



**POWYS TEACHING HEALTH BOARD  
EXPERIENCE, QUALITY & SAFETY COMMITTEE**

**CONFIRMED**

**MINUTES OF THE MEETING HELD ON THURSDAY 1 OCTOBER 2020  
VIA MICROSOFT TEAMS**

**Present:**

Melanie Davies	Vice-Chair (Committee Chair)
Trish Buchan	Independent Member (Committee Vice-Chair)
Frances Gerrard	Independent Member
Susan Newport	Independent member

**In Attendance:**

Alison Davies	Executive Director of Nursing and Midwifery
Carol Shillabeer	Chief Executive
Claire Madsen	Director of Therapies and Health Sciences
Clare Lines	Assistant Director Commissioning Development
Elaine Matthews	Audit Wales
Jamie Marchant	Executive Director of Primary, Community & Mental Health
Jayne WheelerSexton	Assistant Director of Nursing Safeguarding
Julie Rowles	Director of Workforce, OD and Support Services
Paul Buss	Medical Director
Rani Mallison	Board Secretary
Rebecca Collier	Relationship Manager, Health Inspectorate Wales
Wendy Morgan	Assistant Director of Quality and Safety

**Apologies for absence:**

None

**Committee Support:**

Holly McLellan	Senior Administrator/Personal Assistant to Board Secretary
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EQS/20/58	<b>WELCOME AND APOLOGIES FOR ABSENCE</b> The Committee Chair welcomed Members and attendees to the meeting, and CONFIRMED there was a quorum present.
EQS/20/59	<b>DECLARATIONS OF INTERESTS</b> No interests were declared.
EQS/20/60	<b>UNCONFIRMED MINUTES OF THE EXPERIENCE, QUALITY AND SAFETY COMMITTEE MEETING HELD ON 30 July 2020</b> The minutes of the previous meeting held on 30 July 2020 were AGREED as being a true and accurate record.
EQS/20/61	<b>MATTERS ARISING FROM PREVIOUS MEETINGS</b> No matters arising were declared.
EQS/20/62	<b>COMMITTEE ACTION LOG</b> The Committee received the action log and the following updates were provided.  The Board Secretary noted that all actions positions are as reported, none are due in the immediate future. The Board Secretary raised that all actions had been deferred due to COVID-19 and identified as not for immediate action however issues around estates have been identified.  The Committee Chair raised that moving forward a revision of the action log would be beneficial.  The Committee Vice Chair raised that EQS/19/89 infection control of visiting clinicians should be prioritized for follow-up. The Assistant Director of Quality and Safety responded EQS/19/89 was being followed up on by the Quality and Safety team. The Medical Director confirmed their support in resolving EQS/19/89.
<b>ITEMS FOR APPROVAL/RATIFICATION/DECISION</b>	
EQS/20/63	<i>There are no items for inclusion in this section.</i>
<b>ITEMS FOR DISCUSSION</b>	
EQS/20/64	<b>SAFEGUARDING</b> <b>a) ANNUAL REPORT 2019-20</b>

	<p>The Assistant Director of Nursing Safeguarding presented the previously circulated paper which provided an overview of the PTHB Safeguarding Annual Report 2019/20 to the Experience, Quality and Safety Committee.</p> <p>The Assistant Director of Nursing Safeguarding advised that the Annual Safeguarding Report outlined the key areas of development and achievement which have supported PTHB to meet its statutory responsibilities in safeguarding the people of Powys during 2019/20. Additionally, areas for improvement and recommendations for further development in the forthcoming year are highlighted.</p> <p>The Committee Vice-Chair acknowledged that compliance was improving and queried what level of assurance could be taken that as an organisation PTHB was fulfilling its responsibilities. The Assistant Director of Nursing Safeguarding responded that significant work had been undertaken to ensure the terms of reference displayed how PTHB was meeting statutory responsibilities. Over the next 12 months a good level of assurance would be provided.</p> <p>The Committee Vice-Chair thanked the Assistant Director of Nursing Safeguarding and asked for confirmation that PTHB would be in a stronger position next year. The Assistant Director of Nursing Safeguarding responded noting that the current position is strong however identified the presentation as the key issue. Progress was being made to make it more robust and to highlight gaps.</p> <p>The Committee Chair noted that the focus had been more robust since the appointment of the Assistant Director of Nursing Safeguarding.</p> <p>The Committee Chair raised the importance of improving the visibility of safeguarding and assurance. The Committee Chair offered to discuss with the Executive Director of Nursing and Midwifery and return findings to the Experience, Quality and Safety Committee.</p> <p><b>Acton: Committee Chair and Executive Director of Nursing and Midwifery.</b></p> <p>The Committee Chair queried the Independent Members on if they felt they had been receiving enough information.</p>
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	<p>The Committee Vice Chair responded that the IMs do receive enough information and the Clinical Quality Framework would provide a full circle view.</p> <p>The Committee NOTED and DISCUSSED the paper and thanked the Assistant Director of Nursing Safeguarding.</p> <p><b>b) EXPERIENCE STORY</b></p> <p>The Assistant Director of Nursing Safeguarding presented the previously circulated experience story which captured a conversational interview with a looked after child performed by a Childrens Nurse who wanted to establish the effects of COVID-19 on a looked after children.</p> <p>The Assistant Director of Nursing Safeguarding advised that there were 246 Powys looked after children spread across 10 Children’s Homes. 155 are from Powys the others are brought into Powys. The Assistant Director of Nursing Safeguarding also noted that the PTHB expressed pride for the contribution made by the Looked After Child and Care Workers.</p> <p>The Committee Chair noted that the experience story demonstrated resilience, maturity and how the pandemic had changed our society.</p> <p>The Executive Director of Nursing and Midwifery raised that effects on children was one of the categories of harm from COVID-19. It was beneficial that there had been opportunity to look at the wider issues in relation to COVID-19 such as the experience story.</p> <p>The Director of Therapies and Health Sciences queried whether it would have been possible to use the experience story as part of the publicity campaign.</p> <p>The Committee Chair queried if a follow-up could be had to find out how the young person was and if they would be interested in sharing their up to date views. The Committee Vice-Chair noted that it was important to keep the young person’s wellbeing the priority. It should be considered if a higher profile would be appropriate. The Assistant Director of Nursing Safeguarding responded that the young person was well and kept in touch with the Children’s Nurse. The</p>
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	<p>young person had given consent for their story to be part of a newsletter. The Assistant Director of Nursing Safeguarding would make contact through the appropriate channels to confirm whether the young person would be willing to talk to PTHB again.</p> <p><b>Action: The Assistant Director of Nursing Safeguarding.</b></p> <p>The Executive Director of Primary, Community &amp; Mental Health commended the Experience Story as having been very powerful.</p> <p>The Medical Director noted that the sentiments of the Experience Story are unlikely to be isolated. Mental health of young people should be taken into account, key areas include how safe exercise could be used to help with individuals mental health.</p> <p>The Committee Vice Chair raised that similar sentiments were identified in the Farmers Meeting and queried whether work could be undertaken through charitable funds. The Chief Executive responded that this is scheduled to be discussed in board development in December. The Chief Executive offered to circulate information gathered by the World Health Organisation on COVID-19 impacts on mental health. Mental health would also feature in Board's response to the winter protection plan.</p> <p>The Committee thanked the Assistant Director of Nursing Safeguarding and NOTED the Experience Story.</p>
EQS/20/65	<p><b>COMMISSIONING ASSURANCE REPORT</b></p> <p>The Assistant Director Commissioning Development presented the previously circulated paper which highlighted to the Experience, Quality and Safety Committee any providers in Special Measures or scored as Level 4 under the PTHB Commissioning Assurance Framework. It also provided an update in relation to Shrewsbury and Telford Hospitals NHS Trust and other key issues.</p> <p>The Assistant Director Commissioning Development advised that the report highlighted providers in Special Measures or scored as Level 4 at the July 2020 PTHB Internal Commissioning Assurance Meeting (ICAM), which</p>

was then considered at the Delivery and Performance Meeting on the 20<sup>th</sup> August and 15<sup>th</sup> September 2020 at the Quality and Governance Group. There has been an issue with the synchronisation of meetings, so this report also contains information received after those dates. There are:

- 4 providers with services in Special Measures
- 1 provider at Level 4

The report provides an update on a number of serious matters, particularly:

- Shrewsbury and Telford Hospitals NHS Trust (SaTH)
- Accelerated system change affecting South Powys
- and the deteriorating position in relation to referral to treatment times (RTT) times.

The Assistant Director Commissioning Development raised that Worcestershire had come out of special measures since the report was submitted. The final version of the risk-based plan would be brought forward and would need to interfacing with the improvement plan within SaTH. The Assistant Director Commissioning Development noted concerns that a lower peak would be would be more difficult to manage. The situation had deteriorated since the report was submitted. The Assistant Director Commissioning Development raised it would be important to differentiate between risk stratification and harm review.

The Committee Chair thanked the Assistant Director Commissioning Development for a clear report.

Susan Newport queried the staffing arrangements if field hospitals were used. The Assistant Director Commissioning Development responded that staffing arrangements was a key point taken to Welsh Government. Staffing and maintaining community services would help people stay out of hospital. The Assistant Director Commissioning Development apologised for not being able to provide a solution and noted these are NHS wide problems. An advantage in PTHB would be to keep primary and community care strong.

Frances Gerrard noted there was little option other than field hospitals however a staffing logistics system would need to be developed. Frances Gerrard raised that without

	<p>extra capacity PTHB would not be able to provide some services during winter 2020. The Director of Workforce, OD and Support Services responded that there was no evidence that the Grange University Hospital was drawing staff from PTHB. PTHB had a temporary staffing unit to fill roles when staff were off sick. If a department was running understaffed it was escalated through appropriate channels.</p> <p>The Chair queried if anything further could be done to provide assurance. The Assistant Director Commissioning Development responded that there is assurance in midwifery. The adversity of COVID-19 had provided opportunities such as repatriation of services and good practice had been noted. There was a significant amount of risk in managed PTHB commissioned services such as growing waiting times, risks are being identified.</p> <p>The Committee Chair queried if it would be necessary to escalate to Board. The Chief Executive responded that it had been escalated to Board and it would be entirely appropriate for further discussion to be had at Board Development, and by a committee to ensure people are seen appropriately and in the right time frames. Detailed scenarios were being constructed on winter pressures. On wider specialties where pre COVID-19 pressure existed new solutions would need to be developed. PTHB could use this as an opportunity for improvement.</p> <p>The Medical Director raised that 'choose wisely' would be a good basis for a value programme in Powys.</p> <p>The Committee DISCUSSED the commissioning assurance report.</p>
EQS/20/66	<p><b>SERIOUS INCIDENTS AND CONCERNS REPORT</b></p> <p>The Executive Director of Nursing and Midwifery presented the previously circulated paper which provided the Experience, Quality and Safety Committee with a summary of patient experience and concerns, including complaints, patient safety incidents and claims for July 2020. The report also outlines serious incidents reported to Welsh Government and Her Majesty's Coroner's enquiries that have been received by the health board.</p>

	<p>The Executive Director of Nursing and Midwifery advised that the data depicted within the report is taken from the Datix system, unless otherwise specified, and is correct at the time it was taken from the system. The data quality and confidence are subject to limitations of the current Datix system, which is subject to change as part of the Once for Wales Concerns Management System initiative, currently due for implementation by April 2021.</p> <p>The Committee Vice Chair raised that in incident reporting, the Datix system is fundamental to our understanding of concerns raised on the front line. Incorrect completion of Datix is concerning as there had been a number of initiatives to improve correct documentation. The Committee Vice Chair queried what new tactics had been developed to improve to improve completion of Datix. The Board Secretary responded that the committee had received briefings on the Once for Wales concerns management systems. The implementation of a planned approach would be instrumental in shaping a cultural shift moving forward.</p> <p>The Director of Workforce, OD and Support Services noted there was a full programme infrastructure to initiate the cultural elements improvement. The Director of Workforce, OD and Support Services raised that there was policy work to be discussed and picked up outside of Experience, Quality and Safety Committee. <b>Action: The Director of Workforce, OD and Support Services.</b></p> <p>The Committee Chair raised that the Experience, Quality and Safety Committee would need to be sighted on the policy work.</p> <p>Frances Gerrard queried if Datix was to be superseded with a newer system. The Board Secretary responded that it would be a new system for the same provider as Datix.</p> <p>Frances Gerrard raised that Datix had had a bad track record which created significant resistance. The Executive Director responded that there had been issues on how Datix had been configured and reconfigured by PTHB therefore PTHB must take responsibility where the problem has been self-caused. The quality of PTHB data goes into</p>
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	<p>make better quality decisions meaning this upgrade would be an important opportunity.</p> <p>The Committee Chair thanked the Executive Director of Nursing and Midwifery for the paper which the Committee NOTED and DISCUSSED.</p>
EQS/20/67	<p><b>INSPECTIONS AND EXTERNAL BODIES REPORT</b></p> <p>The Assistant Director of Quality and Safety presented the previously circulated paper which provided the Experience, Quality &amp; Safety Committee with an update on the most recent Regulatory Inspections undertaken and any planned inspections the health board has been notified of.</p> <p>The Assistant Director of Quality and Safety advised that PTHB is constantly striving to continue to make improvements in response to recommendations made following such inspections and ensure any learning is shared widely. The monitoring and management of the Health Inspectorate Wales (HIW) electronic tracking tool, previously implemented by the Clinical Governance Team, has recently been handed over to the Quality and Safety Team, who will maintain the tracker, and develop means to close completed improvement plans with HIW.</p> <p>The Committee Vice Chair noted improvement in the environmental health inspections of hospital kitchens. The Committee Vice Chair queried on the Health Inspectorate Wales (HIW) tracker were all inspections being tracked or just HIW. The Assistant Director of Quality and Safety responded that work is being undertaken to ensure all inspections are picked up on. A more robust overall tracker would be required going forward.</p> <p>The Committee Chair thanked the Assistant Director of Quality and Safety and the Committee NOTED and DISCUSSED the paper.</p>
EQS/20/68	<p><b>MENTAL HEALTH ACT COMPLIANCE &amp; POWERS OF DISCHARGE REPORT</b></p> <p>The Executive Director of Primary, Community &amp; Mental Health presented the previously circulated paper which provided the committee with assurance that Powys</p>

	<p>Teaching Health Board is compliant with the legal duties under the Mental Health Act 1983 (MHA). Referencing the most recent quarterly management information and activity data in relation to the Hospital Managers' scheme of delegated duties under the MHA including amendments (section 23), the report demonstrates the activity undertaken regarding admissions and other related arrangements.</p> <p>This report is not to be considered as a performance report as the data and activity cannot be viewed in that way. This report summarises the activities pertaining to the use of Mental Health Act within Powys Teaching Health Board services in the reporting period and summarises the compliance with the Act accordingly.</p> <p>The Executive Director of Primary, Community &amp; Mental Health advised that the report provides assurance in respect of the work that has been undertaken during the reporting period that those functions of the Mental Health Act 1983 (the Act), which have been delegated to officers and staff under the policy for Hospital Managers' Scheme of Delegation are being carried out correctly and that the wider operation of the Act across the Health Board area is operating within the legislative framework.</p> <p>The Committee Chair noted, in the last paper results from interviews showed 3/6 patients said they were not provided with advocacy. The Committee Chair queried if the report could include a section on advocacy and if patients were aware of it.</p> <p>Frances Gerrard queried the deaths of detained patients. The Executive Director of Primary, Community &amp; Mental Health responded that there was one death which was being investigated as a Serious Untoward Incident currently, the patient would not be identified for patient confidentiality reasons. The Executive Director of Primary, Community &amp; Mental Health offered to provide further information in an Experience, Quality and Safety In-Committee meeting.</p>
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	<p>The Committee Chair thanked the Executive Director of Primary, Community &amp; Mental Health for the paper and the Committee NOTED the contents of the report.</p>
EQS/20/69	<p><b>STAFF WELL-BEING AND ENGAGEMENT REPORT</b></p> <p>The Director of Workforce, OD and Support Services presented the previously circulated paper which provided the Experience, Quality and Safety Committee an update on staff well-being and engagement.</p> <p>The Director of Workforce, OD and Support Services advised the wellbeing and engagement of staff is a key strategic priority for PTHB and has been an integral part of the IMTP for a number of years. Immediately prior to COVID-19 emerging as a significant risk, PTHB were externally assessed against the Corporate Health standards and successfully maintained its Gold level status.</p> <p>The report provides an update on actions taken by the health board in response to the new and emerging issues created by COVID-19 and the support provided to staff during the past 6 months.</p> <p>The Committee Chair thanked and congratulated the Director of Workforce, OD and Support Services for a comprehensive report and for upkeeping statutory and mandatory training. The director of workforce, OD and Support Services responded that in keeping up to date on Personal Appraisal and Development Reviews (PADRs) it is hoped PTHB will be able to respond quickly and proactively to staff needs.</p> <p>The Committee Vice Chair noted the paper was easy to understand and focused.</p> <p>The Committee NOTED and DISCUSSED the paper.</p>
EQS/20/70	<p><b>INFORMATION GOVERNANCE QUALITY REPORT</b></p> <p>The Board Secretary presented the previously circulated paper which provided the Experience, Quality and Safety group with assurance on the quality of key information governance aspects.</p>

	<p>The Board Secretary advised that the paper had been developed to provide an assessment against key information governance (IG) quality indicators.</p> <p>The Committee Vice Chair queried if information sharing protocols in key areas such as safeguarding were in place. The Board Secretary responded that an overview could be brought forward however normally they are taken forward on a risk-based basis.</p> <p>The Committee Vice Chair queried if information sharing protocols would be in place between organisations. The Board Secretary responded that the Wales Information Sharing protocol covers elements of this.</p> <p>The Chief Executive raised the duty to cooperate and share information to the benefit of patients. Where information was shared even with no agreed protocol in place it can be justified where there was an overriding benefit to the patient. Information sharing in situations where safeguarding was a concern had been brought to the attention of PTHB.</p> <p>The Committee Vice Chair requested assurance that staff were aware of the possibility of information sharing without protocol. The Chief Executive responded that it was part of the professional registrant code of conduct.</p> <p>The Board Secretary raised that each breach is assessed on severity and any action necessary is taken forward.</p> <p>The Committee Chair thanked the Board Secretary for the paper and the Committee NOTED the content.</p>
EQS/20/71	<p><b>THE PUBLIC SERVICES OMBUDSMAN FOR WALES ANNUAL REPORT AND ACCOUNTS 2019/2020</b></p> <p>The Assistant Director of Quality and Safety presented the previously circulated report which provided the Experience, Quality and Safety Committee with an overview of the Public Services Ombudsman for Wales Annual Letter for 2019/2020.</p>

	<p>The Assistant Director of Quality and Safety advised that the Public Services Ombudsman of Wales had requested by the 30 November outcomes on the following actions:</p> <ul style="list-style-type: none"> <li>• Presentation of the Annual Letter to the Board to assist Board Members in their scrutiny of the Board's performance.</li> <li>• Work with the PSOW Improvement Officer and Complaints Standards colleagues to improve complaint handling practices and standardise complaints data recording.</li> <li>• Inform the PSOW of the outcome of the Health Board's considerations and proposed actions within the Annual Letter.</li> </ul> <p>The Committee Chair noted there will be a drop-in concerns once the continuing health care conditions go through the system. The Committee Chair queried where PTHB stood in an all wales position. The Assistant Director of Quality and Safety responded that this was detailed in the paper.</p> <p>The Committee Vice Chair raised that feedback from complaints often defines staff attitude as a key factor. The Committee Vice Chair queried if training could be established to we help staff to deal with complaints. The Committee Chair responded that many complaints can be managed right at the start of the process.</p> <p>The Committee Chair thanked the Assistant Director of Quality and Safety and the Committee NOTED the content of the paper.</p>
EQS/20/72	<p><b>MORTALITY REPORTING</b></p> <p>The Medical Director presented the previously circulated paper which provided an update to Experience, Quality &amp; Safety Committee on the mortality review process implemented across the Health Board together with actions that were being taken to show improvement.</p> <p>The Medical Director advised that the PTHB approach to case review had been developed with the aim of ensuring a standardised format and process. This would ensure higher quality, more consistent reviews, and a robust process for escalation and dissemination of learning. The learning from</p>

	<p>mortality case review would be used to drive service improvement and offer assurance to patients, stakeholders and the Board that the causes and contributory factors of all deaths had been considered and appropriately responded to.</p> <p>The Committee Vice Chair queried if this was cross Powys of just in Brecon and, if perinatal deaths were longer term or just recent perinatal deaths being considered. The Medical director responded that the process was being taken one step at a time. Many instances are subject to legal or other issues. Early next year there would be a clear picture of all deaths across PTHB sites. The Medical Director noted that at that stage Medical Examiners would then be liaised with to coordinate learning.</p> <p>The Committee Vice Chair queried if mortality reviews were being undertaken across the whole of the county or just in Brecon. In addition, the Committee Vice Chair asked would it be possible for the committee to have sight of the Extended Perinatal Mortality Data in addition to the Perinatal Mortality Data in future. The Medical director responded that the process was being taken one step at a time.</p> <p>Susan Newport queried whether the higher numbers of sepsis are due to transfer of very ill patients. The Medical Director responded that there had not been sufficient data yet to ascertain that. A positive culture would need to be developed of learning on how to identify sepsis.</p> <p>The Committee Chair thanked the Medical Director and the Committee NOTED and DISCUSSED the paper.</p>
EQS/20/73	<p><b>CLINICAL AUDIT REPORT</b></p> <p>The Medical Director presented the previously circulated paper which informed the Experience, Quality and Safety Committee regarding the progress of the 2020/21 Clinical Audit plan and request permission for changes to the annual audit plan.</p> <p>The Medical Director advised the report provided a current position in relation to the 2020/21 Clinical Audit plan. As</p>

	<p>the Clinical Audit plan is a Board-owned document, the Directors and Service Leads requested that the Experience, Quality and Safety Committee acknowledge that new arrangements were being developed to link the future audit programme more closely to professional development through medical and nursing revalidation and organisational risk and to give approval for the proposed changes to the plan requested in this report.</p> <p>The Committee Chair raised that the committee was asked to note the changes in the audit structure.</p> <p>The Committee APPROVED the proposed changes to the annual audit plan.</p>
<b>ITEMS FOR INFORMATION</b>	
EQS/20/74	<p><b>REVIEW OF COMMITTEE PROGRAMME OF BUSINESS</b></p> <p>The Board Secretary presented the previously circulated paper which provided the Experience, Quality &amp; Safety Committee with the 2020/21 workplan, as at September 2020.</p> <p>The Board Secretary advised the Annual Programme of Business has been developed with reference to:</p> <ul style="list-style-type: none"> <li>▪ The Committee's Terms of Reference as agreed by the Board;</li> <li>▪ the Board's Assurance Framework;</li> <li>▪ key risks identified through the Corporate Risk Register, Commissioning Assurance Framework; and Operational Risk Registers.</li> <li>▪ audit and regulatory reports identifying weaknesses in internal control (following consideration by the Audit, Risk and Assurance Committee);</li> <li>▪ key statutory, national and best practice requirements and reporting arrangements.</li> </ul> <p>The Committee NOTED the work plan.</p>
EQS/20/75	<p><b>PUTTING THINGS RIGHT CLAIMS AND COMPENSATION ANNUAL REPORT 2019- 2020 (FINAL)</b></p> <p>The Executive Director of Nursing and Midwifery presented the previously circulated paper which provided the Experience, Quality and Safety Committee with information</p>

	<p>on the progress and performance of Powys Teaching Local Health Board in their management of concerns during 2019-2020. This report includes compensation claims management.</p> <p>The Executive Director of Nursing and Midwifery advised that the report was prepared in line with 'The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011', of which Regulation 51 provided that a responsible body must have prepared an annual report. The report was published in support of PTHB's Annual Quality Statement.</p> <p>The Committee NOTED the paper for information.</p>
<b>OTHER MATTERS</b>	
EQS/20/76	<p><b>ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND OTHER COMMITTEES</b></p> <p>The Committee Chair raised the issues of treatment times noting it would be brought to other committees.</p>
EQS/20/77	<p><b>ANY OTHER URGENT BUSINESS</b></p> <p>No urgent business.</p> <p>The Committee Chair thanked all members.</p>
EQS/20/78	<p><b>DATE OF THE NEXT MEETING</b></p> <p>6 November 2020, Microsoft Teams.</p>