Quality, Safety and Experience (QSE) Committee
Minutes of the Meeting Held in public on 15.1.21 via Webex

Present:

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

In Attendance:

Jackie Allen	Chair of Community Health Council (CHC)
Louise Brereton	Board Secretary *(observing)*
Peter Bohan	Associate Director of Health, Safety and Equality
Kate Dunn	Head of Corporate Affairs (*for minutes*)
Gareth Evans	Chair of Healthcare Professional Forum
Simon Evans-Evans	Interim Director of Governance
Arpan Guha	Interim Executive Medical Director
Dave Harries	Head of Internal Audit
Gill Harris	Executive Director of Nursing and Midwifery / Deputy Chief Executive
Debra Hickman	Secondary Care Nurse Director
Matthew Joyes	Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience
Andrew Kent	Interim Head of Planned Care Transformation (*part meeting)*
Melanie Maxwell	Senior Associate Medical Director/Improvement Cymru Clinical Lead
Urvisha Perez	Audit Wales (*observing)*
Mike Smith	Interim Director of Nursing Mental Health and Learning Disabilities

Agenda Item Discussed	Action By
QS21/1 Chair's Opening Remarks The Chair welcomed attendees and confirmed that this month's meeting had a refocused and streamlined agenda to assist officers and the wider organisation in their ability to deal with the ongoing pandemic.	
QS21/2 Declarations of Interest None	
QS21/3 Apologies for Absence Recorded for Adrian Thomas, Chris Stockport, Sue Green and Teresa Owen.	
QS21/4 Draft Minutes of Previous Meeting Held in public on the 3rd November 2030 for Accuracy, Matters Arising and Review of Summary Action Log	

QS21/4.1 The minutes were approved as an accurate record pending amendment to QS20/195.1 to read "In terms of the next steps and actions, the Acting Executive Director of Nursing & Midwifery confirmed that the recommendations from the Covid Delivery Group would be developed into an action plan." **QS21/4.2** A matter arising relating to QS20/195 Hospital Acquired Infection in terms of whether the outbreak had been retrospectively reported to the Health and Safety Executive (HSE) and within Datix had received a written update from the Director of Health, Safety & Equality as follows "all clusters outbreaks are investigated with 72 hour review and Make it Safe assessment if the outbreak is deemed to be work related all reports are sent to the HSE and is contained in the Q3 report" **QS21/4.3** Updates were provided to the summary action log.	
QS21/5 Draft Minutes Joint Audit and Quality, Safety & Experience Committee Held on 24.11.20 The minutes were approved as an accurate record.	
QS21/6 Board Assurance Framework (BAF) Principal Risks and Corporate Risk Register (CRR) **QS21/6.1** The Interim Director of Governance confirmed that the reports had been shared with the Audit Committee in December 2020. He reminded members that the BAF was a high level articulation of the risks that may affect the organisation's ability to deliver on its five strategic priorities. There were 23 principal risks at present and the BAF would be discussed at the Health Board meeting on the 21st January 2021, with the relevant sections of the BAF and CRR then being scrutinized by the respective Committees going forward. He noted that the risks were dynamic and ownership therefore lay with the nominated Executive lead with a supporting 'check and challenge' process in place via the Risk Management Group (RMG). **QS21/6.2** Members acknowledged the progress made in terms of risk management and that it was evident that the BAF had further developed and evolved since consideration at the Audit Committee, and would help the Board remain focused on its key risks. The Committee Chair set out some concerns around the mental services sections in the BAF in that she felt there were gaps in evidence of some actions which were shown as complete, and that some of the narrative needed to be reviewed to provide a more accurate reflection of the current situation. She also suggested that some of the descriptions could be better worded and agreed to email her detailed feedback to the Interim Director of Governance and the Executive Director of Nursing and Midwifery in advance of the RMG meeting on Monday 18th January 2021. Other members were invited to send any comments in the same manner. The Executive Director of Nursing and Midwifery would welcome comments to allow for check and challenge by the RMG; she also felt there was a significant gap in terms of a risk around planned care. **QS21/6.3** The Committee Chair raised that a number of the risks appeared to have high risk scores with relatively short "target risk dates" and queried how realistic this was. She queried CRR20-01 (asbestos management and control) as an example, highlighting that some of the actions were not actions but were gaps and that a number of the due dates	IMs IMs

were only 2 weeks hence. It was reported that the action plans in place were robust but there were some inconsistencies in understanding amongst officers whether the "target risk date" was the date that the target risk score was expected to be achieved or the date that the risk would be reviewed. The Interim Director of Governance accepted that there was a need to improve consistency of understanding across the organisation. The Director of Health, Safety & Equality updated the Committee on the plans which were in place to increase assurance against CRR20-01 (asbestos management and control). **QS21/6.4** The Committee Chair queried the statement on the report template that the CRR had been agreed by the RMG as she felt there were several examples where the mitigations and controls were inadequately described and she would have expected these to have been addressed by that group before coming to the Committee. The Interim Director of Governance explained that the RMG had met two months previously and so at that time the due dates may have been deemed achievable. The Committee Chair concluded that the Committee could not be assured that the risks were being managed or that adequate scrutiny had been applied by the RMG on the basis of the number of issues identified by members. The Interim Director of Governance welcomed the discussion and challenge and acknowledged that there was still work to be done on the risk register. It was agreed that members would send detailed feedback to the Interim Director of Governance. **QS21/6.5 It was resolved that** the Committee: 1. Review and note the progress on the Principal Risks as set out in the Board Assurance Framework (BAF) and Corporate Tier 1 Operational risks presented.	
QS21/7 Infection Prevention & Control (IPC) Update **QS21/7.1** The Secondary Care Nurse Director reported that new interim leadership for infection prevention was now in place which was a positive step. She referred to the detailed slide set which had been provided and highlighted key headlines as follows: • Challenges with delivering a rolling programme of Hydrogen Peroxide Vaporisation (HPV) across site. • Clusters and outbreaks of Covid were providing challenges within staff teams also and the fatigue and emotional impact on the workforce should not be underestimated. • Revised cleaning standards had been received from Welsh Government. • Behaviours were a significant element in terms of transmission. • Progression of the business case for infection prevention was being taken forward. • A pilot around lateral flow testing had been undertaken. • Progress in some areas was inhibited by all Wales factors and were currently beyond local control. **QS21/7.2** A discussion ensued. In response to a question regarding the suspension of HPV deep cleaning, the Secondary Care Nurse Director assured members that this was being undertaken but on a more reactive than planned basis. Members noted with concern the deterioration in community acquired infections and it was confirmed this had been picked up in a recent accountability review for primary care and that clinical leadership and the work of local infection prevention groups was key to improvements in this regard. The Acting Executive Medical Director wished to highlight the point on the last slide around culture and habit and he felt that changing mindsets continued to be essential to ensuring that IPC was everybody's business. The Executive Director of Nursing and Midwifery concurred and	

added that the interim appointment of Sally Batley would be key to building on a multidisciplinary approach to IPC. In response to a question from a member regarding outbreaks in care homes the Secondary Care Nurse Director reminded the Committee of the range of support and intervention ongoing with care homes and partners to ensure consistency in standards being applied. The Executive Director of Nursing and Midwifery added that the care homes requiring the most support were identified and targeted as there was evidence that not all were accessing the support available to them. She also reported on the stepping up of the Care Home Cell and that there were daily exception sitreps via the Executive Incident Management Team (EIMT).

QS21/7.3 It was resolved that the Committee take assurance from the Infection Prevention presentation

QS21/8 Health & Safety (H&S) Q3 Report

QS21/8.1 The Associate Director of Health, Safety and Equality presented the report and highlighted the following:

- There was positive progress around fit testing.
- 119 visits from the corporate H&S team had been undertaken in Q3 compared to 128 in Q2.
- There had been 33 H&S reviews in service areas.
- There had been an increase in the number of RIDDORs in Q3 with 95 being Covid related and 24 non Covid related. In comparison there had been 23 in the same quarter for the previous year.
- Themes were being identified from the RIDDORs and in response to some identified issues around non-adherence to social distancing there was work ongoing to address behavioural based aspects.

QS21/8.2 A discussion ensued. In response to a question around the timeframe for compliance with the Improvement Notice regarding failure of a FFP3 mask, the Associate Director of Health, Safety & Equality confirmed this had been adjourned to 19th April 2021 and he was confident that this could be met for Ysbyty Glan Clwyd (YGC). He noted that whilst the Improvement Notice related to YGC specifically, there was an expectation that the organisational response should apply across all sites. He wished to commend the Fit Testers who were working very hard to deliver on the ask. A member enquired as to how fit testing was being recorded and it was reported that advertisements were out for support posts to enable this to be done via the Electronic Staff Record (ESR). Finally, a member enquired as to progress with the development of a business case for additional resources into the corporate team and the Associate Director of Health, Safety and Equality stated that feedback from the review group was now being taking forward in order to finalise the business case.

QS21/8.3 It was resolved that the Committee note the position outlined in the Quarter 3 Report.

QS21/9 Holden Recommendations

QS21/9.1 The Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience presented the report and highlighted that it incorporated updates against three other key reviews from the Royal College of Psychiatrists, Healthcare

Commented [LR1]: Peter also responded to some questions that I'd asked outside of the committee around themes arising from incidents but I can't recall his response. Have you got a note on this?

Inspectorate Wales (HIW) and the Welsh Government Delivery Unit to provide a more rounded piece of assurance to the Committee. He reminded members that the Holden review had been commissioned back in 2013 via the whistleblowing process and as a result the circulation of the report had been restricted. He stated that this had resulted in a lack of clarity in terms of its reporting route and a lack of clarity in governance terms of the tracking of actions. He drew members' attention to the recommendations within his paper that all future significant quality-related reports had resultant action plans tracked via the same governance framework and methodology of that used for HIW actions, and that there were clear close down reports when all actions were complete. The Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience also felt it could be argued that some of the issues raised in 2013 had reoccurred within the Mental Health and Learning Disabilities (MHLDS) division - albeit in different circumstances and with different outcomes. He acknowledged however that this was outside of the scope of this report. Finally, he wished to highlight that there was a directory of evidence against each statement made within the report referenced in the appendix which had not been included in the Committee report but that members could see if they wished. **QS21/9.2** The Executive Director of Nursing and Midwifery welcomed the paper which she acknowledged was the result of comprehensive work. She suggested that consideration be given to further strengthening the sustainability of assurance by revisiting action plans that had been closed down as a cross-check that the quality actions agreed were still in place. **QS21/9.3** A discussion ensued. The Committee Chair recognised the work that had taken place to undertake this review and the challenges of responding to a matter that had occurred seven years ago. She felt that the key issue going forward was to ensure the golden thread of recurring themes from different reviews were triangulated and that they supported organisational learning. Turning to the MHLD division in particular the Committee Chair highlighted that the original report was related to the Hergest Unit and, as referred to by the Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience some of the issues originally identified by the various reviews undertaken in 2013 had recurred but in different parts of the service and for different reasons. This indicates the need to focus on the overall governance framework rather than one area. She felt that the Committee needed to be assured that the matters highlighted within the paper would be addressed going forward and that the governance process were appropriate and sustainable. The Executive Director of Nursing and Midwifery observed that the MHLDs division had been subject to several reviews with resultant action plans which had areas of commonality. She felt that the principle of bringing these together would ensure a consistent approach and maximise learning across the wider organisation not just the division. The Secondary Care Nurse Director suggested that similar findings and observations could probably also be made in other service areas. The Interim Director of Nursing for MHLDs accepted there had been long-standing cultural issues within the division and whilst significant improvements had been made, he suggested that the division was still not where he personally would like it to be in terms of engagement with the workforce and the wider organisation. The Acting Executive Medical Director was supportive of bringing things together where possible and he was aware of examples where the division was working separately – eg; relating to improving clinical effectiveness. The CHC Chair agreed that the underlying cultural issues were significant and that remedial actions needed to be applied on a broader basis across the whole organisation. The Associate Director of Health, Safety and Equality noted that scrutiny and challenge should be viewed as a positive thing and more people needed to accept this mindset. The Interim Director of Nursing for MHLDs confirmed that improvements in terms of organisational	GH

development had been delayed within the division due to Covid but would be picked up again. Finally, a member enquired whether there was a clear communications strategy in place, noting that this was the first time that a detailed narrative against the Holden recommendations had been made available within the public domain. The Executive Director of Nursing and Midwifery undertook to follow this up outside of the meeting with the corporate communications team and the CHC. It was also agreed that officers accept an amendment to the second recommendation regarding broadening this to require an impact assessment at the end of the process to check that closed actions had been embedded. **QS21/9.4 It was resolved that** the QSE Committee note the report and agree that: 1. All future significant quality-related reports have resultant action plans tracked by the Associate Director of Quality Assurance's Office using the same governance framework and methodology of that used for HIW actions to include progress reporting in the Quality Assurance Report to the Patient Safety and Quality Group (and therefore onto QSE Committee). 2. Any significant quality-related reports, when tracked through the process mentioned in the preceding recommendation, are assured in a timely fashion, have clear close down reports when all actions are complete and proactive periodic follow up to ensure actions have been sustained	GH MJ SEE
QS21/11 Planned Care Recovery : update *[Mr Andrew Kent joined the meeting. Agenda item taken out of order at Chair's discretion]* **QS21/11.1** The Interim Head of Planned Care Transformation presented the paper and highlighted that: • The six point recovery plan stood alone but also was a prerequisite for strategic direction in terms of the organisation's intentions regarding the establishment of a Diagnostic Treatment Centre. • The next report to the Committee would incorporate quality and safety elements of Covid related matters. • An artificial intelligence system was being scoped to allow the validation of patient waiting limit information. Work was also to commence on standardisation within validation and to support those areas that weren't currently validating. • A standard operating procedure would be considered by the Planned Care Transformation Group later in January before discussion by the Executive Team. Any patient who decided not to have their procedure would also have a clinical assessment by their clinician to ensure this was appropriate. • Following a beneficial pilot of Attend Anywhere (a virtual platform for clinics) this would be subject to rapid rollout starting with orthopaedics. • An Escape from Pain programme had commenced and work was being undertaken on an App to provide patients with a digital programme to follow. • Waiting List Initiatives were currently low but it was likely that more use would made of this option. • Outsourcing had been put in place for ophthalmology in terms of cataracts which would allow capacity to be increased through the release of substantive staff to undertake other work such as Age-related Macular Degeneration (AMD) and intravitreal cases. • All specialties now undertook a multidisciplinary review on a weekly basis. • A focus on cancer care had resulted in a significant amount of cancer patients being moved over to receive their care in the West from the next week.	

- All sites would be moving to an essential services only basis from the following week with monitoring of clinical harm being undertaken for those P2 patients whose care had been paused.

QS21/11.2 A discussion ensued. Members acknowledged the seriousness of the situation that was set out within the paper and welcomed the accompanying verbal presentation which provided a personalised overview of the mitigating actions being put in place to reduce harm. The Interim Head of Planned Care Transformation stated that he and his colleagues genuinely wanted to be able to deliver for patients and that the challenges facing them were very real with the knowledge there would be a national post-Covid legacy of harm for patients who have had procedures delayed. He stated that the team believed passionately that every single patient that they could arrange to be operated on during the pandemic would be one less who suffered harm and had to wait even longer. Members acknowledged the importance of ensuring the Board, Committees and the wider public were aware of the emotional and physical impact upon staff who continued to work so hard to provide the best quality care, and remained dedicated in their resolve to help patients even during the most challenging times. The Acting Executive Medical Director added that he commended those clinicians who were travelling with their patients to enable them to receive their care on other sites, whilst continuing to balance the Covid risk. The Executive Director of Nursing and Midwifery confirmed that the latest planned care position had been shared at EIMT and she assured members that a clinical risk approach was in place with clinical reviews being undertaken. She made a comment around the differing role of the Finance and Performance Committee in terms of planned care but that the QSE Committee needed to be appraised of quality and safety aspects. The Committee Chair thanked the Interim Head of Planned Care Transformation for his very personalised presentation adding that it provided the Committee with a more informed understanding of the review taking place on patients on whether their treatment could or should go ahead safely at this point. She highlighted however that this detail was not in the written report and therefore would not be as visible to the public. She acknowledged that reports to the Finance and Performance Committee should be focussed on the performance of planned care including waiting times and numbers. However, she agreed with the Executive Director of Nursing and Midwifery that reports to the QSE Committee should be person focussed, providing assurance on how the clinical risk to patients was being managed. The Interim Head of Planned Care Transformation agreed to look at the focus of his report for the next meeting.

QS21/11.3 It was resolved that the Committee note the work to date on the six-point recovery plan
[Mr Kent left the meeting]

QS21/10 Mental Health and Learning Disabilities Exception Report

QS21/10.1 The Interim Director of Nursing (MHLDs) presented the report which was focused around the four priorities to work towards this –

- Stronger and Aligned Management and Governance
- Review of Capacity and Capability
- Delivery of Safe and Effective Services in Partnership
- Engagement with Staff, Users and Stakeholders

He indicated that risks and mitigating actions against each of the priorities were being identified and he was confident there was a far more cohesive approach. Members' attention was drawn to section 3 of the report which provided an analysis of key areas of

improvement which were noted as restoration of capacity and improvements to capability; stronger and aligned management and governance; and improved effectiveness in partnership working. **QS21/10.2** Members welcomed the progress that had been shared and felt that there was a more positive energy across the division. The extension of the secondments within the senior leadership team were also welcomed. A request was made that the next report to the Committee provide a higher focus on the engagement with stakeholders and partners. **QS21/10.3 It was resolved that** the Committee note the report.	MS
QS21/29 Quality Governance Review YGC **QS21/29.1** The Committee Chair stated that the Committee had received a detailed report to discuss in private session but she had asked for a summary statement to be provided in public session. The Executive Director of Nursing and Midwifery confirmed that the quality governance review process had been established in order to provide opportunities for assurances through deep dives and that YGC had been identified as the first site to be assessed through this process. She confirmed that many elements of the report related to the ability to provide sustainable improvements and that relevant teams within the hospital had now been asked to develop detailed improvement plans to support the high level actions. The Secondary Care Nurse Director welcomed the review process and felt it supported the principle of the organisation knowing its sites and services and where the risks were. The Acting Associate Director of Quality Assurance / Assistant Director Patient Safety and Experience confirmed further reviews would be undertaken via a rolling programme but this had been delayed by the pandemic. **QS21/29.2 It was resolved that** the Committee receive the update.	
QS21/12 Nursing Workforce for Acute Sites, Community Hospitals and Community Nursing Services **QS21/12.1** The Chair reminded members that the paper had been submitted within the consent section however she was aware that a member wished to raise a point. This related to Appendix 4ii regarding redeployment and the member suggested that in terms of radiography for example there could be a cohort of other staff, including administrative staff, who could assist. She also made the point that if there was consistency in services it would be easier to redeploy, giving an example that in health visiting not all teams were providing face to face care currently. Finally she wished to acknowledge on behalf of Trade Union partners that they have felt very involved in redeployment discussions. The Secondary Care Nurse Director reported that staffing was reviewed in totality and risk assessments considered by the EIMT. For nurse staffing in particular the situation was very dynamic. **QS21/12.2 It was resolved that** the Committee acknowledge the report and assurance regards the escalation triggers and receive further reports should the need arise to vary Nurse Staffing levels from those previously reported.	
QS21/13 Chair's Report : Patient Safety Quality Group **QS21/13.1** The report was received as a consent item.	

QS21/14 Chair's Report : Strategic Occupational Health & Safety Group **QS21/14.1** The report was received as a consent item.	
QS21/15 Chair's Report : Clinical Effectiveness Group **QS21/15.1** The report was received as a consent item.	
QS21/16 Chair's Report : Patient Carer Experience Group **QS21/16.1** The report was received as a consent item.	
QS21/17 Mental Health & Learning Disabilities Division Resubmission of Written Control Documents **QS21/17.1** The Chair reminded members that the paper had been submitted within the consent section however she was aware that a member wished to raise a general point that written control documents needed to be more cognisant of gender neutral language. **QS21/17.2 It was resolved that** the Committee approve the amended written control documents for implementation.	
QS21/18 Serious Incident Report October and November 2020 **QS21/18.1 It was resolved that** the QSE Committee: 1. Note the report. 2. Note the introduction of the daily Datix review meetings which provides the Health Board with greater oversight and assurance of incidents as they are reported.	
QS21/19 Improvement Group (HASCAS & Ockenden) **QS21/19.1** The Committee Chair wished to highlight that the evidence against the recommendations was subject to review by internal audit colleagues. The Executive Director of Nursing and Midwifery wished to acknowledge the CHC's support to a recent related engagement event. It was also confirmed that as the improvement group's work had concluded, updates would be stood down from the Committee's regular cycle of business, whilst acknowledging that separate but related pieces of work would be embedded within wider governance structures. **QS21/19.2 It was resolved that** the Committee note the progress against the recommendations to date and that the oversight of the remaining open recommendations be provided through existing quality assurance routes.	
QS21/20 Safeguarding **QS21/20.1** The Committee Chair indicated there had been recent conversations around the reporting lines for safeguarding and she felt there was a lack of clarity across the Committee structure which had the potential to cause duplication or create gaps in	LB

assurance. The Board Secretary indicated she would pick this up to review how respective cycles of business complemented each other. **QS21/20.2 It was resolved that** the Committee note the progress made this year by the Corporate Safeguarding Team	
QS21/21 Audit Wales Review of Quality Governance Arrangements **QS21/21.1** It was resolved that the Committee note for information the Audit Wales review of the Health Board's Quality Governance arrangements.	
QS21/22 Public Services Ombudsman Public Interest Report **QS21/22.1** The Committee Chair noted that the report related to urology services which had been an area of concern previously. The Acting Associate Director of Quality Assurance / Assistant Director Patient Safety and Experience added that the start date for the review by Audit Wales had been delayed due to the pandemic. **QS21/22.2 It was resolved that** the Committee receive and note the report formally.	

QS21/23 Healthcare Inspectorate Wales Update Report **QS21/23.1 It was resolved that** the Committee note the following reports; 1. Healthcare Inspectorate Wales National Review Maternity Services, Phase One Report, Published 19 November 2020 2. Healthcare Inspectorate Wales Tier 1 Quality Check (Planned), The Stables Medical Practice (Non NHS Managed) on 8 September 2020. Published 17 November 2020 3. Healthcare Inspectorate Wales Quality Check (Planned), Ablett Unit, Glan Clwyd Hospital on 20 November 2020	
QS21/24 Issues Discussed in Previous Private Session **QS21/24.1 It was resolved that** the Committee note the report	
QS21/25 Documents Circulated to Members 3.12.20 Briefing note on thrombosis 14.12.20 Quarterly Plan Monitoring Report for November	
QS21/26 Issues of Significance to inform the Chair's Assurance Report To be agreed outside of the meeting	
QS21/27 Date of Next Meeting 2nd March 2021. The Committee Chair suggested this would also need to be a focused agenda.	
QS21/28 Exclusion of Press and Public **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.'	