POWYS TEACHING HEALTH BOARD
PATIENT EXPERIENCE, QUALITY & SAFETY COMMITTEE
CONFIRMED

MINUTES OF THE MEETING HELD ON THURSDAY 7 July 2022 VIA MICROSOFT TEAMS

Present:

Kirsty Williams	Vice-Chair (Committee Chair)
Ian Phillips	Independent Member
Mark Taylor	Independent Member

In Attendance:

Hayley Thomas	Director of Primary, Community Care and MH/Deputy CEO
Claire Roche	Director of Nursing and Midwifery
Kate Wright	Medical Director
Claire Madsen	Director of Therapies and Health Sciences
Mererid Bowley	Interim Director of Public Health
James Quance	Interim Board Secretary (from Item 7.1)
Amanda Edwards	Assistant Director – Innovation and Improvement
Jacqueline Seaton	Chief Pharmacist (for Item 2.4)
Bethan Hopkins	Audit Wales

Apologies for absence:

Vivienne Harpwood	PTHB Chair
Carol Shillabeer	Chief Executive
Zoe Ashman	Assistant Director of Quality and Safety
Mitchell Parker	Health Inspectorate Wales
Katie Blackburn	CHC

Committee Support:

Liz Patterson	Interim Head of Corporate Governance

PEQS/22/17	**WELCOME AND APOLOGIES FOR ABSENCE** The Committee Chair welcomed Members and attendees to the meeting and CONFIRMED there was a quorum present.
PEQS/22/18	**DECLARATIONS OF INTERESTS** No interests were declared.
PEQS/22/19	**MINUTES OF THE EXPERIENCE, QUALITY AND SAFETY COMMITTEE MEETING HELD ON 12 May 2022 (FOR APPROVAL)** The minutes of the previous meeting held on 12 May 2022 were AGREED as a true and accurate record subject to the following amendment: Page 5 paragraph 2: 'The rollout of the electronic All Wales ~~Staffing~~ *Nursing Care* Record continued….'
PEQS/22/20	**MATTERS ARISING FROM MINUTES OF PREVIOUS MEETING** There were no matters arising from the minutes of the previous meeting.
PEQS/22/21	**PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE ACTION LOG** It was noted that a number of actions had been outstanding for some time and there had been staffing changes in the interim period. It was requested that additional information be provided to each Director in relation to their actions which would enable a full response to be provided to the next meeting. **Action: Interim Head of Corporate Governance and all Directors with actions.**
ITEMS FOR ASSURANCE	
PEQS/22/22	**INTEGRATED QUALITY REPORT** <u>Quality Overview Report</u> The Director of Nursing and Midwifery presented the report and drew attention to a number of areas.

	• A multi-disciplinary learning event facilitated by the Assistant Director of Quality and Safety had been held to learn from an incident which had taken place. The team had been nervous to take part in this new way of learning, but feedback had been positive, and the staff were creating a short video describing the event and its impact which would be shared with the Committee in the September meeting. • The timetable for the implementation of the National Nosocomial Framework was outlined. The review of Wave 1 of the pandemic had concluded and no cases of harm/death had been identified, therefore it had not been necessary to undertake duty of candour conversations. • Further detail was provided regarding pressure area incidents with the reasons for no value fields outlined as: o incomplete investigations; and o changes/updates to the RLDatix system which required manual processing of completed investigations This area of work was a particular focus for the Assistant Director of Quality and Safety. • Since the last meeting of this Committee and following an Inquest, the health board has received a Regulation 28 Notice. The Committee will be updated on the Regulation 28 Notice when this is completed. *The detail within the report is welcomed. In respect of concerns it appears that there is capacity to manage around 30 concerns at a time but if there are more, or the concerns are complex, then the ability to respond within the 30 day response target is affected. What number of concerns should the health board be able to deal with and meet the 30 day response target?* The Director of Midwifery and Nursing advised that there is a backlog of concerns which need to be addressed. The target is to respond to 75% of concerns within a 30 day response period. This recognises that some concerns are too complex to be able to be responded to within 30 days. To improve the position it is intended to build confidence in early resolution, to improve the confidence of the investigators, and to improve the quality assurance process. Further work is required with the service groups to understand what the organisation is capable of before it is possible to ascertain if additional capacity is required.

	Additional information regarding the work undertaken would help Independent Members assess if additional capacity is required. Additional information including a summary of work to date, identified areas for improvement, and expected outcomes will be included as a presentation in the next quality report to assist the Committee to explore this matter. **Action: Director of Nursing and Midwifery** *What was the outcome at Executive Committee in June 2022 of the business case presented regarding the Management of Deprivation of Liberty Safeguards?* The Director of Nursing and Midwifery advised that the paper had not gone to the Executive Committee but had gone back to the Investment Benefits Group to prepare for the forthcoming implementation of the Liberty Protection Standards. The Committee DISCUSSED and NOTED the Quality Overview Report. <u>Maternity Assurance</u> The Director of Nursing and Midwifery presented the report and noted that there had been a requirement to complete a Maternity and Neonatal Assessment, Assurance and Exception Review and return to Welsh Government. This had taken place at a multi-disciplinary session on 31 May 2022. The findings would be used to inform national priorities, but the process had also been of use to the health board. There have been three Nationally Reportable Incidents (NRIs) submitted to the Delivery Unit between February and May 2022. For each incident, an Investigative Officer has been appointed. One incident would be subject to an external review and the other two investigations may also be subject to an external review. As Lead Officer the Director of Nursing and Midwifery had instigated fortnightly meetings to monitor the three incidents, and as findings became apparent, measures were immediately put in place. Issues of concern included an increase in women making choices outside guidelines and interim arrangements are in place to strengthen links with relevant support. A further

	issue related to the recording of data in relation to detecting small for gestational age babies, some of this was historically recorded by District General Hospital (DGH) Obstetric services. Arrangements have been put in place to ensure the input of this data for all Powys pregnancies. This will enable a Powys specific assurance report to be produced. The Maternity Governance Review was put in place because of a cluster of formal concerns regarding care in labour, or subsequent transfer from Maternity Services. It examined the incident management across the service and the process for dealing with open concerns and management. As a result of the review the Director of Nursing and Midwifery has placed the service in escalation and receives a weekly report including feedback on incidents and identification of any women close to their due date who are opting to act outside guidelines. *The establishment of a weekly forum is an extraordinary escalation. Is this a temporary arrangement and what would be the mechanism to step this down?* The Director of Nursing and Midwifery confirmed this was a temporary measure and was due to extraordinary circumstances. The current Head of Midwifery was leaving shortly to start a role elsewhere in Wales and this job had just gone out to advert. There would be a gap between appointments and interim arrangements would be put in place. It was likely that the escalation would remain in place until the new Head of Midwifery was in post. *The gap and grow compliance is of concern. Can the Committee be provided with details of why such little data has been collected and how long this has been taking place?* The Director of Nursing and Midwifery confirmed that a request had been made for details of compliance for the last financial year, and this year to date. This is important as with the low compliance of data input on gap and grow it has not been possible to use data to understand referral rates for low gestational weight babies. There had been some misunderstanding regarding data input, and addressing this is a key part of the escalation. A senior member of staff has been appointed to oversee this. *The Maternity and Neonatal Assurance Assessment has a number of items coded black for services which are not*

	provided by the health board. Does the Commissioning Assurance Framework provide assurance in these areas? The Director of Nursing and Midwifery confirmed there were a number of gaps relating to services provided by commissioned partners and this would be a key area to examine with other health boards at the national conference taking place on 7 July 2022. *Committee Members have long been assured this is an area that performs well. These reports appear to identify longstanding issues. What has changed from an assurance perspective?* The Director of Nursing and Midwifery acknowledged it was unusual to have three NRIs in short succession and this has provoked questions including in relation to low gestational growth. It is not thought that previously there was false assurance, the assurance given would have been what was known at the time. The Medical Director confirmed that the three NRIs had been correctly identified and should be considered against a backdrop of low patient numbers. The gap and grow position is of more concern and will need to be addressed. The robust actions put in place to support the teams feel an appropriate and proportionate response. *Has a lack of staffing (covid-19, sickness) impacted on the services?* The Director of Nursing and Midwifery noted that workforce issues are a key part of assurance and whilst there have been staffing issues in Ystradgynlais the escalation arrangements meant that attention was drawn to this at an early stage and mitigations which were put in place. The Committee a) DISCUSSED the Maternity Assurance Report, b) NOTED the escalated arrangements outlined by the Director of Nursing and Midwifery, and c) CONFIRMED that this matter would be escalated to Board.
PEQS/22/23	**ANNUAL CLINICAL AUDIT PROGRAMME 2022-23** The Medical Director presented the report noting the links between clinical audit and other quality improvement activities had been strengthened.

	M Bowley left 10.00 *The report does not include mortality reviews. Will these still take place?* The Medical Director confirmed that mortality reviews continue to take place and are reported separately to the Committee. *The presentation makes it difficult to identify if items are on track. Is there capacity to undertake the considerable number of audits outlined?* The Medical Director advised the presentation style would be reviewed. It was acknowledged that there were many audits identified and it would be necessary to focus on key areas. *Are all the items identified appropriate for audit or do they include those which should be taken as business as usual?* The Medical Director confirmed it was the intention to focus on the exceptional rather than the routine but that the current report contained all items for completeness. The Committee NOTED the report.
PEQS/22/24	**CLINICAL AUDIT ASSURANCE REPORT** The Medical Director presented the report noting that of the 92 audits planned for 2021/22, 55 had been completed. The remaining audits had been risk assessed to ensure that any key areas were not missed. The importance of sharing learning with the learning groups was emphasised. *Why are there low numbers of audits taking place in Mental Health Services?* The Medical Director advised that it was not known why a low number of audits had been undertaken in that area over the previous year, during which time service improvements were taking place. An increased number of

	audits in Mental Health Services have been identified for the current year. *Where are service improvements captured other than via audit?* The Director of Primary, Community Care and MH noted that service improvement work was identified within service reviews adding that there had been staffing issues within the clinical audit team. *There are five audits identified which have not been taken forward. How can an item that has been identified as requiring audit be removed?* The Director of Primary, Community Care and MH confirmed that there was a balance in identifying areas for audit with an increasing focus on national audit work. *The Mental Health audit picked up incomplete use of the Wales Applied Risk Research Network (WARRN) tool. The action sits with the WARRN trainers development group which does not give confidence that practice has changed.* The Medical Director confirmed the risk assessment is robust and is used. It has been updated and has been shared with service groups. This was a specific area which the service requested be audited. *What is the position with the 10% of cases not audited using the WARRN tool?* The Director of Primary, Community Care and MH confirmed that all patients had been fully risk assessed and the issue related to the input of data on WCCIS. If any fields are left blank it will appear that the risk assessment had not taken place. The Director of Nursing and Midwifery advised that colleagues were in discussion to implement a system which would allow a live dashboard to be available rather than reporting the historic position. Clinical audit is maturing as a process, and it now seen as participatory rather than something that is done to a service. The Chair requested a demonstration of the Dashboard in a training session.

	Action: Director of Nursing and Midwifery
PEQS/22/25	**MEDICINES MANAGEMENT ASSURANCE PAPER** The Medical Director introduced the Chief Pharmacist who presented the report and drew attention to the following challenges: • a difficulty in making available monoclonal antibodies to Powys patients; • recruitment and retention; • medicines storage - some areas reaching temperatures above 25º C; • medicines security continues to be an issue – a bid has been submitted to Welsh Government; • antimicrobial stewardship – the service does not have a dedicated person to manage this, and high use of antimicrobials may be taking place. Additional analysis and comparisons will be required; • a gap in support to Mental Health services currently commissioned but intended to be brought back in house; • electronic prescribing is taking place on wards, and it is intended to roll this out from GPs to pharmacies; • training; and • a lack of capacity to support prescribing in care homes. *This appears to be a large agenda with too little capacity and a recruitment/retention problem. The next steps outlined in the report appear ambitious but is it realistic and achievable? Are there opportunities across the organisation for cost avoidance/reduction?* The Medical Director confirmed the team has been stretched but has achieved a large amount, in particular acknowledging the workload supporting mass vaccination. The Innovation team undertaking a large piece of work mapping what pharmacy should look like across Powys. Until this work is complete it is difficult to say if the team lacks capacity. *The lack of support to Mental Health services is of concern. What is the timetable to establish what is required?* The Medical Director confirmed it had been scheduled for completion, but the omicron wave had delayed this. It will now be necessary to prioritise this in September.

	The Committee NOTED the Medicines Management Assurance Report.
ITEMS FOR DISCUSSION	
PEQS/22/26	**MENTAL HEALTH ACT HOSPITAL MANAGERS POWER OF DISCHARGE GROUP TERMS OF REFERENCE AND OPERATING ARRANGEMENTS** The Director of Primary, Community Care and MH presented the report noting that the Mental Health Act Hospital Managers Power of Discharge Group (PODG) last met in December 2021. The PODG is Chaired by the Chair of the Patient Experience, Quality and Safety Committee and will next meet on 26 July 2022. Between meetings of the PODG, activity has continued including training, a Hospital Managers Conference which took place in May 2022 and a Clinicians meeting on the Power of Discharge in July 2022. The PODG will report regularly to the Committee. The Committee NOTED the Mental Health Act Hospital Managers Power of Discharge Group Report.
PEQS/22/27	**REFRESHED PATIENT EXPERIENCE FRAMEWORK** The Director of Therapies and Health Sciences advised that there had been a logistics issue which had resulted in the paper being unavailable for the meeting. The Corporate Services Team and Corporate Governance Team were putting in place processes to guard against this happening in the future.
BUSINESS CASES, SERVICE PLANNING PROPOSALS, WHOLE SYSTEM PATHWAY DEVELOPMENT AND RE-DESIGN	
PEQS/22/28	There are no Business Cases, Service Planning Proposals or Whole System Pathway Developments and Re-designs.
ESCALATED ITEMS	

PEQS/22/29	There were no escalated items.
ITEMS FOR INFORMATION	
PEQS/22/30	There are no items for information
OTHER MATTERS	
PEQS/22/31	**CORPORATE RISK REGISTER – RISKS OVERSEEN BY THIS COMMITTEE** The Interim Board Secretary presented the report and noted that a meeting had been arranged with the Service Managers to ensure that the work to develop the risk registers was given the necessary priority. *This work to improve the risk registers is welcomed. How can the organisation balance long term risks which are outside the influence of the health board?* The Interim Board Secretary suggested a future discussion on the development of the risk register at Committee may aid understanding. **Action: Interim Board Secretary** The Committee: a) NOTED the action taken to date and SUPPORTS the proposed action to develop the risk register; and b) NOTED the May 2022 version of the Committee Risk Register.
PEQS/22/32	**COMMITTEE WORK PROGRAMME** The Interim Board Secretary presented the April 2022 – March 2023 Committee Work Programme. The Corporate Governance Team would collaborate with the Executive Director PAs to ensure that appropriate notice was given regarding items due to be brought to the Committee. *Should Clinical Effectiveness and Quality Improvement Highlight Reports be brought to the Committee more frequently?* The Medical Director confirmed that every Committee examined clinical effectiveness and the report would be brought to the meeting in September where a view could be taken of the appropriate frequency for this item.

	The Committee Work Programme was AGREED.
PEQS/22/33	**ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND/OR OTHER COMMITTEES** The Committee will bring to the attention of Board the escalation of Maternity Services as outlined in PEQS/22/22.
PEQS/22/34	**ANY OTHER URGENT BUSINESS** There was no other urgent business.
PEQS/22/35	**DATE OF THE NEXT MEETING** 13 September 2022, via Microsoft Teams.