Betsi Cadwaladr University Health Board

Minutes of the Quality, Safety & Experience Committee meeting held on 6 September 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
Emma Jane Hosking	Acting Deputy Medical Director
Matthew Joyes	Acting Associate Director of Quality Assurance
Phil Meakin	Associate Director of Governance, Governance & Communications
Teresa Owen	Executive Director of Public Health
Philippa Peake-Jones	Head of Corporate Affairs (minutes)
Chris Stockport	Executive Director Transformation and Planning Urology Network Manager (part meeting)
Dino Tedaldi	Programme Director for Clinical Safety Improvement
Gaynor Thomason	Director Of Performance
Amanda Lonsdale	Head Of Governance and Compliance, Mental Health & Learning Disabilities
Hilary Owen	Medical Director, Mental Health & Learning Disabilities
Alberto Salmoiraghi	Audit Wales
Heledd Thomas	Interim Director Mental Health & Learning Disabilities
Iain Wilkie	Executive Director of Nursing and Midwifery
Angela Wood	

Agenda Item	**Action**
QS22.229 – Welcome, Introductions and Apologies for Absence Apologies were received from Gill Harris, Adrian Thomas, Nick Lyons and Molly Marcu. The Interim Director Mental Health & Learning Disabilities, Associate Director of	

Governance, Governance & Communications and Acting Deputy Medical Director introduced themselves and explained their attendance at the meeting. The Chair welcomed the Executive Director of Nursing and Midwifery to her first meeting, it was noted that conversations with regards to the Lead Executive for the Committee were ongoing but the Lead Executive's report would be received from the Executive Director of Nursing and Midwifery in the absence of the Executive Director of Integrated Clinical Delivery/Deputy Chief Executive.	
QS22.230 Declarations of Interest on current agenda **QS22.230.1** Jacqueline Hughes declared an interest in agenda item QS22.251 Regulation 28 Update as one of the notices related to a family member. **QS22.230.2** The Chair noted that there were many recurring themes in numerous reports before the Committee and that many of the same themes dated back to at least 2016, and that this was unacceptable. The Chair advised that the objective of the Committee was to provide the Board with assurance over the quality and safety of services across the Health Board and that patient experience is at the heart of service development. The Chair noted that the Committee could not provide any such assurance to the Board at the moment. The Chair recognised that improvement work was ongoing, but the steps laid out in the reports presented to the Committee were still too focused on policies and training being the answer to remedy these failings. The Chair referred to the advice from Counsel, following the criticisms from HSE, that policies should be the foundation but people will not always comply with policy. The Chair stated that she understood that mistakes happen, and that staff are human and working in a high risk environment under considerable pressure, however, systems and processes must be as robust as possible rather than being overly dependent on person controls. The Chair asked that when reports were being presented it was made clear how the proposals were different from what had been previously received. The Chair advised that she would escalate these concerns to the formal Board meeting later in the month and requested that the Executives consider how they intended to respond when it was escalated, in a manner that could be clearly measured and evidenced so that the same discussions do not reoccur.	
QS22.231 Minutes of Previous Meeting Held in Public for Accuracy **QS22.231.1** The minutes of the meeting held on 5 July were approved subject to Cheryl Carlisle's last name being included and John Gallanders' role be added. **QS22.231.2 It was resolved that** the minutes were approved as an accurate record of the meeting held on 5 July 2022.	
QS22.232 Matters Arising and Table of Actions **QS22/232.1** The Committee reviewed the action log and closed actions where appropriate.	
QS22.233 - Patient Story	

QS22.233.1 The Committee received an account from the staff and stakeholders involved in the Long-COVID Recovery Programme. It was noted that from the outset, the Health Board adopted a strong principal of co-design working closely with patients, stakeholders and clinical practitioners to design a pathway that meets the needs and expectations of people experiencing Long COVID. **QS22.233.2** Some patients expressed an interest in becoming Long COVID Lived Experience Representatives and joined a partnership group to ensure the voice of the patient is heard throughout the development of this new service, building a true approach of co-production. **QS22.233.3** Acting Associate Director of Quality Assurance highlighted that the Health Board was leading the way nationally with regards to the tool and that on the back of this work the Health Board had been shortlisted for three national awards for the service. **QS22.233.4** An Independent Member queried the longevity of the service in relation to resources, what were the number of referrals received to date and how a service would be taken forward for children. The Acting Associate Director of Quality Assurance advised that the number of referrals to date was over 1000 but would circulate the details after the meeting and that referrals for children were going to Alder Hey. The Executive Director of Transformation, Strategic Planning and Commissioning confirmed that there was long term commitment for Long Covid Funding. **QS22.233.5 It was resolved that** the Committee receive and reflect upon the story [Gareth Evans joined the meeting]	MJ
QS22.234 Report of the Lead Executive **QS22.234.1** The Executive Director of Nursing and Midwifery presented the report, highlighting that the report identified her new role and summarised the reportable incidents. Falls and Pressure Ulcers were discussed and the Committee noted that the Executive Director of Nursing and Midwifery would be reviewing Falls and looking into a Multi-Disciplinary Team approach and whether this could be cascaded. **QS22.234.2** The report noted that there had been one new Never Event in the reportable period and no new regulation 28 notices. Complaints closed within the targeted timescale were below 75% and the Executive Director of Nursing and Midwifery stated that this would be an area of focus alongside serious incidents. **QS22.234.3** An Independent Member raised concerns with regards to missing targets on complaints responses. It was noted that this had been a recurring issue for 6/7 years and would be impacting on the quality of provision to patients and asked why this had been such a long-standing issue and what the problem was in relation to resolving it.	

QS22.234.4 The Executive Director of Nursing and Midwifery advised that she would be doing some due diligence on the issues and that collaborative working to support the corporate teams was required to ensure that early resolution meeting with complainants to resolve issues quickly would be required. The Executive Director for Nursing and Midwifery advised that she come back to the Committee with a proposed way forward of how improvements could be made. The Chair noted that the delay in complaint responses was also resulting in inquests being delayed which was unacceptable. **QS22.234.5** An Independent Member welcomed the Executive Director for Nursing and Midwifery to the Committee and wanted confirmation that if patients made a complaint their care was not compromised in any way. Executive Director for Nursing and Midwifery stated that a policy should not be required to make sure that this did not happen and that it was not something that would be accepted. The Acting Associate Director of Quality Assurance confirmed that changes were made the previous year and that if this is identified at all it is reported directly to him. To date, no cases had been reported. **QS22.234.6 It was resolved** that the Committee received the report.	
QS22.235 Quality Aspects of IMTP **QS22.235.1** Executive Director of Transformation, Strategic Planning and Commissioning noted that although the IMTP was not approved as a three-year plan by Welsh Government there had been change in the plan produced with some deliberate steps to build the plan around quality. It was noted that patient experience runs through the entire plan. The commitment to the clinical services strategy and the work currently underway with regards to the Quality Strategy was highlighted and the development of the plan was already in a different place in comparison to previous years. The feedback received was around the narrative on the high-risk areas, that it was a strong start in terms of the new approach and that there was an expectation to see more quality language and thinking going forward. **QS22.235.2** The Chair noted that the initial outcomes highlighted in relation to Health and Safety Statutory Compliance were all staff related. The Executive Director of Transformation, Strategic Planning and Commissioning advised that in the paper presented they were staff related but in the full IMTP they were not and the Executive Director of Workforce and Organisational Development agreed. **QS22.235.3** The Chair queried if video consultations across clinical services were being maximised. The Executive Director of Transformation, Strategic Planning and Commissioning suggested that the question could be widened to capture all virtual consultations and that the whole virtual agenda required more thought and attention but that work was being done with further work to do. The Committee noted that it was imperative that the Health Board did not revert back to pre-Covid ways. **QS22.235.4** The Acting Executive Director of Therapies and Health Science noted that it was important to get the balance right and clinicians need to be	

happy with the service they provide. It was noted that therapies had been successful because they had a digital strategy, however, digital systems need to catch up to support the strategy. **QS22.235.4 It was resolved** that the Committee received the report and noted the areas requiring further development and assurance.	
QS22.236 Board Assurance Framework **QS22.236.1** The Associate Director of Governance, Governance & Communications presented the report on behalf of the Interim Board Secretary. The Committee noted that the mitigations needed to be further refined and tested to ensure they could be relied upon. It was noted that further risks around Urgent care fall within the scope of PFIG and that there would be a review on how the detailed papers for the associated mitigations are aligned in the future to the cycle of business for both committees. **QS22.236.2 It was resolved** that the Committee noted and reviewed the BAF risks that fall within the remit of the Quality, Safety and Experience Committee.	
QS22.237 Corporate Risk Register **QS22.237.1** The Acting Deputy Medical Director presented the Corporate Risk Register on behalf of the Executive Medical Director. It was noted that the Corporate Risk Register was in a dynamic situation and a number of key risks needed to be consolidated to bring them into one place. Several risks that are now on the register are about the new operating model given the significant changes in staff. It was noted that the risk management group would be chaired by the CEO and a full report would return to Committee. The Committee noted that there were 27 risks sitting at tier one, five of them were new and a number have reduced. The mental health risks were highlighted and it was noted that these would be discussed further on in the meeting. **QS22.237.2** The Associate Director of Governance, Governance and Communications advised that he had taken the opportunity to look back over the last three QSE Committee meetings and noted that there were a number of risks that are on Datix but didn't score high enough to be on the Corporate Risk Register, however what was identified was that there were often a number of risks relating to one area that might need to be consolidated. He advised that with regards to the governance and assurance framework, he attended the Executive Team meeting every fortnight. **QS22.237.3** An Independent Member queried how support to Care Homes was being measured and what was being done to reduce risk and also wanted to know if the diabetic retinopathy pathway was in place and how that was impacting on the delivery of care to patents. The Acting Deputy Medical Director advised that she would respond outside of the meeting on these specific points and also how the access to care homes would be taken forward given that it is impacting on patient flow.	EJH

QS22.237.4 An Independent Member requested that a timeline for risk 18113, Position of Trust and Section 5 (Professional Allegations) Implementation and monitoring of Workforce Safeguarding Responsibilities Standard Operating Procedure [Social Services and Well-being (Wales) Act 2014] be shared with the Committee. **QS22.237.5** Concern was raised that the Health Board was not acting within a legal framework in relation to Fire and Asbestos and that there did not seem to be significant effort to rectify the situation. An Independent Member raised the fact that there had not been an evacuation drill at the Wrexham Maelor Hospital there had not been a pilot evacuation for six years. The Executive Director of Workforce and Organisational Development agreed and highlighted that there was a gap analysis done against 33 pieces of legislation which identified significant gaps, clarity has been given about what needs to be done. The Committee were informed that there was significant work underway with regards to Fire Safety being led by Estates and audited by the Workforce and Organisational Development team, the practice evacuation and alarm testing had been reintroduced but significant capital investment is required. Concern was raised that the evacuation drills was documented as a key control whereas it should be identified as a gap in controls. Furthermore, there was no remedial action noted to address the gap. The Executive Director of Workforce and Organisational Development advised that this was one of the reasons the risk score has not been reduced and that this had been picked up and an audit was being undertaken. The Committee discussed the capital plan and the absence of capital funding at a national level, it was noted that direct approaches to Welsh Government for capital investment had been done without success. **QS22.237.6** The Committee noted that the target risk dates need to be reviewed and flagged when they would not be met. It was agreed that the report could only give the Committee partial assurance. The Associate Director of Governance, Governance and Communications advised that he would take forward the Committee's concerns and that the Risk Management Group would receive the specific feedback and return to the Committee. **QS22.237.7 It was resolved** that the committee reviewed and discussed the report.	PM PM
QS22.238 Mental Health Outcomes and Improvements [Gaynor Thomason joined the meeting] **QS22.238.1** The Executive Director of Public Health introduced the paper, noting that in previous meetings the Committee had not been able to take assurance about the plans in place and that the Committee had now been provided with all the details. It was noted that the difference now was that the division was no longer working in isolation, that other directorates have been involved in producing the plan which puts patients at the top. The next phase of the plan was to make it more user friendly and easier to monitor progress by working on the cogs and drivers.	

QS22.238.2 The Interim Director Mental Health & Learning Disabilities reiterated that patient care and experience were at the front of the plan and highlighted the portfolio of six themes. The Committee were informed that the plan made sure that patients were worked with rather than being done to, that engagement and ownership from staff had been forthcoming to ensure that learning needs were understood which had been the issue in the past. It was highlighted that the Programme Director for Clinical Safety Improvement would be leading the work around the notice of contravention and that the specifics from the contravention are incorporated with the work streams and that the plan was a live and evolving document.	
QS22.238.3 An Independent Member advised that he would share some feedback outside of the meeting, but queried how things would be different. It was noted that the Transformation Team being involved should be helping to embed changes across the Health Board. An Independent Member highlighted that there were 100+ references to staff and only 30/40 to patients in the paper. He requested that the paper makes it explicit that patients come first over staff.	JG
QS22.238.4 Concern was raised about the commitments made as a Board to both HIW and the coroner and these were not being embedded within the plan, that the Board required some levels of assurance specifically around ligatures. A query was raised as to why an external trainer was required and why there was reference to phasing given that some actions have been around for six years.	
QS22.238.5 An Independent member highlighted staffing and recruitment and vacancies and how patient safety would be met if recruitment to those positions was not. The Committee noted record keeping being raised again and how staff not complying with standards would be handled.	
QS22.238.6 An Independent Member raised the 2018 £8.5m programme of work on ligature reductions reported on in response to the Ockenden Report and if an accurate report had been given at the time given this additional work now being identified.	
QS22.238.7 The Executive Director of Public Health suggested that she and the Independent Member met after the Committee but highlighted that the Transformation Team were critical to the success of Mental Health Services within the Health Board and that their involvement was enabling a different approach. It was noted that a diagnostic session would be held similarly to the one used for the YGC programme and that despite it feeling similar to previous plans there was a commitment to change and implement the plan this time to make it easier for patients.	TO
QS22.238.8 The Executive Director of Public Health clarified that there was a monthly meeting between CAMHS and Adult Mental health and that there was good support in place for both teams but that the plan in front of the Committee was an adult plan only.	
QS22.238.9 The Executive Director of Public Health responded to the query around mandatory training and advised that it needed to be made easier to	

undertake but that mandatory training in Mental Health had been good. **QS22.238.10** In response to the query around phasing it was noted that this would be reviewed but as previously highlighted it was a live document. **QS22.238.11** The Committee discussed the recruitment to the 200 vacancies and an Independent Member asked why rolling recruitment policies were not being considered. The Executive Director of Workforce and Organisational Development explained that there was little evidence to demonstrate that rolling recruitment works and that it can undermine the reputation of the organisation. The Executive Director of Nursing and Midwifery agreed and said that a targeted recruitment campaign was more effective. She advised the Committee that she had managed to reduce nursing vacancies to nil at her previous Trust. The Independent Member asked for consideration to be given to rolling recruitment campaigns given the large number of vacancies and concerns raised over delays in recruitment processes. It was agreed that a review of conversion from advert to appointment was needed to maximise opportunities. It was noted that trainee to consultant rates were good. **QS22.238.12** The Executive Director of Public Health updated on the Estates and Ligature work noting that work on ligatures had moved on. **QS22.238.13** The Committee noted that with regards to Listening Leads there was ongoing work the patient safety group. **QS22.238.14** The Interim Director Mental Health & Learning Disabilities highlighted that the main difference in comparison to previous plans was that the patients are the focus, that there are more of the right people in the right place doing the right things, that communication was better as was transparency and that there would be no unacceptable practice allowed. It was noted that monthly summit meetings with Executives were challenging but supportive and accountability meetings had been reinstated which were good honest and safe meetings. **QS22.238.15** The Chair concluded that she could see changes in the plan, that she thought it was stronger and welcomed the involvement of the Programme Director for Clinical Safety Improvement but asked for more focus on the outcome measurements and improvements for patients. **QS22.238.16 It was resolved** that Committee reviewed the proposed update on the development of the MH&LD Divisional Improvement Plan.	
QS22.239 YGC Improvement Plan to include the HIW Action Plan **QS22.239.1** The Programme Director for Clinical Safety Improvement presented her report to the Committee advising that the paper was presented to the Cabinet Committee and the programme is now called the Journey to Excellence. The Committee noted that the Integrated Health Communities were launched on 1 August 2022 and the Urgent and Unscheduled Care Pathways were launched the on 5 September 2022. The five themes were identified, and the Committee were	

informed that the Make it Safes were implemented and that the next steps were to ensure that these were the right thing to do and are embedded. It was noted that there was a need to create an Urgent Primary Care Centre, that there are 50 Cogs in development relevant to service delivery. **QS22.239.2** The Programme Director for Clinical Safety Improvement advised that a Programme Management office for Targeted Intervention at YGC had been created and two programme officers had been appointed who were setting up workshops with those delivering the pathways. It was noted that workforce and recruitment was the biggest issue, and the Committee were informed of the detail around this. The Committee were advised that as the pathways were developed there would be a requirement to look at what workforce was required. **QS22.239.3** An Independent Member said that the launch on 5 September 2022 was really positive and that there was a difficult balancing act noting that there was some negativity in some places but that overall it is really positive for staff. **QS22.239.4** The Programme Director for Clinical Safety Improvement advised that because there was an understanding of the staffing issues a forward look at the rota had been requested to identify what can be done as an interim measure to make sure they are prepared for winter. The Chair noted that nationally there were staff shortages and that the Welsh Government were aware of this. **QS22.239.5 It was resolved** that the Committee noted the progress made to date on the YGC Improvement Plan.	
QS22.240 Vascular Improvement Plan **QS22.240.1** The Acting Deputy Medical Director presented the Vascular Improvement Plan noting that it had been received at the Cabinet meeting the previous week. She highlighted that the make safes had been introduced following escalations received from the Vascular Quality Panel. Dual consultant operating for planned and on call remains and the Committee noted that for the vast majority of the time this can be achieved, however support from North West colleagues has only been required a couple of times. It was noted that wide engagement to ensure that everyone is up to speed was occurring. **QS22.240.2** An Independent member raised concern that the coroner had not been made aware of some of the deaths previously and the Acting Deputy Medical Director advised that this was being reviewed at the Vascular Quality Panel. **QS22.240.3** The Committee discussed recruitment, it was noted that the recruitment to the Clinical Director post had not been successful, that the substantive consultants would take on elements of the leadership portfolio and the overall management of the service would fall under the surgical directorate for the time being. An Independent Member queried where this decision had been made, it was agreed to discuss the detail outside of the Meeting. **QS22.240.4** The Acting Deputy Medical Director advised that the audit on note	EJH/CC

keeping on site was showing improvement.

QS22.240.5 The Chair noted that there was a lot more work that was required in terms of the improvement plan as some actions were down as complete but with no end date and some had been superceded but had not been updated as such. She asked if there had been a review on completed actions to ensure that they had been completed. The Chair also highlighted that shorthand had been used in the plan which weakened the audit trail.

QS22.240.6 It was resolved that the Committee:

- noted the progress in delivery of the Vascular Improvement Plan and commencement of work to align the Improvement methodology with the wider Targeted Intervention framework approach
- noted that the Board has received Escalations from the Vascular Quality Panel and that immediate make safes, introduced on July 8th 2022 remain in place.
- noted the current contingency planning through an Emergency Preparedness, Resilience and Response (EPRR) response to the short and medium term fragility of the north Wales vascular service.
- noted the development of an updated engagement plan to ensure partners, staff and patients are informed of current issues within the service.
- Noted the review of vascular services by Healthcare Inspectorate Wales to take place over the coming weeks

QS22.241 Urology Improvement Plan

[Dino Tedaldi joined the meeting]

QS22.241.1 An Independent Member thanked the Urology Network Manager for the paper noting that he was doing a walk about in the Urology Department at the Wrexham Maelor Hospital the following day. He observed that the review had taken a long time to commence and raised a query about the Robot.

QS22.241.2 The Urology Network Manager advised that the Royal College review would commence at the end of October/beginning of November. With regards to robotic assisted surgery, it was noted that this was situated at Ysbyty Gwynedd and that the consultant supporting the surgery was going on a three day training programme in October and the first surgery would take place in November.

QS22.241.3 The Chair concluded that the Committee had longstanding serious concerns about the Urology Service and the improvements need to be progressed.

QS22.241.4 It was resolved that the Committee to scrutinised the report considered if any areas should be escalated for consideration by the Board.

QS22.242 Quality and Performance Report [Amanda Lonsdale joined the meeting] **QS22.242.1** The Director of Performance presented the report noting that the Performance Report now links to the Corporate Risks, that the format of the report had changed but that at a further Board Workshop session on 20 September it would be decided what measures are reported to each Committee. It was noted that on 13 October there would be a Board workshop on making data count. **QS22.242.2** The Chair noted that the graphs were better, and the narrative improved. She advised that she had concerns around sepsis and had raised this in a number of meetings and wanted clarity about what was being done to address the problem. The Acting Deputy Medical Director noted that this would be raised in the next report and that further investigation was required to understand if the issues were a failure to recognise pathways or vulnerability but that it was not going in the right direction. She agreed to follow up on the matter highlighting the Committee's concerns, noting that the other Acting Deputy Medical Director was leading on the work. **QS22.242.3** An Independent Member raised concerns around the declining position for young diabetic people. The Executive Director of Nursing and Midwifery agreed to look at the pathway and identify the issues. **QS22.242.4 It was resolved** that the Committee received the report.	EJH AW
QS22.243 Patient Safety Report **QS22.243.1** An Independent Member advised that there were issues with inadequate recording and issues around reports generally not being completed, he noted that there were three wards where the Health and Safety Executive felt that there was room for improvement. **QS22.243.2** An Independent Member queried whether projects which were apparently delivery good results, such as the joint community falls project were being rolled out. The Executive Director of Transformation, Strategic Planning and Commissioning advised that in the past there had been an issue that schemes had been started without consideration of where they would end up, but that the Executives were absolutely clear that the current position is not where they would want to be and the revised business case process had been streamlined and clarity has been given that a business case is not about setting something up. **QS22.243.3** The Acting Associate Director of Quality Assurance clarified how methodology for the improvement work had been identified and that the Health and Safety Executive had been to observe the work. The approach had been collaborative and the Health and Safety Executive were in agreement that it was the correct method and way forward. **QS22.243.4** The Chair noted that she had raised a number of questions outside the	

meeting on the report and expected those to be responded to. [Dave Harries left the meeting] **QS22.243.5** The Chair raised concerns about a number of statements that had been made in the report, the first was about a patient waiting in an ambulance for 17 hours and the reason for this being reported as the ED was over stretched. Secondly with regards to the ophthalmology case, the paper states that the harm caused was unavoidable due to the lack of capacity. The Chair raised that neither of these statement could be made. The Acting Associate Director of Quality Assurance agreed that the Chair's points were valid, and the language used was clumsy. **QS22.243.6** The Chair noted that there was no learning identified again and therefore the Committee could not take assurance. She highlighted that she had previously requested that near misses be included in the report and that the dates of incidents in relation to the claims should be provided. Neither had been addressed. The Acting Associate Director of Quality Assurance apologised for not advising the Chair in advanced that the information previously requested would not be able to be brought at that time. **QS22.243.7** An Independent member raised concerns about two incidents and the Executive Director of Nursing and Midwifery advised that she would provide an update for him outside of the meeting. **QS22.243.8 It was resolved** that the Committee received the report.	MJ AW
QS22.244 Patient & Carer Experience Report **QS22.244.1** The Committee received the report, an Independent Member asked if the report under section 2.7 was referring to 436 patient complaints being overdue in July, how many people submitted FOI's and whether the Ombudsman complaints had been cross referenced. He also queried how many complaints came from MP/MS correspondence. **QS22.244.2** The Executive Director of Nursing and Midwifery advised that she hoped to be in a significantly different position in a few months' time. The Acting Associate Director of Quality Assurance advised that the position the Health Board is in now in terms of overdue complaints is very similar to when he arrived. He said that significant improvements had been made and that there is a plan in place to address the numbers. He noted that with regards to the Ombudsman, what was included was the annual level and that the Health Board had the highest rate of referrals. The Committee noted that the way that the data was presented was not necessarily helpful. **QS22.244.3** An Independent Member noted that the HMP Berwyn complaints had increased and asked how support for carers and family members was being taken forward. The Acting Associate Director of Quality Assurance advised that from a carers perspective there was a carers engagement officer and from the work undertaken within that role a plan has been formulated which will be taken forward.	

The Director of Communications and Engagement has been tasked with reviewing how telephony within the Health Board can be improved. **QS22.244.4 It was resolved** that the Committee received the report.	
QS22.245 Quality/Safety Awards and Achievements **QS22.245.1 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.	
QS22.246 Health and Safety Executive (HSE) Compliance Update **QS22.246.1** An Independent Member queried, with regards to the mental health issues and the estates, what assurance could the Health Board give to the public and patients that what has been picked up by HSE have now been fully addressed. The Executive Director of Workforce and Organisational Development could not provide the Board with full or acceptable assurance that it could be evidenced that there was a safe system in place at the time of the meeting but confirmed that as for a level of reassurance, significant work was being undertaken to remediate the position. **QS22.246.2** The Executive Director of Public Health advised that a significant amount of work has been undertaken by the team since they had been involved, the Improvement and Development Group has been created and will be key for activity going forward and will report through QSE. **QS22.246.3** The Chair advised that there would be a more detailed discussion in the private session due to patient identifiable information and the advice given under legal privilege. **QS22.246.4** The Chair noted that the Board had been previously advised that policies were updated and embedded, however, the response letter to the HSE says that they are being worked through. The Executive Director of Workforce and Organisational Development advised that advice was taken on the matter and because there was no way of evidencing that they were embedded, they were unable to say so in the response. The Interim Director Mental Health and Learning Disabilities advised that the policies had been updated but that the process was a live and ongoing one. The Chair noted with concern that the Health Board was in this position and confirmed that further discussion would take place in the private session and report to the Board. **QS22.246.5 It was resolved** that the Committee: • noted the detailed breaches and response issued on 11 August 2022 • noted the measures to provide additional oversight of the work underway to address the breaches identified by the Health & Safety Executive	
QS22.247 Mortality Review Update	

QS22.247.1 The Acting Deputy Medical Director presented the paper highlighting that a higher percentage of deaths are being returned back to the Health Board for review. The detail was shared and it was noted that Sepsis had been highlighted as an area requiring further investigation. The Committee were informed that there was a lot of work ongoing on and that the Health Board is in a better place than previously. **QS22.247.2** The Committee discussed that the mortality reviews only relate to cases where the death is on site and therefore deaths in the community are not incorporated currently. The Acting Deputy Medical Director advised that if the family has raised a concern however then the case is picked up. **QS22.247.3** The Chair noted that Mortality reviews are on the public Board Agenda Meeting later in the month. **QS22.247.4 it was resolved** that the Committee noted the report.	
QS22.248 Chairs Assurance Reports from Strategic and Tactical Delivery Groups **QS22.248.1 It was resolved** that the Committee receive Chair's Assurance Reports and attendees were asked to raise any questions outside of the meeting.	
QS22.249 HMP Berwyn – Annual Report **QS22.249.1 The Committee resolved** to receive the HMP Berwyn Annual Report and attendees were asked to raise any questions outside of the meeting.	
QS22.250 Safeguarding Annual Report **QS22.250.1 It was resolved** that the Committee received the Safeguarding Annual Report and attendees were asked to raise any questions outside of the meeting.	
QS22.251 Regulation 28 Update **QS22.251.1** The Acting Associate Director of Quality Assurance reminded the Committee that at the meeting in July an interim position had been shared and the update being received was the outcome of this work. It was noted that prior to 2020 a different system had been in place. The paper themed the Regulation 28 notices and the Committee were informed that a significant number had been received on unscheduled care pressures and that given the different system prior to 2020, it had had been difficult to get evidence of action. It was noted that the changes in ambulance handovers would be monitored to ensure that a clear and robust plan can be provided to address the issues. **QS22.251.2** The Chair queried the assurance level of the paper noting that it had been identified as acceptable, however, given the number of notices where evidence could not be provided this seemed to be overly confident. The Acting Associate Director of Quality Assurance advised that the authors of the paper had	MJ

reviewed the evidence and identified the assurance level as acceptable. It was noted that the falls pathway language needed clarification and that an update be received following CEG. **QS22.251.3 It was resolved** that the Committee noted the report.	
QS22.252 – Infection Prevention Annual Report **QS22.252.1 It was resolved** that the Committee received the Infection Prevention Annual Report and attendees were asked to raise any questions outside of the meeting.	
QS22.253 HIW Update **QS22.253.1** The Chair noted that the report did not provide any assurance that previous themes arising from HIW inspections have been addressed because there is insufficient information provided. The Executive Director of Nursing and Midwifery agreed with the Chair and advised that she and the Acting Associate Director of Quality Assurance would be doing an historical review of action plans to ensure that there is assurance and that the evidence is in place. **QS22.253.2** The Chair raised her concerns about the YGC Action plan and the Executive Director of Nursing and Midwifery noted that she would be working with the Programme Director for Clinical Safety Improvement and her team to ensure that robust evidence could be provided. **QS22.253.3 It was resolved** that the Committee received the report	
QS22.254 Issues Discussed in Previous Private Session **QS22.254.1** The Chair noted that the Health and Safety Executive and Regulation 28 had been received at the previous meeting in Private. **QS22.254.2 It was resolved** that the Committee noted the issues discussed in the QSE Private Session of 6 July 2022.	
QS22.255 Date of next meeting **QS22.255.1** It was noted that the next QSE Meeting would be held on 1 November 2022.	
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.	