GIG CYMRU NHS WALES | Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

POWYS TEACHING HEALTH BOARD
PATIENT EXPERIENCE, QUALITY & SAFETY COMMITTEE

CONFIRMED

MINUTES OF THE MEETING HELD ON TUESDAY 16 APRIL 2024 VIA MICROSOFT TEAMS

Present:

Kirsty Williams (KWi)	Vice-Chair (Committee Chair)
Jennifer Owen Adams (JOA)	Independent Member
Simon Wright (SW)	Independent Member
Ian Phillips (IP)	Independent Member

In Attendance:

Claire Roche (CR)	Director of Nursing and Midwifery
Kate Wright (KW)	Medical Director
Pete Hopgood (PH)	Director of Finance, Information and IT
Hayley Thomas (HT)	Chief Executive
Zoe Ashman (ZA)	Assistant Director of Quality and Safety
Jason Crowl (JC)	Assistant Director Health and Safety and Support Services
Helen Bushell (HB)	Director of Corporate Governance
Amanda Edwards (AE)	Assistant Director – Innovations and Improvement

Observing:

Carl Cooper (CC)	Chair PTHB
Ian Virgil (IV)	Internal Audit
Daisy Dee (DD)	Health Inspectorate Wales

Apologies for absence:

Joy Garfitt	Interim Director Operations, Community Care and Mental Health
Claire Madsen	Director of Therapies and Health Sciences
Mererid Bowley	Director of Public Health
Debra Wood Lawson	Director of Workforce and OD
Sonia Thomas	Llais

Committee Support:

Liz Patterson	Interim Head of Corporate Governance

PEQS/24/01	**WELCOME AND APOLOGIES FOR ABSENCE**

	KWi welcomed all to the meeting. Apologies for absence were noted as recorded above.
PEQS/24/02	**DECLARATIONS OF INTERESTS** No interests were declared in addition to those already declared in the published register.
PEQS/24/03	**MINUTES OF THE EXPERIENCE, QUALITY AND SAFETY COMMITTEE MEETING HELD ON 23 JANUARY 2024** The minutes of the previous meeting held 23 January 2023 were AGREED as a true and accurate record subject to the inclusion of the rationale for items to be held In-Committee.
PEQS/24/04	**PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE ACTION LOG** KWi presented the action log noting that there were two completed actions, three actions not yet due and four actions which were given the following oral updates: • **PEQS/23/40 The disaggregation of inherited and acquired pressure sore incident** – CR advised this work had been delayed due to significant absences in the Community Services Group, but this would be picked up and included in the Integrated Quality Report. Action to remain open. • **PEQS/23/23a -The Mental Capacity Act and the backlogs in the system** – CR advised a paper was considered at Executive Committee with an action to discuss at the Joint Leadership Team (JLT) with Powys County Council. A workshop has taken place with operational leads where actions and solutions were identified to improve the response to the Mental Capacity Act. The implementation of these solutions will be fed back to JLT and to this Committee. Action to remain open. • **PEQS/23/12 – process of off listing patients and number of patients affected under GP Behavioural Contracts** – PH advised that liaison had taken place with Llais, and an update would be circulated to the Committee. Action to be closed on receipt of information. • **PEQS/23/63 – Safeguarding training implementation** – CR advised that this information was contained within the cover paper for the Joint Inspection of Child Protection arrangements. Action Closed. The updates to the Action Log were NOTED.

ITEMS FOR ASSURANCE	

PEQS/24/05	**INTEGRATED QUALITY REPORT:**
	CR presented the report and drew attention to the following areas:-
	• All implementation actions are complete for the Duty of Candour;
	• Four actions remain outstanding for the implementation of the Duty of Quality which are due for completion by June 2024;
	• A full update on the implementation of the Duty of Quality and Candour will be provided in the first Annual Report;
	• Compliance with the 30 day response time for Putting Things Right (PTR) has increased from 27% two years ago, to 57% last year and 81% this year;
	• The proportion of complaints settled by early resolution is showing a gradual increase from around half to two thirds over the last nine months;
	• The number of Duty of Candour cases is increasing as colleagues become familiar with the new duty;
	• The Infection Prevention and Control (IPC) action plan is nearing conclusion, and all actions are on track for completion;
	• A summary of outstanding Health Inspectorate Wales actions is provided showing six actions overdue, four actions with revised timescales and eight actions not yet due, and
	• There are two key matters for Board highlighted:
	  ○ The resource to support patient experience, and
	  ○ Timely management of incidents
	Independent Members asked the following questions for assurance:
	All six overdue HIW actions involve the local authority. Is the local authority engaging in partnership on these matters?
	DF confirmed that whilst there were six overdue actions when the report was compiled, since then these six actions have been addressed. ZA advised that any updates to the tracker are quality assured before they are reported as complete.
	
	The report includes some welcome improvements in a number of areas. Will it be possible to maintain and improve further on the position?
	CR expressed confidence the improvements would be sustained given the trajectory had been over two years.

	That there is no longer a backlog of outstanding complaints gives further confidence the position can be maintained. *Now that the necessary kit has been purchased to record patient stories, will these be shared with Board and Committee to demonstrate the Health Board is a learning organisation?* CR advised that in the absence of a dedicated Patient Experience team, the team were seeking to resolve this across the organisation with the intention of working in a matrix style to maximise the benefits of the resources available. *Is it possible to test how the successful the learning environment is?* CR advised that the newly approved Integrated Quality and Performance Framework, which includes local escalation arrangements, and the establishment of an Integrated Quality and Performance Group should enable reporting which will demonstrate the success of the learning environment. It is expected that this will take approximately two years to reach maturity. KW added that the Learning Group was maturing, and additional information could be shared with Committee on the themes and methods of sharing learning. Clinical audits also play a role in demonstrating learning, and finally, a reduction in the number of incidents received can demonstrate learning. *The sustained improvement is welcomed, and the work undertaken to reach this position is noted. The report notes significant challenge continues with the timely management of incidents. What actions are being taken to address this?* ZA advised that improvements in the management of incidents have been more complex as a new system was implemented last October. At this point there were over 2,000 open incidents, these have been reduced to approximately 1,000 open incidents with around 150 incidents occurring each month. Incident reporting has been impacted by the Duty of Candour, but the team are improving at a sustainable pace. The highest risk cases have been reviewed and staff have been trained on incident management. The improvement trajectory around incidents could be shared with Committee. **Action: Assistant Director of Quality and Safety**

	How is the patient experience data captured in the Civica system being used to inform learning and commissioning? ZA advised that responses via the Civica system from a commissioned care perspective had increased over the last 4-5 months from around 150/month to 270/month. Overwhelmingly positive feedback had been received relating to care provided by the Wye Valley NHS Trust, but further detail shows that after care provided in the community was good too. As this information is shared teams become more proactive in seeking feedback which has led to an increase in patient experience data. The intention is to share this feedback with GP practices where much of the care takes place. *Is there capacity within the team to service the level of patient experience data that is now available?* ZA advised that it would be necessary to scope the requirements in relation to the duty of quality, duty of candour and reporting requirements of the Integrated Quality and Performance Report. *On Graph 6 (feedback on Your NHS Experience), why are the last two months showing mostly red performance?* ZA advised that some of this performance is likely to always be red, for example 'were you able to speak Welsh to staff' is likely to be red for care provided in England, however, there were particularly low numbers of responses in February and March which may skew the figures. A fuller report on this information can be provided to the next meeting. **Action: Assistant Director of Quality and Safety / Director of Nursing, Quality, Women and Family Health** *The information presented on Living Well is welcomed. Could a similar focus on other services be provided in future reports?* ZA confirmed a similar highlight on other services would be included in future reports. **Action: Assistant Director of Quality and Safety / Director of Nursing, Quality, Women and Family Health**

	How will the effectiveness of the Quality and Engagement Act Implementation be monitored? CR noted that there is a cultural element to many of the indicators and the confidence to identify a duty of candour case is one which can indicate effective implementation of the Quality and Engagement Act. *In relation to the Health Inspectorate Wales reports what is the difference between an amber and red classification?* CR confirmed that an amber classification meant a timescales had been revised, whereas a red classification meant the action was overdue. *Can the number of Nationally Reportable Incidents (NRIs) be confirmed?* ZA confirmed that the number of NRIs was 18. This was likely to be lower in the next report as a number of cases were awaiting quality assurance before sign off. The Committee: • RECEIVED the report and take 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.
PEQS/24/06	**MENTAL HEALTH QUALITY AND SAFETY REVIEW** CR introduced the report in response to some of the actions on the Action Log and in relation to Chief Executive's request for a deep dive into Mental Health incident management, outlining some of the actions taken since the previous meeting of this Committee. Attention was drawn to the following matters: • an audit of the clinical systems had been undertaken - this identified a number of gaps requiring triangulation of the ongoing work being progressed through incident management, • the Integrated Quality and Performance framework has been updated to include a proposed internal escalation framework, • local Mental Health services have been placed into a period of escalation; at level 2A, and • an escalation oversight meeting has been created. DF advised the team had been supported with operational oversight and resources to deliver the actions. The team were making good progress.

	KW advised that the team had experienced difficulties with staff absence and one of the Assistant Medical Directors was assisting with ensuring polices were up to date which provided additional capacity. HT noted that the learning from local escalation of maternity services had informed the internal escalation framework, including in relation to de-escalation. The Executive Team have provided wrap around support for the service to aid improvement. The letter from the regulator was received after local escalation had been implemented and the relationship with the regulator will be key. Independent Members asked the following questions for assurance: *How are the staff within a service supported when the service is put into escalation? Is there shared experience from maternity services that can be used to support colleagues in mental health?* CR confirmed that for any improvement to be successful, staff need to feel psychologically safe and can speak up. Having this support is extremely important and has been a priority in moving forward with this process. The senior Mental Health team are putting together a variety of different forums to support the staff on the ground, including multiple meetings and walk arounds. The Executive Management team are providing support to Senior Managers on a team and individual basis. In addition, there is ongoing dialogue with the Midwifery team who have previously experienced escalation. *What happens after de-escalation, will the Health Board be in a similar situation in another 12 months' time? Is there something more radical that needs to be done to prevent further occurrence of this situation?* HT confirmed the need for a safe service with the current model; that the nature of the demand, the clinical presentation and acuity of patients had changed substantially. This has happened across the whole system. Actions need to be taken to address the current situation, and sustainability conversations are needed as part of the Accelerated Sustainable Model; these will involve staff working within the service and will need to fit into the regional and national model for mental health. DD (Health Inspectorate Wales representative) noted the HIW had written to the Health Board regarding a cluster of concerns. A follow up meeting has been scheduled to determine next steps and timescales.

	What arrangements have been made for stakeholder engagement with service users and other key partners. How is reassurance going to be provided to users and key stakeholders in relation to this escalation. CR advised an engagement plan is to be developed, this will include all stakeholders and Llais and will use existing engagement arrangements including the Mental Health Patient Experience Forum. Board will be appraised via the Committee Chair's report. *How will improvement be measured, and does the service have sufficient capacity to make the necessary improvements and attend to service transformation under the Accelerated Service Model?* CR confirmed a continuous improvement plan has been devised, which has been divided into two parts – part A and part B. Part A looks at the improvements required to be in a recovery position, looking at the key indicators that led to the decision of escalation; Part B is linked to the medium-longer term transformation of the service. HT reported that steps have been taken to deal with the immediate issues which had taken considerable resource. There are ongoing conversations with the Executive team regarding protecting the capacity for this work to be undertaken. There is a need to engage with the current teams on transformation and change, to identify efficiencies and be an effective as possible. KWi noted this Committee will receive formal progress updates for the duration of the escalation period for Mental Health Services. The Committee: 1. **NOTED** the actions that have been taken since 23 January 2024 2. **NOTED** the escalated status of Mental Health Services to Level 2a (in line with the newly approved escalation framework within the Integrated Quality and Performance Framework IQPF) **3.** Took **ASSURANCE** of the plans in place to monitor progress in mental health services to ensure effective oversight, assurance and improvement.
PEQS/24/07	**CLINICAL AUDIT ANNUAL PROGRAMME** KW presented the Clinical Audit Plan and drew attention to • a continual aim of strengthening the plan; • improved triangulation of concerns and incidents; • more focus on areas of new practice and new policies;

	• reviewed the plans to avoid repeated audits on areas where assurance has been provided; • will participate in national clinical audits when the programme has been clarified; • received a 'substantial' Internal Audit on the clinical audit plan with 'reasonable' for capacity. The team has worked with clinical teams with an aim to ascertain the capacity gap; and • Mental Health audit plan has been strengthened focused; it is expected this will evolve as the service works through a period of escalation. IV (Internal Audit) confirmed the position in respect of Internal Audit and welcomed that the recommendations regarding capacity were being addressed. HT observed that audits varied in terms of resource required and that examination of the experience of teams audited this year may assist in mapping future capacity requirements. *When will the information on Primary Care Group GP Services (p18 of the report) be available?* KW advised the dates and themes of the GP services audits are to be added to the plan. **Action: Medical Director** The Committee RECEIVED and APPROVED the clinical audit plan 2024-2025.
PEQS/24/08	**JOINT INSPECTION ON CHILD PROTECTION ARRANGEMENTS (JICPA) ACTION PLAN** CR presented the report, providing an overview of the improvements allocated to the Health Board, the actions required, by when and by whom and how these actions have been Red Amber Green (RAG) rated. These actions will be reviewed internally through the Safeguarding Strategy Group and the arrangements for monitoring the multi-agency improvement plan will be taken through the partnership arrangements that are currently in place. Independent Members asked the following questions for assurance: *Can you give an insight into the challenges when identifying the levels of training appropriate to members staff.*

	The Health Board had already identified this as a key area for improvement and had agreed a series of actions to take and monitor through the Strategic Safeguarding Group. The recommendations of JIPCA added to this. The training requirements have been identified with the team and workforce colleagues. It has been necessary to ensure that staff are released for training and there is capacity within the safeguarding team to be able to provide the training. Now there is a full complement of staff supporting the safeguarding team, there is confidence the necessary mechanisms are in place to increase the training. *Is Improvement 3 (…children in Powys frequently require access to health care and services across borders…) an IT or a commissioning team issue?* CR advised this recommendation came from information and intelligence that was gleaned from the staff survey. This is one of the key areas that staff reported as being problematic. Firstly, there is a need to collaborate with the teams to fully understand the issue to inform the next phase of the improvement plan. It was noted that there is further work is ongoing, the progress against the action plan will be reported quarterly to the Safeguarding Strategic Group, the Executive Committee and to this Committee. **Action: Director of Nursing, Quality, Women and Family Health** The Committee: 1. **NOTED** the Joint Inspection of Child Protection Arrangements (JICPA) report and findings. 2. **NOTED** the improvements identified for PTHB and took **ASSURANCE** from the arrangements for monitoring progress. 3. **NOTED** the arrangements for monitoring the multi-agency whole system improvement plan.
PEQS/24/09	**CHILD PRACTICE REVIEW** CR presented the report drawing attention to the recent publication of the Child Practice Review (CPR) relating to the sad death of a young person that was a Powys resident. The report does not go into detail but describes the work done to date, and how the findings of the Child Practice Review will continue to inform the improvements and actions to be undertaken by the Health Board. Attention was drawn to following matters:

	• the action plan will be owned by Mid and West Wales Safeguarding Board; • the action plan will not be made public; and • the Health Board will ensure that, in line with the Duty of Quality and Candour, the actions within the organisations responsibility are undertaken. Independent Members asked the following questions for assurance: *What is the gap in professional curiosity that this report highlights? What has been done to address this, should that gap exist?* CR advised that safeguarding was a highly complex area and whilst professional curiosity was required it was necessary to remember that human factors are at play in the way caseloads are managed and how day to day events are presented to professionals. Many factors will impact on a clinicians assessment, but some factors may not be seen by the clinician. KW noted professional curiosity was critical and this was a welcome reminder of this. *The report says that an annual audit plan of the Children Not Brought policy was carried out in December. What was the outcome of that? From previous experience children who are not brought and children who are not visible are a common theme in Child Practice Reviews.* CR advised that the outcome of the Audit would be shared with Members. *What mechanisms can be strengthened to ensure that the voice of the child is heard when dealing with complex cases?* CR advised much of work has been done to ensure that for Children Looked After, that the young person's social and care plan is owned by them in partnership with health providers and social workers as part of the care coordination team. It is good practice to be able to demonstrate that the voice of the child is front and centre to their care plan. For a very young child the Parenting Charter and the voice of the parent is very important. The outcome of the Was Not Brought Audit in December 2023 is to be circulated to the Committee. **ACTION: Director of Nursing, Quality, Women and Family Health**

	A report is to be provided to a future meeting of the Committee focusing on the work being undertaken, and the mechanisms in place to ensure that the voices of the children and young people are being heard. **ACTION: Director of Nursing, Quality, Women and Family Health** The Committee: 1. **NOTED** the recommendations within the Concise Practice Review for PTHB, 2. **NOTED** the reviews and improvements undertaken to date., 3. **NOTED** the internal process to implement and monitor the PTHB Specific Practice Review Learning within the Safeguarding Practice Improvement Group which reports to the Strategic Safeguarding Group, and 4. **NOTED** the expected date for the Mid and West Wales Safeguarding Board CPR Multi Agency Action Plan to be shared with Safeguarding Board members.
ITEMS FOR APPROVAL	
PEQS/24/10	**COMMITTEE ANNUAL REPORT** The Chair introduced the report which summarises the 2023-24 key areas of business and activity. Independent Members asked the following questions for assurance: *Given there is a theme about sustainability, is there something specific about considering areas that have got high vacancy and high agency use because of the impact that that has on the quality and sustainability of services. Is this something to consider going forward?* KWi advised the matter will be considered in the future work programme, and the Terms of Reference for the Committee could potentially be updated. **ACTION Director of Corporate Governance** The Committee: • **CONSIDERED** the Patient Experience, Quality and Safety Committee Annual Report for 2023/24 summarising the key areas of business activity undertaken; and • **RECOMMENDED** the report to the Board for the 22 May 2024 meeting.
PEQS/24/11	**COMMITTEE ANNUAL WORK PROGRAMME**

	HB confirmed the work programme will follow at the next meeting. HB advised the information received from the Terms of Reference and the Committee Effectiveness review is being collated, the Board will then receive an overview of this information which will be brought back to this Committee for consideration.
ITEMS FOR DISCUSSION	
There were no items for discussion	
ESCALATED ITEMS	
PEQS/24/12	**INFECTION PREVENTION AND CONTROL (IPC) IMPROVEMENT PLAN PROGRESS REPORT (CONTAINED WITHIN THE INTEGRATED QUALITY REPORT)** KWi noted this had been considered as part of the Integrated Quality Report and details would be included in her Chair's Report to the Board. Independent Members asked the following questions for assurance: *How does a matter get to be de-escalated?* HB advised that the IPC Annual report will be brought to the next Committee meeting; this will allow this Committee to consider the escalation status, and if there is further work to be done or if the matter can be de-escalated to business as usual.
ITEMS FOR INFORMATION	
PEQS/24/13	The following Internal Audit Reports were shared for information: • Annual Internal Audit Plan (2024/25) • Board Committee Effectiveness (2023/24) • Infection Prevention and Control
OTHER MATTERS	
PEQS/24/14	**COMMITTEE RISK REGISTER** HB introduced the Risk Register noting that Risk 3 relates to the potential for poor quality care, which this is a live risk across the organisation. IP raised concerns about the lack of a single Integrated record of care. Staff are having to use multiple systems, both paper and electronic, which is a significant risk to the continuity and the quality of care as the information needed to effectively treat the patient does not appear in one place. This has an impact on quality and raises the profile of

	Digital First as an enabler. The Committee: • **CONSIDERED** the corporate risks within the committee's remit, and • • took **ASSURANCE** that risks are being managed in line with the Risk Management Framework.
PEQS/24/15	**ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND/OR OTHER COMMITTEES** The Committee will bring to the attention of Board the local escalation of Mental Health Services and will update Board on Infection Prevention and Control.
PEQS/24/16	**ANY OTHER URGENT BUSINESS** There was no other urgent business.
PEQS/24/17	**DATE OF THE NEXT MEETING** To be confirmed, via Microsoft Teams.
PEQS/24/18	**CONFIDENTIAL ITEM** 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.***

PRESENT:

Kirsty Williams	(Chair)
Jennifer Owen Adams	(Independent Member)
Simon Wright	(Independent Member)
Ian Philips	(Independent Member)

IN ATTENDANCE:

Claire Roche	(Director of Nursing and Midwifery)
Pete Hopgood	(Director of Finance, Information and IT)
Kate Wright	(Medical Director)
Hayley Thomas	(Chief Executive Officer)
Helen Bushell	(Director of Corporate Governance)
Liz Patterson	(Interim Head of Corporate Governance)

APOLOGIES FOR ABSENCE:

Joy Garfitt	(Interim Director Operations, Community Care and Mental Health)
Claire Madson	(Director of Therapies and Health Sciences)

PEQS IC/24/19	**DECLARATIONS OF INTEREST** There were no declarations of interest
PEQS IC/24/20	**MINUTES OF THE IN-COMMITTEE MEETING HELD ON 23 JANUARY 2024** The minutes of the In-Committee meeting held on 23 January 2024 were approved as a correct record subject to correcting the date of the next meeting.