



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd
Addysgu Powys
Powys Teaching
Health Board

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE

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

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

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

1. PRELIMINARY MATTERS

1.1 WELCOME AND APOLOGIES (PEQS/26/28)

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

1.2 DECLARATIONS OF INTEREST (PEQS/26/29)

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

1.3 PATIENT STORY (PEQS/26/30)

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

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

Independent Members asked the following questions for assurance:

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

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

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

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

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

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

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

HB advised that

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

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

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

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

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

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

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

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

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

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

Action: Executive Medical Director

3. ESCALATED ITEMS

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

CMo joined 09.57

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

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

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

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

Independent Members asked the following questions for assurance:

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

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

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

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

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

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

The Committee:

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

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

CMo left 10.19

4. ITEMS FOR APPROVAL RATIFICATION / ASSURANCE

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

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

4.2 COMMITTEE ACTION LOG (PEQS/26/34)

HB presented the action log noting the following updates:

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

Independent Members asked the following questions for assurance:

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

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

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

The Committee:

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

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

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

Independent Members asked the following questions for assurance:

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

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

The Committee:

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

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

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

Independent Members asked the following questions for assurance:

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

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

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

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

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

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

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

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

The Committee:

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

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

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

Independent Members asked the following questions for assurance:

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

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

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

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

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

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

The Committee:

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

4.6 INTEGRATED QUALITY REPORT (PEQS/26/38)

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

Independent Members asked the following questions for assurance:

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

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

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

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

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

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

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

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

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

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

The Committee:

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

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

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

Independent Members asked the following questions for assurance:

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

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

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

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

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

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

The Committee:

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

4.8 MATERNITY SERVICES (PEQS/26/40)

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

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

Independent Members asked the following questions for assurance:

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

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

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

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

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

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

The Committee:

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

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

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

Independent Members asked the following questions for assurance:

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

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

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

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

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

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

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

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

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

Independent Members asked the following questions for assurance:

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

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

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

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

What actions are being taken to address these future challenges?

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

The Committee:

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

4.11 NURSE STAFFING LEVELS (PEQS/26/43)

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

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

Action: Director of Corporate Governance

Independent Members asked the following questions for assurance:

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

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

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

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

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

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

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

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

The Committee:

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

4.12 QUALITY MANAGEMENT SYSTEM (PEQS/26/44)

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

RBW made the following observations:

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

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

Independent Members asked the following questions for assurance:

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

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

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

5. ITEMS FOR DISCUSSION

There were no items for discussion

6. CONSENT AGENDA (PEQS/26/45)

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

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

7. OTHER MATTERS

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

There were no items of any other business.

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

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

7.3 COMMITTEE REFLECTION (PEQS/26/48)

The following reflections were provided by members:

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

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

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

The date of the next meeting is scheduled on 15 October 2026 via Microsoft Teams.

Meeting closed 13:22.

7.5 CONFIDENTIAL MATTERS

The following motion was passed:

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