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Bwrdd Iechyd
Addysgu Powys
Powys Teaching
Health Board

PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE

CONFIRMED MINUTES OF THE MEETING HELD ON 29 APRIL 2025 at 09:00 THE BOARD ROOM, MACHYNLLETH HOSPITAL AND VIA MICROSOFT TEAMS

| MEMBERS | | |
|-------------------------------|-----|--|
| Kirsty Williams | KWi | Vice Chair (Committee Chair) |
| Jennifer Owen Adams | JOA | Independent Member (Third Sector) |
| Ian Thomas | IA | Independent Member (General) |
| IN ATTENDANCE | | |
| Zoe Ashman | ZA | Interim Assistant Director Women & Children |
| Katie Blackburn | KB | Regional Director of Llais |
| Helen Bushell | HB | Director of Corporate Governance / Board Secretary |
| Susan Dinsdale | SD | Head of Nursing for Children |
| Amanda Edwards | AE | Assistant Director Innovation and Improvement |
| Nicola Johnson | NJ | Executive Director of Planning, Performance and Commissioning (for Item 4.1) |
| Louisa Kerr | LK | Assistant Director Mental Health (for Item 5.4) |
| 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 |
| Claire Roche | CR | Executive Director of Nursing, Quality, Women and Family Health |
| Heidi Sinclair | HS | Head of Quality and Safety |
| Kate Wright | KW | Executive Medical Director |
| APOLOGIES FOR ABSENCE: | | |
| Carl Cooper | CC | Chair of PTHB Board |
| Hayley Thomas | HT | Chief Executive |
| Simon Wright | SW | Independent Member |

1. PRELIMINARY MATTERS

1.1 WELCOME AND APOLOGIES (PEQS/25/01)

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

1.2 DECLARATIONS OF INTEREST (PEQS/25/02)

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

1.3 PATIENT STORY (PEQS/25/03)

A recording of the experience of two parents accessing neurodiversity assessments and services was shared with the Committee. The patient story linked to a later item on the agenda on neurodiversity services in escalation and KWi expressed gratitude to the participants for sharing their experiences.

2. CONSENT AGENDA BUSINESS

The Chair asked members if they wished to bring forward any items from the Consent agenda to the main agenda.

No items were raised by Committee Members.

3. ITEMS FOR APPROVAL / DECISION / RATIFICATION

3.1 MINUTES OF PREVIOUS MEETING (PEQS/25/04)

The minutes of the meeting held on 11 February 2025 were **CONFIRMED** as an accurate record.

3.2 COMMITTEE ACTION LOG (PEQS/25/05)

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

- PEQS/24/52b 'Mental Health Services update - A review of the Integrated Quality and Performance Framework'. EL suggested this action should be split into two with one action relating to the ongoing monitoring of Mental Health Services post escalation (timescale to be agreed after the Item 5.4 Staff experience of Mental Health and Learning Disabilities service in escalation), and one action relating to the review of the Integrated Quality and Performance Framework to be brought to the July meeting of the Committee.

Action: Director of Corporate Governance

The remaining actions were noted as either not yet due or completed.

3.3 COMMITTEE ANNUAL WORK PROGRAMME 2025/26 (PEQS/25/06)

HB presented the work programme which had been created based on the terms of reference, risk registers and other sources of information. It was noted that the work programme would remain flexible throughout the year to accommodate any matters that arose.

Members asked the following questions for assurance:

How will cross cutting issues such as Better Together be routed through Committees?

HB advised that the Joint Chair's Forum had a role to play in deciding where cross-cutting matters were placed. It was likely that the Better Together programme would be considered at the Board rather than at Committee level.

Is there a formal process for moving items between Committee Work Programmes?

HB advised that the Committees work collaboratively and items that have been referred to another Committee are recorded in the minutes and tracked via the action log.

CM requested the addition of an Annual Report on Medical Devices and ad hoc audits to be included on the Annual Work Programme.

KWi suggested that consideration should be given as to whether this should be included in the Terms of Reference for the Committee.

Action: Director of Corporate Governance

The Committee **APPROVED** the Committee Work Programme for 2025/2026.

3.4 COMMITTEE ANNUAL REPORT (PEQS/25/07)

The Patient Experience, Quality and Safety Committee Annual Report 2024/25 was **APPROVED**.

NJ joined the meeting 09.35

4. ESCALATED ITEMS

4.1 CHILDREN'S NEURODIVERSITY SERVICES (PEQS/25/08)

NJ presented the report which provided an outline on progress at six months in relation to escalation status. Attention was drawn to the following areas:

- The service model had been redesigned and modernised and service standards were now met
- All apart from one of the actions identified in September had been completed. The remaining action was now underway
- Additional funding from Welsh Government had enabled the service to reduce waits to under 2 years
- Since March 2025 the internal wait list has been cleared
- The 2025/26 plan is to maintain the 2 year wait list enabled by a commitment from the Executive team to maintain temporary staffing levels
- It will be necessary to demonstrate sustained improvement before de-escalation can be considered

CR noted that whilst a considerable amount of progress had been made challenges remained.

Members asked the following questions for assurance:

Has turnover of workforce contributed to the problems in this service?

ZA advised that workforce turnover had not been a contributing factor. There was a small core workforce supplemented by temporary staff funded by Welsh Government which had enabled the service to be transformed.

KW noted the common theme expressed in the patient story that communications needed to be improved, and now the service has been reorganised it will be possible to provide better communications with patients.

ZA advised that it was now possible to share with patients the number they are on the list and confirm that they will be seen within two years. There are currently around 1,100 children on the list, and these will be seen in turn rather than cases being expedited.

Does the Health Board have the resources to meet the demand in this service?

CR advised that time limited funding had been received from Welsh Government to improve the service. This had ceased, and it was the responsibility of the Health Board to put in place sustainable arrangements.

Are there opportunities for the third sector to provide support which would enable the Health Board to focus on core provision?

CR advised it had been necessary to get the foundations of the service right and then work with colleagues in the local authority to provide support that is not medicalised. The service is only seeing those children that need to be assessed, and where assessment is not appropriate the family are signposted to appropriate services.

Feedback from staff highlights this has been a particularly challenging period. What support is in place for staff?

SD advised the team were on a firebreak week ensuring all the processes are working correctly with opportunities to feedback difficulties. Training and supervision are priorities.

EL noted it was necessary to look after the well-being of the senior leadership team in addition to the operational team

Thanks were expressed to the team for the work undertaken to improve the service.

KWi requested that the next update include details regarding the funding for the service.

Action: Executive Director of Planning, Performance and Commissioning

The Committee:

- **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 Neurodevelopmental Services

NJ left the meeting 10.00

4.2 CIVICA – PATIENT EXPERIENCE SYSTEM (PEQS/25/09)

KWi noted this item was escalated to the Board, however, would be considered under item 5.1 Integrated Quality Report and confirmed this item would remain as an escalated item.

4.3 INFECTION PREVENTION CONTROL (PEQS/25/10)

CR presented the report advising Infection Prevention and Control was an area of concern two years ago. A gap analysis was undertaken and a two-year improvement plan developed. 45 of the 47 improvement actions have been completed with the remaining two actions due for completion in the next few weeks. Thanks were expressed to the Infection, Prevention and Control teams along with associated teams who have facilitated the improvements. The Executive Committee have recommended Infection Prevention and Control be de-escalated.

Members asked the following questions for assurance:

What assurance can be given that the improvements documented will be sustained after de-escalation?

CR advised that a sustainable workforce had been put in place with a number of roles which facilitated career progression, along with a Nurse Consultant. The audit

arrangements have been strengthened which will enable regular monitoring. Infection Prevention and Control performance will be reported to the Committee via the Integrated Quality Report.

The Committee:

- Took **ASSURANCE** from the progress and achievements within the Infection Prevention and Control improvement plan
- **NOTED** the plan has been de-escalated by Executive Committee.

5.ITEMS FOR ASSURANCE

5.1 INTEGRATED QUALITY REPORT (PEQS/25/11)

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

- Year-end compliance for response to concerns under Putting Things Right was 80% against a 75% target of a response within 30 days, although the Q4 figure was 71%. The Health Board are starting to use the Beacons dashboard to compare compliance against other Health Boards. The Health Board are taking 30 days to respond compared to some other Health Boards who respond in less than 20 days and the opportunity to respond more quickly whilst ensuring a quality response is the intention.
- Over half of Nationally Reported Incidents (NRIs) remain open for more than 90 days (in part due to complexity of pathways and a small investigation team). Whilst recognising the improvements in response times, the Beacons dashboard has identified areas where more improvement can be made
- The Welsh Risk Pool assessment identified six areas of substantial assurance with one area of reasonable assurance which included two red items (investigation outcomes to be recorded on DATIX, and Key Performance Indicators are needed for managing incident reporting)
- Duty of Candour incidents are increasing which is welcome as it demonstrates colleagues developing confidence in handling these matters
- The Peoples Experience Framework has been recently published by Welsh Government. The Health Board are now undertaking a self-assessment against the framework. A Patient Experience Lead is being recruited to facilitate co-ordination and reporting on patient experience.
- The Safeguarding in Health report has been published and a Safeguarding in Health assurance group will be created to increase the focus on safeguarding from a health perspective in response to a series of recent Child Practice Reviews

KW drew attention to recent changes which extended the work of Medical Examiners from initially reviewing deaths in secondary care and community hospitals to reviewing all deaths since September 2024. The process is well developed, however, there have been delays in the system nationally due to a quick roll out. These delays are being addressed nationally. The Health Board have a low number of referrals compared to other Health Boards and no significant concerns have been raised. The arrangements will enable whole system learning.

Members asked the following questions for assurance:

What has been the impact of resourcing the Patient Experience Lead, will other work cease to enable this work to be undertaken, and how does this link with the work that Llais produces?

CR noted that the proposals for patient experience, along with proposed changes to the Putting Things Right arrangements related to the Cabinet Secretary's aim to improve openness and transparency in health. Resource is a concern, and the impact of the proposed changes will need to be understood. The Health Board work closely with Llais whose Regional Director is a member of the Patient Experience Framework Steering Group to ensure maximum opportunities for information triangulation.

HB advised that Patient Experience was a matter escalated to Board by the Committee and the adoption of the Peoples Experience Framework will be a Board matter. Llais will be invited to a Board Development session in the summer to examine working arrangements in relation to patient experience between both organisations.

HS advised that the self-assessment against the People's Experience Framework was partially completed, and presentations are in preparation for Executive Committee on the revised Putting Things Right guidance to then share with teams across the Health Board.

KB confirmed that good sharing arrangements were already in place between the Health Board and Llais and stressed that there should be a rounded view of experience as there was on occasion a focus on negative experiences.

Is it known why some other Health Boards are able to respond more quickly to concerns than Powys?

CR advised that whilst benchmarking data was available there were questions such as, were concerns all recorded in the same way or did some Health Boards include minor concerns managed elsewhere under an early resolution process which could lead to differences in response times.

How will improvement in investigating NRIs be undertaken?

CR advised that this linked to the production of Key Performance Indicators which would be set and monitored as an outcome from the Welsh Risk Pools report. This will be included in the next Integrated Quality Report.

Action: Executive Director of Nursing, Quality, Women and Family Health

Is Powys specific data not available from the Medical Examiner service?

KW advised that Powys specific data was just becoming available and would be included in the next Integrated Quality Report.

Action: Executive Medical Director

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 ANNUAL CLINICAL AUDIT PROGRAMME (PEQS/25/12)

KW presented the report advising that each service areas draws up an audit plan. These focus on areas including perceived risk, where new processes have been put in place, where there have been incidents and where improvement is needed. This is collated into a Clinical Audit Programme and triangulation has been undertaken with input from senior colleagues. A quarterly Audit Hour has been introduced which will strengthen learning across the organisation.

Members asked the following questions for assurance:
What is done with the information gained by the audits?

KW advised that the information was examined in the Service Groups with any concerns being escalated as necessary.

HB suggested that the Annual Report on Clinical Audit should contain detail on assurance routes for reporting.

Action: Executive Medical Director

KWi noted consideration is being given to how the Committee hear from the service groups via the Integrated Quality Report

The Committee:

1. **RECEIVED** and **APPROVED** the Clinical Audit Plan 2025/26

5.3 MONITOR HEALTH BOARD ACTIONS OF JOINT INSPECTION OF CHILD PROTECTION ARRANGEMENTS (PEQS/25/13)

CR presented the Report noting the Joint Inspection of Child Protection Arrangements (JICPA) had taken place in autumn 2023 with the report published in February 2024. The Mid and West Regional Safeguarding Board monitored implementation of the action plan for all partners. In relation to Health Board actions, it was confirmed that all actions had been completed, however, attention was drawn to the continued difficulty in reaching 85% compliance for Level 3 safeguarding which is currently recording 75% compliance having risen from 59% compliance.

Members asked the following questions for assurance:

Why is it difficult to reach 85% compliance for Level 3 Safeguarding training?

CR explained that Level 3 safeguarding is delivered face to face, and difficulties arise in releasing staff from operational duties. This is a problem faced across Wales and is not specific to the Health Board.

How is the Health Board assured that information sharing across the complex pathways attended by Powys patients in place to ensure safe practice?

CM confirmed that Wales was some way off having seamless digital information sharing with local authorities commissioning their own separate systems. There will need to be an overarching connecting care approach which includes the ability to identify and escalate concerns identified in different organisations.

The Committee:

- Took **ASSURANCE** from the progress made in progressing the health board specific actions within the JICPA.

LK joined the meeting 10.55

5.4 STAFF EXPERIENCE OF MENTAL HEALTH AND LEARNING DISABILITY SERVICES IN ESCALATION (PEQS/25/14)

EL introduced the item noting that Mental Health and Learning Disability Services had been the first service subject to local escalation under the Integrated Quality and Performance Framework in March 2024.

LK gave a presentation noting weekly escalation oversight meetings had taken place, a maturity matrix and conditions of sustainability were established, with the service was de-escalated in October 2024. Attention was to the following areas:

- A number of helpful procedural matters had been identified,
- After initial anxiety staff felt well supported, but were challenged by additional asks, in particular in relation to two serious incidents when the escalation pace did not change,
- Senior Leadership Team found a level of resilience which was not expected but a significant amount of out of hours working was required resulting in some burnout and low immunity
- There were mixed views on whether the timing for de-escalation was right or too soon, but it is recognised the service is stronger and safer as a result of significant effort. It had been expected that de-escalation would feel like an achievement, but it felt like business as usual with sustaining the position whilst balancing operational issues remaining a challenge.

CR welcomed the feedback which helped colleagues understand the experience of escalation. The experience of a team previously under local escalation included a sense of fear and failure and the organisation needed to address this within the framework. Identifying the correct time to de-escalate was important as there is a sense of safety whilst in escalation.

EL observed that as an Executive Director who joined the organisation whilst the service in the process of de-escalation there was still a level of focus and pressure on the team and the impact will be long lasting.

KW noted that there had been significant improvements in the service but there remained more to do. A lesson learnt had been for services to ask for help as soon as difficulties are identified rather than waiting for problems to be noticed.

Members asked the following questions for assurance:

Is this a good example of compassionate leadership?

LK confirmed that being in escalation from a service perspective compassionate leadership had been felt. However, capacity remained a challenge which influenced the degree to which compassion was experienced.

KWi observed that when Velindre Ward had been visited by the Chair and Vice-Chair the staff had described management as an umbrella protecting staff from the stress of escalation.

When would be appropriate to receive an assurance report on post-escalation monitoring?

LK suggested that the autumn meeting would be appropriate as the service would be one year post escalation.

Action: Executive Director Primary Care, Community and Mental Health

LK left the meeting 11.25

5.5 ANNUAL ASSESSMENT OF COMMITTEE EFFECTIVENESS (PEQS/25/15)

HB presented the report outlining the results of the Committee Effectiveness review.

CR welcomed the feedback and noted that updates from service groups including Women's and Children's, Mental Health and Community Services would be included in the next Integrated Quality Report.

Action: Executive Director of Nursing, Quality, Women and Family Health

Members asked the following questions for assurance:

How content are the Committee that the improvement agenda is being sufficiently challenged?

CR was of the view that the Committee are impactful and had seen improvements, however, they may be an opportunity to challenge the other committees to see the duty of quality as central to work across the board.

5.6 REVIEW OF TERMS OF REFERENCE (PEQS/25/16)

HB presented the report noting the following items to be amended:

- The addition of Medical Appliances Annual Report
- Remove Clinical Quality Framework and add Integrated Quality and Performance Framework

Action: Director of Corporate Governance

The Committee:

- **ENDORSED** the proposed amendments to the Terms of Reference subject to the amendments listed above,
- **AGREED** that the Chair of the Committee and Director of Corporate Governance will finalise the revised Terms of Reference for presentation to the Board in May 2025 for approval.

5.7 COMMITTEE RISK REGISTER (PEQS/25/17)

HB advised that the Board had approved the Board Assurance Framework in March 2025 and work was underway to create a Strategic Risk Register and Organisational Risk Register which would be brought to Board in May 2025.

6. ITEMS FOR DISCUSSION

There were no items for discussion

7. CONSENT AGENDA

7.1 INTERNAL AUDIT REPORTS (PEQS/25/18)

The Committee **RECEIVED** the Internal Audit Report on Patient Flow and Discharge Management, and Additional Learning Needs Legislation which had been received by the Audit, Risk and Assurance Committee on 11 March 2025. These internal audits had reported Reasonable Assurance.

Further Internal Audits would be received where relevant to the remit of the Committee.

The Joint Commissioning Committee Quality Patient Safety Committee Summary Reports 03 February 2025 was received.

7.2 AUDIT WALES (PEQS/25/18)

The Committee **RECEIVED** the Audit Wales report on Cancer Services.

7.3 JOINT COMMISSIONING COMMITTEE QUALITY PATIENT SAFETY COMMITTEE (PEQS/25/20)

The Committee **RECEIVED** the Joint Commissioning Committee Quality Patient Safety Committee Highlight Report from the meeting held on 18 March 2025.

8. OTHER MATTERS

8.1 ANY OTHER URGENT BUSINESS (PEQS/25/21)

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/25/22)

It was noted that the Chair would provide updates on those items escalated to Board including the de-escalation of Infection Prevention and Control.

8.3 COMMITTEE REFLECTION (PEQS/25/23)

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

- Holding the meeting in person was welcomed
- It was challenging to Chair a hybrid meeting
- The sharing of presentations in advance was welcomed
- There was a real attention, focus and honest commitment to the agenda and welcoming of colleagues attending to share information
- A positive experience from those joining virtually

8.4 DATE OF NEXT MEETING (PEQS/25/24)

The date of the next meeting is scheduled on 31 July 2025 via Microsoft Teams.
Meeting closed 12.20

8.5. CONFIDENTIAL MATTERS

The Chair, with advice from the Director of Corporate Governance, has determined that the following items include confidential or commercially sensitive information which is not in the public interest to discuss in an open meeting at this time. The Board is asked to take this advice into account when considering the following motion to exclude the public from this part of the meeting:

Motion under Section 1(2) Public Bodies (Admission to Meetings) Act 1960

"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 | KWi | Vice Chair (Committee Chair) |
| Jennifer Owen Adams | JOA | Independent Member (Third Sector) |
| Ian Thomas | IA | Independent Member (General) |

IN ATTENDANCE

| | | |
|----------------|----|--|
| Zoe Ashman | ZA | Interim Assistant Director Women & Children |
| Helen Bushell | HB | Director of Corporate Governance / Board Secretary |
| Susan Dinsdale | SD | Head of Nursing for Children |
| Amanda Edwards | AE | Assistant Director Innovation and Improvement |
| 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 |

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| Claire Roche | CR | Executive Director of Nursing, Quality, Women and Family Health |
| Heidi Sinclair | HS | Head of Quality and Safety |
| Kate Wright | KW | Executive Medical Director |
| APOLOGIES FOR ABSENCE: | | |
| Carl Cooper | CC | Chair of PTHB Board |
| Hayley Thomas | HT | Chief Executive |
| Simon Wright | SW | Independent Member |
| 8.6 WELCOME AND APOLOGIES FOR ABSENCE (PEQS IC/25/25) | | |
| The Chair welcomed everyone to the meeting. Apologies for absence were noted as above. | | |
| 8.7 DECLARATIONS OF INTEREST (PEQS IC/23/26) | | |
| No interests were declared in addition to those already declared within the published register. | | |
| 8.8 BRIEFING ON SUICIDES (PEQS IC/25/27) | | |
| Rationale for item being held in private: Matters for which the discussion of which in public would be likely to prejudice the effective conduct of public affairs. | | |
| The Committee RECEIVED a briefing on recent unexpected deaths. | | |

Meeting closed at 12.38