PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE

CONFIRMED MINUTES OF THE MEETING HELD ON 07 NOVEMBER 2024 at 10:00 VIA MICROSOFT TEAMS

MEMBERS		
Kirsty Williams	KWi	Vice Chair (Committee Chair)
Steve Elliot	SE	Independent Member
Mick Giannasi	MG	Independent Member
Simon Wright	SW	Independent Member
IN ATTENDANCE		
Zoe Ashman	ZA	Interim Assistant Director Women & Children
Helen Bushell	HB	Director of Corporate Governance / Board Secretary
Jason Crowl	JC	Assistant Director of Support Services (for item 4.4)
Amanda Edwards	AE	Assistant Director Innovation and Improvement
Nicola Johnson	NJ	Executive Director of Planning, Performance and Commissioning (for item 4.2)
Elaine Lorton	EL	Executive Director of Primary Care, Community and Mental Health
Claire Madsen	CM	Executive Director of Allied Health Professionals, Health Sciences and Digital
Mark McIntyre	MM	Deputy Director People and Culture (for item 5.2)
Claire Roche	CR	Executive Director of Nursing, Quality, Women and Family Health
Heidi Sinclair	HS	Head of Quality and Safety
Richard Stratton	RS	Assistant Medical Director
Jayne Wheeler-Sexton	JWS	Assistant Director of Nursing, Safeguarding
APOLOGIES FOR ABSENCE:		
Jennifer Owen Adams	JOA	Independent Member
Hayley Thomas	HT	Chief Executive
Debra Wood Lawson	DWL	Executive Director People and Culture
Kate Wright	KW	Executive Medical Director

1. PRELIMINARY MATTERS

1.1 WELCOME AND APOLOGIES (PEQS/24/47)

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

1.2 DECLARATIONS OF INTEREST (PEQS/24/48)

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

1.3 PATIENT STORY (PEQS/24/49)

The Committee received a recording produced by Larna Andrew, Paediatric Physiotherapist outlining Meggie's experience of physiotherapy in Powys.

Members welcomed the story noting how there had been a focus on supporting Meggie to achieve her goal of becoming a lifeguard. Arrangements for transition between children's and adult services was raised and it was confirmed that a paper on transition arrangements would be brought to the next meeting.
Action: Executive Director of Nursing, Quality, Women and Family Health

Thanks were expressed to Meggie and the Physiotherapy Team for sharing the story.

2. CONSENT AGENDA BUSINESS

The Chair asked members if they wish to bring forward any items from the Consent agenda to the main agenda. No items were raised.

3. ITEMS FOR APPROVAL / DECISION / RATIFICATION

3.1 MINUTES OF PREVIOUS MEETING (PEQS/24/50)

The minutes of the meeting held on 05 September 2024 were **CONFIRMED** as an accurate record.

3.2 COMMITTEE ACTION LOG (PEQS/24/51)

HB outlined the Action Log recorded updates with the following information provided:

- Two actions (PEQS/23/39a and b) have been deferred to the February 2025 meeting with the consent of the Chair and remain recorded as 'on track',
- Two actions (PEQS/24/10 and 24/31) are not yet due and remain 'on track', and
- The remaining outstanding actions had been closed.

4. ESCALATED ITEMS

4.1 MENTAL HEALTH SERVICES UPDATE (PEQS/24/52)

CR presented the update outlining that Mental Health Services had been placed in local escalation by the Executive Committee under the Integrated Quality and Performance Framework in March 2024. An Executive Oversight Group had been established chaired by the Executive Director of Nursing, Quality, Women and Family Health. An Improvement Plan was established and the progress to date outlined. The Executive Committee had considered the progress made and continued delivery of the implementation plan and agreed the service be de-escalated from 16 October 2024.

Members asked the following questions for assurance:

How is the organisation responding to the leadership scores on page 9 of the appendix which appear to show concerns relating to 'empowers develops potential' and 'adapts to change, supporting others to do the same'?
CR advised that a Workforce and Culture Group had been established comprised of colleagues from Mental Health Services and the People and Culture service to improve leadership skills in the service.

Has the service been in local escalation for sufficient time to demonstrate sustained improvement, and, how robust is the evaluation process which has led to the de-escalation – the service has moved through the maturity matrix at lightning speed; however, the report contains information such as in relation to levels of agency staffing which do not align with a mature service?
CR advised that local escalation was a means to put in place an immediate support and oversight group with very specific parameters for improvement. On de-escalation, services are overseen by way of Integrated Quality and Performance Groups. Mental Health Services were the first service to be put into local escalation under the Integrated Quality and Performance Framework and learning from this experience will be used when considering arrangements for other services which may be at risk of going into local escalation.

When a service goes into local escalation a considerable amount of support is put in place which will disappear when the service is de-escalated. What confidence is there that the necessary improvements will continue when intense levels of support are removed?
EL advised that whilst the team have been in escalation there has not been a substantive Executive Director in post, but her recent appointment had settled this position. The focus now was to review the interim leadership team and make substantive appointments and ensure the progress made to date was built upon.

NJ noted that a lessons learned report would be undertaken which would be considered by Executive Committee and this Committee. The first round of Integrated Quality Performance Reports was taking place and a one-year review of the Integrated Quality and Performance Framework was also planned.

HB added that colleagues from Mental Health Services would be invited to a future meeting of the Committee to outline their experience of a service under escalation.

The Committee:

1. **TOOK ASSURANCE** that the implementation of the IQPF Escalation Oversight mechanism is providing robust oversight of the quality improvement and risk mitigation work being undertaken within Mental Health Services.
2. **NOTED** and **DISCUSSED** the contents of the report including progress that has been made against the improvement plan**.**
3. **NOTED** the Executive Committee decision that the service group is de-escalated at this point, taken on the 16 October 2024.
4. **NOTED** the service would continue to need further support.
5. **REQUESTED** an update to the February 2025 meeting of the Committee.

Action: Executive Director of Primary Care, Community and Mental Health

6. **REQUESTED** the review of the Integrated Quality and Performance Framework be brought to a future meeting of the Committee.

Action: Executive Director of Planning, Performance and Commissioning

4.2 NEURODIVERSITY SERVICES (PEQS/24/53)

KWi advised that this item had been transferred from the Delivery and Performance Committee to ensure an appropriate focus on quality as well as performance of the service.

ND as Senior Responsible Officer introduced the item outlining that Executive Committee via the Integrated Quality and Performance Framework had identified concerns that has resulted in a decision to put the service into Level 3 local escalation. An Executive Oversight Group (EOG) had been established which will meet fortnightly where the improvement plan and de-escalation criteria will be established. The EOG will report monthly to Executive Committee and to each meeting of this Committee.

Members asked the following questions for assurance:
Can assurance be given that putting a service into escalation will not delay improvement?
CR as operational lead for the service explained that the service welcomed the additional focus that local escalation would provide. The service was already working on improvements rather than waiting to produce an improvement plan. Learning from the experience of Mental Health Services in escalation has shown a need to be clear about de-escalation criteria.

NJ shared that in addition to the operational improvement already taking place additional funding to tackle the backlog has been confirmed by Welsh Government.

What mechanisms can be put in place to enable the Committee to receive feedback from the two Co-production Groups that have been established?
ZA confirmed that two Co-production Groups had been established with representatives from the Health Board, the County Council and parents of children and young people. Feedback from these groups would be brought to the February 2025 meeting of the Committee.
Action: Executive Director of Nursing, Quality, Women and Family Health

There appears to be common issues arising among the two services that have gone into escalation (leadership, staffing etc). What actions are being taken to enable early identification of issues that can be addressed to avoid escalation?
CR advised that, as the arrangements put in place to undertake Integrated Quality Performance Reports, and as the Integrated Quality and Performance Framework matured, it will be possible to identify themes and areas of commonality which will enable earlier identification of emerging issues.
CR thanked Deb Austin for the work she had undertaken, commissioned by the Chief Executive to review the service and offer constructive challenge.

The Committee:

- **RECEIVED** the paper and **NOTED** the Executive Committee's decision to place the service into Level 3 local in line with the escalation framework within the IQPF.
- **NOTED** the assurance reporting timetable back to the PEQs Committee.

4.3 CIVICA – PATIENT EXPERIENCE SYSTEM (PEQS/24/54)

KWi noted this item was escalated to the Board, however, would be addressed under item 6.1 Patient Experience Framework.

4.4 INFECTION PREVENTION CONTROL (PEQS/24/55)

KWi noted this item was escalated to the Board, however, would be addressed under item 5.1 Integrated Quality Report.

5.ITEMS FOR ASSURANCE

5.1 INTEGRATED QUALITY REPORT (PEQS/24/56)

CR introduced the paper and drew attention to the following areas:

- Progress in responding to concerns within the 30-day deadline had been sustained although low numbers meant this indicator may be subject to volatility. It is necessary to ensure that the quality of response is maintained,
- Overall, the organisation is predominantly responding to concerns via early resolution,
- Incident management figures are shown in graphs 6 and 7 and show the Health Board has focussed on closing incidents in a timely manner (the large number of open incidents in Mental Health Services had been an indicator of problems in that service),
- The disaggregated data for pressure ulcers is included along with learning that has taken place in pressure ulcer panels,
- The Public Services Ombudsman for Wales (PSOW) Annual Letter had been received confirming 21 complaints had been submitted, and the PSOW had intervened in 14% of cases, and
- Infection Prevention and Control remains an escalated item (in quarter 1 of year 2 of the improvement plan). 93% of actions are completed and improvements now need to be embedded and sustained.

Members asked the following questions for assurance:
What is the mechanism for responding to concerns and issues raised in the Llais reports?
HB advised that a group including participants from the Health Board, Llais and the County Council meet regularly to consider feedback to Llais. Llais send a Regional Directors report to the bi-monthly Board meetings.

Most of the feedback shown in graph 13 relates to outreach services. What response is received from locally provided services including GPs and Pharmacies?
HS acknowledged that there was much work to be done to fully utilise the Civica system and this would be covered further in the Patient Experience Framework presentation.

The Committee:

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

5.2 HEALTH AND SAFETY QUARTERLY REPORT (PEQS/24/57)

MM presented the quarter 2 report on Health and Safety Performance and drew attention to the following areas:

- An Internal Audit Review of Health and Safety arrangements had given 'Reasonable' assurance in 2023 with nine management actions. Three remain outstanding and the progress made was detailed within the report,
- Overall, the number of incidents remains low, however, the number of RIDDOR reports is increasing. Analysis of these reports show there is no particular trend or area of concern,
- The number of incidents of violence and aggression is of concern and further work has been requested to analyse the data to check against the strategies and training in place,
- Stress, anxiety and depression account for 10% of all episodes of absence and further work is taking place to ascertain if patterns of stress absence can be identified, and
- Did Not Attend rates at training sessions are an area of concern, particularly in relation to face fit testing.

Members asked the following questions for assurance:
There appears to be a mismatch between training for violence and aggression and incidents thereof. Does the training offered meet what is required?
MM advised that Aneurin Bevan University Health Board had been commissioned to provide this training and it will be necessary to ascertain if the original amount of training commissioned was more than was actually required.

Is there a cost to training not attended?
MM confirmed there was a cost relating to training not attended. There is a degree of complexity relating to front line staff accessing training.

Is over provision of training restricted to Health and Safety training or is it wider noting the Cabinet Secretary has been clear that NHS Wales must drive out waste?
MM noted there was an ever-increasing demand from Government for statutory and mandatory training. Frontline clinical staff are required to undertake 67 hours of training within their first year, however, with pressures on front line staff it is difficult to provide accessible training. The People and Culture team alongside the Nursing Directorate are considering how to prioritise the training offer but this is acknowledged as a risk. A conversation is also taking place with Welsh Government as, whilst each individual training requirement makes sense, cumulatively it is unsustainable. The aim is to reduce the rate of Did Not Attend training.

Can training be provided ward by ward to enable frontline staff to be away from their post for the shortest time? Travel is a barrier to training accessibility.
MM confirmed this was part of the wider discussion to enable the most people to access training at an economy of scale.

The Committee:

1. **RECEIVED** the contents of the key Health and Safety metrics for Quarter 1 and 2 took **ASSURANCE** that appropriate reporting arrangements are in place.

5.3 MONITORING OF HEALTH BOARD ACTIONS FROM CHILD PRACTICE REVIEW (PEQS/24/58)

CR presented the update of progress against actions arising from the Concise Child Practice Review (CYSUR 3 2021) resulting from the sad unexpected death of a young person in Powys in 2020. The Mid and West Wales Safeguarding Board are responsible for monitoring improvements against the nine recommendations made. Five of the recommendations relate specifically to the Health Board and progress against the five recommendations was outlined within the report.

The Committee:

1. Took **ASSURANCE** in relation to the progress and improvements made in implementing the Concise Child Practice Review (CYSUR 3 2021) Action Plan.

5.4 ANNUAL ASSURANCE REPORT MEDICAL DEVICES AND POINT OF CARE TESTING (PEQS/24/59)

JC presented the paper which gave an overview of the performance of the Medical Devices and Point of Care Testing over 2023-24 and a review of the challenges and risks drawing attention to the following areas:

- Progress is being made against the recommendations of the Internal Audit undertaken in 2021 with four recommendations complete and elements outstanding in relation to staff training, contract monitoring and point of care testing,
- Risks on the Therapies and Health Sciences Directorate Risk Register include point of care testing and governance, equipment maintenance and acquisition of medical devices,
- There have been 67 incidents report with no particular theme other than failure of a medical device,
- 17 Freedom of Information requests have been received largely from the commercial sector,
- Training challenges relate to capacity and ability to undertake training across the Powys sites,
- £167k has been received to purchase replacement equipment,
- £1m has been received as part of the Radiology Information System Procurement for new radiology equipment,
- Additional equipment made available during the pandemic has been distributed, and
- Contract monitoring has improved.

EL welcomed the report, supported the point of care testing arrangements in place and would like to see the service extended to the rural population in Powys.

Members asked the following questions for assurance:
The replacement of out-of-date equipment is welcomed. What arrangements are in place for this to be removed from service areas rather than taking up valuable storage space?

JC advised that close working was being undertaken with contractors picking up stock that needs to be removed and recycled via appropriate decontamination arrangements.

What arrangements are in place to ensure appropriate storage arrangements are in place across the whole of the estate?
JC acknowledged storage is a challenge to ensure that items are stored appropriately across multiple sites. The service is working with estates on arrangements to have a central site in Bronllys that would provide equipment on a 'just in time' basis.

CM added that when the service transferred to her area there was no electronic inventory. An inventory system W-POCT was purchased, and items uploaded from beds to handheld items used by community colleagues. The system receives alerts relating to individual pieces of kit that need to be removed. A governance structure has been put in place with the clusters which will develop this work in primary care to the further benefit of patients.

The Committee:

- **REVIEWED** the attached report and accept this as an accurate overview of the service.
- Took **ASSURANCE** that the medical devices and Point of Care Testing requirements have been fulfilled.

5.5 CLINCIAL AUDIT PROGRESS REPORT (PEQS/24/60)

RS presented the report giving an update on the 2024/25 Clinical Audit Plan drawing attention to:

- the introduction of the Medical E-Governance (MEG) system for ward level audits enabling trends and learning to be identified,
- the intended work with primary care regarding audit and improvement activities as part of revalidation processes,
- a spotlight audit of the Respiratory Care Programme for children with severe Cerebral Palsy, and
- changes to the clinical audit programme were outlined

The Committee:

- **RECEIVED** the update report and took **ASSURANCE** that clinical audit is progressing in year.

5.6 COMMITTEE RISK REGISTER (PEQS/24/61)

HB presented the report advising that this was the first time the new version of the Committee Risk Register had been shared with the Committee since the revised Corporate Risks were taken through Board in September 2024. Two risks fall under this Committee:

- Risk 004: Increase in demand, inequality of access, complexity of patient needs, or failure to respond to demand pressures for PTHB provided services results in poorer outcomes and experience for the citizens of Powys, and
- Risk 005: Increase in demand, inequality of access, complexity of patient needs, or failure to respond to demand pressures for commissioned

services results in poorer outcomes and experience for the citizens of Powys. Commissioned services may include urgent and emergency health and social care system.

Risk 004 is owned by the Executive Director of Planning, Performance and Commissioning and the Executive Director of Primary Care, Community and Mental Health, and Risk 005 is owned by the Executive Director of Planning, Performance and Commissioning.

The Risk Register is reported to each meeting of the Board and the Committee will get information slightly before Board, or information that has already been received at Board depending on the Committee and Board meeting cycle.

The Committee:

- **RECEIVED** and **DISCUSSED** the corporate risks within the Committee's remit and any relevant issues
- **TOOK ASSURANCE** that risks are being managed in line with the Risk Management Framework.

6. ITEMS FOR DISCUSSION

6.1 PATIENT EXPERIENCE FRAMEWORK (PEQS/24/62)

CR gave a presentation on the People's Experience Framework to be made available with Committee Members after the meeting:

- The title has changed from 'Patient Experience Framework' to 'People's Experience Framework' to align with work ongoing nationally with an official national launch anticipated in Spring 2025,
- The Framework will encompass a number of areas including Putting Things Right, Duty of Candour, collaborative partnerships with Llais – Independent Advocacy, Public Services Ombudsman for Wales, and support the Health and Care Quality Standards,
- The Framework will require experience measures to be built into contractual arrangements (commissioned services),
- Robust validation will be required to include five core questions in every survey,
- The Safe Care Partnership will support public co-design of services,
- The HOPE (Head of Patient Experience) Network is a peer network in place for support and shared learning,
- PTHB assets include a Bereavement Service, the CIVICA patient experience survey system (in place since December 2022), the DATIX system which records enquires and concerns and the Patient Experience Steering Group including participants from across the Health Board, Primary Care and Community Services colleagues,
- Other assets include the Dementia Leads Steering Group, a multi-stakeholder group with colleagues from Powys County Council and people living with dementia, the Engagement and Insight Group (which includes the Regional Partnership Board and Public Service Board), Mental Health Services stakeholder groups, Children's Services stakeholder groups and a Quality and Safety Patient Experiences group for Therapies and Health Sciences,
- There are a number of building blocks in place and these need to be developed and connected so the whole patient experience story is told,

- It is intended to appoint a Patient Experience Co-ordinator reporting to the Head of Quality and Safety from within the Directorate to bring together all the work taking place across the organisation on patient experience,
- The Audacity App is available to help produce patient stories by colleagues across the various services but there is a current lack of capacity within the team to support this, and
- A draft Patient Experience Framework will be brought to the next meeting of the Committee.

Members made the following comments:

- *Can the Framework be explicit to outline how both themes are being picked up, and action is being taken by the organisation to address such themes?*
- *Whilst it is difficult to make a case for investment in the current financial situation it is incumbent on Board Members to champion the use of Patient Experience to improve safety and reduce harm in a very difficult environment.*
- *Can the Framework make explicit the links to other parts of the system such as Risk?*

CR suggested that the use of Patient Stories in other Committees could be considered, along with accessing patient stories collected by other organisations such as the Welsh Ambulance Services Trust which relate to patients in Powys.

Action: Director of Nursing, Quality, Women and Family Health (to bring the Draft People Experience Framework to the February 2025 meeting of the Committee).

7. CONSENT AGENDA

7.1 JOINT COMMISSIONING COMMITTEE QUALITY PATIENT SAFETY COMMITTEE SUMMARY REPORTS (PEQS/24/63)

The Committee **RECEIVED** the Joint Commissioning Committee Quality Patient Safety Committee Summary Reports of 16 July and 17 September 2024.

7.2 INTERNAL AUDIT REPORTS (PEQS/24/64)

The Committee **RECEIVED** the Internal Audit Report on End-of-Life Care Services which had been received by the Audit, Risk and Assurance Committee on 08 October 2024. Further Internal Audits would be received where relevant to the remit of the Committee.

7.3 WORK PROGRAMME (PEQS/24/65)

The Committee **RECEIVED** the Committee Work Programme as of November 2024.

8. OTHER MATTERS

8.1 ANY OTHER URGENT BUSINESS (PEQS/24/66)

There were no items of any other business.

8.2 ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND/OR OTHER COMMITTEES (PEQS/24/67)

It was noted that the Chair would reference that:

- Mental Health Services had been removed from local escalation by the Executive Committee, but that a further update report would be brought to the next meeting of the Committee and this item would remain escalated to Board,
- Neurodiversity Services have been put into local escalation (a new escalation to Board),
- Patient Experience Framework – that work continued, and a draft Framework will be brought to Committee in February 2024, and
- The improvement plan for Infection, Prevention and Control is broadly complete and assurance will now be sought that the improvements are embedded.

8.2 COMMITTEE REFLECTION (PEQS/24/68)

The following summary of business and reflections were provided by members:

- A temporary member of the Committee took assurance that the organisation has an open and transparent approach that is not shy to put services into local escalation where appropriate
- A different temporary member of the Committee welcomed the easy to read, informative papers which picked out key issues. The open conduct at the meeting was welcomed and the lack of defensiveness noted
- An Executive Director noted real challenge from Independent Members with a good level of scrutiny and impactful questions
- The Director of Corporate Governance noted the important link between finance and quality and welcomed the discussion and Independent Member feedback on Patient Experience.

8.3 DATE OF NEXT MEETING (PEQS/24/69)

The date of the next meeting is scheduled on 11 February 2025 at 09:30 via Microsoft Teams.

Meeting closed at 13.08