GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

OPERATIONAL QUALITY, SAFETY & EXPERIENCE

SUB-COMMITTEE UPDATE REPORT

Date of last meeting: 14 May 2024

Quoracy: Met

Report by: Olwen Morgan, Chair

KEY DISCUSSION POINTS AND MATTERS TO BE ESCALATED FROM THE DISCUSSION AT THE MEETING:

Alert[1] (may require discussion)

The Operational Quality, Safety & Experience Sub-Committee wish to **alert** members of the Quality, Safety & Experience Committee that:

- Concerns were raised regarding the roll out of the **Death Certification Reform and Medical Examiners** process whereby all clinical notes and charts must be scanned to the MES. Unfortunately, the Health Board does not have sufficient staff resources to scan and send the documentation in a timely manner, or to upload data into the Datix system. Engagement opportunities and training plans are underway. Communication with all Doctors has taken place in relation to responsibilities for completion of Medical Certification and Cause of Death. Additional resource is being sought to enable completion of Glangwili Hospital roll-out and further meetings are being arranged with the newly appointed Deputy Medical Director to support the implementation of the process.

Advise[2] (to monitor)

The Operational Quality, Safety & Experience Sub-Committee wish to **advise** members of the Quality, Safety & Experience Committee that:

- Plans are going forward for the Health Board to meet the requirements for the national implementation of **Martha's Rule** (a patient safety initiative which was triggered by the death of a teenage girl). A Working Group has been established and an initial scoping meeting has taken place. The next meeting will set out the terms of reference for the working group and actions required. A scoping exercise will then take place to establish what services are available in the Health Board which will be able to take on this work. A further update will be brought to the Operational Quality, Safety & Experience Sub-Committee in July 2024.

- There has been increasing concern regarding **Vascular Access** and the care of peripherally inserted central catheter (PICC) and midlines after insertion. A meeting will take place within the next few weeks to determine the current

---

[1] *There is a lack of confidence that any action in place is sufficient to address the issue satisfactorily and/or within the scope of the operational team or executive to resolve. Engagement, action or intervention required.*
[2] *There are areas of concern where assurance has been taken on actions in place but requires close monitoring. An early warning of an emerging and potentially serious concern.*

needs and any training requirements for staff.

- The Sub-Committee received a report providing an update on **Estates and Facilities** throughout the health board sites. A number of issues were highlighted including increased spending on pest control, Trade Unions raised a number of staffing concerns which have been raised at Executive Level; lack of nursing representatives in groups such as the Synbiotix cleaning audit and internal audit scores are at times, being marked by the team themselves. The Sub-Committee requested further information on some areas including Cook Freeze Hybrid solution, mandatory training for facilities staff and issues with laundry services to be included in the revised report to be brought back to Sub-Committee in July 2024.

- Within **Unscheduled Care in Glangwili (GGH) and Prince Philip (PPH) Hospitals**, It was advised that both Emergency Departments in GGH and Acute Medical Assessment Unit (AMAU) in PPH continue to have ambulance handover delays. However, work was being undertaken to monitor this. The Sub-Committee were informed that more patients could be seen in Same Day Emergency Care (SDEC) rather Accident and Emergency. Task and Finish groups for both PPH and GGH were in place to review further opportunities. The Sub-Group was also informed that the current workforce model is being reviewed due to sickness absence. It was noted that performance in terms of CDiff continues to be a concern across the HB. Targeted work continues within both GGH and PPH to reduce incidences of hospital acquired infection. Three new risks have been added to the register: risks to patients safety due to the use of room 7/8 surge area for the Emergency Department, risk to patient safety due to incorrect staffing and skill mix on Cleddau/SAU, and risk to patient safety due to gaps within CNS Stroke service.

Assure[3] (to note)
The Operational Quality, Safety & Experience Sub-Committee wish to **assure** members of the Quality, Safety & Experience Committee that:

- Assurance was taken on the matters for escalation and the mitigation actions taken to manage (as far as is possible) risks across **Radiology Services**.

- The Sub-Committee was assured that the mitigations in place are adequate or otherwise for **Unscheduled Care in Bronglais Hospital (BGH)**. The Sub-Committee noted that all outstanding actions identified in the Quality and Safety BGH Unscheduled Care Internal Audit Report, have now been given a “reasonable” assurance rating, and that following the report there has been a significant reduction in the number of incidents in the holding area as at 30 November 2023 (reduced from over 550 to 54). Work is undergoing to relocate members of staff to an off-site location to facilitate the chemotherapy day unit building work to commence, a lack of sufficient space is a current risk.

- The Sub-Committee was assured that the mitigations in place are adequate or otherwise for **Unscheduled Care in Withybush Hospital (WGH)** including that Remedial work on Reinforced Aerated Autoclave Concrete (RAAC) had

[3] *There is confidence that actions are robust and will be sufficient to address the issue or generally operating effectively. Routine monitoring.*

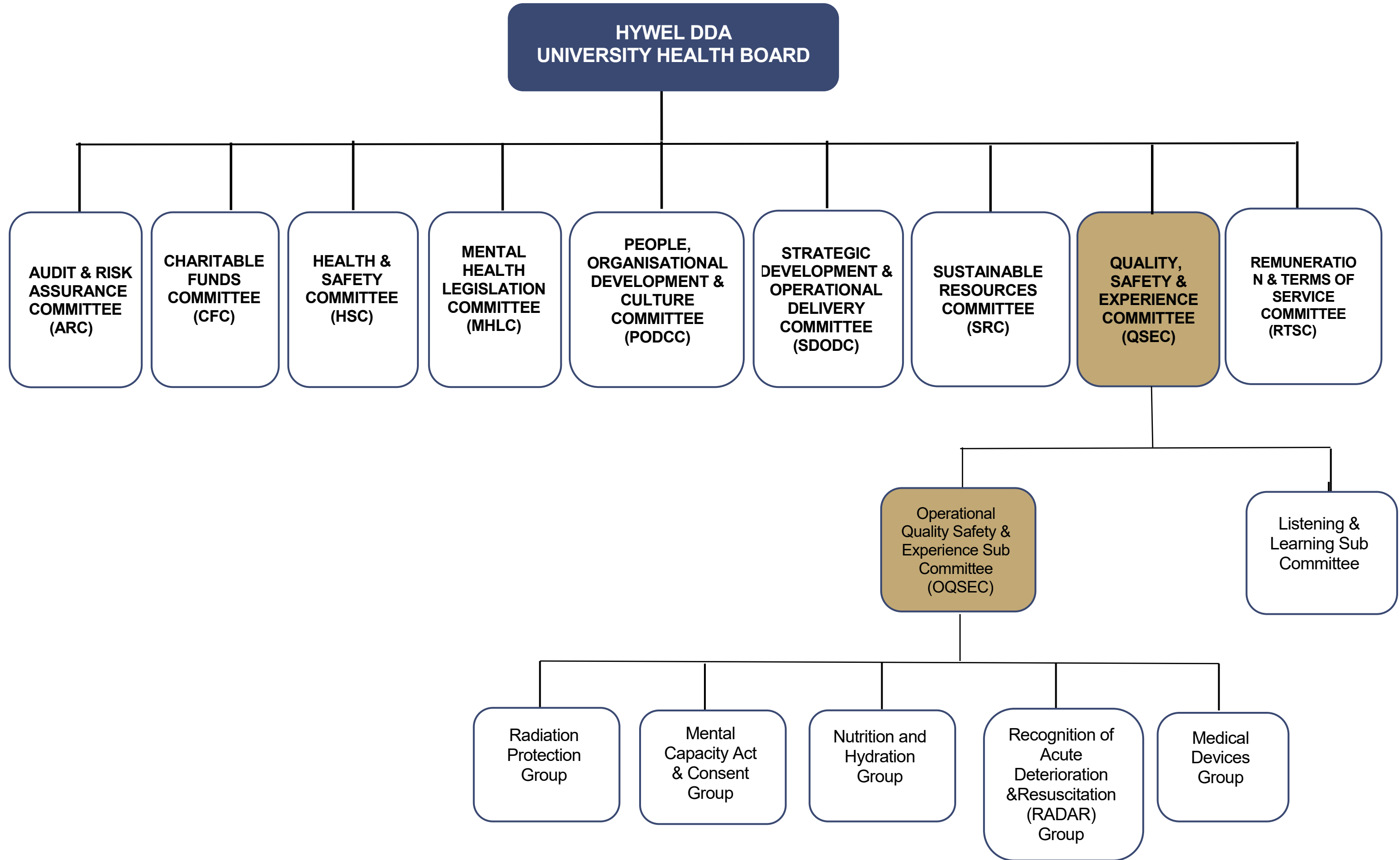
now been completed. The Sub-committee noted that a review group has been set up for CDiff cases across WGH and multi-disciplinary team (MDT) scrutiny of all infection incidents across the site are undertaken regularly, and also that Individual Complaint Support Officers for Accident and Emergency and PALS were now in place.

- The Sub-Committee were assured from the **Medical Devices Group** (MDG) report on its activities and decisions, and the approval of its Terms of Reference.

Review of Risks
A number of new, high and extreme risks were reported to the Sub-Committee.

Recommendation
The Quality, Safety & Experience Committee is asked to note the report.

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Hywel Dda University Health Board



OPERATIONAL QUALITY, SAFETY & EXPERIENCE SUB-COMMITTEE

DRAFT TERMS OF REFERENCE

Version	Issued to:	Date	Comments
V0.1	**Quality, Safety & Experience Assurance Committee Workshop**	29.05.2018	
V0.2	**Operational Quality Safety and Experience Assurance Sub Committee**	10.07.2018	Approved
V0.3	**Operational Quality Safety and Experience Assurance Sub Committee**	20.09.2018	Approved
V0.4	**Quality, Safety & Experience Assurance Committee**	16.10.2018	Approved
V0.5	**Operational Quality Safety and Experience Assurance Sub Committee**	24.01.2019	Approved
V0.6	**Quality, Safety & Experience Assurance Committee**	05.02.2019	Approved via Chairs Action 28.03.2019
V0.7	**Operational Quality Safety and Experience Assurance Sub Committee**	03.09.2020	Approved
V0.8	**Quality, Safety & Experience Assurance Committee**	06.10.2020	Approved
V0.9	**Operational Quality Safety and Experience Sub Committee**	06.07.2021	Approved
V0.9	**Quality, Safety & Experience Committee**	10.08.2021	Approved

V10	**Operational Quality, Safety and Experience Sub Committee**	02.11.2021	Approved
V10	**Quality, Safety, Experience Committee**	07.12.2021	Approved
V11	**Operational Quality, Safety and Experience Sub-Committee**	06.07.2023	Approved
V11	**Quality, Safety, Experience Committee**	08.08.2023	Approved
V12	**Operational Quality, Safety and Experience Sub-Committee**	14.05.24	Approved
V13	**Quality, Safety and Experience Committee**	11.06.2024	For Approval

1. Constitution

1.1 The Operational Quality, Safety & Experience Sub-Committee has been established as a Sub-Committee of the Quality, Safety & Experience Committee and constituted from 1 June 2018, replacing the Acute Services Quality, Safety & Experience Sub-Committee and the Primary & Community Services Quality, Safety & Experience Sub-Committee. From September 2020, the Operational Quality, Safety & Experience Sub-Committee subsumed the Mental Health and Learning Disabilities Quality, Safety & Experience Sub-Committee.

2. Purpose

2.1 The Operational Quality, Safety & Experience Sub-Committee will, as delegated by the Quality, Safety and Experience Committee, monitor the operational quality and safety governance arrangements of Acute, Mental Health & Learning Disabilities services and Primary and Community services. In doing so, the sub-committee will hold services accountable for the management and mitigation of those quality and safety issues, thus allowing the Quality, Safety and Experience Committee to be strategically focused and provide upward assurance to the Board.

3. Key Responsibilities

3.1 Aligned to the Duty of Quality and Health & Care Quality Standards, the sub-committee will monitor the quality, safety and experience of care delivered to patients. Data triangulation from the Quality & Safety and Performance Dashboards will inform this alongside patient feedback, surveys and patient stories. Lack of assurance and resolution is escalated to the Integrated Quality, Planning, Finance and Delivery Group (IQPFD) to inform the Directorate Improving Together process and to Board via the Quality, Safety and Experience Committee.

3.2 Where re-directed by the Listening & Learning Sub-Committee, monitor concerns (incidents, complaints and claims) ensuring that they are being managed in a robust and timely manner at service level, agreeing mitigating actions where required.

3.3 Request a deep dive report.

- When action plans following investigations into serious incidents and concerns and the identification of lessons learned breach the agreed timescales. Ensuring actions are completed in a robust and timely manner and seek assurance that learning is disseminated and embedded across all the Health Board's activities as appropriate.
- To consider themes arising from triangulated information at service specific level and agree and monitor any action plans required to deliver improvements.
- To consider any concerns escalated through the 'Quality Panel'.

3.4 Ensure and monitor compliance with national guidance, including NICE, NSFs, National Confidential Enquiries, outcome reviews and national clinical audits and Health Board clinical written control documents.

3.5 Inform and monitor progress against agreed performance indicators in the Quality & Safety Dashboard and the Performance Dashboard as identified by the Quality & Safety Intelligence Group.

3.6 Seek clarification and assurance on the management of operational risks that have been aligned to the Sub-Committee where the risk tolerance is exceeded or where there is a lack of timely action. Lack of assurance and resolution is escalated to the Quality, Safety and Experience Committee

3.7 Receive Directorate /Site Exception Risk Reports and seek assurance on new elements of a directorate risk which requires consideration on a broader scale. Any risk escalated should clearly reference the risk as noted on the register.

3.8 Receive assurance from those Groups reporting to the Sub-Committee and consider how escalated issues are addressed/resolved.

3.9 Receive position reports on:

- Quality Impact Assessment Panel
- Quality Panel
- Risk Register
- Key Risks associated with preventing harm to patients determined through Triangulation of data.

3.10 Assure itself that clinical written control documentation, which falls within the remit of the Sub-Committee, has been adopted, developed, or reviewed in line with HDdUHB Policy 190 – Written Control Documentation prior to approving it.

3.11 Develop an annual work plan, responding to operational service priorities, consistent with the strategic direction for the organisation, for approval by the Quality, Safety and Experience Committee. Oversee delivery to improve the quality, safety and effectiveness of care delivered and enhance the patient experience.

3.12 Inform the work plans for reporting Groups and vice versa.

3.13 Address any other requirements stipulated by the Quality, Safety and Experience Committee.

3.14 Agree issues to be escalated to the IQPFD Group and the Quality, Safety and Experience Committee with recommendations for action.

4. Membership

4.1 The membership of the Sub-Committee shall comprise:

Title
Assistant Director of Nursing, Quality and Patient Experience (Chair)
Clinical Director and Associate Medical Director Primary Care (Vice Chair)
Deputy Medical Director – Acute Services
Deputy Medical Director – Primary Care & Community Services (Vice Chair)
Assistant Director of Nursing, Acute Services
Assistant Director of Patient Experience
Independent Member, HDdUHB
Associate Medical Director, Quality & Safety
Deputy Director of Operations

Head of Quality and Governance
Deputy Director of Allied Health Professionals
Assistant Director of Public Health
Head of Workforce
Digital Director
County Directors x 3
Head of Medicines Management
Senior Nurse, Infection Prevention
Representative from each Triumvirate (either the General Manager or Head of Nursing)
Assistant Director of Primary Care
Assistant Director of Nursing Mental Health & Learning Disability

4.2 The membership of the Sub-Committee will be reviewed on an annual basis.

5. Quorum and Attendance

5.1 A quorum shall consist of no less than a third of the membership, one of whom must be the Chair or Vice Chair of the Sub-Committee, together with representation from both Medical and Nursing.

5.2 An Independent Member shall attend the meeting in a scrutiny capacity. The scrutiny role of Independent Members in Sub-Committees is to ensure their effectiveness in terms of processes and outcomes. That their work is organised and undertaken in accordance with their terms of reference. That they have clarity about the limits of their delegated powers and responsibilities. That they understand fully their relationship with and reporting responsibilities to their parent Committee

5.3 Any senior officer of the UHB or partner organisation may, where appropriate, be invited to attend, for either all or part of a meeting, to assist with discussions on a particular matter.

5.4 The Sub-Committee may also co-opt additional independent external ‘experts’ from outside the organisation to provide specialist skills.

5.5 Should any officer member be unavailable to attend, they may nominate a fully briefed deputy to attend in their place, subject to the agreement of the Chair.

5.6 The Chair of the Operational Quality, Safety & Experience Sub-Committee shall have reasonable access to Executive Directors and other relevant senior staff.

5.7 The Sub-Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of specific matters.

6. Agenda and Papers

6.1 The Sub-Committee Secretary is to hold an agenda setting meeting with the Chair and/or the Vice Chair, at least **six** weeks before the meeting date.

6.2 The agenda will be based around the Sub Committee work plan, identified risks, matters arising from previous meetings, issues emerging throughout the year and requests from

Sub Committee members. Following approval, the agenda and timetable for request for papers will be circulated to all Sub Committee members.

6.3 All papers must be approved by the Lead/relevant Director.

6.4 The agenda and papers for meetings will be distributed **seven** days in advance of the meeting.

6.5 A draft Table of Actions will be issued within two days of the meeting. The minutes and Table of Actions will be circulated to the Chair within seven days to check the accuracy, prior to sending to Members to review within the next seven days.

6.6 Members must forward amendments to the Sub-Committee Secretary within the next seven days. The Sub-Committee Secretary will then forward the final version to the Sub-Committee Chair for approval.

7. Frequency of Meetings

7.1 The Sub-Committee will meet bi-monthly and shall agree an annual schedule of meetings. Any additional meetings will be arranged as determined by the Chair of the Sub-Committee.

7.2 The Chair of the Sub-Committee, in discussion with the Sub-Committee Secretary, shall determine the time and the place of meetings of the Sub-Committee and procedures of such meetings.

8. Accountability, Responsibility and Authority

8.1 The Sub-Committee will be accountable to the Quality, Safety & Experience Committee for its performance in exercising the functions set out in these terms of reference.

8.2 The Sub-Committee shall embed the HDdUHB's vision, corporate standards, priorities and requirements, e.g. equality and human rights, through the conduct of its business.

8.3 The requirements for the conduct of business as set out in the HDdUHB's Standing Orders are equally applicable to the operation of the Sub-Committee.

9. Reporting

9.1 The Sub-Committee, through its Chair and members, shall work closely with the Board's other committees, including joint /Sub Committees and groups to provide advice and assurance to the Board through the:

9.1.1 joint planning and co-ordination of Board and Committee business; and
9.1.2 sharing of information;

9.2 In doing so, the Sub-Committee shall contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

9.3 The Sub-Committee may, subject to the approval of the Quality, Safety & Experience Committee, establish groups or task and finish groups to carry out on its behalf specific aspects of Sub-Committee business. The Sub-Committee will receive an update following each group's meetings detailing the business undertaken on its behalf. The following groups have been established:

9.3.1 Recognition of Acute Deterioration and Resuscitation Group
9.3.2 Nutrition and Hydration Group
9.3.3 Mental Capacity Act and Consent Group
9.3.4 Medical Devices Group (including Point of Care Testing and Ultrasound Governance)
9.3.5 Radiation Protection Group

9.4 The Sub-Committee Chair, supported by the Sub-Committee Secretary, shall:

9.4.1 Report formally, regularly and on a timely basis to the Quality, Safety & Experience Committee on the Sub-Committee's activities. This includes the submission of Sub-Committee update report, as well as the presentation of an annual report within 6 weeks of the end of the financial year.
9.4.2 Bring to the Quality, Safety & Experience Committee's specific attention any significant matters under consideration by the Sub-Committee.
9.4.3 Bring to the Integrated Quality, Finance, Planning and Delivery Group's attention any significant matters arising from the quality metrics or matters discussed at the Sub-Committee.

10. Secretarial Support

10.1 The Sub-Committee Secretary shall be determined by the Director of Corporate Governance /Board Secretary.

11. Review Date

11.1 These terms of reference and operating arrangements shall be reviewed on at least an annual basis by the Sub-Committee for approval by the Quality, Safety & Experience Committee.

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Y PWYLLGOR ANSAWDD, DIOGELWCH A PHROFIAD
OPERATIONAL QUALITY, SAFETY AND EXPERIENCE SUB COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	14 May 2024
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Operational Quality, Safety and Experience Sub Committee Annual Report 2023/24
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	William Oliver, Chair, Operational Quality, Safety and Experience Sub Committee
SWYDDOG ADRODD: **REPORTING OFFICER:**	Mrs Sharon Daniel, Executive Director of Nursing, Quality and Patient Experience

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of the paper is to present the Operational Quality, Safety and Experience Sub Committee (OQSESC) Annual Report to the Quality, Safety and Experience Committee. The attached report provides assurances in respect of the work that has been undertaken by the OQSESC in the 2023/24 financial year and provides information relating to the continued development of the role of the sub committee and its members and sets out how the QSEC has met its Terms of Reference.

Cefndir / Background

The Health Board's Standing Orders and the Terms of Reference (ToR) for the OQSESC require the submission of an Annual Report to the Committee to summarise the work of the Sub Committee and to identify how it has fulfilled the duties required of it.

This OQSESC Annual Report specifically comments on the key issues considered by the Sub Committee in terms of operational quality, safety and experience, and the adequacy of the response, systems and processes in place during 2023/24.

Asesiad / Assessment

Please see the attached OQSESC Annual Report 2023/24.

Argymhelliad / Recommendation

The Sub Committee is requested to endorse the OQSESC Annual Report 2023/24

Amcanion: (rhaid cwblhau)
Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality [Quality and Engagement Act (sharepoint.com)]	Not Applicable
Galluogwyr Ansawdd: Enablers of Quality: [Quality and Engagement Act (sharepoint.com)]	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	3b Healthcare Acquired Infection Delivery Plan
Amcanion Llesiant BIP: UHB Well-being Objectives: [Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022]	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Agendas and minutes of meetings 2023/24
Rhestr Termau: Glossary of Terms:	Contained within the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	OQSESC Chair, Lead Directors and Committee Members

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not Applicable
Ansawdd / Gofal Claf: Quality / Patient Care:	Not Applicable

Gweithlu: **Workforce:**	Not Applicable
Risg: **Risk:**	Not Applicable
Cyfreithiol: **Legal:**	Not Applicable
Enw Da: **Reputational:**	Not Applicable
Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	Not Applicable

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Operational Quality, Safety and Experience Sub Committee Annual Report 2023/24

The OQSESC Annual Report 2023/24 provides assurances in respect of the work that has been undertaken by the Sub Committee during 2023/24 and outlines the main achievements that have contributed to robust integrated operational governance across the Health Board (HB). Six meetings took place during 2023/24:

- 11 May 2023
- 6 July 2023
- 21 September 2023
- 7 November 2023
- 9 January 2023
- 5 March 2024

❖ **Patient Stories**

During 2023/24 the following patient and staff stories were shared to open the meetings which was helpful in setting a sense of focus for discussions.

- **Patient Story (Glangwili Surgery)- May 2023**
  The Sub Committee received first-hand experience from a patient who had been in a motorcycle accident with her husband. Following the accident, the patient was air lifted to Heath hospital in Cardiff where she spent two weeks before being transferred for another three weeks to Glangwili Hospital. The patient experienced multiple injuries and underwent surgery following the accident. The nursing staff were commended for their moral support during an incredibly difficult time for the patient and positive feedback was shared for the therapy dog. The video highlighted that the little things make a big difference when receiving care in a hospital setting, and also sparked discussion around digital accessibility for contact with loved ones and environmental factors with references to the view from the window etc.

- **Llais Cymru- July 2023**
  The Sub Committee received a presentation on the recently formed Llais Cymru Citizens Body, which is a new independent statutory body that has replaced the Community Health Council.

- **Patient Story (Maternity Services)- September 2023**
  The Sub Committee received a patient story from a husband recalling his experiences of his wife giving birth to their child. It was highlighted that the woman and the consultant involved had also recorded their experiences, which has provided a valuable opportunity to hear different perspectives and allow make service improvements. The long-term implications of inappropriate

comments made by clinicians and staff, as well as inappropriate non-verbal communication was discussed.

- **Patient Story (Frailty)- March 2024**
  The Sub Committee received a patient story that was presented to the Quality, Safety and Experience Committee in October 2023 from a patient's son relaying his experience of his mother's admission and discharge from hospital following a fall which she experienced during the night-time, with concerns raised regarding the standards of care provided for his mother and communication from staff prior to discharge. It was agreed during Committee that the story would be shared with the Sub Committee for learning opportunities. Capacity challenges and demand pressures were reflected upon whilst Members also recognised the unacceptable standards of care and the impact of events on patients and family.

Operational Risk Register:

A report was received on a bi-monthly basis that provided the operational risks assigned to the sub-committee which are monitored and escalated where required.

Group Update Reports

- ❖ **Medical Devices Group (MDG):** The Sub Committee received an update from the MDG during July and November 2023, some of the key highlights included:
  - ➢ The ongoing monitoring of the clinical engineering performance report focussing on Pre-planned Preventative Maintenance (PPM) and repairs in the context of a limited Clinical Engineering (CE) resource, an expanded post-COVID-19 Medical Devices Inventory.
  - ➢ In November 2023, MDG received the medical devices training team report and noted increased training for several additional devices such as dynamic mattresses, electrocardiogram recorders, PAT slides, pain management devices and vital signs monitors.

- ❖ **Nutrition and Hydration Group:** The Sub Committee received an update from the Nutrition and Hydration Group during in December 2023 and January 2024 and some of the key highlights included:
  - ➢ The roll out of the Cook/ Freeze provision of meals programme across the three hospital sites.
  - ➢ The ongoing development to improve patient meals and hydration provision across the Health Board.

  During the meeting in January 2024, the Sub Committee raised concern regarding inconsistencies in the provision of hydration and nutrition for

patients across healthcare settings. It was agreed that a deep dive would be scheduled in March 2024 to provide assurance and an update of work underway to identify the presence of malnutrition and appropriate equitable treatment across all Health and Care Settings. The Sub Committee received a presentation in March 2024 and whilst Members noted that operational pressures are, at times, adversely impacting in-patient nutritional care, assurance was provided on the following:

- Acute operational monitoring and reporting of nutrition and hydration is improving but needs to strengthen in other areas.
- Nutrition and Hydration Group is sighted on areas for improvement and supports collaborative and aligned improvement plans.

❖ **Radiation Protection Group:**

The Sub Committee received an update from the Radiation Protection Group during September 2023 and March 2024.

In September 2023 Members noted that the Laser Protection Policy had been agreed in principle with multiple amendments being incorporated following extensive consultation. This is on the Risk Register as there is no laser protection service available from Swansea Bay, due to qualified laser protection experts/advisors being very rare and difficult to recruit. The new policy does contain a contingency to train an appropriate Clinical Engineer to provide a local service, should staffing capacity allow for this. RPG received assurance that appropriate Laser Protection advice is currently being provided by an outsourced company.

In September 2023, the Sub Committee received an update regarding a technical failure with the GAMMA 3D Scanner at Withybush Hospital. Following repair, the technician has advised that the equipment will need to be used to ensure it is working effectively and scanning has recommenced following a dynamic risk assessment.

In March 2023, the Sub Committee received the key highlights from the Group including:

- Following the Ionising Radiation (Medical Exposure) Regulations 2017 inspection at Withybush Hospital (WGH) nuclear medicine inspection in 2021, all actions have now been completed.
- The Sub Committee received an overview of the accidental and unexpected exposure incidents across the Health Board and the service response in terms of learning. The Sub Committee also noted the low number of accidental and unexpected exposures for the reporting period.
- The Medical Physics Advisor noted difficulties in accessing Hywel Dda data via Datix system. A request has been made to Welsh Risk Pool to change the pathway which has been undertaken and there is now amended Employers Procedures for staff to follow.

- **Recognition of Acute Deterioration and Resuscitation Group (RADAR):** The Sub Committee received updates from the RADAR Group during its meetings in July and November 2023 and January 2024. The Group provided leadership and steered the implementation of the National Early Warning Score in every hospital and in primary care and community services across the Health Board, and provided leadership for the implementation of the RRAILS bundles and Acute Kidney Injury (including recognition, assessment, response and sepsis bundles) in all in-patient areas. In July 2023, the Sub Committee received an update on the change of the title of the group from the Resuscitation and RRAILS to RADAR and noted that the Membership of the group had been revised. The revised Terms of Reference were submitted to OQSESC and approved in November 2023.

The following Directorates presented quarterly update reports to the Sub Committee during 2023/24.

- Women and Children's Services
- Scheduled Care Services
- Public Health Services
- Mental Health and Learning Disabilities
- Community Services
- Therapies Services
- Primary Care Services
- Radiology Services
- Pathology Services
- Oncology Services
- Estates and Hotel Services

During the first quarter, due to concerns relating to increasing pressures on urgent and emergency care services, the Unscheduled Care Directorate leads at Withybush, Prince Philip, Bronglais and Glangwili Hospital were asked to continue to provide reports bi-monthly.

As part of the update reports to the Sub Committee, Directorate leads were asked to share the minutes and outline any matters for escalation from their respective Directorate Quality, Safety and Experience Group meetings, as well as any new/emerging matters, particularly in terms of patient experience e.g. key findings from HIW, peer reviews or other bodies. Several emerging themes were apparent through the update reports provided by Directorate leads during the year such as relentless pressures across services, workforce and accommodation challenges which are being mitigated as far as possible across services. The Chair highlighted that many risks being faced across Directorates are due to capital funding

challenges and invited the Head of Capital Planning to the Sub Committee in January 2024 to provide an overview of the role of the Capital Planning team and a summary of the management process for funding allocation. Members recognised the scale of the challenge in terms of limited funding and the backlog of work required. Following an update provided on a matrix prioritisation tool which has been developed to allocate investment on a risk and safety basis, it was agreed that this would be shared for information. Members were asked to ensure that they inform the team of upcoming equipment replacement or maintenance for planning purposes as soon as possible.

Clinical Effectiveness Report: In September 2023**,** an internal audit of NICE Guidelines recommended a review of governance reporting arrangements, including the role of the Operational Quality, Safety and Experience Sub-Committee (OQSESC). Despite being identified as a purpose within the Terms of Reference, OQSESC was not routinely receiving an update on NICE guidance dissemination and compliance status. It was proposed and agreed that a report will be generated from the Audit and Management and Tracking System (AMaT) which includes new and updated NICE guidelines, the Service Leads that the guidelines have been assigned to and status of compliance. A member of the Clinical Effectiveness team agreed to present an update report at OQSESC three times per year and a tailored version will be presented to the Directorate Quality and Safety Group meetings. In March 2023, the Sub Committee received the Health Board wide compliance with Health Technology Wales and NICE guidance recommendations at its meetings in November 2023 and March 2024. In March, Members noted that there are 50 overdue guidance statement entries on the Audit Management and Tracking System (AMAT) and leads were urged to contact the Clinical Effectiveness team with any updates. It was noted that the introduction of the AMaT system is still in its early days and that outstanding guidance compliance would be scrutinised and discussed at future meetings once the system was fully embedded.

CIVICA Patient Experience System: In July 2023, the Sub Committee received an update on the roll out of the CIVICA patient experience system and Members were pleased to note that technical issues that were previously raised as a matter of concern have been resolved and the patient experience system is now accessible on all Hywel Dda devices and externally on mobile phone devices.

Out of Hours Peer Review: In May 2023, the Sub Committee received the key highlights from an Out of Hours Peer Review, the outcome and actions to address the recommendations. The Peer Review follow up session took place in April 2023 and positive feedback has been received on the progress of the associated action table. Assurance was received that there are no concerns to escalate from the service with regards to the actions which are being addressed and tracked by the Assurance and Risk Team. Intelligence is being sought on the impact of full rotas on urgent and emergency services. It was acknowledged that there are a wide range of variations that will need to be considered as part of the data collation to ascertain

what difference this is making for patients. In response to a request for an update on in six months' time, in January 2024, Members received an update on the number of improvements undertaken including increase in pharmacy support, enhanced clinical leadership and overall increase in shift fill for the rotas. Members noted the Organisational Change Process, which is currently under consultation, will firm up the management structure and roles and be the foundation for the service developments.

Additional Learning Needs: The Sub Committee received an update on the Additional Learning Needs and Educational Tribunal (Wales) Act 2018 in November 2023 (ALN Act) which aims to deliver better outcomes and experience for children and young people aged between 0- 25. Whilst currently 'part' of Women and Children's Services, the Act impacts on several different services across the Health Board, particularly Therapies and Mental Health and Learning Disabilities. In collaboration with education partners, work is underway to implement new operational processes across the three counties, which NHS staff 'feed' into education's 'person-centred planning processes' and through which key statutory duties for the Health Board are enacted.

Patient Safety Solutions Presentation: In January 2024, Members received an organisational update on Patient Safety Solutions (Alerts and Notices) and noted that the Health Board have a good compliance rate; with 79 out of 80 PSA's compliant which is on par with other organisations across Wales. The Sub Committee agreed to review the safety alerts and provide feedback at the next meeting on which patient safety alerts and notices would be most appropriate to undertake an audit.

Clinical Record Keeping Audit: In July 2024 the Sub Committee were updated that the Health Board have approved a new Clinical Record Keeping Policy in February 2023. The Policy was developed with multidisciplinary input and supports effective record keeping by providing clear professional and organisational standards that all clinical staff must adhere to.

- **Written Control Documents:** Several written control documents were presented and approved by the Sub Committee in 2023/24 including the following:
  - The Quality, Safety and Experience Committee Terms of Reference
  - The Sub Committee and Operational Groups Terms of Reference

In February 2024, the Quality, Safety and Experience Committee supported the need to strengthen the operational governance arrangements for the Sub Committee and it was agreed that the Terms of Reference would be reviewed.