OPERATIONAL QUALITY, SAFETY & EXPERIENCE

SUB-COMMITTEE UPDATE REPORT

Date of last meeting: 11 July 2024

Quoracy: Met

Report by: Dr Sion James, 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:

- Despite there being an improvement in resources, capacity and engagement to ensure compliance with the **Medical Examiners (Wales) Regulations** which becomes statutory in September 2024**,** the Sub Committee remain concerned that the level of capacity required is not achievable. This has been escalated as a Corporate Risk and the Directorate and Sub Committee will continue to monitor this.

Advise[2] (to monitor)

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

- National and local working groups have been established and action plans developed in readiness for the implementation of **Martha's Rule (Call for Concern).** While it was noted that a draft process will be in place by September 2024, concern was raised by the Sub Committee of the potential cross site medical capacity challenges and the potential for the patient/ family-initiated escalation process to be open to misinterpretation. Members agreed that adequate screening processes will need to be implemented.

- A number of significant updates were reported from the **Unscheduled Care Directorates** at the three acute hospital sites, and while the one-hour ambulance delays have shown some improvement due to the mitigating actions undertaken, the 12-hour waits within the A&E departments are not decreasing, and patient experience within the area is being closely monitored. A Patient Advice and Liaison Service (PALS) Officer and Complaints Officer have been recruited and are based on site which is helping to support patients and the timely management of complaints.

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[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*.

- Discussion took place on staff receiving timely access to Resuscitation Training via the **Mental Health and Learning Disabilities Update Report**. The demand and capacity issues for Resuscitation staff on a Health Board wide basis was highlighted. A review of the level of training needed by different staff via Directorate Leads and ESR is being undertaken. Cascade Training is being provided in a staged approach to train staff to deliver training within their respective services where appropriate.

Assure[3] (to note)

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

- In terms of the provision of continence products for children and young people (CYP), a non-compliance risk has been raised in relation to this WHC: Risk 1615 – "Care of CYP with Continence problems"; there is currently no budget for Paediatric incontinence in Hywel Dda. This is part of a wider service review of Hywel Dda Children's disability services. An options appraisal paper is being completed to be presented at the **Women and Children's Directorate** Quality and Safety meeting in August 2024 and an update will be shared with OQSESC in September 2024.

- In terms of the **C-Diff Healthcare Acquired Infection** rates, members noted that while Health Board-wide engagement is improving; there remains ongoing challenges with the required clinical engagement for the scrutiny reviews and compliance with Start Smart and Stop Audits. Audits are being undertaken by the Infection Prevention Control Teams and improvement plans are being developed at the monthly multi-disciplinary meetings.

Written Control Documents

The Sub Committee approved the following Written Control Documents:

- 1158 Cardiac Monitoring Procedure
- 867 All Wales ICD Deactivation Policy and Deactivation of an Implantable Cardiac Defibrillator Procedure
- 811 Mental Capacity Act Guideline
- 309 Long Term Care Operational Care Policy
- The Sub Committee approved the RADAR terms of reference.

Recommendation

The Quality, Safety & Experience Committee is asked to note the content of the report, approve the revised Terms of Reference and approve Policy 309 Long Term Care Operational Care Policy which is on the QSEC agenda for 15 August 2024.

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

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	15 August 2024
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Quality, Safety and Experience Sub Committee (QSESC) Terms of Reference
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	James Severs, Executive Director of Allied Health Professions and Health Science
SWYDDOG ADRODD: **REPORTING OFFICER:**	Sharon Daniel, Interim 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 this paper is to ensure that the Quality, Safety and Experience Sub Committee (QSESC) has clear Terms of Reference which detail its purpose, responsibilities, and operating arrangements.

Cefndir / Background

The Terms of Reference for the Quality Safety Experience Committee (QSEC) were approved in June 2024 as part of the Committees Annual Work Plan. With an action to review the Committee's responsibilities from the Targeted Intervention (TI) escalation status by Welsh Government to determine if the Committee are meeting these requirements and review the work plan accordingly. Also to explore including reference to the Committee's role in monitoring the compliance with Quality and Engagement Act.

To achieve these recommendations there was a requirement to review the governance arrangements at Sub Committee level. This informed the review of the Operational Quality, Safety, Experience Sub-Committee Terms of Reference, and the development of the Quality Safety Intelligence Group (QSIG).

QSIG now exists as part of the Executive Team Structure and is a sub -group of the Integrated Quality, Finance and performance Delivery Group (IQPFD). The purpose of QSIG is to ensure robust oversight and monitoring of the Directorates quality, safety and experience activities and escalation processes with a focus on the Health Board's *TI escalation status*.

The Operational Quality, Safety & Experience Sub-Committee (OQSESC) has now been replaced by the Quality, Safety and Experience Sub Committee (QSESC). QSESC will, as delegated by QSEC, monitor the quality, safety and experience governance arrangements of Acute, Mental Health & Learning Disabilities and Primary and Community services ensuring *alignment to the Duty of Quality and Health & Care Quality Standards*. In doing so, the sub-committee will hold services accountable for the management and mitigation of those quality and safety issues, thus allowing QSEC to be strategically focused and provide upward assurance to the Board.

Asesiad / Assessment

TERMS OF REFERENCE
The QSESC Terms of Reference (ToR) have been reviewed and some changes and amendments have been made which are clearly marked in **red** text on Appendix 1.

In summary:

- 'Operational' in OQSESC's title has been omitted
- Address the need for this Sub-Committee to monitor Directorate quality and safety governance arrangements to allow QSEC to be more strategically focused.
- QSESC will be chaired by the Clinical Executive Directors on a rotational basis.
- Membership has been reviewed
- The reporting/advisory groups have been reviewed as follows:
    - The following Groups remain:
        - Recognition of Acute Deterioration and Resuscitation Group
        - Nutrition and Hydration Group
        - Mental Capacity Act and Consent Group
        - Medical Devices Group (including Point of Care Testing and Ultrasound Governance)
    - The following Group has been removed:
        - Radiation Protection Group will, going forward, report into Health & Safety Committee
    - The following groups have been added
    - Infection Prevention Strategic Steering Group
    - Human Tissue Authority
    - Medical Exposure Group
    - Effective Clinical Practice Group
    - Strategic Safeguarding Group

These groups will set the standard and monitor compliance. They will provide a summary of their meetings to the Directorates. When assurance cannot be provided a deep dive will be requested (Quality Panels have been removed from the ToR)

Reporting to QSEC will be by exception and will include any significant matters under consideration by the Sub-Committee.

The annual workplan will be revised to ensure that the Advisory Groups report twice a year to QSESC.

Argymhelliad / Recommendation

QSEC is requested to:

- APPROVE the updated QSESC's Terms of Reference

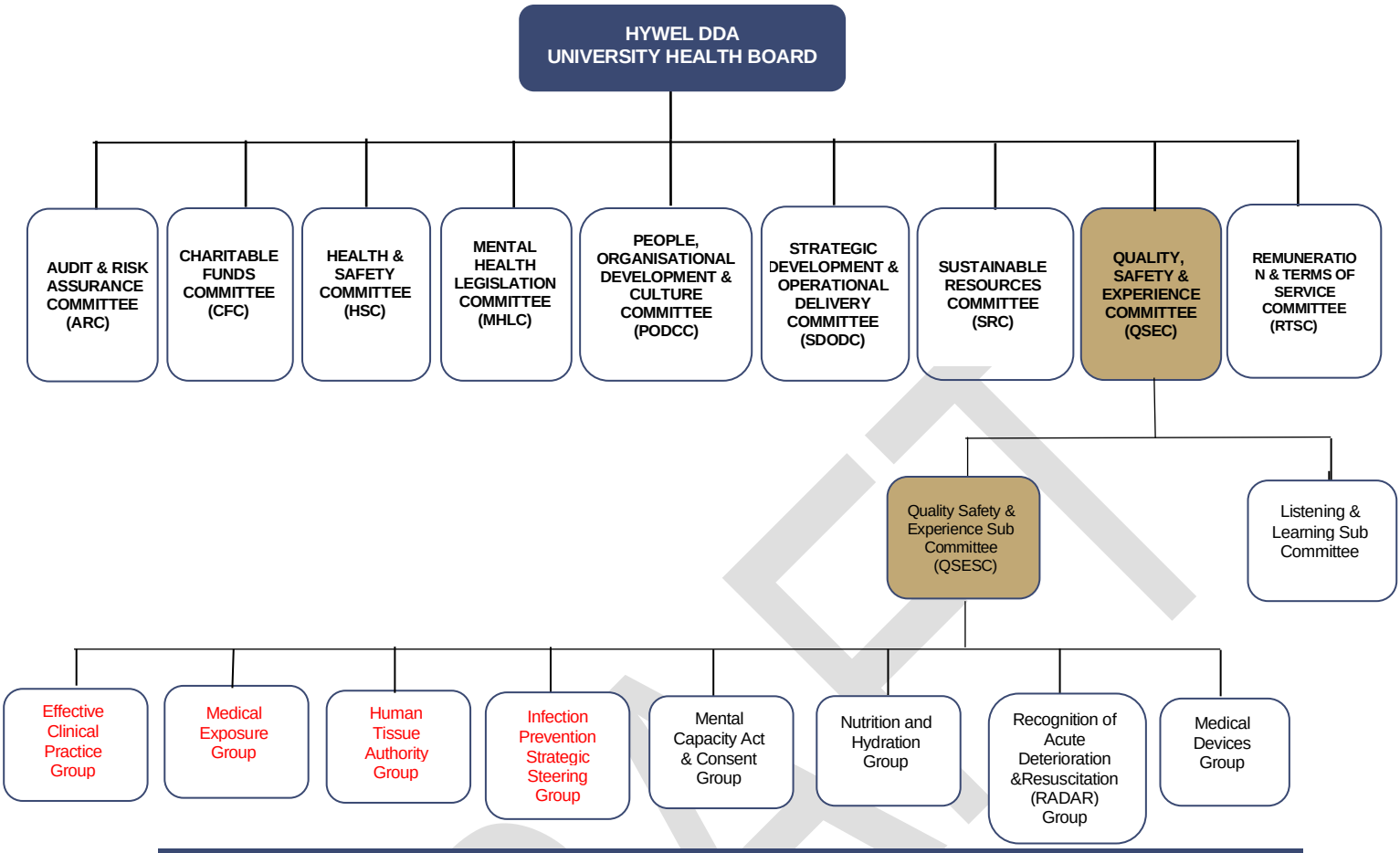
Amcanion: (rhaid cwblhau)
Objectives: (must be completed)

Committee ToR Reference Cyfeirnod Cylch Gorchwyl y Pwyllgor	12.1: These Terms of Reference and operating arrangements shall be reviewed on at least an annual basis by the Committee.
Cyfeirnod Cofrestr Risg Risk Register Reference:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	QSESC Terms of Reference
Rhestr Termau: Glossary of Terms:	Contained within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg: Parties / Committees consulted prior to Audit and Risk Assurance Committee:	Director of Corporate Governance (Board Secretary) Assistant Director of Assurance and Risk

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No direct impacts
Ansawdd / Gofal Claf: Quality / Patient Care:	No direct impacts
Gweithlu: Workforce:	No direct impacts
Risg: Risk:	No direct impacts
Cyfreithiol: Legal:	No direct impacts
Enw Da: Reputational:	No direct impacts
Gyfrinachedd: Privacy:	No direct impacts

Cydraddoldeb: **Equality:**	No direct impacts



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	Approved
V14	**Quality, Safety and Experience Committee**	15.08.24	For Approval

1. Constitution

1.1 The Quality, Safety & Experience Sub-Committee has been established as a Sub-Committee of the Quality, Safety & Experience Committee and constituted from 1 September 2024, replacing the Operational Quality, Safety & Experience Sub-Committee. From June 2018 the Operational Quality, Safety & Experience Sub-Committee replaced 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 Quality, Safety & Experience Sub-Committee will, as delegated by the Quality, Safety and Experience Committee, monitor the quality, safety and experience governance arrangements of Acute, Mental Health & Learning Disabilities 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 reviewed by the Quality Safety Intelligence Group (QSIG) 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 Escalation and Directorate Improving Together processes 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.

3.4 Ensure and monitor compliance with recommendations from external reviews and national guidance, including HIW, Royal Colleges, 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 QSIG.

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 Aligned to the Domains of the Duty of Quality 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 the Advisory Groups reporting to the Sub-Committee and consider how escalated issues are addressed/resolved.

3.9 Receive position reports on:

- Quality Impact Assessment 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 Advisory 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.

4. Membership

4.1 The membership of the Sub-Committee shall comprise:

Title
Executive Director of Allied Health Professionals and Healthcare Sciences (Chair)Chair)
Executive Director
Executive Director of Nursing, Quality and Patient Experience
Assistant Director of Nursing, Quality and Assurance
Assistant Director, Legal and Patient Support

Clinical Director and Associate Medical Director Primary Care
Deputy Medical Director – Acute Services
Deputy Medical Director – Primary Care & Community Services
Assistant Director of Nursing, Acute Services
Assistant Director of Patient Experience
Associate Medical Director, Quality & Safety
Head of Quality and Governance
Deputy Director of Allied Health Professionals
Deputy Director of Health Science
Director of Public Health
Director of Midwifery
Clinical Director Pharmacy
Deputy Chief Operating Officer
Head of Workforce
Digital Director
County Directors x 3
Head of Medicines Management
Senior Nurse, Infection Prevention
Representative from each Triumvirate (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 Clinical Professions (Medicine, Nursing. Allied Health Professionals and Health Sciences) and each Directorate/Care Group.

5.2 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.

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

5.4 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.

5.5 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 Infection Prevention Strategic Steering Group
9.3.6 Human Tissue Authority Group
9.3.7 Medical Exposure Group
9.3.8 Effective Clinical Practice 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.