last updated February april 26)

Acronym	
ADoECP	Associate Director of Estates, Capital & Property
CEO	Chief Executive Officer
DCG	Director of Corporate Governance
DIT	Director of Improvement & Transformation
EMD	Executive Medical Director
ED PH	Executive Director of Public Health
ED P&C	Executive Director of People and Culture
ED PP&C	Executive Director of Planning, Performance and Commissioning
ED FCSS	Executive Director of Finance, Capital & Support Services
ED AHPHSD	Executive Director of Allied Health Professions, Health Sciences and Digital
ED NQW&FH	Executive Director of Nursing, Quality, Women and Family Health
EDPCCMH	Executive Director of Primary Care, Community & Mental Health
ABUHB	Aneurin Bevan University Health Board
AFC	Agenda for Change
AGW	The Auditor General for Wales
AHPs	Allied Health Professionals
ALN	Additional Learning Needs
AO	Accountable Officer
ARAC	Audit, Risk and Assurance Committee
ASM	Accelerated Sustainable Model
AR	Audit Recommendations
APB	Area Planning Board
BAF	Board Assurance Framework
BCUHB	Betsi Cadwaladr University Health Board
BMA	British Medical Association
CAAP	Clinical associate in applied psychology
CAMHS	Child and Adolescent Mental Health Services
CCN	Childrens Community Nursing
CEMT	Chief Executive Management Team
CHC	Continuing Health Care
CIW	Care Inspectorate for Wales
CLIP	Collaborative Learning in Practice

CNO	Chief Nursing Officer
CPD	Continued Professional Development
CPR	Child Practice Review
CRR	Corporate Risk Register
CSP	Clinical Service Plan
CTMUHB	Cwm Taff Morgannwg University Health Board
CV	Curriculum Vitae
CVUHB	Cardiff and Vale University Health Board
CWMPAS	Mid and West Wales Regional Safeguarding Adults Board
CYSUR	Mid and West Wales Regional Safeguarding Children Board
CTC	Care Transfer Co-ordinator
CCOMG	Complex Care Operational Management Group
DATIX	Incident Management System
D&P	Delivery and Performance Committee
DCG	Delivery Co-ordination Group
DGH	District General Hospital
DHCW	Digital Health and Care Wales
DNA	Did not Attend
DNACPR	Do Not Attempt Cardio-Pulmonary Resuscitation
DPA	Data Protection Act
DToC	Delayed Transfer of Care
D2RA	Discharge to Recover and Assess
DST	Decision Support Tool
EASC	Emergency Ambulance Services Committee
EOG	Executive Oversight Group
EOY	End of Year
EMRTS	Emergency Medical Retrieval & Transfer Service
EPMA	Electronic Prescribing and Medicines Administration
ESR	Electronic Staff Record
EMI	Elderly Mentally Infirm
FBC	Full Business Case
FOI	Freedom of Information
FFT	Friends and Family Test
FTE	Full Time Equivalent
F&P	Finance and Performance Committee
GDS	General Dental Services
GIRFT	Getting It Right First Time
GMC	General Medical Council
GMS	General Medical Services
GP	General Practitioner

GNCC	General Nursing Complex Care Team
H&S	Health and Safety
HCA	Health Care Assistant
HCS	Health and Care Standards
HCSW	Health Care Support Worker
HDUHB	Hywel Dda University Health Board
HEIW	Health Education and Improvement Wales
HIW	Healthcare Inspectorate Wales
HP	Health Protection
HPF	Healthcare Professionals Forum
IBG	Investment Benefit Group
ICF	Integrated Care Funding
IEN	Internationally Educated Nurse
IG	Information Governance
IM	Independent Members
IMTP	Integrated Medium Term Plan
IP&C	Infection Prevention and Control
IQPF	Integrated Quality Performance Framework
IQPG	Integrated Quality & Performance Group
IQPR	Integrated Quality Performance Report
IT	Information Technology
JAG	Joint Advisory Group (on Gastrointestinal Endoscopy)
JCC	Joint Commissioning Committee
JD	Job Description
JET	Joint Executive Team
JIPCA	Joint Inspection of Child Protection Arrangements
JLT	Joint Leadership Team (PTHB and PCC)
JR	Judicial Review
KPI	Key Performance Indicator
LoF	League of Friends
LA	Local Authority
LHB	Learning Health Board
LMC	Local Medical Committee
LPF	Local Partnership Forum
LRF	Local Resilience Forum
LTA	Long Term Agreement
MAC	Mindfulness, Acceptance and Compassion Team
MD	Ministerial Direction
MD's	Minimum Data Set

MDTs	Multi-Disciplinary Teams
MEG	Medical E-Governance System
MEG	Main Expenditure Group
MH	Mental Health
MHD	Mental Health & Learning Disability
MIU	Minor Injury Unit
MOU	Memorandum of Understanding
MOA	Memorandum of Agreement
MSK	Musculoskeletal
MV	Mass Vaccination
NHSE	National Health Service England
NHS	National Health Service
NHSWE	NHS Wales Executive
NICE	National Institute of Health and Clinical Excellence
NRI	Nationally Reportable Incidents
NWSSP	NHS Wales Shared Services Partnership
NNA	Nursing Needs Assessment
OBC	Outline Business Case
OCP	Organisational Change Process
OOC	Out of County
OOH	Out of Hours
ORS	Opinion Research Services
OSCE	Objective Structured Clinical Examination
OT	Occupational Therapy
PA	Physician Associate
PADR	Personal Appraisal Development Review
PAVO	Powys Association of Voluntary Organisations
PET CT	Positron Emission Tomography Computed Tomography
PCC	Powys County Council
PEQS	Patient Experience, Quality and Safety Committee
PHE	Public Health England
PHW	Public Health Wales
PMVA	Prevention and Management of Violence and Aggression
PPPH	Planning, Partnerships and Population Health Committee
PSB	Public Service Board
PSOW	Public Services Ombudsman for Wales
PTHB	Powys Teaching Health Board
PTR	Putting Things Right
P&C	People and Culture Committee
QA	Quality Assurance

RaTS	Remuneration and Terms of Service Committee
RCN	Royal College of Nursing
RIIC	Research, Innovation & Improvement Coordination
RIF	Regional Investment Fund
RISP	Radiology Information System Procurement
RJAH	Robert Jones and Agnes Hunt
RN	Registered Nurse
RPB	Regional Partnership Board
RTT	Referral to Treatment
RTS	Routemap To Sustainability
Q1 Q2 Q3 Q4	Quarter 1 (April, May, June), Quarter 2 (July, August, September), Quarter 3 (October, November, December), Quarter 4 (January, February, March)
QSEG	Quality, Safety and Experience Group
SAR	Subject Access Request
SAS	Specialty and Specialist
SBAR	Situation, Background, Assessment, Recommendation
SBUHB	Swansea Bay University Health Board
SDEC	Same Day Emergency Care
SLA	Service Level Agreement
SOC	Strategy Outline Case
SOP	Standard Operating Procedure
SaTH	Shrewsbury and Telford Hospital NHS Trust
SPB	Strategic Programme Board
SRO	Senior Responsible Owner
TaODEC	Tactical Organisation Development, Engagement and Communication
TI	Targeted Intervention
ToR	Terms of Reference
TRAC	Online Recruitment Management System
T&V	Transformation & Value
TUPE	Transfer of Undertakings Protection of Employment
VERS	Voluntary Early Release Scheme
WAST	Welsh Ambulance Services NHS Trust
W&C	Workforce and Culture Committee
WCCIS	Welsh Community Care Information System
WG	Welsh Government
WHC	Welsh Health Circular
WHSSC	Welsh Health Specialised Service Committee
WNB	Was Not Brought
WOD	Workforce and Organisational Development

WPAS	Welsh Patient Administration System
WPOCT	Welsh Point of Care Test System
WRES	Workforce Race Equality Standard
WTE	Whole Time Equivalent
WVT	Wye Valley Trust
YTD	Year to Date