Betsi Cadwaladr University Health Board

Minutes of the Quality, Safety & Experience Committee meeting held on 1 November 2022
Via Teams

Present:

Lucy Reid	Independent Member (Chair)
Cheryl Carlisle	Independent Member
Jacqueline Hughes	Independent Member
John Gallanders	Independent Member
Hugh Evans	Independent Member

In Attendance:

Gareth Evans	Acting Executive Director of Therapies & Health Science
Sue Green	Executive Director of Workforce and Organisational Development
Dave Harries	Head of Internal Audit
Gill Harris	Deputy CEO/Executive Director of Integrated Clinical Services
Matthew Joyes	Acting Associate Director of Quality Assurance
Phil Meakin	Associate Director of Governance
Teresa Owen	Executive Director of Public Health
Philippa Peake-Jones	Head of Corporate Affairs (minutes)
Angela Wood	Executive Director of Nursing and Midwifery
Geraint Parry	Quality Improvement Fellow (for part)
Paul Andrew	Director Of Operations (for part)
Jim Mcguigan	Deputy Director Of Integrated Clinical Delivery (for part)
Sara Hammond-Rowley	Consultant Clinical Psychologist (for part)

Agenda Item	Action
QS22.266 – Welcome, Introductions and Apologies for Absence Apologies were received from Chris Stockport	
QS22.267 Declarations of Interest on current agenda **QS22.267.1** The Executive Medical Director declared an interest in the RCGP report	
QS22.268 Minutes of Previous Meeting Held in Public for Accuracy **QS22.268.1** The minutes of the meeting held on 6 September 2022 were	

approved as an accurate recollection of the meeting subject to the spelling of the last name of the Internal Auditor and the correct title to be used for the Executive Director Transformation and Planning. **QS22.268.2 It was resolved that** the minutes were approved as an accurate record of the meeting held on 6 September 2022	
QS22.269 - Matters Arising and Table of Actions **QS22/269.1** The Committee reviewed the action log and closed actions where appropriate.	
QS22.270 - Patient Story **QS22.270.1** The Committee watched a video on the collection of experiences from staff from WAST and BCUHB Occupational Therapy Service describing the Falls Response Team pilot. **QS22.270.2** Attendees were very supportive of the pilot noting that the sooner it is rolled out across the Health Board the better and that what was key and had not been highlighted in the video was the communication with the family of a patient. The Acting Associate Director of Quality Assurance advised that the family were kept informed. **QS22.270.3** An Independent Member queried where St John's Ambulance featured in the pilot, it was noted that the call handler fields the response. A discussion took place around funding and the Acting Associate Director of Quality Assurance advised that he would respond outside of the meeting. **QS22.270.4** The Chair thanked the team for providing the update but highlighted that it was a service update as opposed to a patient story. She reiterated the purpose of the patient story was to hear the voice of the patient and asked for this to be considered for future updates to the Committee. **QS22.270.5 It was resolved that** the Committee receive and reflect upon the story	MJ
QS22.271 Report of the Lead Executive **QS22.271.1** The Committee received the report of the Lead Executive, it was noted as the quality effectiveness work was undertaken there would be an opportunity to look at the "so what" collectively. **QS22.271.2** An Independent Member queried the level of progress for complaint responses highlighting that there was a 25% response rate rather than 75% response and what would be happening to address this. The Executive Director of Nursing and Midwifery advised that trajectories were being reviewed with a significant improvement taking place moving from the high 400's down to 200's and that these were being reviewed at accountability meetings. The Acting Associate Director of Quality Assurance advised that there should be a	

significant impact by early December. Attendees discussed the quality of responses and the sign off process for each response and how they are measured. It was noted that with regards to Ombudsman referrals the Health Board was in the middle of the pack and in line with the average for Wales. **QS22.271.3 It was resolved** that the Committee received the report.	
QS22.272 Corporate Risk Register **QS22.272.1** The Associate Director of Governance clarified the role of the QSE Committee noting that they had operational oversight and a role to scrutinise the risks presented. It was noted that there was a new section in the report called emerging risks and that the paper highlighted the new risks being proposed. **QS22.272.2** An Independent Member queried the 4/5 Health and Safety Risks and that these were sitting with the Executive Director of Finance. The Chair also challenged the scoring for compliance with contractors risk and whether this should be on the corporate risk register. She said she remained concerned about the lack of clinical risks on the register. The Executive Director of Workforce and Organisational Development reminded the Committee that in 2019 a full gap analysis was undertaken in relation to the 33 pieces of legislation and throughout 2019/20 it was agreed that the delivery against all of the Health and Safety Risks that were solely Estate's risk would be managed through Estates rather than with the Health and Safety Department. The Executive Director of Workforce and Organisational Development concluded that she would be happy to provide all of the Health and Safety Risks should this be necessary. The Chair queried the mitigations in place as she would have expected the risk scores to be reducing. **QS22.272.3** The Deputy CEO/Executive Director of Integrated Clinical Services advised that the Associate Director of Governance and his team were working with the leads to refresh the register and stepping up the Risk Management Group. It was noted that the IHC's are reviewing and challenging the risks and mitigations. **QS22.272.4** The Interim Board Secretary advised that at the last RMG meeting a Health and Safety Report had been received and that one of the actions taken was to make violence and aggression and ligature corporate risks. **QS22.272.5** The Chair queried the number of policies referenced in the action updates stating they were going to the Committee but had not been presented. The Associate Director of Governance clarified that the newly established HBLT would do some harmonising of the risks and identified Health and Safety Risks will need to be taken to RMG. **QS22.272.6** An Independent Member highlighted that Safeguarding Forums were not taking place and the Deputy CEO/Executive Director of Integrated Clinical Services advised that she would take the matter outside of the meeting. **QS22.272.7** A query was raised by an Independent Member around the Welsh Risk Pool's tolerance regarding non-compliance with regards to claims and the	GH

Acting Associate Director of Quality Assurance advised that reimbursement was generally subject to learning and that a case management report would be submitted detail around the national procurement platform were shared. **QS22.272.8** The Chair thanked the Associate Director of Governance for a more succinct report but noted that more clinical risks were required. It was noted that risk owners needed to update the risks. The Chair also highlighted that the need to review the legionella risk as it was particularly concerning if management considered that despite the controls in place, the organisation was unable to prevent a legionella outbreak. It was noted that this would be picked up by the Strategic Occupational Health and Safety Group (SOHG). **QS22.272.8** The Committee discussed mandatory training and the Executive Director of Workforce and Organisational Development noted that mandatory training would be reviewed to address non clinical contact employees. **QS22.272.9 It was resolved** that the Committee reviewed and discussed the report.	SG
QS22.273 Polices for Approval **QS22.273.1** The Committee approved the Thromboprophylaxis Policy noting that it was currently in Draft and was an All-Wales Policy. **QS22.273.2** The Committee were content with the IPC Policy but noted the EQIA was missing and that subject to that being circulated outside of the meeting the policy would be approved.	
QS22.274 Mental Health Outcomes and Improvement **QS22.274.1** The Executive Director of Public Health welcomed Paul Lumsdon, Interim Director of Nursing, to the meeting advising that progress was being made and that the service was an improvement journey. The Interim Director of Nursing advised that he would review the papers and appendices and look at how these should be summarised now that programme governance was aligned. Staff engagement and leadership capacity were highlighted noting that a matrix approach with regards to quality improvement and service development is being taken forward but that the transformation would take some time. Short, medium, and long term goals will be identified and reported back to the committee. **QS22.274.2** Independent Members advised that the Gant charts would need to be updated for the next meeting and a sense of what has changed, where the problems are, what is proving difficult and where the risks lie would need to be clear with concerns around capacity identified. The Executive Director of Public Health shared the concerns about capacity, noting that the new Head of Strategy starts in December which should increase momentum. **QS22.274.3** The Interim Director of Nursing advised that there was a need to refine where progress has been made without taking away detail and that this would be picked up in future updates.	

QS22.274.4 The Executive Director of Workforce and Organisational Development advised that the recruitment for a permanent Director of Mental Health and a Director for Nursing would commence shortly and that she recognised that there was an outstanding retrospective piece of work around Hergest NOC needed to be triangulated across to other Committees agreeing that restraint practice needed to be reinvigorated and come back to both MHACC and QSE. **QS22.274.5** Attendees discussed the restraint practice report noting that there was a lot of work to do. The Interim Director of Nursing advised that the permanent advisement was really welcomed and that there needed to be a shift from interims to permanent staffing, he agreed that the restraint work was a large piece of work that would need to be returned to Committee. **QS22.274.6** The Executive Director for Public Health advised that the Operating Model for the Division had returned to ET and that final changes were being made to confirm the structure. **QS22.274.7** The Chair asked for clarification that the five concerns raised in the HIW report were being fed into the improvement work. It was noted that better attention is being given to evidencing actions whilst noting that Hergest was still very fragile and that there was a need to wrap the team around Hergest. **QS22.274.8** The Interim Director of Nursing advised that he would prepare the next report for the Committee based on feedback given within the discussions. **QS22.274.9 It was resolved** that Committee reviewed the proposed update on the development of the MH&LD Divisional Improvement Plan.	PL
QS22.275 YGC Improvement Plan [Geraint Parry and Paul Andrew joined the meeting.] **QS22.275.1** The Deputy CEO/Executive Director of Integrated Clinical Services advised that although a lot of work had been done there was more to do and that the team were working with both WOD and the OMD with regards to medical leadership. **QS22.275.2** The Committee were informed that a stronger foundation was in place with Geraint Parry and Paul Andrew in post and noted that embedding practice is essential. Launch events had taken place with staff and there had been the start of an Integrated Medical Board with real engagement from the medical leaders with the vision of how to get MDTs working while learning from each other. **QS22.275.3** An Independent Member advised that it was essential to be realistic with the approach but was positive with the response that has been seen so far and that there were challenges at YGC that would make it difficult for the perception for improvement but that Cabinet was focussed on the right	

conversations and that the programme was in as good a place as could be expected at that time.

QS22.275.4 An Independent Member raised the two outstanding actions with regards to children and young people noting that two weeks ago the children and young people event took place and that support from Improvement Cymru representative has been sought and will engage with colleagues from ED, Paediatrics to identify training needs.

QS22.275.5 A discussion took place around reducing 12 hour stays and ensuring that this was not being done at the expense of anything else. It was noted that the cogs are being looked at both for 12 and four hour average waiting time to ensure that everyone is being looked at equitably and that overall the waiting time had been improving but not at the cost of something else.

QS22.275.6 The Committee discussed the concern around safety huddles noting that HIW had reported an inconsistent approach. Proposals had been submitted to ensure that the team take clinical ownership of these. Attendees discussed locum staffing handovers and the protocols in place.

QS22.275.7 The Committee discussed the targeted recruitment campaign noting that the work was focusing on the areas where there are significant hot spots, noting that this could either be a department or a type. This work was ongoing with the workforce team with the second element being that people do want to move and how this is supported without creating a risk. The Executive Director of Workforce and Organisational Development advised that a detailed report was being presented at Cabinet with recruitment and retention being two elements.

[Geraint Parry and Paul Andrew left the meeting.]

QS22.275.8 It was resolved that the Committee noted the progress made to date on the YGC Improvement Plan.

QS22.276 Vascular Improvement Plan

QS22.276.1 The Committee noted that the Vascular Improvement Plan was drafted in the old format but that it was being updated in line with the YGC Improvement Plan, but that this would be done following the imminent HIW inspection in December. The updated plan will be received at the Vascular Steering Group.

QS22.276.2 The Executive Medical Director gave an update on what was being received at the Steering Group noting that a deep dive into amputation rates and associated mortality was being undertaken and that it was showing no room for complacency but that the health board was not an outlier. The Committee were informed that the EPRR response that had been in place to manage rotas had been stood down the previous week. The Committee noted that MDTs reviews would continue to take place with Stoke but that dual operating had not needed to be used.

QS22.276.3 It was resolved that the Committee: • Noted the progress in the vascular improvement plan and the imminent move to using a maturity matrix to monitor progress. • Noted the progress which has been made to stabilise the consultant workforce, improve the clinical leadership of the service and further develop relationships with peer services. • Noted the assurance arising from longitudinal clinical outcome data. • Noted that current Emergency, Preparedness, Resilience and Response (EPRR) framework was stood down the previous week (but that it would remain as an option if the situation becomes more fragile). • Noted the review of vascular services by Healthcare Inspectorate Wales is now due to take place in December 2022. • Noted the issue of a Prevention of Future Deaths report following an inquest into the death of a patient with ischaemic lower limbs.	
QS22.241 Urology Improvement Plan This item was withdrawn.	
QS22.242 Quality and Performance Report This paper had not been provided to the Committee.	
QS22.279 Patient Safety Report **QS22.279.1** The Chair was grateful that the near misses had been included in the paper this time but asked what the process for learning was and that this would need to be identified going forward. The Acting Associate Director of Quality Assurance noted that this would be included in future reports as well as themes organisationally. The Executive Director of Nursing and Midwifery advised that she was looking to have an organisational learning review meeting, the learning of which would be shared with QSE. **QS22.279.2** The Chair highlighted the references in the report to incomplete documentation as a cause of the incident and wished to reiterate, again, that it was important that if a process was not followed it was understood why this had happened. A discussion took place around the WHO checklist work that had been commissioned and it was agreed that the Committee would undertake a deep dive session on this work and that as part of this approach a review on how success was being measured would be included. **QS22.279.3** The Acting Associate Director of Quality Assurance advised that he would share the information outside of the meeting with regards to the HMP Berwyn death in custody.	PPJ MJ

QS22.279.4 Attendees discussed overdue incidents and the Executive Director of Nursing and Midwifery advised that she would be applying the same rigour to complaints as to incidents. She shared the induction protocols for agency and bank staff and highlighted that the bulletins would be the repository of information. **QS22.279.5 It was resolved** that the Committee received the report.	
QS22.280 Human Tissue Act Inspection Report **QS22.280.1** The Executive Medical Director presented the report highlighting the findings of the inspection. The Chair noted the areas of non compliance that had been identified in the inspection and expressed concern that the Committee had been provided with assurance in December 2021 that appropriate actions had been taken in response to the Maidstone and Tunbridge Wells case. The Executive Medical Director and Deputy CEO/Executive Director of Integrated Clinical Services advised that further understanding was required to understand the background to this. **QS22.280.2** The Executive Director of Workforce and Organisational Development advised that there was a debate around whether or not the recommendations were required as a professional security review had been undertaken and it should not have needed to come to the Committee. The Chair advised that the Committee were assured at the time that the recommendations arising from the review in December 2021 were being taken forward. She reminded the Committee that specific assurance had been requested from an Independent Board Member at the time and this was followed up by a report from the Patient Safety and Quality Group about mortuary security. The Executive Director of Workforce and Organisational Development advised that she have to review who gave that assurance. **QS22.280.3** The Chair also queried reference in the report to the current security risk score for Ysbyty Gwynedd as being 20, which according to the Risk Management Policy would mean it should have been escalated onto the Corporate Risk Register. The Executive Director of Workforce and Organisational Development responded that it was not 20. The Board Secretary advised that the license holder needed to be looped into the Corporate Governance and that a decision as to who the license holder should be going forwards, it was suggested that it should be a member of the HBLT. **QS22.280.4** It was noted that in one of the appendices a number plate was clear and this would be removed from the public domain. **QS22.280.5 It was resolved** that the Committee noted the response to HTA inspection findings / progress with security review.	NL/MM PPJ
QS22.281 HIW Update The Chair welcomed a much clearer report although was unsure about what the appendix referring to 0's meant. The Acting Associate Director of Quality Assurance advised that the 0 referred to a partially complete action, he noted that	

he had been to YGC and had gone through the March inspection report and was content to close off 50% but the remainder lacked evidence, some of this was about the site not updating the evidence rather than it not having taken place. **QS22.244.4 It was resolved** that the Committee noted the report.	
QS22.282 Quality/Safety Awards and Achievements **QS22.282.1 It was resolved** that the Committee received the report on Quality/Safety Awards and Achievements and attendees were asked to raise any questions outside of the meeting.	
QS22.284 Sepsis Review **QS22.284.1** The Committee received the report noting that this had been a learning exercise. Risks were discussed and it was suggested that this should be included in the risk relating to management of the deteriorating patient.	
QS22.285 HMP Berwyn **QS22.285.1** The Committee noted that the report was a Prison Inspectorate Report not a HIW Inspectorate Report. Concern was raised with regards to what was identified as urgent for both dental and GP appointments and the Deputy CEO/Executive Director of Integrated Clinical Services advised that she would follow up on this outside of the meeting.	GH
QS22.286 RCGP Report [Jim Mcguigan has joined the meeting.] **QS22.246.1** The Executive Medical Director raised a declaration of interest in that his ex-wife had been the author of the RCGP report but was no longer involved. **QS22.246.2** The Deputy Director of Integrated Clinical Delivery advised that he has a series of meetings with RCGP scheduled and that there was further work to do that would be report back into QSE. **QS22.246.3 It was resolved** that the Committee noted the findings of the report and the proposed next steps.	
QS22.287 GP Out of Hours **QS22.287.1** It was noted that the presentation was shared late the previous evening given the recent working on the project, however, it was shared late given the pressures in the system. The Deputy Director of Integrated Clinical Delivery advised that the action plan attached set out dates that are being worked through. The Deputy CEO/Executive Director of Integrated Clinical Services thanked the team for the significant progress being made in this area and noted the commitment to bring out of hours under Primary Care giving the full benefit of the integrated systems.	

QS22.287.2 A further report will return to the Committee in due course.	
QS22.288 - Psychological Interventions (including Psychological Therapies) for Children and Young People [Sara Hammond-Rowley joined the meeting.] **QS22.288.1** The Consultant Clinical Psychologist shared the the baseline mapping data collection and gaps and challenges these being around data systems, KPI's and reliable data and workforce recruitment, retention and training. It was noted that there were things that were being done really well, that there is a wide range of different interventions and therapies with a great relationship with Bangor University, and close working with Local Authorities and that there were pockets of excellent practice aligned with hearing the voice of Children and Young People. **QS22.288.2** The Committee thanked the author for a comprehensive report noting the concern around capacity to deliver and the reliance on partners. The Chair requested that a similar report focussing on adults be received by the March QSE meeting.	
QS22.289 - Ophthalmology Update (how we are managing the risk stratification) The Deputy CEO/Executive Director of Integrated Clinical Services presented the report noting that she would like the deep dive to have the full oversight of the Interim Director of Regional Delivery. Independent Members thanked colleagues for the speed that this was being addressed and queried any movement on the paediatric service with the Deputy CEO/Executive Director of Integrated Clinical Services advising that she would update on that outside of the meeting. Independent Members queried the Abergele site noting the cleanliness issue and were advised that this had been picked up. Further discussions took place around the Estate Strategy noting that until it had been received it would be difficult to answer whether concerns around the Abergele site had been addressed. **QS22.289.1 It was resolved** that the committee support: • Instigating an Ophthalmology steering group focusing on secondary care service • Aligning the work to the eye care collaborative • Reviewing the risks associated to the service across North Wales	
QS22.291 Chair's Assurance Reports **QS22.291.1** Chairs Assurance reports were received noting that the SOHG had not met and that CEG would be picked up at the forthcoming MHACC on Friday.	
QS22.292 Public Interest Ombudsman Report **QS22.292.1** The Committee received the report noting that it included another	

action plan and that this was essential to share evidence and close once it is submitted. It was noted that most actions are transactional with findings being shared with the Walton Centre with the only action outstanding being to review the complaints process which an All-Wales response is pending.	
QS22.255 Date of next meeting **QS22.255.1** It was noted that the next QSE Meeting would be held on 20 January 2023.	
QS22.256 Exclusion of Press and Public **QS22/256.1 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.	