Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Operational Quality, Safety & Experience Sub-Committee

Enw'r Cyfarwyddiaeth: Name of Directorate:	Operational Quality, Safety and Experience Sub-Committee (OQSESC)
Swyddog Adrodd: Reporting Officer:	Mr William Oliver (OQSESC Chair)
Cyfnod Adrodd: Reporting Period:	July 2023

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

- **Operational Quality, Safety and Experience Sub Committee Terms of Reference:** The Sub Committee received and ratified the OQSESC Terms of Reference. Following a request for clarity on specific reporting requirements from the Directorates, the Chair confirmed that the reporting template and guidance will be revised and circulated following a discussion with the Director of Nursing, Quality and Experience.

- **Llais Cymru Presentation:** The Sub Committee received an introductory presentation from Llais Cymru, the recently formed independent statutory body that has replaced the Health Board's Community Health Council and Members undertook to share the PowerPoint presentation and contact details with their wider teams.

- **Operational Risk Register Report:** An update report was received by the Sub Committee on the Health Board's overview of top reported risks and actions for mitigation.

  Referring to Risk Reference 1293 *(Avoidable harm to patients at Minor Injuries Unit (MIU) PPH), the Sub Committee received an update on the positive feedback from the Health Inspectorate Wales (HIW) on the MIU pathway that is in place.* The concerns that were raised by HIW specifically relate to the treatment for major injury and medical patients who present to the Unit and the ability to transfer these patients to an appropriate care setting. Work is underway to address these challenges, which include a joint approach with Welsh Ambulance Service Trust (WAST) and the 111-telephone service to improve communication with the public.

  Discussion took place regarding risk reporting, and it was suggested that it may be helpful to include a column with contributing factors for the risk updates as there are apparent themes which sometimes sit outside of the remit of the Directorate to address, such as resourcing/ staffing/ estates challenges. The Head of Assurance and Risk updated the Sub Committee that this will form part of a piece of work being undertaken by the Associate Medical Director for Quality and Safety to propose a governance framework for assessing the criteria of risks and fragile services in the Health Board. This will provide steer on prioritisation and also ensure Board can be adequately sighted.

- **CIVICA Patient Experience System:** A presentation was shared with the Sub Committee on the national developments of the Patient Experience system and assurance was provided that since the previous update, the connectivity and technical issues that were raised have been resolved.

- **Women's and Children's Services:** The Sub Committee received an update from the Women and Children's Services, the key risks within the service, progress of HIW recommendations and areas of exception highlighted through the Safety Dashboard.

  The Sub Committee noted that Sonography services within the Health Board's antenatal clinics are currently fragile, attributed to a lack of Sonographers. This is a direct consequence of sickness absence due to Repetitive Strain Injury (RSI), shortfall in workforce compounded by staff retirement and an inability to recruit Sonographers across all radiology sites within the Health Board.

  Within the Directorate, there has been a marked increase in the use of agency Registered Nurses (RN). Ongoing discussions are underway with Recruitment to explore the use of internationally educated nurses within Paediatric Services to see if paediatric specific competencies can be developed to address the issues of them joining the Nursing and Midwifery Council (NMC) Register as a Paediatric Nurse. Once achieved, this will provide career progression opportunities.

  Sickness within the Directorate is currently running at 5.4%. All sickness is being managed in line with the Health Board Sickness Policy and on an individual case by case basis. The sickness absence figures are an improving picture with all services actively managing their team's sickness absence.

  In June 2023, the Directorate held a 'risk clinic' where all service and directorate risks were reviewed. Due to the success of the 'risk clinic' there are ongoing discussions so see if this clinic should be held every six months.

- **Therapies Services:** The Sub Committee received and noted the content of the Therapies Services Update report but, due to a scheduling overlap apologies were noted from the Clinical Director of Therapies.

- **Public Health Services:** The Sub Committee noted that the use of unregistered and wider registrant workforce, in order to ensure the range and size of workforce needed to achieve the mass vaccination approach, has been achieved due to the introduction of legislative changes (Regulation 247a) on a temporary basis as a result of the global COVID -19 pandemic. The World Health Organisation (WHO) has recently stepped down the emergency response to Covid-19, impacting on the temporary legislative changes. As a result of this, the Legal Team at Welsh Government (WG) are looking at Regulation 247a and associated protocols but there are no changes to operations at the moment. Protocols surrounding the delivery of the Spring Booster, which is coming to an end in July 2023, are valid for the unregistered and wider registrant staff to continue to vaccinate. The impact on workforce for the planned Autumn Booster remains unclear and planning is underway to scope the impact of any changes if the programme is required to operate with a registrant workforce only. The matter is being addressed at a national level.

- **Scheduled Care Services**: The Sub Committee received an update on the fragility of the Emergency Surgery on call rota at Withybush Hospital (WGH) with a patient impact assessment and update scheduled for the Quality, Safety and Experience Committee on 8 August. There has recently been a severe incident reported on the Emergency Medical Retrieval & Transfer System (EMRTS) in relation to a patient transfer. An Incident Management Group, supported by the Quality, Assurance and Safety Team (QAST), has

been established to consider this incident and whether the Standard Operating Procedure needs to be amended.

The Directorate plan to bring an update on Ophthalmology service fragility to the next Sub Committee in view of recent workshops and the 'Getting It Right First Time' (GIRFT) Review being undertaken during July 2023.

- **Withybush Hospital:** The Sub Committee noted that the wider system pressures continue to necessitate an increased functional bed base and associated risk within the Unscheduled Care Directorate in WGH. Fire Improvement works have been underway across the WGH site since June 2021 and, as things currently stand, are expected to continue until 2028. Phase 1 is nearing completion with a bedded decant facility to facilitate Phase 2 under construction. The need for further urgent estates work in relation to the survey of Reinforced Autoclaved Aerated Concrete (RAAC) planks has been identified with the potential to result in significant operational service delivery disruption.

- **Bronglais Hospital:** The Sub Committee received an update on the ongoing challenges for staff working and clinical space at Bronglais Hospital (BGH). Opportunities to lease desk spaces are being pursued however current mitigations are insufficient to provide relief.

  The inability to cover the Clinical Site Manager rota and the medical workforce staffing deficits remain challenging.
  The overseas recruitment process for F1 and F2 doctors was discussed and the challenges due to withdrawal from posts during the on boarding process and the additional support required for doctors who have undertaken training overseas was noted.
  In relation to the Clinical Site Manager rota it was noted that at times, when the Head of Nursing and Senior Nurse Manager are not available, cover for non-clinical functions is maintained by a non-clinical member of the Management Team remaining on site (in effect the Service Delivery Manager or General Manager). Due to the uniqueness of the Clinical Site Manager role, the job description has been submitted for job matching and the role has been matched to a Band 8a. An SBAR has been submitted to the Operational Planning and Delivery Group for consideration and approval.

  Members were advised that the attainment of safe nurse staffing levels currently relies on the use of agency staff. The withdrawal of accommodation expenses for agency nurses was raised as a concern which may cause long term agency staff to leave posts. The international recruitment initiative has resulted in some improvement in staffing however, significant vacancy rates remain.

  .**Glangwili and Prince Philip Hospital:** The Sub Committee were advised that the RN vacancy position has improved at Glangwili Hospital (GGH) and Prince Philip Hospital (PPH) respectively, with the recruitment of RN's and overseas RNs gaining their PIN registration code. There remains a RN and Healthcare Support Worker (HCSW) deficit on both sites, across all areas, necessitating continued use of Bank and Agency staff to mitigate risks. This position continues to impact upon quality, safety and patient experience.

  Members noted that inpatient falls remains a clinical risk across the sites. The QAST team are undertaking a scoping exercise within the medical wards to identify themes from falls incidences followed by targeted intervention. Outcome data to date is positive with reduced incidences of falls in these areas.

- **Recognition of Acute Deterioration and Resuscitation (RADAR) Group Update:** The Sub Committee received an update on the change of the title of the group from the Resuscitation and RRAILS to RADAR and noted that the Membership of the group is being revised to improve medical representation. The revised Terms of Reference will be submitted for approval to OQSESC in the meeting scheduled for September 2023.

  The Sub Committee were informed that the Deanery potentially may not fund Advanced Life Support (ALS) courses for F1 doctors in Wales going forward. A Health Education Improvement Wales (HEIW) Board meeting will be held for further discussions. Other Health Board's across Wales are continuing to plan ALS courses with the understanding that these will be funded for this year.

  The Sub Committee approved the Intra-Osseous Guideline (684) and the Recording a Standard 12-lead Electrocardiogram Procedure (439)

- **Medical Devices Group Update Report and Terms of Reference:** The Sub Committee received and approved the Medical Devices Group Terms of Reference and noted the key highlights from the update report including:

  - The additional risk to fragile Ultrasound services posed by ageing Ultrasound equipment at BGH leading to difficulties undertaking obstetric Ultrasound and also compromising the quality of images (Risk 1659). The risks are being addressed through a control group.
  - The on-going issue around the inability to roll out the Glucose Meter Point of Care Testing (POCT) and new pregnancy testing POCT due to Wi-Fi connectivity issues.
  - The deteriorating position regarding an ageing Patient Controlled Analgesia (PCA) pump inventory, limited replacement options and the use of alternative devices which may lead to sub – optimal pain relief. It was agreed by the Group that a strategic replacement programme is required and the establishment of a Task and Finish group to develop a replacement business case by the Scheduled Care Directorate was agreed.

- **Clinical Record Keeping Policy:** The Sub Committee received a PowerPoint presentation on the Clinical Record Keeping Policy noting that the Health Board approved a new Clinical Record Keeping Policy in February 2023. The Policy was developed with multidisciplinary input and supports effective record keeping by providing clear professional and organisational standards that all clinical staff must adhere to. The Sub Committee noted that the next steps include designing and piloting an audit programme, using the Audit Management and Tracking (AMaT) system and establishin a multidisciplinary Clinical Record Keeping Policy Implementation Group. The Sub Committee were requested to provide nominations for representation on the Implementation Group by 30 July 2023.

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

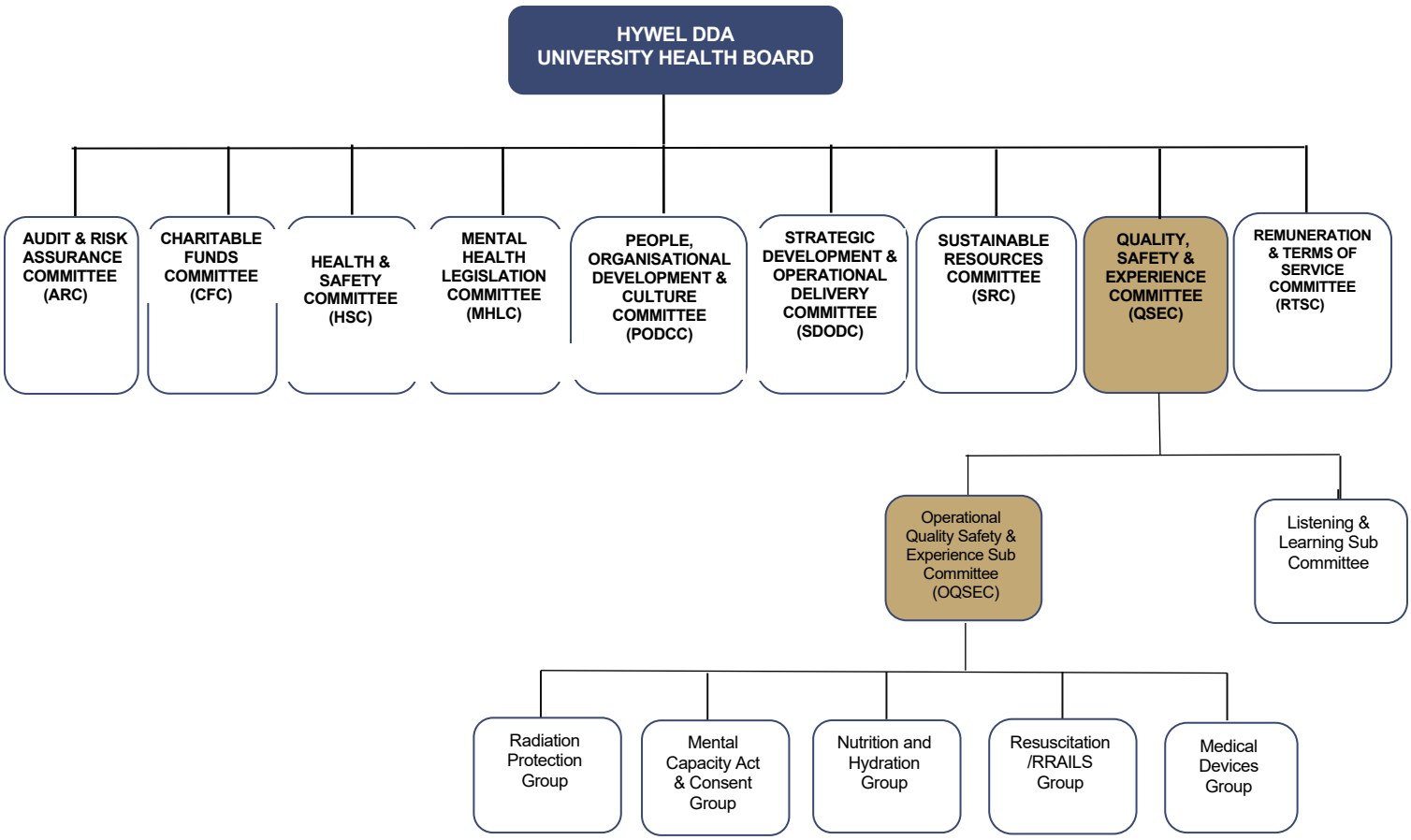
- Concern was raised regarding the deteriorating Sonography Workforce position.
- The Sub Committee raised concern regarding the risks due to failure of staff to follow the Health Board's Transfusion Policy for pre-transfusion sampling and fraudulently completing the Group and Save (G+S) request form and sample with a different time to when the sample was actually taken. Concerns were raised regarding the errors due to poor practice. It was noted that Transfusion Leads are meeting on 16 June 2023 to discuss this risk further (Risk 1542)

- Concern was raised regarding training staff capacity to meet the demand for Advanced Life Support Training following Health Education and Improvement Wales's decision to withdraw it from Junior Doctor trainees.
- The operational challenges due to the need to undertake urgent survey works into the condition of Reinforced Autoclaved Aerated Concrete (RAAC) planks in specified areas of WGH were raised as causing challenges in service disruption.

Argymhelliad:
Recommendation:

The Quality, Safety and Experience Committee is asked to note the content of the 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	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	Approved
V11	**Operational Quality, Safety and Experience Sub-Committee**	06.07.2023	Approved
V11	**Quality, Safety, Experience Committee**	08.08.2023	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 1 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
- Radiation Protection 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 Therapies and Health Science (Chair)
Clinical Director and Associate Medical Director Primary Care (Vice Chair)
Deputy Medical Director – Primary Care & Community Services (Vice Chair)
Independent Member, HDdUHB
Associate Medical Director, Quality & Safety
Deputy Director of Operations
Head of Quality and Governance
Assistant Director of Public Health
Head of Workforce
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)
Assistant Director 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 request 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 A draft Table of Actions will be issued within **two** days of the meeting. The minutes and Table of Actions will be circulated to the Chair within **seven** days to check the accuracy, prior to sending to Members to review within the next seven days.

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)
9.3.5 Radiation Protection Group

9.4 The Sub-Committee Chair, supported by the Sub-Committee Secretary, shall:

9.4.1 Report formally, regularly and on a timely basis to the Quality, Safety & Experience 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.