PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE

CONFIRMED MINUTES OF THE MEETING HELD ON 11 FEBRUARY 2025 at 13:00 VIA MICROSOFT TEAMS

MEMBERS		
Kirsty Williams	KWi	Vice Chair (Committee Chair)
Jennifer Owen Adams	JOA	Independent Member (Third Sector)
Ian Thomas	IA	Independent Member (General)
IN ATTENDANCE		
Zoe Ashman	ZA	Interim Assistant Director Women & Children
Katie Blackburn	KB	Llais
Helen Bushell	HB	Director of Corporate Governance / Board Secretary
Lucie Cornish	LC	Director of Improvement and Transformation (for Item 5.7)
Susan Dinsdale	SD	Head of Nursing for Children (for Items 4.1 and 5.7)
Amanda Edwards	AE	Assistant Director Innovation and Improvement
Kate Evans	KE	Women's and Childrens Risk Governance Lead
Pete Hopgood	PH	Executive Director Finance, Capital and Support Services
Louisa Kerr	LK	Assistant Director Mental Health (for Items 5.2 and 5.4)
Elaine Lorton	EL	Executive Director of Primary Care, Community and Mental Health
Claire Madsen	CM	Executive Director of Allied Health Professionals, Health Sciences and Digital
Jacqui Seaton	JS	Chief Pharmacist (for Items 5.5 and 5.6)
Heidi Sinclair	HS	Head of Quality and Safety
Kate Wright	KW	Executive Medical Director
APOLOGIES FOR ABSENCE:		
Carl Cooper	CC	Chair of PTHB Board
Nicola Johnson	NJ	Executive Director of Planning, Performance and Commissioning
Claire Roche	CR	Executive Director of Nursing, Quality, Women and Family Health
Hayley Thomas	HT	Chief Executive
Jayne Wheeler-Sexton	JWS	Assistant Director of Nursing, Safeguarding
Simon Wright	SW	Independent Member

1. PRELIMINARY MATTERS

1.1 WELCOME AND APOLOGIES (PEQS/24/70)

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

1.2 DECLARATIONS OF INTEREST (PEQS/24/71)

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

2. CONSENT AGENDA BUSINESS

The Chair asked members if they wished to bring forward any items from the Consent agenda to the main agenda.

HB advised that the Consent Agenda contained an Internal Audit Report on the Deprivation of Liberty Safeguards which had been received at the Audit, Risk and Assurance Committee (ARAC). Internal Audit Reports are then shared with relevant Committees for information. In the case of this Internal Audit Report ARAC have transferred an action which requests that this Committee monitor implementation of agreed management actions (see Item 3.2). This will be scheduled into the work programme.

No items were raised by Committee Members.

3. ITEMS FOR APPROVAL / DECISION / RATIFICATION

3.1 MINUTES OF PREVIOUS MEETING (PEQS/24/72)

The minutes of the meeting held on 07 November 2024 were **CONFIRMED** as an accurate record.

3.2 COMMITTEE ACTION LOG (PEQS/24/73)

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

- Six actions had been completed and closed
- Two actions were on track
- Four actions have been transferred into this Committee from other Committees:
    - From Planning, Partnerships and Population Health Committee - to agree frequency of updates in relation to antibiotic resistance. KW undertook to meet with the antimicrobial team to confirm a suggested six-month cycle **Action: Executive Medical Director**
    - From Delivery and Performance Committee – to examine how quality is measured in general and community dental services. EL agreed to bring this to the July 2025 meeting. **Action: Executive Director Primary Care, Community and Mental Health**
    - From Audit, Risk and Assurance Committee to monitor implementation of agreed management actions in relation to the Internal Audit Report on Deprivation of Liberty Safeguards. HB undertook to confirm with CR if the report should be presented in April or July 2025. **Action: Director of Corporate Governance**
    - From Delivery and Performance Committee to reflect on quality elements in relation to JAG (Joint Advisory Group on gastrointestinal

endoscopy) accreditation – scheduled for July 2025 meeting. **Action: Executive Director Primary Care, Community and Mental Health**

There appears to be an increasing number of actions from other Committees to this Committee to monitor. Is this a proportionate level of action transfers?
HB advised this was a timely question as the team were undertaking reviews on Committee effectiveness and Terms of Reference alongside work planning. This will be shared at the Joint Chair's Group to ensure a balanced, appropriate risk-based plan for the year.

KWi observed the necessity to consider the particular focus that this Committee has on quality when work planning.

4. ESCALATED ITEMS

4.1 CHILDREN'S NEURODIVERSITY SERVICES (PEQS/24/74)

KW presented the report on behalf of NJ advising that Children's Neurodiversity Services had been put into Level 3 local escalation under the Integrated Quality and Performance Framework in October 2024 after a significant increase in the number of referrals into the service and a number of identified performance and quality concerns namely:

- A continued and consistent failure to meet agreed improvements, including failure to deliver Ministerial Priority measures,
- Performance for Neurodevelopmental assessment continued to fall outside of the lower control limit, with performance flagged as a special cause for concern due to the consecutive decreasing trend.
- Challenge that the Referral to Treatment backlog not resolved as expected.

An Executive Oversight Group was established which first met on 29 October 2024.

An Improvement Plan was agreed with 43 actions of which:

- 15 have been completed
- 9 with progress being made and on track and will be completed within timescale
- 18 with progress being made, action likely to be achieve within timescale
- 1 is significantly behind schedule with no progress made / or progress made but timescale not achieved. This action is being addressed to support job planning with support of an Assistant Medical Director
- All 8 Welsh Government (WG) standards are met within current service delivery model.

Details of focussed actions were outlined as shown in the report along with next steps. KW cautioned that despite the progress made, the position remains challenging.

ZA drew attention to the following:

- a welcome reduction in Did Not Attend rates to below the Welsh average,
- that the week-long multi-disciplinary team focus had been effective,
- that there had been a reduction in long waits for assessment – with no patients now waiting beyond three years, and the intention that no patients

would wait more than two years, although a small number are expected to be waiting over 2 years as of 31 March 2024.

- The intention to have no more than 300 patients waiting over a year will not be met, as the original trajectory only took into account first assessments, not those patients who required more than one assessment. A revised 'committed' target has been calculated to include all patients on the pathway.
- It will be necessary to get to a position where pathways are closed in a timely way, therefore pathways will not be opened until cases are ready to be seen as previously pathways were opened and this resulted in patients waiting years for the pathways to be closed.
- Co-production is working well with monthly evening meetings where the following activity has taken place; a logo for the service has been agreed, a template letter for assessment conclusion agreed, production of literature for 0-5 years and 5-11 years, plans for a digital story in quarter 4, questionnaires for CIVICA agreed, and uniform preferences outlined.

EL left the meeting 13.25

Independent Members asked the following questions for assurance:
Is this a team particularly affected by staff turnover?
SD confirmed that the increasing numbers of staff were reflective of an increase in demand. When the service had been established it was expecting to receive 60 referrals a year, it is now receiving over 60 referrals a month.

Is the service on a trajectory which will lead to de-escalation and what will be required to reach this position given the challenges outlined within the report?
KW advised that de-escalation would be appropriate when the service was able to demonstrate that the systems and processes were in place to enable sustained performance and quality. Improving performance was likely to remain challenging for some time and was linked to resource availability.

To what extent does the service work with the local authority, and are there opportunities to pool resources?
ZA advised that the service worked closely with the local authority who were producing an Additional Learning Needs Strategy during summer 2025 which was an important link to neurodiversity. A shared platform is used to undertake multi-disciplinary team assessments. In addition, the Start Well programme under the Regional Partnership Board had a strong focus on neurodiversity. Mapping of the offer from health, social care and education has been completed to ensure appropriate links are in place, and the co-production work is attended by colleagues from early years and education.

Are there any opportunities for the team to learn from the experience of the Midwifery team who were previously in escalation?
AE advised that a member of the Midwifery Team had previously attended the learning from experience group and consideration will be given to how this experience could be shared with the Neurodiversity Team.

In relation to the one area which is significantly behind schedule (job planning for consultant Paediatricians) what action is being taken to address this?

KW advised that the Assistant Medical Director is working with the Paediatricians to ensure the Job Plans are written.

Can assurance be given that there is an appropriate focus on improvement both in the performance and quality realm?
ZA confirmed a weekly meeting is held with the NHS Executive in relation to the additional funding provided and the team have been explicit that the intention is to shorten pathways, reduce waiting times and to improve the position for new patients as well as those part way through the system.

KB observed that neurodiversity is a priority for Llais and a challenge nationally.

KWi noted that whilst considerable progress had been made, and thanked the team for all their work, there were still a number of families waiting over two years for an assessment and there remained much work to be done to ensure a quality sustainable service was in place.

The Committee:

- **TOOK ASSURANCE** that the implementation of the IQPF Escalation Oversight mechanism is providing robust oversight of the quality improvement and risk mitigation work being undertaken within Neurodevelopmental Services, and
- **NOTED** and **DISCUSSED** the contents of the report and including the action plan and progress report.

4.2 CIVICA – PATIENT EXPERIENCE SYSTEM (PEQS/24/75)

CM presented the report on behalf of CR advising that publication of the Wales Patient Experience Framework was expected imminently ahead of implementation in April 2025. It will be necessary to undertake an assessment of the data held against the data required during March. The team already understand where gaps might be, and it is hoped the appointment of a colleague will enable implementation to be supported.

KWi confirmed this item would remain as an escalated item.

4.3 INFECTION PREVENTION CONTROL (PEQS/24/76)

KWi noted this item was escalated to the Board, however, would be addressed under item 5.1 Integrated Quality Report.

5.ITEMS FOR ASSURANCE

5.1 INTEGRATED QUALITY REPORT (PEQS/24/77)

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

- Concerns management continues to perform well with an average of 80% responded to within 30 days
- Themes of concerns included communication issues, clinical treatment and attitude and behaviour which was disappointing although small numbers of concerns meant caution should be applied to themes
- Duty of candour cases continue to rise as a result of increased awareness, but no redress cases have been triggered
- Incident management are showing a high number of low to medium harm with an increasing number of timely incident closure

- 52% of Nationally Reportable Incidents remain open due to a number of complex mental health cases which take longer to investigate
- In relation to Civica responses it should be noted that some months have low responses, particularly for provider services
- 46 actions have been completed on the Infection Prevention and Control improvement plan with one expected to be completed by February 2025 and one expected to be completed within the planned timeframe
- There remain a small number of outstanding actions from Health Inspectorate Wales (HIW) inspections to complete

EL joined the meeting 13.55

EL advised that HIW were currently undertaking an unannounced inspection of Clywedog Ward.

Members asked the following questions for assurance:
How prepared are the Health Board to take part in single unified safeguarding reviews?
KW advised that a response to this query would be sought and provided to the Committee.
Action: Executive Medical Director

Why is there a dramatic reduction in responses to your NHS experience between June and July 2024?
ZA advised that this related to a data lag when seeking information relating to external providers.

Infection prevention and control is currently escalated from the Committee to Board. What is the process for de-escalating this item?
HB advised that CR was intending to bring a paper to the Executive Committee and then this Committee giving assurance on actions taken in relation to infection prevention and control with a recommendation that the Committee can advise Board that this is de-escalated.

Are the number of overdue nationally reportable incidents (NRIs) proportionate to the size of population the Health Board serves?
KW advised that the small numbers dealt with in the Health Board meant fluctuations were more marked. There were a number of complex mental health cases which took time to investigate.

Is the number of overdue NRIs an early indicator of a deterioration in performance in this area?
KW advised that the team operate in a busy environment but were aware of the need to ensure that these matters were attended to promptly and improve the response times.

The Chair noted that the Committee would monitor the position and would not wish to see a further deterioration in timeliness of responses.

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 ADULT MENTAL HEALTH SERVICES MONITORING POST LOCAL ESCALATION (PEQS/24/78)

LK joined the meeting and presented the Adult Mental Health Services post local escalation monitoring report and drew attention to the following areas:

- In relation to incident management, when the service was escalated in March 2024 there were 480 overdue incidents going back up to two years. This has reduced and stabilised to between 60-100 incidents
- The Nationally Reportable Incident position has improved significantly
- Policy and audit trackers have been prioritised with the most important policies updated first and a system to identify those policies about to go out of compliance
- A review of audits has identified themes for learning including in relation to training
- Senior Management meet quarterly to ensure improvement is sustained and continues to be made

Members asked the following questions for assurance:
Are any of the outstanding overdue incidents from the cohort of overdue incidents that were identified in March 2024, and if so, do they create a particular threat to patient safety or the Health Boards reputation?
LK confirmed that the majority of incidents identified in March 2024 had been investigated and closed, and any that remained open were associated with awaited Coroner findings. The process for investigating incidents had been strengthened and the three teams were working closely to close incidents in a timely manner but also identify incident themes and share learning to make improvements across the service.

Now this service has been de-escalated from local escalation how do the Executive Committee receive assurance that the improvements are sustained and ongoing?
EL advised that Adult Mental Health Services have reported through the usual assurance mechanisms since de-escalation. These mechanisms include a Directorate Management Team which meets monthly to receive assurance on all areas within the Directorate including the financial position, planning and performance, and quality and safety matters. Any items requiring escalation are directed to Executive Committee and onwards to a Board Sub-Committee where appropriate. Within the Mental Health Services division reporting frameworks have been strengthened and aligned to the organisational integrated quality and performance framework to ensure that appropriate information is shared with the Directorate Management Team to provide assurance on the service.

The post escalation period is a potential area of risk as the intense focus on a service area is removed. What actions are being taken to ensure that the investment and attention on this service are appropriate to ensure improvement continues?
EL advised that one of the first challenges as a new Director was to review staffing models to ensure they were appropriate to provide safe, high-quality

delivery. This review is approximately 80% complete and there may be opportunities, particularly within Mental Health and Learning Disability services to make significant spend to save arrangements. It is not anticipated that there will be savings within the operational structure, and it is likely that modest workforce investment will be required to generate a sustainable model.

KW concurred that workforce fragility had led to the need for local escalation and the team were working hard to make substantive appointments. There was also a focus on putting in place strong systems and processes which will help maintain improvements and identify emerging issues much earlier which can be addressed before the service deteriorates.

EL concluded by noting that de-escalation of this service had happened comparatively quickly but rather than meaning the improvements had been concluded, it meant that the team had mitigated to a satisfactory level the issues that had been identified. It will be necessary to substantiate the largely interim staffing arrangements to ensure a sustainable position and that a continuous improvement cycle is embedded.

The Committee:

1. Took **ASSURANCE** that MH&LD Services are maintaining good practice achieved through delivery of the continuous improvement response plan in relation to measures for which they were escalated.
2. **NOTED** and **DISCUSSED** the contents of the report.
3. Took **ASSURANCE** from the ongoing monitoring and evaluation mechanisms in place as part of the Integrated Quality and Performance Framework (IQPF).

LK left the meeting 14.45

5.3 MATERNITY SERVICES ASSURANCE REPORT (PEQS/24/79)

ZA presented the Maternity Services Assurance Report and drew attention to the following areas:

- A low number of formal concerns recorded the majority of which are being managed as early resolutions
- Intrapartum transfer rates remain static which each case being reviewed
- Home birth rates are 9% of all births which is higher than the all Wales rate of 3%
- Regular meetings take place with commissioned service partners
- Cwm Taf Morgannwg have moved maternity services from the Prince Charles Hospital in Merthyr Tydfil to Bridgend. Powys women are able to access care in Hereford as an alternative to Bridgend.
- Monitoring of gap and grow has improved significantly
- Training compliance is 100%
- Improvements have been made to the triage process
- Data quality has improved
- Women's health is getting more complex, and it is necessary to work with obstetric partners to manage increased health needs

Members asked the following questions for assurance:
Is the trajectory for home births in Powys increasing and are Powys mothers encouraged to birth at home?

KE advised that during the period of local escalation the numbers of births in Powys (both home births and in birth centres) decreased but this has increased over recent months as psychological safety of staff has improved and women are empowered to choose where to give birth.

Much improvement is evidenced in the report, what checks and balances are in place to ensure this improvement is sustained?
KE confirmed the Improvement Plan will be renamed the Continuous Improvement Plan which will be amended to include new actions that arise going forward.

Given the financial pressures facing the Health Board, what impact will the workforce review have on maternity service provision?
KE advised that the service is seeking to utilise existing staff in the best way which may involve splitting some roles as not all posts are required to be full time in Powys in this small service.

Given that Powys commission maternity care from a large number of partner organisations, what processes are in place should there be problems in one of the commissioned services?
KE advised that quarterly meetings take place with senior partners in commissioned services where all cases are tracked, and issues can be escalated if necessary.

Have the issues relating to gap and grow compliance been fully resolved?
KE advised that maternity services across Wales were working hard to ensure that arrangements for viewing growth charts when care was shared between providers (including in England) was in place. It is hoped that this issue will be resolved in the coming year.

Given the known issues in ambulance services do Powys maternity services experience problems accessing intrapartum transfers?
KE advised that unexpected transfers do happen for women who decide to birth locally outside of guidelines. However, local midwifes monitor women during and post birth to identify any signs that the women or baby need to be transferred to hospital. Maternity calls trigger an immediate amber call to ambulance services and response times have been monitored and are found to be between 9 and 32 minutes.

The Committee:

- **RECEIVED** the report and took **ASSURANCE** about the quality and safety governance mechanisms in place within maternity services.

JS joined the meeting 15.00

5.4 MENTAL HEALTH POWER OF DISCHARGE ANNUAL REPORT INCLUDING COMPLIANCE WITH LEGISLATION (PEQS/24/80)

LK joined the meeting and presented the Mental Health Power of Discharge Annual Report drawing attention to the following areas:

- No non-compliance was identified in relation to the use of sections of the Act

- Slightly reduced numbers were recorded in comparison to previous years which may be due to a reduced bed base because of environmental works
- A review of length of stay of patients under the Act is in progress
- Trend data had been provided to Committee members
- Police Stations will now no longer be places of safety, in the past year custody has only been used once
- A Health Inspectorate Wales (HIW) inspection of Newtown Community Mental Health Team had a positive outcome although noted a lack of administrative capacity which the service is working to address through the Admin review
- An unannounced inspection is currently taking place on Clywedog Ward

Members asked the following questions for assurance:
What plans are in place for a place of safety when police custody is no longer available?
LK confirmed that not being able to use police custody as a place of safety may result in a delay between assessing a person and finding an appropriate placement. However, police custody is rarely used, and this would not be a common occurrence.

The lack of fundamentally defective detentions is welcomed. What action is being taken to address the minor administrative errors which have been recorded?
LK confirmed that minor administrative errors could be for example spelling a name with an E rather than an A. Checking ensures these errors are picked up quickly and rectified. If errors are more fundamental, then a review meeting would take place with partners, however, these it is rare for fundamental errors to occur.

What plans are in place to encourage take up of Independent Mental Health Advocates (IMHAs)?
LK explained that IMHAs are proactively offered to all patients but take up is low with data available to demonstrate the offer has been made which is shared with the Power of Discharge Committee. The new Mental Health Act will alter the position to ensure that patients must proactively opt to not have an IMHA. This may alter demand for an IMHA, and this will be monitored and reported to the Power of Discharge Committee.

The HIW Inspection report for Newtown notes a lack of administrative capacity. What actions are being taken to address this finding?
LK noted there was one Mental Health Administrator post and with the increase in demand in the service, capacity and cover was an issue. Cover arrangements are in place, but further capacity is required to enable resilience in the service. A job description has been through job evaluation and will now go through the recruitment authorisation process.

The Committee:
- **RECEIVED** the report and took **ASSURANCE** that the performance of the service in relation to the administration of the Mental Health Act 1983 has been compliant with legislation.

LK left the meeting 15.20

5.5 MEDICINES MANAGEMENT ANNUAL REPORT (PEQS/24/81)

KWi welcomed JS to the meeting noting this was JS' last meeting before retirement. KWi thanked JS for all the work she had undertaken in this area and wished her well for the future.

JS presented the Medicines Management Annual Report and drew attention to the following areas:

- Electronic prescribing and Medicines Administration (EPMA) has been implemented in Builth Wells, Llandrindod Wells, Presteigne and Knighton and will be starting in Rhayader, Ddyfi Valley, Ystradgynlais and Llanfyllin after April 2025.
- Electronic prescribing for hospital services (wards and outpatients) will be rolled out in early summer starting in the South Cluster area then out to the rest of Powys
- The Medicines Safety Officer works with the Community Pharmacy Service to share learning from medicine safety incidents across the organisation
- Opportunities to take efficiencies from the medicines budget are continually sought for example via windfall savings when drugs come off patent. A team member uses Power BI which primary care can always refer to for up-to-date information on prescribing and comparative prescribing data between practices
- Workforce pressures continue to be prevalent with difficulties recruiting in North Powys and to pharmacy posts with mental health specialisms. Opportunities to train existing team members could be considered
- Access to wider data needs to be improved, for example when in discussions with practices in relation to antimicrobial activity, access to admission for infection data would help provide a full picture
- 56-day prescribing remains a challenge with 79% of Powys patients registered with a dispensing practice who will not move to 56-day prescribing
- Work is ongoing to improve arrangements in relation to high-cost prescribing

Members asked the following questions for assurance:
What progress is being made in reducing inappropriate prescribing?
JS noted that central messages from Welsh Government in relation to inappropriate prescribing would be of great help to Health Boards, but these have not been forthcoming. The team write letter templates for practices to use when items are deemed inappropriate (for example removing bath and shower emollients). The 'easy' items have been removed, and it is time to tackle those items that people have been receiving for a long time and do not want to change. The formulary is being strengthened and made more user friendly, and clinicians are encouraged to use it.

What will the new Chief Pharmacist need to focus on in their first 100 days?
JS recommended a focus on finance and the efficiency plan, then windfall savings, such as in relation to a particular drug that has recently come off patent and could save £0.5m a year. However, dispensing practices have a dispensing deal and this is a challenge for the Health Board.

The Committee:

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

5.6 ANNUAL REPORT OF ACCOUNTABLE OFFICER FOR CONTROLLED DRUGS (PEQS/24/82)

JS presented the report which was taken as read.

The Committee:

- **RECOGNISED** the progress that has been made during the last 12 months **NOTING** that there is further work required to strengthen some arrangements across the health board and through collaborative working with partners., as outlined in the report.
- Took **ASSURANCE** that future actions have been identified to address the further work.

JS left 15.40

5.7 TRANSITION OF CARE ANNUAL REPORT 2023/24 (PEQS/24/83)

ZA presented the report and drew attention to:

- This was the 2023/24 report which had been delayed with the 2024/25 report expected to the July meeting of the Committee. Apologies were offered for the late production of the report and bi-annual updates were offered on this item
- An Oversight Group is in place to manage and oversee transitions across all services from age 14 onwards
- A gap analysis has been undertaken and submitted to Welsh Government. The gaps and challenges identified are being addressed including working with commissioned colleagues

KWi observed the late production of the report noting the Committee expected timely production of Annual Reports. Members agreed to receive the Transition of Care Annual Report 2024/25 to the July meeting of the Committee and review the frequency that this item should be monitored at this time.
Action: Director of Nursing, Quality, Women and Family Health

Members asked the following questions for assurance:
How does the service work with schools in the area of transition, including in relation to the ALN act which covers young people up to the age of mid 20s?
ZA advised there is a quarterly in-house monitoring meeting, and a bi-monthly multi-disciplinary complex case meeting including social care and education. It should be noted that complex case numbers are not large.

The Committee:

- **RECEIVED** and took **ASSURANCE** against the progress being made across the Health Board in relation to Welsh Government Transition and Handover Guidance (2022).

5.8 COMMITTEE RISK REGISTER (PEQS/24/84)

HB presented the report advising that the Corporate Risk Register had been taken to Board in January 2025. Two risks fall under this Committee:

- Risk 004: Increase in demand, inequality of access, complexity of patient needs, or failure to respond to demand pressures for PTHB provided

services results in poorer outcomes and experience for the citizens of Powys, and
- Risk 005: Increase in demand, inequality of access, complexity of patient needs, or failure to respond to demand pressures for commissioned services results in poorer outcomes and experience for the citizens of Powys. Commissioned services may include urgent and emergency health and social care system.

Both risks are owned by the Executive Director of Planning, Performance and Commissioning and there has been no change in the risk scoring.

The Committee:
- **RECEIVED** and **DISCUSSED** the corporate risks within the Committee's remit and any relevant issues
- **TOOK ASSURANCE** that risks are being managed in line with the Risk Management Framework.

6. ITEMS FOR DISCUSSION

There were no items for discussion

7. CONSENT AGENDA

7.1 INTERNAL AUDIT REPORTS (PEQS/24/85)

The Committee **RECEIVED** the Internal Audit Report on Deprivation of Liberty Safeguards which had been received by the Audit, Risk and Assurance Committee on 14 January 2025. This internal audit had reported Limited Assurance, and the Audit, Risk and Assurance Committee had requested that the Patient Experience, Quality and Safety Committee monitor progress against recommendations (Action ARAC/24/75).

The Committee also received the Board and Committee Effectiveness Internal Audit which had received Substantial Assurance for information.

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

7.2 WORK PROGRAMME (PEQS/24/86)

The Committee **RECEIVED** the Committee Work Programme as of February 2025.

8. OTHER MATTERS

8.1 ANY OTHER URGENT BUSINESS (PEQS/24/66)

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/24/67)

It was noted that the Chair would provide updates on those items escalated to Board.

8.2 COMMITTEE REFLECTION (PEQS/24/68)

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

- A challenging meeting due to a number of staff absences, thanks were recorded to those colleagues who had covered for absent staff members
- The detail presented at Committees is wide ranging and consideration may need to be given to the level of detail that is provided, however, it is likely it will be needed given the remit of the Committee
- Without being complacent good progress is being made in some areas which should be noted
- The Committee provides an opportunity to challenge the organisation where problems are identified and monitor progress to address any such issues
- Transitions is an area that Llais receives concerns on, and the Transitions Annual Report gave insight into the work ongoing in this area
- The questions raised were all relevant providing honest communication and scrutiny. It is clear Committee Members have read and understood the papers and are able to question colleagues on what the information presented means for the people of Powys. The meeting felt inclusive and functional.

8.3 DATE OF NEXT MEETING (PEQS/24/69)

The date of the next meeting is scheduled on 29 April 2025 at 10.00 in Machynlleth. Microsoft Teams.

Meeting closed at 16.00