Betsi Cadwaladr University Health Board

Minutes of the Quality, Safety & Experience Committee meeting held on 5 July 2022
Via Teams

Present:

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

In Attendance:

Gareth Evans	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
Fleur Jones	Audit Wales
Nick Lyons	Executive Medical Director
Molly Marcu	Interim Board Secretary
Teresa Owen	Executive Director of Public Health
Philippa Peake-Jones	Head of Corporate Affairs (minutes)
Chris Stockport	Executive Director Transformation and Planning
Mike Smith	Interim Director Of Nursing Mental Health
Gaynor Thomason	Acting Executive Director for Nursing and Midwifery
Patrick Hill	Deputy Director Medical Physics
Amanda Lonsdale	Director Of Performance, Performance Directorate

Agenda Action	**Item**
QS22/111 Apologies for Absence **QS22/111.1** Apologies were received from Hugh Evans, Adrian Thomas	
QS22/112 Declarations of Interest **QS22/112.1** No declarations of interest were raised.	
QS22/113 Minutes of Previous Meeting Held in Public for Accuracy **QS22/113.1 It was resolved that** the minutes were approved as an accurate record of the meeting held on 3 May 2022.	

QS22/114 Matters Arising and Table of Actions **QS22/114.1** The Committee reviewed the action log and closed actions where appropriate. **QS22/114.2** The Acting Executive Director Of Therapies & Health Science advised that he would split action 10 given that the Psychological Therapies Report had been removed from the website but the action to reconcile between the outcome of the actions against the original report had not been concluded.	GE
QS22/115 Patient Story **QS22/115.1** The Committee received an account from the mother whose daughter had attended Emergency Department at Glan Clwyd Hospital following a bad fall. The Committee noted that the fall had resulted in obvious facial fractures and had left her daughter in an extremely distressed and agitated state. As a registered health professional, she knew her daughter needed urgent medical attention and took her straight to the Emergency Department where they both received exemplary treatment. The Committee noted that the staff she encountered including Security Guards, Emergency Department, ENT and Maxfax clinicians, were conscientious and thorough but still delivered care with kindness and compassion to both her daughter and herself. **QS22/115.2** The Acting Associate Director of Quality Assurance highlighted the positive feedback, that the care received was person centred, sensitive and respectful throughout. It was noted that the positive feedback had been shared with all the relevant departments. **QS22/115.3** An Independent Member queried the age of the patient and the Acting Associate Director of Quality Assurance advised that he did not know their age exactly but believed that they were a young adult. **QS22/115.4** An Independent Member noted that he would have liked to hear what followed, for example, what was their experience with outpatients. **QS22/115.5** The Chair asked whether the reasons why this patient's experience had been so positive in comparison to others that are recounted had been looked at. She wanted to know what had been different on that day, and if there had been a specific clinical lead around for example, so the department could reflect on why this had gone so well. The Acting Associate Director of Quality Assurance advised that what had come across very clearly was that staff took the time to listen and that it was quite difficult to share compassion, but that this time, despite being very busy, staff had gone the extra mile. **QS22/115.6** The Acting Executive Director for Nursing and Midwifery advised that going forward themes and action plans would be created to understand the circumstances around experiences shared. **QS22/115.7 It was resolved that** the Committee receive and reflect upon the	MJ

story	
QS22/116 Report of the Lead Executive **QS22/116.1** The Executive Director of Integrated Clinical Delivery/Deputy Chief Executive presented her report highlighting that a new Director of Governance would be starting with the Health Board in the coming weeks and that they would be asked to take a piece of work forwards around the Ockenden and HASCAS reports ensuring that actions have been embedded. **QS22/116.2** An Independent Member queried if month end figures being shared at Committees was causing a delay in reporting events such as Regulation 28 notices or Never Events in a timely way and queried the coronial process and what was causing the delays with that. It was noted that Never Events are shared with the Board once reviews have taken place. The Acting Associate Director of Quality Assurance gave a brief update on a recent Never Event noting that a rapid learning session had taken place that morning following the wrong size implement being used in a joint replacement and that the event would be taken forward through the rapid review process. It was agreed to discuss the matter further in the Private Session. **QS22/116.3** The Acting Associate Director of Quality Assurance advised that the challenge was around completing the final report to the Coroner. The Executive Medical Director advised that a monthly look ahead had been established on Coroner's Inquests and that a weekly update was being received on the Tawel Fan Inquests. With regards to delays in Inquests it was noted that there was a back log with the Coroner due to Covid restrictions, however, when the Coroner raises further questions it is often necessary to repeat the process again. **QS22/116.4** The Executive Director of Workforce and Organisational Development advised that when managers are giving statements in good faith they should be supported to do so. She suggested that it would be helpful to jointly plan work with the Health and Safety Executive (HSE) as the regulator would jointly work with both the Coroner's Office and the HSE. **QS22/116.5** An Independent Member clarified that the report being discussed covered the period up to the end of May and queried if it would it be possible to do a pre-emptive report to be produced ahead of any Inquest. The Executive Medical Director advised that further work was required with regards to record keeping but that sometimes it was difficult to anticipate what the Coroner would ask but that learning from best practice elsewhere could help. **QS22/116.6** The Acting Associate Director of Quality Assurance clarified the Coronial process noting that Inquests should be completed within six months. It was noted that what is currently occurring is that the media are attending all inquest hearings which is unusual. **QS22/116.7** The Chair noted that this would be picked up in the private session and that a report in the public meeting would be received at the meeting in September 2022.	SG

QS22/116.8 It was resolved that the Committee received the report. [Patrick Hill joined the meeting]	
Strategy and Policy	
QS22/117 Community Health Council Speech and Language Therapy Report **QS22/117.1** The Acting Executive Director Of Therapies and Health Science presented the report noting that it was on the agenda as a consent item. The themes identified in the report were highlighted as user involvement in service planning and improvement, improvement in the number of Welsh speaking practitioners and improvements in general access to the service and wait times. It was highlighted that the review had been undertaken during Covid and that the recovery plan for speech and language following Covid aligns to the report. **QS22/117.2** The Chair of the North Wales Community Health Council advised that it would be helpful to repeat the safe space event given that the report was undertaken during the Covid pandemic. **QS22/117.3** An Independent Member noted that it was distressing to read that parents were fighting to get into the service. A discussion took place around workforce and that courses being run in North Wales were able to be delivered in both Welsh and English and that there was interest in setting up a post graduate speech and language course. **QS22/117.4** A discussion took place around wait times noting that targets being highlighted were Welsh Government targets and that the wait times for the provision for new patients had improved. It was noted that more dynamic reporting was required rather than being so heavily reliant on Welsh Government targets. **QS22/117.5 It was resolved** that the Committee considered the findings of the NWCHC report and the service plan to address the identified learning points.	
QS22/118 Discharge Standard Operating Procedure **QS22/118.1** The Executive Director of Integrated Clinical Delivery/Deputy Chief Executive clarified the reason the Committee were receiving the Discharge Standard Operating Procedure (SOP). It was noted that the SOP had been produced to pre-empt the policy that was being drafted and that it was required due to procedures being inconsistent across the Health Board. **QS22/118.2** An Independent Member welcomed the consistent approach across the Health Board and commented that on page five of the document family should be referenced and that clarification around the meaning of transport was required at the end of section four. **QS22/118.3** A discussion took place around who would discharge the patient, the	

Committee noted that a discharge professional was being identified. The Committee discussed what happened if there was a delay in a patient being admitted and it was noted that why patients were leaving was being reviewed to ensure that they are not leaving at risk. It was agreed that the Executive Director of Integrated Clinical Delivery/Deputy Chief Executive, Executive Medical Director and the Acting Executive Director for Nursing and Midwifery would pick up a piece of work around team working and appropriate leadership and that a form of words would be included in the SOP around this area. **QS22/118.4** The Chair raised lasting power of attorney not being included in the discharge document and requested that clarity on page five around the nurse or doctor role for discharging be resolved. **QS22/118.5** It was agreed that any further points be raised with the Executive Director of Integrated Clinical Delivery/Deputy Chief Executive by the end of the day and that the SOP would be recirculated for approval and implemented by August if possible. It was noted that once the SOP was in place the NU01 would be archived. **QS22/118.6 It was resolved** that any further points be raised by the end of the day and that the amended SOP would be recirculated for approval with implementation being sought as soon as possible.	ALL
QS22/119 Medical Devices Training Policy **QS22/119.1** The Acting Executive Director Of Therapies & Health Science presented the policy highlighting that there was a long standing risk around the ability to provide assurance on training for medical devices as there was not a system in place, but an ongoing live discussion on the subject was happening. **QS22/119.2** An Independent Member queried how colleagues would know if a device was red, amber or green. The Deputy Director Medical Physics clarified that there was no colour coding on devices and the policy sets out that line managers are responsible for training their staff. It was noted that there is a RAG list, which should be included as part of staff induction. The Committee noted that an area of risk would be around agency and locum staff, but additional features had been included in the new policy to clarify arrangements for these staff. **QS22/119.3** The Executive Director of Integrated Clinical Delivery/Deputy Chief Executive advised that in her experience devices had been visually identifiable and Acting Executive Director Of Therapies & Health Science and the Deputy Director Medical Physics agreed to explore these options **QS22/119.4** It was agreed that the Deputy Director Medical Physics and Executive Director of Workforce and Organisational Development would look at the triangulation with HSE findings and the policy outside of the meeting. **QS22/119.5** An Independent Member raised a query around mandatory training. It was agreed that the Executive Director of Workforce and Organisational Development would produce an assurance report on Mandatory Training and that	GE/PH SG/PH SG

this would go to PPPH Committee first and then be circulated to QSE attendees. **QS22/119.6** Attendees discussed the risk around agency and temporary staff and it was agreed that this would be reviewed and reflected in the policy. It was agreed that the policy would be refined and re-circulated to the Committee and a Chair's Action taken to sign it off. **QS22/119.7 It was resolved** that the Committees discussions be reflected upon and an amended policy circulated to be approved by Chair's Action.	GE
QS22/120 Mental Health Improvement Plan **QS22/120.1** Executive Director of Public Health advised that she would present the detailed plan to the Chair and Independent member on Friday but that good progress was being made. **QS22/120.2** An Independent Member advised that there was an element of receiving the same information as was highlighted in 2018, he raised concerns that there was no confidence that the was any movement and that significant down turn in the service was evident. It was noted that patients and carers needed to be referenced and valued. It was noted that some of the recommendations should be normal practice and not be required in an action plan, concern was raised that actions do not have timelines against them and therefore progress is not being made at speed. **QS22/120.3** The Executive Director of Public Health advised that there was a different approach being taken to ensure some of the basics are right, that patients and carers had been at the heart of the plan and that the plan had been produced to capture six themes that are outstanding and highlight the way forward. It was noted that there were over 100 vacancies within the service and that the recruitment into these posts would see the pace of delivery improve. **QS22/120.4** The Interim Director Of Nursing Mental Health advised that resource would always be the issue as would the environment but the detail would be the changing factor. **QS22/120.5** The Chair enquired as to why the detailed improvement plan had not been provided as requested in March and May and for the July meeting, she clarified that she had not asked for a presentation on the Betsi approach again but the full improvement plan to ensure that the Committee received the detail to be able to give the Board assurance. **QS22/120.6** The Executive Director of Public Health clarified that she had presented what the Executives had felt was appropriate. The Chair advised that if a Committee Chair asks for a specific report or plan it was not the role of the Executive Team to change what is presented at the Committee without the agreement of the Chair. The Interim Board Secretary agreed to give this feedback to the Executive Team. **QS22/120.7** The Executive Director of Integrated Clinical Delivery/Deputy Chief	MM

Executive advised that reflected on the previous discussion around the HASCAS work and invited an Independent Member to be involved in those discussions should they wish. **QS22/120.8 It was agreed** that a meeting would be convened between the Committee Chair and the Independent Member lead to review the detailed action plan on Friday and subject to the outcome of that meeting it may be that the matter is referred to the Board. **QS22/120.9 It was resolved** that the Committee took no assurance from the document presented and requested a further feedback session on the detailed plan.	TO
QS22/121 Corporate Risk Strategy **QS22/121.1** The Interim Board Secretary presented the Corporate Risk Strategy highlighting that it was presented at the Audit Committee and that following feedback a meeting had been held with an Independent Member to assess any changes that may be required, these had been incorporated and were highlighted to the Committee via presentation. **QS22/121.2** An Independent Member fed back that it was a much easier document to read and understand. The Interim Board Secretary agreed to review Executive Director titles. **QS22/121.3** The Committee endorsed the Strategy and accepted the recommendation that the Risk Management Group formally report into QSE in the future. **QS22/121. It was resolved** that the Committee noted and endorse the objectives of the risk management strategy and noted and endorsed the Risk Management Strategy for Board approval in July 2022. [Amanda Lonsdale joined the meeting]	MM
QS22/122 Quality & Performance Report **QS22/122.1** The Chair welcomed the Director Of Performance to the meeting and invited questions from members. An Independent Member said that it was disappointing to see the CAMHS figures deteriorating. The Executive Director for Public Health advised that in the adult area mental health demand is running high and is likely to get worse. It was noted that the implementation of the new operating model was having an impact on CAMHS. The Executive Director of Integrated Clinical Delivery/Deputy Chief Executive offered to discuss this further with the Independent Member the following day while they visit YGC. **QS22/122.2** The Chair was disappointed with the deterioration in access to psychological therapies and queried if the service was on target to address that in quarter two. The Executive Director of Public Health agreed to produce a briefing note for the Committee.	TO

QS22/122.3 The Chair raised concerns around sepsis performance. The Executive Medical Director advised that he was concerned about day to day management and that in parallel a discussion around implementation was taking place in clinical audit to identify the issues. **QS22/122.4** The Director Of Performance advised that positively the area of childhood immunisation was on track. The Chair noted that she had heard of concerns around the flu vaccinations not being given at the same times as the Covid ones this year and the impact that may have on the ability to deliver the vaccination programme in primary care. The Executive Director of Public Health advised that JCVI guidance was being followed and discussions were on going with regards to dual vaccinations. **QS22/122.5** An Independent Member highlighted that the paper advises that there were no Never Events in April and May and asked for clarity around this area. The Acting Associate Director of Quality Assurance confirmed that this was correct but that one had been identified after publication of the report. **QS22/122.6** The Acting Board Secretary and Executive Medical Director agreed to pick up a discussion around mortality and benchmarking. **QS22/122.7 It was resolved that** the Committee scrutinised the report noting that there was nothing to escalate to Board.	MM/NL
QS22/123 Patient Safety Report **QS22/123.1** The Associate Director of Quality Assurance presented the Patient Safety Report, noting that he would review page 10 on rapid review and the specific gap identified. A discussion took place around documentation being completed or not such as a falls assessment not being the reason why these incidents occur and therefore to adequately respond to the recurring theme, a more robust action needs to be identified. **QS22/123.2** Acting Executive Director for Nursing and Midwifery advised that the report was a first step and a look back but what was needed would be the improvement work to include KPI's to identify cause and how they will be addressed to ensure it doesn't happen again. **QS22/123.3** The Chair queried the reference to the incident involving the spinal anaesthetic and the Associate Director of Quality Assurance advised that there was a lack of clarity both from the Royal College as well as the Health Board at this point in time. **QS22/123.4** The Executive Director of Workforce and Organisational Development advised that in an accountability review meeting one of the discussions that took place was on mitigated actions and that unless these are able to be put in place and maintained they should not be identified. **QS22/123.5** It was agreed that the Executive Director Transformation, Strategic	

Planning and Commissioning and the Associate Director of Quality Assurance discuss outside of the meeting the details around the consultant who had felt vulnerable with regards to the absence of a check list given that they may well be in the perfect position to lead an improvement piece of work. **QS22/123.6** The Committee discussed the delay in completing investigations in a timely manner, noting that support in this area needs to be given at induction. **QS22/123.7** The Associate Director of Quality Assurance clarified Surgical Safety meant what is nationally reportable and that Never Events are reported elsewhere. He shared the process around rapid learning panels noting that actions are identified following a rapid learning panel/review on Datix, when a completed investigation report is received the early learning is supported by evidence. The work is being taken forward in the round with the Clinical Effectiveness Team to align to the clinical audit plan. **QS22/123.8** Attendees discussed the commissioned Aqua Training emphasising that the training needs to be completed as soon as possible to address the culture issues identified. The Associate Director of Quality Assurance advised that the dates were confirmed for all three cohorts. Discussion around a coordinated training approach took place. **QS22/123.9** The Chair raised a question around the reporting of Ombudsman's cases and it was agreed to pick up outside the meeting the Patient and Carers report. **QS22/123.10 It was resolved** that the Committee received the report	MJ
QS22/124 Quality/Safety Awards and Achievements **QS22/124.1** The Quality/Safety Awards and Achievements paper was received with thanks. **QS22/124.2 It was resolved** that the Committee noted the report.	
QS22/125 YGC Improvement Plan **QS22/125.1** The Chair advised that a cabinet meeting had been convened to talk about the YGC Improvement Plan noting that the Health Board Chair had been very specific about what he expected to see at that meeting. It was noted that a lot of information was received at the meeting on 26 May 2022 in terms of the approach to the development of the plan. **QS22/125.2** The Executive Director of Integrated Clinical Delivery/Deputy Chief Executive clarified that there was a dynamic plan that means that the actions from the Hospital Management Team are uploaded into the Improvement plan concentrating on the actions that were identified in the HIW report and the Vascular report around immediate improvement while at the same time applying a governance structure to support TI. The Committee were informed that weekly meetings were taking place with the Hospital Management Team to receive	

evidence focussing on assurance that there is evidence to support that services are safe. It was noted that there is a communication piece of work ongoing. **QS22/125.3** Attendees discussed governance noting that the HIW report had been received at the private QSE meeting on 26 May session and that Cabinet has been set up to review progress to strengthen the level of scrutiny. **QS22/125.4** The Chair noted that she had still yet to see the detail on the YGC Improvement Plan but that she was hoping to see it at the Cabinet meeting. **QS22/125.4 It was resolved that** The committee endorsed the approach being undertaken, the structure of the plan which was based upon thematic and temporal triangulation and includes key outcome measures and noted the progress to date in developing the plan and that the detailed plan would be received at Cabinet.	
QS22/126 Urology **QS22/126.1** The Executive Director of Integrated Clinical Delivery/Deputy Chief Executive apologised to the Committee for there not being a written paper. She highlighted that a multidisciplinary workshop was scheduled for two days' time and that at the meeting the priorities would be agreed with clinicians. The Committee were updated on the recruitment of the network lead. **QS22/126.2** The Committee noted that there was further progress with the robot and that conversations were ongoing with the manufacturers to ensure that the skills of the theatre team were honed to enable them to utilise the robot both post and pre operatively. It was noted that it would first be used in gynaecology as work is undertaken to upskill the urology surgical team. Once this team were competent the colorectal team would be brought in and there would be joint clinical ownership to ensure that the pace is picked up.	
QS22/127 Human Tissue Authority Preparedness Report **QS22/127.1** The Executive Medical Director advised that he had withdrawn the item as the paper was not of the quality required to be received at QSE. It was noted that the inspection would take place in the coming week and that feedback would be received on 18 July 2022. The Chair requested that the QSE receive a briefing before the next meeting given the concerns around safety, best practice and the lack of Human Tissue Reportable Incidents.	NL
QS22/128 Vascular Update **QS22/128.1** The Executive Medical Director recognised the ongoing issues with the Vascular services. It was noted that the same improvement methodology is being brought into the existing vascular improvement plan. Feedback from the Vascular Quality Panel is being received and identifying new concerns with the service mainly around post operative care. It was noted that the Clinical Lead appointment did not happen and that the concern remains that there will not be any applicants for the post and that this would leave a key risk around vascular	

leadership. **QS22/128.2** The Chair enquired as to what would happen if there were no suitable applicants and the Executive Medical Director concluded that a mitigating paper was being presented at the Executive meeting the following day on the subject. **QS22/128.3** Attendees discussed the failure to proceed with the appointment, it was agreed that the detail be shared with the Committee on why appointment had not happened. The Chair advised that the work being undertaken outside of the meeting needed to ensure that it is not person dependant. **QS22/128.4 It was resolved that** the received the update from the Vascular Steering Group.	NL
QS22/129 Chair's Assurance Reports from Strategic and Tactical Delivery Groups **QS22/129.1** The Reports were received as a consent item noting that if attendees had any queries, these should be raised outside of the meeting.	
QS22/130 Issues Discussed in Previous Private Session **QS22/130.1** It was noted that at the 26 May QSE the Committee had received updates on the HIW reports and action plans.	
QS22/131 Date of next meeting **QS22/131.1** 6 September 2022	