Quality, Safety and Experience (QSE) Committee
Minutes of the Meeting Held in public on 11.1.22 via Teams

Present:

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

In Attendance:

Gareth Evans	Chair of Healthcare Professional Forum (*part meeting)*
Simon Evans-Evans	Interim Director of Governance
Sue Green	Executive Director of Workforce and Organisational Development (OD)
Gill Harris	Executive Director of Nursing and Midwifery / Deputy Chief Executive
Dave Harris	Internal Audit
Richard Hayward	Health Inspectorate Wales
Medwyn Hughes	Independent Member
Matthew Joyes	Acting Associate Director of Quality Assurance
Molly Marcu	Interim Deputy Board Secretary
Teresa Owen	Executive Director of Public Health
Jo Whitehead	Chief Executive
Philippa Peake-Jones	Head of Corporate Affairs (minutes)
Mike Smith	Interim Director Of Nursing Mental Health
Chris Stockport	Executive Director Primary Care and Community Services
Conrad Wareham	Interim Deputy Medical Director
Berwyn Owen	Chief Pharmacist (for agenda item 22.18)
Louise Howard-Baker	Assistant Director of Pharmacy (East) (for agenda item 22.18)

Agenda Item Discussed	Action By
It was noted that the meeting was being recorded in Teams for administrative purposes.	
QS22/01 Patient Story **QS21/01.1** Attendees noted the patient story outside of the meeting. No comments were raised.	
QS22/002 Apologies for Absence **QS22/02.1** Apologies had been received for Nick Lyons, Adrian Thomas and Louise Brereton	

QS22/03 Declarations of Interest **QS22/03.1** There were no declarations noted.	
QS22/04 Minutes of Previous Meeting Held in Public on 2.11.21 for Accuracy **QS22/04.1** The minutes were agreed as an accurate record subject to Jo Whitehead being in attendance for part of the meeting.	
QS22/05 Matters Arising and Table of Actions **QS22/05.1** Updates were provided to the summary action log and actions were agreed as closed where highlighted **QS22.05.2** The Executive Director of Nursing and Midwifery highlighted that the meeting agenda has been streamlined in response to the system pressures from Covid and unscheduled care aligned with the step up of Gold response. The Chair added that the meeting was utilising a consent agenda where members have been able to raise questions in advance which will be appended to the minutes on publication for openness and transparency.	
QS22/06 Report of the Chair - CONSENT **QS22/06.1** It was noted that this paper was being taken as a consent item and there were no questions raised. The Committee noted that this report had already been reported to Board.	
QS22/07 Report of the Lead Executive **QS22/07.1** The Executive Director of Nursing and Midwifery updated on the Patient Safety Group highlighting that the approach to 24 hour reviews and never events are being reviewed to ensure actions are closed down and thematic learning is shared. As part of the new approach a weekly Executive update will be given. Investigations are being reviewed to ensure that the person investigating is the right person to lead the investigation. It was noted that due to recent system pressures some meetings have had to be stood down. **QS22.07.2** The Executive Director of Nursing and Midwifery advised that duty of Candour work would be led by Acting Associate Director of Quality Assurance. The Committee noted the requirements of this work, the detail and staffing required to undertake it. It was noted that significant progress in this area had already been made across the Health Board	
QS22/08 Clinical Services Strategy	

QS22/08.1 The Interim Deputy Medical Director, updated the Committee on the Clinical Services Strategy. It was noted that the Clinical Strategy is currently in draft format and the initial timescale for publication is on track to come to the Board Workshop in March *[post meeting note the Workshop is scheduled for April].* The Strategy will be supported through the establishment of a Clinical Senate. Further work is ongoing to ensure that the Senate comprises of the future multi-disciplinary Clinical Leaders, not just Doctors, who will be delivering the Strategy across the Health Board. Other Health Board's strategies were being reviewed to ensure that we are consistent with the requirements from Welsh Government whilst also ensuring that the Strategy reflects what is required for the local population in North Wales. **QS22/08.2** The Chief Executive joined the meeting advising that the Strategy would be a broad clinical strategy with the ability to undertake individual service reviews with the intention of being able to consult as needed. It was noted that this would be with the intention, that if any service reconfiguration was required, then an agreed framework would be in place in which to make the decisions subject to a public engagement consultation. It will provide a benchmark and enable more effective decision making and give the Health Board the ability to have senior Local Authority conversations with regards strategies and reviews going forwards. **QS22/08.3** The Clinical Senate configuration was discussed and it was noted currently medical representation was across both Primary and Secondary Care but further input was required from other professional fields and that this was being addressed. It was noted that it will link in with the transformation work to enable a multi professional approach as well as the Population Needs Assessment which is currently being undertaken at the same time.	
QS22/09 Covid 19 Update **QS22/09.1** The Executive Director of Nursing and Midwifery / Deputy Chief Executive gave a presentation to the Committee based on the latest update coming out of the Gold Meetings, taking place three times a week, and highlighted that this was the reason the slides had been published the day before the meeting, to ensure up to date information was given. It was noted that the objective for stepping up Gold was to: • reduce harm from SARS-CoV2 infections, • reduce harm due to surge pressures on the health and social care system, • reduce harm from population based health protection measures, • reduce harm from economic harms and reduce harm from health inequalities as a result of SARS-CoV2 infections. The Committee were reminded that the step up was initially to facilitate the roll out of the enhanced vaccination programme. The Executive Director of Nursing and Midwifery / Deputy Chief Executive thanked everyone and the teams involved that have stepped aside from their day jobs and forfeited leave to be able to support the vaccination programme to protect our population and our staff. **QS22/09.2** The Committee noted that there were no new decisions to make by Gold this week. At Cabinet and Board Briefing there had been Infection Prevention and Control	

(IPC) support for reducing the isolation timescales from 15 days down to 10 days in extenuating circumstances where there was a risk of contacts on a ward and that would be with senior IPC sign off and Gold sign off. **QS22/09.3** The Committee noted that Gold has asked Silver to review the visitor status in line with the current infection rate across the Health Board and the impact that it was having on the services. **QS22/09.4** The Committee also noted that Planned Care was being reviewed on a week by week basis and that Planned Care was not stepped up in the previous week because of the general upsurge in activity within unscheduled care. This resulted in all available beds were taken up by unscheduled care and some surge beds were opened. **QS22/9.5** Surveillance and Trigger information was reviewed and The Executive Director of Nursing and Midwifery / Deputy Chief Executive and Executive Director of Public Health highlighted that schools going back may have an impact on community infection rates and that these are being monitored. **QS22/9.6** It was noted that there has been an improvement in ICU capacity and what is being seen in critical care is as would be normal for this time of year, there is capacity and the four surge plans have not been required. Whole Health Board surge plans are being drawn up for the whole year. **QS22/9.7** Bed occupancy remains high and the Committee noted that surge plans are being drawn up to address this. The Executive Director of Workforce and Organisational Development updated what impact the change in testing guidance would have on the workforce. **QS22/9.8** The Chief Executive raised a question in relation to Planned Care asking that the Sites are encouraged to maintain as much activity as possible and if there could be the option of designating one of the sites as a green site to be able to commence planned care. It was noted that the Planned care team are taking a forward look at planned care activity on a weekly basis and reviewing risks if one area were identified to commence Planned Care. **QS22/9.9** The Committee raised a question around the number of locums being employed from England and if they are being tested prior to their shift commencing. The Committee noted that all staff numbers had reduced over the previous weeks, and that the guidance remained that all staff should test prior to coming into work. **QS22.9.10** The Committee asked if all offers for vaccination programme volunteers are being accepted and that pre-employment checks were taking place. The Director of Workforce described that there are two different pathways in place, details around systems to capture offers and deployment were shared and that pre-employment checks were in place. **QS22.9.11** The Committee discussed the requirement for integrated working with Local Authorities and a combined health and social care workforce and how this would work given the shortage of staff across the piece. It was noted that conversations around	 PPJ

mitigation of totality of risk needed to be undertaken and that a system wide business continuity response is required. **QS22.9.12 It was resolved that** the Committee: Received the Covid 19 update and that the slide pack would be uploaded after the meeting.	
QS22/10 Corporate Risk Register **QS22/10.1** The Chair introduced the agenda item noting that the paper had been received late. The Interim Director of Governance advised that at review at the Executive Team meeting prior to Christmas it was requested that wherever big risks are asking for extensions to timelines then extensions should be accompanied by a full explanation as to why it has not been possible to deliver. These updates had been requested over the Christmas period and the paper updated to reflect these. **QS22/10.2** The Committee commented that discussion had taken place at the Audit Committee around working arrangements with Local Authorities, for example, where buildings don't belong to us, and that a Memorandum of Understanding be drawn up with regards to Health and Safety. It was noted that this action had been taken forward and would be triangulated between the two Committees. **QS22/10.3** The Chair raised the action around the Executive Team discussing consistency of the risk ratings. It was noted that due to pressures in the system this had not taken place but would do so as soon as possible. **QS22/10.4** The Chair advised that, whilst being aware of the reasons the report was delayed, this should not be repeated as publication of a report as late as this was made it difficult to scrutinse. It was noted that should the Committee feel they need to ask further questions this can be done outside of the meeting and would be handled in the same way as the Consent items. **QS22/10.5** The Chair raised concerns about the lack of clinical risks on the corporate risk register. The Chief Executive noted that once internal audit have issued their brief, and any early sight would be helpful, it will identify the gap in clinical risk and the new Executive Director responsible for risk will be able to take this matter forward. The Executive Director of Nursing & Midwifery was able to advise that the Acting Director of Quality would be escalating the following new clinical risks at the next RMG - falls, WHO check list adherence and pressure ulcers. The Executive Medical Director has separately requested sepsis be added to these. It was noted that the management of risk and escalation needs to be reviewed to ensure that the high level risks are the right ones and to ensure that there is a route for Board level oversight which highlights patient safety culture. **QS22/10.6 It was resolved that** the Committee: • Note the Risk Management Group was stood down on the 13 December 2021 to allow Gold Command and the vaccination management to be progressed.	SG SEE NL/ SEE/ JP

• Note the Risk Management Group Chair's Actions process was followed to approve the risks for presentation to the Executive Team, before onward presentation to Board Committees. • Note the Key Field Guidance Document has been updated following Audit Committee members feedback and is attached as Appendix 3. • Review and note the progress on the Corporate Tier 1 Operational Risk Register Report as set in detail at Appendix 1:	
QS22/11 Quality and Performance Report **QS22/11.1** The Chair noted that this item was down for consent, however there were a number of concerns with the report including inaccurate data. As a result, the Committee would not be accepting the report. The lead Executive is working on an amended report taking into consideration comments made from the Committee outside of the meeting.	SH
QS22/12 Patient Safety Report – CONSENT **QS22/12.1** It was noted that this paper was being taken as a consent item and there were no questions raised. Any questions raised outside of the meeting will be attached to the minutes as an addendum.	
QS22/13 Quality/Safety Awards and Achievements - CONSENT **QS22/13.1** It was noted that this paper was being taken as a consent item and there were no questions raised. Any questions raised outside of the meeting will be attached to the minutes as an addendum.	
QS22/14 Hergest HIW Report and Action Plan **QS22/14.1** It was noted that this paper was being taken as a consent item as there was an overlap with the Serious Incident Review. The Chair noted that any questions raised on this item should focus on the HIW Report and Action Plan, it was noted that the report was disappointing to read with reference to recurring themes from previous inspection reports. It was noted that a 'whole system' response was required with regards to learning. **QS22/14.2** The Interim Director Of Nursing Mental Health agreed with the comments made by the Chair. The context to the inspection was noted, that it took place on a day immediately following a bank holiday on the back of an extremely difficult weekend. The Committee noted that the inspectors were given some inaccurate information from staff on arrival which was clarified when they returned. **QS22/14.3** The Interim Director of Nursing Mental Health updated the Committee on the staff deployment decision making group and the decisions they had had to take around moving staff from across the Health Board to give cover given the bank holiday, summer holidays and the impact of Covid 19 on staffing levels.	

QS22/14.4 The Chair highlighted the reoccurring themes being referenced in the report and questioned sustainable learning and what change was happening as a result of that learning. It was noted this would be discussed in the Private session in conjunction with the serious incident review report. The Executive Director for Public Health highlighted the action plan and noted that learning, moving at pace and cascading across the service was essential. The Committee noted that some of the comments made in the report were positive specifically around the caring nature of the staff, engagement with patients, dignity and respect. **QS22/14.5** Richard Hayward from Health Inspectorate Wales noted that it was positive that the report had been taken very seriously and was interested on the emphasis that there was learning cascading across. The Committee noted that there were some positive parts to the report including the significant improvements that had taken place between the first and second visit. **QS22/14.6** The Chief Executive advised that there had been a meeting with divisional representatives and most of the Executive Directors, the Chair, Vice Chair and an Independent Member. The meeting focussed on the improvement reports received within the Mental Health Services and across the organisation, and was to ensure that the range of issues that each of the reports have highlighted are reviewed and address and improvement and change methodologies are undertaken. The Chair highlighted that the need to evidence change was required.	
QS22/15 Vascular Services **QS22/14.6** The Chair opened the item noting the content of the paper and taking it as read opening up for questions. An Independent Member raised concerns that historically the Committee had been informed that comparisons had not been due to the lack of information available but that subsequently that information had been provided. The Interim Deputy Medical Director advised that in his opinion the challenge is understanding what the information is identifying and that the way historical data has been compiled and classified has raised difficulties in comparison to current data. An example of mortality and amputation figures was shared with the Committee and good clinical practice was explained. It was noted as the action plan is worked through, further questions are being raised. The Interim Deputy Medical Director advised that his objective was to get a sustainable and effective service to ensure that it is understood what can be done going forwards. **QS22/14.6** An Independent Member raised an historical staff survey and whether building up resilience was being included in the action plan. The Executive Director for Workforce advised that a specific piece of work, as part of the Discovery Phase, is going to take place with the team similarly to that undertaken with Mental Health colleagues. **QS22/14.6** The Committee raised concerns on the point raised in the report about being an outlier in post amputation mortality and asked who was taking responsiblity for this. The Interim Deputy Medical Director advised that there may be some data issues that contributed towards this, however, there has been an improvement in the figures in recent times. It was noted that the team are working through the recommendations, ensuring that MDTs are taking place and that individuals are being given the best possible care by meeting best practice standards. The Interim Deputy Medical Director	

advised that he was attending the Vascular Governance meetings and was able to put direct challenge to discussions taking place. It was noted that improvement on the quality of data had been raised with the group and the post amputee mortality rates were being reviewed very closely at the monthly meetings. It was confirmed that there has been no evidence of unnecessary amputations but scope to improve on the package of care to meet best practice standards. **QS22/14.7** The Chief Executive advised that performance and data issues are the same issues already being worked on in response to the Royal College of Surgeons first stage review and a cross reference would help give assurance. It was noted that the format of the document being reviewed had not uploaded effectively and that a single improvement plan format was being produced based on improvement methodologies that will return to a QSE workshop. The Chair agreed to decide how best to take assurance on this point after the meeting. **QS22/14.8 It was resolved that** the Committee: • Note progress in delivery of the Vascular Improvement Plan.	NL LR
QS22/16 Safeguarding Q1/2 Report - CONSENT **QS22/16.1** It was noted that this paper was being taken as a consent item and there were no questions raised. Any questions raised outside of the meeting will be attached to the minutes as an addendum.	
QS22/17 Learning from Morfa Ward (Llandudno) **QS22/17.1** The Chair introduced the item opening up for questions. An Independent Member made an observation around the requirement for clear roles and lines for accountability and managerial support and looked forward to see evidence of this given the very disappointing situation that had occurred. The Executive Director of Nursing and Midwifery / Deputy Chief advised that this action plan has been drafted based on the learning from the HASCAS scrutiny and methodology. It was noted that the action plan was not final because there was a need for inclusivity with partners, carers and citizens that relates back to the Stakeholder Reference Group. It was noted that the report addresses the need for Health Board wide learning to be embedded. **QS22/17.1** The Chair noted that although the action plan was not the final version, cross referencing and training needed to be reviewed going forward. It was noted that the Quality Improvement Group meeting at the end of this month would meet to improve the action plan and give it the check and balance that was required. This will need to feed back to QSE. **QS22/18.2 It was resolved that** the Committee received the report.	MJ
QS22/18 Learning from Medication Incidents	

QS22/18.1 It was noted that although this paper was being taken as a consent item there were no questions raised. Any questions raised outside of the meeting will be attached to the minutes as an addendum. **QS22/18.2** The Chair complimented the paper for being clear, easy to read and referencing human behaviours and that this would be welcome in other patient safety reports as well. The Chief Pharmacist and his colleagues were thanked for a well-produced paper. **QS22/18.3** The Chief Pharmacist noted that he had joined the call with the Assistant Director of Pharmacy (East) who was retiring and wished to formally thank her for her significant contribution around medicine, safety both in North Wales and nationally. This was echoed by the committee.	MJ
QS22/19 Health and Safety - CONSENT **QS22/19.1** It was noted that this paper was being taken as a consent item and there were no questions raised. Any questions raised outside of the meeting will be attached to the minutes as an addendum.	
QS22/20 Quality in General Surgery – Ysbyty Glan Clwyd **QS22/20.1** The Committee noted the context for the report which had been provided following concerns arising from a thematic review of quality and safety in surgery at Ysbyty Glan Clwyd (YGC). These concerns included the results of the national bowel cancer audit which suggested a higher than expected mortality in the 2 years after surgery at YGC, which was discussed in private session at the last Committee meeting. The Committee noted the immediate, medium and longer term actions planned to address the issues identified and thanked the Executive Medical Director for a very clear and comprehensive paper addressing the matter.	
QS22/21 Quality Governance Self-Assessment Action Plan (Maternity Services) – CONSENT **QS22/21.1** It was noted that this paper was being taken as a consent item and there were no questions raised. Any questions raised outside of the meeting will be attached to the minutes as an addendum. **QS22.21.2 It was resolved that** the Committee: • Approve closure of the Quality Governance Self-Assessment Action Plan	
QS22/22 Internal Audit Report into HASCAS - CONSENT **QS22/22.1** The Chair queried why the whole report has not been received. Dave Harris from Internal Audit noted that there is a typographical error and Huw Jones should be replaced Huw Thomas and that it is a partial briefing paper because a number of steps had not been signed off due to actions pausing due to Covid 19. The Executive Director	GH

of Nursing and Midwifery / Deputy Chief advised that those outstanding areas were going back through patient safety and quality group to be able to give assurance to QSE. It was agreed that if there were any areas that required escalation this would be done in the usual process through to QSE.	
QS22/23 Chair's Reports from Strategic and Tactical Delivery Groups - CONSENT **QS22/23.1** It was noted that this paper was being taken as a consent item and there were no questions raised. Any questions raised outside of the meeting will be attached to the minutes as an addendum.	
QS22/24 Nurse Staffing Levels Policy amendments - CONSENT **QS22/24.1** It was noted that this paper was being taken as a consent item and there were no questions raised. Any questions raised outside of the meeting will be attached to the minutes as an addendum.	
QS22/25 Closing Business **QS22/25.1** There was not closing business to note.	
QS22/25 Issues Discussed in Previous Private Session **QS22/25.1** The Committee noted that the Report into the Mortality Post Bowel Cancer had been addressed under item QS22/20.	
QS22/26 Documents Circulated to Members **QS22/26.1** The Chair highlighted the falls policy which had been circulated post publication for Chair's Action.	
QS22/27 Agree Items for Chair's Assurance Report **QS22/27.1** The Chair agreed to give some thought as to how to pick up the Vascular action plan assurance.	
QS22/28 Review of risks highlighted in the meeting for Referral to Risk Management Group **QS22/28.1** There were no risks highlighted in the meeting for referral.	
QS22/29 Review of Meeting Effectiveness **QS22/29.1** The Committee and attendees discussed the use of the consent agenda. It was noted that a number of items that were too important not to discuss. It was noted any questions raised outside the meeting would be addendum to the minutes to ensure clarity and scrutiny.	
QS22/30 Date of Next Meeting	

QS22/30.1 1 March 2022	
QS22/31 Exclusion of Press and Public **QS22/31.1 It was resolved that** representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960.	

Questions Raised outside of the meeting:

Question	Raised by	Answer	Answered by
QS22/16 Safeguarding Q1/2 Report MHLD Division Adult at Risk reports are down by 26%, do you think this is because of targeted approach, or reduction in staffing capacity, and have you the evidence for this if so?	Cheryl Carlisle	The reduction in Adult at Risk reporting could be the result of a number of key activities which have been implemented to follow a targeted approach as a result of activity and supporting data, and the implementation of the Designated Safeguarding Persons role (All Wales Safeguarding Procedures 2019). This includes: • Bespoke training, case specific desktop reviews, and a greater participation in ward level Multi-disciplinary Team Meetings (MDTs). • Increase in contact and communication between teams and Corporate Safeguarding as a result of the new Safeguarding Multi-agency statutory guidance. • Concerns are discussed with the Safeguarding Team and actioned immediately with consideration given to the Wales Safeguarding Procedures and specifically the Adult at Risk process prior to submission of the report to the LA. This supports the decision making regarding the Adult at Risk threshold and reduces inappropriate Adult at Risk Reports. • Where concerns are raised and do not meet the 'At Risk' threshold other action is	Michelle Denwood

		considered to ensure any potential risks are reduced and the opportunity for clinical reflection/supervision and training is implemented.	
QS22/16 Safeguarding Q1/2 Report DoLS team report a 44% increase in applications – how are you recording the complexity and resource shortfall please?	Cheryl Carlisle	The increase in DoLS applications is in line with the National picture. The increase in demand has been acknowledged by Welsh Government with non recurring funding provided to support BCUHB activity. The resource shortfall and the increase in complexity is monitored and recorded by the following: • The collation of data and activity follows a National programme of collation and submission to WG. This evidences the compliance aligned to the legal time frames against each application and highlightes the delay in process at each step of the actvity. • DoLs - Court of Protection activities are recorded, timeframes documented and the analysis of each case. • Case Supervision of the Best Interest Assessors (BIAs). • Desktop reviews, learning events and the engagement in statutory safeguarding reviews and untoward incidents supports the collation of evidence and reporting.	Michelle Denwood

		• DoLS is a Tier 1 Risk on the Corporate Risk Register. Controls and actions are monitored by the MHACC & C and by the Safeguarding Reporting Framework.	
QS22/16 Safeguarding Q1/2 Report CAMHS – increase of 22% in Section 136 assessments, but downward trajectory in the number of assessments in this period. Could you explain further please?	Cheryl Carlisle	The increase of 22% is the result of the significant increase in S136 presentations during May and June 2021. This is associated with the increased acuity and complexity of patients that are receiving support within the community and CAMHS services. Clinical activities by specialist services are reported by their quality and assurance processes.	Michelle Denwood
QS22/16 Safeguarding Q1/2 Report IRIS – please can you expand on the current challenges regarding which GP Primary will participate, and the funding fall out of this problem, and how it is being handled?	Cheryl Carlisle	BCUHB Safeguarding Team are fully engaged and have been promoting and supporting this valuable project. During Q1/2 the Domestic Abuse Safety Unit (DASU) had discussions with Wrexham and North Denbighshire Primary Care Clusters. Both decided not to take on the project which caused a delay and the potential for DASU to use the funding for another activity outside of BCUHB. 18th January 2022. An update was received from the Regional Domestic Abuse and Sexual Violence Coordinator. Central and South Denbighshire Primary Care Clusters have agreed and are to commence the IRIS project.	Michelle Denwood

		Progress todate is that the Clinical Lead and Educator Advocate have been appointed. Training of General Practitioners has commenced.	
QS22/16 Safeguarding Q1/2 Report Audit Quality of Adult Safeguarding Documentation - an improvement, but how are we embedding learning? The same for the Child at Risk please? (it says 'Child at Report')	Cheryl Carlisle	Both Adult at Risk Reports and Child at Risk Reports undertake a Quality Assurance process. • Report documentation and content is analysed on a weekly basis with any concerns in the documentation highlighted to the author or manager. • The Corporate Safeguarding team work with wards and teams to support the implementation of any improvements to the quality of the reporting and the decision making. • This activity can be addressed following a variety of activities; Governence /Quality & Safety Meetings, Safeguarding Forums, and/or directly with the individual or service. • Findings and areas for improved practice are reinforced using different approaces and methadology for example; 7 Minute Briefings, Individual and Group Safeguarding Supervisions, and the monthly Corporate Safeguarding Bulletin that is shared across BCUHB, feedback from reviews.	Michelle Denwood

		• Key themes and trends which require improvement are highlighted and supported by bespoke training. • To evidence any improved practice (Learning) is measured by a number of methods including; audit, case supervision, and the result of the review and analysis of best practice, incident reviews, patient stories, feedback and face to face engagement.	
QS22/11 Quality and Performance Report Going through the QP report, I'm not quite sure what has happened. It seems to have gone backwards in terms of quality and meeting the needs of the Committee. We have new indicators included that we don't normally have and it's not clear why. For example, on page 7 there is an indicator for "European standardised rate of alcohol attributed to hospital admissions for individuals [sic] resident in Wales", a number 357.6 and an upwards arrow. There is no context provided and so it's difficult to see why it's before the Committee In contrast, the patient safety alert indicator is still missing, despite this having been identified as not only an issue that needs reporting but also a contributory factor to recent Never Events.	Lucy Reid	I apologise that the report is not the previously agreed version and I have asked Gavin Halligan Davies (Interim Director of Performance) to identify what has occurred. I completely understand your frustration with these matters, as the suite of reports do not provide the assurance the Committee(s) require and have not done so for an extended period. With regards to your specific queries: 1. I am investigating why the content of the report has changed. 2. The colour and direction of the arrow is not indicative of the status of the measure, but represent a trend line which shows whether performance is improving or declining. We are looking to	Sue Hill

A number of arrows appear to be green rather than red, for example on page 12, the percentage of children and young people waiting less than 26 weeks for neurodevelopment assessment is reported as 31.90% against a target of >=80 but has a green upwards arrow - why? There is a narrative for Adult Psychological Therapy but it is reported as now being above target. The narratives should be by exception to explain why the HB is below target - hence the headings "issues affecting performance" and "actions". As I said, the report is listed for consent in the meeting and so was not going to be discussed. However, I am inclined to announce in the meeting that the Committee is not accepting the report due to the number of issues in it and the fact that it does not assist us to focus on the business/safety critical performance indicators which is what we have repeatedly asked for.		revise the current style of reporting (subject to agreement) to graphical reporting which will resolve the ambiguity of the arrows. 3. As part of the Governance and PAF we are looking to identify success as well as issues around performance, but I will check in this instance why this was included.	
QS22/14 Hergest HIW Report and Action Plan It is concerning that the report specifically calls out the recurring themes and lack of learning evident from that. I would like to be better assured as to how HIW reports are being	Lucy Reid	Paper received in the Private Session with the External SIR and the Action Plan The Morfa Ward current action plan populated, noting further work would be required and this will be monitored through the Quality Improvement Group meeting at the end of this month and then report into QSE.	Matt Joyce

monitored - they seem to have fallen off the radar again, albeit I understand the pressures.			
QS22/14 Hergest HIW Report and Action Plan In terms of the HIW report - this is very disappointing but concurs with my concerns in terms of culture, governance and learning as key areas that still need to be addressed. Looking at the actions arising from the recommendations, they are very transactional rather than focusing on the why in order to address the how. This will hinder sustainable learning. An example being the recording of capacity assessments - the action refers to sending a bulletin and then undertaking audits. Have you looked at why the assessments aren't being undertaken/recorded? The purpose of the audit is to check compliance but first you have to address why they are not complying. A further action refers to "Ensure the risk assessment and Bed Escalation Decision Making Guide is completed for every admission to identify the most appropriate bed" - how will this be "ensured"? In terms of the OPMH pathway, some of the actions aren't actions that meet the	Lucy Reid	The Chair raised a number of these questions in the meeting the below minute highlights how change and improvement methodologies are required and are being drawn up. The Chief Executive advised that there had been a meeting with divisional representatives and most of the Executive Directors, the Chair, Vice Chair and an Independent Member. The meeting focussed on the improvement reports received within the Mental Health Services and across the organisation, it was to ensure that the range of issues that each of the reports have highlighted are reviewed and address and improvement and change methodologies are undertaken. The Chair highlighted that the need to evidence change was required.	Response given in meeting

recommendation - it is progress towards completing the action. I note that there is reference to encouraging the engagement with the Stronger Together programme but given some of the cultural issues raised in the HIW report, what is the plan for a wider cultural piece for the Division? Fundamentally, how can we be assured that the change required from any learning arising from these incidents is happening and is sustainable?			