Bundle Quality, Safety & Experience Assurance Committee 6 October 2020

4.1 Operational Quality, Safety and Experience Sub-Committee Update and Revised Terms of Reference

Presenter: Alison Shakeshaft

Item 4.1 OQSESC Report September 2020

Appendix 1 Operational QSESC 280920 v8 - for QSEAC ratifcation

Enw'r Pwyllgor: **Name of Sub-Committee:**	Exception Report from Operational Quality, Safety And Experience Sub-Committee (OQSESC)
Cadeirydd y Pwyllgor: **Chair of Sub-Committee:**	Ms Alison Shakeshaft, Executive Director of Therapies and Health Science
Cyfnod Adrodd: **Reporting Period:**	3rd September 2020

Materion Ansawdd, Diogelwch a Phrofiad:
Quality, Safety & Experience Matters:

OQSESC Terms of Reference (ToR)
The revised OQSESC ToRs were presented for review. The revised ToRs were approved, subject to the Chair seeking confirmation regarding the reporting line for the Organ Donation Committee being to QSEAC. The TORs have subsequently been amended and are attached as Appendix 1 for QSEAC's ratification.

Nutrition and Hydration Group (NHG) Update Report - An update report from the NHG meeting held on 9th July 2020 was presented with the following highlighted:

- 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 Personal Protective Equipment (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.
- Members noted the impact of COVID-19 on the nutritional wellbeing of isolated and vulnerable patients and 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.

The Sub-Committee was assured by the work of the NHG.

Medical Devices Group (MDG) Update Report. An update report from the MDG meeting held on 2nd July 2020 was presented with the following highlighted:

- 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.

- Members were informed that the introduction of new Medical Devices Regulations, due to come into effect in May 2020 has 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.

The Sub-Committee was assured by the work of the MDG.

Report on the Statutory Pre-Planned Maintenance (PPM) (Building and Engineering services)

- Members received an assessment of maintenance performance during quarter one. While noting a small drop (91% against a 95% target) for high risk building maintenance, Members were assured that this was not an un-reasonable position given the complexities that COVID-19 restrictions have placed on access, closure of areas, re-purposing of others, demand and a number of other factors. Members were 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

- Members received a report outlining processes to manage super-bariatric patients during the current COVID-19 period. Members believed that neither the paper nor 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 the next OQSESC meeting with the Chair agreeing to discuss the necessary amendments with the author.

Defibrillator Replacement Plan

- A report was received outlining issues in relation to the defibrillator replacement plan, noting that whilst securing funding for the replacement defibrillators has now been resolved, the process highlighted a gap in the process, whereby associated patient safety risk had not been reported via the Quality, Safety and Experience reporting structure. Members 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. Members were 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 - Members 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 will be complete by the end of September 2020 and subsequently approved by the Director of Nursing, Quality and Patient Experience, Members expressed concern at the length of time it has taken to resolve many of the issues.

Risgiau:
Risks (include Reference to Risk Register reference):

Operational Risk Report - 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 being relating to staffing, with the remainder relating to ICT issues.

Members noted that a small number of risks appeared to have not been reviewed for over a year and the assurance and risk representative assured that guidance has been reiterated to all directorates for monthly reviews of all red risks and bi-monthly for amber risks.

It was noted that many of the Therapy Services red risks were related to staffing, and that work will be undertaken to amalgamate these into fewer Directorate level risks. In particular, therapies staffing issues related to stroke, with Members noting that the Health Boards Stroke Re-design Programme has been paused due to COVID-19. When this re-commences a business case for increased therapies stroke staffing will be developed.

The following specific risks were discussed:

- 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). These risks are due for review and it is anticipated that the risk scores should now reduce.

Members sought assurance that risks will be reviewed more frequently, with the Chair requesting all risks to be reviewed by the next OQSESC meeting on 5th November 2020.

Directorate/Site Exception Reports on Risks/Concerns for Escalation – Members received 7 Site/Directorate Exception Reports, most of which focussed 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 Members were assured that directorate teams were managing risks appropriately through appropriate mitigations, there were some areas where detailed plans will 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).

Members noted the severe 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 will 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.

The Quality, Safety and Experience Assurance Committee is asked to note the following areas of concern:

- The impact of COVID-19 on the deterioration in waiting times performance in Planned Care
- The impact of COVID-19 on the environment and ability to continue all areas of service provision on the PPH site

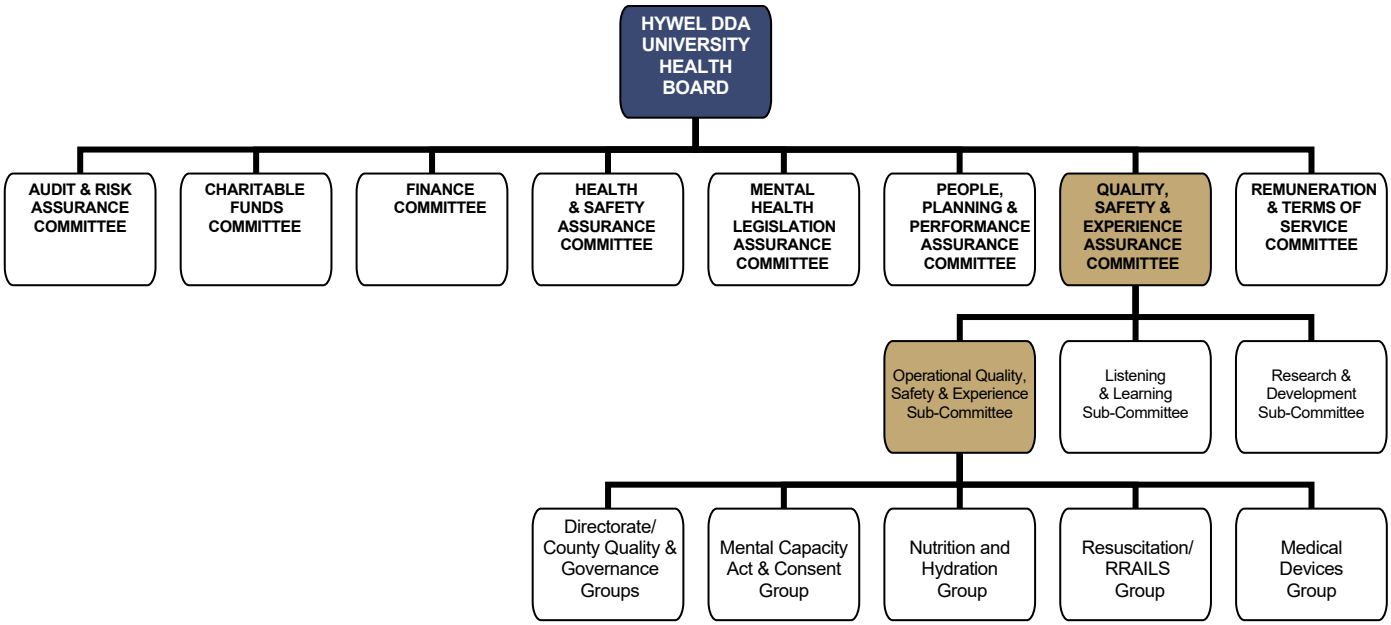
- Lack of assurance that not all risks aligned to OQSESC are being reviewed regularly and as such, the sub-committee cannot be assured that all risks are being appropriately managed

Argymhelliad:
Recommendation:

The Quality, Safety and Experience Assurance Committee is asked to note the content of this report and ratify the revised OQSESC Terms of Reference.

Dyddiad y Cyfarfod Pwyllgor Nesaf:
Date of Next Sub- Committee Meeting:

5th November 2020



OPERATIONAL QUALITY, SAFETY & EXPERIENCE SUB-COMMITTEE

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
V.08	**Quality, Safety & Experience Assurance Committee**	06.10.2020	

1. Constitution

1.1 The Operational Quality, Safety & Experience Sub-Committee has been established as a Sub-Committee of the Quality, Safety & Experience Assurance Committee and constituted from 1st June 2018, replacing the Acute Services Quality, Safety & Experience Sub-Committee and the Primary & Community Services Quality, Safety & Experience Sub-Committee.

2. Membership

2.1 The membership of the Sub-Committee shall comprise:

Title
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

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

3. Quorum and Attendance

3.1 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.

3.2 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, and in particular 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, and that they understand fully their relationship with and reporting responsibilities to their parent Committee

3.3 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.

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

3.5 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.

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

3.7 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 particular matters.

4. Purpose

4.1 The Operational Quality, Safety & Experience Sub-Committee will monitor, as delegated by Quality, Safety and Experience Assurance Committee, the acute, mental health & learning disabilities services, primary and community 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, freeing up the Quality, Safety and Experience Assurance Committee to be more strategic in its approach and providing an upward assurance.

5. Key Responsibilities

5.1 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.

5.2 Ensure that concerns (incidents, complaints and claims) are being managed in a robust and timely manner at service level, agreeing mitigating actions where required.

5.3 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.

5.4 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.

5.5 Inform and monitor progress against agreed performance targets identified in the Quality & Safety Dashboard.

5.6 Consider the themes arising from triangulated information at service specific level, and agree and monitor any action plans required to deliver improvements.

5.7 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, eg where risk tolerance is exceeded or lack of timely action.

5.8 Receive assurance from those Groups reporting to the Sub-Committee, and consider how escalated issues are addressed.

- Directorate (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
- ~~Organ Donation Group~~

5.9 Receive position reports on:

- **Key Risks associated with preventing harm to patients:**
  - Falls
  - Pressure Damage

- **Quality Improvement Pathways:**
  - Dementia/Delirium
  - Frailty
  - Clinical pathways e.g. Stroke/Diabetes/Cardiology/Ophthalmology in line with National Audit Reports

5.10 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, 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.

5.11 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 Assurance Committee and oversee delivery to improve the quality, safety and effectiveness of care delivered, and enhance the patient experience.

5.12 Seek assurance reports from relevant partnerships, and consider the actions required in relation to any quality and safety issues identified.

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

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

5.15 Agree issues to be escalated to the Quality, Safety and Experience Assurance Committee with recommendations for action.

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 papers will be circulated to all Sub-Committee members.

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

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

6.5 The minutes and action log will be circulated to members within **ten** days to check the accuracy.

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 Assurance Committee for its performance in exercising the functions set out in these terms of reference.

8.2 The Sub-Committee shall embed the UHB'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 UHB'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, ensuing 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 Assurance 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 Directorate (County) Quality & Governance Groups
9.3.2 Resuscitation/RRAILS Group
9.3.3 Nutrition and Hydration Group
9.3.4 Mental Capacity Act and Consent Group
9.3.5 Medical Devices Group (including Point of Care Testing and Ultrasound Governance)
~~9.3.6 Organ Donation 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 Assurance 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 Assurance Committee's specific attention any significant matters under consideration by the Sub-Committee.

10. Secretarial Support

10.1 The Sub-Committee Secretary shall be determined by the Lead Director (Director of Therapies & Health Science).

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 Assurance Committee.