POWYS TEACHING HEALTH BOARD
EXPERIENCE, QUALITY & SAFETY COMMITTEE

CONFIRMED

MINUTES OF THE MEETING HELD ON THURSDAY 4 FEBRUARY 2021 VIA MICROSOFT TEAMS

Present:

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

In Attendance:

Carol Shillabeer	Chief Executive
Stuart Bourne	Director of Public Health
Lucie Cornish	Assistant Director of Therapies and Health Science
Alison Davies	Director of Nursing and Midwifery
Marie Davies	Deputy Director of Nursing
Clare Lines	Assistant Director of Commissioning Development
Claire Madsen	Director of Therapies and Health Sciences
Rani Mallison	Board Secretary
Jamie Marchant	Director of Primary, Community Care and Mental Health services
Julie Richards	Head of Midwifery and Sexual Health
Julie Rowles	Director of Workforce, OD and Support Services
Jeremy Tuck	Assistant Medical Director
Geoffrey Davies	Community Health Council
Elaine Matthews	Audit Wales

Apologies for absence:

Paul Buss	Medical Director
Susan Newport	Independent Member

Committee Support:

Elizabeth Patterson	Corporate Governance Manager
Shania Jones	Committee Secretary

EQS/20/99	**WELCOME AND APOLOGIES FOR ABSENCE** 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. The Committee Chair explained that the Health Board continued to work through an unprecedented time and so business as usual is not as was. The Board has taken a decision to ensure its committees have short meetings with concise agendas focussing on the essential matters during this time. The Board will be holding a development session in February, focussed on planning for recovery and to explore the priorities for the year ahead – there is no doubt that there will need to be further re-prioritisation of focus and resource as we move forward. The Committee itself will need to be mindful of the importance of taking a balanced view as to where its focus is in the coming months, recognising there is work to be done in improving quality governance arrangements whilst also ensuring the organisation has capacity to enable ongoing response to the pandemic and recover thereof.
EQS/20/100	**DECLARATIONS OF INTERESTS** No interests were declared.
EQS/20/101	**UNCONFIRMED MINUTES OF THE EXPERIENCE, QUALITY AND SAFETY COMMITTEE MEETING HELD ON 3 DECEMBER 2020** The minutes of the previous meeting held on 3 DECEMBER 2020 were AGREED as being a true and accurate record.
EQS/20/102	**MATTERS ARISING FROM PREVIOUS MEETINGS** No matters arising were declared.

EQS/20/103	**COMMITTEE ACTION LOG** The Committee received the action log and the following updates were provided. ARA/20/82 – Transferred from Audit, Risk and Assurance Committee. Internal Audit Report: Fire Safety (Limited Assurance). A follow-up report to be presented to the Experience, Quality and Safety Committee. EQS 19/22 – The Hazels (Community Mental Health) Llandrindod Wells – application to reconfigure/refurbish submitted to Welsh Government as part of the Llandrindod Hospital Programme Business Case. £50k discretionary capital allocated for immediate repairs subject to Board approval.
ITEMS FOR APPROVAL/RATIFICATION/DECISION	
EQS/20/104	There are no items for inclusion in this section
ITEMS FOR DISCUSSION	
EQS/20/105	**SERIOUS INCIDENTS AND CONCERNS REPORT** The Director of Nursing and Midwifery presented report noting that the Audiology Department had recorded the highest number of compliments which was a result of the proactive approach to gaining patient experience feedback. This approach would be taken forward to the Patient Experience Group as an example of good practice. Patient experience will be particularly important as part of the renewal planning post COVID-19, to help inform service delivery. It was noted that a national All Wales Patient Experience system had been recently launched. It was noted that whilst performance regarding acknowledgement of complaints were within the Welsh Government target, improvement was needed to maximise the health board's response. The performance for responding to formal complaints fluctuates but is well below the target and requires improvement. Significant work was being undertaken to target the areas in need of most improvement for example, the management of concerns, whilst it is anticipated that the outcome of the independent and internal reviews will identify further areas for improvement. In respect of the data provided related to Commissioned Services, please note that the concerns raised during the month indicated do not necessarily correlate to the month of attendance or admission that the concern realties to.

	It was noted by the Director of Nursing and Midwifery that graph 12 'Incidents reported 01 November 2019 – 31 December 2020' demonstrated a steady trend and variation may correlate to changes in service delivery as a result of the pandemic. In relation to Patient Safety Solutions, compliance is being assured in two and as a result of recent appointments into the senior theatres team, progress is expected in complying with the remaining notice. *The report is reflective and transparent; however, it appears that the organisation may be vulnerable to delays in investigations which could lead to external criticism.* The organisation is working intensively to address this and has committed resources to enable a full understanding of the position, supported by transparency of reporting. *In regards to Graph 13, it was noted that there was high number of concerns raised by the service group for Women and Children. Can more information be provided as to what is happening there?* The Director of Nursing and Midwifery explained that this graph illustrated the pattern of reporting by service groups over a period of time and reporting was encouraged to enable learning to take place. The quantity of reports is one of the indicators to consider. Women and Children's Service Group hold regular meetings to scrutinise their patterns or reporting, including the type and volume of incidents. The Delivery Unit intend to publish pan Wales reporting which may assist in benchmarking with others, bearing in mind the comparability of services. *Should Committee be concerned regarding areas that are not reporting concerns?* Service group incident reporting was encouraged but the reason for areas that are not reporting as many incidents could be due to the area being less a clinically focused area. Therefore, it may be more helpful to see the local trends within the service group over time rather than as a direct comparison. *Are any compliments collected online? Focusing more on how are individual's treated under normal circumstances? For example, how have people responded online to the Vaccination programme. Might this be a more accessible way for the public to engage?*

	The Chief Executive advised work is being undertaken to collect the feedback received by the Powys Teaching Health Board either via social media or through letters to the Health Board. A public Q&A session was held in order to gain more feedback from patients and families. It was important to understand what had been said regarding the Vaccination programme and the Health Board itself. In regard to the Vaccination Programme, the feedback has been overwhelmingly positive, there had been areas of improvements identified which had been very small and focused. The Director of Therapies and Health Sciences advised that the All Wales patient group had tested a real time feedback IT system. There was an opportunity for a Powys Teaching Health Board to consider adopting this system, however, there would be a cost implication and a Business Case would be submitted and will be brought back to the committee at a later date as a business case. *In the section of the report 'Incident Reporting by the Service Groups', can there be an explanation on what the incidents cover in future papers?* The Director of Nursing and Midwifery agreed to include a definition of incidents in future papers. *Are patients and families informed of delays in respect of inquests and concerns?* The Director of Nursing and Midwifery explained that the HM Coroner's Office keeps in contact with families, where the Coroner is involved. The delay is a Wales wide issue. However, concerns, there is a need for significant improvement in the way contact is maintained with families where a concern or serious incident is identified, this is a key aspect of the improvement work and will be further assisted by the deployment scoping that is currently underway, which will help clarify roles and responsibilities. The committee DISCUSSED and NOTED the Serious Incidents and Concerns Report.
EQS/20/106	**INSPECTIONS AND EXTERNAL BODIES REPORT** The Director of Nursing and Midwifery presented the report informing Committee of the outcome of regulatory inspections that had taken place during this period and outlining the progress of the actions that were taken

	forward as part of the inspection process against the Health Inspectorate Wales (HIW) tracker. *It would be helpful to have a generic tracker than a HIW tracker for the recommendations. It would be helpful to know the Public Service Ombudsman and the CIW work is going ahead.* The Director of Nursing and Midwifery clarified that the tracker does include all recommendations and the tracker's title needs to be amended to reflect this. *There are 26 overdue recommendations. Can further information be provided in respect of these, in particular those relating to 2018 and 2019.* This information will be brought to the next Committee. **Action: Director of Primary Care Community & Mental Health** The Director of Primary, Community Care and Mental Health services provided additional information regarding the outstanding actions. A number of actions relate to estates however, this does not necessarily mean that estates were the issue. In addition, these actions have been risk assessed and may be considered to be of lower priority when set against requirements in relation to the pandemic. The committee DISCUSSED and NOTED the Inspections and External Bodies Report.
EQS/20/107	**MORTALITY REPORTING** The Assistant Medical Director presented the Mortality Report on behalf of the Medical Director outlining the changes that had been made to strengthen the mortality review process. Prior to these changes there was a good practice of stage one reviews being undertaken. Stage two reviews had not been systematised therefore, the Medical Director initiated an action in order to begin the process. *Has plans to review infections as part of a national programme begun?* The Assistant Medical Director informed the committee that the meeting to discuss the nosocomial tool was rescheduled. *Is nosocomial toolkit is fit for purpose?*

	The Assistant Medical Director explained that there has been no opportunity to test it, but will give detailed feedback once testing has begun. *Will the Datix Mortality Module be taken up with the new appointed Medical Examiner (ME)?* The Assistant Medical Director explained that the current system had been paused. It would be helpful to have an All Wales reporting system for transparency and a level of equity. The delayed arrival of the ME hindered the ability to move forward on the mortality review process. However, the foundations had been set in order to start the process and to demonstrate that the review process has been taken seriously. The committee DISCUSSED and NOTED the Mortality Report.
EQS/20/108	**SAFEGUARDING UPDATE** The Director of Nursing and Midwifery presented the safeguarding update. The report gave the committee assurance concerning the way in which safeguarding and public protection had been handled during the COVID-19 pandemic. The Director of Nursing and Midwifery advised that safeguarding had remained a key priority throughout the COVID-19 pandemic. The report included examples of developments of progress made regarding how matters were addressed within Powys, and advised of the next steps that to be taken for improvements surrounding the safeguarding agenda. *In terms of the Child Protection Medicals, is the out of hours support provided by Cwm Taf Morgannwg University Health Board available across Powys or just within the South Powys?* The Assistant Director of Commissioning Development explained that the arrangement with Cwm Taf is for South Powys. *The 'Looked After Children' health assessment in Children's homes, is currently being done remotely. Will face-to-face assessments resume as the vaccine is distributed?* The Director of Nursing and Midwifery confirmed that as guidance changes, the assessments that require face-to-face assessments will resume provided it is safe to do so.

	There had been an increase in referrals to Child Protection and an increase in Domestic Violence during the COVID-19 pandemic. Will the service have the capacity and capability to meet the new challenges it is facing? The Director of Nursing and Midwifery explained that there was concern for children and families in this prolonged period of lockdown. This is wider than safeguarding and the service will work closely with local authority partners to ensure current arrangements meet the need or consider any changes to services that may be required. *Are Shropdoc, who provide out of hours service for clinical matters, aware of these changes in the location of Child Protection Medicals in South Powys? Can assurance be given that the doctors who are working with Shropdoc know how to access the appropriate services? Do Shropdoc practitioners receive Level 3 updates?* The Assistant Director of Commissioning Development explained that direct contact was made with Shropdoc to provide them of all details related to the changes with weekly telephone conferences arranged to discuss matters of mutual concern. All doctors who are working with Shropdoc that provides care for Powys are required to be on the Welsh performance list, which provides a large amount of information and experience. The committee DISCUSSED and NOTED the Safeguarding Update.
EQS/20/109	**COVID-19 INCIDENT MANAGEMENT UPDATE REPORT** The Director of Public Health presented the paper which highlighted the appropriate operation and effectiveness of the local outbreak management response in regards to the COVID-19 pandemic. The report provided the committee assurance that the outbreak management was well organised and managed. The Communicable Disease Outbreak Plan for Wales (2020), was the approved plan by the Welsh Government, NHS Wales and the Directors for Public Protection for dealing with an outbreak and the immediate response. The plan was followed closely and focused on 'how incident response was handled and organised within Powys'.

	This was related to hospitals outbreaks during the pandemic and further guidance had been recently published. An addendum was added in the last six months concerning the management of outbreaks in a hospital setting. There are two Incident Management Team (IMTs) structures which are interlinked with an overarching multi-agency Incident Management Team, that includes colleagues from Police, local authority and Public Health Wales, and includes cross border colleagues where necessary. IMT reports twice weekly to the Health Board's prevention and response group with escalated decisions taken to Gold Group. Reports are given to the Welsh Government which detail incidents, cases and control measures that are underway. *Are there particular members of the team which have particular influence and expertise in different areas? How does that impact on a particular team?* The Director of Public Health explained that it is a rare skillset, on an All Wales level therefore, not a lot of people had the particular skills which is required and it has been more difficult in the PTHB team to access specialist skills when required. However, as the team has gained experience they have been able to apply this learning. *When are test samples being analysed regarding the new variant? Is there any further intelligence regarding that?* The Director of Public Health explained that not all samples are analysed but of those that are a high percentage are testing positive for the new variant. The committee DISCUSSED and NOTED the Covid-19 Incident Management Update Report. *Julie Richards joined the meeting.*
EQS/20/110	**MATERNITY SERVICES PRIORITIES** The Head of Midwifery and Sexual Health presented the report highlighting the findings and recommendations from the Ockenden Report of Maternity services published in December 2020, which aligned to the Health Inspectorate Wales (HIW) National Report for Maternity Services published January 2021.

	The purpose of the report was to provide an overview of the themes and messages that emerged, which informed key priorities to develop Powys' Maternity Services Improvement Plan and the Assurance Framework for Commissioned Services. *The Chair requested consideration that a patient story be included on the Committee Work Programme.* **Action: Board Secretary** *In regards to complaints received by women who had experienced difficult births in the past. Can assurance be given that issues that could be avoided, will not happen again? What is in place to provide assurance to current parents and historical parents that the Health Board has taken the issues raised in the HIW tracker and the Ockendon Report seriously?* The Head of Midwifery and Sexual Health advised that the Powys Maternity and Partners Voices partnership had been established. Cases that had been identified with issues were provided with support and feedback on improvements made. Additionally, the Health Board will continue to publish information on a regular basis to evidence improvements made. It is the intention of the 2021 improvement plan to bring all recommendations in to a central plan. *Given the circumstances, can a time frame be provided as to when this Maternity Assurance Framework will be brought through the committee?* The Director of Primary, Community Care and Mental Health services reinforced the importance of the Maternity Assurance Framework therefore, the aim would be to bring this issue back to the EQ&S Committee as soon as possible. The committee DISCUSSED and NOTED the Maternity Service Priorities paper.
EQS/20/111	**CAF ESCALATION REPORT & SATH UPDATE** The Assistant Director of Commissioning Development presented the CAF Escalation Report and SaTH Update advising that the report highlighted the providers that are currently in Special Measures or scored a level four following January 2021 Powys Teaching Health Board Internal Commissioning Assurance Meeting (ICAM).

	This was unprecedented and it is important to consider the position as a Health Board. Could this fundamentally change the way care will be provided in the future? The Chief Executive agreed and welcomed the sense of moving towards recovery and renewal. The pandemic should be considered as an opportunity to investigate as a Health Board what challenges had been presented and what innovative responses had been made. The next stage of the pandemic would be to understand the future implications of COVID-19 and support clinicians and managers to prepare to tackle the various harms caused by the pandemic *With regards to the renal transplant waiting list was there a conversation between the commissioning team and WHSSC regarding waiting times?* The Assistant Director of Commissioning Development confirmed that this issue was being monitored on a monthly basis. The committee DISCUSSED and NOTED the CAF Escalation Report & SaTH Update.
ITEMS FOR INFORMATION	
EQS/20/112	There are no items for inclusion in this section
OTHER MATTERS	
EQS/20/113	**ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND OTHER COMMITTEES** There are no items for inclusion in this section
EQS/20/114	**ANY OTHER URGENT BUSINESS** No urgent business. The Committee Chair thanked all members.
EQS/20/115	**DATE OF THE NEXT MEETING** 15 April 2021, Via Microsoft Teams