Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

COFNODION HEB EU CYMERADWYO O GYFARFOD Y PWYLLGOR ANSAWDD, DIOGELWCH A PHROFIAD
UNAPPROVED MINUTES OF THE QUALITY, SAFETY AND EXPERIENCE COMMITTEE MEETING

Date and Time of Meeting:	1.30 pm, 10th August 2021
Venue:	Boardroom, Ystwyth Building/ MS Teams

Present:	Ms Anna Lewis, Independent Member (Committee Chair) Mrs Judith Hardisty, HDdUHB Vice Chair Mr Paul Newman, Independent Member (VC) Ms Ann Murphy, Independent Member (VC)
In Attendance:	Mrs Mandy Rayani, Director of Nursing, Quality & Patient Experience Dr Philip Kloer, Medical Director & Deputy CEO (VC) Mr Andrew Carruthers, Director of Operations (VC) Mrs Ros Jervis, Director of Public Health (VC) Mrs Louise O'Connor, Assistant Director (Legal Services/Patient Experience) (VC) Ms Alison Shakeshaft, Director of Therapies and Health Science (VC) Ms Jill Paterson, Director of Primary Care, Community and Long Term Care Mrs Joanne Wilson, Board Secretary (VC) Dr Subhamay Ghosh, Associate medical Director for Quality and Safety (VC) Ms Jenny Pugh Jones, Head of Medicines Management (VC) Ms Sian Passey, Assistant Director of Nursing (VC) Ms Lisa Humphrey, Interim General Manager (VC) Ms Debra Bennett, Cancer Services Delivery Manager (VC) Ms Claire Hathaway, Trauma Lead Manager (VC) Mr Peter Cnudde, Consultant Orthopaedic Surgeon (VC) Ms Sian Hopkins, Head of Quality Improvement and Practice and Professional Development (VC) Ms Marilize Preez, Improvement and Transformation Lead (VC) Dr Senthil Kumar, Consultant Physician (VC) Ms Bethan Andrews, Service Delivery Manager, Stroke and COTE (VC) Donna Coleman, Chief Officer, Community Health Council (VC) Mr Alun Rees, Operational Facilities – Reverse Mentor (Director of Nursing, Quality & Patient Experience) Ms Sonja Wright, Committee Services Officer (Secretariat)

QSEC (21)82	INTRODUCTIONS AND APOLOGIES FOR ABSENCE	Action
	The Chair, Ms Anna Lewis, welcomed all to the Quality, Safety & Experience Committee (QSEC) meeting and drew Members' attention to the new title of the Committee, which had been revised in line with the new Corporate Governance Structure as approved by the July 2021 Public Board.	
	Apologies for absence were received from: • Mrs Delyth Raynsford, Independent Member (Committee Vice-Chair) • Professor John Gammon, Independent Member • Miss Maria Battle, HDdUHB Chair	

	• Ms Mandy Davies, Assistant Director of Nursing and Quality Improvement • Mrs Cathie Steele, Head of Quality & Governance • Dr Barbara Wilson, Community Health Council	

QSEC (21)83	**DECLARATIONS OF INTERESTS**	
	There were no declarations of interests.	

QSEC (21)84	**MINUTES AND MATTERS ARISING FROM THE MEETING HELD ON 8th JUNE 2021**	
	RESOLVED - that the minutes of the meeting held on 8th June 2021 be approved as a correct record. Following the presentation of a Deep Dive review of Mental Health and Learning Disabilities (MHLD) services at the previous QSEC meeting on 8th June 2021, and in response to a request from the Chair that further information be provided in relation to anticipated timescales for the implementation of plans to manage waiting lists and to address other identified issues, a position report relating to specific areas of the MHLD Directorate was shared with Members under 'Matters Arising'. Mrs Judith Hardisty advised Members that the bid to Welsh Government (WG) for funding to support additional capacity within Memory Assessment Services referenced in the report, had been signed off by the Regional Partnership Board. Members remarked that, while the report included useful updates relating to the individual services, it did not provide details of forecast trajectories relating to the management of waiting times. Mrs Mandy Rayani undertook to ensure that an update relating to planned timescales would be shared with Members.	**MR/ AC**

QSEC (21)85	**TABLE OF ACTIONS FROM THE MEETING HELD ON 8th JUNE 2021**	
	Members reviewed the Table of Actions from the meeting held on 8th June 2021, and noted that all actions had been completed, or were being progressed. With regard to action (21) 65 (Risk 684): *To follow up with relevant Lead Executives the lack of an agreed replacement programme for radiology equipment across the Health Board,* Mrs Rayani confirmed that further discussions relating to a replacement programme had been held with WG, and undertook to seek clarification that costs relating to the existing equipment replacement backlog would be covered by WG funding. Members were further advised that Risk 684 had been updated to reflect the latest position. With regard to action (21) 66: *To provide an update to the Committee on the management of the MHLD waiting list situation,* Members noted that an update would be circulated to Members as discussed under 'Matters Arising'.	**MR**

QSEC (21)86	**APPROVAL OF QSEAC SELF-ASSESSMENT PROCESS**	
	Members received the Self-Assessment of Effectiveness Questionnaire template which is intended for use in the Committee's annual self-assessment exercise for 2020/21, noting that the questionnaire includes an extraordinary question which relates to the Committee's role in the HB's response to COVID-19. Mrs Rayani highlighted the following statement in Question 2: *'[The Committee] commissions work in support of [the Health Board's overarching strategic priorities and delivery plans]'* and requested that the wording be amended to reflect the fact that the Committee commissions reviews, as opposed to work. Members further noted that the dates of the review period, as presented in the questionnaire, should be amended to 2020/21. Subject to these amendments, Members supported the use of the template for use in the Committee's annual self-assessment of effectiveness exercise.	**SW** **SW**
	The Committee **APPROVED** the Self-Assessment of Effectiveness Questionnaire which, subject to the amendments agreed, will be used in the Committee's annual self-assessment exercise for 2020/21.	

QSEC (21)87	**QSEC TERMS OF REFERENCE**	
	The Committee's revised Terms of Reference (ToR) were presented for information. Members noted that the revised ToR had been approved by the Board at its meeting on 29th July 2021, subject to removal of references to Research and Innovation, which is now included within the remit of the new People, Organisational Development and Culture Committee. Dr Philip Kloer reflected that, given the cross-cutting nature of Research and Innovation work, there would be occasions where relevant items would need to be reviewed by QSEC for assurance purposes, and it was confirmed that these would be reflected on the Committee's Work Programme, as and when they arose.	
	The Committee **NOTED** QSEC's revised Terms of Reference.	

QSEC (21)88	**DEEP DIVE REVIEW: WAITING TIMES FOR SINGLE CANCER PATHWAY (RISK 633)**	
	The findings from a Deep Dive review of the HB's ability to meet the 75% waiting times target for the new Single Cancer Pathway (SCP) by March 2022 were received by the Committee. Ms Lisa Humphrey highlighted the following key points: • All patients are to begin treatment within 62 days from the point of suspicion, rather than point of referral. • All patients are to be diagnosed and informed whether cancer is diagnosed or ruled out within 28 days of the pathway start date. This, together with the recovery of unscheduled work post-COVID-19, has	

increased demand, which has had a significant impact on Radiology, Pathology and Endoscopy capacity.

- The starting performance measure until March 2022 will be 75%, and will be revised upwards in subsequent years. This measure will not include pathway adjustments which had previously been made if patients were unavailable for treatment, and all waits will now be included in reporting. While this clearly benefits patients, the new measure will impact upon the HB's performance figures.
- A national framework for cancer harm reviews within NHS Wales is proposed, which will allow clinical assessment of patients waiting in excess of 104 days for a first definitive treatment in order to identify avoidable harm. Cancer Service Managers are proactively engaging with Multi-Disciplinary Teams (MDTs) to launch the National Cancer Pathway Review Framework and to provide tailored clinical data which will enable teams to assess their performance against targets and to review patient prioritisation processes. To date there has been an encouraging level of clinical engagement in this process.
- A HB Pathway Review Group will be established from late September 2021, which will review all patients waiting over 62 and 104 days to assess harm; the Group will also carry out joint reviews of tertiary cancer treatments with other Health Boards.
- Cancer Services, Informatics and WG will work together over the next 3 months to design and implement a cancer data dashboard which can be interactively interrogated by individual MDTs. A review of an existing dashboard which utilises informatics systems from other Welsh Health Boards will be undertaken to determine whether it can be adapted for use in-house.
- The HB is in the process of setting up a pilot Rapid Diagnosis Clinic to help achieve an earlier diagnosis of cancer in patients who do not meet the site-specific Urgent Suspected Cancer (USC) referral criteria, with pilot funding for 12 months having been secured from the Wales Cancer Network.
- While other Health Boards are outsourcing much of their Endoscopy work, Hywel Dda University Health Board (HDdUHB) is managing this internally, with significant support from the use of FIT10 screening in the management of USC patients on a colorectal pathway. There are plans to extend FIT10 testing to Primary Care. It was agreed that learning from national screening programmes would be shared with Members. **LH**
- Recruitment to an Oncology Triage Line Team is underway; a proposal to operate this Triage Line on a 24/7 basis has been submitted to Tactical Group.

Responding to a query from Mr Paul Newman in relation to the data that the HB is collecting regarding outcomes e.g. 5 year survival rates, and how these compare with reported outcomes in other Health Boards or at a national level, Ms Debra Bennett explained that 5 Year survival-rate data is collected and collated centrally by the Welsh Cancer Intelligence and Surveillance Unit.

Mr Newman further queried the modelling that has been undertaken by the HB regarding the likely level of demand for cancer services in future years, and how the organisation plans to meet that demand. Ms Bennett informed Members that Health Boards are working with the Wales Cancer Network, and

	appointing SCP Improvement Leads for each HB to work on this, in line with the National Optimal Pathways (NOPs) for Cancer, which inform local and national capacity and demand modelling. Members were additionally advised that NOPs form part of a wider SCP programme of work which will support Health Boards in identifying common themes and likely trajectories for demand. Further to these responses, Ms Bennett undertook to produce a briefing paper which will provide further detail for Members. In response to a query from Mrs Hardisty regarding confirmation of Primary Care representation on the Pathway Review Group, Members were advised that the Deputy Associate Medical Director, Primary Care and the Deputy Medical Director, Primary Care and Community Services would serve as members of the Group. Being advised that Tertiary Specialist Centre capacity pressures at Swansea Bay University Health Board (SBUHB) continue to compromise cancer services, Members expressed concern in regard to associated treatment delays. Mrs Hardisty commented that, while not underestimating the work which is being undertaken to mitigate delays, consideration must be given to the point at which performance issues are escalated and alternative service provision is reviewed. Mr Andrew Carruthers informed Members that monthly performance Touchpoint meetings with SBUHB have been established, and that performance issues are highlighted at regular meetings which are held with the SBUHB Chief Executive. In regard to considering alternative providers for specialist cancer services, Mr Carruthers observed that commissioning services from an alternative provider would prove challenging, given that the same issues are currently impacting all Welsh tertiary services. While seeking to assure Members of increased confidence engendered by the more formalised governance structures which are now in place, Mr Carruthers recognised that broader pan-specialty conversations may be required at Executive level regarding access to tertiary services, given the existing challenges. Ms Lewis welcomed Executive discussion of patient access to Tertiary Cancer services, noting that actions identified in relation to tertiary pathways into SBUHB would be fed back to QSEC. It was further agreed that access issues would be formally highlighted as a concern to the Board in the Committee's Update Report.	**DB** **SW**
	The Committee **NOTED** the findings and the update provided by the Deep Dive review of the Single Cancer Pathway, and accepted the recommendations contained therein: • To note the impact that COVID-19 is still having on cancer pathways; • To take assurance in the mitigating actions in place; • To take assurance that the current performance trajectory is above the 1% improvement per month predicted and, if continued, will enable the 75% target to be met by March 2022.	

QSEC (21)89	**DEEP DIVE REVIEW: STROKE**	
	The findings from a Deep Dive Review of Stroke services performance were presented to the Committee.	

Ms Bethan Andrews highlighted the following key points:

- Service re-modelling work has resumed; discussions and planning will be resumed with ARCH (A Regional Collaboration for Health) and with SBUHB in relation to the establishment of a Hyper-Acute Stroke Unit (HASU).
- While waiting lists for stroke services do not provide any cause for concern, diagnostic capacity remains a concern - although this is a broader issue and is not specific to stroke services - and work to improve capacity is being undertaken.
- Virtual Out-Patient consultations, which were undertaken during the pandemic are now continuing as good practice, however some patients will need to be seen face-to-face; this has also been accommodated.
- Thrombectomy has now come on line for a 7-day service, which is progressing to a 24/7 service and a new IT platform has been implemented for faster transfer of imaging to the North Bristol Trust Thrombectomy Unit.

Members were advised that while the Stroke teams on all 4 sites are committed to their patients and service, it is recognised that improvements are required within the service and that there are significant challenges in maintaining high standards of care across the sites - chiefly relating to staffing capacity, the need to re-model services, and recovery from the COVID-19 pandemic.

Dr Senthil Kumar elaborated upon the nature of these challenges, informing Members that work to return to pre-pandemic service standards is impacted by staffing capacity, ward closure and COVID-19-related disruption. It is becoming harder to sustain service standards and targets over 4 sites, and there is a lack of funding, which particularly affects therapy services. Members were also advised of funding shortfalls for psychological support and early supported discharge, which play a significant role in the treatment and rehabilitation of stroke patients, and were informed that the service is working closely with the Psychology Team to develop a plan/ business case to support the provision of psychology therapy.

Ms Alison Shakeshaft re-iterated the commitment of the HB's Stroke team, particularly in light of the constraints within which they are currently operating, and informed Members that the Board has recognised the challenges inherent in the HB's current Stroke service model. Members were advised that a number of business cases involving significant sums had previously been submitted to support service capacity, and that, given a national lack of Stroke therapist support, a re-design of the HB's service had been planned, which would include a review of the current offer across 4 sites. Ms Shakeshaft explained that following the COVID-19 pandemic, the service re-design will be resumed, and will be based upon the development of short-to-medium-term, rather than long-term, service provision, with work focused upon Carmarthenshire, given its proximity to the Stroke Department in Morriston Hospital, and conversations being held with SBUHB regarding the establishment of a HASU.

Recognising the need for Members to gain assurance regarding the quality and safety of the Stroke services provided by the HB (notwithstanding the challenges and constraints), Mrs Rayani queried how the outcomes of Stroke

	audit work are used to monitor and maintain the safety of the services provided. Ms Andrews explained that Stoke teams on each site hold monthly local unit performance meetings, and that biannual meetings are held between all 4 unit teams, Welsh Ambulance Service NHS Trust, the Stroke Association, Accident and Emergency teams and other Acute Hospital teams in order to review data, share good practice and identify areas for improvement to ensure positive patient outcomes. Ms Andrews added that the Stroke service also works closely with the Third Sector in order to ensure that patients' views are fed into plans and discussions. Members noted the scores and themes identified in the SSNAP (Sentinel Stroke National Audit Programme) audit report, covering the period from January 2021 to March 2021, which were included in the slides. Ms Shakeshaft explained that this is a very comprehensive live audit, covering urgent intervention, urgent assessment, in-patient rehabilitation and discharge standards, and is carried out for every patient, using a complex set of metrics that generate scoring levels from A (best) to E (worst). Referencing a scoring of 'D' assigned to Prince Philip Hospital (PPH) Stroke Unit, Mr Newman queried what this score indicated from a patient safety perspective. Dr Kumar explained that the score mainly reflected low therapy capacity within the unit, adding that 4 of the 10 measures upon which scores are based are linked to therapy provision. Members were further informed that at the time the audit was undertaken, the PPH unit had necessarily been re-located due to ward closures related to COVID-19. Ms Shakeshaft re-iterated that in order to achieve a fundamental improvement in the performance of the HB's Stroke service, short-to medium-term re-design work must be undertaken, however cautioned that there is no expedient solution. Mrs Joanne Wilson informed Members that there is a planned discussion of the Stroke service at the Board meeting on 30th September 2021, where risks and strategic developments would be discussed. It was agreed that further SSNAP audit data, providing a refreshed view of Stroke Units' performance would be provided to Members at the QSEC meeting to be held 7th December 2021, by which time a clearer view of strategic decisions and trajectories should be available, and that this would be reflected on the Committee's work programme.	**SW**
	The Committee **NOTED** the constraints and challenges which currently impact the HB's Stroke service, together with mitigations in place, and **NOTED** the need to escalate to Board that fundamental improvements can only be made when re-design work requiring investment linked to short, medium and longer-term priorities has re-started and been completed.	

QSEC (21)90	**UPDATE ON COVID-19 RELATED ACTIVITY**	
	An update on the HB review of suspected nosocomial COVID-19 in-patient infections was presented to the Committee, together with an update regarding related COVID-19 activity. Members were informed that the aim of the review is to understand the factors that contributed to the 48 COVID-19 outbreaks experienced during October 2020 and February 2021, to identify the impact upon patients, and to identify potential learning from these outbreaks, which would be shared across the organisation.	

	Members were presented with comparative data from patient reviews reflecting cause of death where COVID-19 was a predominant cause, and where it was a contributory factor, together with data indicating levels of nosocomial COVID-19 infections recorded between October 2020 and March 2021. Members were further presented with data from reviews of COVID-19 outbreaks occurring on specific wards across all sites, which had occurred between October 2020 and January 2021. Ms Sian Passey explained that many areas for improvement had been identified at an early stage from these reviews, together with evidence of good practice. Members were advised that individual patient reviews are currently 70% complete, and that next steps include the progression of thematic outbreak reviews and the establishment of a multi-disciplinary Control Group to discuss the findings from each infection review and share learning. Expressing a level of disappointment that compliance with hand hygiene has shown to be less than 85% in some areas, Mrs Hardisty sought assurance that this issue would not continue to re-occur within hospital settings. Ms Passey explained that regular hand hygiene audits are undertaken on hospital wards, including observational audits undertaken by the Infection Prevention and Control team, and that any observations are fed directly back to individual staff members. Mrs Rayani informed Members that in addition to hand-hygiene audits, a system of collaborative environmental safety and cleanliness checks has been established, results of which are fed back to Heads of Nursing and to scrutiny meetings. Members were advised that a reference in the presentation to an increase in community-acquired infection rates reflects a moment in time, and were assured that rates are now stabilising.	
	The Committee **NOTED** the content of the Update on COVID-19 Related Activity report and **RECEIVED ASSURANCE** that: • The Health Board has systems and processes in place to respond to and monitor emerging trends and issues associated with COVID-19; • Whilst the local COVID-19 rate is currently low, continued monitoring of the local and national situation is being undertaken and the Health Board is adapting to and adopting changes and requirements at pace.	

QSEC (21)91	**QUALITY AND SAFETY ASSURANCE REPORT**	
	The Quality and Safety Assurance Report was presented to the Committee, providing Members with information on patient safety incidents, including externally reported patient safety incidents, quality improvement, Welsh Health Circulars (WHCs) and inspections by Healthcare Inspectorate Wales. Members' attention was drawn to the following points: • During the last financial year, the reporting requirements for serious incidents to the Delivery Unit changed and therefore a quarter-by-quarter comparison cannot be made as to whether incident numbers have increased or decreased; • Between 4th January 2021 and 13th June 2021, there was reduced reporting of harm-related incidents due to the significant pressures on NHS health services.	

	• From 14th June 2021, the term 'Serious Incident' (SI) has been replaced by 'Patient Safety incident' – these being reportable nationally. Whether to record incidents as SIs is left to individual Health Boards' discretion. A quality assurance system is in place for incidents which are recorded on *Datix*. • The Quality Improvement Team has resumed its support in priority clinical areas with a high number of inpatient falls; the initial focus on improvement has been in Withybush General Hospital, with the introduction of monthly Falls Improvement Meetings. • With regard to the implementation of WHCs, many which are rated 'Amber' relating to previous years (some to 2016); these will be reviewed to determine which can now be closed, and by December 2021 it is hoped to have either closed these, or to have provided a rationale for retaining 'open' status. With regard to reportable incidents, Mr Newman queried whether there are areas where performance is worse and if so, whether these areas are subject to heightened levels of management intervention. Ms Passey explained that reports are reviewed by senior Triumvirate teams within each acute hospital, adding that consideration is being given to the support which can be provided to operational teams, recognising that significant pressure due to the COVID-19 pandemic has impacted upon performance. Mrs Rayani highlighted WHC 012-21: *Implementing the agreed approach to preventing Violence and Aggression towards NHS staff in Wales* and suggested that this be moved to the remit of the Health and Safety Committee (HSC). Mrs Hardisty, as HSC Chair, agreed.	**SW**
	The Committee: • **NOTED** the content of the Quality and Safety Assurance Report, being assured that processes are in place to review and monitor patient experience highlighted through incident reporting, complaints and feedback and external inspections. • **NOTED** compliance with Welsh Health Circulars aligned to QSEC.	

QSEC (21)92	**ACCESSING EMERGENCY SPECIALIST SPINAL SERVICES UPDATE**	
	Members received the Accessing Emergency Specialist Spinal Services Update report, presented to the Committee to provide assurance that services and positive outcomes are being achieved for HB residents. Members were informed that access to emergency spinal services has historically proven challenging, despite the existence of a Spinal Protocol with Cardiff and Vale University Health Board (CVUHB) and SBUHB, and that while the protocol has been in operation since 2011, transferring patients to the relevant tertiary teams in a timely and safe manner has continued to be an issue. Ms Claire Hathaway informed Members that since the presentation of an update to QSEC regarding access to services at its meeting on 2nd February 2021, significant progress has been made upon the spinal pathway, with a number of multidisciplinary task and finish groups having been established to undertake a holistic assessment of the entire patient pathway, and a final	

	project report having been presented to the NHS Wales Collaborative Executive Group on 6th April 2021, where all recommendations were accepted. Members were advised that CVUHB and SBUHB will develop a business case to establish an operational delivery network (ODN) for spinal services through their Regional and Specialised Services Provider Planning Partnership, and that to progress this work, the Partnership has agreed to establish a shadow network within existing resources which will work with the wider spinal community to develop the business case for the ODN and to review trauma pathways in collaboration with the Major Trauma Network (MTN). Members were assured that the establishment of the MTN has facilitated easier access to spinal services in CVUHB and SBUHB, and has improved patient repatriation pathways. Dr Kloer emphasised that the update provided related to emergency Spinal Services, and that other work is being progressed in relation to elective spinal treatments. Recognising that access to specialist rehabilitation in SBUHB is much improved, Dr Kloer queried whether this has resulted in a reduced waiting list for services. Ms Hathaway confirmed a significant improvement in patient turnaround time and in post-surgery support. In response to a query from Mrs Hardisty as to whether there is currently a duplication or split of services between CVUHB and SBUHB, Dr Kloer explained that while SBUHB leads the ODN, having an Enhanced Trauma Unit, emergency spinal work is sent to CVUHB. Notwithstanding these arrangements, Dr Kloer recognised the need for further work upon urgent and elective spinal pathways, which would be undertaken jointly with SBUHB and CVUHB.	
	The Committee **RECEIVED** assurance that ongoing work on emergency specialist spinal services continues, and that the introduction of the Spinal Pathways through the Major Trauma Network, together with the identified work streams being explored through the South Wales Spinal Network team, is continuing to improve patient experience in this area.	

QSEC (21)93	**CLINICAL AUDIT UPDATE**	
	The Committee received a report providing a position statement with regard to clinical audit activity. Members noted the following key points: • While WG has indicated that as from March 2020, all clinical audit data collection would be suspended, this has not resulted in a total suspension of data collection, and the HB has maintained a number of audit projects in the interim. • The Clinical Audit Department has been working with relevant services to conclude the 2019/21 audit programme and an annual report will be produced and presented at various forums. • The Clinical Audit Department has been working to develop the 2021/22 audit programme, and will expand the programme to other forums and engage with other specialties to ensure that the programme is representative of the whole HB. The new programme will seek to	

	focus on the recovery from COVID-19, reflecting audits that assess care both during and after, and provide evidence for effective new ways of working, service redesign or areas that have been identified as a risk during the pandemic. • The Clinical Audit Scrutiny Panel continues to meet, and is now under the direction of a new Chair and Clinical Director for Clinical Audit. Members received a presentation outlining the role of the National Joint Registry (NJR). Mr Peter Cnudde advised Members that the NJR provides information for patients, surgeons, Orthopaedic departments and Health Boards in relation to joint replacement operations and outcomes, and supports shared decision making between all parties in relation to implant surgery choices. Members were informed that patients are able to obtain information relating to individual surgeons and hospitals, while surgeons and hospitals can view and analyse data relating to mortality and revision risks relating to specific operations, in addition to profiling patient characteristics and implant choices and costs. Mr Cnudde drew Members' attention to the role played by the NJR in continually monitoring performance at individual surgeon and hospital level, and in providing early warning to consultants and organisations regarding emerging performance issues. Members were advised that the NJR utilises continuous audit outcomes to update relevant data, and noted recommendations that it be actively used to provide information to patients, and to inform consultant appraisal processes. Responding to a query from Mrs Hardisty as to HB expectations regarding consultant download of their individual NJR performance reports and declaration sign-off, Dr Kloer explained that all specialists are advised to do this, and undertook to provide further information to Mrs Hardisty outside of the Committee meeting. Mr Subhamay Ghosh confirmed that NJR reports are used as part of consultant appraisals. Members thanked Mr Cnudde for an informative presentation, commenting that it is helpful for the Committee to understand the NJR process, and reflecting that there may be further scope to utilise the data provided by the Registry in undertaking performance analysis and appraisals.	**PK**
	The Committee **NOTED** the role of the NJR in providing performance and outcomes data relating to joint replacement surgery, and the potential of this data to inform patients and to support consultant appraisal processes.	

QSEC (21)94	**WAITING LIST SUPPORT PROGRAMME UPDATE**	
	The Committee received an update in relation to the Waiting List Support Service (WLSS) Programme, which has been established to deliver Planning Objective 1E within the HB's strategic priorities, in terms of providing and maintaining personalised contact with patients awaiting elective care. Members were advised that the WLSS offers a single point of contact for patients, replacing a number of disparate communication and advice channels which had previously been available to patients, and centralising all information within a single online resource. Ms Marilize Du Preez informed Members that a pilot had been established to test WLSS processes, and that patient advice is being developed to reflect the	

	age ranges and queries of individuals accessing the service. Members were informed that information is printed and sent by post to those patients who expressed a preference for receiving communications in hard copy form. Noting that evaluation of the WLSS pilot indicates that each contact takes approximately 7 minutes to process, Mr Newman queried how capacity would be managed once the service is scaled up to match anticipated demand, and whether this might necessitate a streamlining of the contact process. Ms Sian Hopkins explained that the call length depends upon the cohort in which individual patients are included, adding as an example that for some treatments, patients may be directed to other online resources. Members were assured that the provision of advice and information once, and from a single point of contact, will result in freeing up nursing and clinical resources. In response to a query from Mrs Hardisty relating to the provision of online advice to patients with sensory deprivation, Members were advised that this is currently being scoped, in conjunction with other agencies. Ms Hopkins further assured Members that work to ensure the accessibility of resources would be undertaken with Learning Disbility groups, such as the Dream Team. Ms Lewis commended the programme, noting the robust work undertaken in a short space of time, given the constrained circumstances, and the learning generated by this initiative which might be shared with the wider organisation. Members noted that a further, more detailed update on the WLSS would be provided at the Board Seminar meeting on 19th August 2021.	
	The Committee **NOTED** the work undertaken to date to develop the Waiting List Support Service, recognising the complexity of this planning objective.	

QSEC (21)95	**OPERATIONAL QUALITY, SAFETY AND EXPERIENCE SUB-COMMITTEE UPDATE REPORT**	
	Members received the Exception Report from the Operational Quality, Safety and Experience Sub-Committee (OQSESC) meeting held on 6th July 2021, together with the OQSESC revised Terms of Reference for approval. Mrs Hardisty expressed concern at a report from the Medical Devices Group relating to the suggested re-use of single use medical items. Ms Shakeshaft assured the Committee that the Medical Devices Group emphatically does not support the re-use of single use, invasive items, adding that this proposal related specifically to the re-use of harmonic shears. Referencing the 73 risks which have a current risk score exceeding the risk tolerance level which are assigned to the Sub-Committee, Ms Lewis queried whether this figure might be an under-representation and expressed a level of concern in view of the fact that these risks exceed tolerances. Ms Lewis further queried how these risks might be contextualised and calibrated in terms of a management view of what constitutes an acceptable number of risks. Mrs Shakeshaft explained that risks assigned to OQSESC have historically always numbered around, or in excess of, 90, the reason being that risks assigned to a number of different Directorates feed into, or are escalated to, the Sub-Committee. Ms Shakeshaft added that conversations relating to the number of assigned risks are frequently held at OQSESC meetings, with suggestions made that a review of risk appetite be undertaken. Mrs Wilson explained that with regard to risk escalation, a clear process	

	regarding sign-off by the relevant Executive Director is in place, however noted that a number of the risks assigned to the Sub-Committee are out of date. Members were further advised that the number of assigned risks is, in fact, proportionate to the size of the organisation, given that they include those which are covered by the Operations and Primary Care, Community and Long Term Care Directorates. Mr Carruthers confirmed that discussions are being held on the way in which incidents and risks are recorded on the *Datix* system with the Head of Assurance and Risk, recognising that in some cases there may be duplication of records, and advised Members that work is being undertaken to review the level at which individual risks should be reflected.	
	The Committee **NOTED** the update from the Operational Quality, Safety and Experience Sub-Committee meeting held on 6th July 2021, and **APPROVED** the Sub-Committee's revised Terms of Reference.	

QSEC (21)96	**LISTENING AND LEARNING SUB-COMMITTEE UPDATE REPORT AND REVISED TERMS OF REFERENCE**	
	Members received the Exception Report from the Listening and Learning Sub-Committee (LLSC) meeting held in August 2021, being advised that Mr Newman has taken the position of Chair of the Sub-Committee, and that meetings would now be held bi-monthly, rather than monthly. Members were informed that work has been undertaken to review and rationalise existing patient surveys, and that LLSC has offered to assist services in undertaking surveys which will enable them to improve patient experience. Mrs Rayani assured Members that patient concerns which are fed into the LLSC will be addressed and would be shared with the wider organisation in order to identify learning.	
	The Committee **NOTED** the content of the Listening and Learning Sub-Committee Update Report and **RECEIVED ASSURANCE** from the actions taken by the Sub-Committee to mitigate identified risks.	

QSEC (21)97	**EFFECTIVE CLINICAL PRACTICE ADVISORY PANEL UPDATE**	
	The Effective Clinical Practice Advisory Panel Report was presented to the Committee, providing an update on the establishment of the Effective Clinical Practice Advisory Panel and a summary of key matters discussed at the two meetings of the Panel held in March and June 2021. Members noted that the Panel will play a key role in overseeing the development of an Effective Clinical Practice Strategic Framework, which will provide a structure for the delivery of HB Planning Objective 5K, and that the Panel has considered proposals for the introduction of Medical Clinical Governance Leads to act as a point of contact for clinical governance at each site, aligned to the relevant Committees and Directorates. Members were also advised of the role of the Panel in supporting the HB to develop systems and processes for disseminating, implementing and risk-assessing against NICE guidelines and quality standards, to identify any gaps	

	and action required to improve the quality of services, and to provide assurance to WG that NICE guidelines have been considered. Mrs Rayani highlighted the important role of Whole Hospital Audit Meetings in enabling learning from best practice to be shared across the organisation.	
	The Committee **NOTED** the content of the Effective Clinical Practice Advisory Panel Update Report and **RECEIVED ASSURANCE** from the progress which had been made by the Panel and by the sub-groups which report up to it.	

QSEC (21)98	**MEDICINES MANAGEMENT OPERATIONAL GROUP UPDATE**	
	The Medicines Management Operational Group (MMOG) Update Report was presented to Committee, providing an overview of the work undertaken by the Group during 2020/21, together with the MMOG and Local Intelligence Network Annual Reports for 2020/21. Members were informed that as the report covers the previous 6-month period, specific patient safety reports had been previously highlighted to the Committee, and were assured that the report demonstrates the positive progress and collaborative work which has been undertaken between Primary and Acute Care since March 2021. Members' attention was directed to the significant work undertaken to ensure that the operational processes in the HB's Aseptic Units meet the necessary standards to mitigate risks, as evidenced in recent audits, and noted that work relating to the facilities in which Bronglais and Withybush General Hospitals Aseptic Units operate is required in order to move the Units from a 'Critical' to a 'Satisfactory' risk position. Members were advised that an increasing risk has been identified in the lack of e-prescribing and medicines administration (EPMA) systems and the continued use of paper systems within the HB, with a recent WG review having highlighted risks relating to a lack of electronic systems, together with the patient safety benefits of moving to an e-prescribing system. Members were informed that while significant levels of engagement across all professions are required to implement an EPMA system, benefits from the system are already being evidenced within SBUHB in terms of significant reductions in medication errors, increased efficiency in prescribing processes, and the availability of live data to support audit, quality improvement and financial controls. Responding to a query from Ms Lewis as to whether the HB is actively considering the implementation of an EPMA system, Mrs Jenny Pugh Jones advised Members that a meeting would be held on 11th August 2021 to consider the development of a business case for an e-prescribing system, adding that a framework outlining specifications had already been developed. Members were further informed that both the HB and WG are very supportive of a move to an EPMA system. Mr Newman reflected that while a significant financial investment would be required to implement e-prescribing within the organisation, this would be justified by the benefits in terms of increased patient safety, and commented upon the impetus that would be required in order to establish full engagement across the HB with the implementation of an EPMA system.	

	The Committee **NOTED** the content of the Medicines Management Operational Group Update Report and **RECEIVED ASSURANCE** that actions taken by the Group to mitigate identified risks are adequate. The Committee also **NOTED** the MMOG and Local Intelligence Network Annual Reports for 2020/21	

QSEC (21)99	**POLICIES FOR APPROVAL**	
	The Committee received the updated *Putting Things Right: Management and Resolution of Concerns* Policy for approval, being advised that the policy had been through due written control documentation process and consultation, and would be brought back to QSEC for review at whichever point is appropriate. Members also approved a request to extend the review dates of the following policy documents to 31st December 2021, to allow sufficient time and resources to finalise the review process: • Staff Attending Inquests/ Court and Assisting Police Investigations Guideline; • The Production and Use of Surveys Guideline; • The Use of Patient and Carer Information Policy; • Use of Patient and Carers Stories Guidelines.	
	The Committee **APPROVED** the updated *Putting Things Right: Management and Resolution of Concerns* Policy and **APPROVED** a request to extend the review dates of the following written control documents: • Staff Attending Inquests/ Court and Assisting Police Investigations Guideline; • The Production and Use of Surveys Guideline; • The Use of Patient and Carer Information Policy; • Use of Patient and Carers Stories Guidelines.	

QSEC (21)100	**QUALITY, SAFETY & EXPERIENCE ASSURANCE COMMITTEE WORK PROGRAMME 2021/22**	
	The Committee received the Quality, Safety & Experience Assurance Committee Work Programme 2021/22, noting that this would be updated in light of discussions held at the meeting.	
	The Committee **NOTED** the Quality, Safety & Experience Assurance Committee Work Programme 2021/22.	

QSEC (21)101	**QUALITY, SAFETY & EXPERIENCE ASSURANCE COMMITTEE DECISION TRACKER 2021/22 - AMBER ACTIONS ONLY**	
	No report presented as all actions have been completed.	

QSEC (21)102	**QUALITY, SAFETY & EXPERIENCE ASSURANCE COMMITTEE SUB-COMMITTEES' DECISION TRACKER 2021/22 – AMBER ACTIONS ONLY**	
	No report presented as all actions have been completed.	

QSEC (21)103	**MATTERS FOR URGENT ATTENTION**	
	No matters for urgent attention were raised.	

QSEC (21)104	**DATE & TIME OF NEXT MEETING**	
	Tuesday 5th October 2021, 1.30 pm - 4.00 pm	