Minutes of the Meeting Held in public on 1.3.22 via Teams

Present:

Lucy Reid	Independent Member (Chair)
Jackie Hughes	Independent Member
Cheryl Carlisle	Independent Member
Lyn Meadows	Independent Member

In Attendance:

Jackie Allen	Chair, North Wales Community Health Council
Gareth Evans	Chair of Healthcare Professional Forum (*part meeting)*
Simon Evans-Evans	Interim Director of Governance
Sue Green	Executive Director of Workforce and Organisational Development (OD)
John Gallanders	Independent Member
Gill Harris	Executive Director of Nursing and Midwifery / Deputy Chief Executive
Matthew Joyes	Acting Associate Director of Quality Assurance
Mandy Jones	Director of Nursing
Nick Lyons	Executive Medical Director
Molly Marcu	Interim Deputy 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
Chris Stockport	Executive Director Primary Care and Community Services
Joanna Watson	Good Governance Institute
Iain Wilkie	Interim Director of Mental Health

Agenda Item Discussed	Action By
It was noted that the meeting was being recorded in Teams for administrative purposes.	
QS22/36 Patient Story **QS22/36.1** The Acting Associate Director of Quality Assurance introduced the story which was from the parents of baby Hunter and noted that the covering paper highlighted the range of improvements in response to their experience. He thanked the parents for sharing their story. **QS22/36.2 The** Executive Director of Public Health acknowledged that it was a very sad story and that the Womens team have reflected, that there has been a lot of learning from this experience, and they are working closely with neonatal. **QS22/36.3** The Committee acknowledged the bravery of the parents to have shared their story, concern was raised that the review into the case had been a desk top exercise and that the parents were not given the opportunity to input into the report. The Acting Associate Director of Quality Assurance advised that this had been an error and they should have been given the opportunity. It was noted that the parents had	

since met with a number of staff, their story has been shared in supervision meetings to embed the learning from what happened. **QS22/36.4** The Committee noted that the visiting guidance between England and Wales had been different at the time which had meant that the experience that the parents had was different between hospitals. The Executive Director of Nursing and Midwifery / Deputy Chief Executive advised that the policy on visiting and wider guidance is being reviewed by Welsh Government and should any changes occur the policy will change. It was noted that individual cases should be assessed with regards to visiting. **QS22/36.5 It was resolved that** the Committee receive and reflect upon the story.	
QS22/37 Apologies for Absence **QS22/37.1** Apologies had been received for Adrian Thomas and Louise Brereton – welcome to John Gallanders, new Independent Member	
QS22/38 Declarations of Interest **QS22/38.1** There were no declarations noted.	
QS22/39 Minutes of Previous Meeting Held in Public on 11.1.21 for Accuracy **QS22/39.1** The minutes were agreed as an accurate record subject to Jo Whitehead being in attendance for the meeting and the change in the date from February to January 2022.	
QS22/40 Matters Arising and Table of Actions **QS22/40.1** Updates were provided to the summary action log and actions were agreed as closed where highlighted.	
QS22/41 Report of the Chair **QS22/41** The Chair's Assurance report was received and agreed.	
QS22/42 Report of the Lead Executive **QS22/42.1** The report of the Lead Executive was received, the Executive Director of Nursing and Midwifery / Deputy Chief Executive highlighted the areas of concern addressed in the report in particular noting the failure to escalate in a timely way and that a piece of work being led by Mandy Jones about having a coordinated approach in relation to escalation has commenced. **QS22/42.2 It was resolved that** the Committee received the report.	

QS22/43 Recommend Quality Aspects of the Integrated Medium Term Plan (IMTP) **QS22/43** The Executive Director Primary Care and Community Services presented the paper thanking John Darlington and Matt Joyes for producing the report. It was noted that the Health and Social Care (Quality and Engagement) (Wales) Act yet to be passed, has been used as a tool to pull together the quality aspects of the IMPT report. An Independent Member noted that Public Health does feature but that this could be an area to highlight further. Another Independent Member queried how the issues around eye care will be evaluated and how all carer's issues are being included. The Executive Director Primary Care and Community Services clarified that with regards to eye care, the specification for follow up is clearly laid out in terms of clinical expectations and that patient outcomes and experience would be collected during the pathways with a view that this will improve the pathway. It was noted that the carer's perspective is being brought through the IMTP and will be clear in the wider document which will be reviewed at Board Meetings. **QS22/43.2** A discussion took place around Cancer Pathways it was noted that a strategic cancer group buddying with the Greater Manchester Board is being set up where a number of issues will be taken forward including MDT working and access. It was agreed that the Executive Director of Nursing and Midwifery / Deputy Chief Executive and Cheryl Carlisle would pick up this discussion offline. **QS22/43.3 It was resolved that** the Committee received the report.	GH/CC
QS22/44 Quality Priorities **QS22/44.1** The Executive Director of Nursing and Midwifery / Deputy Chief Executive presented the paper highlighting that during Covid the Quality Strategy had been put on pause but that it is now being re-started and stakeholder engagement would be key. It was noted that there would be other priorities but these are the ones being highlighted for the Committee. **QS22/44.2** The Interim Deputy Board Secretary suggested that the priorities be aligned to the Board Assurance Framework and agreed to pick this up outside of the meeting. The Executive Medical Director welcomed the document, clarification was sought with regards to terminology and the phrase "patients" mainly being aligned with secondary care. Attendees discussed the Speak Out Safely facility and the other ways available to raise concerns, how concerns will be addressed. It was noted that the Vice Chair and the CEO have monthly meetings with the Speak Out Safely guardians. **QS22/44.3** Acting Associate Director of Quality Assurance reiterated that the priorities shared are interim, that Public Health will be addressed as part of the Quality Strategy that engagement would be with patients, carers and language would be reviewed but noted that there has never been an overarching word for patient that has been unanimously agreed. **QS22/44.4** The Executive Director of Nursing and Midwifery / Deputy Chief Executive advised that if a complaint had been received then the Health Board had already failed. The Chair suggested that the strategy be a live ongoing one that is continuously reviewed.	MM

QS22/44.5 The Acting Associate Director of Quality Assurance thanked the Committee for the feedback and noted that it would be a multifaceted approach with the Health and Safety team and other areas being fully involved. A focus on moving away from compassion towards kindness was fully supported. **QS22/44.6 It was resolved that** the Committee endorsed the priorities noting that they would likely change as the strategy progressed.	
QS22/45 Workshop Feedback Update **QS22/45.1** The Executive Director of Nursing and Midwifery / Deputy Chief Executive advised that following a recent meeting it was agreed to pilot a revised Committee coversheet for Committee papers to enable the papers to give more assurance, reflect risk, identify why the paper was being received at the committee and reduce the size of papers to focus down on answering the question. That each patient story, wherever possible, should link to an agenda item and reflect what difference has been made. It was reflected that the Committee needed to continuously ask the "so what?" question to ensure that it doesn't become transactional and the agenda should be flexible. **QS22/45.2** The Interim Deputy Board Secretary advised that authors should be asked togauge the level of assurance they are giving with their papers and that the annual report had previously been a retrospective assessment but that a holistic process is being developed which will include an annual survey to feed in to ensure that the Committee terms of reference are being discharged in a dynamic smarter way.	
QS22/46 Vascular Steering Group Update [Joanna Watson joined the meeting] **QS22/46.1** The Executive Medical Director advised that the update had been recently reviewed at the Extraordinary Board meeting. It was noted that Susan Aitkenhead had been appointed as Chair of the Vascular Quality Panel. There is process ongoing to appoint a lead who has been working nationally with the Royal College of Surgeons, to work one day per week to move some of the softer sides of the agenda forward. It was noted that a Memorandum of Understanding with Liverpool has been written and is currently being finessed. **QS22/46.2** An Independent Member advised that she felt more assured than she had in previous years but asked whether it would be possible to tell if a "good day" had been had within the service as a result of the actions. The Executive Medical Director advised that in his opinion the vascular improvement plan is right, that the next step would be to produce a vascular quality dashboard so that it would be possible to understand at a glance what was happening. It was noted that the number of patients actually treated is very small, the vascular society have produced some guidance and the national guidance is welcomed. Welsh Government are now working with the Health Board to produce a quality dashboard.	

QS22/46.3 An Independent Member queried that with regard to the contract in place with Liverpool, who would have the responsibility for the patients and that the paper highlights additional workforce requirements and if it would be possible to understand what was required. **QS22/46.4** The Executive Medical Director advised that there are some patients that would be transferred to Liverpool but the Memorandum of Understanding is around the multidisciplinary discussions and that the majority of patients would stay with the Health Board. With regards to recruitment it was clarified that this included the diabetic foot pathway that are not necessarily part of the vascular service. **QS22/46.5** The Chair of the Committee queried what the delay was on some of the improvement actions including the helpline. The Executive Medical Director advised that he had made the decision not to set up a helpline until the Vascular Steering Group had been set up, however, he acknowledged this had been the wrong decision to make and the helpline is now in place. The Acting Associate Director of Quality Assurance advised that the line was operating within 48 hours of the decision being made to open and actively promoted from the Monday thereafter. It was noted that there had not been much activity on the helpline but there was a dedicated complaints team enabled to specifically deal with vascular concerns and that this would be reported through the vascular quality panel. **QS22/46.6** The Chair of the Committee advised that there was a meeting scheduled to discuss regular reporting to the Minister and that the Chair had already met the Minister about the service. It was noted that all reports that go to the Minister will also be reported to the QSE Committee and that it was essential that the Health Board is able to provide evidence based progress. **QS22/46.7 It was resolved that** the Committee received the update from the Vascular Steering Group.	
QS22/47 Urology Service Review of Terms of Service **QS22/47.1** The Executive Director of Nursing and Midwifery / Deputy Chief Executive informed the committee that an external review by the Royal College had been requested by the Board on the Urology Service. It will link in with the ongoing Vascular work. It was noted that the Terms of Reference for this review had been discussed and agreed in collaboration with the Royal College and the Committee are being asked to approve subject to some very minor amendments. **QS22/47.2** The Executive Medical Director advised that he supported the terms of reference and that the delay in these being brought for approval was due to him wanting to take personal responsibility for them being correct as it was essential that the change in Urology needed to start immediately. The Executive Director of Nursing and Midwifery / Deputy Chief Executive advised that this meant that the work would be across the Health Board and that it would be drilled down through the Network manager to ensure there is one version of the truth, that the MDT are supported with the advantages of buddying up with Manchester to understand best practice and getting things right first time.	

QS22/47.3 The Committee discussed the learning from the Vascular review to ensure that lessons had been learned with regards to providing the Royal College with the correct information and files and that the Urology team understood why the review was taking place and that they were fully engaged. The Executive Medical Director advised that they were, that he has met with the Urology Consultants and the Urology Improvement Group would be included in the process. **QS22/47.4** The Committee discussed patients being included in the review and that a workforce model defines what clinical staffing means and that the whole of the workforce is identified not just those with clinical positions. It was noted that when staff enter the conversations they understand what any implications may be. **QS22/47.1 It was resolved that** the Committee approved and endorsed the draft terms of reference.	
QS22/48 Harms Report **QS22/48.1** The Executive Director of Nursing and Midwifery / Deputy Chief Executive presented the paper, the purpose of which was to highlight to the Committee all of the risks that are being managed as part of the current challenges presented because of outbreaks, beds spaces and workforce gaps. The paper focussed predominantly on falls and pressure ulcers and that close work was ongoing with the Workforce team. It was noted that the national pressure ulcers review is taking place over the next 12 months. The Committee discussed duty of candour and how patients were being communicated with. **QS22/48.2** The Chair queried the differences highlighted in the report with Ysbyty Gwynedd compared to the other sites and the Acting Associate Director of Quality Assurance clarified that this was because they have had both falls and pressure ulcer issues. The environment was discussed, the learning from the falls group has been shared to allow good practice to be shared. **QS22/48.3** The Executive Director of Workforce and Organisational Development provided an update on Health and Safety Executive feedback noting that there is a good element of control and templates are right, that there is high compliance on training but low compliance on risk assessment as a result of this not being seen as part of the clinical notes. It was noted that the focus was now on making sure people are doing what they need to do and at the right time and queried how some of this has not been identified through our own processes. **QS22/48.5 It was resolved that** the Committee noted the report **QS22/55 NU06 – The Prevention and Management of Adult In-Patient Falls** [taken out of agenda sequence] **QS22/55.1** The Committee went on to discuss the Falls Policy in conjunction with the Harms Report. There was a discussion about the monitoring and compliance against the Falls Policy. It was agreed that section 7.4 be updated to include weekly group	MJ

meetings, how the learning would be shared, how the accountability framework and weekly groups would be included and how all falls would be reported and reviewed. **QS22/55.2 It was resolved that** the Committee reviewed the policy and agreed to ratify via chairs action subject to the changes discussed on section 7.4 in agenda item QS22/48 (for launch pan BCUHB March 2022).	
QS22/49 Corporate Risk Register Exception Report relating to Quality Risks **QS22/49.1** The Committee noted the ongoing challenge between corporate and clinical risk and were informed that a really useful discussion at the last Risk Management Group had taken place and that the risk team are also looking at patient feedback and having conversations with the teams alongside ongoing work with the work aligning the Risk Register to the BAF. The target dates were discussed and the Interim Director of Governance agreed to review. **QS22/49.2** The Committee noted the timely access to care homes risk with the Executive Director of Nursing and Midwifery / Deputy Chief Executive highlighting that looking across the Health Board, the longer someone stays under the care of the Health Board, the longer they are likely to develop a pressure ulcer and fall. It was noted that work is ongoing with Local Authorities. **QS22/49.3** The Interim Deputy Board Secretary advised that the paper should say in future when there is a clear misalignment between the risk appetite and where we are. **QS22/49.4** An Independent Member raised the two years wait for an urgent outpatient appointments on site is the highest risk. The Executive Director of Nursing and Midwifery / Deputy Chief Executive advised that a risk assessment for each site is being undertaken to assess which can be brought on line, it was noted that much of outpatient capacity is taken up by follow ups and patient initiated follow ups are being considered to create capacity. **QS22/49.5** The Chair requested that the process of risk management and governance is reviewed outside of the meeting to ensure that the Committee are clear what is being asked of them.	SEE SEE/ MM/NL
QS22/50 Patient Safety Report **QS22/50.1** The Chair noted that she had provided the Acting Associate Director of Quality Assurance with some feedback noting that these would be addressed outside of the meeting and attached to the minutes. It was noted that fundamentally, concern was that there was no assurance over the learning from incidents, that the report was informing about the incidents and the immediate learning, but not what has happened to previous incidents. This learning should feed into the clinical audit plan where reoccurring themes are identified and what learning and changes have taken place because of this. The Never Event action plan that was sent back to the service had not returned to Committee, it was requested that this be done. **QS22/50.2** The Chair highlighted that this agenda item was supposed to provide a deep dive of Never Events and that she was disappointed with the lack of detail within the	PPJ MJ

report. The Acting Associate Director of Quality Assurance apologised for missing the expectation with the report, he noted that there had been 9 Never Events in the current financial year with 5 in the previous year. The recurring theme that is that the majority are surgical and in particular with regard to the use of the surgical checklist. It was agreed that further work would be done outside of the meeting and that when deep dives are undertaken clarity about what is being asked is defined. It was noted that Internal Audit would be able to support this work. **QS22/50.3** The Acting Associate Director of Quality Assurance advised that the Coroner was reviewing a number of cases at the moment involving delays with ambulances, not just associated with the BCUHB, he was looking at other Health Boards in the round. **QS22/50.3** The Chair noted that a robust clinically focussed audit plan is required and that this should be reviewed at the next meeting. She also requested an update on all previous Regulation 28's. **QS22/50.4 It was resolved that** the Committee receive the report	NL/MJ
QS22/51 Quality Awards, Achievements and Recognition **QS22/51.1 It was resolved that** the Committee received the Quality Awards, Achievements and Recognition paper.	
QS22/52 Patient and Carers Experience Report **QS22/52.1 It was resolved that** the Committee received the Patient and Carers Experience Report and that any questions should be raised outside of the meeting.	
QS22/53 External Serious Incident Reviews MHLD [Iain Wilkie joined the meeting] **QS22/53.1**. The Chair noted that the reports on both incidents had been received in full by Committee members but a redacted version of the reports being shared in the public domain had been done so to protect the individuals involved and their families. It was noted that Serious Incident Reviews would not normally be reported in the public domain but that recognition was given to the seriousness of the incidents and that for the interests of transparency the reports were being shared in this way. It was noted that the focus for the Committee was about learning and what was being done to address this. **QS22/53.2** The Committee noted that there was an overall action plan that brought together the detailed action plans shared. It was noted that the action plan will be shared with the Adult Safeguarding Board at the appropriate time given that both external reviews had only just been received. It was noted that the Health and Safety Executive investigation is ongoing.	

QS22/53.3 An independent Member raised concerns around mandatory training issues, staff records, communications and the need for confirmation that patients are dealt with in the round especially regarding substance misuse. The Interim Director Of Nursing Mental Health explained the current staffing arrangements. The Committee discussed the Section 136 and the issue of revolving doors, it was noted that a person cannot be detained under section 136. The Executive Director of Public Health advised that she would bring back some information on how the co-occurring approach around Section 136 is being handled. A discussion took place around on the job learning being more valuable than e-learning packages. The Interim Director of Mental Health advised that further work was required on maintaining adequate training records and that he would take this and how staff are managing substance misuse forward outside the meeting to go through governance. **QS22/53.4** The Chair noted that the Ty Llewelyn action plan had not yet been published in the public domain and that further work would be required before it is to ensure that actions appropriately address the recommendations. The Chief Executive noted that the Health Board wide action plan lacks outcomes and timescales, that what is currently presented is a good start, but required tangible outcomes. The Executive Director of Public Health agreed that she would look at the outcomes, it was noted that these should link to the QPR. **QS22/53.5** The Interim Director of Mental Health advised he would be working with the Director of Transformation and Improvement and reaching out to other Health Boards to identify how they have embedded sustainable learning. The Chair requested that the Committee receive a more dynamic improvement plan that consolidated all of the findings from the external reviews whilst also incorporating systemic improvements identified from previous reviews. She expected this to be provided to the next Committee meeting. **QS22/53.6** The Committee discussed observations of patients at HMP Berwyn, The Acting Associate Director of Quality Assurance advised that a piece of work on death in custody and thematics has been completed and he would review. **QS22/53.7** It was agreed that the Ty Llewelyn action plan would be revisited and reviewed outside of the meeting. The Chair noted that the items listed in the private session of the meeting were not for discussion but for background reading. **QS22/53.8** Jackie Allen reflected on the Mental Health Report and the ligature risks, advising that the CHC will be having a conversation with the Health Board to see if there would be anything they could do to assist. **QS22/53.9 It was resolved that** the Committee receive the report	TO TO
QS22/54 Chairs Assurance Reports **QS22/54.1 It was resolved that** the Committee received the Chairs Assruance Reports for information.	
QS22/56 Infection Prevention and Control Policy – Hand Hygiene	

QS22/56.1 Jackie Hughes raised concerns around the wording and terminology of the policy, specifically around "staff" and "dress code" and agreed to circulate her comments after the meeting. **QS22/56.2 It was resolved that** Jackie Hughes agreed to circulate her comments on the policy after the meeting and that the policy would need to go through Infection Prevention Steering Group.	JH
QS22/57Health & Safety Policy - CCTV **QS22/54.1 It was resolved that** the Health and Safety Policy – CCTV was approved	
QS22/58 Complaints Policy and Procedure **QS22/58.2 It was resolved that** the Complaints Policy and Procedure was approved	
QS22/59 Issues Discussed in Previous Private Session **QS22/59.1** The Committee noted that the Hergest Serious Incident Review had been received.	
QS22/60 Documents Circulated to Members **QS22/60.1** The Committee noted that no documents had been circulated to Members.	
QS22/61 Agree Items for Chair's Assurance Report to Board **QS22/61.1** The Chair agreed to review these out of the meeting.	
QS22/62 Review of risks highlighted in the meeting for Referral to Risk Management Group **QS22/62.1** There were no risks highlighted in the meeting for referral.	
QS22/63 Review of Meeting Effectiveness **QS22/63.1** It was agreed to look at meeting effectiveness outside of the meeting.	
QS22/64 Date of Next Meeting **QS22/64.1** 3 May 2022	
QS22/65 Exclusion of Press and Public **QS22/65.1 It was resolved that** representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be	

prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960.	

QUESTIONS AND ANSWERS DEALT WITH OUTSIDE THE MEETING

Questions raised by the Chair outside the meeting on the Patient Safety Report	**Answers given by the Acting Associate Director of Quality Assurance**
I find myself reading this report and getting no assurance over the learning from our patient safety incidents. As we have discussed previously, there is no closing of the loop and instead we have a description of incidents that have occurred (albeit at least now with some immediate learning identified), but no outcome from investigations. The immediate learning that is described in many cases is transactional, referring to how people will be reminded of what they should be doing or stating what should be done - not the how. I have provided some examples below.	Focus on immediate learning which is transactional – for the identified incidents these are those occurring in the prior 2 months and reflects the rapid review. In most cases the actual investigations are not completed. We have been asked to really focus on the rapid reviews and rapid learning panels (24-72 hours post incident) but I do think we should flip this and focus on reporting to QSE the outcome of investigations as this is where most of the detailed learning and improvement actions arise from.
Of most concern to me though is despite the agenda item explicitly stating the "Patient Safety report - focus on Never Events/Regulation 28" there is in fact only 2 referred to in different sections of the report and in extremely brief detail. There is no update on previous ones or details of close down of previous. We still have nothing further reported to the QSE Committee regarding the Urology Never Event for example that took place over 2 years ago.	Lack of mention of Reg 28s – The two mentioned are the only two we have had for some time. The last R28 response was June 2021. The actions were referenced in the report at the time (implementation of an end of day safety huddle).
In terms of the HIW review of the patient discharge from YGC, I would like assurance to be provided to the next Committee in terms of the Make it Safe process. This is not the first case recently where the process has been less than robust and I think the Committee needs to have assurance that these have been isolated examples rather than a problem with the process itself. How is the quality of MiS and RLP being reviewed? There is also reference in the report to a separate investigation being undertaken into	Make it Safe Rapid Review at YGC– we have two investigations underway, the first covering the actual incident and the second specifically looking at the failure of the rapid review process. We will of course share the findings when complete. We have also gone back for all SIs since April and collated evidence of rapid review, rapid learning panel and SIR review action plans. This was summarised in a paper for Gill and presented at the last PSQ meeting.

this case - what is this covering, i.e how is it different from the full investigation into the care and treatment of the patient?	
P30 PSN Alerts The updates aren't clear as to current status "underway" with a date of the next meeting isn't particularly helpful. There is no explanation provided as to why those that are overdue have not been completed or the priority given to it. I don't understand why PSN060 has no deadline action complete date (assuming that this is supposed to indicate when the action should be implemented) or why this says it's only applicable to Pharmacy. Pharmacy are not the only disciplines to administer oral medication so although I would expect them to lead, surely it should also refer to other areas as the others have done.	PSN057 Safety Alert – There has been a lack of clinical engagement in completing the necessary actions by the deadline, meetings were arranged but clinical staff did not attend, compounded by prioritisation over the winter period. Louise Howard Baker and Kath Clarke are pursuing this and it has been escalated. It is hoped progress will be made rapidly.
P28 Never Event YGC The report describes human factors that contributed to the event being distraction and lack of situational awareness but the narrative refers to the surgeon and the ODP wandering off whilst the nurse comforted the patient. Was the surgeon called to an emergency? Is there a reason why the ODP had to find the notes at that point? Because distraction and lack of situational awareness usually occur when something unexpected happens such as a rapid deterioration of the patient. This makes me think that the team weren't giving the sign out process the importance that it requires - if it is seen as an unnecessary task to be "ticked off" it will be done quickly or not at all and anyone with doubts won't speak up. Did the investigation consider the work environment and non-technical skills at play?	Never Event YGC – Your assessment is correct, it was an emergency surgery and the sign out processes were not followed correctly. Various points on the incidents – These should of course be answered by the investigation. I think this links to the first point, I think the Committee needs the outcome of SI Reports more than rapid reviews.