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:	Mrs Sian Passey, Assistant Director of Nursing Quality, Assurance and Professional Regulation (OQSESC Chair)
Cyfnod Adrodd: Reporting Period:	2nd November 2021

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

- **Revised OQSESC Terms of Reference (For Approval)**

The Sub-Committee received the revised OQSESC Terms of Reference (ToRs) for approval. Queries were raised on whether the Group Update Reports should only report on new elements of any risk that requires consideration on a broader scale as per the requirement for the Directorate /Site Exception Risk Reports, however it was agreed that, for now, these Group Update Reports should draw out key points for OQSESC's attention. The Sub-Committee approved the OQSESC's revised Terms of Reference for onward ratification by the Quality, Safety and Experience Committee (QSEC). (Appendix 1).

- **Health and Care Standards Report**

The Sub-Committee received a verbal update on Health and Care Standards, noting that the requirement to complete an Annual Quality Statement (AQS) has been stood down due to the COVID-19 pandemic and that new guidance from Welsh Government (WG) which will align to the Health and Social Care (Quality and Engagement) (Wales) Act has been deferred. Members discussed the current pressures across healthcare enquiring whether WG has taken these into consideration to streamline the process involved, appreciating the importance of quality and safety reporting. Members received assurance that influence would be brought through the leadership of HDdUHB's Director of Nursing, Quality & Patient Experience on one of the 5 work streams for the Health and Social Care (Quality and Engagement) (Wales) Act.

- **Trauma Quality Improvement Committee (TQUIC) Reporting to the South Wales Trauma Network Operational Delivery Network.**

The Sub-Committee received an update on behalf of the TQUIC and noted a 15% improvement in data following a recent Rehabilitation Prescriptions audit. Members were advised that a more streamlined pathway is in place for patients with chest wall injuries that require transfer to the Erector Spinae Plane (ESP) blocks at GGH. Members welcomed the positive feedback following the Trauma Team training days and commended the inclusion of the clinicians and specialised nursing staff involved for the care provided to these complex patients, particularly as the pathway development had taken place without any additional funding. The Sub-Committee received assurance that TQIC holds oversight of trauma management throughout HDdUHB to ensure that trauma care in the correct facility is being received.

- **Incident Reporting Procedure**

The Sub-Committee received the Incident Reporting Procedure for approval ahead of implementation and publication, noting that the procedure has been developed to ensure that all staff are able to take appropriate actions to reduce risks for service users and employees. Members further noted that integral to the success of the procedure will be the development of an organisational culture to allow incidents to be reported in an open and fair environment. The Sub-Committee approved the Incident Reporting Procedure for implementation.

- **Update Report from Resuscitation/RRAILS Group**

The Sub-Committee received the Update Report from the Resuscitation/RRAILS Group, including details on the HILL-ROM Pilot project in WGH and South Pembrokeshire Hospital, with Phase 1 anticipated to commence in January 2022 to include a feature which can calculate the National Early Warning Score (NEWS) and is expected to result in the reduction of calculation errors. Phase 2 will include the transcription of information on to the patient electronic information system.

Members welcomed the positive uptake of the sepsis bundle within the Health Board, whilst noting that reduced activity in the Emergency Admissions Unit at Bronglais General Hospital (BGH) may result in missed sepsis diagnosis. For assurance, a snap-shot audit will be completed by the time of the next Resuscitation/RRAILS Group meeting.

Members were informed of a delay in the implementation of the All Wales Do Not Attempt Cardiopulmonary Resuscitation Policy (DNACRP) due to an error in the documentation. However, it is anticipated that the revised policy will be available for presentation to the next Resuscitation/ RRAILS meeting for agreement prior to publication on the intranet.

The Sub- Committee received assurance from the actions taking place to mitigate risks within the Resuscitation/RRAILS Group Update Report.

- **Nutrition and Hydration Group Update Report**

The Sub- Committee received the Nutrition and Hydration Group update report, highlighting implementation of the Synbitoix electronic menu system. Discussion took place on the requirement for nurses to electronically sign off menu choices and the subsequent additional work this could create, with Members receiving assurance that further discussions would follow in regard to system implementation.

Members noted the pilot of the traffic light system to support frail patients at ward level to increase hydration, acknowledging that a decision to roll this out Health Board wide would depend on the outcome of the pilot.

Members were advised that a dedicated Quality Improvement Officer is now in post who will focus on hydration within the Nutrition and Hydration service.

The Sub-Committee received assurance from the actions taking place to mitigate risks within the Nutrition and Hydration Group Update Report.

- **Update Report from Mental Capacity Act (MCA) and Consent Group**

The Sub-Committee received the MCA and Consent Group Update Report, raising as a concern the further delay of the publication of the Liberty Protection Safeguards (LPS) Code of Practice and Welsh Regulations, leading to the cancellation of the scheduled training in place.

Members received an update from the Welsh Risk Pool E-Consent pilot, noting that a discussion with clinicians to progress the pilot is scheduled for 25th November 2021.

Members were informed that the Health Board has received additional funding from WG to support staff knowledge and reduce the backlog of referrals for the Deprivation of Liberty Safeguards (DOLS) and the MCA, with the MCA and Consent Group to monitor the expenditure plans in place. Members were informed of a 19% increase in DOLS referrals to HDdUHB noting that the increased training and the raised awareness had been a factor in this.

Members received an update on the three risks aligned to the Group, with particular reference to Risk **1205,** the inability to meet Welsh Language Standards by ensuring a Welsh speaker is available to undertake capacity assessments in Welsh. In terms of mitigation, Members noted that the next stage will involve identifying staff who are able to carry out assessments in the Welsh language, in addition to providing training in order to support those who wish to learn.

Following a number of queries relating to pilots taking place on new systems across the Health Board, Members received assurance that web-based management project modules support these, with the rationale behind each pilot to improve current systems and processes.

- **Update Report from the Medical Devices Group**

The Sub-Committee received the Medical Devices Group Update Report. Members were informed of a recent audit of the Point of Care Testing (POCT) regarding the patient identification issues that had previously been raised; as these have now been addressed, the Control Group has been stood down.

The Sub-Committee noted the update on Clinical Engineering, focusing on performance, demonstrating that the Planned Preventative Maintenance (PPM) performance has remained static as a result of the significance increase in the medical devices inventory as a response to the pandemic.

The Sub-Committee also received an overview of the recent Medical Device themed Datix incidents, noting that of the 47 identified incidents, no emerging themes were found that would indicate a systematic issue with medical devices management. Members were advised of the national benchmarking underway in terms of medical devices maintenance performance, and whilst noting that the impact is considered low, received assurance that the risks are being managed.

- **Enabling Quality Improvement in Practice (EQIiP) Position Statement**

The Sub-Committee received the EQIiP position statement and noted the commencement of the second cohort of the programme in November 2021. Given the current significant service pressures across the Health Board, Members were heartened to note that 22 improvement projects have been proposed.

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Risks (include Reference to Risk Register reference):

- **Operational Risk Report of Risks Aligned to Operational Quality, Safety Experience Sub Committee**

The Sub- Committee received the Operational Risk Report of Risks Aligned to OQSESC, noting the change in the format of the report highlighting whether risks have been reviewed since the previous OQSESC meeting. Members were assured that discussions are on-going between the Director of Operations, the Head of Risk and Assurance and service leads to update the respective Directorate Risk Registers, with the aim of the discussions to provide risk owners with support on completing and updating their risk registers to ensure that mitigation is appropriate. Following these meetings, the refreshed risk registers will be shared via the corporate governance structure. Members were advised that a recent Audit Wales Governance Quality Review has highlighted that a number of directorate risks have not been updated on the Datix system for a number of years. However, the Sub-Committee received assurance that risks are being discussed and reviewed through the local quality governance meetings.

- **Women and Children's Directorate Exception Report**

The Sub-Committee received the Women and Children's Directorate Exception Report, noting that the temporary relocation of the Paediatric Ambulatory Care Unit, WGH to Glangwili General Hospital (GGH) will be included within the directorate risk register. Members were advised that feedback has been requested from the parents/ guardians of discharged patients via a questionnaire, and that discussion are ongoing to increase the number of responses received. The Sub-Committee received assurance that the Women and Children's Directorate have robust processes and mechanisms in place to ensure they are providing a safe quality, effective, efficient service for service users.

- **Mental Health and Learning Disabilities (MH&LD) Exception Report**

The Sub-Committee received the MH&LD Exception Report and were informed of the changes underway to the management and reporting arrangements of the Directorate Risk Register to streamline the escalation and management of risks processes and improve connectivity between improvement plans and the risk register. Members were assured that MH&LD have robust processes and mechanisms in place to ensure they are providing a safe quality, effective, efficient service for service users.

- **GGH and PPH Unscheduled Care Exception Report**

The Sub-Committee received an Exception Report detailing the current risks at GGH and PPH as a consequence of the pressures experienced within the Unscheduled Care pathway, with the following key areas of concern highlighted:

- Staffing
- Extreme discharge delays
- COVID-19
- Demand
- Ambulance demand and provision
- The implications of Primary Care pressures

Members noted the complex and challenging position within the Unscheduled Care pathway and the continuous mitigation undertaken by staff during a time of exceptional pressures on a day to

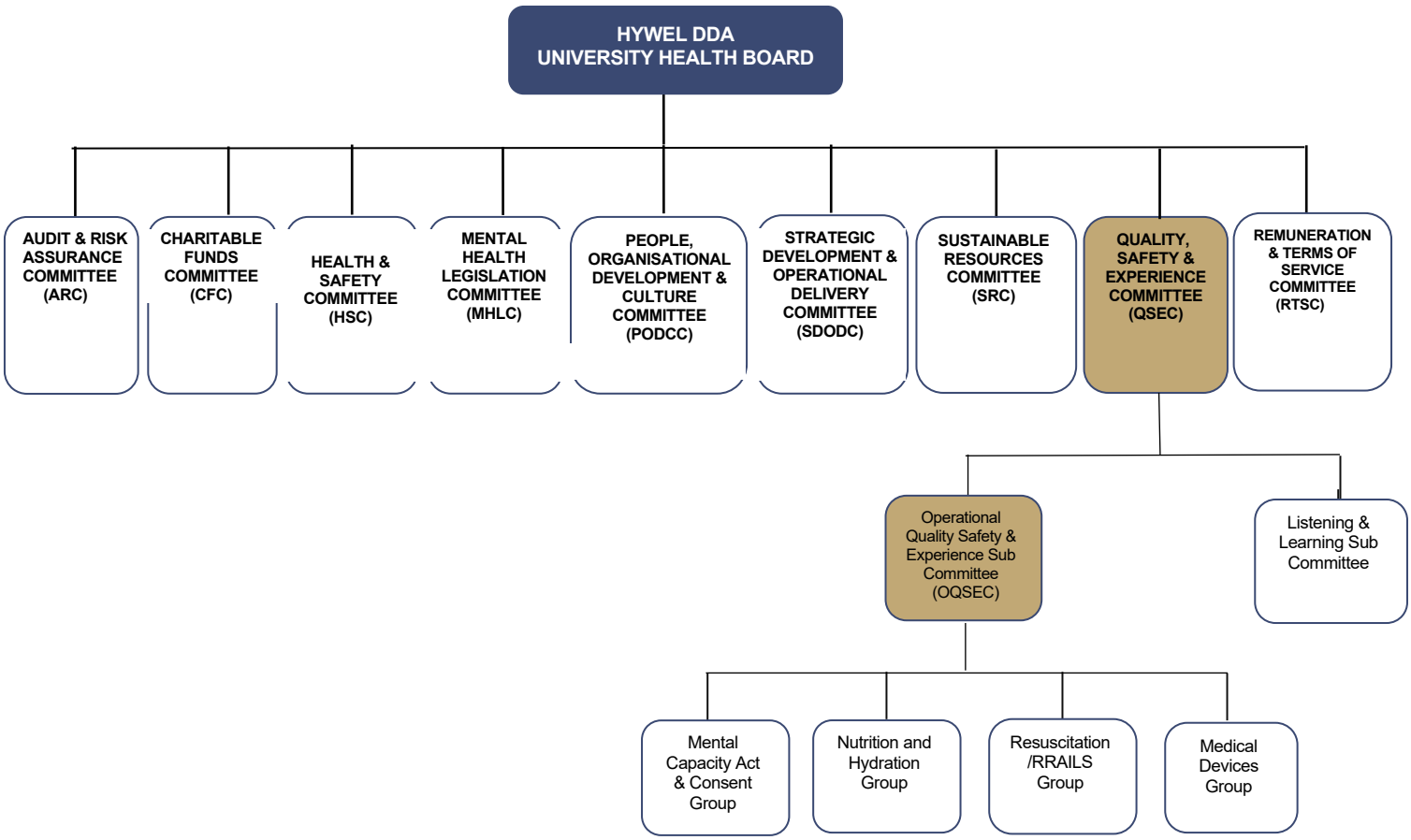
day basis to reduce risks associated with the key concern areas highlighted. . It was recognised that due to the complexities of the system not all risks can be mitigated completely, however, a number of control measures were being instigated to try to minimise risks within the system. A discussion pursued in relation to the requirement to align the concerns noted within the exception report with the relevant risk noted on the risk registers, this would support assurance being given around the mitigations in place relating to the current risks within the system. The review of risk registers by the Director of Operations with the operational services will support this requirement in future exception reporting

Whilst discussing the key areas of concern, Members were informed that the Wales Ambulance Service NHS Trust (WAST) has a 4 level 'Clinical Safety' policy that allows them to focus on the most urgent calls which can further increase pressures at the front doors of hospitals and Minor Injury Units (MIU). Members were informed that WAST's enactment of their Clinical Safety policy without prior discussion with the Health Board has been escalated as a concern to the Director of Operations.

Given the continued challenges across the unscheduled care system in GGH and PPH, it was agreed that only limited assurance could be received from the GGH and PPH Unscheduled Care Exception Report. Members did recognise that operational teams were managing the risks on a day to day basis and that the risk registers were highlighting the actions being taken

Argymhelliad:
Recommendation:

The Quality, Safety and Experience Committee is asked to note the content of the OQSESC Update Report and the continued challenges across the unscheduled care system in GGH and PPH, and approve the OQSESC's revised Terms of Reference.



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	Approved
V0.9	**Quality, Safety & Experience Committee**	10.08.2021	Approved
V10	**Operational Quality, Safety and Experience Sub Committee**	02.11.2021	Approved
V10	**Quality, Safety, Experience Committee**	07.12.2021	For Approval

1. Constitution

1.1 The Operational Quality, Safety & Experience Sub-Committee has been established as a Sub-Committee of the Quality, Safety & Experience 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.

2. Purpose

2.1 The Operational Quality, Safety & Experience Sub-Committee will monitor, as delegated by the Quality, Safety and Experience 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 Committee to be more strategic in its approach and providing an upward assurance.

3. Key Responsibilities

3.1 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 Committee.

3.2 Where re-directed by the Listening & Learning Sub-Committee, monitor concerns (incidents, complaints and claims) ensuring that they are being managed in a robust and timely manner at service level, agreeing mitigating actions where required.

3.3 Request a deep dive report when:

- Action plans following investigations into serious incidents and concerns and the identification of lessons learned breach the agreed timescales. 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.
- To consider themes arising from triangulated information at service specific level, and agree and monitor any action plans required to deliver improvements.
- To consider any concerns escalated through the 'Quality Panel'.

3.4 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.

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

3.6 Seek assurance on the management of operational risks that have been aligned to the Sub-Committee, where the risk tolerance is exceeded or a lack of timely action in order to provide assurance to the Quality, Safety and Experience Committee that risks are being managed effectively and report any areas of concern.

3.7 Receive Directorate /Site Exception Risk Reports and seek assurance on new elements of a directorate risk which requires consideration on a broader scale. Any risk escalated should clearly reference the risk noted on the register.

3.8 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

3.9 Receive position reports on:

- **Key Risks associated with preventing harm to patients determined through:**
  - Triangulation of data;
  - Risk Registers;
  - Quality Panels;

  or any other reporting mechanisms.

3.10 Assure itself that clinical written control documentation, which falls within the remit of the Sub-Committee, has been adopted, developed or reviewed in line with HDdUHB Policy 190 – Written Control Documentation prior to approving it, 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.

3.11 Develop an annual work plan, responding to operational service priorities, consistent with the strategic direction for the organisation, for approval by the Quality, Safety and Experience Committee and oversee delivery to improve the quality, safety and effectiveness of care delivered, and enhance the patient experience.

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

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

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

4. Membership

4.1 The membership of the Sub-Committee shall comprise:

Title
Assistant Director of Nursing Assurance & Safeguarding (Chair)
Associate Medical Director, Workforce & Primary Care (Vice Chair)
Independent Member, HDdUHB
Assistant Director, Operational Nursing & Quality Acute Services
Associate Medical Director, Quality & Safety
Deputy Director of Operations
Assistant Director of Therapies and Health Science – Professional Practice, Governance & Safety
Assistant Director of Public Health
Assistant Director of Workforce & OD
Digital Director
County Directors x 3
Head of Medicines Management
Therapies Lead
Health Science Lead
Senior Nurse, Infection Prevention
Representative from each Triumvirate (either the General Manager or Head of Nursing)
Head of Primary Care
Mental Health & Learning Disability representative

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 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 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 Committee on the Sub-Committee's activities. This includes the submission of Sub-Committee update report, as well as the presentation of an annual report within 6 weeks of the end of the financial year;
9.4.2 Bring to the Quality, Safety & Experience Committee's specific attention any significant matters under consideration by the Sub-Committee.

10. Secretarial Support

10.1 The Sub-Committee Secretary shall be determined by the Board Secretary.

11. Review Date

11.1 These terms of reference and operating arrangements shall be reviewed on at least an annual basis by the Sub-Committee for approval by the Quality, Safety & Experience Committee.