PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE

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

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

1. PRELIMINARY MATTERS

1.1 WELCOME AND APOLOGIES (PEQS/25/58)

The Chair welcomed everyone to the meeting. Apologies for absence were received as recorded above.
The newly appointed Executive Director of Nursing, Quality, Women and Family Health (PHo) was welcomed to the meeting.

1.2 DECLARATIONS OF INTEREST (PEQS/25/59)

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

2. CONSENT AGENDA BUSINESS

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

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

3. ITEMS FOR APPROVAL / DECISION / RATIFICATION

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

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

3.2 COMMITTEE ACTION LOG (PEQS/25/61)

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

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

The change of date requests were accepted.

Independent Members asked the following questions for assurance:
Should the Committee be concerned that a number of actions have been requested for deferral, and what is driving the delays?
HT acknowledged the substantial concern regarding the position in relation to open actions and undertook to complete an assessment of the position against reporting requirements to be brought to the next meeting.
Action: Chief Executive

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

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

4. ESCALATED ITEMS

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

CMo joined 09.35

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

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

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

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

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

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

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

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

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

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

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

The Committee:

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

CMo left 10.13

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

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

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

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

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

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

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

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

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

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

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

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

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

The Committee:

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

5.ITEMS FOR ASSURANCE

5.1 INTEGRATED QUALITY REPORT (PEQS/25/64)

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

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

Duty of Candour and Redress

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

Incident Management

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

National Reportable Incidents (NRIs)

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

Framework and Governance

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

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

Infection Control and ANTT (Aseptic Non-Touch Technique)

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

Regulatory and External Engagement

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

Quality Improvement and Future Planning

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

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

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

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

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

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

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

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

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

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

5.2 MATERNITY ASSURANCE REPORT (PEQS/25/65)

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

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

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

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

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

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

The Committee:

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

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

JL joined the meeting 11.45

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

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

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

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

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

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

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

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

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

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

JL left 12.05

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

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

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

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

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

The Committee:

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

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

JB joined the meeting 12.10

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

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

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

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

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

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

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

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

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

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

Independent Members asked the following questions for assurance:

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

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

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

5.7 COMMITTEE RISK REGISTER (PEQS/25/70)

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

The Committee

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

6. ITEMS FOR DISCUSSION

There were no items for discussion

7. CONSENT AGENDA

7.1 INTERNAL AUDIT REPORTS (PEQS/25/71)

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

7.3 WORK PROGRAMME (PEQS/25/72)

The Work Programme was **RECEIVED.**

8. OTHER MATTERS

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

There were no items of any other business.

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

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

8.3 COMMITTEE REFLECTION (PEQS/25/75)

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

- SW was commended for chairing his first meeting effectively, managing time well despite a packed agenda.

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

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

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

8.5. CONFIDENTIAL MATTERS

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

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

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

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

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

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

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

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

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

Meeting closed at 12.43