



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

CONFIRMED

**MINUTES OF THE MEETING HELD ON THURSDAY 3 JUNE 2021
VIA MICROSOFT TEAMS**

Present:

Trish Buchan
Frances Gerrard
Susan Newport

Independent Member (Chair)
Independent Member
Independent Member

In Attendance:

Alison Davies
Kate Wright
Claire Madsen
Wendy Morgan
Julie Richards

Director of Nursing and Midwifery
Medical Director
Director of Therapies and Health Sciences
Assistant Director of Quality and Safety
Head of Midwifery and Sexual Health (Joined for
Item 3.2 and 3.3 only)
Assistant Director of Women and Children's
(Joined for Item 3.2 and 3.3 only)

Louise Turner

Observers:

Sara Utlej
Rhobert Lewis
Ronnie Alexander

Audit Wales
Independent Member

Apologies for absence:

Melanie Davies
Jamie Marchant

Vice-Chair (Committee Chair)
Director of Primary, Community Care and Mental
Health.
Director of Workforce, OD and Support Services
Board Secretary

Julie Rowles
Rani Mallison

Committee Support:

Elizabeth Patterson
Shania Jones

Corporate Governance Manager
Charity Administration Support Officer

EQS/21/22	<p>WELCOME AND APOLOGIES FOR ABSENCE</p> <p>The Committee Chair welcomed Members and attendees to the meeting, and CONFIRMED there was a quorum present. Apologies for absence were NOTED as recorded above.</p>
EQS/21/23	<p>DECLARATIONS OF INTERESTS</p> <p>No interests were declared.</p>
EQS/21/24	<p>UNCONFIRMED MINUTES OF THE EXPERIENCE, QUALITY AND SAFETY COMMITTEE MEETING HELD ON 15 APRIL 2021</p> <p>The minutes of the previous meeting held on 15 April 2021 were AGREED as being a true and accurate record.</p>
EQS/21/25	<p>MATTERS ARISING FROM PREVIOUS MEETINGS</p> <p>No matters arising were declared.</p>
EQS/21/26	<p>COMMITTEE ACTION LOG</p> <p>The Committee received the action log and the following updates were provided:</p> <p>ARA/20/82 – Fire Safety Internal Audit Report – this item was now overdue – the Director of Nursing and Midwifery undertook to check with the Board Secretary when this would be rescheduled.</p> <p>EQS/19/89 – Assurance that visiting clinicians were compliant with training – the Medical Director advised this was a complex situation as PTHB do not appraise visiting clinicians who are employed by other Health Boards. Visiting clinicians tend to be a stable workforce and assurance could be taken from that however, it was acknowledged that there would be more risk around substitute clinicians. A paper would be brought to committee outlining the key areas of risks and work undertaken to address this.</p> <p>The remaining actions were not yet due.</p>
ITEMS FOR APPROVAL/RATIFICATION/DECISION	
EQS/21/27	<i>There are no items for inclusion in this section</i>
ITEMS FOR DISCUSSION	
EQS/21/28	CLINICAL QUALITY FRAMEWORK, IMPLEMENTATION PLAN UPDATE

	<p>The Director of Nursing and Midwifery presented the report noting it had previously been identified that each of the five goals outlined within the paper would need an Executive Director as lead. The review and priorities for 2021/22 were noted, with revised priorities to be presented to the Quality, Governance Group in July 2021. The RAG ratings remained the same.</p> <p><i>Regarding the RAG rating, are the items that are white because they are not due or have not been re-prioritised?</i></p> <p>The Director of Nursing and Midwifery explained the process is operated within a three-year cycle and the white areas were added as previously included in year 2 priorities and are only now entering the cycle however, there may be changes to priorities following the review process.</p> <p>The Committee DISCUSSED and NOTED the Clinical Quality Framework, Implementation Plan Update.</p>
EQS/21/29	<p>SERVICE GROUP, QUALITY GOVERNANCE REPORTING:</p> <p>a) MENTAL HEALTH This item had been DEFERRED.</p> <p>b) WOMEN AND CHILDREN'S The Director of Nursing and Midwifery introduced the paper and the recently appointed Assistant Director of Women and Children's Manager presented an update on the refinement of the Women's and Children's Quality Governance Framework 2021/22 which had been developed in 2020 and had since been implemented.</p> <p>It was highlighted that the service groups report to the Director of Primary, Community Care and Mental Health and that the Women and Children's service group comprises of midwives, health visitors, school nurses amongst others. The reporting structure was outlined within the report including the links with the PTHB Clinical Quality Framework.</p> <p>The Governance Framework includes the following forums:</p> <ul style="list-style-type: none"> • Individual teams and services • Incident Oversight Groups • Audit • Policies and Procedures • Child Death Review meetings • Patient Experience Forum • Health and Safety <p>These all feed into the Senior Clinical Leadership Group and ultimately to the Director of Primary, Community Care and</p>

	<p>MH. The Assistant Director of Women and Children's Manager wished to build on this foundation to ensure that frontline practice was observed and learning embedded across the directorate.</p> <p><i>Women and Children are more likely to have suffered silently during the pandemic. How does the undisclosed suffering get translated into support?</i></p> <p>The Assistant Director of Women and Children's explained that this is a continuous challenge, the aim was to build upon the patient experience forum to collectively keep the communication channels open. It was important that the feedback from the mechanisms outlined within the report was acted upon and staff were working together to meet those challenges.</p> <p>The Director of Nursing and Midwifery further explained that this was a national issue and one way in which PTHB were responding was by focussing on children and young people in the annual plan, where a specific priority has been identified.</p> <p>The Medical Director added that there was a research group in place that looked at harm and it was important to listen to all voices and not just to those that shouted the loudest.</p> <p><i>Do frontline staff who see this have the opportunity to raise concerns?</i></p> <p>There were a number of forums and opportunities for where these issues could be raised. PTHB was well placed for this as the organisation was close to its communities.</p> <p><i>What is the expectation moving forward? Will this be within an aggregated report provided by the Director of Primary, Community Care and Mental Health?</i></p> <p>The Director of Nursing and Midwifery confirmed the report highlighted the structure in place which enables the women and children's service group can discharge its responsibility in terms of quality and patient safety, and this in turn will help the service group generate data to inform the aggregated report, expected next time. The intention was to receive a single report of collated information from the service groups that identified the important elements of quality governance for those groups.</p> <p>The Women and Children's Service Group report was DISCUSSED and NOTED.</p>
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EQS/21/30	<p>MATERNITY SERVICES ASSURANCE FRAMEWORK & IMPROVEMENT PLAN</p> <p>The Head of Midwifery and Sexual Health presented the report highlighting updates in regard to the Maternity Service Improvement plan, the scheduling of a Powys Maternity and Neonatal Performance Board by Welsh Government, development of an assurance committee in SaTH and reference to work underway within the maternity and neonatal workstream of the South Powys Programme Board.</p> <p><i>What is the national stance on partners being present during birth?</i></p> <p>The Head of Midwifery and Sexual Health explained that the visiting framework provided by the Welsh Government (issued in July 2020 and updated in November 2020) was used nationally which allowed the support of a birth partner during active labour. In Powys it was possible to offer birth partner support from the onset of labour through to post birth support. Powys women who attend District General Hospitals were subject to the visiting arrangements in the hosting Health Board. In Powys labouring women are offered a home assessment to enable them to stay at home with support for the most appropriate time. The National Visiting Framework was being reviewed in respect of post-natal support and scan attendance. PTHB was already offering support attendance at scans and was examining the potential to invite support partners to antenatal appointments.</p> <p>The key feedback from families was that they would like to be considered as families not visitors when the baby is on special care unit.</p> <p>Maternity Services Assurance Framework and Improvement Plan was DISCUSSED and NOTED by the Committee.</p>
EQS/21/31	<p>APPROACH TO ASSESSING HARM FROM COVID-19</p> <p>The Medical Director gave an oral report regarding the approach to assessing harm from COVID-19 outlining that this was a rapidly evolving field and there was a large amount of work being undertaken locally and nationally. It was important that there was a consistent approach to assessing harm.</p> <p>There were several aspects of harm that could be identified including harm directly from COVID-19, from stress on the system or from stopping normal activity. The challenge presented was to prioritise and to make a fair assessment on the basis of where was the greatest need. It was not</p>

	<p>just about assessing the harm but about the use of mechanisms to assess and mitigate simultaneously.</p> <p>There were several national initiatives underway which PTHB were involved with including nosocomial harm and harm from long delays to planned treatment. Each Health Board are assessing the delays in order to gauge what proportion of individuals no longer need planned care and which individuals need to be prioritised.</p> <p>A mini pilot has taken place within Powys, where the orthopaedic list was triaged, patients were contacted and the list re-triaged. This identified a number of patients who no longer needed to be on the list, a number of patients who could be offered bridging treatment and for the remaining patients the problem had been defined and a plan for care produced. This would inform consideration of other lists. It had been ascertained that the old system of simply referring a patient to the orthopaedic waiting list was not the best approach.</p> <p>It was important to be aligned to the national frameworks due to the level of work commissioned by PTHB. It was intended to bring a more defined framework to Committee later in the year.</p> <p><i>Regarding orthopaedics, is there movement towards a strategy where patients are able to access a physiotherapist instead of seeing a GP first? This happens in England and patients then end up on an orthopaedic list without the opportunity for alternative approaches outlined above. Is PTHB or Wales looking to emulate this approach?</i></p> <p>The Medical Director explained that this was an opportunity to review the system regarding valued-based care to ensure duplication is avoided. Historical pathways may need to change.</p> <p>The Director of Therapies and Health Sciences confirmed that England had a different system for triaging patients whereby GPs no longer see orthopaedic patients. Powys are reviewing their pathways and there are several options including a first contact physio or podiatrist and there was potential for other therapists to be based in GP practices. At present the pathway is convoluted and needed to be rationalised.</p> <p><i>Whilst there is total support for expertise of first care practitioners there is concern that GPs will be deskilled by the loss of this work to other staff.</i></p> <p>The Medical Director agreed the concern noting one of PTHBs strength was the expertise amongst primary care.</p>
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	<p>It was expected that the pathways would be different to those in England.</p> <p><i>Can assurance be given that Independent Members will be sighted on this progress?</i></p> <p>The Director of Therapies and Health Sciences explained it was part of the renewal priorities around the managing long term conditions and as such will be reported through this mechanism. The Board Secretary to advise of the reporting arrangements for this item.</p> <p>Action: Board Secretary</p> <p>The Committee DISCUSSED and NOTED the approach to assessing harm from COVID-19.</p>
EQS/21/32	<p>APPROACH TO LEARNING UPDATE</p> <p>The Medical Director presented the paper outlining that PTHB already had a strong learning culture. It was a complex organisation with many small teams spread over a large area interfacing with many other health boards across Wales and England. This could bring opportunities as well as challenges. The principles, culture, mechanisms, and opportunities for developing shared learning were outlined.</p> <p><i>Regarding commissioned work, what is in place to give assurance that learning takes place in those environments? Do these come through the National Practice and Audit Wales?</i></p> <p>The Medical Director explained that there are commissioning assurance frameworks which will seek to take assurance from some areas. However, the Health Board will aim to seek more assurance from commissioners regarding some of those compliances with National Audit.</p> <p><i>In respect of the silent harms known to be taking place can assurance be given that the Health Board be focus on protected characteristics and socio-economic duty when reviewing the learning?</i></p> <p>The Medical Director assured the Committee that the protected characteristics and the socio-economic duty would be considered at the learning and experience group which was attended by a large range of participants.</p> <p>The Committee NOTED and DISCUSSED the Approach to Learning Update.</p>
EQS/21/33	<p>SERIOUS INCIDENTS AND CONCERNS REPORT</p> <p>The Assistant Director of Quality and Safety presented the Serious Incidents and Concerns Report to the Committee.</p>

	<p>It was noted that the serious incidents and concerns report would change in its contents because the service groups will be reporting on their performance in terms of patient experience, incidents, concerns and other quality related matters. Additionally there would be changes as part of the move from the Datix system to Once for Wales Concerns Management System that might mean that data will be presented differently.</p> <p>It was confirmed that the Putting Things Right Policy had been sent to the Public Services Ombudsman for Wales after the May 2021 Board meeting and it was intended to develop a Complaints Charter. This would be shared with Members on completion.</p> <p>The performance on responding to complaints within 30 working days is improving.</p> <p>Training had been arranged on complaints handling by the Public Services Ombudsman for Wales and it was intended to provide this training to a wider cohort of staff.</p> <p><i>The number of complaints on a monthly basis is small, how does this number compare with other Health Boards?</i></p> <p>The Director of Nursing and Midwifery explained it would be difficult to compare numbers of complaints with other health boards as the way in which services were commissioned and provided, differed for other health boards in Wales and therefore not comparing like for like. The Assistant Director of Quality and Safety further explained that there is no benchmarking data available for concerns. On average the organisation receives approximately 20-30 complaints per month (up from around 15-19 during the covid pandemic). Complaints regarding commissioned services were considered but only if the PTHB is advised by a commissioned service they had been received.</p> <p>In terms of incidents the PTHB average is approximately 250 per month (2,000 to 3,000 per year) compared to approximately 17-20,000 in a large health board who provide secondary care service. The caveat regarding comparisons outlined above also applies to comparisons of incidents.</p> <p><i>Do the complaints team investigate complaints regarding long waits. If so do all patients know this is a method that can be used?</i></p>
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	<p>There are complaints are received in relation to waiting timers. As systems recver post covid and patient experience are brought to the fore, the aim is always for matters to be resolved to the complainants satisfaction informally wherever possible.</p> <p>The Committee NOTED and DISCUSSED the Serious Incidents and Concerns Report.</p>
EQS/21/34	<p>INSPECTIONS AND REGULATION REPORT</p> <p>The Assistant Director of Quality and Safety presented the inspections and regulation report noting that Tier 1 Quality Checks had taken place at Clywedog Ward, Llandrindod Wells Memorial Hospital and two improvements had been identified:</p> <ul style="list-style-type: none"> • The health board must provide HIW with assurance as to how the site can best meet the needs of these patient groups [functional and organic] in both the short term and longer term, specifically if the use of bays in accommodating patients with organic and functional needs fully promotes patient wellbeing and dignity. • The health board is advised to review and update its environmental/COVID-19 related risk assessment(s). <p>A response would be submitted to Health Inspectorate Wales (HIW) in June 2021 and it was confirmed that the second recommendation had been completed.</p> <p>The Quality Check of the Felindre Ward at Bronllys Hospital had been scheduled for 30 March 2021 however, it had been postponed to 27 April 2021 which had also been postponed by HIW. A new date was awaited.</p> <p>The paper highlighted the current position of the recommendations, actions and progression across the Health Board which provided assurance of those taken forward and the ones that had been closed.</p> <p><i>When will Independent Members have an opportunity to consider the plans to address the accommodations for patients with organic and functional needs for Clywedog Ward?</i></p> <p>The Assistant Director of Quality and Safety explained that a date had been issued for completion, and initial work had been undertaken but was still work in progress. An update was due to be submitted to HIW end of June 2021 which may provide more clarity.</p>

	<p>The Director of Nursing and Midwifery offered to include the response in the Regulatory Inspections Report at the next meeting.</p> <p>ACTION: Director of Nursing and Midwifery</p> <p>The Committee NOTED and DISCUSSED the Inspections and Regulation Report.</p>
EQS/21/35	<p>INFECTION PREVENTION AND CONTROL REPORT</p> <p>The Director of Nursing and Midwifery presented the report to Committee noting that Infection Prevention Control (IPC) was a shared responsibility across the organisation.</p> <p>The ICP plan was developed proactively pre-COVID and majority of the plan had been delivered. The outstanding actions had been carried over to the current year. The team were recruiting a registrant and an administrator to help with the pressures on this service due to the pandemic.</p> <p>Attention was drawn to the Environmental Cleanliness dashboard which the IPC group receive, and the expectation of receipt of Welsh Government guidance in relation to revised cleanliness standards. It was noted that the 2020-21 Infection Prevention and Control Annual Report was currently being drafted and progress would be reported to the IPC Group in June 2021.</p> <p>A new approach to post-infection review around all blood stream infection will help to identify areas of learning and improvement.</p> <p>The team had worked with partners to monitor water safety and improve ventilation together with other estates-based activity in response the pandemic. Decontamination work had been strengthened with senior leadership identified in this area and a nosocomial group formed to consider Welsh Government policy and guidance, and aspects of prevention of nosocomial transmission.</p> <p><i>Is it known if the drop in C.difficile cases is due to a reduction in sampling or a reduction in prescribing?</i></p> <p>The Director of Nursing and Midwifery advised that the Chief Pharmacist would be asked for their views on this question which would be included in the next Infection Prevention and Control update.</p> <p>Action: Director of Nursing and Midwifery</p> <p><i>Will the annual report be brought back to the Committee once it has been agreed by the ICP Group?</i></p> <p>The Director of Nursing and Midwifery assured the Committee that the Annual Report will be presented to EQS</p>

	<p>Committee once it has gone through the internal governance arrangements.</p> <p>The Committee NOTED and DISCUSSED the Infection, Prevention and Control Report.</p>
EQS/21/36	<p>MEDICAL REVALIDATION PROGRESS REPORT 2019/2020</p> <p>The Medical Director presented the Medical Revalidation Progress Report 2019/2020 to Committee noting that overall the organisation was doing well as it was on a par or slightly better than the rest of Wales. However, it was expected the number of referrals would increase in line with the national trend. There had been an increase in the number of deferrals as it has not been possible to undertake the 360° feedback element. This was a temporary position. Attention was drawn to the need to appoint a Lay person to the group along with additional appraisers including a dedicated appraiser for secondary care. Whilst the quality of appraisals was good there was a need to undertake Whole Practice Appraisals.</p> <p><i>One of the aspects of the pandemic has been the sudden opportunity for learning and an appraisal offers the opportunity to reflect.</i></p> <p>It was confirmed that one of the areas where it had been easy to find evidence in the appraisal process was quality improvement.</p> <p>The Committee DISCUSSED and NOTED the Medical Revalidation Progress Report 2019/2020.</p>
EQS/21/37	<p>CLINICAL AUDIT PROGRAMME REPORT</p> <p>The Medical Director presented the report highlighting that the audit plan for the coming year had been agreed in December 2020, and was running to plan. Many planned audits for the 2019/20 period had not taken place due to the pandemic and the service groups have reviewed and risk assessed them. Some had been cancelled while others have rolled over to 2021/22. The majority of audits that did take place had good results.</p> <p><i>The Falls Audit has been delayed due to insufficient capacity. When will this take place?</i></p> <p>The Assistant Director of Quality and Safety explained that a number of directorates were working together on this. The Falls Group had recently been re-established and it work would progress over the next few months. This will be included in the report of the Director of Primary, Community Care and MH.</p>

	<p>Action: Director of Primary, Community Care and MH</p> <p>The Committee DISCUSSED and NOTED the Clinical Audit Programme Report.</p>
EQS/21/38	<p>SAFEGUARDING DURING COVID</p> <p>The Director of Nursing and Midwifery presented the Safeguarding during COVID report in response to a question raised at Board.</p> <p>It was noted that there was recognition across all agencies and services related to the possible wider societal harm from Covid-19. The paper set out the Health Board's approach to working together to prevent and address the elements of domestic violence wherever possible.</p> <p>The report set out the next steps to address and engage recommendations from the internal audit report.</p> <p>The Committee DISCUSSED and NOTED the Safeguarding during COVID paper.</p>
ITEMS FOR INFORMATION	
EQS/21/39	<p>WHSSC QUALITY & PATIENT SAFETY COMMITTEE, MEETING HELD 11 MAY 2021, CHAIRS REPORT</p> <p>The Committee NOTED the paper.</p>
OTHER MATTERS	
EQS/21/40	<p>ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND OTHER COMMITTEES</p> <p>There are no items for inclusion in this section.</p>
EQS/21/41	<p>ANY OTHER URGENT BUSINESS</p> <p>No urgent business.</p> <p>The Committee Vice-Chair thanked all members.</p>
EQS/21/42	<p>DATE OF THE NEXT MEETING</p> <p>15 July 2021, at 10:00, via Microsoft Teams</p>