Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ANSAWDD, DIOGELWCH A SICRHAU PROFIOD
QUALITY, SAFETY AND EXPERIENCE ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	13 April 2021
TEITL YR ADRODDIAD: TITLE OF REPORT:	Draft Operational Quality, Safety and Experience Sub-Committee (OQSESC) Annual Report 2020/21
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Alison Shakeshaft, Chair, OQSESC, Executive Director of Therapies & Health Science
SWYDDOG ADRODD: REPORTING OFFICER:	Sarah Bevan, Committee Services Officer

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 present the draft Operational Quality, Safety and Experience Sub-Committee (OQSESC) Annual Report 2020/21. The OQSESC Annual Report provides assurances in respect of the work that has been undertaken by the Sub-Committee during 2020/21 and outlines the main achievements which have contributed to robust integrated governance across the University Health Board (UHB).

Cefndir / Background

The UHB's Standing Orders and the terms of reference for the OQSESC require the submission of an Annual Report to the Quality, Safety & Experience Assurance Committee to summarise the work of the Sub-Committee and to identify how it has fulfilled the duties required of it.

The fundamental purpose of the Sub-Committee is to focus on the acute services, primary and community services, and mental health and learning disabilities services (MH&LD), quality and safety governance arrangements at an operational level, bringing together accountability and ownership for those quality and safety issues to be resolved operationally, freeing up the Quality, Safety and Experience Assurance Committee to be more strategic in its approach and providing onward assurance to the Board.

The OQSESC Annual Report specifically comments on the key issues considered by the Sub-Committee in terms of quality, safety and experience, and the adequacy of the response, systems and processes in place during 2020/21.

Asesiad / Assessment

OQSESC has been established under Board delegation reporting to the Quality, Safety & Experience Assurance Committee.

The terms of reference clearly detail the Sub-Committee's purpose to provide assurance to the Quality, Safety & Experience Assurance Committee around the organisation's acute, primary and community, and MH&LD services quality and safety governance arrangements at an operational level, bringing together accountability and ownership for those quality and safety issues to be resolved operationally, and providing an upward assurance. The OQSESC terms of reference were most recently revised at the September 2020 Sub-Committee meeting and approved by QSEAC on 6th October 2020.

In discharging this role, the Sub-Committee is also required to oversee and monitor the quality, safety and experience agenda against the following areas of responsibility:

- Resuscitation/RRAILS
- Nutrition and Hydration
- Mental Capacity Act and Consent
- Medical Devices
- Radiation Protection

Other areas of focus include:

- Clinical pathways such as stroke, diabetes, cardiology
- Operational risks from the acute, primary and community, and MH&LD services, where there is an impact on patient quality, safety or experience.

OQSESC Groups
The Groups reporting to OQSESC during 2020/21 were as follows:

Resuscitation/RRAILS Group – established to:
- Provide assurance that robust and reliable mechanisms for the early detection and response to acute illness and management of cardio/respiratory arrest are in place

Nutrition and Hydration Group – established to:
- Set the strategic direction and provide assurance on all matters relating to nutritional care, including aspects of catering services

Mental Capacity Act and Consent Group – established to:
- Provide clear leadership in the promotion of the application of the Mental Capacity Act in every day clinical practice
- Ensure that there is a framework in place to support staff in relation to the Mental Capacity Act and monitor compliance with this legislation through appropriate assurance mechanisms
- Provide assurance that consent processes are being adhered to across the UHB, and where necessary agree corrective action
- Ensure that the Welsh Government Policy for Consent to Examination and Treatment and the associated consent forms are kept up to date and implemented in all relevant areas of the UHB

Medical Devices Group – established to:
- Provide assurance around strategic medical devices management and associated risk matters

Radiation Protection Group – established to:

- Consider radiation protection issues relating to ionising radiations (e.g. X-rays and radioactive materials including radon) and non-ionising radiations (e.g. lasers, MRI, phototherapy, ultrasound) within the Health Board.
- Review implementation of the Health Board's radiation protection arrangements for health and safety, environmental protection (and medical exposures via the Medical Exposure Committee).
- Identify and monitor current activities and developments relating to the use of radiations.
- Review radiation risks and inform the Chief Executive of measures to be taken to secure compliance with relevant legislation and to manage risks.

The OQSESC Annual Report 2020/21 is intended to outline how the Sub-Committee and its Groups have complied with the duties delegated by the Quality, Safety & Experience Assurance Committee through the terms of reference set, and also to identify key actions that have been taken to address issues within the Sub-Committee's remit.

Constitution

From the terms of reference approved in October 2020, the membership of the Sub-Committee was agreed as the following:

- Executive Director of Therapies and Health Science (Chair)
- Assistant Director, Operational Nursing & Quality Acute Services – Vice Chair
- Associate Medical Director, Workforce & Primary Care
- Associate Medical Director, Quality & Safety
- Deputy Director of Operations
- Assistant Director of Nursing Assurance & Safeguarding
- Assistant Director of Therapies and Health Science – Professional Practice, Governance & Safety
- Assistant Director of Workforce & OD
- Assistant Director of Informatics
- County Directors x 3
- Independent Member, HDdUHB
- Head of Medicines Management
- Therapies Lead
- Health Science Lead
- Senior Nurse, Infection Prevention
- Representative from each Triumvirate
- Head of Primary Care
- Head of Nursing, Mental Health and Learning Disabilities

Meetings

Since April 2020, OQSESC meetings have been scheduled on a bi-monthly basis as follows:

- 7th May 2020*
- 2nd July 2020
- 3rd September 2020

- 5th November 2020
- 7th January 2021*
- 28th January 2021 – extraordinary meeting to discuss the on-call system for staffing Bronglais General Hospital (BGH) out of hours (OOH) in theatres.
- 4th March 2021 (narrative to be added to the final Annual Report following the meeting)

* These OQSESC meetings were stood down due to the extraordinary pressures being experienced across all Hywel Dda sites due to COVID-19, in order to free staff up to focus on discharge activity and manage flow.

As OQSESC is directly accountable to the Quality, Safety & Experience Assurance Committee for its performance, following each meeting it provides an assurance to the Committee through a formal written update report, which is received at the subsequent Committee meeting.

During 2020/21 the Sub-Committee met on five occasions and was quorate at all meetings.

Sub-Committee Terms of Reference and Principal Duties
In discharging its duties, OQSESC has undertaken work during 2020/21 against the following areas of responsibility in relation to its terms of reference:

- Monitor the quality, safety and experience of care delivered to patients through, for example, surveys and patient stories, and escalate issues that cannot be resolved operationally to the Quality, Safety and Experience Assurance Committee.
- Ensure that concerns (incidents, complaints and claims) are being managed in a robust and timely manner at service level, agreeing mitigating actions where required.
- Monitor action plans following investigations into serious incidents and concerns and the identification of lessons learned, by ensuring actions are completed in a robust and timely manner, and seek assurance that learning is disseminated and embedded across all of the Health Board's activities as appropriate.
- 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.
- Inform and monitor progress against agreed performance targets identified in the Quality & Safety Dashboard.
- Consider the themes arising from triangulated information at service specific level and agree and monitor any action plans required to deliver improvements.
- Seek assurance on the management of operational risks that have been aligned to the Sub-Committee, and provide assurance to the Quality, Safety and Experience Assurance Committee that risks are being managed effectively and report any areas of concern, e.g. where risk tolerance is exceeded or lack of timely action.
- Receive assurance from those Groups reporting to the Sub-Committee and consider how escalated issues are addressed:
    - Directorate and County Quality & Governance Groups
    - Resuscitation/RRAILS Group
    - Nutrition and Hydration Group
    - Medical Devices Group (including Point of Care Testing and Ultrasound Governance)

- Mental Capacity Act and Consent Group
- Receive position reports on:
  - Key Risks associated with preventing harm to patients
  - Quality Improvement Pathways:
- 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, and to provide evidence of that assurance to the Clinical Written Control Documentation Group when recommending a procedure or guideline for uploading or a policy for final approval by the Clinical Written Control Documentation Group.
- 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 Assurance Committee and oversee delivery to improve the quality, safety and effectiveness of care delivered, and enhance the patient experience.
- Seek assurance reports from relevant partnerships, and consider the actions required in relation to any quality and safety issues identified.
- Inform the work plans for reporting Groups and vice versa.
- Address any other requirements stipulated by the Quality, Safety and Experience Assurance Committee.
- Agree issues to be escalated to the Quality, Safety and Experience Assurance Committee with recommendations for action.

Specific Areas of Responsibility

In discharging its duties during 2020/21, OQSESC received and considered the following during 2020/21:

Health Board wide Assurance Reports:

- **Cancer treatment during COVID-19** - the Sub-Committee received a comprehensive report outlining a summary analysis on the impact of COVID-19 on cancer referral rates, treatment volumes, and referral to diagnostic rates, and also on the current scope of cancer services and treatments during COVID-19, including the Health Board's response to Welsh Government (WG) on the 'Response to the Framework for Recovery of Cancer Services' benchmarked against the eight key actions. Assurance was received on the Health Board's position of a 49% reduction rate on cancer referrals against a 70% reduction across the whole of Wales, and that any suspended treatment pathways had been in line with guidance. Patients on these pathways have since been tracked and treatment recommenced. It was noted that the biggest COVID-19 impact on the diagnostic pathway was colorectal, which was caused by the suspension of Endoscopy Services due to the risk of the aerosol generating procedures and potential COVID-19 transmission. Assurance was also received in terms of surgical cancer treatments with a surgical pathway being maintained for patients that meet the specific criteria through Health Board commissioned services at Werndale Hospital. Despite the lack of Level 2/3 facilities at this hospital, many patients were able to proceed with their treatment. Those patients who were outside of the criteria subsequently received their required surgical interventions within the acute hospitals through the reintroduction of planned care pathways across the acute sites. Through prompt and effective planning,

oncology appointments have continued virtually, and chemotherapy services maintained across the sites. This also applied to diagnostic investigations, radiological imaging, and phlebotomy services. Only one area of concern was highlighted which related to potential delays for patients through capacity issues experienced at the tertiary centres.

- **Hospital Acquired Thrombosis** - the Sub-Committee received a Health Board position report in relation to Hospital Acquired Thrombosis (HAT) which became a Tier 1 target in 2015/16. WG normally receive reports from the Health Board both monthly and quarterly which include data on the number of positive cases of Venous Thrombo Emboli (VTE) within 90 days of discharge and the number of preventable and unpreventable cases. It was noted that this line of reporting had been suspended during the COVID-19 period, however assurance was received on the following:
    - Health Board internal scrutiny and review processes have been maintained via Root Cause Analysis reports reviewed at local clinical team level and by the Thrombosis Group.
    - Dissemination of Learning from Events through various fora including Directorate / Site Clinical Governance meetings and directly to individual clinicians.
    - In line with the All Wales Thrombo-Prophylaxis Policy, a single risk assessment tool has been developed with the aim of improving compliance, with assessment of patients within a 24 hour period of admission with a planned introduction imminent.
    - All avoidable cases are reviewed by the legal team to ensure patients are kept informed and redress offered if necessary.
    - Development of a HAT Improvement Plan previously endorsed by QSEAC.
    - Establishment of a task & finish group to monitor and implement the plan.

- **Inpatient Falls** - the report on data for inpatient falls during the previous 18 months on each acute hospital site provided a variable illustration on the trends relating to falls and the correlation with quality improvement work initiated in areas deemed as high risk. It was noted that there was a significant downward trend over the 3 month period from the commencement of the initial COVID-19 period, however this was attributed to the reduction of hospital admissions to the non-COVID-19 areas during the pandemic. The Sub-Committee also noted that the quality improvement work had paused due to staff redeployment during COVID-19. Assurance was received that diligence on falls risk assessments is being maintained and post falls protocols followed in clinical areas.

- **Pressure Damage** - the report on pressure damage highlighted a slight increase in pressure damage during 2019/20 particularly in Quarters 3 and 4 which linked to changes made to the reporting and investigating processes as demonstrated by the reclassification of 78 reported incidents not deemed to be actual pressure damage through validation by the Tissue Viability Team. This upward trend was also illustrated in the first quarter report of 2020/21 with a total of 19 incidents in April 2020, 24 in May 2020 and 30 in June 2020. As there is ongoing work to address these, the Sub-Committee received an assurance that these numbers would decrease following the validation process. The impact of pressure damage related to the use of Personal Protective Equipment (PPE) during the COVID-19 period was described in the main as facial indentation caused by the use of face masks with 9 reported incidents. The Sub-Committee received an assurance by the preventative processes put in place such as use of gel strips to reduce pressure and staff awareness training to mitigate risk. The

Sub-Committee acknowledged the additional work being undertaken within acute services to introduce the new All Wales Pressure Damage Assessment Performa, the ongoing works to critically analyse avoidable and unavoidable pressure damage and also introduce improvements to support evidence-based practice.

Pharmacy and Medications Management – Medication Incidents - the Sub-Committee received the Pharmacy and Medicines Management Assurance Report on Primary Care, Community and Acute Services which included reference to the challenges in providing accurate data on medication incidents across the sectors. This largely relies on the DATIX Incident Reporting System which many independent contractors in primary care do not have access to, and pharmacy in the community is only required to report incidents involving controlled drugs, hence the higher number of medication errors reported through the DATIX system across acute services. Assurance was provided that there are a number of mechanisms in place to support learning from reported incidents and to identify opportunities to avoid harm to patients. All improvement plans following the scrutiny of medication errors are subsequently reviewed by the Medicines Event Review Group (MERG) where areas of concern are identified, and shared learning facilitated across the Health Board. The Sub-Committee noted the common themes on medicines management highlighted in Healthcare Inspectorate Wales (HIW) Reports and the repeat offenders in terms of medication errors, which require a change in culture. This particular theme was incorporated into a Health Board workshop on medication errors held in the autumn. The Sub-Committee received an assurance by the systems currently in place and acknowledged the efforts being made to improve processes and to mitigate risk to patients through a zero tolerance approach.

Operational Risk Management

- **Health Board Overview on Top Rated Risks / Actions for Mitigation** – at its meeting on 2nd July 2020, the Sub-Committee noted the content of the Operational Risk Management Report and the mitigation plans put in place. Directorate/Site Services Leads and County Representatives were requested to discuss the risks within their respective Directorate/Site Clinical Governance meetings to ensure that the exception reports and quality issues are aligned.
- **Operational Risk Report** – at its meeting on 3rd September 2020, the Sub-Committee received the Operational Risk Report noting the addition of 7 risks and the removal of 9 risks from the OQSESC Risk Register since the previous meeting, with 2 increasing and 2 decreasing their risk scores. There were 21 red risks, the majority of these relating to staffing, with the remainder relating to ICT issues. It was noted that a small number of risks appeared to have not been reviewed for over a year and the assurance and risk representative at the meeting advised that guidance had been reiterated to all directorates for monthly reviews of all red risks and bi-monthly for amber risks. It was also noted that many of the Therapy Services red risks related to staffing, and that work would be undertaken to amalgamate these into fewer Directorate level risks. In particular, therapies staffing issues relating to stroke, with the Sub-Committee noting that the Health Boards Stroke Re-design Programme had been paused due to COVID-19; once this re-commences, a business case for increased therapies stroke staffing will be developed. Risks 654 and 658 (risk of harm to inpatients at high risk of malnutrition and; risk of poor outcomes for frail and elderly patients in the community with or at risk of malnutrition) were specifically discussed with it noted that these risks are due for review with the anticipation that

the risk scores should reduce. The Sub-Committee sought assurance that risks would be reviewed more frequently, with the Chair requesting all risks to be reviewed by the next OQSESC meeting on 5th November 2020.

- **Operational Risk Report** – at its meeting on 5th November 2020, the Sub-Committee received a composite report describing the operational risks assigned to OQSESC with current scores exceeding the tolerance level. The Sub-Committee noted that two risks (stroke and frail elderly) did not appear to have been reviewed since 2019, however, assurance was provided that these had been reviewed since the report had been prepared. The Sub-Committee also noted that risk 654 (inpatient malnutrition), which had previously been of concern to the Sub-Committee, had now been de-escalated from a Red 20 to a level 10.

Directorate / Site Exception Reports on Risks / Concerns for Escalation

- At its meeting on 2nd July 2020, the Sub-Committee reviewed the recurring themes throughout the exception reports from all Acute and Community Services which outlined the substantial change to services including the introduction of surge capacity as part of the emergency planning associated with COVID-19. Also highlighted were the risks associated with the reintroduction of planned care surgical pathways into some acute sites that had not dealt with major surgical cases for a significant number of years. The plans put in place to ensure patient safety and support staff in these circumstances was acknowledged by OQSESC. The high number of existing nursing vacancies evident across the hospital sites was noted and assurance derived from the efforts made to secure temporary backfill for registered nurse vacancies, with the Sub-Committee commending the development of Healthcare Support Worker (HCSW) Band 4 posts to support the registered nurse workforce.
- At its meeting on 3rd September 2020, the Sub-Committee received 7 Site/Directorate Exception Reports, the majority of which focused on staffing issues, and the impact of COVID-19 on services including staffing availability and facilities/environments. Whilst good progress was noted in a number of areas and the Sub-Committee was assured that directorate teams are managing risks through appropriate mitigations, there were some areas where detailed plans would be required to resolve a number of issues e.g. the impact of COVID-19 on space availability to deliver all services at Prince Philip Hospital (PPH). The Sub-Committee acknowledged the impact COVID-19 has had on planned activity and waiting times and that the Executive Team has requested a recovery plan from the Scheduled Care Directorate, supported by the Transformation Team. It was noted that web-based information would soon be available to patients and their families, providing weekly service updates. It was agreed that the impact on planned care services should be escalated to QSEAC.
- At its meeting on 5th November 2020, Directorate Risk Escalation Reports were received from Mental Health and Learning Disabilities, with the Sub-Committee raising concerns regarding the waiting lists involved and requesting a further report to the next Sub-Committee meeting; Scheduled Care; Women and Children's; and 3 County Community Nursing.

Compliance Status: External Health Regulator Review / Improvement Plan – Healthcare inspectorate Wales: Annual Review - the annual summary of the HIW inspections undertaken within the Health Board during 2019/20 was acknowledged by the Sub-Committee including the themes identified within the recommendations made by HIW for the Health Board. Assurance was provided that learning is evident particularly in paediatrics and medicines management and that HIW recommendations are discussed as part of the Directorate / Site

Clinical Governance Meetings. The Sub-Committee noted that it is anticipated that HIW would be restarting its inspection programme in the near future following a period of suspension during the COVID-19 pandemic.

Report on the Statutory Pre-Planned Maintenance (PPM) (Building and Engineering services) – the Sub-Committee received an assessment of maintenance performance during Quarter 1, 2020/21. While noting a small reduction (91% against a 95% target) for high risk building maintenance, the Sub-Committee was assured that this was not an un-reasonable position given the complexities that COVID-19 restrictions had placed on access, closure of areas, re-purposing of others, demand and a number of other factors. The Sub-Committee was further assured that there has been little impact on the built environment, with regards to maintenance compliance, mitigated by the cancellation of a significant amount of planned building work due to inactive services as a result of COVID-19, for example theatres and endoscopy, and that actions were in place to mitigate the shortfall in target PPM.

Covid-19 Super Bariatric Report - the Sub-Committee received a report outlining the processes to manage super-bariatric patients during the COVID-19 period. The Sub-Committee believed that neither the paper nor the pathway were sufficiently developed at this time. Furthermore, given that no one was available to present to the report, it was agreed to defer the item until a future OQSESC meeting with the Chair agreeing to discuss the necessary amendments with the author.

Defibrillator Replacement Plan – the Sub-Committee received a report outlining issues in relation to the defibrillator replacement plan, noting that whilst securing funding for the replacement defibrillators had now been resolved, the process highlighted a gap in procedures whereby associated patient safety risk had not been reported via the Quality, Safety and Experience reporting structure. The Sub-Committee agreed that, in relation to capital replacement programmes it would be helpful to look at the risks around the challenges brought forward each year, what is funded and the residual unfunded elements. It was agreed that regardless of where the risk sits, OQSESC should be tied into the process to ensure patient safety matters are visible. The Sub-Committee was assured that workshops are being arranged to articulate this process in relation to medical devices and equipment replacement programmes.

Wards 1&3 Orthopaedic Serious Incident Action Plan – the Sub-Committee received an update regarding progress against the four outstanding actions in the Action Plan, with two actions now completed and the remaining two due for completion by the end of September 2020. Whilst it is anticipated that the action plan would be complete by the end of September 2020 and subsequently approved by the Director of Nursing, Quality and Patient Experience, the Sub-Committee expressed concern at the length of time it had taken to resolve many of the issues involved.

Closure Report – Withybush Wards 1 and 3 Orthopaedic Serious Incidents – the Sub-Committee received the Closure Report for the Withybush Wards 1 and 3 Serious Incidents, with the Sub-Committee assured that all actions were complete and had been considered at 2 formal quality panels and could therefore be formally closed. It was noted that there had been learning from the length of time taken to reach completion with Health Board processes now in place to monitor action plans at 6 month intervals.

On-call system for staffing Bronglais General Hospital (BGH) Out of Hours in Theatres – the Sub-Committee received options to resolve the changes to the on-call system for staffing BGH out of hours (OOH) in theatres at its extraordinary meeting on 28th January 2021. It was noted that the main risk of avoidable harm is to maternity patients who may require a category 1 caesarean section during these hours. The Sub-Committee noted that application of option 3, would significantly reduce the risk score from 15 to 5 and that this approach mirrors the current operating theatre provision for the obstetric OOH support at GGH where no concerns had been raised by HIW at its recent inspection of the Health Board. Option 3 consisted of the implementation of Operating Department Practitioner (ODP) overnight cover, a resident overnight Healthcare Support Worker (HCSW), and one on-call scrub overnight shift cover. Assurance was received that option 3's reduced risk score of 5 is within the Health Board's tolerance for safety.

Feedback on Attendance at Local Governance Meetings – the Sub-Committee received a verbal update regarding feedback from local governance meetings with the development of a template for terms of reference and agendas for the directorate and county quality and safety meetings, which will be taken through the Bronze Groups for wider discussion and consultation.

Annual Quality Statement (AQS) and Healthcare Standards (HCS) – the Sub-Committee received the proposal for the development of the AQS for 2020/21, which is based on the methodology used for 2019/20 and is supported by evidence around the HCS. The Sub-Committee received assurance that younger service users would be included on the review panel, with the Sub-Committee supporting the proposal.

Feedback from Groups
In terms of feedback from Groups:

Resuscitation/RAILS Group – written update reports from the Resuscitation/RAILS Group (RRAILS) highlighting the key areas of work scrutinised have been received by OQSESC during 2020/21. The Sub-Committee received assurance through the progress reported by the Resuscitation/RAILS Group, and noted the following, including key risks and issues and matters of concern:

- Confirmation that consistent feedback has been received from the Hospitals RRAILS Group with no concerns escalated.
- The Out of Hospitals RRAILS Group Community National Early Warning Score (NEWS) project has been on hold due to the suspension of the Enabling Quality Improvement in Practice (EQIiP) projects during the COVID-19 pandemic. Despite this situation, assurance was provided that community based training had been maintained for District Nurses/GP Practices/ and Out of Hours GPs.
- Work streams relating to the sub group for Paediatrics / Mental Health / and Trauma have been ongoing with no concerns highlighted.
- Assurance received that the Acute Kidney Injury work is being progressed through a pilot to be established in Withybush General Hospital (WGH).
- A briefing received on the transfer of the All Wales DNRCPR forms into Community and Primary Care. The Policy itself has been revised and now stipulates that following appropriate training, Registered Nurses including District Team Leads can sign the form.
- As part of the revision of the Resuscitation Council Guidelines, COVID-19 Response and Resuscitation Flow Charts have been developed with pathways that have been endorsed by the COVID-19 Gold Command Group. To reduce risk to staff and

others in terms of aerosol generation and potential COVID-19 transmission, all patients are to be treated as if they have COVID-19 in relation to resuscitation response. Assurance was provided that in the event of a sudden collapse, all secondary care areas have access to full PPE. It was noted that provision of the latter in Mental Health and Learning Disability / and General Practices is progressing, whilst recognising that further assurance is required in relation to Community Hospitals.

- Due to ongoing delays with the medical review process following inpatient cardiac arrests, a task and finish group has been established to investigate the cause and determine a way forward to reduce delays.
- A position update provided on the Verification of Death Policy (VOD) in adults which is being updated in relation to Welsh Government (WG) guidance on community and virtual VOD. Confirmation was received that the Health Board will not be including family member involvement in this procedure. Assurance was provided that extensive training of over 200 nurses had been conducted across the Community and Field Hospital settings. It was anticipated that the project would be subject to evaluation in July 2020.
- The use of the Sepsis Bundle in the Emergency Departments was reported as consistent, however ward numbers had dropped considerably due to reduced numbers of patients on the wards during COVID-19. Assurance was provided that there will be robust monitoring of Sepsis Bundles in the ward areas to stabilise compliance. Sepsis work in the community would be restarted as part of the EQIiP programme.
- No significant impact was reported on compliance with the admission recognition and response bundles.

Nutrition and Hydration Group – written update reports from the Nutrition and Hydration Group (NHG) highlighting the key areas of work scrutinised have been received by OQSESC during 2020/21. The Sub-Committee received assurance through the progress reported by the Nutrition and Hydration Group, and noted the following, including key risks and issues and matters of concern:

- A decision is awaited regarding the Health Board's (HB) position as to whether naso-gastric (NG) tube placement is a potential aerosol generating procedure (AGP) or not. A report has been presented to the PPE Cell, which defined the problem as high risk and given that clarity was still required, the Chair agreed to raise the issue with Executive colleagues to reach a resolution.
- The HB's work to comply with the actions set out in the Food Safety in NHS estates and facilities alert (EFA-2020/991) and implementation of procedures for mental health patients fed via NG with restraint, paused due to COVID-19. However, this has now re-commenced with progress closely monitored by NHG.
- The Sub-Committee noted the impact of COVID-19 on the nutritional wellbeing of isolated and vulnerable patients and that the increase in food poverty in some communities has caused concern, and were assured that NHG will review the Malnutrition Call to Action Task and Finish Group ToRs to ensure the wider impact is considered.
- The NHG is developing a cohesive approach to governance and will develop a NHG Dashboard.

- An Estates and Facilities alert had been received in relation to allergy management, and an action plan would be developed following the appointment of the new specialist service manager for catering.
- An evidence review has been undertaken, regarding the potential impact of hydration status on staff when wearing PPE, which will be reviewed by the Group.

Mental Capacity Act and Consent Group – written update reports from the Mental Capacity Act and Consent Group (MCACG) highlighting the key areas of work scrutinised have been received by OQSESC during 2020/21. The Sub-Committee received assurance through the progress reported by the Mental Capacity Act and Consent Group, and noted the following, including key risks and issues and matters of concern:

- A legislative gap regarding the ability to lawfully enforce isolation of patients who are infected with COVID-19. The Sub-Committee was advised that this had been escalated to WG, however there has been no response to date. Agreed actions were to re-issue the correspondence to WG, submit a paper on the issue to the Executive Team and for the Vice Chair to discuss with colleagues across other Health Boards.
- As a consequence of COVID-19, the Liberty Protection Safeguards due to be implemented on 1st October 2020 have been deferred to April 2022.
- The Welsh Risk Pool has issued a risk management alert stating that from 2021, Health Boards are required only to use the EIDO patient information leaflets. It was noted that Medical Directors had raised concerns about this and the Chair agreed to ensure Directors of Nursing and Therapies and Health Science are also aware.
- An agreement has been reached for psychiatrists to undertake the mental health assessment part of Deprivation of Liberty Safeguards (DoLS) for patients within Mental Health Services. It was noted, however, that the service is struggling to complete other section 12 responsibilities in relation to the Mental Health Act. The Director of Operations and the Deputy Medical Director for Acute Hospital Services have arranged for further discussion on the possibility of training physicians to be able to contribute to being assessors.

Medical Devices Group – written update reports from the Medical Devices Group highlighting the key areas of work scrutinised have been received by OQSESC during 2020/21. The Sub-Committee received assurance through the progress reported by the Medical Devices Group, and noted the following, including key risks and issues and matters of concern:

- While the Control Group addressing the incorrect patient ID at Point Of Care Testing (PoCT) has not met during the COVID-19 period, spot audits have demonstrated a significant reduction in this practice, with confirmation received that the Control Group will be re-established once COVID-19 priorities allow the POCT manager to conduct further audits.
- The new system to provide end to end assurance for all medical device alerts received by the Health Board has been purchased and is being issued to all device asset owners.
- The Sub-Committee was informed that the introduction of new Medical Devices Regulations, due to come into effect in May 2020 had been delayed until May 2021, with the Health Board on track to meet these regulatory obligations.
- 100% Planned Preventative Maintenance performance has been maintained for high risk devices during the COVID-19 period despite a significant increase in the Medical Devices Inventory.

- Discussions held regarding the potential re-use of single use medical devices as Health Board policy does not currently allow this, however guidance has been received from the Medicines and Healthcare products Regulatory Agency (MHRA), that this can be undertaken. The Scheduled Care Team is in support of the principle and further discussion is underway. It was agreed that a report with the full details, risks and benefits would be provided to the Executive Team for full consideration prior to requesting approval for any pilot testing to be undertaken.
- Confirmation that 26 occurrences had been recorded of battery failure in T34 palliative care syringe drivers in community settings. The MHRA has issued a field safety notice stating that the Health Board should not implement any further version 3 pumps until the company has resolved the issues regarding the batteries. The Sub-Committee was advised that a risk based approach had been undertaken on clinical impact due to the shortage of syringe drivers and that following discussions with County Leads, the syringe drivers have been put in use with the batteries replaced by the Health Board. The Medical Devices Group has approved this approach and other Health Boards have adopted the same process.

Radiation Protection Group (RPG) – Group Update Reports are scheduled to be presented twice a year to OQSESC, however as the May 2020 and January 2021 Sub-Committee meetings had been stood down due to COVID-19 challenges, the next update report will be presented to the Sub-Committee in May 2021.

Key Risks and Issues/Matters of Concern/Escalation to Quality, Safety & Experience Assurance Committee

During 2020/21, in addition to the Operational Risk Report presented to each meeting, the following key risks and issues/matters of concern were raised to the Quality, Safety & Experience Assurance Committee:

- The impact of COVID-19 on the deterioration in waiting times performance within Planned Care;
- The impact of COVID-19 on the environment and the ability to continue all areas of service provision on the PPH site;
- Lack of assurance that not all risks aligned to OQSESC are being reviewed regularly and as such, the Sub-Committee cannot be assured that all risks are being appropriately managed.

OQSESC Developments for 2021/22

The Sub-Committee continues to evolve and reviews its effectiveness on a regular basis. The Sub-Committee continues to discuss and refresh the mechanism for monitoring and providing assurance to QSEAC in relation to operational risks with a potential quality or safety impact on patient care.

Argymhelliad / Recommendation

To endorse the Operational Quality, Safety and Experience Sub-Committee Annual Report 2020/21.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	10.4.1 Report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes the submission of a Committee update report, as well as the presentation of an annual report within six weeks of the end of the financial year.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability

Effaith/Impact:	
Ariannol / Financial: **Ansawdd / Patient Care:** **Gweithlu / Workforce:** **Risg / Risk:** **Cyfreithiol / Legal:** **Enw Da / Reputational:** **Gyfrinachedd / Privacy:** **Cydraddoldeb / Equality:**	Contained within the report.