Operational Quality, Safety & Experience Sub-Committee

Enw'r Cyfarwyddiaeth: Name of Directorate:	Exception Report from Operational Quality, Safety and Experience Sub-Committee (OQSESC)
Swyddog Adrodd: Reporting Officer:	Alison Shakeshaft, Director of Therapies and Health Science (Sub-Committee Chair)
Cyfnod Adrodd: Reporting Period:	6th July 2021

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

- **Review of Operational Quality, Safety and Experience Sub-Committee Terms of Reference:** The Sub-Committee approved the OQSESC revised Terms of Reference for onward submission to the Quality, Safety and Experience Committee (QSEC) for approval (see attached at Appendix 1).
- **Resuscitation/ RRAILS Group Update Report:** The Sub-Committee received the Resuscitation/ RRAILS Group Update Report, advising of concerns around the reduced sepsis bundle activity within the Emergency Admissions Unit at Withybush General Hospital (WGH), which may result in missed sepsis cases. An audit has been undertaken to identify the accurate number of sepsis bundles that should have been completed and whether there had been any missed cases of sepsis. The Sub-Committee was advised of amendments to the Health Board's Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) guidance to improve the process for DNACPR decisions. The Group's Terms of Reference were approved subject to the minor amendments raised by the Sub-Committee.
- **Mental Capacity Act and Consent Group Update Report:** The Sub-Committee received the Mental Capacity Act and Consent Group Update Report, advising of the development of a Liberty Protection Safeguards (LPS) Implementation Plan whilst awaiting publication of the LPS Code of Practice from Welsh Government (WG).
- **Medical Devices Group Update Report:** The Sub-Committee received the Medical Devices Group Update Report, advising of concerns regarding the Vanguard proposal for the re-use of harmonic shears, referencing Risk 134 on the risk register, and the risk of needing to destroy large numbers of surgical instruments following suspected prion contamination arising during invasive procedures. It was noted that one mitigation to this risk is the switch to single use items where possible. The Group expressed concern that the re-use of single items, whilst presenting some financial and environmental benefits, could hinder the mitigation of this risk. The Sub-Committee was advised that, as a result of a recent Health and Safety Executive (HSE) enforcement notice in relation to sharps injuries, a review of non-safety sharps has identified that these are still being ordered via Procurement. To ensure that devices are used appropriately, services will be notified of the requirement to undertake a risk assessment before being allowed to order these items. The Sub-Committee was advised of two further issues not documented within the update report; firstly the recall notice from the company involved for continuous positive airway pressure (CPAP) and bi-level positive airway pressure (BiPAP) devices regarding risks

associated with the products' sound abatement foam. A 12 month review of the fitting of filters would require all devices to be registered via respiratory clinic. Assurance was provided that the recall has been communicated to all relevant teams, with an all Wales project established to address any issues, and discussions held regarding communication to patients affected by the recall via the Health Board's website and social media platforms. Additional communication would be disseminated to patients within the next few weeks regarding the replacement of filters, however there is no solution anticipated within the next 6-12 months as the company involved would be required to redesign and remanufacture the filtration devices. The second issue related to Patient Safety Alert (PSA) 2021/003, which had been issued in England although not yet formally in Wales, regarding air flow meters and the risk of devices being plugged into the oxygen flow instead of the air flow. In terms of ambiguity surrounding the management of England-only alerts in Wales, the Health Board is acting upon this alert from a safety perspective.

- **Radiology Quality, Safety and Experience Group Update Report, Terms of Reference, and Radiation Protection Policy:** The Sub-Committee received the Radiology Quality, Safety and Experience Group Update Report, advising of the new governance structure in place. The Sub-Committee noted the revised Terms of Reference. Sub-Committee approval of the Radiation Protection Policy was deferred to the 7th September 2021 meeting.
- **Patient Safety Solutions:** The Sub-Committee received the Patient Safety Solutions report, advising of PSN051/February 2020: Depleted batteries in intraosseous injectors, which is currently open and outside of the action timescales. The Sub-Committee was advised that confirmation from the RRAILS Group that the devices within the Operating Department Practitioner (ODP) bags have been replaced is awaited and would be discussed at the RRAILS Group on 21st July 2021.
- **Consent to Hospital Post-mortem Examination Policy**: The Sub-Committee ratified the 243 Consent to Hospital Post-Mortem Examination Policy, noting that the policy had been revised to enable the consultant pathologist and mortuary staff to support clinical discussions with the families involved in order to obtain consent.

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

Health Board Overview on Top Reported Risks and Actions for Mitigation – the Health Board Overview on Top Reported Risks and Actions for Mitigation report was presented to Members, consisting of 73 risks assigned to the Sub-Committee which have a current risk score exceeding the risk tolerance level. In response to concerns raised that the report may not reflect the true extent of the current situation, the Sub-Committee was reminded that it is the responsibility of each Directorate to identify risks and flag them to Executive Directors. Referring to the action from the previous Sub-Committee meeting for the Head of Assurance and Risk to discuss how the Corporate Risk Register is reviewed at the Executive Team Risk Session on 7th July 2021, with a refresher session to be arranged with the senior operational triumvirate teams, the Sub-Committee was advised that the Executive Team session had been cancelled and would be reconvened at a future date.

Directorate Risk Exception Reports

- **Women and Children's Directorate:** The Sub-Committee was advised that, in response to a directive from WG, the Health Board has been directed to make preparations to support a 20-50% increase in presentations of Respiratory Syncytial Virus (RSV), with the anticipation that cases will begin to rise ahead of the NHS winter period, which will commence in August 2021, with a further anticipatory peak in November 2021. It was noted that a surge plan would be escalated through the Health Board's Bronze Command arrangements ahead of presentation to WG on 9th July 2021.

- **Accident & Emergency, GGH:** The Sub-Committee was advised of a 35.5% increase in A&E attendances from the previous year, which highlighted significant clinical safety incidents in the department, in conjunction with nursing and medical staffing deficits. It was noted that staff in the department are experiencing increased pressure with an increase in patient complaints. Over the past few months, nursing and medical staffing deficits have further affected the department, with data relating to A&E breaches illustrating that A&E clinician breaches are currently the most common cause. Cultural and leadership concerns have also been identified, which are being addressed with support provided by Workforce and Organisational Development (OD) colleagues. To help mitigate the risks currently identified, an Urgent Response Group has been established, with the aim to pro-actively support the Directorate in securing additional temporary and longer term staffing solutions, and improving the processes within the department. Given that many of the proposed actions have significant resource implications, a detailed action plan with leads and timescales, together with a supporting financial plan is being finalised following further discussions with Executive colleagues and senior management teams. Whilst being assured by the appropriate mitigating actions in place, the Sub-Committee acknowledged that some elements of mitigation are out-with the Health Board's direct control.

- **Mental Health and Learning Disabilities (MHLD) Directorate**: The Sub-Committee was advised of the deep dive relating to Risk 1032 presented to the Quality, Safety and Experience Assurance Committee (QSEAC) at its meeting on 8th June 2021, highlighting the vulnerability of data collection and that the Committee had requested an update at its meeting on 10th August 2021 to include a trajectory of when the situation is likely to improve. The Sub-Committee received assurance that the MHLD Triumvirate team meet twice monthly to review the risk register and Heads of Service provide a summary of the risks identified and control measures in place via reports to the MHLD's Quality, Safety and Experience Group (MHLD QSEG).

Argymhelliad:
Recommendation:

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

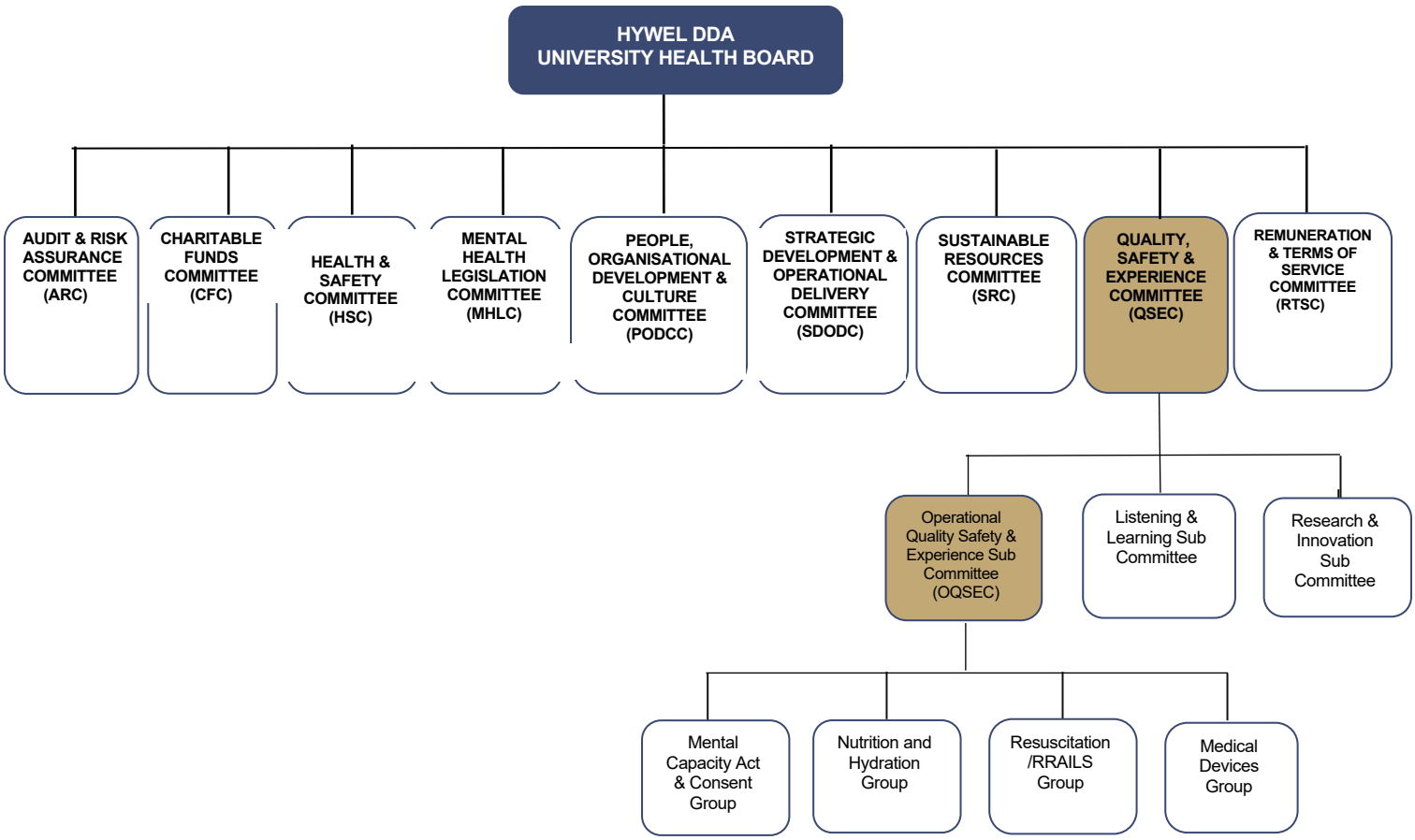
- The two additional issues of concern brought to the Sub-Committee's attention regarding the recall notice and PSA 2021/003.
- Concerns raised by the Medical Devices Group regarding the proposal for the re-use of single use, invasive items.
- Discussions held surrounding the A&E (GGH) Exception Report and wider discussions held regarding workforce and the pressures on demand for services.

- Concerns raised in regard to the anticipated 50% increase in RSV over the coming Winter and the subsequent impact on delivery of services, whilst acknowledging the development of a surge plan to address this issue.

The Quality, Safety and Experience Committee is requested to approve the Operational Quality, Safety and Experience Sub-Committee Terms of Reference.

The Quality, Safety and Experience Committee is requested to note the content of this OQSESC update report.

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board



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
V0.8	Quality, Safety & Experience Assurance Committee	06.10.2020	Approved
V0.9	Operational Quality Safety and Experience Sub Committee	06.07.2021	For Approval
	Quality, Safety & Experience Committee	**10.08.2021**	**For Approval**

1. Purpose

1.1 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.

2. Key Responsibilities

2.1 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.

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

2.3 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.

2.4 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.

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

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

2.7 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.

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

- Resuscitation/RRAILS Group
- Nutrition and Hydration Group
- Medical Devices Group (including Point of Care Testing and Ultrasound Governance)
- Mental Capacity Act and Consent Group

2.9 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

2.10 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.

2.11 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.

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

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

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

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

3. Constitution

3.1 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. From September 2020, the Operational Quality, Safety & Experience Sub-Committee subsumed the Mental Health and Learning Disabilities Quality, Safety & Experience Sub-Committee.

4. Membership

4.1 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 Public Health
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

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, 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

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 particular 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 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 Resuscitation/RRAILS 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)

9.4 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.