



## Quality, Safety and Experience (QSE) Committee

### Minutes of the Meeting Held in public on 24.9.19 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
Mrs Marian Wyn Jones	Independent Member ( <i>part meeting</i> )

#### In Attendance:

Mrs Deborah Carter	Associate Director of Quality Assurance ( <i>part meeting</i> )
Mrs Kate Dunn	Head of Corporate Affairs
Dr David Fearnley	Executive Medical Director
Mr Steve Forsyth	Director of Nursing, Mental Health and Learning Disabilities ( <i>part meeting</i> )
Mrs Fiona Giraud	Director of Midwifery & Women's Services ( <i>part meeting</i> )
Mrs Sue Green	Executive Director of Workforce and Organisational Development (OD)
Mr Dave Harries	Head of Internal Audit
Ms Louise Howard-Baker	Assistant Director for Medicines Management (East Area) ( <i>part meeting</i> )
Mr Rhys Jones	Healthcare Inspectorate Wales (HIW) ( <i>observing – part meeting</i> )
Ms Rebecca Masters	Consultant in Public Health ( <i>deputy for Miss Teresa Owen</i> )
Dr Melanie Maxwell	Senior Associate Medical Director / 1000 Clinical Lead ( <i>part meeting</i> )
Dr Jill Newman	Director of Performance
Dr Berwyn Owen	Chief Pharmacist ( <i>part meeting</i> )
Mr Andy Roach	Director of Mental Health and Learning Disabilities (MHLDS)
Ms Emma Scott	Healthcare Inspectorate Wales (HIW) ( <i>observing</i> )
Dr Chris Stockport	Executive Director of Primary and Community Services
Mr Adrian Thomas	Executive Director of Therapies and Health Sciences
Mr Mark Thornton	Chair of Community Health Council (CHC)

Agenda Item Discussed	Action By
<b>QS19/126 Chair's Opening Remarks</b>  The Chair welcomed everyone to the meeting.	
<b>QS19/127 Declarations of Interest</b>  None were declared.	

<p><b>QS19/128 Apologies for Absence</b></p> <p>Apologies were recorded for Mr Gareth Evans, Mrs Gill Harris and Miss Teresa Owen</p>	
<p><b>QS19/129 Minutes of Previous Meeting Held in Public on the 16.7.19 for Accuracy, Matters Arising and Review of Summary Action Log</b></p> <p><b>QS19/129.1</b> The minutes were agreed to be an accurate record and updates were provided for recording within the summary action log.</p> <p><b>QS19/129.2</b> A matter arising was raised regarding children's services and the Executive Director of Primary &amp; Community Services undertook to share a copy of the relevant Healthcare Inspectorate Wales report ahead of it being agendered (alongside the organisational response) in November.</p> <p><b>QS19/129.3</b> A matter arising was raised regarding breast radiologists and the Executive Director of Therapies &amp; Health Sciences confirmed that plans were progressing to enable the risk to be reduced in due course, with existing capacity being maximised to provide a service on all three acute sites.</p>	CS
<p><b>QS19/129 Briefing Notes Circulated to Members</b></p> <p><b>QS19/129.1</b> Members asked that the briefing note circulated on the 3.9.19 regarding mapping of indicators from the operational plan be revisited for appropriateness, particularly around which indicators should be mapped to the other Committees, such as the Strategy, Partnerships &amp; Population Health (SPPH) Committee.</p>	JN
<p><b>QS19/130 Patient Story</b></p> <p><b>QS19/130.1</b> The Associate Director of Quality Assurance presented the patient story which related to a dementia patient and issues raised by her son around their experiences within the Emergency Department (ED) at Ysbyty Glan Clwyd (YGC). The story highlighted concerns around the use of the dementia butterfly sticker on the patient's bed, and the proximity of the bed to the nurses' station that had caused confusion to the patient when she overheard discussions.</p> <p><b>QS19/130.2</b> A discussion ensued. Members felt it would be worthwhile investigating alternative mechanisms for identifying dementia patients (eg; coloured wristbands or dementia 'passports') but acknowledged that individuals and families may have different preferences. The Associate Director of Quality Assurance confirmed that patient safety would always be prioritised but agreed to feedback on the discussion to the Dementia Lead Nurse. It was also acknowledged there was variation across sites, particularly in community hospitals, and the availability of trained dementia co-ordinators. The Associate Director of Quality Assurance and the Executive Director of Primary &amp; Community Services would work to develop an assurance report for the Committee.</p>	DC DC CS
<p><b>QS19/131 Mental Health &amp; Learning Disabilities Division Exception Report</b> <i>[Mr Steve Forsyth joined the meeting]</i></p>	

**QS19/131.1** The Chair thanked the team for what she felt was a much more balanced, informative report. The Director of Nursing, Mental Health and Learning Disabilities (MHLDS) alerted the Committee to areas of positive progress in that the memory service in the West was the only one in Wales to achieve formal accreditation, and that the service had received positive feedback following a recent unannounced visit by HIW to Cefni Hospital. He invited comments and questions on the paper.

**QS19/131.2** A question was asked regarding the timelines for actions within the improvement plan and it was confirmed that the November report would include clear trajectories for compliance. A comment was made that some of the actions appeared to be simple things which should be able to be implemented quickly without the need to pilot any arrangements, and also that many of the issues were estates related. It was reported that pilots were being carried out within a safe environment before rolling out, and that in terms of estates issues the Division was working very closely with the estates teams with appropriate escalation being made to the Director of Estates and Facilities. The Chair of the CHC noted that issues had been raised regarding documentation and record keeping which he felt were fundamental aspects of quality. It was noted that this was a consistent theme within the ward accreditation process as well and that the move from paper notes was a priority. A member enquired whether the use of agency staff or administrative vacancies was a contributory factor to poor record-keeping but it was reported that this wasn't a significant issue for the Division although there was an administrative and clerical review ongoing across the Health Board. The Director of MHLDS explained that the review of the service model going forwards includes looking at referrals from primary care and how to engage with clusters. The Health Board Vice Chair stated it was heartening to see the impact of changes being made but that more assurance was required around the delivery of the Strategy and investment within mental health for the future. The Director of MHLDS confirmed that the November paper would include further detail around the delivery plan and business case, benchmarking data and clear milestones against delivering the Strategy. He also wished to assure the Committee that there was a mitigating plan for pharmacy in the East.

**QS19/131.3** It was resolved that the Committee note:

1. The progress that is being made to Mental Health and Learning Disability Services, specifically as requested in relation to:
  - Compliance with Mental Health Measure
  - Lessons Learned from incidents
  - HIW outstanding actions
  - Milestone and measures in relation to implementation of the Together for Mental Health strategy and operational plan but requested further detail on this at the next meeting.
2. The risks that are identified are being managed through locality structures and overseen by Divisional Directors

*[Mr S Forsyth and Mrs M W Jones left the meeting]*

### **QS19/132 Annual Plan Monitoring Report**

**QS19/132.1** The Director of Performance presented the report which sets out progress against key actions within the annual plan. She suggested that the relevant reports be circulated via email on the intervening months between QSE Committee meetings. The Director of Performance also highlighted that the actions had been RAG rated and

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milestones included where they existed. She apologised that two of the red rated actions did not have an accompanying explanatory narrative. These related to endoscopy against which a paper was submitted to the in committee session of the Finance & Performance Committee in August setting out plans for additional capacity, and secondly relating to diagnostics which was being addressed through the work with the Interim Recovery Director and insourcing. A member asked about the update on the robotic service which was referenced in the paper and it was explained that this narrative had been included for the Finance and Performance Committee. The Chair suggested that the quality checks of this paper need to be improved. A member also asked if the format could be reviewed to ensure that the progress aligns with the actions more clearly.

**QS19/132.2** The CHC Chair noted that for the previous year the Board had achieved 60% completion against the plan and felt that very often the focus dropped off part way through the year requiring the need for a sudden increase in effort at year end. The Director of Performance explained that there was an enhanced level of scrutiny on a monthly basis by the Executive Team on a confirm and challenge basis, although there was naturally more activity within quarters three and four.

**QS19/132.3** It was resolved that the report be noted but that the Committee have requested improved quality assurance on the information contained within the paper.

### **QS19/133 Integrated Quality & Performance Report**

**QS19/133.1** The Director of Performance presented the report and highlighted that there were a number of 'greyed' indicators which was due in part to the mix of annual and monthly indicators, and also the effect of a major IT incident in Wales on data availability. She added that there was a continued reduction in serious untoward incidents and that a more detailed paper was on the agenda relating to falls and pressure ulcers. The Director of Performance referred to performance against postponed procedures at short notice, accepting these result in a very poor experience for patients and did not support the efficient use of resources. She went on to highlight that the vacancy levels remained of concern in terms of the Board's ability to consistently maintain high standards of care to patients across all sites. She concluded by reporting that there was evidence of short term investment into Child Adolescent Mental Health Services (CAMHS) and that overall performance against the Mental Health Measure was good for CAMHS.

**QS19/133.2** A discussion ensued. Members expressed concern at the performance for postponed procedures and noted that there was a related audit report that had been received by the Audit Committee. Associated challenges around the availability of high dependency beds and anaesthetists were noted. The Associate Director of Quality Assurance reported that there was a defined work programme in place and the Executive Director of Workforce and OD indicated that variations in practice should be discussed at job planning meetings and appraisals but this remained challenging. The Chair suggested that whilst the narrative within the paper was helpful it needed to align more closely to the actual indicator so it is clear what action is being taken to address postponed procedures for non-clinical reasons not all reasons. She asked that an exception report be timetabled in six months to inform the Committee how the organisation was responding to the audit report. A member noted the deterioration in mortality rates. The Senior Associate Medical Director indicated that an update was awaited for the Wrexham site but accepted that the variance needed to be understood. The CHC Chair referred to the incidents graphs on

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page 13 which he felt implied that the plan was to achieve half of the target by year-end. The Director of Performance clarified that the plan was for the monthly trajectories and performance was being tracked against these with the target taking precedence not the plan. The CHC Chair also noted a deterioration in infection rates which was disappointing given the level of effort that had been invested. The Associate Director of Quality Assurance stated that the target related to healthcare acquired infections whereas the majority of infections within BCU were community acquired. She felt that the Board should be most concerned about those avoidable infections acquired whilst patients were in its care. With regards to mental health targets for adult assessments and therapeutic interventions it was noted that the graphs appeared to indicate performance was drifting downwards. The Director of MHLDS indicated that some areas were consistently compliant but others had real capacity issues and short term posts were being considered to change the model of delivery. He assured the Committee that BCUHB was not a significant outlier across Wales. A member raised the issue of ward staffing levels and skill mix and the Executive Director of Workforce and OD reported that this element of the report did not provide bank agency usage and vacancy and the ratio was skewed as it included additional duties which were predominantly undertaken by health care support workers.

**QS19/133.3** It was resolved that the Committee note the current performance and commitment to improve the relevance of the narrative against actions. The Committee also resolved to receive an exception report on postponed procedures at a future meeting.

#### **QS19/137 Medicines Management Key Risks**

*[Agenda item taken out of order at Chair's discretion. Dr Berwyn Owen and Ms Louise Howard-Baker joined the meeting]*

**QS19/137.1** The Chief Pharmacist presented the paper which provided the Committee with a copy of HMP Berwyn's first Her Majesty's Inspectorate of Prisons' inspection report which included a joint inspection with Health Inspectorate Wales of the Health and Wellbeing Services at HMP Berwyn, together with the associated action plan. He invited a discussion or questions from members.

**QS19/137.2** The Chair referred to previous discussions around pharmacy support within mental health. The Chief Pharmacist confirmed that funding was historically based on clinical risk. In terms of MHLDS the legacy goes back to the closure of the Denbigh Hospital and a belief that pharmacy services within mental health was funded corporately. The Associate Director of MHLDS confirmed there was now a clear agreement in place and the strategy was being worked through with the Medicines Management team. A member raised the issue of the EU exit and potential medicines shortages. The Chief Pharmacist indicated that the EU exit was only one of several factors regarding shortages but work was ongoing with a small team with expertise in procurement. The issue of communicating key messages around any shortages was raised and the worry that members of the public may unnecessarily choose to stockpile medicines. The Chief Pharmacist was confident there would be an appropriate communications strategy in place by the time of the EU exit. A question was raised regarding the risk set out regarding prescribing competencies of new intake FY1, FY2 and locum doctors. The Assistant Director for Medicines Management explained that this related to occasions where it was not possible to identify the prescriber. Reference was also made to concerns around staffing shortages and offsite dispensing for a particular pharmacy corporate that had been reported in the media. The Chief Pharmacist explained that the company were moving away from branch dispensing and confirmed the

<p>Medicines Management teams were working closely with the company concerned. The Assistant Director for Medicines Management indicated that as part of the quality improvement element within the new GP contract there was work ongoing to target potential harms, and she tabled a screenshot from All Wales Toxicology and Therapeutics Centre data. She said that clinical coding would be key to collecting supplementary information and discussions were taking place as part of a national programme. A proposal would be prepared.</p> <p><b>QS19/137.3 It was resolved that the Committee note the report.</b></p> <p><i>Dr Berwyn Owen and Ms Louise Howard-Baker left the meeting</i></p>	
<p><b>QS19/138 Royal College of Obstetricians / Royal College of Medicine (RCOG/RCM) Review of Maternity Services at Cwm Taf Health Board (15-17 January 2019) : Report Published by Welsh Government on 30th April 2019 : Q 2 Update</b>  <i>[Agenda item taken out of order at Chair's discretion. Mrs Fiona Giraud joined the meeting]</i></p> <p><b>QS19/138.1</b> The Director of Midwifery and Women's Services took the opportunity to inform the Committee of an unannounced visit to Ysbyty Glan Clwyd (YGC) by Healthcare Inspectorate Wales (HIW) the previous week. There were some actions for immediate attention which were being picked up and the learning from the visit had been shared with staff the next day. Ms Emma Scott confirmed that HIW had been welcomed at the inspection and she was assured that the immediate actions had been dealt with, and there was demonstrable evidence of good leadership.</p> <p><b>QS19/138.2</b> In terms of the RCOG/RCM review members felt that the paper provided a good level of assurance in terms of maternity services as a whole in light of the Cwm Taf review and that progress was commendable. Members noted however, that the volume of paperwork provided was felt to be overwhelming. The Associate Director of Quality Assurance suggested that the coversheet did take members through the key areas of concern. A question was raised around resuscitation trolley checks and it was confirmed this rested with ward nursing staff. A member asked whether the reference to a perinatal mortality review should be a matter of concern and the Director of Midwifery and Women's Services confirmed this was not the case and it has been developed to provide assurance ahead of publication of the full EMbRACE report.</p> <p><b>QS19/138.3 It was resolved that the Committee to note the assurances provided by the Directorate which were commendable and support the identified areas for improvements.</b></p> <p><i>[Mrs F Giraud, Mr R Jones and Dr M Maxwell left the meeting]</i></p>	
<p><b>QS19/134 Concerns, Litigation, Incidents, Coroner and Healthcare Inspectorate Wales (CLICH) Report</b></p> <p><b>QS19/134.1</b> The Associate Director of Quality Assurance presented the report to members, noting that many areas of work had been discussed under earlier agenda items but invited any comments or questions.</p> <p><b>QS19/134.2</b> The Chair wished to record her thanks for the improved level of analysis within the report although she felt the outstanding HIW actions could be more clearly identified. A</p>	

member noted that the Central area appeared negatively in a range of areas and sought assurance that this was recognised by the area. The Associate Director of Quality Assurance confirmed that the area team had responded positively to the challenges. The CHC Chair referred to expectations around addressing complaints within 30 days, and it was reported that there were trajectories in place but meeting the target consistently remained challenging due to competing priorities within the teams, and the impact of holiday and sickness absence. The Chair noted reference to “operator error” having been identified in a claim and enquired whether the human factor elements such as supervision had been explored. The Associate Director of Quality Assurance reported that there was a known complication with the particular procedure in question, and that the experienced clinician concerned had undertaken retraining and there had been no reoccurrence. The Executive Medical Director welcomed the learning from claims however felt that learning should commence at the point that the organisation was aware something had gone wrong, not at the end of the claim process. The Chair enquired whether any of the unexpected deaths reported were of specific cause for concern and the Associate Director of Quality Assurance reported that none of the cases related to BCUHB care provision being directly attributable to the death. The Chair also referred to a Never Event relating to the incorrect use of oral and intravenous syringes and the Associate Director of Quality Assurance gave further background to the case and confirmed that different colour syringes were now in use. The CHC Chair noted the HIW action regarding separation of commissioner/provider role for managed practices and the Executive Director of Primary and Community Services confirmed that this had been a live conversation since the first managed practice was established but he confirmed that operationally there had not been any issues of concern.

**QS19/134.3 It was resolved that the Committee to note the content of the report**

### **QS19/135 Occupational Health and Safety Gap Analysis Report**

**QS19/135.1** The Executive Director of Workforce and OD presented the report which provided an evidence-based assessment of where the organisation was in terms of health and safety. She highlighted that the report set out the need to develop a three year risk-based improvement plan which would provide the ability to plan in a systematic way and to identify correlation between the gap analysis, legislation and incidents. Members were assured that the intensive gap analysis process had been led by the Health and Safety team with the support of stakeholders and Trade Union partners and had involved visits to 117 premises, a generic health and safety audit and more detailed assessments of violence and aggression, security and occupational health. The Executive Director of Workforce and OD assured the Committee that any significant concerns identified were addressed at the time of the audit, and that areas of good practice were also identified. Throughout the process there had been good engagement and a willingness to move forward in a sustainable manner, with an acknowledgement that there had been a lack of ownership to health and safety in some areas. The Executive Director of Workforce and OD indicated that there would be a clear need to undertake a re-audit at some point and that in terms of the methodology used it was noted that an internal audit review indicated a level of reasonable assurance. The Health and Safety Executive (HSE) had commenced a programme of inspections of Welsh Health Boards and BCUHB were likely to be involved. Reference was made to the overarching risk on the corporate risk register which had been reviewed following the gap analysis and it was noted a refreshed risk would be developed. Finally the Executive Director of Workforce and OD reported that the issue of security across the organisation had been separated out from the health and safety gap analysis

<p>and following a change in tender arrangements would be subject to a full review with a separate report being provided to the QSE Committee in due course.</p> <p><b>QS19/135.2</b> The Consultant in Public Health welcomed the comprehensive risk assessments but suggested that it would be helpful to establish links between Estates and Facilities and legionnaires. The CHC Chair felt the gap analysis and testing of the service would stand the Health Board in good stead for any HSE review. The Committee Chair found the report to be transparent and thorough and would provide a robust basis on which to move forwards with actions being prioritised by risk. She noted that the outcome of the previous self assessments undertaken against this gap analysis would suggest this process needs improving.</p> <p><b>QS19/135.3 It was resolved</b> that the Committee:</p> <ol style="list-style-type: none"> <li>1. Note the position outlined in Gap Analysis Report.</li> <li>2. Support the proposed improvement plan and findings of the gap analysis of legislative compliance and subsequent proposed project plan and time line.</li> </ol>	SG
<p><b>QS19/136 HMP Berwyn : Health and Wellbeing Service Her Majesty’s Inspectorate of Prisons’ Inspection Report and Action Plan</b></p> <p><b>QS19/136.1</b> The Executive Director of Primary and Community Services presented the paper, highlighting that the inspectorate report related to the whole prison service and not just the provision of health care. He confirmed it was the first inspection of this nature at the prison and that the healthcare element had been undertaken jointly by Her Majesty’s Inspectorate of Prisons and Healthcare Inspectorate Wales (HIW). Overall the report was broadly positive with a small number of observations requiring attention.</p> <p><b>QS19/136.2</b> A discussion ensued. A member expressed concern at the level of dental provision and the Executive Director of Primary and Community Services suggested that the issue related to the estate not being fit for purpose and secondly around capacity to deliver. Since the inspection a second dentist had now been appointed and some of the estate’s issues had been addressed. A member queried the decision to remove men from the dental waiting list if they had less than six months of their term to serve, and the Executive Director of Primary and Community Services confirmed he has also raised this very point as a concern. Members were pleased to see the positive impact of deploying a paramedic to the prison site in terms of preventing emergency admissions and that the pilot had been escalated to Wales Ambulance Services Trust to seek approval to provide on a more sustainable basis. In response to a question regarding medication lockers for those men with chronic diseases it was confirmed that the majority of such medication was self-managed. A member asked how the prison service was evaluating progress against the philosophy set out when the facility first opened, and the Director of Mental Health &amp; Learning Disabilities (MHLDS) reported that he had met with the new governor who was keen to drive the rehabilitation agenda far more robustly. He also indicated that the MHLDS Division had a strong interaction with the prison including the provision of psychiatric sessions. Finally, the Executive Director of Primary and Community Services referred to a recent adverse news article and assured the Committee that BCUHB officers had picked up some of the specific healthcare points.</p> <p><b>QS19/136.3 It was resolved that</b> the Committee receive and note the report.</p>	

<p><b>QS19/139 Quality &amp; Safety Group Assurance Reports July and August 2019</b></p> <p><b>QS19/139.1</b> The Committee Chair reported that she had raised a number of points with the Associate Director of Quality Assurance outside of the meeting in relation to the report. It was noted that the risk around breast radiology had been mitigated via an appointment of a breast radiologist and cover being provided from other areas. In terms of the Countess of Chester issue it was confirmed this related to North Wales maternity patients and there was a meeting scheduled next week to review, although the Committee were assured there weren't any concerns around individual patients. Reference was also made to an incident within radiology with an MRI scanner being out of service for a period of time and which had been mitigated by using scanners on other sites. The Associate Director of Quality Assurance also explained that the reference to a number of clinically complex cases within Women's Services would be detailed within the next scheduled report to the Committee from the Division. The Committee Chair enquired about the paediatric ophthalmology issue and it was confirmed this related to the loss of a clinician however resources were being utilised from other sites to mitigate the risk. The Executive Director of Primary and Community Services drew attention to the closure of a Wrexham care home and that the intervention had been undertaken on a joint basis with the Local Authority. The CHC Chair made reference to a new nutrition and hydration screening tool and the Associate Director of Quality Assurance confirmed that the nursing teams were well sighted but the nutrition team had felt they were not fully consulted.</p> <p><b>QS19/139.2</b> It was resolved that the Committee receive and note the report.</p>	DC/TO
<p><b>QS19/140 Progress report of recommendations arising from HASCAS independent investigation and Ockenden governance review</b></p> <p><b>QS19/140.1</b> The Committee Chair reported that she had raised a number of points with the Associate Director of Quality Assurance relating to the report outside of the meeting. The Associate Director of Quality Assurance set out the intention to move as many of the actions as possible onto a routine business footing, and confirmed that progress would also be subject to internal audit scrutiny. Whilst there had been significant progress against the breadth of the recommendations the challenge was to be able to provide assurance that an action had been completed as far as it could possibly be. The Chair queried the proposal to record a closed action as 'fully implemented' and suggested that there needed to be a clear audit trail in this regard. A comment was made that there was now a more helpful integration of actions and themes from a range of reviews. It was highlighted that the stakeholders themselves were clear that they would not be part of a decision to close off an action.</p> <p><b>QS19/140.2</b> It was resolved that the Committee note progress against the recommendations to date.</p>	
<p><b>QS19/141 Ward Accreditation, Health Acquired Pressure Ulcer (HAPU) Collaborative &amp; Falls Collaborative update</b></p> <p><b>QS19/141.1</b> The Associate Director of Quality Assurance presented the paper, highlighting that 70 wards had now been assessed, with a gold standard yet to be confirmed. "Going for Gold" workshops were planned to share the learning from Year 1 and to try and help silver wards move into the gold category. It was noted that one 'red' ward was classified as</p>	

<p>having significant safety concerns and was subject to weekly monitoring and a revisit planned during October. It was hoped that ward accreditation would also be undertaken within Emergency Departments.</p> <p><b>QS19/141.2</b> A discussion ensued. A member noted that further financial support may be required and the Associate Director of Quality Assurance confirmed that the previous allocation of £1m per year would continue. With regards to the process for identifying the cohorts for the collaboratives it was confirmed that a suite of actions for the areas with the most significant issues would be rolled out. The CHC Chair acknowledged that there was a real energy across sites for the programme and a clear aspiration to improve.</p> <p><b>QS19/141.3</b> It was resolved that the Committee continue to support the Ward Accreditation process and implementation of the Improvement Collaboratives.</p>	
<p><b>QS19/142 BCUHB Response to Healthcare Inspectorate Wales (HIW) Annual Report 2018-19</b></p> <p><b>QS19/142.1</b> The Associate Director of Quality Assurance presented the report, reminding members that there had been full discussion by the whole Board at a workshop. She added that the report demonstrated the breadth of the inspection programme undertaken by HIW.</p> <p><b>QS19/142.2</b> It was resolved that the Committee note the contents of the HIW Annual Report and the Health Board's response to the report.</p>	
<p><b>QS19/143 Public Sector Ombudsman Wales Annual Letter 2018-19</b></p> <p><b>QS19/143.1</b> The Committee Chair welcomed the broadly positive report which she felt reflected the good work undertaken by the Concerns team. In response to a question from a member it was confirmed that the Ombudsman had not to date used their additional powers.</p> <p><b>QS19/143.2</b> It was resolved that the Committee note the Annual letter and the actions taken by the Health Board for information.</p>	
<p><b>QS19/144 2019 Annual Nurse Staffing Levels (Wales) Act 2016 Reporting framework</b></p> <p><b>QS19/144.1</b> The Associate Director of Quality Assurance presented the paper which detailed a slightly amended framework for reporting. It was noted that the suggested timetabling would need to be adjusted further to marry up with the meeting pattern of the Committee.</p> <p><b>QS19/144.2</b> It was resolved that the Committee amend its cycle of business in respect of the compliance report for Nurse Staffing Act 2016.</p>	KD
<p><b>QS19/145 Accessible Healthcare Annual Report incorporating Wales Interpretation Translation Service Report</b></p> <p><b>QS19/145.1</b> The Associate Director of Quality Assurance presented the report to the Committee. Members welcomed the information provided but a comment was made that a</p>	

<p>self assessment would have been helpful to provide an indication to the reader as to whether the organisation was on track or not, and for the report to more clearly highlight good news and positive stories. This would be fed back to the team as it was noted the report was written using a provided template. A suggestion was made that the Board could look at leading by example in terms of accessibility – for example, using some British Sign Language within introductions at meetings. The recommendation within the paper was considered and members felt it should be softened to read:</p> <p><b>QS19/145.2 It was resolved that</b> the Committee endorse the controls/corrective actions highlighted in this report aimed at ensuring staff, managers and other stakeholders recognise and act on their responsibility to ensure that service users with sensory loss are able to access our services on the same basis as all other service users.</p>	
<p><b>QS19/146 Policies, Procedures or Other Written Control Documents for Approval</b></p> <p>The Committee Chair stated that the Committee would be unable to approve any of the submitted documents as she felt the accompanying Equality Impact Assessments were not fully compliant. In addition, she was disappointed that many of the documents contained typographical and formatting errors. The other members supported this view and the Executive Director of Workforce and OD agreed that further work was required on the EQIAs.</p> <p><b>QS19/146.1 Organ Donation Policy</b></p> <p>In addition to the generic comments above, the Committee noted a specific typographical error that the word “implanted” should read “implemented”. Members were fully supportive of the policy principles. The Executive Director of Therapies and Health Sciences would take these comments back for further consideration.</p> <p><b>QS19/146.2 Handcuffs Policy</b></p> <p>In addition to the generic comments above, the Committee queried whether the terminology could be amended, however, the Executive Medical Director outlined the specific nuances around the use of handcuffs which required the policy. The Independent Member (Trade Union) suggested that the policy should describe more clearly the scenarios and options when a member of staff needs to agree to be handcuffed to an individual. The Director of Mental Health would take these comments back for further consideration.</p> <p><b>QS19/146.3 Threats to the Person in Forensic Establishments Policy</b></p> <p>In addition to the generic comments above, the Committee queried the consistent reference to the Firearms Act within the EQIA and why this was deemed to be relevant against each protected characteristic. The Committee also suggested the policy should be reviewed by the Occupational Health and Safety Group. The Director of Mental Health would take these comments back for further consideration.</p> <p><b>QS19/146.4 Major Incident Protocol – Ty Llywelyn Medium Secure Unit</b></p> <p>In addition to the generic comments above, the Committee queried why there was reference to referrals from GPs when the policy relates to a forensic medium secure unit</p>	<p>AT</p> <p>AR</p> <p>AR</p>

<p>and how this protocol differed from the Threats to the Person in Forensic Establishments Policy. A member queried the necessity of involving the Modern Matron in advance of calling 999. The Executive Director of Workforce and OD noted the lack of reference to security providers within the scope. The Committee also suggested the protocol should be reviewed by the Occupational Health and Safety Group. The Director of Mental Health would take these comments back for further consideration.</p> <p><b>QS19/146.5 It was resolved that</b> the Committee require each of the written control documents to be amended in light of the specific comments, reviewed for grammatical and typographical errors, their EQIA refreshed, and resubmitted to the next meeting or for Chair's action.</p>	AR
<p><b>QS19/147 Issues Discussed in Previous In Committee Session</b></p> <p><b>It was resolved that</b> the Committee note the information in public.</p>	
<p><b>QS19/148 Documents Circulated to Members</b></p> <p><b>It was resolved that the</b> Committee note the circulation of the following briefings and information:</p> <ul style="list-style-type: none"> <li>12.6.19 Concerns Trajectories</li> <li>4.7.19 Policy approval process</li> <li>9.7.19 Gosport briefing</li> <li>9.7.19 Homeless &amp; Vulnerable Groups qualitative report</li> <li>9.7.19 Complaints handling / PSOW letter</li> <li>16.7.19 QSG notes May and June 2019</li> <li>24.7.19 Copy of endoscopy paper with formatting corrected</li> <li>17.9.19 QSG notes July and August 2019</li> </ul>	
<p><b>QS19/149 Issues of Significance to inform the Chair's Assurance Report</b></p> <p>To be agreed outside of the meeting</p>	
<p><b>QS19/150 Date of Next Meeting</b></p> <p>Tuesday 19.11.19 @ 9.30am</p>	
<p><b>QS19/151 Exclusion of Press and Public</b></p> <p>Resolution to Exclude the Press and Public - "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."</p>	