Quality, Safety and Experience (QSE) Committee
Minutes of the Meeting Held in public on 4.5.21 via Teams

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
Kate Dunn	Head of Corporate Affairs (*for minutes*)
Gareth Evans	Chair of Healthcare Professional Forum (*part meeting*)
Simon Evans-Evans	Interim Director of Governance (p*art meeting)*
Sue Green	Executive Director of Workforce and Organisational Development (OD)
Arpan Guha	Acting 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
Mandy Jones	Nurse Director – Ysbyty Gwynedd Hospital Management Team (*part meeting)*
Matthew Joyes	Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience
Melanie Maxwell	Senior Associate Medical Director/Improvement Cymru Clinical Lead (*part meeting)*
Karen Mottart	Hospital Medical Director – Ysbyty Gwynedd Hospital Management Team (*part meeting)*
Teresa Owen	Executive Director of Public Health (*part meeting*)
Urvisha Perez	Audit Wales (*observing)*
Georgina Roberts	Head of HR– Ysbyty Gwynedd Hospital Management Team (*part meeting)*
Dawn Sharp	Deputy Board Secretary (*part meeting)*
Mike Smith	Interim Director of Nursing for Mental Health and Learning Disabilities *(part meeting)*
Chris Stockport	Executive Director Primary and Community Services
Adrian Thomas	Executive Director Therapies and Health Sciences
Lesley Walsh	Head of Nursing – Ysbyty Gwynedd Hospital Management Team (*part meeting)*
Jo Whitehead	Chief Executive (*part meeting*)
Barry Williams	Interim Hospital Director, Ysbyty Gwynedd Hospital Management Team (*part meeting)*
Kamala Williams	Acting Head of Performance (*part meeting)*

AGENDA ITEM DISCUSSED	ACTION BY
QS21/58 Chair's Opening Remarks	

QS21/58.1 A warm welcome was extended to Urvisha Perez who was observing the meeting on behalf of Audit Wales.	
QS21/59 Declarations of Interest QS21/59.1 Jackie Hughes declared an interest in item QS21/63 in that she attended the strategic outbreak meetings in a Staff Side partner role and that her substantive post was also based at Ysbyty Gwynedd.	
QS21/60 Apologies for Absence **QS21/60.1** None recorded	
QS21/61 Minutes of Previous Meeting Held in Public on 2.3.21 for Accuracy, Matters Arising and Review of Summary Action Log **QS21/61.1** The minutes were approved as an accurate record and updates provided for recording within the summary action log. *[Simon Evans-Evans joined the meeting]*	
QS21/62 Patient Story **QS21/62.1** The Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience presented the patient story which focused on a patient's experience from diagnosis through treatment to his eventual death, as told by his wife. The story had been shared digitally with members and it was reported that more use would be made of technology to capture audio and video stories in the future. The Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience highlighted positive comments within the story around the North Wales Cancer Centre but also drew members' attention to the key themes and learning within the paper. He indicated that a case study would be prepared to share learning and that a Covid-19 patient experience training module had been relaunched with a stronger focus on communication and patient/carer involvement. **QS21/62.2** A discussion ensued. Members reflected on the importance of ensuring patients maintain dignity during their treatment and in staff knowing individual patient needs and preferences. In response to a question regarding the use of bank staff at the North Wales Cancer Centre the Executive Director of Workforce and OD confirmed that generally cancer services were proactive in managing their vacancy levels and the aim was always to minimise the reliance on agency staff. However, she assured the Committee that where vacancies did exist the focus would be on establishing a relationship with a core group of bank staff so they became almost an extended team. An Independent Member felt that the 'invisible patient' element described within the story was of concern and that ward staff needed to understand the importance of getting to know a patient and their family members. A question was asked regarding feedback to the family member who had provided the story and it was confirmed that the BCUHB team member who took the story had retained contact with her and would provide formal feedback following the Committee meeting. A concern was noted around the issue of missing healthcare records when attending another centre of care and the Chair would wish to see information governance and confidentiality processes used in a more enabling way. She also welcomed the personal touch that this digital story had provided.	

QS21/62.3 It was resolved that the Quality, Safety and Experience Committee receive and reflect upon the patient story.	
QS21/63 Ysbyty Gwynedd Outbreak **QS21/63.1** The Chair introduced this agenda item and advised that an external review is being undertaken and that the report should be available for the July Committee meeting. She welcomed members of the Ysbyty Gwynedd (YG) Hospital Management Team (HMT) to the meeting. The Hospital Medical Director wished to record how sorry she and other team members were for the outbreak and the effect on patients, families and staff. A presentation was delivered by the HMT which encompassed: • The timeline of the outbreak • Contributory factors including complacency, fatigue and changes between first and second waves • Control measures and learning from key themes (leadership/behaviours; operational practice; technical and infrastructure) • Infection prevention control measures before and during the outbreak • Lessons learned – highlighted key lesson related to social distancing and adhering to behaviours particularly in shared staff welfare areas such as canteens • Approach to sharing learning - primarily an intention to become more outward facing and to improve clarity of communications • Embedding and sustaining lessons *[Mr G Evans left the meeting]* **QS21/63.2**. In response to a question regarding domestic staff and cleaning, it was confirmed that following meetings with estates and facilities teams there were now enhanced cleaning hours on 5 wards but not all. Recruitment continued and there was a clear recognition of the need to meet Covid-19 standards with interim arrangements in place via additional healthcare support workers. A member raised a concern about reference to the training of staff in the use of Personal Protective Equipment (PPE) and the HMT acknowledged that refresher training hadn't been as timely across all staff groups during the second wave but that additional resources had now been offered to Infection Prevention & Control teams with the upskilling of key staff to enable cascade of training. In response to a question around culture it was acknowledged that good leadership was critical although there hadn't been a specific ward or area where culture had been identified as a major issue. The Hospital Nurse Director added that the main areas of challenge currently were around environmental contacts and heavy use touch points such as doors and telephones. A specific champion had been identified to address this and extra cleaning had been put into place for these areas. **QS21/63.3** A conversation took place around how the HMT and wider staff within the hospital felt following the outbreak. The HMT felt it was essential and appropriate to be open and honest about what had happened although this was challenging. Teams were clear that the harm and worry caused to patients and families must be acknowledged but that a focus must be on learning lessons and preventing similar occurrences. As a leadership team the HMT felt it was their responsibility to make it as easy as possible for staff to do the right thing in terms of compliance with infection prevention processes. The Executive Director of Nursing and Midwifery recognised the difficult situation that the HMT were in and thanked them for their candour at the Committee meeting. She acknowledged how tired the staff were as a	

whole but commended them for responding to the outbreak so positively. She alluded to a perception that specific outbreaks and infection prevention control in general were still seen as predominantly a nursing issue. The Hospital Medical Director confirmed that all staff groups had taken responsibility and every clinical group was struggling to come to terms with the outbreak. **QS21/63.4** The Chair appreciated the transparency awarded within the presentation and discussion. She expressed her disappointment in that the reasons described for the outbreak were well known and were the same pressures that other health organisations were experiencing throughout the UK. She felt that leadership and accountability were key and that an enhanced check and challenge approach needed to be established. She asked whether the Committee could be assured that the same level of complacency would not return as the Hospital moved on from the outbreak. The Hospital Medical Director stated that there had been appropriate controls in place on the site however there were insufficiencies in terms of measuring compliance and in ensuring that the controls were embedded and sustainable. She added that the principle of making it hard for individuals to do the wrong thing was being followed, and it was noted that external 'critical friend' reviews would help the HMT in terms of a fresh approach. The Executive Director of Workforce & OD suggested there could be a useful exercise for the Health Board to reflect on the outbreak which could provide rich learning to help the organisation consider the effectiveness of its leadership. She also referred to the 'Stronger Together' route map which would help embed a learning culture as a positive opportunity. **QS21/63.5** The Executive Director of Primary and Community Services wished to record his thanks for the HMT's attendance in difficult circumstances and he commended the evident leadership. In terms of the outbreak he felt there was much to be learned collectively by the organisation. The Acting Executive Medical Director supported this and appreciated the candour and approach of the HMT. He asked whether there was a view as to how much of the learning from the Wrexham outbreak had filtered across other sites. The Interim Hospital Director confirmed that the HMT were sighted on the Wrexham outbreak but he felt that a more aggressive and proactive approach could have been taken to establish what actions could be taken prevent occurrence on the YG site. The Hospital Medical Director added that similarities were recognised from the report of the Wrexham outbreak and controls were put in place, however, the checking and refreshing of those controls should have been stronger to ensure they were properly embedded.	
QS21/64 Covid Update **QS21/64.1** The Chair welcomed the comprehensive update and indicated that she found the composite report approach helpful and she would wish to see this continued. She suggested that as members would have read the report she would go straight to discussion and questions. **QS21/64.2** A member enquired whether it was thought that the Health Board was sufficiently agile to respond to the ever-changing nature of the vaccination and Test Trace Protect (TTP) programmes. The Executive Director of Public Health felt that agility had been proven to date but it was difficult to know what the future might hold, for example the impact of the pilots for large gatherings. She assured the Committee that the Board would continue to work with NHS Wales and other partners to deliver what was required. In response to a question regarding vaccination communications other than via the Health Board website, the Executive	

Director of Nursing and Midwifery stated that a significant amount of work was being undertaken with Local Authority colleagues and other networks in terms of the hard to reach groups. A specific question was raised regarding the statement that over 4000 returns had been made from unpaid carers and whether the Board knew what the overall benchmark total should be. The Executive Director of Nursing and Midwifery would follow this up outside of the meeting and reply directly. In response to a point raised regarding discrepancies in take up figures across the East and West areas, the Executive Director of Nursing and Midwifery confirmed that work was ongoing but assured members that a number of vaccines were repatriated and additional clinics held. The Chair enquired how the vaccination programme would continue in the longer term once the Mass Vaccination Centres had been decommissioned. The Executive Director of Nursing and Midwifery indicated that a range of options were being considered, including consideration of 'pop up' venues with Local Authority colleagues. All options would need to take into account issues around vaccine storage and the additional challenges for delivery in a primary care setting. [*Teresa Owen left the meeting]* **QS21/64.3** The Chair referred to the statement in the paper regarding receipt of a contravention letter from the Health and Safety Executive (HSE), and the Executive Director of Workforce and OD confirmed that the requirements had already been met following a related matter around fit testing. An Independent Member enquired as to the situation with the outbreak within HMP Berwyn and the Executive Director of Primary Care and Community Services confirmed this was under control and he undertook to provide some data outside of the meeting. **QS21/64.4 It was resolved that** the Committee note the position outlined in the report	GH CS
QS21/65 Mental Health and Learning Disabilities Division receipt of and actions from the "Review of the Discharge of Mental Health Patients During the Covid-19 Pandemic" *[Gareth Evans and Teresa Owen rejoined the meeting]* **QS21/65.1** The Interim Director of Nursing for Mental Health and Learning Disabilities undertook to circulate a copy of the report prepared in August 2020 by Clare Darlington to Independent Members of the Committee. The report stemmed from an incident in March 2020 where a number of patients were inappropriately discharged from the Division back to primary care. The report found key points of learning around communications and capacity and the Interim Director of Nursing for Mental Health and Learning Disabilities confirmed that the Division accepted the findings and recommendations and had developed an associated action plan in response. **QS21/65.2** The Chair was aware that a reflective session had been held within the Division to go through the report and that it had been a challenging time for staff but she was pleased to have observed an improved communications culture in areas that she had visited. She also noted that the media coverage in 2020 had focused solely on the discharge of patients and noted that the investigation had clarified that safety net arrangements had been put in place for each patient. The Chair pointed out that the report itself had not been shared as part of the Committee papers so it was difficult for members to be assured that the Division had addressed the recommendations. She asked for the report to be shared with members after the meeting.	MS MS

QS21/65.3 A discussion ensued. An Independent Member made a comment around the use of acronyms in that they could mean different things depending on the setting and service – for example SLT was used for both Senior Leadership Team and Speech and Language Therapy. She felt that consistency and referencing of acronyms could be improved and the Board Secretary undertook to give this some thought in the wider terms of Board and Committee papers. An Independent Member enquired how many patients had been affected and it was confirmed this was over 100. The Chair advised it was a lot higher than this but could not recall the exact numbers. Another Independent Member noted there was reference to keeping in touch conversations with Local Authority leads in response to Recommendation 2 and asked if these had commenced and how any issues were escalated. The Interim Director of Nursing for Mental Health and Learning Disabilities indicated this was underway and that escalation would be through re-establishing the strategy and partnerships element within the Division. In response to a further question, he confirmed that the review of Part 1 of the Mental Health Measure had started as part of the adult and community pathway review. An Independent Member also enquired regarding the identification of harm and it was confirmed there was no evidence of actual harm although a small number of the patients discharged did go on to access mental health services. Finally, the Interim Director of Nursing for Mental Health and Learning Disabilities indicated that work continued to strengthen the Patient Carer Experience sub-groups to ensure they were more closely aligned to the Board's strategy and able to develop learning and actions from patient experience. **QS21/65.4** The Chair stated that it was not clear from the report how the actions would actually address the recommendations. She acknowledged that the service had reflected on the findings of the review, but the Committee could not be assured from the report before it that the actions would fully address the recommendations. It was agreed that the Chair would meet with the Interim Director of Nursing for Mental Health and Learning Disabilities to go through the report and action plan. **QS21/65.4 It was resolved that** the Committee note:- 1. That the division fully accepts both the findings and recommendations of the report 2. That the division has considered and stated its learning from the report, subject to the actions agreed 3. That the division has stated its actions to prevent recurrence both tactically and strategically as it plans its next steps.	LB MS
QS21/66 Mental Health and Learning Disabilities Exception Report **QS21/66.1** The Chair indicated that as members would have read the comprehensive report she would go straight to questions. An Independent Member queried why the new Divisional Director of Operations post was referred to as interim; the Chief Executive reported that moving to make some interim appointments permanent was ongoing however it was important to get it right and ensure that particular employment complications were managed appropriately. In response to a question regarding communication between the various elements of the governance meeting structure the Interim Director of Nursing for Mental Health and Learning Disabilities noted that the Senior Leadership Team coordinated and attended all meetings but he would feed this point back. [*Melanie Maxwell left the meeting*] **QS21/66.2** A question was raised how the effectiveness of mental health services was measured, ensuring the right interventions at the right time. The Interim Director of Nursing for Mental Health and Learning Disabilities noted that this was supported through the	MS

performance dashboard and the Clinical Effectiveness Group (CEG). The Chair added that the next phase of the governance review would also address committee effectiveness including the Mental Health Act Committee. The Executive Director of Public Health added that the CEG was key to delivering NICE guidance and pulling together outcomes across a wider portfolio than just mental health. **QS21/66.3** The point was made whether both children and adult mental health services should be reporting in the same way as part of the Targeted Intervention arrangements. The Executive Director of Public Health noted that children's services had different challenges but accepted that papers needed to be more focused but convey the same information to Committee members. The Chair felt it would be helpful to receive similar updates from children's mental health services but suggested this was picked up as part of the review of Committee cycles of business within the ongoing governance review. **QS21/66.4 It was resolved that** the Committee note the update from the Mental Health & Learning Disabilities Division.	
QS21/67 Quality Governance Review : Ysbyty Glan Clwyd (YGC) **QS21/67.1** The Executive Director of Nursing and Midwifery presented the paper which set out progress with the planned review based on Care Quality Commission (CQC) methodology. The review had been undertaken following a number of concerns about service provided by YGC site and the report now provided a range of organisation-wide learning around the use of data for intervention, learning and decision making. **QS21/67.2** A discussion ensued. The Chair indicated that she had expected to have received the Improvement Plan as part of the agenda pack, and the Secondary Care Nurse Director responded that the initial focus had been on strengthening governance and leadership, and implementation of 'Make it Safe' processes. The Committee were assured that a range of immediate actions had been put in place as set out in the paper, and there were other areas of progress which were difficult to articulate. The Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience stated that the Improvement Plan would be developed by the new Director of Nursing when appointed. The Chair responded that whilst she understood the reasons for the delay she remained concerned that there was not yet an agreed Improvement Plan. **QS21/67.3** An Independent Member raised a point around the self-assessment process in that the review team might not come to the same conclusions which should require the gaps to be addressed. The Secondary Care Nurse Director indicated that they would need to identify the evidence to find the common ground, and that there was extensive triangulation from a number of sources as part of the review process. In response to a question regarding how the Executive Team will ensure that the new site leadership team are supported to deliver what was required of them, the Chief Executive indicated a more proactive approach was required, to build on areas such as the use of dashboards to provide timely clinically relevant information. She referred to recent walkarounds on hospital sites and that she had been pleased to see scores displayed forward accreditation which linked in to the conversations the Board was having around a balanced scorecard approach and signalled the commitment to put patients at the heart of everything.	

QS21/67.4 It was resolved that the Quality, Safety and Experience Committee receive the update.	
QS21/68 Healthcare Inspectorate Wales Update **QS21/68.1** The Chair indicated that as members would have read the report she would go straight to questions. She enquired regarding an overdue action pertaining to ligature risk assessments and the Interim Director of Nursing for Mental Health and Learning Disabilities confirmed that although there had been extensive estates work to address this risk, new guidance meant that the risk assessments were having to be revisited. **QS21/68.2** In response to a question regarding the timeframe for a pathway of age appropriate mental health beds, the Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience undertook to obtain an update from the service and circulate this outside of the meeting. **QS21/68.3** An Independent Member noted that given the pandemic the summary of inspections for 2020-21 was on the whole positive. The Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience agreed but added a caveat that about a quarter of the inspections were follow up reviews. **QS21/68.4** A concern was raised regarding the implications of findings relating to infection prevention control at Ward 11 in YGC. It was agreed that this would be followed up by the Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience with the Executive Director of Nursing and Midwifery. **QS21/68.5** The Chair enquired how issues raised by HIW relating to independent providers were followed up, and the Executive Director of Primary Care and Community Services confirmed that this was the case, with breach notices raised where applicable but he accepted this was not clear in the paper. This would be addressed in future reports. *[Mike Smith left the meeting]* **QS21/68.6 It was resolved that** the Quality, Safety and Experience Committee receive the report for assurance.	MJ MJ MJ/CS
QS21/69 Healthcare Inspectorate Wales Maternity Review : BCU Action Plan **QS21/69.1** The Chair indicated that as members would have read the report she would go straight to questions. An Independent Member enquired how the first action relating to patient language of choice would be audited, and the Executive Director of Public Health undertook to check this with the service and confirm outside of the meeting. A formatting error against recommendations 3 and 4 was noted and the Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience would circulate a corrected version. The Chair referred to recommendation 12 around patient stories and felt that the response was very localised and should be strengthened to cover all services at Board / Corporate level. The Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience confirmed there was a plan for this level of meetings.	TO MJ

QS21/69.2 It was resolved that the Quality, Safety and Experience Committee receive the report for assurance.	
QS21/70 Quality Governance Self Assessment Action Plan (Maternity Services) **QS21/70.1** The Chair indicated that as members would have read the report she would go straight to questions. She referred to the stated timescale for national clinical audits and the green rating within the paper, but was conscious that clinical audit activity had been paused. The Acting Executive Medical Director confirmed that clinical audit had now recommenced and the Clinical Effectiveness sub group was re-engaging with this agenda with the intention of ensuring clinical audit was aligned to the development of the overarching clinical strategy. The Chair felt that on this basis the RAG rating should not be green, and the Acting Executive Medical Director undertook to pick this up with the Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience outside of the meeting. **QS21/70.2 It was resolved that t**he Committee note the report and update of the Quality Governance Self-Assessment Action Plan.	AG MJ
QS21/73 Quality & Performance Report *[Agenda item taken out of order at Chair's discretion. Kamala Williams joined the meeting]* **QS21/73.1** The Chair indicated that as members have read the report she would go straight to questions. An Independent Member noted the statement that there was a high percentage of re-referrals for mental health and asked whether this meant there were low waiting lists. The Acting Director of Performance indicated there was an upward trajectory for assessments within 28 days however there remained significant issues within children's mental health services – particularly for neuro assessments. Another Independent Member asked why there was such a widening gap between adult and children's services. The Acting Director of Performance undertook to take this away as an action to be considered at the accountability review meetings later that week. In terms of neuro assessments, the Executive Director of Primary Care and Community Services noted the challenges of undertaking these remotely with children and whilst face to face activity had increased there was a backlog. He would work with the team to provide a recovery projection over the next few months. In response to a question regarding delivery of the sepsis bundle the Acting Executive Medical Director was cautiously positive and confirmed there were conversations ongoing with the site lead clinicians regarding these responsibilities. **QS21/73.2 It was resolved that** the Committee note the report *[Kamala Williams and Jo Whitehead left the meeting]*	KW CS
QS21/71 Patient and Carer Experience Q4 Report **QS21/71.1** The Chair felt that the reporting style had matured and although there was still more to do, it was pleasing to see evidence of increased engagement and learning. She indicated that as members would have read the report she would go straight to questions. In response to questions from an Independent Member, the Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience confirmed that reference to complaints response performance included children's services, and that a central complaints	

contact point was established some 12 months ago which had helped to ensure urgent matters were escalated in a timely fashion. A point was then raised regarding patient feedback methodologies and the role of volunteers. The Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience accepted there were limitations with the current system, and feedback levels had decreased during the pandemic. A new multi-layered system, procured on a once for Wales basis, was being rolled out and would be live by end of June. Patient Experience and Patient Advice and Liaison Service teams had been trained up in its use together with some Robin volunteers. **QS21/71.2** An Independent Member raised that a common concern from families was around communication and telephones not being answered. The Executive Director of Nursing and Midwifery acknowledged that this was frustrating and set out her ambition for more ward clerks and support staff to free up nursing time more appropriately. Another Independent Member welcomed the introduction of the bereavement service which she was aware had been well-received. She also raised the 'pay as you go' TV facility in Ysbyty Gwynedd which she felt was an infection risk in terms of the touch points, and it was noted this was likely to be phased out with the introduction of ipads as an alternative. Finally, it was confirmed that photographs could be included within the 'letters to loved ones' scheme. **QS21/71.3 It was resolved that** the Committee note the ongoing planned improvement work, including review of various Health Board processes. *[Jo Whitehead rejoined the meeting]*	
QS21/72 Patient Safety Q4 Report **QS21/72.1** The Chair indicated that as members would have read the report she would go straight to questions. In response to a query regarding information on catastrophic events, the Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience reminded members that Welsh Government had stood down this reporting requirement for this year so there was no rolling comparison. He assured the Committee that the number reported was not of significant concern and he accepted that a more thematic rolling report would be helpful going forward. **QS21/72.2** A comment was made that it was difficult to track inquest data and the Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience acknowledged there were issues with the current system which was still based on the former Clinical Programme Groups structure, but would improve from July. An Independent Member asked about support to staff around inquests and it was reported that this did happen but some types of inquest did not require witness statements. An Independent Member added that she had received positive feedback from staff around the support they had received in relation to writing witness statements or attending inquests. **QS21/72.3** The Chair was pleased to note evidence of improved triangulation coming through in the report, however, she still felt that the reporting of Never Events could be strengthened in terms of closing the loop. She would wish to discuss further with the Executive Director of Nursing and Midwifery and the Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience. The Chair also referred to the section within the report on significant claims and learning. As a general point she felt it was helpful to provide details of the amount paid against each claim. She went onto refer to a specific claim around	MJ GH

delay in diagnosis of appendicitis and said that the narrative did not include learning nor was it clear which governance meeting was being referred to. The Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience would check and ensure consistency in future reports. Finally, the Chair noted reference to issues with the return of documentation and/or evidence and asked if these delays had resulted in any issues. The Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience indicated that Welsh Risk Pool had been more flexible with deadlines over the past year so these were not areas of concern. **QS21/72.4 It was resolved that** the Quality, Safety and Experience Committee: 1. Note the report. 2. Note the focus on improving learning, reducing incidents resulting in avoidable harm and the evolving improvement of assurance in this area recognising significant work remains. 3. Note the delay of the Once for Wales Concerns Management System. 4. Receive this report and provide feedback on its evolving content and layout. *[Jackie Allen and Gill Harris left the meeting]*.	MJ
QS21/75 Board Assurance Framework and Corporate Risk Register *[Dawn Sharp joined the meeting]* **QS21/75.1** The Chair reported that in consultation with the other Independent Members it had been agreed not to receive the Corporate Risk Register report as there were dates and information within the paper that did not align to the actions that the Committee was being asked to take. In addition, there were decreases in scores which were not explained within the narrative, and some of the dates when the risks were last reviewed were incorrect. She asked that these matters be resolved outside of the meeting. **QS21/75.2** In terms of the Board Assurance Framework (BAF), the Deputy Board Secretary invited questions on Appendix 1. A discussion took place regarding BAF20-14 (Security Services). The Executive Director of Workforce and OD stated there had been recognition that health, safety and security had been under-resourced and that the pandemic had also impacted disproportionately on this area. She suggested that the Board did recognise the need for additional resource and improved connectivity and stated that she would be concerned if additional support had not been mobilised by the next Committee meeting. The Chair queried whether this particular risk merited the increase in score (from 15 to 20) given its proportionality to other clinical risks within urology, cancer or ophthalmology for example. *[Jo Whitehead left the meeting]* The Executive Director of Workforce and OD noted that she did not envisage the risk remaining at 20 for any length of time and accepted the points around calibration and moderation as a whole, which would be taken back to the Risk Management Group. *[Gill Harris rejoined the meeting]* **QS21/75.3** The Chair acknowledged the amount of work going into developing the BAF which she could see was progressing positively. **QS21/75.4 The recommendation was amended and it was resolved that** the Committee review and note the progress on the Principal Risks as set out in the Board Assurance Framework (BAF) *[Dawn Sharp left the meeting]*	SEE SG

QS21/76 Annual Assurance Report on compliance with Nurse Staffing Levels (Wales) Act 2016 **QS21/76.1** The Secondary Care Nurse Director presented the paper which incorporated both the annual report and a triannual amalgamated report, highlighting that the template was prescribed on an all Wales basis. The Executive Director of Nursing and Midwifery noted that this was the first time the triannual report had been produced and it was a challenging year with the high levels of staff redeployment and therefore caution should be exercised in comparing levels to previous years. The Secondary Care Nurse Director added that the duty would also be extended to paediatric in-patient wards from October 2021. **QS21/76.2** A discussion ensued. An Independent Member referred to BAF20-25 regarding the impact of Covid-19 on staffing levels and suggested that the narrative could be more explicit to clarify this risk related to a direct and indirect impact. She also enquired whether compliance could be colour-coded but it was clarified that the template was prescribed. In response to a question from the Chair as to whether people had returned to the organisation post redeployment, it was agreed that the Executive Director of Workforce and OD would follow up this data. **QS21/76.3 It was resolved that** 1. The Committee note and support the following next steps which are incorporated into the overall Health Board recruitment and retention programme : a. Targeted focus of innovative Nurse recruitment campaigns both locally, nationally and internationally b. Succession planning for the future, ensuring we are developing our next generation leaders c. Creatively co-designing our post graduate programmes as key attractors d. Analysing workforce data to better inform Nurse recruitment and retention initiatives e. Review of implementation of new roles to support the nursing recruitment pipelines f. Expansion of quality improvement driven collaborates to assist in reducing variation and harm reduction with a zero tolerance approach g. Development of a Nurse performance dashboard as a further monitoring and assurance tool in real time h. Further analysis of deviations from previous reporting periods and analysis of the first triennial reporting period of the Act 2. The Committee support the sharing of outputs of the Nurse Staffing reviews with the Finance and Performance Committee to support changes to the Nurse staffing establishments as presented	SG
QS21/77 Patient Safety Quality Group : Chair's Triple A Report QS21/77.1 The report was noted.	
QS21/78 Antimicrobial Prescribing Policy **QS21/78.1** It was noted that the policy has been agreed at Antimicrobial Steering Group; Medicines Policies and Procedures Group; Drug and Therapeutics Group and the former Quality Safety Group. The Chair enquired how prescribers would be alerted to the changes within the revised policy – given they were substantial. The Executive Director of Nursing and Midwifery indicated there was an associated programme of training and rollout which would include primary care prescribers.	

QS21/78.2 A wider point was raised around the management of clinical policies and the route for approval. The Board Secretary confirmed she was looking at the governance route for policies with the Interim Director of Governance. The Executive Director of Workforce and OD suggested it might be helpful to consider the tiered approach taken by the Remuneration and Terms of Service Committee. **QS21/78.3 It was resolved that** the Committee approve the Antimicrobial Prescribing Policy.	LB
QS21/79 Committee Annual Report 2020-21 **QS21/79.1** The Chair informed members that in conjunction with the Executive Director of Nursing and Midwifery the annual report had been amended to reflect that delivery against a range of committee objectives had been stepped down in-year. She confirmed that she had alerted other Committee Chairs and the Board Secretary to the fact that the QSE report would look different to others when submitted to the Audit Committee workshop. [*Debra Hickman left the meeting]*. The Board Secretary added that she agreed the amendments made the report more meaningful and she would support a flexible approach but would ensure she discussed the matter with the Audit Chair ahead of the workshop. **QS21/79.2** The Executive Director of Therapies and Health Sciences referred to the attendance record within the report and suggested that it could be clearer which meetings had been held with a reduced attendance in line with governance processes during the pandemic as context for the record of attendance. **QS21/79.3 It was resolved that** pending the agreed amendment the Committee approve the annual report for submission to Audit Committee.	KD
QS21/80 Issues Discussed in Previous Private Session **QS21/80.1 It was resolved that** the Committee note the report	
QS21/81 Documents Circulated to Members 25.2.21 Operational Plan Monitoring Report and Quality Performance Report 13.4.21 Internal Audit Limited Assurance Report - MH&LD Governance Arrangements	
QS21/82 Board of Community Health Councils in Wales "Feeling Forgotten?" Report **QS21/82.1** The report was noted. The Executive Director of Nursing and Midwifery added that the Board would reflect on the report and develop its response.	
QS21/83 Issues of Significance to inform the Chair's Assurance Report To be agreed outside of the meeting	
QS21/84 Date of Next Meeting 6.7.21	

QS21/85 Exclusion of Press and Public **QS21/85.1 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.'	