Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

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Minutes of the Quality, Safety & Experience Committee meeting held on 3 May 2022
Via Teams

Present:

Lucy Reid	Independent Member (Chair)
Jackie Hughes	Independent Member
John Gallanders	Independent Member

In Attendance:

Ramesh Balasundram	Hospital Medical Director (part of the meeting)
Gareth Evans	The Acting Executive Director Of Therapies & Health Science
Sue Green	Executive Director of Workforce and Organisational Development
Gill Harris	Executive Director of Integrated Clinical Delivery/Deputy Chief Executive
Dave Harris	Internal Audit
Matthew Joyes	Acting Associate Director of Quality Assurance
Mandy Jones	Director of Nursing
Fleur Jones	Audit Wales
Joanne Kendrick	Head Of Nursing East, Mental Health & Learning Disabilities
Nick Lyons	Executive Medical Director
Kirsty Lagdon	HIW
Molly Marcu	Interim Board Secretary
Teresa Owen	Executive Director of Public Health
Philippa Peake-Jones	Head of Corporate Affairs (minutes)
Mike Smith	Interim Director Of Nursing Mental Health
Gaynor Thomason	Acting Executive Director for Nursing and Midwifery
Conrad Wareham	Interim Deputy Medical Director
Iain Wilkie	Interim Director of Mental Health

Agenda Item	Action
QS22/75 Patient, Carer or Staff Story **QS22/75.1** The Acting Associate Director of Quality Assurance introduced the story which was shared by a gentleman who is the sole carer for his mother who has severe mixed dementia. The carer explained that his mother was admitted to Ysbyty Glan Clwyd with chest pains and vomiting. The carer explained the issues that his mother and he encountered during her stay including the lack of dementia training or understanding of the Butterfly Scheme and that an important letter explaining her diagnosis and his full time carer responsibilities was lost by the hospital.	

QS22/75.2 The Acting Associate Director of Quality Assurance advised that the Butterfly Scheme was being adopted across the Health Board, that actions had been agreed around patient property and that there was a specific piece of improvement work taking place to ensure that dementia care training is undertaken by all staff. The Committee thanked the carer for sharing his experience. **QS22/75.3** The Executive Director of Integrated Clinical Delivery/Deputy Chief Executive advised that she would ensure that the Butterfly Scheme had been implemented by testing and monitoring. It was noted that there had been a failure on the guidance in place for visiting and that a piece of work is now taking place to check that all wards have the correct visiting policies and that staff understand what they are. **QS22/75.4** An Independent Member highlighted that dementia strategies had been signed up to two years previously and that he was disappointed to hear the experience shared at the meeting. He questioned why the Butterfly Scheme needed to be relaunched and why there was no mention of the third sector support services available. Concern was raised around mandatory training. **QS22/75.5** The Committee noted that work is ongoing with the Transformation Team to ensure that everything being discussed does not return and is embedded and not lost in the system and that the same approach and methodology is used. **QS22/75.6** The Executive Director of Workforce and Organisational Development clarified mandatory training and that Dementia Training is not currently part of level one training and that this may need to be reviewed. She highlighted that it may not be the training that was the problem but the application of the training. **QS22/75.7** The Acting Executive Director for Nursing and Midwifery noted that recognition to the story must be noted and that the author comes across as a caring and kind individual who just wanted to get care for his mother. The powerful message noted was about the number of unpaid carers in the system, the Committee noted the Dementia Hospital Charter being reviewed at a later item in the meeting. The Acting Associate Director of Quality Assurance advised that he would investigate if there were electronic triggers available in the system to highlight if patients are dementia diagnosed when the attend in a hospital setting. **QS22/75.8** An Independent Member reiterated her disappointment at a story such as this is being heard again at the Committee and that the Dementia Champions needed some support and help around their role as a carer within the organisation. It was noted that it is not just dementia patients who struggle to navigate the system and that sometimes language was a barrier or patients who require additional care but do not have dementia also find it difficult. **QS22/75.9** The Executive Director of Integrated Clinical Delivery/Deputy Chief Executive agreed that wider awareness was required and that a link into Communications to support would be helpful, that one of the things just been revised is the visiting guidance into the Emergency Departments (EDs) which will	 **MJ**

be reviewed at the Executive Team meeting the following week, this would allow patients to be accompanied into the ED if they are unwell, of an age or trying to articulate in a language of their choice. **QS22/75.10** It was noted that all of the stories reviewed are shared back with the service and with managers and that this has been done or is in the process of being done. The theme in many of the stories received is that of compassion and basic communication which leads to patients and carers having a much better experience. **QS22/75.11** The Committee Chair requested that an update of the dementia strategy implementation to be received at a future meeting. The Acting Executive Director for Nursing and Midwifery agreed that she would invite the Dementia Lead to a future meeting which would also help the Board to be reminded about their own dementia responsibilities. **QS22/75.12 It was resolved** that the Committee receive and reflected upon the carer story.	 **GT**
QS22/76 Apologies for Absence **QS22/76.1** Apologies were received from Cheryl Carlisle, Chris Stockport, Adrian Thomas	
QS22/77 Declarations of Interest **QS22/77.1** No declarations of interest were raised. It was noted that now Hugh Evans had joined the Health Board and had been invited to be a member of the QSE Committee.	
QS22/78 Minutes of Previous Meeting Held in Public for Accuracy **QS22/78.1** The Acting Executive Director Of Therapies & Health Science noted that this was the first day attending the meeting in this role and that a change was required in the minutes on Page one to reflect this. **QS22/78.2** An Independent Member agreed to send comments to the Head of Corporate Affairs outside of the meeting. **QS22/78.3** With regards to the Action around The Executive Director of Public Health to bring back some information this was in relation to the co-occurring approach rather than 136 and should be amended in the minutes and action log. **QS22/78.4 It was resolved** that subject to the noted amendments the minutes were approved.	 PPJ JH PPJ
QS22/79 Matters Arising and Table of Actions **QS22/79.1** The Committee reviewed the action log and closed actions where appropriate.	

QS22/80 Report of the Chair **QS22/80.1** The Committee received the Chair's Report. **QS22/80.2 It was resolved** that the Committee received the Chair's report.	
QS22/81 Report of the Lead Executive **QS22/81.1** The Executive Director of Integrated Clinical Delivery/Deputy Chief Executive presented her report and it was agreed to invite the Dementia Team back in to triangulate the work that is being taken forward in workshop. It was noted that the Okenden Report would return to a future meeting but issues had been identified that were wider than Maternity. **QS22/81.2** An Independent Member noted that the report highlights a number of Reports where by Improvement Work will Commence or is being planned and that going forward timelines would be helpful. The Executive Director of Integrated Clinical Delivery/Deputy Chief Executive advised that conversations are ongoing with regards to a single improvement approach and that some of the standards within Ysbyty Glan Clwyd (YGC) are being reviewed in the forthcoming week at the Executive Team Meeting. **QS22/81.3 It was resolved** that the Committee received the Lead Executive's report.	
QS22/82 Clinical Audit Plan **QS22/82.1** The Committee noted that the overarching plan was not received and that given that the role of the Committee was to approve and be assured, an extraordinary meeting be convened for this to take place. **QS22/82.2 It was resolved** that an extraordinary meeting should be convened.	PPJ/MM
QS22/83 Psychological Therapies Report **QS22/83.1** The Acting Executive Director Of Therapies & Health Science presented the paper advising that he was proposing three specific actions, these being: • **Action 1**: Map our current position across all adult (physical and mental health) and children's services using the existing Matrics Cymru and Matrics Plant frameworks. Timeline – By September 2022. • **Action 2**: Review the terms of reference for the BCUHB Psychological Therapies Management Committee. Timeline – By July 2022. • **Action 3**: The Psychological Therapies Management Committee will oversee the construction of a plan to develop a framework for psychological informed care with BCUHB. Timeline – By December 2022.	

QS22/83.2 The Committee discussed the actions and felt that ensuring that the patient was at the centre was critical, specifically that children and young people moving through the patient pathway were not lost. The Committee were supportive of the actions with the agreement that the full report was taken off the web page and a link to it remains, this will enable focus going forward to be the patient centred way. It was noted that Report's conclusions/recommendations are of note, but are not universally accepted as valid, and historically it had been sensitive to some people **QS22/83.3** The Chair concluded that discussion had been about the fact that the three actions would enable a re-set, that the demand on the service and the type of therapy has changed that was being reviewed. Given the support for the three actions it was agreed that the link could be taken down, however, following the completion of these three actions a reconciliation between the outcome of these actions against the original report, it should be noted that any reasons behind the changed be clarified. **QS22/83.4** **It was resolved** that the Committee agreed with the above stated three actions to move forward and that the report be removed from the website and replaced with a link and that the triangulation between outcomes be clarified.	**GE**
QS22/84 Dementia Hospital Charter **QS22/84.1** The Committee received the report and it was agreed to ask the Dementia Leads to return to QSE. It was noted that this should also return to a Board Workshop specifically for Board Training **QS22/84.2** The Committee were extremely supportive of the Charter. **QS22/84.3** **It was resolved** to support the requirement for the Board engage in training.	GT/MM
QS22/85 Covid 19 Update **QS22/85.1** It was noted that this item was down for Consent, the Committee approved the six recommendations. It was noted that the step down of Gold required Cabinet approval and that a report would be shared with them. The Committee discussed staff leaving the organisation and it was noted that contingency cover was being implemented. **QS22/85.2** **It was resolved** that the Committee the received and acknowledged the Charter.	GH
QS22/86 Patient Safety Report **QS22/86.1** The Acting Associate Director of Quality Assurance presented the Patient Safety Report and focussed on the overall Serious Incident increase, it was noted that investigations were being monitored within specific timescales with embedded learning coming from the investigations. It was noted that there were	

42 nationally reportable incidents during the two month period monitored and three were classified as never events. The themes of the Serious Incidents were noted as falls, pressure ulcers and deteriorating patients. The details of the Never Events were clarified. **QS22/86.2** The Acting Associate Director of Quality Assurance advised that one open independent investigation would be coming to the next QSE meeting with the primary issues highlighted as communications. It was noted that there were two safety alerts still open and that these would have completed in the next two weeks. It was noted that the challenge was the consistent application across all of the services. **QS22/86.3** The Committee noted that we are seeing inquests listed due to the significant numbers not heard over the Covid period. It is further noted that Regulation 28's had been received with a notice of two weeks. **QS22/86.4** An Independent Member raised concerns that the learning coming out of these events should be standard basic practice the Committee queried basic training and that fundamental care not being implemented. **QS22/86.5** The Acting Executive Director for Nursing and Midwifery agreed with the Committee noting that it was now important to remind people of their professionalism, revisit inductions, check that people understand what they should be doing and that they understand that training is their responsibility and should be available. It was noted that the matron check list had been strengthened. **QS22/86.6** The Executive Director of Workforce and Organisational Development requested that reference to HSE is included in the report both in terms of reporting, triangulation and learning from near misses. The Committee noted the live investigation in to the incident at the Hergest Unit. The Acting Associate Director of Quality Assurance advised that further work was required around near misses, that the new Datix system being implemented would help. **QS22/86.7** The Chair advised that focus needed to be on near misses and risk rather than outcome. **QS22/86.7** An Independent Member referenced overdue reports, them being overdue because background documents were unavailable, he also queried the length of time litigation took and the impact this would have on families being unacceptable. The Acting Associate Director of Quality Assurance agreed with the points raised around overdue reports and clarified the reason why litigation took the length of time it did. **QS22/86.8** The Committee was extremely concerned with the contents of the report, that although there is a lot of action taking place there it was not having the desired impact. It was suggested that future deep dives would be required to triangulate and understand the impact. The Chair thanked the Acting Associate Director of Quality Assurance on the quality of the information contained in the report.	MJ

[Neil Rogers and Neil and Ramesh Balasundram joined the meeting] **QS22/86.9 It was resolved** that the Committee noted the report.	
QS22/87 Quality/Safety Awards and Achievements **QS22/87.1** The Quality/Safety Awards and Achievements paper was received with thanks. **QS22/87.2 It was resolved** that the Committee noted the report.	
QS22/88 Vascular Services **QS22/88.1** The Executive Medical Director presented the paper noting that the CHKS report would return to the Vascular Steering Group but that it would not be received until it was of good quality. The report was commissioned to understand that if by changing to a centralised approach outcomes were unchanged. It was noted that the standing down of the make safes would be an Executive Decision. The Executive Medical Director and the Acting Board Secretary advised that they had met with the Chair of the Vascular Quality Panel and that the Panel will report directly into QSE. **QS22/88.2** The Committee discussed resource it was noted that The Acting Associate Director of Quality Assurance had moved four staff to give support to the Vascular Quality Panel and will be called the Vascular Quality Team and would be picking up the Serious Incidents. **QS22/88.3** An Independent Member asked that given the 28 day make safes in place had cancellation of appointments impacted on delays. The Executive Medical Director advised that there had been scarcely any change to patients due to the 28 day make safes. He agreed to share to the number of Vascular concerns that had been received and what other ways concerns had been received following the help line. **QS22/88.4 It was resolved** that the Committee received the report from the Vascular Steering Group.	NL
QS22/89 Update on the Urology Transformation Programme **QS22/89.1** The Executive Director of Integrated Clinical Delivery/Deputy Chief Executive gave an update on the Urology Review highlighting that all of the Ombudsman actions were complete and that an improvement group had been set up. It was noted that the Terms of Reference had been agreed and supported and the request for the external Royal College review was being taken forward and improvement plans would be aligned. **QS22/89.2** The Executive Director of Integrated Clinical Delivery/Deputy Chief Executive highlighted that the Cancer Improvement Group had been set up and was buddying with the Manchester Cancer Board and that the Chair is an	

urologist. The Network Director is appointed and Network Manager interviews would commence the following week. The Clinical Lead had been signed off and it was going out to advert. The robot had arrived and a training schedule was being developed. **QS22/89.3 It was resolved** that the Committee received the Urology Transformation Programme update.	
QS22/90 YGC Action Plan **QS22/90.1** The Acute Care Director presented the plan as distributed, it was noted that the HIW Action Plan would likely be signed off by Tuesday 10 May. A query was raised as to who would be taking the actions forward and that many of the actions described were quite broad. **QS22/90.2** The Acute Care Director advised that a lot of site issues related to congestion, manifesting with ambulances being held outside. It was noted that the immediate turnaround plan, highlighted in appendix 4 of the papers, which ran during March, had shown significant results. **QS22/90.3** The Acting Executive Director for Nursing and Midwifery queried how these were going to be embedded given that the issues being raised were not new issues. The Acute Care Director advised that a rhythm of the day is consistently taking place, day in and day out, and that this felt like it was having an impact. Professional Medical Standards within YGC were begin highlighted to employees. The Hospital Medical Director highlighted that the culture within the organisation had been very negative. **QS22/90.4** An Independent Member raised concerns that, if letters and job descriptions, were having to be distributed he was concerned about the workforce being fit for purpose. The Committee noted that it was a specific HIW action to remind staff about their professional responsibility and this had been done. **QS22/90.5** The Executive Medical Director clarified that assurance could not be taken from the plan but that it signalled that there were good things happening but that there was recognition that there were significant concerns. **QS22/90.6** The Executive Director of Workforce and Organisational Development asked the Committee to acknowledge that there were colleagues in YGC and across the whole of the organisation who came to work to do the right thing. That there has been significant feedback that it needs to be made easier for people to do the right thing, that the only way culture is changed is by changing behaviours and raising concerns with individuals. It was noted that currently within the organisation there were less than 10 cases of capability proceedings. She queried how feedback from discovery had been incorporated into the plan. The Acute Care Director advised that it was not in there and it was agreed that the Workforce Team would support where appropriate. **QS22/90.7** The Chair commented that at the March 2022 meeting it was	SG

requested that the overarching Action Plan should return to the Committee and that what had been received was one specific Action Plan. The Acute Care Director advised that there were individual plans but that they had not been incorporated into the one plan. It was noted that the reason for an overarching plan was due to the wider concerns that had been discussed over the previous three to four years. It was noted that the Committee understood completely that there are massive cultural issues but what was not clear was what the Hospital Management Team were doing about it and that improvements must be seen urgently. **QS22/90.8** It was agreed that a full action plan would be received at the Extraordinary QSE Committee to be convened as soon as possible. **QS22/90.9** Independent Member Jaqueline Hughes declared an interest in the item given her substantive post is in radiology. **QS22/90.10 It was resolved** that the overarching YGC Improvement Plan return to an Extraordinary QSE meeting to be scheduled as soon as possible.	
QS22/91 HIW Reports & Action Tracker **QS22/91.1** The Chair received the report with thanks noting that it was extremely helpful from an assurance perspective. **QS22/91.2** It was noted that the paper provided the Committee with an annual look-back report on HIW activity during the preceding year. As part of the Committee's return to normal business, following easing of pandemic arrangements, the report would be regularly received at QSE going forward. **QS22/91.3** The Committee discussed learning and themes it was agreed that an additional six month review needed to be included into the process. **QS22/91.4** It was agreed that the Acting Associate Director of Quality Assurance take off line the follow up process for HIW actions and provide an update at the next meeting. **QS22/91.5 It was resolved** that the Committee received the report for assurance, with acknowledgement that further work was required to provide full assurance.	MJ
QS22/92 Mental Health & Learning Disabilities (MHLD) Update **QS22/92.1** The Committee received the updated it was noted that a project plan had been requested in relation to Co-horting including timescales. It was noted that the Department was in the process of producing this with planning colleagues. **QS22/92.2** The Interim Director Of Nursing Mental Health gave the following update in relation to the phases:	

• Phase 1 to stop admission to Hergest subject to acute care meeting discussion re clinical need and best interests - due 21 February (with one admission taking place in March) • Phase 2 to restore some admission capacity in the west area within specialist older peoples MH services in Cefni Hospital – this was planned from March to April but due to a court of Protection case it would now be July. • Phase 3 to propose to re-provide services above from Cefni hospital to the Hergest site in the former Gwalchmai ward – timing to likely to be August/September. • Phase 4 to consider the long term strategy and need for the service in the West area as part of the division's estate work – no timing noted **QS22/92.3** The Executive Director of Public Health advised that there were some high level plans and that good progress was being made, that vacancies are being managed and that work is ongoing with CHC colleagues. **QS22/92.4** The Committee discussed the overarching Improvement Plan raising concerns around the urgency that it was being developed. It was agreed that the Executive Director of Public Heath would take this forward with the Transformation Team with the full support from the Committee that the division is to be given all the tools available. **QS22/92.5** A discussion took place around ICan and what support was being provided with when coming into contact with vulnerable people who have not yet been diagnosed. It was noted that the ligature risk was presented at the risk group and was being populated to identify a wider Health Board risk, the mitigation of which is being drafted. **QS22/92.6 It was resolved** that the Committee accepted and received the update.	
QS22/93 Chair's Reports from Strategic and Tactical Delivery Groups **QS22/93.1** The Committee Received the Reports. **QS22/93.2 It was resolved** that the Committee received the reports from the Strategic and Tactical Delivery Groups and any questions would be raised outside of the meeting.	
QS22/94 Audit Wales Quality Governance Report **QS22/94.1** The Committee Received the Report.	
QS22/95 Issues Discussed in Previous Private Session **QS22/95.1** It was noted that the issues discussed at the Private Session of the	

Meeting held on 1 March 2022 were the External Serious Incident Review – MHLD: Ty Llewelyn and the External Serious Incident Review – MHLD: Hergest. **QS22/95.2** It was noted that the only discussed at the Private Session of the Meeting held on 23 March 2022 was the Ysbyty Glan Clwyd (YGC) Emergency Department Health Inspectorate Wales (HIW) report and improvement Plan	
QS22/96 Documentation Circulated to Members **QS22/96.1** There were no documents circulated to Members	
QS22/97 Agree Items for Chair's Assurance Report **QS22/97.1** The Chair agreed to reflect after the meeting.	
22/98 Review of risks highlighted in the meeting for referral to Risk Management Group **QS22/98.1** The Chair agreed to reflect after the meeting.	
QS22/99 Review of Meeting Effectiveness **QS22/9.1** Given timing the Chair agreed to reflect after the meeting.	
22/100 Date of next meeting **5 July 2022**	