



**GIG**  
CYMRU  
**NHS**  
WALES

Bwrdd Iechyd  
Addysgu Powys  
Powys Teaching  
Health Board

**POWYS TEACHING HEALTH BOARD  
SUMMARY OF THE PATIENT EXPERIENCE, QUALITY & SAFETY  
COMMITTEE  
MEETING HELD ON THURSDAY 3 FEBRUARY 2022  
VIA MICROSOFT TEAMS**

**Present:**

Trish Buchan	Independent Member (Committee Vice-Chair)
Kirsty Williams	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
Kate Wright	Medical Director
Stuart Bourne	Director of Public Health
James Quance	Interim Board Secretary
Wendy Morgan	Assistant Director of Quality and Safety
Zoe Ashman	Assistant Director of Quality and Safety
Bethan Hopkins	Audit Wales
Katie Blackburn	CHC
Mitchell Parker	Health Inspectorate Wales

**Apologies for absence:**

Vivienne Harpwood	PTHB Chair
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**Committee Support:**

Stella Parry	Interim Corporate Governance Manger
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## **COMMITTEE ACTION LOG**

The Committee DISCUSSED and NOTED the Action Log:

- PEQS/21/17 (Audit Wales: WHSSC Governance Arrangements): It was requested that this item be brought forward of 24<sup>th</sup> March 2022
- IC\_PEQS/21/5 (Presentation to In-Committee): It was requested that the Action be clarified to include the title of the presentation: Children and Young People Admitted in Crisis
- PEQS/21/31 (Pressure Ulcers and CAUTI in Community Settings): It was requested that this item be brought forward of 24<sup>th</sup> March 2022

## **COMMISSIONING ESCALATION REPORT**

The Committee received the item which provided an overview of providers in special measures or scored as level 4 and above. The Health Board's Internal Commissioning Assurance Meeting (ICAM) did not meet in September 2021. Based on commissioner/provider meetings with all commissioned providers outside of Powys during November and December 2021, along with the information gathered via that process, Commissioning Assurance Framework (CAF) scores and ratings had been maintained from those set in October 2021, there were:

- 2 providers with services in special measures
- 1 provider at level 4

The report also provided:

- A high-level summary of key issues in relation Shrewsbury and Telford Hospitals NHS Trust (SaTH) and Cwm Taf Morgannwg University Health Board (CTMUHB)
- Referral to treatment times (RTT) times

It was noted that a further inspection was scheduled in January 2022 by NHS Improvement and NHS England focusing on The Royal Shrewsbury Hospital. The feedback report would be included in future reports to the Patient Experience Quality and Safety Committee.

The Committee DISCUSSED this Commissioning Escalation Report.

## **SERIOUS INCIDENTS AND CONCERNS REPORT**

The paper 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 November 2021 to 31 December 2021. An update on progress in relation to the support for the procurement of the Civica patient experience system was also provided.

The Committee DISCUSSED and NOTED the Serious Incidents and Concerns Report.

## **MATERNITY SERVICES ASSURANCE FRAMEWORK**

The report provided a position in relation to the maternity pathway for women in Powys, and provided an overview of:

- The Maternity Commissioning Assurance Framework
- Commissioned maternity services subject to special measures:
  - Shrewsbury and Telford Hospitals NHS Trust (SaTH)
  - Cwm Taf Morgannwg University Health Board (CTMUHB)
- The South Powys Programme Maternity and Neonatal Workstream
- The Powys Maternity Improvement Plan and HIW Maternity recommendations
- External scrutiny with Welsh Government Maternity and Neonatal
- Performance Board outcomes
- Welsh Risk Pool Fetal Surveillance Audit and;
- Internal Audit for Safeguarding Supervision Midwifery Compliance.

The Committee DISCUSSED the Maternity Services Assurance Framework.

## **ITEMS DISCUSSED IN-COMMITTEE**

Due to the sensitivity of the information involved, the following items were discussed by the Committee in a closed meeting:

- Serious Incidents and Complex Concerns Overview
- Procedural Response to Unexpected Death in Childhood (PRUDiC)

There was no other urgent business.

## **DATE OF THE NEXT MEETING**

24 March 2022, Microsoft Teams.