



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

CONFIRMED

**MINUTES OF THE MEETING HELD ON THURSDAY 7 OCTOBER 2021
VIA MICROSOFT TEAMS**

Present:

Melanie Davies	Vice-Chair (Committee Chair)
Trish Buchan	Independent Member (Committee Vice-Chair)
Frances Gerrard	Independent Member
Ian Phillips	Independent member
Mark Taylor	Independent member

In Attendance:

Alison Davies	Director of Nursing and Midwifery
Claire Madsen	Director of Therapies and Health Sciences
Jamie Marchant	Director of Primary, Community Care and Mental Health
Kate Wright	Medical Director
Stuart Bourne	Director of Public Health
Marie Davies	Deputy Director of Nursing
Wendy Morgan	Assistant Director of Quality and Safety
Julie Richards	Women and Children's Service Manager
Rani Mallison	Board Secretary

Apologies for absence:

Rebecca Collier	Welsh Government
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Committee Support:

Holly McLellan	Senior Administrator/Personal Assistant to Board Secretary
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PEQS/21/01	<p>WELCOME AND APOLOGIES FOR ABSENCE</p> <p>The Committee Chair welcomed Members and attendees to the meeting, and CONFIRMED there was a quorum present. Apologies for absence were NOTED as recorded above.</p>
PEQS/21/02	<p>DECLARATIONS OF INTERESTS</p> <p>No interests were declared.</p>
PEQS/21/03	<p>UNCONFIRMED MINUTES OF THE EXPERIENCE, QUALITY AND SAFETY COMMITTEE MEETING HELD ON 2 July 2020</p> <p>The minutes of the previous meeting held on 30 July 2020 were AGREED as being a true and accurate record.</p>
PEQS/21/04	<p>MATTERS ARISING FROM PREVIOUS MEETINGS</p> <p>No matters arising were declared.</p>
PEQS/21/05	<p>COMMITTEE ACTION LOG</p> <p>There were no action log updates.</p>
ITEMS FOR APPROVAL/RATIFICATION/DECISION	
PEQS/21/06	There were no items for inclusion in this section.
ITEMS FOR DISCUSSION	
PEQS/21/07	<p>Integrated Quality Report: Directorate of Primary, Community Care and Mental Health</p> <p>The Director of Primary, Community Care and Mental Health presented the report which provided the Committee with a summary of patient quality and safety metrics across three service groups within the DPCCMH Directorate for the period of April to June 2021.</p> <p>The report was the first report developed directly by the Service Groups and Directorate and followed on from reports from each Group to the Experience Quality and Safety Committee earlier in 2021/22 which outlined the mechanisms within the groups to monitor and manage the area of work.</p> <p>Further work would continue to develop the scope of the reports with work undertaken closely with colleagues across PTHB including the Quality and Safety team and the new Assistant Director of Performance. A focus would be on</p>

consistency of format and presentation, where applicable, but also detailed trend analysis and any potential for benchmarking. The report was process heavy whereas moving forward outcomes would become a focus.

Could a sentence outlining the average performance be included moving forward? The patient input of QR codes was positive but information needed to be triangulated. Awareness of the pressures put on staff to fill out additional data for mapping should be considered.

The Director of Primary, Community Care and Mental Health agreed that the overlap between reports needed to be refined to balance between duplicating and reporting. There was a section around patient experience which covered the wider Health Board. The Director of Nursing and Midwifery added that in terms of duplication of reporting the Putting Things Right and claims report had been moved to a Health Board wide perspective.

In terms of the Ligature Risk Management what was the second component of compliance comprised of?

The Deputy Director of Nursing responded that the first component disclosed that the policies were in place, the second component was to test compliance. The Assistant Director of Quality and Safety noted that compliance had been reported on the review of local authority compliance.

Was there a metric to report on the Learning Disability Mental Health of individuals?

The Director of Primary, Community Care and Mental Health responded that there was national work on Mental Health but Learning Disabilities had not been part of this.

Could more information on the School Nurse Service be provided?

The Director of Primary, Community Care and Mental Health responded that School Nurse Services were in place but the focus currently was on influenza vaccinations.

The Neurodevelopment (ND) Service would be a key topic moving forward could the Board be further sighted on this?

The Director of Primary, Community Care and Mental Health responded that the Delivery and Performance

Committee had been updated and further updates would be brought to the next committee.

What was being done to address Powys families who have reported that they are feeling they are missing out on face to face antenatal class?

The Director of Primary, Community Care and Mental Health responded that virtual group meetings were being worked on nationally in an effort to bring together group services.

To what extent did the Hospital Acquired Pressure Ulcer rates change?

The Director of Primary, Community Care and Mental Health responded that it was difficult to capture the differential. There was a decrease in recorded level 3 Full Thickness Skin Loss and level 4 Full Thickness Tissue Loss.

Could prospective plans to ensure patients had the best care be developed as opposed to identifying issues after the event?

The Director of Primary, Community Care and Mental Health offered to discuss outside of the committee, work was being undertaken on system resilience for the winter. The Board Secretary raised there should be awareness of the separation of management information from committee information.

Was Clinical Staff attendance on shared learning poor?

The Director of Primary, Community Care and Mental Health responded that the range was key, ensuring all professional groups attended not just a large number of staff.

Action: The Director of Primary, Community Care and Mental Health to confirm statistics on clinical staff attendance of shared learning.

The Chair raised that cover papers were helpful to draw out the most significant points, achievements and concerns.

The Board Secretary responded that an overarching dashboard would be brought in to draw out the key points. The Director of Primary, Community Care and Mental Health advised that the level of detail was to provide assurance. As the report developed it would become more

	<p>streamlined for the next committees. The Executive Director of Therapies & Health Science raised that the Audit Cycle would support the quality driven approach.</p> <p>Highlighting the top 3 concerns in the Executive Summary would allow for horizon scanning in supplement or addition to a dashboard.</p> <p>The Committee DISCUSSED and NOTED the contents of the report including the planned work to scope additional metrics relating to quality and safety in specific areas.</p>
PEQS/21/08	<p>Putting Things Right, Compensation and Claims Report</p> <p>The Assistant Director of Quality and Safety presented the paper which provided an overview of the way in which Putting Things Right was discharged within the Health Board, along with compensation claims activity for the period 1 April 2021 to 31 July 2021.</p> <p>The paper provided an overview of the Health Boards approach to Putting Things Right, which included the systems and processes in place to support discharge of the function, along with any outputs and outcomes. Reference was made to patient experience and concerns, which included complaints, patient safety incidents, and compensation claims for the period 1 April 2021 to 31 July 2021 and trends.</p> <p>Recent data issues in the extraction of data from old Datix to new Datix were identified. Sessions would be created for staff to help with the extraction of data and reports from the system going forwards. Despite concerns that incident reporting would fall there had been an increase of incidents reported. There had been an increase in complaints in primary care around access to dental services.</p> <p>The Public Services Ombudsman for Wales (PSOW) report had been brought forwards. Reporting was to be submitted by 15 November 2021. No themes or trends were identified in the complaints data.</p>

In the Ombudsman report did the 0.12 complaints received per 1000 residents for PTHB show that PTHB alongside CVUHB had the least complaints?

The Assistant Director of Quality and Safety confirmed and noted improvements would be recognised going forward.

The engagement and training sessions were noted as positive.

For complaints handling, to what extent could low numbers be identified in complaints under the direct control of PTHB?

The Assistant Director of Quality and Safety responded that some issues had been identified and had been used to inform the improvement plan.

When was the PTHB Putting Things Right policy undergoing its first Audit?

The Director of Nursing and Midwifery responded that the Putting Things Right policy was undergoing its first structured Audit, reactive information had been utilised to drive improvements. A deep dive was underway to ensure plans were progressing appropriately.

To what extent would it be expected to see PTHB placed below the national average on the Serious Incidents Graph considering PTHB did not have acute services?

The Director of Nursing and Midwifery responded that being placed below the national average was not a measure that could be easily translated as being meaningful, given the reporting of all incidents, including those designated as serious, was actively encouraged. The information enabled incident reporting parameters to be benchmarked with the rest of Wales. It was possibly more helpful to understand whether there were themes or trends in certain areas, for example, avoidable falls or skin damage, which better enable comparisons and improvement where needed. Feedback would be provided to the Delivery and Performance Committee.

Did the Serious Incidents Graph relate to Powys provided services of Powys patients in other locations?

The Assistant Director of Quality and Safety confirmed the incidents were drawn from services provided in Powys.

	<p><i>How was a serious incident categorised?</i></p> <p>The Assistant Director of Quality and Safety responded that categorisation was defined within the new patient safety framework and had changed from previous definitions used within Putting Things Right. Future reports would include the definition utilised.</p> <p>The Committee DISCUSSED and NOTED the report.</p>
PEQS/21/09	<p>Regulatory Inspections Report</p> <p>The Assistant Director of Quality and Safety presented the report which articulated the receipt and outcomes of regulatory inspections that had occurred during the reporting period and shared the Health and Social Care Regulatory Reports dashboard.</p> <p>Recent activity related to Healthcare Inspectorate Wales (HIW) inspections provided assurance on progress with Tier 1 and unannounced inspections. Quality check summary reports for dental practices were highlighted within the report, the primary care team lead the assurance monitoring arrangements.</p> <p>An update on the National Maternity improvement plan priorities 2021, was seeking agreement to extend the timeframe for 5 actions. HIW had confirmed their decision not to progress with phase 2 of the review.</p> <p>A dashboard overview of the current position was provided, related to the implementation of actions in response to recommendations from the Health and Social Care Regulators.</p> <p><i>What was the status of the 11 actions outstanding for Felindre from 2021/22 and the outstanding action from 2019/20 from the Health Inspectorate Wales review of Mental Health services?</i></p> <p>The Director of Primary, Community Care and Mental Health responded that updates were being pursued and would follow with more context. A number of the outstanding Felindre actions sat with the Estates Department. The lack of current information was as a result of the synchronisation of the Committee schedule with potential update dates.</p>

	<p>The Committee DISCUSSED the report and AGREED the revised timeframes for the National Maternity Improvement Plan priorities 2021.</p>
<p>PEQS/21/10</p>	<p>Infection Prevention and Control Report</p> <p>The Deputy Director of Nursing presented the report which provided an update of the work undertaken in Infection, Prevention and Control in the last year. Included were the Powys Teaching Health Board Annual Report for Infection, Prevention and Control and the Annual Authorised Engineer Report into Decontamination Services.</p> <p>The report Infection Prevention and Control Annual Report made three formal recommendations:</p> <ul style="list-style-type: none"> • The Operational Decontamination Lead or Infection Prevention Control nomination should represent Powys Teaching Health Board on the All Wales Decontamination and Sterilization Group. Such representation was historically in place. <p>Status: Completed</p> <ul style="list-style-type: none"> • Decontamination centres that undertook the reprocessing of flexible endoscopes should strive to achieve accreditation, and operation of a quality management system, in compliance with the medical devices directive/ISO 13485 standard. This represented best practice and a policy should be in place for the Health Board to work towards this standard. <p>Status: Work was ongoing towards completion.</p> <ul style="list-style-type: none"> • The management structure was in place across the organisations. However, interviews indicated concerns with resource time allocation needed to undertake the management of decontamination across the organisation. It was recommended the structure be reviewed and appropriate resource allocated. <p>Status: Estates were to assess the role and if there was a case to increase capacity.</p> <p><i>The IPC team were commended for their work over the last 18 months.</i></p>

	<p><i>Assurance over IPC had improved greatly. Antimicrobial resistance, plans were being put in place to strengthen the 2022 response. Given the recommendations had not previously been progressed due to the absence of a Chief Pharmacist what assurance could be taken moving forward?</i></p> <p>The Director of Nursing and Midwifery responded that a recent Welsh Health Circular had been received on the topic. Progression was a priority the Antimicrobial Stewardship Group (AMR) had identified the need to strengthen the resource to achieve this.</p> <p>The Committee</p> <ol style="list-style-type: none"> 1. DISCUSSED and NOTED the annual report. 2. DISCUSSED AND NOTED the planned approach to address the improvement actions required by the Annual Authorised Engineer Report into Decontamination Services 3. RECEIVED the update provided in investigation of Covid-19 infection within hospital settings in Powys
PEQS/21/11	<p>Maternity Assurance Report</p> <p>The Head of Midwifery and Sexual Health presented the report which provided the position in terms of the maternity pathway for the women of Powys, with a focus on:</p> <ol style="list-style-type: none"> 1. Maternity Commissioning Assurance Framework. 2. Commissioned maternity services subject to special measures. 3. South Powys Programme Maternity and Neonatal Workstream. 4. Powys Maternity Improvement Plan, main focus. 5. External scrutiny. <p>Moving forward the next steps would be:</p> <ul style="list-style-type: none"> • Continued implementation of the Powys Maternity Improvement Plan. • Maintain oversight and escalation of commissioned services through the Commissioning Assurance Framework (CAF), to include increased scrutiny of neonatal services.

- Continue to develop and embed governance and maintain reporting arrangements.

Were Powys residents delivering in the Grange University Hospital?

The Head of Midwifery and Sexual Health confirmed there was normal flow through the pathways which meant deliveries did go to the Grange University Hospital. Patients reported the obstetric care appointments to be accessible. Some appointments had been virtual which was received positively during the pandemic. Patients appreciated the individual rooms in the Grange University Hospital. High risk patients were going into pressured maternity services, PTHB was mindful of this and the support that could be offered. The Grange University Hospital were expecting a significant increase of patients in September 2021 with an approximate 600 births expected instead of the normal 450. Midwives reported few significant events or concerns but highlighted that the service was pressured.

The Director of Public Health raised that there was tentative news that investment in Healthy Lifestyles would reoccur.

Could more information be provided on the Wye Valley NHS Trust inaccessibility incident?

The Head of Midwifery and Sexual Health responded that Wye Valley NHS Trust had been experiencing a high level of acuity, the Community Midwife had tried to access a postnatal re-admission. The Community Midwife was concerned that if the patient was admitted there would be a lack of capacity to provide care. The Community Midwife outsourced admission to a district general hospital due to concern for the patient. The Wye Valley NHS Trust provided assurance that the hospital did have capacity.

Had an event of this nature occurred before or occurred in other areas?

The Head of Midwifery and Sexual Health responded that an event of this nature had not occurred before and it was a standalone event. A weekly cross Wales meeting took place to discuss assurance on pressures in neonatal services.

	<p>The Director of Nursing and Midwifery highlighted that there was openness and transparency around the work in progress and risk mitigation.</p> <p>The Committee DISCUSSED and NOTED the report.</p>
PEQS/21/12	<p>Commissioning Escalation Report</p> <p>The Director of Nursing and Midwifery presented the report which highlighted providers in Special Measures or scored as Level 4 and above following the 18 August 2021 PTHB Internal Commissioning Assurance Meeting (ICAM). At the time of the last meeting there were:</p> <ul style="list-style-type: none"> • 2 providers with services in Special Measures; • 1 provider at Level 4. <p>The report also provided:</p> <p>A high-level summary of key issues in relation Shrewsbury and Telford Hospitals NHS Trust (SaTH) and Cwm Taf Morgannwg University Health Board (CTMUHB).</p> <p><i>Was any information from the Prince Charles Hospital available?</i></p> <p><i>Would all PTHB providers be in special measures for access in the near future?</i></p> <p>It was confirmed that most services were under pressure as a result of the ill effects of the covid19 pandemic .</p> <p><i>The Chair questioned if the Commissioning Escalation report should be escalated by the Committee?</i></p> <p>The Director of Nursing and Midwifery responded that this was a consideration for Wales and the UK, the Corporate Risk Register (CRR) looked at the quality and performance as separate entities currently. Quality in relation to the receipt of poor care was identified. The CRR provides an opportunity for this to be discussed in more detail.</p> <p>The Chair raised that although PTHB was in an improved position there was still an overlay of winter pressures. PTHB had not seen that degree of pressure before.</p> <p>The Medical Director agreed that it was an important point to raise, openness was needed around how high the risks were for patients. There should be mindfulness not to reset</p>

	<p>PTHB's risk tolerance. The current level of risk should not become the new normal.</p> <p>The Director of Public Health raised that a draft of a winter plan came out on the week of 4 October 2021, framed around the 5 harms of COVID-19. Part of the plan centred around capacity in the system.</p> <p>The Board Secretary advised that the CRR was actively reviewed and used to inform workplans of committees and the Board.</p> <p>The Committee DISCUSSED and NOTED the report.</p>
PEQS/21/13	<p>Clinical Quality Framework: Goal 5, Intelligence</p> <p>The Director of Public Health presented the report which provided a summary of progress in the implementation of the actions set out under Goal 5 of the Health Board's <i>Improving Clinical Quality Framework</i>. There were four actions under Goal 5, two of which had had work taken forward, and two of which required further work to define and describe their scope. The paper also noted two more recent developments; a draft report from Audit Wales and a Welsh Government quality framework, which recognised that there was a need to align elements of these two documents under Goal 5 to recognise their contribution to the aim of this goal.</p> <p><i>What were the timeframes on the Clinical Quality Framework?</i></p> <p>The Director of Public Health responded that the Audit Wales recommendations had a set timeframe. The Board Secretary added that the report was being finalised and would be presented to Audit, Risk and Assurance Committee on 16 November 2021. The ambition was to have work completed within a 6-month time frame.</p> <p><i>In terms of data analytics, Welsh Government would want datasets manipulated and managed. Could infrastructure be put in place prior to this to deal with the quantity of data output?</i></p> <p>The Director of Public Health responded that, PTHB's analytic capability at current would not be sufficient. A</p>

	<p>strategic understanding of the direction of development over the next few years would be necessary.</p> <p><i>For the input of primary data sources, what consideration had been given to minimising additional work at ward level?</i></p> <p>The Director of Public Health responded that, additional data sources would have to be sourced as a bi-product that was secondary to routine. It needed to be built into systems but it was hoped that the Welsh Government infrastructure would provide a national approach.</p> <p><i>To what extent could additional support be bought into PTHB? Could funding be provided through Charitable Funds?</i></p> <p>The Director of Public Health responded that Charitable Funds funding would need to be scoped to assess if it met the criteria. The result of an unsustainable project due to outsourcing or bring in non-team staff would be a potential issue.</p> <p>The free resource of Senior Medical Students could be utilised for 6 weeks of projects.</p> <p>The Committee DISCUSSED and NOTED the report.</p>
PEQS/21/14	<p>Committee Workplan 2021/22</p> <p>The Board Secretary presented the paper. The greater proportion of agenda items were rolling standard items. The work plan was dynamic and would be picked up through agenda setting meetings.</p> <p><i>Could an A4 summary of the Committee’s Terms of Reference (ToR) be set as the front or last page of the agenda pack as a reminder for the Committee?</i></p> <p>The Board Secretary responded that a summary of the ToR could be tailored from the paper taken to the Board on 28 July 2021. The work plan would not always be able to provide full coverage of the breadth of the Committee but would provide the scope.</p> <p>The Committee DISCUSSED and NOTED the report.</p>
ITEMS FOR INFORMATION	

PEQS/21/15	<p>Approved Minutes of the Experience, Quality & Safety Committee meeting held 15 July 2021</p> <p>The minutes of the previous meeting held on 15 July 2021 were AGREED as being a true and accurate record.</p>
PEQS/21/16	<p>Patient Experience, Quality & Safety Committee Terms of Reference, approved by Board 29 September 2021</p> <p>The Committee NOTED the report.</p>
PEQS/21/17	<p>Audit Wales Review: WHSSC Governance Arrangements and WHSSC Management Response</p> <p><i>How would issues identified in WHSSC be addressed?</i> The Chair responded that PTHB needed to decide what was appropriate and proportionate. The Board Secretary added that quality issues were not the only factor.</p> <p>Action: Board Secretary to progress.</p> <p>The Committee NOTED the report.</p>
PEQS/21/18	<p>WHSSC Quality Patient Safety Committee Summary from meeting on 10 August 2021</p> <p>The Committee NOTED the report.</p>
PEQS/21/19	<p>Quality and Engagement Act Implementation Programme Summer Newsletter</p> <p>The Committee NOTED the report.</p>
OTHER MATTERS	
PEQS/21/20	<p>ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND OTHER COMMITTEES</p> <p>There are no items for inclusion in this section</p>
PEQS/21/21	<p>ANY OTHER URGENT BUSINESS</p> <p>There was no urgent business.</p>
PEQS/21/22	<p>DATE OF THE NEXT MEETING</p> <p>2 December 2021 at 14:00, via Microsoft Teams.</p>