PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE

CONFIRMED MINUTES OF THE MEETING HELD ON 31 JULY 2025 at 09:30 VIA MICROSOFT TEAMS

MEMBERS		
Kirsty Williams	KWi	Vice Chair (Committee Chair)
Mick Giannasi	MG	Independent Member (General)
Jennifer Owen Adams	JOA	Independent Member (Third Sector)
IN ATTENDANCE		
Zoe Ashman	ZA	Assistant Director Quality and Safety
Helen Bushell	HB	Director of Corporate Governance / Board Secretary
Tracey Coombe	TC	Llais (until 10.30)
Carl Cooper	CC	Chair of PTHB Board
Amanda Edwards	AE	Assistant Director Innovation and Improvement
Nilufa Hossain	NH	Assistant Medical Director Quality and Safety and Clinical Governance
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	CM	Executive Director of Planning, Performance and Commissioning (for Item 4.1)
Claire Roche	CR	Executive Director of Nursing, Quality, Women and Family Health
Heidi Sinclair	HS	Head of Quality and Safety
Aime Symes	AS	Director of Midwifery, Women and Family Health
Hayley Thomas	HT	Chief Executive
Jayne Wheeler-Sexton	JWS	Assistant Director Safeguarding (to 10.18)
Kate Wright	KW	Executive Medical Director
APOLOGIES FOR ABSENCE:		
Katie Blackburn	KB	Regional Director of Llais
Nicola Johnson	NJ	Executive Director Planning, Performance and Commissioning
Ian Thomas	IA	Independent Member (General)
Chris Walsh	CW	Independent Member (Local Authority)
Simon Wright	SW	Independent Member (University)

1. PRELIMINARY MATTERS

1.1 WELCOME AND APOLOGIES (PEQS/25/28)

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

1.2 DECLARATIONS OF INTEREST (PEQS/25/29)

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

1.3 PATIENT STORY (PEQS/25/30)

ZA read out 'Our Birth in Powys', the story of Emily, Luke and Baby Eswen which KWi noted drew attention to the challenges and unpredictability faced by a Midwife led service in a rural community. Thanks were expressed to the family for sharing their story.

2. CONSENT AGENDA BUSINESS

The Chair 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.

3. ITEMS FOR APPROVAL / DECISION / RATIFICATION

3.1 MINUTES OF PREVIOUS MEETING (PEQS/25/31)

The minutes of the meeting held on 29 April 2025 were **CONFIRMED** as an accurate record.

3.2 COMMITTEE ACTION LOG (PEQS/25/32)

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

- PEQS/24/83c (a report on General Dental Services to be presented to the Committee in July) – request to defer to October 2025
- PEQS/24/83 (Transition of Care Annual Report) – request to defer to October 2025.

The change of dates were accepted, with KWi noting that be no further extension requests would be accepted in relation to the Transitions of Care Annual Report. CR gave an assurance that this item would be presented to the October meeting.

Verbal updates were given for the following items:

- PEQS/24/52b (a review of the Integrated Quality and Performance Framework) This had been presented to Board in May and was therefore COMPLETE
- PEQS/25/08 (details of funding for Neurodevelopmental Services). To be considered after item 4.1 on the agenda
- PEQS/24/11a (key performance indicators to be included relating to Nationally Reportable indicators in the Integrated Quality Report). It was confirmed these are included in the Integrated Quality Report and was therefore COMPLETE
- PEQS/25/11b (Powys specific data from the Medical Examiner Service to be included in the Integrated Quality Report). KW confirmed that this data had not

been available for the July meeting and requested a date change to October. Item DEFERRED

- PEQS/25/12 (Clinical Audit Programme to include detail on assurance routes for reporting). KW advised Clinical Audit is evolving rapidly and this would be addressed in more detail in the July 2026 Clinical Audit Programme. A date change to July 2026 was requested. Item DEFERRED.
- PEQS/25/15 (updates from Service Groups to be included in the Integrated Quality Report). The Integrated Quality Report includes updates from Service Groups. Item COMPLETE

Independent Members asked the following questions for assurance:
There appears to be an unusually high number of open actions for this Committee, what is the reason for this?
KWi advised that the Committee receive a number of actions from other Committees to monitor, and have requested additional information on a number of areas. It may be timely to reflect on the appropriateness of the additional requests.

HB confirmed that this Committee along with Finance and Performance Committee carry the heaviest loads and this is being analysed and will be considered in the Chairs' Forum.

3.3 SAFEGUARDING ANNUAL REPORT (PEQS/25/33)

JWS presented the report which provided a comprehensive overview of safeguarding activity at local, regional, and national levels, highlighting achievements, challenges, and priorities.

Independent Members asked the following questions for assurance:
Are the safeguarding team making internal changes to manage increasing complexity and volume without additional resources?
JWS advised the safeguarding team had matured significantly over the past five years. Although no additional resources had been allocated, the team had been redesigned to better meet increasing demands. Succession planning and staff development had been prioritised, and team members had been exposed to regional and national safeguarding networks. This approach had enabled delegation of responsibilities and enhanced resilience within the team.

Were there any changes planned for 2025–26 that differed from previous years to improve agility and expertise?
JWS advised that the team had planned to use data trends, such as the rise in neglect, to shape future safeguarding priorities. A pilot of a neglect toolkit in collaboration with the local authority had been initiated to address emerging needs. The team had also focused on building resilience through safeguarding supervision and cross-organisational exposure.

Was there a different or more innovative way to deliver Level 3 safeguarding training to improve compliance?
JWS advised the safeguarding team had recognised the need for more creative approaches to training. They had proposed using podcasts, YouTube videos, and

newsletters to support learning. Staff were encouraged to reflect on their practice and use daily experiences to demonstrate compliance, moving beyond traditional training sessions.

How was the safeguarding team addressing the challenge of low compliance in Adult Level 3 safeguarding training?
JWS advised that whilst child safeguarding training had reached over 75% compliance, adult safeguarding remained at 49%. The team had identified that half of the non-compliant staff had completed the training but had not finalised their e-passports. This insight had guided targeted follow-up and support.

How was the safeguarding team managing differences in "Was Not Brought" policies across Welsh and English borders?
JWS confirmed that the newly launched "Was Not Brought" guidance was a Welsh national document, and Health Board had contributed significantly to its development. Whilst the guidance did not apply to across the border in England, the team had maintained strong links with English safeguarding boards and held regular meetings to share learning and address cross-border issues.

How was the safeguarding team supporting staff when referrals were rejected?
JWS noted staff were encouraged to escalate concerns through internal processes. The safeguarding team had committed to supporting such challenges and had maintained open communication with the local authority to ensure mutual understanding of thresholds.

The Patient Experience, Quality and Safety Committee **APPROVED** the Annual Safeguarding Report for 2024/25.

JWS left the meeting 10.18

3.4 DUTY OF QUALITY ANNUAL REPORT (PEQS/25/34)

CR presented the report which demonstrated the Health Boards maturity in deploying and reporting on its duty of quality. It reflected how quality is embedded across the organisation, not only annually but also through the quarterly Patient Experience, Quality and Safety Committee updates.

TC left the meeting 10.28

Independent Members asked the following questions for assurance:
Are the charts on page 18 of the report duplicates?
ZA confirmed this would be checked and amended if necessary, prior to publication of the final report.

Is there sufficient context for patient experience data in relation to the 1,147 responses received?
CR noted that the People's Experience Framework would support maturity in this area.

How will improvements in mental health services be sustained following escalation?
CR and HT explained that the IQPF and Executive oversight mechanisms were designed to ensure sustainability, with plans to revisit lessons learned one year after de-escalation.

How is learning from duty of candour incidents shared across the organisation?
CR highlighted the importance of systematic learning and referenced the 'SHARE' (Speak up, Hear, Act, Respect and Empower) initiative as a visual tool to support this effort.

What is the People's Experience Framework and how will it be used?
CR explained that a self-assessment was underway across all services to identify strengths and gaps. The framework would support systematic engagement and learning from patient experiences.

How will community engagement be improved?
CR confirmed that this was a priority and would be embedded within the People's Experience Framework and the Integrated Quality Report going forward.

The Duty of Quality Annual Report 2024/25 was **APPROVED**.

3.5 MENTAL HEALTH SERVICES ACT HOSPITAL MANAGERS POWER OF DISCHARGE GROUP TERMS OF REFERENCE (PEQS/25/35)

KWi introduced the report advising minor clarifications and amendments had been suggested to the Terms of Reference.

Independent Members asked the following question for assurance:
Given the importance of the decisions being made to both the individual and society does a mechanism existed to review, test, and ensure consistency and equality across different discharge panels?
KWi suggested the inclusion of reference to a commitment to organisational learning within the Terms of Reference and EL undertook to examine how to enable the organisation to provide assurance of the appropriateness and consistency of panel decisions.

The Committee **DISCUSSED** and **APPROVED** revised Terms of Reference and Operating Arrangements for the Mental Health Act Power of Discharge Group, as sub-Group of the Patient Experience, Quality and Safety Committee, subject to the inclusion of reference to organisational learning as outlined above.

3.6 COMMITTEE GOVERNANCE ACTION PLAN (PEQS/25/36)

HB introduced the report outlining that the Committee Governance Action Plan was presented for approval, following recent discussions within the Committee and at Board level. It focused on two priority areas, patient voice and organisational learning, rather than attempting to document every action. The plan would be monitored through the Chairs' Forum and embedded into the agenda to ensure implementation.

The Committee **RECEIVED** the Committee Continuous Development Plan 2025-26 and took **ASSURANCE** that the implementation of continuous development actions will be monitored throughout the year as a key principle of good corporate governance.

4. ESCALATED ITEMS

4.1 CHILDREN'S NEURODIVERSITY SERVICES (PEQS/25/37)

CMo joined the meeting 10.47

CMo presented the report advising that the Executive Team had acknowledged the substantial progress made in the Children and Young People Neurodevelopmental Service but clarified that the service remained under Level 2A escalation. This decision aligned with the annual planning cycle, where it had been agreed to maintain current performance rather than pursue further improvement, allowing for strategic engagement with national funding discussions.

Independent Members asked the following questions for assurance:
What does "no change to maturity assessment" mean, and how could the Committee be assured that internal processes were sufficiently mature and sustainable?
CR advised that the maturity assessment was not an exact science but a cautious self-evaluation. Although there had been significant improvements in systems and processes, cultural transformation required more time. The internal escalation process was designed to address specific remedial actions rather than deliver widespread transformation. Overestimating maturity would be premature and that the service was still in the midst of cultural development.

Is it correct that the standard waiting time for a neurodevelopmental assessment was two years?
CMo confirmed that the two-year (104-week) wait was the minimum standard set by Welsh Government across Wales. The service was actively working to reduce this through phase two of the improvement programme, supported by a business case submitted to the Investment and Benefits Group. Improvement trajectories were being developed to assess capacity needs and reduce waiting times.

Was there any information available regarding the quality of interactions with children and young people who had been seen, beyond the numerical data?
KWi noted the request for this information to be included in future reporting.
Action: Executive Director of Planning, Performance and Commissioning

What methods are being used to triangulate the self-assessment process underpinning the maturity matrices. Was there any peer review or external challenge involved to ensure that the assessments were not solely based on internal perceptions?
CR responded that the team had been liaising with the national NHS Performance and Improvement team, which provided an opportunity for external challenge and peer review. This engagement was intended to act as a critical friend to support the robustness of the self-assessment process. KW added that internal peer review had also been strengthened, with decisions now being made through a multidisciplinary team format, which had not previously been the case.

It is noted that the maturity matrix had not shifted, is this due to capacity issues? Have the service got the right staffing levels and personnel in place, or is this yet to be resolved?
CR confirmed that capacity remained a key issue and was central to the business case being developed. The aim was to secure continued financial support and investment to stabilise the team, moving away from reliance on temporary or fixed-term funding.

KW added that rising demand had made it difficult to assess actual capacity needs, but recent work had improved confidence in the systems and processes, helping to clarify future capacity requirements.
HT also noted that funding and capacity were part of ongoing national discussions and that all health boards were facing similar challenges.

The improvements in triage and the reduction in acceptance rates are welcomed. Can assurance be given that children who genuinely needed services are not being excluded?
CR explained that the Health Board was working in partnership with the local authority and education system to ensure that children not requiring medical intervention still received appropriate support or signposting. This collaborative approach was essential for meeting the diverse needs of children and families.

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** from the ongoing monitoring and evaluation mechanisms in place as part of IQPF.
4. **NOTED** that the recommendation that the service is de-escalated to Level 2a was approved by the Executive Committee on 23 July 2025.

CMo left the meeting 11.16

4.2 PEOPLE EXPERIENCE FRAMEWORK UPDATE (PEQS/25/38)

KWi noted this item was escalated to the Board, however, would be considered under item 5.1 Integrated Quality Report and confirmed this item would remain as an escalated item.

5.ITEMS FOR ASSURANCE

5.1 INTEGRATED QUALITY REPORT (PEQS/25/39)

CM joined the meeting 11.21

CR introduced the report which covers April to June (Quarter 1) and drew attention to the following areas:

- Compliance is recorded as above 75% in responding to concerns, with recent improvements.
- Graph 2 shows an average response time of 29 days for formal concerns; other Welsh organisations respond faster, highlighting a need for improvement in timeliness.
- Graph 3 indicates strong early resolution performance, with only one concern reopened in the past 14 months.
- Section 2.3 discusses duty of candour cases, noting a slight decrease compared to the same period last year, with 29 cases currently open and emerging themes identified.
- Section 2.5 presents incident data by severity, but many incidents lack a severity value. This is flagged as a key issue.
- Three internal audit reports are referenced:
    - One on quality and safety governance, which received reasonable assurance and offered recommendations for improving the report format.

- One on the people's experience framework, introducing the SHARE initiative and plans for a network of champions.
- One on Mattresses which received Limited Assurance. An action plan is in place to address the findings which will be monitored via the clinical service group to completion and ongoing monitoring
- The report includes service updates from women's and children's services, community services, and mental health.
- Two key matters for the attention of the Committee:
  - The issue of incidents with no attributed severity value.
  - A planned organisation wide self-assessment using existing resources and promoting collective ownership.

Independent Members asked the following questions for assurance:
Is the breakdown of data by individual groups significant, should it be a cause for concern?
CR advised that the breakdown marked the beginning of a shift towards collective ownership across service areas. The integrated quality report was primarily authored by the quality and safety team, but the goal was for relevant sections to be owned by respective service groups. This would be achieved through improved reporting structures and maturity in data handling.

Is the organisation gaining full value from Civica and is the data was being used effectively to drive improvements? Why is the June data missing?
ZA explained that although Civica had been implemented earlier, the organisation had only recently appointed a People's Experience Lead who was now actively interrogating the data and sharing feedback with services. The People's Experience Framework was being developed, and improvements were expected in the coming months.

What problem the organisation was trying to solve regarding incidents recorded with no value?
CR clarified that the issue was being flagged to alert the committee (not for immediate action) as all incidents should be recorded with a harm value, whether no harm, low, moderate, or severe. HS was managing the improvement process, and updates were being provided to teams regularly. The matter was a priority and would be tracked through integrated quality and performance group
HS advised that this would be reported to the Committee via the quarterly Integrated Quality Report.

What progress is being made in reducing antimicrobial usage? Should the organisation be acting more urgently given the potential risks.?
KW explained that an Antimicrobial Stewardship Pharmacist had been appointed and was actively implementing measures to improve prescribing practices. The issue was complex but expressed confidence that improvements would be seen as the Pharmacist's plan was put into action.

Can the organisation sustain its improved performance in responding to complaints?
CR responded that although there had been a slight dip below the 75% compliance target earlier in the year, this was due to small numbers and the disproportionate

impact of complex cases. Performance had improved steadily over the past three and a half years and that benchmarking response times against other organisations was helping to maintain focus and drive further improvement.

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 COMMITTEE RISK REGISTER (PEQS/25/40)

HB presented the report which was based on the newly developed Strategic Risk Register considered at Board on 30 July 2025. Two risks are assigned to the Committee relating to Commissioning and Provider Services.

Independent Members asked the following question for assurance:
How will the newly introduced risk register be applied in practice within Committee settings? How might it influence agenda planning, paper content, and scrutiny responsibilities, and how could Independent Members effectively enact the register in their roles?
HB advised that risk management was both a technical and cultural process. The Risk Register served as a central tool to consolidate direction, actions, and assurances, enabling transparent tracking and reporting. Its value lay in how senior leaders actively managed risks day-to-day. The Risk Register would inform agenda and work programme planning, with assurance drawn from a range of reports.

Might a Board Development session on the risk register be useful for Independent Members?
HB supported the idea of a Board Development session.
Action: Director of Corporate Governance

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

5.3 UPDATE ON JAG (JOINT ADVISORY GROUP ON GASTROENTESTINAL ENDOSCOPY) ACCREDITATION (PEQS/25/41)

EL updated the Committee on the status of JAG accreditation for endoscopy services. The accreditation had been lost in November 2024 due to a lack of appropriate medical leadership, previously provided via a Service Level Agreement with Cwm Taf Morgannwg UHB, which did not meet JAG standards. A local consultant had since been appointed in June to fulfil the leadership role, with plans underway to transition this into a substantive post. The service continued to perform well, with no breaches beyond eight weeks and positive feedback from a recent assessment of bowel screening. A re-accreditation visit was scheduled for November 2025, and the team remained optimistic about a successful outcome.

5.4 MONITOR IMPLEMENTATION OF MANAGEMENT ACTIONS FOR DEPRIVATIONS OF LIBERTY STANDARDS INTERNAL AUDIT REPORT (PEQS/25/42)

CR presented the report noting that the Internal Audit report which had been brought to the Committee due to limited assurance rating, included six recommendations. One of the actions has already been completed, while the remaining five are partially complete, primarily due to dependencies on the business case and the appointment of the DoLS coordinator, both of which are now progressing. All actions are in place and advancing, even though some timelines have shifted.

Independent Members asked the following question for assurance:
When are the partially completed actions likely to be completed?
CR advised that as soon as the appointed individuals started in post the actions could be completed, and this was likely to be within the next two months.

The Committee took **ASSURANCE** on the progress made within the Action Plan aligned to the Limited Internal Audit report on Deprivation of Liberty Safeguards.

5.5 CLINICAL AUDIT PROGRAMME ANNUAL REPORT 2024/25 (PEQS/25/43)

KW presented the report noting that the majority of the audits had been completed with a few withdrawn, paused or rolled forward. The Powys Audit Hour had proved successful and would continue to take place. Clinical audit was evolving, and a formal review was planned before the next planning round to clarify which audits were clinical and subject to this reporting process and what other routes were available to report on non-clinical audits. HB would be asked to advise with governance arrangements.

CM advised that the incomplete audits in audiology and podiatry resulted from severe staffing challenges which were being addressed. A decision had been taken to prioritise national audits.

Independent Members asked the following questions for assurance:
Has the impact of the Powys Audit Hour been evaluated?
KW acknowledged that formal evaluation had not taken place but would be considered, potentially led by the Learning from Experience Group. Informally, shared feedback had been positive, with benefit being seen in bringing together small, and sometimes siloed staff groups.

Why has the Adult Community Mental Health Team audit been deferred to 2025/26?
KW and EL advised that for those items which noted a deferral it would be necessary to bring an update on the Clinical Audit Programme to Committee.
Action: Executive Medical Director

What has led to the deferrals?
EL advised that there were two elements to this matter, firstly were the audits being undertaken as business as usual, and secondly the collation of the report to Committee. There had been some confusion as to what was required for the report. This was being addressed and should improve going forward.

The Committee took **ASSURANCE** that the 2024-25 Clinical Audit programme has been delivered subject to the updates to be provided via the action above.

5.6 INFECTION PREVENTION AND CONTROL (IPC) ANNUAL ASSURANCE REPORT (PEQS/25/44)

CR presented the report highlighting its increased maturity and key achievements for 2024–25, including progress on the IPC improvement plan and a reduction in C. difficile infection rates. The MEG audit system was outlined as a valuable tool for IPC audits and noted the inclusion of antimicrobial stewardship and decontamination as core IPC functions. There is a need to expand IPC's reach across services including primary care and dental.

Despite capacity challenges, the IPC team's efforts were praised, and the IPC steering group were formally thanked, especially Estates and Facilities colleagues, for their proactive support in maintaining environmental cleanliness.

Independent Members asked the following questions for assurance:
Do the Executive Team feel satisfied with the maturity of the culture across the health board, specifically, whether all staff, from clinical to support roles, were consistently prioritising IPC in their daily work?
CR responded that while there is more assurance now than two years ago, due to the IPC improvement plan and strengthened monitoring mechanisms, achieving a widespread culture of collective ownership remains an ongoing challenge. Recent audits showed areas for improvement, such as environmental cleanliness and mattress hygiene, and there was a need for timely tracking and leadership development within clinical areas to sustain progress.

Having seen through this meeting occasional pockets of non-compliance (such as the mattress audit), what can be done at a strategic level to foster a culture of compliance, and personal responsibility?
CR advised that the team has recently discussed how to improve visibility and accountability, including conducting unannounced joint visits where they reviewed note keeping, medicines management, IPC practices, and spoke directly with patients. There was a need to avoid a culture of fear, instead promoting readiness and local ownership. Building a culture of compliance is a shared leadership responsibility across the organisation and requires a more proactive, strategic approach.

HT emphasised the importance of addressing compliance culture across the organisation, referencing the mattress audit as a signal of broader issues. The need for clear leadership roles and accountability at all levels was highlighted. Targeted conversations are underway to reinforce this. It is important to identify compliance hotspots and patterns across sites. Ongoing work to strengthen professionalism and standards was taking place and there was a need to provide further assurance to committees.

CM acknowledged the need to be able to rely on staff to meet the required standards and as clinical and professional leads to set the appropriate standards. A standardised checklist is being devised to use for visits in consultation with the unions.

The Committee took **ASSURANCE** from the contents of the Infection, Prevention and Control annual report that the Health Board is fulfilling its responsibilities.

5.7 ELECTRONIC PRESCRIBING AND MEDICINES ADMINISTRATION (EPMA) SYSTEM UPDATE (PEQS/25/45)

KW presented the report outlining the project was progressing well. It has been difficult to quantify monetary benefits, but the quality improvements were significant and are expected to enhance services, particularly in areas like antimicrobial stewardship, prescribing visibility, and polypharmacy management. The project is seen as a key enabler for other initiatives, generating excitement across teams. However, challenges include staff turnover, largely due to late confirmation of Welsh Government funding, resulting in reliance on fixed-term contracts. Despite this, all roles are currently filled. From next year, the project will transition to business-as-usual funding, supported by an Investments and Benefits Group case. A minor correction was noted in the rollout chart. December should not show a gap, and a continuous rollout is planned to accelerate progress. Training is underway over the summer, with rollout to inpatient wards starting in Q3, followed by outpatient areas in the next phase.

Independent Members asked the following questions for assurance:
What will happen to the project when the funding ceases in March 2026?
KW advised that the project was designed to support inpatient rollout, and additional funding would be sought to support outpatient rollout.

Has a baseline been measured to enable benefits realisation to be calculated?
KW highlighted that a substantial amount of work was done for the original business case submitted to Welsh Government, including financial efficiency modelling. Although the projected monetary benefits appear low, there is a strong belief that the actual impact will be greater.

CM confirmed that a benefits realisation documentation process was part of the original submission and measuring will take place once the system is in place.

HT added that given this was a national programme, there would be an overall evaluation from a national perspective.

The Committee:
1. Took **ASSURANCE** from the progress made
2. **NOTED** the upcoming milestones and intended benefits.

6. ITEMS FOR DISCUSSION

There were no items for discussion

7. CONSENT AGENDA

7.1 INTERNAL AUDIT REPORTS (PEQS/25/46)

The Committee **RECEIVED** the following Internal Audit Reports
- Pharmacy Stores (Reasonable)
- Quality, Safety and Governance (Reasonable Assurance)
- Business Continuity Planning (Substantial Assurance)
- Risk Management (Reasonable Assurance)
- Mattresses Final Report (Limited Assurance)

which had been received by the Audit, Risk and Assurance Committee on 13 May, 17 June and 08 July 2025.

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

7.3 JOINT COMMISSIONING COMMITTEE QUALITY PATIENT SAFETY COMMITTEE (PEQS/25/47)

The Committee **RECEIVED** the Joint Commissioning Committee Quality Patient Safety Committee Highlight Report from the meeting held on 20 May 2025.

7.3 WORK PROGRAMME (PEQS/25/48)

The Work Programme was **RECEIVED.**

8. OTHER MATTERS

8.1 ANY OTHER URGENT BUSINESS (PEQS/25/49)

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/25/50)

It was noted that the Chair would provide updates on those items escalated to Board including the de-escalation of Neurodevelopmental Services to level 2a.

8.3 COMMITTEE REFLECTION (PEQS/25/51)

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

- KWi noted this was CR's last meeting and thanked her for the visible progress that had been made during her time with the Health Board.
- CC noted that this was KWi's last meeting and thanked her for fostering an environment of robust scrutiny as Chair of the Committee.
- Having the meeting the day following July Board was not sustainable. The summer 2026 Committee date to be reviewed.
-

8.4 DATE OF NEXT MEETING (PEQS/25/52)

The date of the next meeting is scheduled on 23 October 2025 via Microsoft Teams.
Meeting closed 12.50.

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		
Kirsty Williams	KWi	Vice Chair (Committee Chair)
Mick Giannasi	MG	Independent Member (General)
Jennifer Owen Adams	JOA	Independent Member (Third Sector)
IN ATTENDANCE		
Zoe Ashman	ZA	Interim Assistant Director Women & Children
Carl Cooper	CC	Chair of PTHB Board
Amanda Edwards	AE	Assistant Director Innovation and Improvement

Paul Hanna	PH	Head of Mental Health Nursing
Nilufa Hossain	NH	Assistant Medical Director Quality and Safety and Clinical Governance
Elaine Lorton	EL	Executive Director of Primary Care, Community and Mental Health
Louisa Kerr	LK	Assistant Director Mental Health and Learning Disabilities
Claire Madsen	CM	Executive Director of Allied Health Professionals, Health Sciences and Digital
Claire Roche	CR	Executive Director of Nursing, Quality, Women and Family Health
Hayley Thomas	HT	Chief Executive
Kate Wright	KW	Executive Medical Director
APOLOGIES FOR ABSENCE:		
Helen Bushell	HB	Director of Corporate Governance / Board Secretary
Ian Thomas	IA	Independent Member (General)
Chris Walsh	CW	Independent Member (Local Authority)
Simon Wright	SW	Independent Member

8.6 WELCOME AND APOLOGIES FOR ABSENCE (PEQS IC/25/53)

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

8.7 DECLARATIONS OF INTEREST (PEQS IC/23/54)

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

KWi noted she was a Co-Director of Powys Samaritans which was recorded in her declaration.

8.8 MINUTES OF THE IN-COMMITTEE MEETING HELD ON 29 APRIL 2025 (PEQS IC/25/55)

The minutes of the In-Committee meeting held on 29 April 2025 were **APPROVED**.

8.9 BRIEFING ON SUICIDES (PEQS IC/25/56)

Rationale for item being held in private: Contains matters for which the discussion public would be likely to prejudice the effective conduct of public affairs.

That Committee **NOTED** the contents of this report and took **ASSURANCE** from the mechanisms in place on a multi-agency basis to work collaboratively to deliver suicide prevention and postvention activity.

8.10 ANY OTHER BUSINESS (PEQS IC/25/57)

There was no other business.

Meeting closed at 13.33