Quality, Safety & Experience (QSE) Committee

Minutes of the Meeting Held in public on 19.3.19 in The Boardroom, Carlton Court, St Asaph

Present:

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

In Attendance:

Ms Clare Bevan	Director of Quality, Safety & Patient Experience WAST (for Minute QS19/25+27)
Mrs Deborah Carter	Associate Director, Quality Assurance
Mr Steve Forsyth	Director of Nursing Mental Health & Learning Disabilities (MHLDS) (for Minute QS19/38)
Mrs Sue Green	Executive Director of Workforce & Organisational Development (OD)
Ms Debra Hickman	Secondary Care Nurse Director (for Minute QS19/48)
Dr Louise Howard-Baker	Assistant Director, Pharmacy (for Minute QS19/37)
Dr Evan Moore	Executive Medical Director (part meeting)
Dr Jill Newman	Director of Performance
Dr Berwyn Owen	Chief Pharmacist (for Minute QS19/37)
Miss Teresa Owen	Executive Director of Public Health
Ms Dawn Sharp	Assistant Director and Deputy Board Secretary
Dr Chris Stockport	Executive Director of Primary and Community Services
Mr Adrian Thomas	Executive Director of Therapies & Health Sciences

Agenda Item Discussed	Action By
QS19/24 Chair's Opening Remarks The Chair welcomed everyone to the meeting.	
QS19/25 Patient Story **QS19/25.1** Members were shown a short video illustrating the difficult experience of a patient and her relatives involving the Welsh Ambulance Service and the Health Board. The Director of Quality, Safety and Patient Experience from Welsh Ambulance Services NHS Trust was present and outlined the positive joint work that had been undertaken by the Health Board and Trust to address the issues highlighted by this incident and improve	

services in terms of the overall patient journey, with particular focus on ambulance and handover delays. The Director also explained the review of Amber calls as part of the discussions (see minute QS19/27) **QS19/25.2** The Chair referred to the recent update that had been presented to the Audit Committee in relation to Ambulance handover. Whilst welcoming the reduction in Ambulance handover delays, the report to the Audit Committee had highlighted concerns regarding the associated risk transfer in terms of 'corridor nursing' and had requested assurance that this was being managed. The Associate Director of Quality Assurance set out the overall context and the appropriateness of transferring the risk to the hospital and reminded Members of the greater clinical risks faced by the wider community in circumstances where there was no ambulance resource as a result of handover delays. This was acknowledged by the Committee, however members raised concerns over some recent experiences of patients in the Emergency Departments. It was agreed that members would share individual case information outside of the meeting with the Associate Director of Quality Assurance. **QS19/25.3** Discussions continued with regard to the demand for Advanced Paramedic Practitioner roles in both the Ambulance Service and Health Board as part of the ongoing development of multidisciplinary team-working in primary and community services. Members acknowledged the benefits of moving these discussions forward in partnership and the importance of joint workforce planning going forward. The Executive Director of Workforce and Organisational Development agreed to initiate discussions along with the Executive Director of Primary and Community Services. **IT WAS RESOLVED THAT:** (1) the actions being taken to improve services for patients be welcomed; and (2) the Executive Director of Workforce and Organisational Development initiate workforce planning discussions as outlined.	SG
QS19/26 Listening & Learning From Experience Report *The Executive Medical Director joined the meeting.* **QS19/26.1** The Associate Director Quality Assurance presented the report which provided a summary of the patient/service user experience within BCUHB in line with the Health Board's mandatory responsibility to listen, learn and act on feedback (Welsh Government, 2015a). It set out the overall aim for the Patient and Service User Experience Strategy 2019 -2022 which was to promote and sustain a shared ambition for patient/service user experience across the Health Board. This includes identifying key themes and trends, interventions arising from these, and detailing key actions aimed at improving the capacity and capability of BCUHB to listen, learn and act on service user feedback in the 2019/2020 strategy work plan. The format of the report had been reviewed by a working group and it was recognised it was work in progress. The Committee were asked to support the change in name of the Patient Advice and Support Service to the Patient Advice and Liaison Service	

to assist service users to understand the function in line with a well recognised identity. Members agreed that this would be beneficial and supported the change. **QS19/26.2** Members welcomed the revised format of the report and suggested further improvements going forward to present the information in a positive way, condense the information where possible and ensure that graphs were dyslexia friendly. It was agreed that any further feedback on the report or the draft strategy would be forwarded by the end of April 2019. **IT WAS RESOLVED THAT** : (1) progress be noted and Members forward feedback on the report and the draft Strategy to the Associate Director Quality Assurance by the end of April 2019; (2) the renaming the Patient Advice & Support Service (PASS) to Patient Advisory Liaison Service (PALS) in line with the national recognised identity of this service by service users be ratified.	All
QS19/27 Discussion with Wales Ambulance Services NHS Trust - Amber Review Report from Emergency Ambulance Services Committee (EASC) *(Item taken in conjunction with QS 19/25)* **QS19/27.1** The Director of Quality, Safety & Patient Experience for WAST described the review of the Amber calls within the Welsh Ambulance Services' (WAST's) clinical response model, undertaken by EASC. The 'Amber' category of call was for those patients with serious conditions that were not immediately life-threatening but which were urgent and might need treatment and care at the scene or rapid transport to a healthcare facility. This was an independent review using an expert reference panel which had been launched in May 2018 to understand whether there:- • Was a systemic problem with the Amber category that was resulting in worsening outcomes for patients? • Were patients in the Amber category waiting too long for an ambulance response and if so, what was the impact on their health and experience? **QS19/27.2** The review made a number of recommendations including: • Ensuring that planned resources were sufficient to meet expected demand • The ambulance service must deliver against its planned resource • Health Boards' must take appropriate actions to ensure that lost hours for ambulances outside hospitals reduce • The longest waits for patients in the community must be reduced **QS19/27.3** There was discussion about the numbers of calls in each category and the geographical challenges across North Wales contributing to response times. The Committee noted the significant reduction that had been achieved in ambulance handover delays and whilst it was recognised that there are still	

improvements to be made, this would assist in reducing lost hours for ambulances and long waits for patients in the community as well. **IT WAS RESOLVED THAT** the report be received and the reductions in Ambulance waits be welcomed.	
QS19/28 Declarations of Interest There were no declarations of interest recorded at the meeting.	
QS19/29 Apologies for Absence The Chair acknowledged apologies of absence received from Gareth Evans, Gill Harris, Melanie Maxwell, Andy Roach and Mark Thornton.	
QS19/30 Minutes of Previous Meeting Held in Public on 22.1.19 for Accuracy, Matters Arising and Review of Summary Action Log **QS19/30.1** The minutes were agreed as an accurate record subject to noting the presence of Lyn Meadows from Minute number 19.4.1. **QS19/30.2** Updates were provided to the summary action log and recorded therein. The Chair noted a number of actions had not been completed and were overdue. Members were informed that some of the actions had been included as part of the Board papers. The Chair requested that any actions arising from the QSE Committee be reported back to the QSE Committee. The updates should also fully meet the agreed action before it can be closed.	
QS19/31 Public Accounts Committee (PAC) **QS19/31.1** The Associate Director Quality Assurance provided the Committee with verbal feedback from the recent attendance by the Health Board at the Public Accounts Committee. **IT WAS RESOLVED THAT** the update be noted.	
QS19/32 Integrated Quality & Performance Report (IQPR) **QS19/32.1** The Chair apologised for the report having only been circulated to Members the previous day instead of on the previous working day as had been agreed. The Chair outlined discussions with the Director of Performance going forwards in order to balance the receipt of the most up to date information against the current difficulties with the data only becoming available on the 10th working day of the month. The report outlined the key performance and quality issues that were delegated to the Committee. This month saw the third presentation of the report in the new format with all measures presented in	

Chapter form as per the Health Board version. The Summary of the report was now included as an Executive Summary within the report itself. The Director of Performance explained that the 2019/20 Annual Delivery Framework was yet to be issued by Welsh Government. **QS19/32.2** Members suggested further improvements to the format of the report in terms of consistency and correcting nuances within the document, quality supporting narrative, the ongoing education of leads and the importance of data only being incorporated and presented in a public arena once verified. Further consideration was to be given to the falls data as presented in terms of what was included going forward. The Executive Director of Public Health referred to the Child Adolescent Mental Health (CAMHS) information and the current backlog in central. A deep dive session was to be held and would form part of the continuous improvement programme. Members noted that a Board development session on 18th April was planned. The Executive Director of Public Health confirmed that she was the Executive Lead for CAMHS as the service will not be transferring to the Mental Health and Learning Disabilities Division as previously discussed. The Chair asked that the IQPR be updated to ensure that the correct Executive Leads were identified. A CAMHS divisional update would be provided to the next meeting in May. Concerns were also expressed about the accuracy of the performance being reported for GP practice opening hours. The Executive Director of Primary and Community Services agreed to discuss this further outside the meeting with the Director of Performance. **IT WAS RESOLVED THAT:** the report be noted.	JN TO CS
QS19/33 Update on Infection Prevention and Control across BCUHB (*Item taken following QS19/38)* **QS19/33.1** Members welcomed the positive update from the Associate Director of Quality Assurance. The need for all Health Boards to reduce avoidable infections remained a high priority across Wales and continues to be scrutinised. Healthcare-associated infection, incorporating decontamination, cleanliness and antimicrobial resistance, remained on the corporate risk register. This had been reviewed by the corporate nursing team and remained with a combined risk score of 20. (Likelihood = 4, Impact = 5). A wide range of mitigating actions and control measures were in place which included implementation of the Safe Clean Care Campaign. Key issues highlighted in the report included: • A brief summary of infection performance data for key infections targets, including benchmarking against other Welsh Health Boards. • An update on the Safe, Clean, Care (SCC) campaign. • Update on the Welsh Government review of the decontamination of medical devices across BCUHB. • Update on improvements to environmental cleanliness across BCUHB.	

QS19/33.2 Members referred to recent walkabouts and the positive feedback received, particularly in terms of the ward dashboard performance. In terms of performance the Health Board was now positioned 3rd best in Wales. **IT WAS RESOLVED THAT:** the current performance in relation to key infections, and how BCUHB benchmarks with other Welsh Health Boards be noted together with the progress of key elements of the Safe Clean Care Campaign.	
QS19/34 Health & Safety (H&S) Update **QS19/34.1** The Executive Director of Workforce & OD presented the paper which provided an update on the actions approved by the Health Board at its meeting on 1st November 2018. The Board had recognised that the lack of a visible functioning system and structure for the effective management of health and safety presented a significant risk to the organisation. The recruitment of a new Associate Director of Health and Safety and Equality had recently taken place and the new appointee was due to take up post on 13th May. The two Heads of Health and Safety were now also in post and were having a positive impact in addressing the key risks which included a fundamental review of security arrangements. **QS19/34.2** Following concerns raised regarding the process for the management of RIDDOR reporting, a revised interim process had been implemented to ensure: • Central decision making and reporting to the Health & Safety Executive (HSE) through the Health and Safety team; • Joint review of clinical RIDDORS between H&S and Quality team to ensure consistency of decision making and identification of themes; • Proper/timely investigation and learning from incidents is undertaken. **QS19/34.3** Between 1st January 2019 and 28th February 2019 there had been 11 staff safety reports and six patient safety reports. As a result of recent chemical exposure incidents, the HSE had indicated that they would be visiting the Health Board to investigate. The Health and Safety Team would be managing the preparation and arrangements for the visit. Evaluation of the process would be undertaken and a Procedure was to be drafted for approval though the Health and Safety Group in May 2019 (following commencement of the new Associate Director). In addition, agreement would need to be reached in relation to the reporting of such incidents moving forward as this will move from the Terms of Reference for the Quality and Safety Group (QSG) to Health and Safety Group (HSG) from 1st April 2019. **QS19/34.4** The need for a systematic approach to managing Health and Safety was to be documented in a 3 year Improvement Plan in line with the Workforce Strategy. Members questioned whether the three-year timeframe was too	

long. The Executive Director confirmed that all actions in the plan would be progressed simultaneously and an update in terms of percentage compliance against each of the actions would be provided each year. The Committee also emphasised the importance of taking forward the Health and Safety agenda in partnership with staff side. **QS19/34.5** The lack of a visible functioning system and structure for the effective management of health and safety was previously noted as a significant risk to the organisation. The current entry on the Risk Register had been reviewed and updated from an initial risk score of 20 (L4xC5) 31/03/2016 to a risk score of 15(L3xC5) 28/01/2019. Members expressed concern that the risk score had been reduced given that the improvements were not yet embedded and that the governance structures were still to be implemented. The Executive Director explained the rationale given the current wording of the risk and agreed to reconsider the scoring in the context of an updated risk description. The Executive Director confirmed that delivering against the actions outlined supported the delivery of the recommendations set out within the Internal Audit Report of 2018. **IT WAS RESOLVEDTHAT:** (1) the Committee note the position outlined in the report; and (2) the Executive Director of Workforce and OD review the current tier 2 risk entry description and scoring.	SG
QS19/35 Draft Annual Quality Statement 2018-19 *(Item taken following QS 19/33)* **QS19/35.1** The Associate Director of Quality Assurance presented the draft Annual Quality Statement (AQS) for comments / feedback on content. The AQS provided an open and honest overview in terms of the quality agenda of the Health Board's services, progress against the previous year's priorities, other areas of development and achievements for the past year. It also provided an overview of areas for focused improvement for the coming year. Data contained within the AQS related to year end quality measures that had been presented to the Committee prior to the AQS inclusion. To support the easy access approach as required for the AQS the data was presented where appropriate as an infographic (as used in the early pages in the draft AQS document). The working draft AQS had been developed following submissions across the Health Board and formatting would take place during the final stages and following feedback from all the groups/committee. **QS19/35.2** Members made a number of suggestions regarding the document being too secondary care focussed and including additional information regarding other services; the focus for next year being to demonstrate improvements in organisational learning and ensuring that the Wales for Africa references provided clarity regarding the wider international health links that	

the Health Board had. Members were encouraged to provide any further feedback to the Director by the end of the first week of April. **QS19/35.3** The Chair advised the Committee that a discussion had taken place at the Audit Committee with the Welsh Audit Office with regards to reporting progress within the AQS in relation to the Clinical Audit Plan and that further advice is being sought. **IT WAS RESOLVED THAT:** the comments put forward by the Committee be noted and any further feedback by Members be submitted to the Director by the end of the first week in April.	All
QS19/36 Committee Annual Report 2018-19 **QS19/36.1** The Associate Director of Quality Assurance presented the draft Committee Annual Report for 2018-19 which had been prepared on a BCU-wide template. The report would require further amendment to incorporate themes from the March Committee meeting and was to be submitted to a workshop of the Audit Committee on the 14th May 2019. Members suggested a correction to the reference regarding an external Health and Safety report. The Committee agreed to provide any further feedback to the Office of the Board Secretary by the end of the first week in April, including any proposed changes to the Terms of Reference to allow for Chair's Action to be taken to submit to Audit Committee workshop. **QS19/36.2** The Chair referred to a workshop she intended to hold to review the work and cycle of business of the Committee to improve effectiveness and review the plan for 2019/20. **IT WAS RESOLVED THAT:** (1) the comments referred to above be taken into account and any further feedback be provided to the Office of the Board Secretary by the end of the first week in April.	All LR/KD KD
QS19/37 Pharmacy & Medicines Management Annual Quality and Safety Report 2018-19 *(Item taken immediately after AS 19/34)* **QS19/37.1** The Chief Pharmacist presented the report which provided an annual statement to the Committee on Pharmacy & Medicines Management's Quality and Safety using the Health & Care Standards Framework. Risks highlighted in the report related to: • Pharmacy support to Mental Health Division; • The replacement of the pharmacy robots in Ysbyty Gwynedd and Wrexham Maelor; • Medicines shortages; • Pharmacy support to cancer services in Bangor and Wrexham; • Recruitment	

QS19/37.2 Members noted the emphasis being placed on moving to an electronic prescribing system which would follow on from the implementation of a new NHS Wales pharmacy system of which the Health was in the second tranche. It was agreed to make a number of minor drafting changes to the document prior to its presentation to Board. **QS19/37.3** Members also raised the issue of sickness in Ysbyty Gwynedd being considerably higher than the other two hospital sites. The Chief Pharmacist explained that a significant number of staff being on maternity leave and temporary staffing support had been contributory factors. **QS19/37.4** It was agreed that a further report would be prepared for the September meeting of the Committee and that this would feature on the cycle of business going forward (in addition to the Annual report being presented in March). The report would focus on key risks and how these were being managed, performance indicators together with details of lessons learnt and implementation from incidents. The Chair agreed to discuss the detail of the report with the Chief Pharmacist outside the meeting. **QS19/37.5** Members particularly welcomed the work undertaken on suspected medication-related admissions that had been tracked by Wrexham Maelor Hospital Pharmacists since April 2006 in a safety programme devised and led by one of the Patient Safety Pharmacists. Despite being constrained by limited resources, the programme had prompted some notable positive local/national changes in practice benefiting NHS Wales' patients, staff and beyond. The Chief Pharmacist agreed to give further consideration to how this might be rolled out across all three sites in North Wales and linking in with the Quality Improvement Hub. **IT WAS RESOLVED THAT:** (1) the Committee note the report and recommended it to Board subject to minor adjustments discussed at the meeting; (2) a further report be prepared for the September meeting as outlined above; and; (3) the Chief Pharmacist give further consideration to how the work undertaken on suspected medication-related admissions can be rolled out across all three hospital sites.	LR BO
QS19/38 Mental Health & Learning Disabilities Division Update on Quality Improvement Governance Plan *(Item taken immediately after QS19/37 which was taken out of agenda order). The Director of Nursing (MHLDS) joined the meeting for this item.* **QS19/38.1** The Director of Nursing (MHLDS Division) presented the report which provided an update on the Quality Improvement and Development Plan. Key achievements noted in the report included: • Improvements to pathways particularly Older People's Mental Health (OPMH)	

• Staff engagement initiatives and communication • Improvements to the environment • Clinical governance arrangements • Proposed changes to the workforce **QS19/38.2** The report also highlighted the direction of travel and key actions for delivery over the next 90 days which would focus on: • Production of a Division wide action plan that engages with each of the area teams • Development of the quality improvement strategy to articulate what good looks like for sustained improvement **QS19/38.3** Whilst welcoming the report and positive progress, members expressed concerns with regard to the report not providing the necessary detail on how the actions aligned to the strategy with clearly articulated impacts and timelines. The Director of Nursing emphasised the importance of embedding the necessary culture change and the positive feedback from the latest two Healthcare Inspectorate Wales (HIW) inspections which demonstrated sustained improvements. In response to questions relating to savings targets the Director outlined the reporting arrangements to the Finance and Performance Committee and the need to pump prime the new service model. The Chair stated that from an assurance perspective it was important for the report to address all areas for improvement and to clearly articulate how organisational learning was being progressed. Reference was made to previous discussions at the Special Measures Improvement Framework (SMIF) Task & Finish Group and the associated sign off for the mental health actions, and the need for the information and evidence to be presented to the Committee for review. This was particularly important given the continued deterioration in the mental health performance measures in the IQPR with little narrative to explain the worsening position. Members felt that whilst the report provided a lot of commentary about the positive improvements being made as part of the TODAYICAN initiative, there was no acknowledgement or narrative about the current performance levels or clear plans to address areas in need of improvement. The Chair also explained the importance of providing detail on the identification and implementation of lessons learnt as part of a balanced report along with progress against HIW recommendations. **QS19/38.4** In order to move matters forward it was agreed to receive an supplementary update from the Mental Health Division addressing additional areas of improvements and request an update from the Director for Mental Health and Learning Disabilities. **IT WAS RESOLVED THAT:** (1) the contents of the report be noted;	AR/SF
QS19/39 Quality & Safety in Primary Care *(Item taken following QS 19/36)*	

QS19/39.1 The Executive Director of Primary & Community Services presented the report which provided an overview of the arrangements in place in relation to the quality and safety of primary care services. Demand for services across the NHS and care services was increasing; in addition there was a strategic direction to care for patients closer to home where safe to do so. Across primary care there were also challenges in ensuring that the clinical multi-professional workforce was available to meet demand. The Health Board was continuing to support recruitment campaigns, along with the development of training and primary care services, to ensure the sustainability and quality of provision. **QS19/39.2** The Executive Director sought Members' views on the future content of reports and it was agreed that this would be discussed further at the forthcoming workshop. **IT WAS RESOLVED THAT:** (1) the arrangements in place in relation to Quality and Safety in Primary Care and priorities for 2019/20 be noted; and (2) the future content of reports be discussed at the forthcoming workshop.	LR/KD
QS19/40 Clinical Audit Report **QS19/40.1** The Chair informed members of the Audit Committee's feedback following consideration of the report last week. The Audit Committee were not assured with the report in that it did not meet the specific actions identified as part of previous Structured Assessments and the Joint Audit, Quality, Safety and Experience meetings in both 2017 and 2018. Members had expected the report to set out how clinical audit would address the strategic objectives of the organisation taking a risk-based approach to support quality improvement going forward. They felt that the report presented was too high level and were seriously concerned at the time lapse since the issues had been first identified. Wales Audit Office had advised that a clinical audit plan should be presented to the next Audit Committee meeting in May in order to satisfy the requirements in both the Annual Governance Statement and Annual Quality Statement. This was being progressed in partnership with the Executive Team and the Office of the Board Secretary . **IT WAS RESOLVED THAT** a revised report together with a clinical audit plan for the year ahead be presented to the May Audit Committee and shared with members of the QSE Committee.	AT
QS19/41 Special Measures: Review of expectations allocated to the Quality, Safety & Experience (QSE) Committee **QS19/41.1** The Associate Director of Quality Assurance presented the report reminding Members of the background to the report. The SMIF Task & Finish	

Group had previously agreed that special measures expectations would be allocated to the most relevant committee for review, with a view to the committee providing updates where necessary and assurance on progress to the SMIF Task & Finish Group. **QS19/41.2** Work on the October 2018 – March 2019 section of the Framework had included a session held by the Executive Team in January 2019, dedicated to examining special measures progress in detail. As a result, it had been deemed that several of the expectations had been satisfactorily addressed and could be closed for monitoring purposes. The SMIF T&F confirmed the decisions at its February 2019 meeting. **QS19/41.3** All 'open' SMIF monitoring log expectations allocated to the Committee from the section of the Framework ending March 2019 were presented for comment. Members provided feedback as follows:- • Line 65 – there was a need to demonstrate that lessons learnt and implementation of HIW recommendations were embedded. As agreed earlier in the meeting a further, more detailed report from the Mental Health Division would be circulated to members. • Line 66 – Members were not satisfied with the level of detail provided and suggested inclusion of a table clearly setting out the actions taken to address matters. **IT WAS RESOLVED THAT :** feedback be provided to the SMIF as detailed above.	
QS19/42 Pressure Ulcer Collaborative (Hospital Acquired Pressure Ulcers/HAPU) Update **QS19/42.1** The Associate Director of Quality Assurance presented the report which provided an update of progress to date of the first Health Board Pressure Ulcer Collaborative. The purpose of the Collaborative which had commenced on 3.11.18 was to develop a Health Board standard approach to care with the aim of reducing tissue damage and pressure ulcers for in patients. The Pressure area care standard/bundle of interventions was to be a Health Board '*Always event'* for all inpatients screened as at risk of developing skin damage/pressure ulcers. **QS19/42.2** The report highlighted lessons learned, benefits and challenges whilst facilitating a collaborative across the Health Board in preparation for Health Board wide implementation of the standard and provided valuable lessons in preparation for the Falls collaborative planned to commence April 2019. There had been an increase in the number of incidents being reported for HAPU which was believed to be due to increased staff knowledge, improved surveillance and focus on transparent reporting for all grades of pressure damage. Testing of interventions so far had highlighted inappropriate	

seating for patients with reduced mobility and had required that chairs be condemned which will require replacing with more suitable alternatives. The Committee were informed that the Welsh Government had reviewed reporting criteria for HAPU and this may result initially in an increase in numbers reported. **IT WAS RESOLVED THAT :** (1) the collaborative approach adopted by the Health Board be continued for future collaboratives; and (2) the potential of an increase in HAPU reported initially during the roll out phase be acknowledged.	
QS19/43 Ward Accreditation Dashboard **QS19/43.1** Members welcomed the report which provided an overview of the Ward Accreditation programme together with an update of implementation, initial themes and initial feedback of the Ward Accreditation programme across the Health Board. The Ward Accreditation process highlighted any areas of concern, issues or risks that were shared with the ward team and senior team immediately or as part of the validation process depending upon the level of risk. The process had highlighted areas requiring financial support and may highlight areas that required further financial support to improve upon as part of patient and staff safety and overall quality agenda. These areas might differ from one ward to another but were being monitored by the quality Improvement team. **IT WAS RESOLVED THAT :** support through the Leadership of the Ward Accreditation process be continued and a strong commitment to being a part of the Ward Accreditation process be maintained.	
QS19/44 Stroke Services Update **QS19/44.1** The Executive Medical Director presented an update on progress within Stroke Services on the implementation of the 2017 Royal College of Physicians (RCP) Peer Review report and compliance with Standards and Guidelines. Members noted that the update did not have any financial implications but acknowledged the further work being undertaken in Stroke services which would identify the significant investment needed to improve the service to required performance and patient safety standards. Members were informed that whilst the full business case was not affordable, progress was being made in terms of implementation of key elements that would deliver the greatest benefits. **IT WAS RESOLVED THAT :** the report be received and the improvements that have been made within existing resources be noted.	

QS19/45 Care Inspectorate Wales Inspection into Older Adult Services in Wrexham County Borough Council **QS19/45.1** The Associate Director of Quality Assurance presented the paper which provided an update on the recent Healthcare Inspectorate Wales (HIW) and Care Inspectorate Wales (CIW) joint inspection of Older Persons Services in Wrexham Local Authority. **IT WAS RESOLVED THAT:** (1) the implementation of a new framework of inspection by CIW with HIW be noted; (2) the overview of the inspection process of Wrexham County Borough Council as the first in North Wales of the National Inspection into Prevention and promotion of independence for older adults living in the community be noted; and (3) the initial feedback of Inspectors relating to the partnership working of the WCBC and BCUHB be noted.	
QS19/46 Policies, Procedures or Other Written Control Documents for Approval Approval of the following Policies, together with their associated EqIAs was sought, all of which had been approved by the Quality and Safety Group:- **QS19/46.1 Medicines Policy** **IT WAS RESOLVED THAT** the Medicines Policy MM01 be approved. **QS19/46.2 Medical Gas Staff Responsibilities** **IT WAS RESOLVED THAT** the Policy relating to Medical Gas Staff Responsibilities be approved. **QS19/46.3 Non Ionising Radiation Protection Policy** **QS19/46.3.1** It was agreed to amend the Policy to reflect the Executive responsibility for Health and Safety now sitting with the Executive Director of Workforce and OD. **QS19/46.3.2 IT WAS RESOLVED** that the Non Ionising Radiation Protection Policy be approved, subject to the amendment outlined above. **QS19/46.4 Physical Restraint Guidelines**	AT

QS19/46.4.1 The Executive Director of Workforce and OD indicated an amendment required to the wording of the role of security staff and it was agreed that this would be provided outside the meeting. **QS19/46.4.2 IT WAS RESOLVED THAT :** the Physical Restraint Guidelines be approved for implementation within the Health Board, subject to the amendment clarifying the role of security staff in relation to restraint. **QS19/46.5 Proactive Reduction Therapeutic Management Behaviours with Challenge** **IT WAS RESOLVED THAT** the Policy on Proactive Reduction Therapeutic Management Behaviours with Challenge be approved for implementation within the Health Board.	SG
QS19/47 HASCAS Independent Investigation and Ockenden Governance Review: Progress Report **QS19/47.1** The Associate Director Quality Assurance presented the paper which provided progress updates as at the end of Q4 against the recommendations arising from both the HASCAS independent investigation and the Ockenden governance review. Additional resources required had been identified for a number of recommendations to progress the necessary work needed to deliver improvements. Members noted that a report was to be submitted for approval to the Executive Team setting out the additional resources and related costings, including any additional workforce requirements. The Chair welcomed the revised format of the report which provided greater clarity on the progress being made against the recommendations. **IT WAS RESOLVED THAT :** the progress of the recommendations be noted.	
QS19/48 Nurse Staffing Report (*This item was taken following QS 19/44)* **QS19/48.1** The Secondary Care Nurse Director presented the report which set out details of the compliance with the Nurse Staffing Act 2016, highlighting any associated harms as a result of staffing breaches in line with the Act, together with the actions taken to mitigate any identified risks. Members noted that patient acuity data was not available until w/c 11th March 2019 in order to complete a fully triangulated staffing review, which would be included within the May 2019 report. **QS19/48.2**The report set out the agreed staffing establishments to meet the requirements of the Nurse Staffing Levels Act 2016, noting that the funded	

establishments did not support additional escalated beds (as indicated in Appendix 1. It was noted that this was the third review of nursing establishments since implementation of the Act. Reference was made to impending changes to the reporting template. The Chair commented that the existing template was helpful and the Director agreed to share these observations with those leading the work. **IT WAS RESOLVED THAT:** (1) it be noted that a further detailed update will follow in May 2019; and (2) the Secondary Care Nurse Director convey the views of the Chair in relation to the existing template to those leading the work.	
QS19/49 Quality Safety Group (QSG) Assurance Report (Item taken following QS 19/47) **QS19/49.1** The Associate Director of Quality Assurance presented the paper which highlighted the following matters:- • Instability to Gwanwyn ward – measures had been put in place to use agency staffing, reduction in beds and weekly escalation review of the ward to ensure stability. • District nursing staff in the West were having significant issues with mobile phones and had been informed by informatics that the service would have to purchase new ones if required = Risk score 15 • Endoscopy performance/ surveillance, issues identified with delays. Work programme was being defined to mitigate any risks. • Safeguarding - It had been identified that the new nursing job descriptions have lost the standardised message regarding accountability for safeguarding, and the medical staff job description has lost the wording regarding notifying organisation of any police investigations. The Director of Quality Assurance and Executive Director of Workforce and OD agreed to discuss this further outside the meeting and it was confirmed that the omissions were not from posts currently being advertised. • The positive work being undertaken by the Ward Accreditation team and the positive feedback and engagement being seen from ward/ area staff was highlighted. • Clinical Audit Programme – This had been discussed in the QSG workshop in November and was referred to separately on the QSE agenda. **QS19/49.2** The Chair informed Members of ongoing discussions regarding the future format and level of detail reported from QSG to the Committee. **IT WAS RESOLVED THAT** the update be received.	DC SG
QS19/50 An Update on Incidents Which Occur Within BCUHB Which are Classified as Never Events **QS19/50.1** The Associate Director of Quality Assurance presented the update for information at the request of the Executive Director of Nursing and Midwifery. The report was presented monthly to the Executive Management	

Group (EMG). Serious incidents, including Never Events (NE) were reported on a regular basis to local quality and safety meetings, weekly incident review meetings and the Quality and Safety Group. Incidents classed as Never Events were specified by Welsh Government and detailed in WHC/2018/12. Each event was escalated immediately to the clinical executives and as from October 2018, the Independent members were also informed. Never Events were defined as Serious Incidents that were wholly preventable because guidance or safety recommendations were available at a national level and should have been implemented by all healthcare providers. Never Events required full investigation under the Serious Incident Framework and included the need to fully and meaningfully engage patients, families and carers at the beginning of and throughout any investigation. There were a number of questions raised about the detail contained within the report relating to the description and action taken. It was agreed that these would be discussed separately with the Associate Director of Quality Assurance and updates provided to the next meeting as required. **IT WAS RESOLVED THAT** : (1) Any questions arising from the update would be discussed with the Associate Director of Quality Assurance; and (2) the Committee note the Never Events that have occurred as detailed in the report.	LR/DC
QS19/51 Issues Discussed in Previous In Committee Session **IT WAS RESOLVED THAT** the report be noted.	
QS19/52 Documents Circulated to Members **IT WAS RESOLVED THAT** circulation of the following information on the dates indicated be noted:- • 6.2.19 Follow up action CRR13 Mental Health • 14.2.19 QSG Notes January • 20.2.19 Ward Accreditation Update	
QS19/53 Issues of Significance to inform the Chair's Assurance Report The Chair agreed to prepare her assurance report for the Board.	
QS19/54 Date of Next Meeting Tuesday 21st May @ 9.30am in Carlton Court	
QS19/55 Exclusion of Press and Public	

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.'	