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

MINUTES OF THE MEETING HELD ON THURSDAY 12 MAY 2022 VIA MICROSOFT TEAMS

Present:

Kirsty Williams	Vice-Chair (Committee Chair)
Frances Gerrard	Independent Member
Ian Phillips	Independent Member
Tony Thomas	Independent Member

In Attendance:

Carol Shillabeer	Chief Executive
Claire Roche	Director of Nursing and Midwifery
Claire Madsen	Director of Therapies and Health Sciences
Kate Wright	Medical Director
James Quance	Interim Board Secretary
Zoe Ashman	Assistant Director of Quality and Safety
Julie Richards	Women's and Children's Service Manager
Amanda Edwards	Assistant Director – Innovation and Improvement
Richard Stratton	Assistant Medical Director
Joy Garfitt	Assistant Director for Mental Health Services
Mitchell Parker	Health Inspectorate Wales
Phil Jones	Audit Wales
Sonia Thomas	Community Health Council
Viv Harpwood	PTHB Chair

Apologies for absence:

Mark Taylor	Independent Member
Hayley Thomas	Director of Primary, Community Care and MH
Louise Turner	Assistant Director of Women's and Children's Services
Katie Blackburn	CHC

Committee Support:

Liz Patterson	Interim Head of Corporate Governance

PEQS/22/01	**WELCOME AND APOLOGIES FOR ABSENCE** The Committee Chair welcomed Members and attendees to the meeting and CONFIRMED there was a quorum present. Independent Member Tony Thomas kindly had attended to ensure that the quorum was secure. The Chair welcomed Richard Stratton, newly appointed Assistant Medical Director to his first meeting. Apologies for absence were NOTED as recorded above.
PEQS/22/02	**DECLARATIONS OF INTERESTS** No interests were declared.
PEQS/22/03	**MINUTES OF THE EXPERIENCE, QUALITY AND SAFETY COMMITTEE MEETING HELD ON 24 MARCH 2022 (FOR APPROVAL)** The minutes of the previous meeting held on 24 March 2022 were AGREED as a true and accurate record.
PEQS/22/04	**MATTERS ARISING FROM MINUTES OF PREVIOUS MEETING** *In respect of opioid use will the health board continue to compare against English benchmarks to stretch improvement aims?* The Medical Director confirmed that Welsh guidance would be followed but that it was the intention not to accept good but to strive for excellence.
PEQS/22/05	**PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE ACTION LOG** PEQS/21/50 – The Board Secretary advised that in respect of No Surprises notifications the normal escalations routes would be followed which included Member briefings. It was not necessary to set up a separate process for this issue. PEQS/21/31 – Pressure Ulcers are reported within the Concerns Report. CAUTI (catheter acquired urinary tract

	infections) will be included in the Concerns Report going forward.
ITEMS FOR APPROVAL/RATIFICATION/DECISION	
PEQS/22/06	There were no items for inclusion in this section.
ITEMS FOR ASSURANCE	
PEQS/22/07	**CHC VIRTUAL VISIT** The Director of Nursing and Midwifery presented the report produced by the CHC regarding the Virtual Visits that had taken place supported by colleagues within Community, Nursing, Quality and Safety and Digital teams in the Health Board. The report detailed a number of positive findings including staff were very good and attentive to patient needs; a patient's family were unable to visit but the patient had access to the telephone and had been able to speak to them; and all patients reported they received very good care. A number of areas for improvement were identified including Wi-Fi connections, nutritional needs and estates issues. The recommendations had been shared with Executive colleagues to ascertain how each can be addressed. *Will a formal response be provided to the CHC?* The Director of Nursing and Midwifery advised that the CHC had received an acknowledgment of their report and recommendations but that a response would be prepared which would be shared with Committee members. **Action: Director of Nursing** *What plans are in place for improving patient feedback opportunities?* The Director of Nursing and Midwifery advised that the imminent implementation of Civica patient experience software would enable consistent patient feedback. With regard to face to face visits it is expected that there will be

	a gradual return to safe infection prevention control visits and the CHC would be welcomed back in this context. The Medical Director advised that funding had been made available to survey sites to identify what infrastructure was required. *Connectivity featured highly in the report. Given our commitment to digital first is there a detailed plan to overcome some of the digital issues highlighted?* The Chief Executive confirmed that reliable connectivity was necessary across all sites to allow for the implementation of a hybrid model as a result of the pandemic but also due to climate change. An Interim Digital Strategy is in place and a Board Development session is planned on digital and this is a subject area which will require ongoing focus. **Action: Interim Board Secretary**
PEQS/22/08	**QUALITY PERFORMANCE:** The Director of Nursing and Midwifery presented the three reports advising that these reports would soon be presented as a combined report. **a) COMMISSIONING ASSURANCE REPORT** Attention was drawn to the publication of the Final Ockenden Report on 30 March 2022 following the Independent Review of Maternity Services at Shrewsbury and Telford Hospitals NHS Trust (SaTH) published in December 2020. The December 2020 report identified 52 actions. The status of these actions was outlined. Attention was also drawn to the Cwm Taf Morgannwg University Health Board (CTMUHB) Maternity and Neonates Improvement Programme which remains in place. An unannounced inspection had taken place by the Health Inspectorate Wales (HIW) of Ty Llidiard (CTMUHB). The report was published on 4 March 2022 and found 6 improvements were required.

	Referral to treatment times continued to be challenging with pressures around workforce capacity, operational capacity and unscheduled care pressures impacting on this. *The paper notes that particular attention is given to those who have waited the longest. Whilst long waits will not be solved overnight what is been done to ensure that this does not result in the deepening of inequality due to geographical differences in access?* The Chief Executive advised that this was an area the Executive Committee were working on. There was an intention to bring straight forward activity that had been outsourced back to insourced provision. It may be necessary to make decisions regarding strategic pathway changes (in consultation with the Community Health Council) because of differences in different areas of the county. *Record keeping appears to be a common theme though the report. How will this be addressed?* The Director of Nursing and Midwifery confirmed that record keeping continued to be of concern. The rollout of the electronic All Wales Nursing Care Record continued, however, it did require staff to input data. This would enable improved quality assurance. *Access to services continues to be a problem which was an issue prior to covid. What action is being taken to address this?* The Medical Director advised that a considerable amount of work would be necessary to tackle this. Proposals regarding regional working were becoming more concrete and harm reduction measures were in place to mitigate for those patients who had the longest waits. The Assistant Medical Director noted that there was a period between primary care making a referral and secondary care seeing a patient when nothing happened. The potential to prioritise waiting lists is an area which the Assistant Medical Director would like to explore. **b) NATIONALLY REPORTABLE INCIDENTS AND CONCERNS REPORT**

	The Assistant Director for Quality and Safety presented the report which outlined the way in which Putting Things Right is discharged within the health board together with the management of Nationally Reportable Incidents (previously known as Serious Incidents). The service has strengthened its learning and development and are implementing incident management meetings on a fortnightly basis. The Once for Wales Content Management System has been implemented and work is being undertaken to use full functionality of the system. The Mortality Model on this system is being introduced this month. Nosocomial infections are reported monthly to Welsh Government. The figures may change as investigations are completed and understanding of nosocomial infection improves. Compliance with the Putting Things Right 30 working day response time is poor and below the 75% target. A review has been undertaken with areas for improvement identified. The Public Services Ombudsman for Wales (PSOW) has identified the following top concerns for the health board: dental services; communications; and delays. The position in respect of Pressure Ulcers was included at the request of the committee. There is a backlog in investigating pressure area incidents but with the information available there does not appear to be a trend. *Is there a mechanism for ensuring that if any PSOW case will be reported in the press that Independent Members are aware of the findings prior to press coverage?* The Chief Executive advised that procedures are in place to ensure this takes place including reporting to the Patient Experience, Quality and Safety Committee In-Committee meeting.

	The report notes a series of issues related to data including that, compliance with Putting Things Right at 16% in March is of concern; much reliance has been placed on the refreshed Improvement Plan. May Independent Members see the revisions? What is a realistic trajectory of improvement? The Director of Nursing and Midwifery confirmed that the concern regarding the Putting Things Right compliance was shared, and it was acknowledged that this needed to improve. In April the figure had increased to 44% and the number of open concerns had reduced to single figures. The whole system approach with a focus on early resolution has resulted in concerns not translating to formal concerns which was a positive outcome. It was necessary to be realistic about the improvement trajectory and aim for a gradual increase to 75% which could be sustained. *What proportion of issues relate to trips, slips and falls.* The Director of Nursing and Midwifery confirmed that when the Incident Review Forum had been re-established greater insights on themes and trends would be available. *When will the backlog of investigations into pressure ulcers be cleared?* The Director of Nursing and Midwifery acknowledged that it was of concern that there were a number of cases that it had not been possible to review. This would be addressed and the improved position would be brought back to committee. **c) INSPECTIONS AND EXTERNAL BODIES REPORT AND ACTION TRACKING** The Assistant Director of Quality and Safety presented the report which articulated the receipt and outcomes of the regulatory inspections which had occurred during the reporting period and tracker. *There are some longstanding recommendations included in the tracker. Is there a mechanism to identify and complete these?* The Assistant Director of Quality and Safety advised that since the report had been written four actions had been

	closed and work was underway to review the other actions. Some of the barriers to completion are due to interdependencies with other areas such as the capital programme. The committee asked that timescales be included within the tracker rather than noting that work was 'ongoing'. **Action: Assistant Director of Quality and Safety** **d) MATERNITY SERVICES ASSURANCE** The Head of Midwifery and Sexual Health presented the report outlining the current position relating to maternity assurance and pathways for women and families in Powys. Attention was drawn to the National Maternity and Neonatal Safety Programme where work was taking place jointly with Improvement Cymru to identify key priorities and improvements in the first phase of the programme. Maternity services had been under pressure during the winter period and both Cwm Taf Morgannwg University Health Board (CTMUHB) and Shrewsbury and Telford Hospitals NHS Trust (SaTH) continued to have their own pressures. Health Inspectorate Wales recommendations regarding birth environments remain outstanding for Knighton and Machynlleth. The recommendations relating to Llanidloes will be addressed next. The service has spent time understanding the recommendations contained within the Ockenden Report and a roundtable event will take place on 31 May 2022 to examine the report. The Maternity Operational Framework has been revised and changes made for example to synchronise leave which will improve the escalation position.

	What does the Maternity Escalation analysis show (graph on page 7)? The graph identifies the different issues that contribute to escalation including sickness, vacancies and annual leave. Annual leave has the greatest impact on escalations and the team are working with workforce colleagues to ensure leave is scheduled throughout the year. Sickness has also had an impact although less so than elsewhere. The Chair shared an example of unsolicited feedback that had been received relating to care by the team at Knighton. *It is recognised that are able to feedback via a QR code but what can be done to enable families to shape services rather than commenting on them after they have been experienced?* The Head of Midwifery advised that an active Powys Maternity Voices Forum exists and that additional opportunities will be available via the National Maternity and Neonatal Safety Programme. The team have also worked on seeking feedback from Dads. The Director of Nursing and Midwifery advised the Midwifery team were undertaking a full critical analysis of the Ockenden Report looking for blind spots and would provide committee with progress in future assurance reports. The Committee DISCUSSED the Commissioning Assurance Report, Nationally Reportable Incidents and Concerns Report, Inspections and External Bodies and Action Tracking Report and Maternity Assurance Report.
PEQS/22/09	**WOMENS AND CHILDREN'S QUALITY REPORT** The Head of Midwifery and Sexual Health presented the report which provided a summary of patient experiences and concerns during quarter 3 and 4 of 2021/22. *The challenges in meeting demand for neurodevelopment services is apparent and not unusual to Powys. How will these challenges be responded to?* The Director of Nursing and Midwifery advised that this was an action as part of the Children and Young People section of the renewal programme.

	How is the Procedural Response to Unexpected Deaths in Children (PRUDiC) review process undertaken? The Head of Midwifery confirmed that reviews are undertaken on a calendar year basis. An annual event is held to review perinatal and maternal deaths and PRUDiC cases. The Director of Nursing and Midwifery advised that the annual review is presented to the Safeguarding Committee and is then included in the Quarter 1 report to the Patient Experience, Quality and Safety Committee. The Women's and Children's Quality Report was DISCUSSED and NOTED.
PEQS/22/010	**MENTAL HEALTH ACT COMPLIANCE AND POWERS OF DISCHARGE ASSURANCE REPORT** The Assistant Director for Mental Health Services presented the report which provided information to assure the committee that the health board were compliant with the legal duties under the Mental Health Act 1983. In comparison with previous years numbers were similar in relation to detention under Section 5 (Doctor and Nurse Holding Powers); Section 2 (Admission for Assessment); Section 3 (Admission for Treatment); Section 4 (Emergency Admission for Assessment); and Section 17A (Community Treatment Order). The figures for Section 136 (Police powers to remove a person to a place of safety) were lower than previous years. It was noted that the preferred place of safety was a health-care setting but in a small number of cases due to violence patients pathways defined that police cells would be used as the place of safety. This measure did fluctuate and there could spike during festivals. Section 136 cases were reviewed for learning purposes. In many cases they related to an inability to assess due to intoxication. In all cases the use of Section 136 was assessed to be appropriate. 179 sets of Section papers were scrutinised over the year. Errors were found on five or less occasions in each quarter

	that were corrected. Over the year no fundamental errors were found. There were no deaths of detained patients over the year. 36 applications for discharge to Hospital Managers and the Mental Health Review Tribunal were made. 14 hearings were held and less than 5 patients were discharged. The Chair of the Patient Experience, Safety and Quality Committee will chair the Mental Health Review Tribunals and training is planned for this role over the summer. *The pandemic has meant that there may have been unusual levels of activity recently. Could the timeframe that the information is compared against be extended?* This will be considered in future reports. *Whilst there are a small number of non-defective errors this is indicative of poor record keeping. What action will be taken to address this?* The Assistant Director of Mental Health Services advised that these errors generally occur outside normal working hours when the Nurse in Charge is responsible for checking the paperwork and there may have been a commotion or violence on the ward which needs immediate attention. This is acknowledged to be a challenge. The committee NOTED the report and was assured that the performance of the services in relation to the administration of the Mental Health Act 1983 was compliant with legislation.
ITEMS FOR DISCUSSION	
PEQS/22/11	**STRATEGIC OBJECTIVE REPORT: QUALITY & ENGAGEMENT (WALES) ACT: IMPLEMENTATION UPDATE** The Director of Nursing and Midwifery presented the report outlining the requirements of the Health and Social Care (Quality and Engagement) Act 2022 which was due to be implemented in spring 2023 and was intended to: • support an ongoing, system-wide approach to quality improvement within the NHS in Wales; • further embed a culture of openness and honesty; and

	• help drive continual public engagement in the design and delivery of health and social care services. The Act reframed and broadened the existing duty of quality on NHS bodies and placed an overarching duty on Welsh Ministers in relation to their health functions. It aimed to improve and protect the health, care and well-being of both current and future populations of Wales by focusing on: • securing Improvement in Health Services; • implementing a Duty of Candour; • establishing a Citizen Voice Body for health and social care; and • the appointment of Vice Chairs for NHS Trusts bringing them in line with Health Boards. The following next steps were intended: • secure Board support; • assess readiness; • secure wider organisational buy in and co-creating a vision; • developing improvement skills and infrastructure; • aligning and coordinating activity; and • sustaining a health board wide approach. In the first instance a Board Development session would be arranged. **Action: Interim Board Secretary**
PEQS/22/012	**COMMITTEE RISK REGISTER** The Interim Board Secretary presented the Committee Risk Register outlining the intention for a meeting with Clinical Directors to assess the risk and break it down into constituent parts. *Will there be a focus on balancing between looking back to identify what went wrong and looking forward to implement systems to improve quality?* The Medical Director noted that the situation was continually changing and there was a considerable amount of information available. It was necessary to prioritise risk but would require continual attention due to the pace of change.

	The Chief Executive noted that the Committee Risk Register related to the pre-pandemic position and arrangements were in place to review it. It was recognised that the situation was dynamic. However, it was necessary to be assured that the right controls and mitigations were in place. The level of risk that would be tolerated would be considered and arrangements for monitoring put in place. The Executive Committee have recently considered risk and a Board Development session on risk would be arranged. *There are some things that are within the control of the health board and some that are not. How can the health board ensure that those areas that are outside of our control can be influenced?* *In some areas the position has moved beyond risk to actual harm (for example ambulance transfers). Where would this be acknowledged?* The Interim naBoard Secretary noted that there needed to be a systematic approach and at present current and residual risks were conflated. The way in which the information was presented would be reviewed to articulate this split more clearly. The Committee CONSIDERED the risks identified within the Committee Risk Register
ITEMS FOR INFORMATION	
PEQS/22/013	**WHSSC QUALITY AND PATIENT SAFETY COMMITTEE CHAIR'S REPORT JANUARY 2022** The WHSSC Quality and Patient Safety Committee Chair's Report January 2022 was RECEIVED.
OTHER MATTERS	
PEQS/22/014	**ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND OTHER COMMITTEES** There were no items to be brought to the attention of Board and other Committees.
PEQS/22/015	**ANY OTHER URGENT BUSINESS** There was no other urgent business. The Director of Nursing and Midwifery noted that it was the International Day of the Nurse. On behalf of the Chief

	Nursing Officer Excellence Awards would be presented for Palliative Care Nurses.
PEQS/22/016	**DATE OF THE NEXT MEETING** 7 July 2022, via Microsoft Teams.