PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE

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

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

1. PRELIMINARY MATTERS

1.1 WELCOME AND APOLOGIES (PEQS/25/81)

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

1.2 DECLARATIONS OF INTEREST (PEQS/25/82)

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

1.3 PATIENT STORY (PEQS/25/83)

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

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

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

2. CONSENT AGENDA BUSINESS

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

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

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

3. ITEMS FOR APPROVAL / DECISION / RATIFICATION

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

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

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

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

3.2 COMMITTEE ACTION LOG (PEQS/25/85)

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

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

Two items had been transferred to other Committees or Fora:

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

The remaining actions were either not due or completed.

The change of date requests were accepted.

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

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

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

4. ESCALATED ITEMS

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

CMo joined 09.35

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

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

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

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

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

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

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

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

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

The Committee:

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

CMo left 10.13

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Committee:

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

5.ITEMS FOR ASSURANCE

5.1 INTEGRATED QUALITY REPORT (PEQS/25/88)

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

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

Independent Members asked the following questions for assurance:

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

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

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

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

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

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

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

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

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

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

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

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

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

5.2 MATERNITY ASSURANCE REPORT (PEQS/25/89)

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

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

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

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

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

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

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

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

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

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

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

The Committee:

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

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

JL joined the meeting 11.15

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

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

Independent Members asked the following questions for assurance:

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

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

The Committee:

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

JL left the meeting 11.35

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

JB joined the meeting 11.35

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

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

Independent Members asked the following questions for assurance:

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

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

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

The Committee:

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

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

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

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

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

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

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

JL and AE left 11.55

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

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

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

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

The Committee

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

5.6 COMMITTEE RISK REGISTER (PEQS/25/94)

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

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

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

Independent Members asked the following questions for assurance:

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

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

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

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

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

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

Action: Director of Corporate Governance / Board Secretary

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

The Committee

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

6. ITEMS FOR DISCUSSION

There were no items for discussion

7. CONSENT AGENDA (PEQS/25/95)

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

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

8. OTHER MATTERS

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

There were no items of any other business.

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