Quality, Safety and Experience (QSE) Committee
Minutes of the Meeting Held in public on 6.7.21 via Teams

Present:

Lucy Reid	Independent Member (Chair)
Jackie Hughes	Independent Member
Cheryl Carlisle	Independent Member
Lyn Meadows	Independent Member
Mark Polin	Health Board Chair – observing (*part meeting)*

In Attendance:

Jackie Allen	Chair of Community Health Council (CHC) *(part meeting)*
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
Gary Francis	Interim Secondary Care Medical Director (*part meeting)*
Sue Green	Executive Director of Workforce and Organisational Development (OD)
Arpan Guha	Acting Executive Medical Director
Gill Harris	Executive Director of Nursing and Midwifery / Deputy Chief Executive
Debra Hickman	Secondary Care Nurse Director (*part meeting)*
Patrick Johnson	Interim Acute Care Director (*part meeting)*
Matthew Joyes	Acting Associate Director of Quality Assurance
Melanie Maxwell	Senior Associate Medical Director/Improvement Cymru Clinical Lead (*part meeting)*
Justine Parry	Assistant Director Information Governance and Risk (*part meeting)*
Urvisha Perez	Audit Wales (*observing)*
Geraint Roberts	Divisional General Manager Cancer Services (*part meeting)*
Neil Rogers	Acute Care Director : Ysbyty Glan Clwyd *(part meeting)*
Mike Smith	Interim Director of Nursing for Mental Health and Learning Disabilities (MHLD)
Chris Stockport	Executive Director Primary and Community Services
Caroline Williams	Performance Lead (Cancer) (*part meeting)*
Kamala Williams	Acting Head of Performance (*part meeting)*

Agenda Item Discussed	Action By
QS21/90 Chair's Opening Remarks **QS21/90.1** The Chair welcomed everyone to the meeting.	
QS21/91 Declarations of Interest **QS21/91.1** None declared	

QS21/92 Apologies for Absence **QS21/92.1** Apologies were recorded for Jo Whitehead, Adrian Thomas, Dave Harries and Teresa Owen	
QS21/93 Minutes of Previous Meeting Held on 4th May 2021 in Public for Accuracy, Matters Arising and Review of Summary Action Log **QS21/93.1** The minutes were approved as an accurate record pending an amendment to QS21/59.1 to make grammatical sense. **QS21/93.2** In terms of matters arising it was reported that the external report into the outbreak at Ysbyty Gwynedd (YG) had only very recently been received within the organisation and was therefore not available in time to share at the Committee meeting. It would be shared at the Health Board on 15th July or sooner for members once factual accuracy had been checked. An Independent Member also enquired as to progress with delivery of the sepsis bundle and the Acting Executive Medical Director acknowledged there had not been the focus required to keep this on track but this would be more evident within the next quality and performance report. The Senior Associate Medical Director/Improvement Cymru Clinical Lead assured the Committee that there was no indication of a deterioration in performance from the latest mortality data but was more of a data collection issue. **QS21/93.3** Updates were provided to the summary action log *[Neil Rogers and Mike Smith joined the meeting. Gill Harris left the meeting]*	
QS21/94 Patient Story **QS21/94.1** The Acting Associate Director of Quality Assurance presented the patient story and confirmed that members had been able to access the audio link provided. He reported that the story had previously been shared at the Patient Safety and Quality Group (PSQG) and an action had been taken from that meeting to share the story across the wider organisation not just within the specific service. **QS21/94.2** Members reflected that there were recurring themes around communication, liaison with families and making assumptions around an individual's needs and circumstances. It was also suggested that the situation could have been avoided if there had been better shared care arrangements. An Independent Member felt that the placement of specialist diabetic nurses within Emergency Departments (EDs) would also be beneficial although other members acknowledged that the core capabilities of ED clinicians should not be diluted. *[Gill Harris rejoined the meeting]* **QS21/94.3 It was resolved that** the Committee receive and reflect upon the patient story.	

QS21/95 Quality Awards, Achievements and Recognition **QS21/95.1** The Chair welcomed the positive content of the paper. **QS21/95.1It was resolved that** the Committee note the report.	
QS21/96 Quality Governance Review : Ysbyty Glan Clwyd (YGC) **QS21/96.1** The Executive Director of Nursing and Midwifery introduced the paper and felt it was worth reminding members of the context to the multidisciplinary and data review which had been undertaken following the triangulation of a number of concerns around the YGC site. She assured members that although publication of the review had been delayed due to the pandemic, work had continued to ensure that progress could be made. It was noted that the new senior leadership team would be in post by early August but that other colleagues had ensured that immediate safety concerns had been addressed in the interim. **QS21/96.2** The Acute Care Director (YGC) thanked the Committee for the opportunity to attend. He confirmed his opinion that the recommendations within the report were sound and that they offered an appropriate route to improvement. He could understand why a previous action plan had been rejected and added that he would wish to refocus the latest version to ensure it was more transformational and was able to deliver against the recommendations. **QS21/96.3** In response to a question from an Independent Member, the Executive Director of Nursing and Midwifery confirmed that the new leadership team appointments were substantive and not interim as the paper suggested. The Independent Member suggested that the newly appointed team would need to read previous reviews and reports relating to YGC, and the Executive Director of Workforce and OD acknowledged that document review was clearly part of the discovery element of *Stronger Together* and would take into account a number of previous reviews, as well as listening to people. **QS21/96.4** An Independent Member raised a point around ensuring that future reviews addressed other North Wales services that were based on the YGC site. The Acute Care Director confirmed that the Hospital Management Team were very aware that not all services on site were directly managed by themselves and this was on his radar. The Independent Member stated that Trade Union partners were looking forward to working with the new team. **QS21/96.5** Another Independent Member welcomed the reference within the action plan to openness and shared learning in terms of patient harm. The Chair felt that the action plan was now far more focused but was concerned about how long it had taken to get to this point. She asked how progress would be monitored. The Executive Director of Nursing and Midwifery indicated there would be a combination of monitoring through the Hospital Management Team site structures and the corporate Patient Safety and Quality Group, with exception reports and scheduled updates to the QSE Committee. **QS21/96.6 It was resolved that** the Committee note the report.	

[Mr Neil Rogers left the meeting]	
QS21/97 Quality and Performance Report **QS21/97.1** The Acting Head of Performance presented the report and highlighted the significant deterioration in CAMHS (Child Adolescent Mental Health Services) performance and that the report included supporting narrative around the actions being taken to address this. She suggested that in terms of the timeline for delivery of improvements, the impact would not be seen for a further couple of months. She also indicated that she had been contacted via email by an Independent Member regarding inconsistencies in infection prevention numbers in that low numbers but high rates were being reported. This had not yet been resolved. **QS21/97.2** An Independent Member expressed concern at the CAMHS situation, in particular the face to face assessments for neurodevelopment. The Executive Director of Primary Care and Community Services recognised the work to be done but this work had started. He noted that the figures were presented in the paper as percentages and did not necessarily mean there had been a severe deterioration in how the service was responding and that it more likely indicated an increase in the numbers of referrals particularly since schools reopened. He acknowledged however that the matter remained of concern. The Interim Director for MHLDS noted the increase in morbidity and set out the challenges for the Division in maintaining a balance between responding to crisis and preventative work. The Chair suggested there might be opportunities to influence national mental health targets and what was measured to provide more meaningful performance reporting. **QS21/97.3** An Independent Member noted that 11 patient falls with harm had been reported for May 2021 which was of concern. The Executive Director of Nursing and Midwifery indicated there was a planned conversation at the Executive Management Group around the falls programme and the Chair suggested that a thematic review on falls should be provided to the Committee. **QS21/97.4** An Independent Member welcomed the Executive Summary section which she found helpful. She sought clarity around the statement that some infection prevention control (IPC) vacancies remained un-recruited to as having been hindered by the complex nature of recruitment processes. The Chair recalled a similar comment regarding CAMHS recruitment. The Executive Director of Workforce and OD did not believe the processes themselves were unnecessarily complex but suggested that some services did require additional support in terms of attracting applicants, and that the processes needed to be able to recognise complex roles. She agreed to take an action away to work through assumptions around recruitment processes that had caused this phrase to be used. The Executive Director of Nursing and Midwifery was of the view that IPC was not necessarily complex in terms of recruitment, however, there was certainly a high demand for people in that field. She added that interviews were scheduled that week for a senior IPC role. **QS21/97.4** In response to a query regarding the reference in the report to a private provider having offered to deliver additional neurodevelopment assessments, the Executive Director of Primary Care and Community Services indicated this was a complex issue in terms of negotiation with the provider and the subject of ongoing	GH SG

debate amongst clinicians. He would be happy to provide a more detailed response outside of the meeting. The Chair also referred to a narrative comment about GP consultation performance but noted that no data had been provided. The Acting Head of Performance agreed to look at this. The Executive Director of Primary Care and Community Services also clarified that the reference referred to Covid-19 consultations not overall GP consultations. **QS21/97.5** Finally the Executive Director of Workforce and OD noted that Quadruple Aim 3 information appeared to be missing from the report. The Acting Head of Performance would look into this. **QS21/97.6 It was resolved that** the Committee discuss and receive the report. *[Kamala Williams left the meeting]*	CS KW KW
QS21/98 Board Assurance Framework (BAF) **QS21/98.1** The Board Secretary presented the paper which included the 12 BAF risks mapped to the QSE Committee. She confirmed that following an individual review of each risk and discussion at the Audit Committee Workshop in May there were no material changes for approval in this report. It was noted that work was progressing on how to make the best use of time at the Risk Management Group (RMG) and also mapping work against the Annual Plan and preparing for the refresh of the Living Healthier Staying Well Strategy. The Board Secretary added that the Good Governance Institute would also be offering additional support to the organisation around the BAF. **QS21/98.2** An Independent Member noted that the winter plan risk had been archived into BAF21-01 (unscheduled care) and asked that the next review strengthen the narrative to ensure it clearly covered the winter planning aspects. The Independent Member also enquired why there were no dates for delivering the target risk and the Interim Director of Governance stated that this had been discussed at the RMG with officers tasked to look at best practice to enable a timeline to be put against the target risk and to identify any gaps between that and risk appetite. **QS21/98.3**The Healthcare Professional Forum Chair felt that the issue of lack of space in terms of the organisation's estate did not come across strong enough within the BAF. The Board Secretary indicated this would be captured within another BAF risk that reported to another Committee. She agreed to include a table within future reports that identified which BAF risk was aligned to which Committee. The Interim Director of Governance highlighted the importance of service areas logging individual risks so that the RMG can consider them in the context of other risks as combined they may need escalation to the Corporate Risk Register (CRR). **QS21/98.4** The Chair referred to the appropriateness of the scoring of BAF21-12 regarding security services, which had been raised in the previous Committee meeting. She noted that it had been scored the same as the pandemic exposure risk for example and questioned whether the impact to the organisation was really comparable. The Executive Director of Workforce and OD responded that the risk level had been reviewed in light of available intelligence in terms of security incidents and breaches and the view was that nothing material had altered that risk. She reminded members that	LB LB

ligature incidents also came under security. She also advised that a deep dive review was being undertaken for security services in a future RMG meeting. The Board Secretary explained that there was work being undertaken on the comparability of scoring. The comments would be taken on board and the risk would continue to be reassessed. **QS21/98.5 It was resolved that** the Committee review and note the progress on the Principal Risks as set out in the Board Assurance Framework.	
QS21/99 Corporate Risk Register *[Justine Parry joined the meeting]* **QS21/99.1** The Interim Director of Governance presented the report which set out progress on the Corporate Tier 1 Operational Risk Register. He reported there was a strong argument at the RMG to reduce the actual risk score on three further risks but this was not yet recommended to the Committee until the RMG had been assured on the evidence behind the actions. A point of accuracy was made in terms of the use of job title Associate Chief of Staff within CRR20-05 which was no longer in use. **QS21/99.2** An Independent Member referred to CRR20-01 relating to asbestos and was surprised that the current risk had not been reduced given the number of completed actions. The Interim Director of Governance confirmed that whilst the actions had been completed, the RMG had not yet seen the evidence that they had had the required impact. **QS21/99.3** A conversation took place around the rationale as described for a reduction in target risk score and similar rationale that would support the reduction in current risk score. The Interim Director of Governance referred to the issue of timeliness and he stated that as and when the working groups had implemented actions they may determine that a lower target risk score could be achieved than originally envisaged. So a reduction in target risk score might not necessarily mean that the actions had been delivered. The Chair clarified that the Committee were being asked to approve the reduction in the target risk score on the basis of a reassessment of what the risk owners believed could be achieved and not on the basis of the actions having been completed as described in the report recommendations. **QS21/99.4** The Chair also pointed out that the graphs indicated that the target risk score was reduced in April but this was not approved at the time. The Interim Director of Governance accepted this point and would amend. He also confirmed that where actions were being archived, the controls in place would not be referred to in subsequent reports. **QS21/99.5** A conversation took place around RAG rating and it was suggested a discussion at Executive Team was required around consistency of RAG rating terminology as it was noted that green in the CRR meant completed whereas in the annual plan it meant on track but not necessarily complete. The Executive Director of Workforce and OD noted that this had been helpful learning from a recent internal audit report.	SEE SEE SEE

QS21/99.6 The Interim Director of Governance also clarified the naming conventions which applied when a risk was escalated from another Tier to the CRR. **QS21/99.7 It was resolved that** the Committee review and note the progress on the Corporate Tier 1 Operational Risk Register Report subject to the clarification on the request to reduce the target risk score. *[Justine Parry left the meeting]*	
QS21/100 Infection Prevention and Control Sub Group Update *[Debra Hickman joined the meeting]* **QS21/100.1** The Secondary Care Nurse Director presented the paper which set out the range of work being undertaken to address Infection Prevention and Control (IPC) risks against the ongoing Covid related challenges. She highlighted that Post Infection Review (PIR) compliance had improved and confirmed that a second round of reassessment of safety, care and accountability meetings were diarised before the end of July. She also confirmed that the initial findings from the report into the external review of the Ysbyty Gwynedd (YG) outbreak did not raise any immediate concerns. **QS21/100.2** In response to a question from an Independent Member, the Secondary Care Nurse Director confirmed that decant processes and hydrogen peroxide vapour (HPV) cleaning were both significant actions in high risk areas and that revisions to national cleaning standards were awaited, as was the outcome of a bid submitted by the Health Board. The Executive Director of Nursing and Midwifery highlighted environmental challenges and how these linked to unscheduled care patient flow in terms of the need to balance social distancing requirements within Emergency Departments (EDs). She assured members that teams were working to identify high risk patients and ensure a consistent approach across sites. **QS21/100.3** The Chair noted reference to an E-coli increase in April and enquired whether this was as a result of a community outbreak. The Secondary Care Nursing Director indicated this was not necessarily so and that many cases were linked to catheter utilisation and follow up. She also clarified that in terms of numbers this was not particularly significant but when reported in percentages looked more of a concern. The Chair asked how vigilance would be maintained in terms of the impact of Covid-19 community transmission rates and the Secondary Care Nurse Director explained that the Safe Clean Care (SCC) programme continued with a focus on clear and consistent messages, and the importance of staff engagement to address behavioural aspects. The Executive Director of Nursing and Midwifery added that the Executive Management Group (EMG) were receiving a Covid update at its next meeting, focusing on 'silent covid' ie; cases where the sufferer did not display any symptoms. **QS21/100.4 It was resolved that** the Committee note the content of the report. *[Debra Hickman left the meeting]*	
QS21/101 Covid-19 Update	

QS21/101.1 The Executive Director of Nursing and Midwifery presented the paper and highlighted that the organisation was very much aware of the impact of the Delta variant across North Wales. In addition, whilst instances of Covid were being seen in those who had been double-vaccinated, these individuals were not necessarily being hospitalised so the impact was more on community services. In terms of the impact on the workforce there was currently no national modelling but BCUHB was undertaking some internally. Members were informed that an outbreak in the Heddfan Unit was being monitored and assurance was given that this had been contained. The Interim Director of MHLDS added that noticeably these cases did not include severe respiratory symptoms. He also stated that of the 9 people affected all had had at least 1 dose of a vaccine. Finally the Executive Director of Nursing and Midwifery reported there were high numbers of the workforce self-isolating and that changes to self-isolation guidance was expected. **QS21/101.2** An Independent Member enquired as to what percentage of BCUHB staff had not been vaccinated and the Executive Director of Nursing and Midwifery agreed to circulate this figure, acknowledging it would be constantly changing. She confirmed there were a range of targeted actions in place to understand why staff were refusing the vaccination including intervention by line managers. The Executive Director of Workforce and OD added that processes were in place to ensure staff had easy access to vaccination opportunities and the system was also being validated as some individuals were receiving reminders when they had already received both jabs, and flowing through into GP records. The Healthcare Professional Forum Chair noted that the percentage of Medical/Dental and Non Agenda for Change staff not vaccinated appeared high (19%). The Executive Director of Workforce and OD did not feel this was an area of particular concern but she undertook to check the data and circulate a note outside of the meeting. **QS21/101.3** The Chair referred to queries and changes to guidance around the Astra Zeneca vaccine and the potential impact on travel. The Executive Director of Nursing and Midwifery set out her hope that this was resolved nationally by the Welsh Government. Finally, the Chair wished to record the Committee's gratitude to all involved in implementing the successful vaccination programme. **QS21/101.4 It was resolved that** the Committee note the position outlined in the report and provide comments on progress of the programmes and issues raised.	GH SG
QS21/102 Serious Incident Report - April and May 2021 (including separate Never Event Thematic Report) **QS21/102.1** The Acting Associate Director of Quality Assurance presented the report which provided the Committee with information and analysis on Serious Incidents and Never Events occurring in the last two months although it was noted that several months of trend data had been included to allow for period on period comparison in the last year. He indicated that longer-term thematic analysis was included in the quarterly Patient Safety Report. The Acting Associate Director of Quality Assurance highlighted that a new electronic reporting process had commenced from April 2021 and a strengthening of data could now start to be seen. He added that there was also a new NHS Wales reporting policy which would not impact upon internal BCU processes but would affect what was reported externally. He further highlighted that the Health and Safety Executive (HSE) had issued the Health Board with an improvement notice	

in relation to falls management in June 2021. This specifically related to falls risk assessments and falls training and followed an investigation into two falls incidents which occurred in 2020. Members were informed that analytical work was being undertaken to review rates of falls and not just the absolute numbers. In terms of inquests, the Acting Associate Director of Quality Assurance confirmed that a Regulation 28 (Prevention of Future Deaths Notice) was received relating to an inquest occurring in mental health services and the response had now gone to the coroner. The MHLDS as part of their response had now introduced a daily third safety huddle at end of the day rather than at the beginning of the day. **QS21/102.2** The Chair referred to a recent Ombudsman public interest report and it was confirmed that this would be reported to the next meeting. The Executive Director of Nursing and Midwifery noted that a 'grand round' event would be taking place to share learning from the ED incident and that significant work had been commenced against the World Health Organisation (WHO) checklist including a revision and standardisation of policies and audit requirements. **QS21/102.3** With regards to the analysis of falls an Independent Member enquired whether this took into account the location in terms of ward, department or area. The Acting Associate Director of Quality Assurance confirmed this was the case however he added a caveat in that the Datix reporting element was poorly configured and meant that the extraction of data was difficult to separate out between where an event took place and another location/service the patient may also be accessing. The Executive Director of Nursing and Midwifery added that rapid reviews of all falls were being introduced as PDSA in real time on the Maelor site. The Chair enquired as to the current position with regards to patient safety alerts and the Acting Associate Director of Quality Assurance acknowledged the situation regarding overdue alerts was poor and disappointing. He noted that there were now more in depth LocSSIPs (Local Safety Standards for Invasive Procedures) available through a library which had been launched, and safety checklists from Healthcare Inspectorate Wales (HIW) were also widely used. **QS21/102.4** The Chair noted that she found the thematic analysis of Never Events very helpful and that as the findings were often superficial it was not surprising that the themes were recurring. The Acting Associate Director of Quality Assurance felt there was demonstrable progress and a more positive approach to ensure comprehensive responses to Never Events. The Chair referred to the urology-related Never Event and enquired what was being done to address issues of surgical culture. The Acting Executive Medical Director indicated there was an outstanding action in terms of culture which he was now minded to consider incorporating into the wider quality-related work at YGC to ensure improvement was sustained. The Executive Director of Nursing and Midwifery also made reference to use of the WHO checklist in terms of behaviours and added that she had asked the new Director of Regional Delivery to take on board aspects of identifying gaps in the service. **QS21/102.5 It was resolved that** the Committee note the report and the significant increase in the number of falls with harm that have occurred over the last 18 months and the planned improvement work.	
QS21/103 Vascular Services Update *[Patrick Johnson joined the meeting]*	

QS21/103.1 The Acting Executive Medical Director presented the paper and highlighted that a range of supporting documentation as referred to within the Action Tracker had been provided as background information for Committee Members. He indicated that the report demonstrated progress since the Royal College of Surgeon's (RCS) review of vascular services and that in summary the process had highlighted a need for improvement in some areas. He suggested that essential to this improvement was the need for a change in culture and a perspective of working together clinically to provide multidisciplinary professional services for vascular patients that may require input from other services. This would be operationalised through the pathway implementation phase. **QS21/103.2** The Acting Executive Medical Director went on to describe that the engagement with the vascular pathway work continued through the refreshed Task and Finish Group which was now being rebadged as a Steering Group. He acknowledged the valuable input of the Community Health Council (CHC) into redrafting the terms of reference. Members were advised that the diabetic arterial pathway was a good illustration of where something previously considered to be a vascular pathway had now become more joined up as a wider pathway of care. The Acting Executive Medical Director confirmed that the secondary care pathway work had now been signed off and work continued to join up the interface. The East Area had some good examples of tracking patients through a pathway. **QS21/103.3** The Acting Executive Medical Director suggested that fundamental to strengthening the hub and spoke model was the optimal utilisation of the hybrid theatre, and noted that there were a number of documents that reflected the breadth of conversations around this issue. He also indicated that active discussions around the number of beds were ongoing, particularly in the West, and he felt it was important to recognise that the original conversation was based on the number of vascular consultants available at that given time, and were reflective of target models at that time. These aspects had clearly changed, and he felt that the conversation now needed to be focused on appropriate bed space for the management of patients who may require vascular intervention, not purely the number of dedicated vascular beds. He gave an example where a patient may be in a vascular bed but requires a procedure to be carried out on their foot by an orthopaedic surgeon. This would require a different model of care and was not entirely dependent on ring-fenced beds for vascular patients. **QS21/103.4** The Acting Executive Medical Director reported that overall there was good progress in terms of an agreement regarding surgical care of the diabetic foot. The current guidance stated that some of this care could be provided by orthopaedic surgeons and he was pleased to report there was, for the first time, agreement across the patch from this group of surgeons. This would support a truly multidisciplinary approach for the patient as opposed to looking solely at their vascular issues. Members were informed that work to refresh consultant job plans to reflect this approach had commenced, but would not be a straight forward process. The Chair was pleased to see a reference to GP engagement in the diabetic foot pathway. **QS21/103.5** In terms of a communications plan to provide assurances to patients it was reported that an early draft was in preparation. The Chair suggested that experiences shared by vascular patients around service improvement could be used as formal patient stories for the next Committee meeting. She found the Appendix describing the vascular	AG MJ

services being provided at each site very helpful. The Chair noted that the development of patient pathways and the review of the bed base was still being developed despite the length of time since the service reconfiguration and that the Committee would require ongoing assurance around progress and pace. She stated that this report provided more detail and confidence in terms of what has been progressed than previously and was also pleased to note that the Director of Regional Delivery would also be supporting the vascular work. The Chair stated that any changes made to pathways or services that differs from previous commitments made by the Board needed to be clearly communicated and explained. An Independent Member enquired how the hybrid theatre use would be monitored and the Acting Executive Medical Director set out the role of the secondary care Quality and Safety groups in terms of continuous learning. An Independent Member suggested that staff behaviours and commitment was so important that it should have been more prominent in the papers. The Acting Executive Medical Director referred to frank and encouraging discussions at a recent engagement event. The Executive Director of Nursing and Midwifery reiterated the importance of the *Stronger Together* approach and that the organisation needed to be clear around what was expected from the service. **QS21/103.6 It was resolved that the** Committee receive the update from the Vascular Task and Finish Group. *[Mark Polin joined the meeting. Gareth Evans and Patrick Johnson left the meeting]*	
QS21/104 Health and Safety Annual and Quarter 4 Report **QS21/104.1** The Executive Director of Workforce and OD presented the report and acknowledged the earlier conversation and concerns around security risks. She then highlighted the impact of the pandemic in terms of training compliance particularly those areas which require face to face delivery. The issue of manual handling compliance had been raised at the Executive Team and additional investment agreed to move the matter forward. She also hoped it would be possible to start to release some resources from within the occupational health and safety teams as the organisation and Wales as a whole moved out of the pandemic. Finally, she reported that the relationship with the Health and Safety Executive (HSE) remained positive, with a good level of trust and confidence. **QS21/104.2** An Independent Member indicated she would wish to see more rigour and pace regarding agile working and the number of staff still working from home due to pandemic restrictions. She also wished to acknowledge the exceptional engagement by occupational health and safety teams with Trade Union partners. Finally, she noted the reference to a violence and aggression training package for managers and offered to circulate a useful video on social distancing. **QS21/104.3** The Chair referred to the comment in the report about the lack of adequate changing facilities for staff and the Executive Director of Workforce and OD confirmed this had been risk assessed and plans were in hand to increase capacity. Where this was not possible a booking system had been introduced and the team were also exploring the use of pods.	JH

QS21/104.4 In response to a question from the Chair regarding the sad deaths of 2 members of staff the Executive Director of Workforce and OD confirmed that the investigations had not raised any points of concern that the organisation wasn't already aware of. The Chair also noted that non-covid related incidents in the central area seemed high. The Executive Director of Workforce and OD was aware of some issues within this area but there were also elements of proactive reporting in terms of resulting in higher numbers. She added that learning could be evidenced albeit not necessarily consistently applied and sustained. The Chair stated that the numbers provided activity but not necessarily assurance and suggested this could be included within the discussions at the forthcoming QSE workshop. **QS21/104.5 It was resolved that the** Committee note the position outlined in the Annual and Quarter 4 Report and support the recommendations identified within the findings within the delegated authority of the Committee: 1. Implement year 2 of the Occupational Health and Safety (OHS) Strategy. 2. Ensure adequate staffing is available to provide an appropriate security function to BCUHB. 3. Ensure adequate staff and premises to provide Manual Handling training 4. Establish a permanent fit test program 5. Develop further policies and safe systems of work to provide evidence of practice. 6. Establish monitoring systems from the Divisions and Hospital Management Teams to measure performance including clear key performance indicators. 7. Train senior leaders and develop further competence in the workforce at all levels 8. Learn lessons from incidents and develop further the risk profile	KD
QS21/105 Mental Health – an Update from the Adult (MHLD) Division and the Child and Adolescent Service (CAMHs) **QS21/105.1** The Interim Director of Nursing (MHLD) presented the paper. He suggested that future reports to the Committee be structured around the Targeted Intervention Improvement Framework (TIIF) domains. This was supported in principle, but the Chair suggested that including some thematic type reviews as appropriate would be helpful to ensure the Committee were sighted on any issues of significance that may sit outside of the maturity matrix. The Interim Director of MHLDS undertook to give some thought as to what might be the key themes for the next report – for example ligature risks. **QS21/105.2** An Independent Member welcomed the summary of risks and issues within the paper but that it did not address what the next stages would be, nor gave milestones to improvement. The Interim Director of MHLDS stated that there were levels of maturity that could be reported on in terms of improvement but Welsh Government had not yet provided a timeline other than a broad expectation to move to level 1 and 2 fairly rapidly. **QS21/105.3** In response to a question regarding interim appointments, the Interim Director of MHLDS acknowledged this remained an issue in terms of sustainability but there were complexities associated with some individual cases. The Executive Director of Workforce and OD reminded the Committee that there was always a role for interim expertise across the Health Board and she was working with the Executive Director of	MS

Public Health regarding the plan for the MHLD Division to ensure short term and longer term stability. **QS21/105.4** The Chair acknowledged the amount of work to be delivered as part of the targeted intervention and the preventative and early intervention side of the service which will need the development of less medicalised service models. The increase in psycho-social cases will need good partnership working with Local Authorities. She referred to the need to significantly improve access to psychological therapies and that the Committee needs to see rapid progress on this. She requested a thematic analysis on psychological services to the November meeting. **QS21/105.5 It was resolved that** the Committee: 1. Note the update from both the Mental Health and Learning Disabilities Division, and Child and Adolescent Mental Health Services (CAMHS). 2. Agreed to the proposed approach to reporting in future to include joint reporting between MHLDS and CAMHS. *[Mike Smith left the meeting]*	MS
QS21/106 Primary and Community Care Quality Assurance Report **QS21/106.1** The Executive Director of Primary Care and Community Services presented the paper, reminding members that primary care was wider than general medical services. He reported that bi-annual 'five domains' assessment of the sustainability of GP practices was being refreshed to take account of Covid related matters. In terms of access to primary care services he acknowledged that there was noise in the system but this was wider than just BCUHB. A related press release and media video was being launched in North Wales to try and address expectations of the service by members of the public. He noted that the triage aspect appeared to be the main point of dissatisfaction with patients but there were no plans to remove this process just yet. He reminded members that face to face consultations continued to be made available when they were needed. **QS21/106.2** An Independent Member expressed concern at the backlog issue and the impact of the likely continuation of social distancing measures. She also felt that sustainability of the GP workforce was of concern. The Executive Director of Primary Care and Community Services indicated that refreshing the assessments would provide a clearer picture of any hotspots. In terms of sustainability, he confirmed that assessing the age profile of the workforce would provide an indication if there was a cohort of clinicians thinking about retirement or leaving the service. With regards to the backlog, work was being undertaken with practices to support them in triaging their chronic patients. **QS21/106.3** An Independent Member enquired regarding the ability of general dental practices to offer the full range of services including aerosol generating procedures (AGPs) once social distancing restrictions were removed. The Executive Director of Primary Care and Community Services confirmed that all practices were currently providing these where needed, however it must be acknowledged there were increased risks and the Health Board and practices had a duty of care to their staff. The Chair enquired whether NHS dental waiting lists were being impacted upon by the prioritisation of private work. The Executive Director of Primary Care and Community Services noted	

that this tension would always be there but monitoring of Units of Dental Activity continued to be monitored. He would also check whether access standards continued to be reported to the Finance and Performance Committee. **QS21/106.3 It was resolved that** the Committee: 1. Note the significant contribution to healthcare provision made across all primary care and community services during the pandemic; 2. Note the increased demands and challenges facing the primary care sector in particular, and actions being taken to support contractor services.	CS
QS21/107 Clinical Audit Forward Plan 2021/22 **QS21/107.1** The Senior Associate Medical Director / Improvement Cymru Clinical Lead presented the paper, highlighting that much audit work had been stood down in the previous year due to the pandemic. She confirmed that the Audit Plan had been discussed at the June 2021 Audit Committee and the Committee had noted concerns around resource issues for the COPD audits and also had felt that current services of concern (e.g., vascular) weren't appropriately reflected within the Tier 1 and Tier 2 schedules. To address this, an appendix had been included for the QSE Committee of Tier 3 audits to work towards the ability to consider whether some needed to move up to Tier 2. The QSE Committee were being asked at this stage to receive the documentation as work in progress. The Committee were however provided with assurance that leads had been identified for the Falls and Fragility Fracture audits which could now be progressed. The Acting Executive Medical Director added that audit teams were looking at thematic groupings of audits to draw out dominant issues as they emerge. **QS21/107.2** The Chair was pleased to see reference to a compliance with LocSSIPs audit but felt that the start date of January 2022 seemed rather late. The Senior Associate Medical Director / Improvement Cymru Clinical Lead indicated this was due to a resource issue but she would follow up the matter outside of the meeting to determine if the audit could be brought forward. **QS21/107.3** The Interim Director of Governance clarified that once the Committee had approved the plan it would therefore not need approval at the Joint Audit and QSE meeting which would be stood down as part of the Integrated Governance Framework (if agreed by the Board later that month). **QS21/107.4 It was resolved that** the Committee approve the draft Clinical Audit Plan 2021/22 as the current working document.	MM
QS21/108 Mortality Report **QS21/108.1** The Senior Associate Medical Director / Improvement Cymru Clinical Lead presented the slides which were cumulative and included information for the whole of 2020. She drew attention to the Medical Examiner service which had been in place on the YGC site for the best part of a year. Further capacity had been achieved through the recent commencement of a scanning element. Whilst early indications about the service were positive there was not yet sufficient comparative data. In terms of primary care it	

was noted that as the Medical Examiner service rolled out and was awarded legal status, there would be a requirement for GPs to undertake mortality reviews also. **QS21/108.2** An Independent Member asked why in-patient mortality information had not been made available by YG. The Senior Associate Medical Director / Improvement Cymru Clinical Lead indicated that this site had traditionally utilised their morbidity and mortality meetings to review deaths and had struggled to align these to the Stage 2 audit process during the pandemic, and whilst lessons were shared internally there was a lack of evidence of lessons learned more widely. The site were however now starting to use the Datix system. **QS21/108.3** An Independent Member referred to the sepsis performance and the impact upon mortality. The Senior Associate Medical Director / Improvement Cymru Clinical Lead confirmed this was being tracked via the Comparative Healthcare Knowledge System (CHKS) and whilst there were some recent concerns that sepsis was increasing, it in fact wasn't and performance seemed in line with the rest of Wales. It was acknowledged that there could still be unavoidable deaths, and monitoring would of course continue. In response to a question around reporting of areas of concern, the Senior Associate Medical Director / Improvement Cymru Clinical Lead confirmed that CHKS data was scrutinized at the Clinical Effectiveness Group and that any key findings would be reported to the QSE Committee. **QS21/108.4** The Acting Executive Medical Director suggested that the utilisation of emerging data was key and that this function needed to be properly resourced. He indicated that a clinical lead for mortality was to be appointed for North Wales which would allow for easier gathering and oversight of pieces of work across both primary and secondary care. **QS21/108.5** An Independent Member noted reference to key learning that external and medical causes of death need to be better documented by staff within children's services, and it was confirmed that progress with this aspect relied on movement with the Medical Examiner approach. **QS21/108.6** The Chair welcomed the progress with mortality reporting however she made a general comment that some actions were more about monitoring requirements and not how the issue would be addressed. She felt that actions needed to be smarter going forward. *[Melanie Maxwell left the meeting]* *Committee agreement??*	
QS21/109 BCUHB Corporate Safeguarding Annual Report 2020/21 **QS21/109.1** The Executive Director of Nursing and Midwifery presented the paper on behalf of the Associate Director of Safeguarding. She noted that there was a substantial improvement in the collaborative work on the safeguarding agenda being undertaken across Wales. She indicated there had been some typographical errors on page 7 of the report and a corrected report was now available. The Chair confirmed that the Mental Health Act Committee had discussed the Deprivation of Liberties Annual report in detail at its last meeting.	

QS21/109.2 An Independent Member suggested that the acronym ACE (Adverse Childhood Experience) was not appropriate as the experience was not "ace"for the children and young people but far from it. The Executive Director of Nursing and Midwifery acknowledged this point and agreed that it would be fed back to the safeguarding team. **QS21/109.3** Another Independent Member welcomed the report which she felt provided some excellent real life examples. **QS21/109.4** The Chair made reference to the new liberty protection safeguards and that the Deputy Minister was seeking assurances that Health Boards were ready for the implementation and for the anticipated increase in applications. She requested that the Committee receive an update on this matter in November. **QS21/109.5 It was resolved that** the Committee receive the Annual Report for the period of 2020-2021 noting the progress, assurance and the innovative work led by the Corporate Safeguarding Team to implement learning throughout the organisation to help keep our patients, staff and organisation safeguarded.	GH GH
QS21/110 Planned Care Recovery Update *[Gary Francis joined the meeting]* **QS21/110.1** The Interim Secondary Care Medical Director presented the paper which set out progress against the recovery plan for planned care. He highlighted a range of key points. Firstly, he noted that the actions were currently mainly around the validation process and that the nature of waits varied from urgent cancer diagnosis, through to ophthalmology and orthopaedics. He reported that the approach for validation was similar across all specialties with recognition of the urgency of some cases. Secondly, he confirmed that a table-top post-validation clinical exercise was being undertaken as an added safeguard for patients following which a letter and questionnaire were sent to the patient. In terms of non-responders, GPs were currently not being asked to assist but this may potentially need to be the case if there were a large number of patients that the Health Board could not trace. Following the validation period the Board would move into the delivery phase, and it was noted that a range of options were described in the paper one of which was "pullback" (a long term project to return to pre-pandemic levels). The Interim Secondary Care Medical Director stated that an assumption for delivery was the ability to restart elective activity and that there be no further surge in Covid cases, together with the availability of support services such as endoscopy and diagnostics. He also reported that in the interim there were regular harm reviews of patients which unfortunately were identifying more patients in the later stages of disease/condition presentation. **QS21/110.2** An Independent Member raised that the paper focused too much on numbers and not quality and safety aspects, and that it would be useful to link complaints relating to waiting times to the process. She also suggested that the patient questionnaire could ask additional questions around the economic impact to the patient, for example sick pay issues. The Interim Secondary Care Medical Director agreed to consider these suggestions further. The Independent Member also noted that the paper made reference to restarting a conversation around increase in bed numbers and wondered if this would create a conflict with the Safe Clean Care programme which	GF

required increasing bed spacing. The Interim Secondary Care Medical Director acknowledged this was challenging as understandably infection prevention and control was essential but the requirements did impact on bed footprint. The Executive Director of Nursing and Midwifery felt that a risk assessed approach would need to be followed. Another Independent Member noted the reference to returning to pre-Covid levels and reminded the Committee of the long waiting times that the Health Board had before the pandemic. She referred to the need for a focus on transformation if waiting times were to be address to a safe, satisfactory level. The Interim Secondary Care Medical Director made the point that pre-covid performance levels were somewhat relative now but that the vision was to provide timely care for all patients and achieving improved outcomes through transforming care. **QS21/110.3 It was resolved that** the Committee note the actions and mitigations being taken to recover the Planned Care waiting lists which have increased during the Covid-19 pandemic as a result of planned care activities having been curtailed to address the surge of admissions. *[Gary Francis left the meeting]*	
QS21/111 Suspected Cancer Pathway Update *[Geraint Roberts and Caroline Williams joined the meeting]* **QS21/111.1** It was reported that a Suspected Cancer Pathway (SCP) was a new Welsh Government target which requires Health Boards to diagnose and treat at least 75% of cancer patients within 62 days of the first suspicion of cancer. The Divisional General Manager felt this was a realistic if challenging target and noted that BCUHB had persistently performed above the all Wales average with the May 2021 figure being 73%. He noted that urology and colorectal cancer performance was currently the most challenged. The paper set out a range of actions to improve performance further including pathway work, the introduction of Faecal Immunochemistry Testing (FIT) for symptomatic bowel patients. In addition £2m had been secured for further improvement work and a business case was being developed for one stop clinics. **QS21/111.2** An Independent Member enquired as to the timeframe for improvements to urology and the Performance Lead indicated that a South Wales pilot was being evaluated with a business case going to the Transformation Group later that week for approval. She was hopeful that a pilot could first commence in Bangor area. The Independent Member also enquired as to the timeframe for the business case for endoscopy capacity and the Performance Lead indicated that as it had a recruitment element it would take longer than hoped. **QS21/111.3 It was resolved that** the Committee note the contents of the paper.	
QS21/112 Sub Group Chairs' Triple A Reports **QS21.112.1** Patient Safety Quality Group 15.6.21 The report was noted. **QS21.112.2** Strategic Occupational Health and Safety Group 25.5.21 The report was noted.	

QS21.112.3 Clinical Effectiveness Group 27.4.21 and 17.6.21 The report was noted. **QS21.112.4** Patient and Carer Experience Group 29.4.21 The report was noted.	
QS21/113 Issues Discussed in Previous Private Session **QS21/113.1 It was resolved that** the Committee note the report	
QS21/114 Documents Circulated to Members **QS21/114.1** The following were noted: 10.5.21 Primary Care Mental Health Discharges Report 22.6.21 Limited Assurance Internal audit reports	
QS21/115 Issues of Significance to inform the Chair's Assurance Report **QS21/115.1** To be agreed outside of the meeting, but to include concerns and risks around CAMHS.	
QS21/116 Date of Next Meeting Private workshop 24.8.21 Committee (public session) 7.9.21	
QS21/117 Exclusion of Press and Public **QS21/117.1 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.'	