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:	7 March 2023

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

Duty Of Quality Presentation: The Sub Committee received an update on the Health and Social Care (Quality and Engagement) (Wales) Act and the requirements for all Health Board's when the Duty of Quality comes into force on 1 April 2023. An overview of the themes of the Act was provided by the Head of Quality and Governance, who highlighted some key changes that will need to be put in place between now and September 2023 including internal and external reporting processes and the requirement to demonstrate how the Health Board's functions will be exercised to improve the quality of services. Members noted the progress of the Quality Management System which will apply appropriate focus on quality control, quality planning, quality improvement and quality assurance with the aim of achieving a learning and improving environment. The draft Quality Management System brief is accessible via a SharePoint page and the Quality and Safety Team will include the links to helpful tools within the same SharePoint page. Members noted that the Quality Improvement Framework will be submitted for Board approval in March 2023. Further consideration will be given on how the Sub Committee plans to demonstrate the changes in the reporting arrangements to include quality matters going forward.

Health Inspectorate Wales Inspection Themes: The Committee received an overview of Healthcare Inspectorate Wales (HIW) inspection reports, recommendations and the emerging themes. Areas of good practice were identified, such as staff responding to patients with a kind and caring manner even when under significant pressures and the overall commitment to learning from the inspections. Members also noted areas for improvement for example regularly undertaking checks on the resuscitation trolleys to ensure the required equipment is accessible in line with the Policy. Work is underway with Directorates to develop smart actions for the Recommendations and discussions are taking place on how the Quality and Safety Team (QAST) can best support the teams in this process. Recommendations arising from HIW such as immediate assurance plans or final reports are being migrated into the new AMAT software and Members acknowledged the benefits of this development and the plans to align the work with the Safety Dashboard.

The Committee were advised that following the HIW national review of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR), the required information has been submitted and the findings will be shared once the outcome report is received.

Impact of Industrial Action: The Committee received an update on the actions undertaken by the Health Board to mitigate the impact of the recent industrial action, with the establishment of the Industrial Action Planning Group. Industrial action by the Royal College of Nursing (RCN) members took place on 15 and 20 December 2022, industrial action by the Welsh Ambulance Service Trust (WAST) took place on 21 December 2022, 11 January 2023, and 20 February

2023. Members were pleased to note that no patients have been reported to have suffered any direct harm as a result of the Industrial Action.

The Industrial Action Planning Group was established as a Health Board wide co-ordinated approach to mitigate the impact of the Industrial Action. The areas of focus included planning for minimal safe staffing levels, reviewing planned care activity, working in partnership with the RCN Local Strike Committee to agree derogations, establishing a process for capturing potential patient harm, establishing appropriate on the day command and control structures and lines of internal communication, and providing regular communications for staff and the public. In total 1107 outpatient appointments were rescheduled across the two dates. Four picket lines were in place across our four acute hospital sites with no issues reported. Members noted that a specific Industrial Action field was included on Datix and to date five incidents were reported from the WAST strikes which were resolved. The Unions are still in discussion with Welsh Government and while Hywel Dda have been proactive in mitigations, it cannot be guaranteed that the impact will be low in the event of further Industrial Action. The Chair thanked the teams across the Health Board for their hard work and commitment to maintain safe services during periods of already significant pressures.

Site Exception Reporting Discussion: Following the Duty of Quality presentation and in light of the requirements set out in the Health and Social Care (Quality and Engagement) (Wales) Act, the Chair highlighted that it will be timely to shift the Sub-Committee reporting for more focus on the quality and improving quality element of services. Members were urged to consider how their Directorate Quality, Safety Groups would reflect the new Duty and noted that work was being undertaken Corporately to amend reporting templates to reflect the requirements of the Duty. The Sub-Committee were asked to consider how we recognise harm that our public come to as a result of inaction (e.g. long waits for scheduled care) as opposed to harm as a result of individual incidents and how this might be linked into the harms dashboard.

Therapies Services: The Sub Committee received an update report from Therapies Services and the ongoing challenges relating to service accommodation, in particularly North Ceredigion, which has an impact on service provision. Members also noted the risks associated with Musculoskeletal (MSK) services in Ceredigion (Risk reference 1318) due to services displaced from Bronglais Hospital during the COVID-19 Pandemic however were pleased to note that alternative accommodation has been secured, with the date for completion to be confirmed.

Members noted the two extreme risks reported via the Directorate Risk Register, firstly Risk Reference 1517 - Escalating routine MSK waiting times, breach of national targets and service recovery with Members pleased to note the last two months have however seen an improving trajectory. Secondly, Risk Reference 1512 - Increased urgent community physiotherapy waiting times and delayed response with actions underway to mitigate the risks including patients at risk of coming to harm or risk of admission being triaged with a higher level of urgency and seen within 72 hours. Members were advised however that this is also becoming a challenge and further work on the triage process will be required. The Committee suggested that it would be beneficial to include the associated impact on patients due to the delays and asked what the team feel are the consequences of workforce gaps and further suggesting that this information is considered as part of the next update report which was agreed.

Women and Children's Services: The Sub Committee received the key highlights from the Women's and Children's Services Exception Report, including the positive outcome of the HIW unannounced site visit to Maternity Services at Glangwili Hospital 28 to the 30 November 2022,

with 14 recommendations for improvement and 50% of these completed to date. Members were pleased to note the progress within the Directorate for reviewing the Datix Risks, with a 'risk clinic' being established. An update was provided on the ongoing staffing challenges within all areas across the Directorate, including nursing, midwifery and medicine. The Directorate continue to work to identify investment for the risk associated with the lack of funding for children and young people receiving end of life care and receiving 24 hour care in line with NICE National Guidance.

Bronglais Hospital: The Sub Committee received the key highlights from the Bronglais Hospital update report noting comments from the Sub Committee on the limited detail provided within the Exception Report which would be fed back to the team for future reporting. An update was provided on the progress in reviewing the Risk Register in collaboration with the Assurance and Risk Team. The risks associated with accommodation challenges, in particular office space and storage remain. Members noted that challenges remain with nursing vacancies, in particular senior nurses, which will require careful monitoring in the summer months due to annual leave. Members of the Management Team are undertaking Nurse Practitioner duties due to the inability to successfully recruit into vacant roles, with the capacity challenges of the Management Team noted. An update on the General Medical Council (GMC) report relating to the register of external visits was requested to be shared with the Sub Committee.

Withybush Hospital: Due to unforeseen circumstances, apologies were noted from the Withybush Hospital representative.

Glangwili And Prince Philip Hospital: Members noted the actions to improve the staffing challenges, with 24 International Nurses recently recruited in post in wards at Glangwili Hospital. Five have passed the Objective Structured Clinical Induction (OSCI) assessment, four of whom have their PIN, with one awaiting receipt of PIN. 19 of the nurses have unfortunately failed their OSCI and are awaiting a date to re-sit. These new staff are, in the main, settling and progressing well and are a valued addition to the Nursing Team, however, some require additional support and supervision. Work is underway to recruit further International Nurses. For future reporting, the Chair suggested that a linechart is included for Members to be more visually sighted on the trajectory in terms of nursing vacancies.

Mental Health and Learning Disabilities: The Sub Committee received a verbal update from the Mental Health and Learning Disabilities Directorate**.** The Directorate continues to experience risks (Score 20 on the Datix system) associated with the waiting times for Autism, Attention Deficit Hyperactivity Disorder (ADHD) and the Memory Assessment Services (MAS) with MAS making recent improvements with the waiting list. With regards to Autism and ADHD, the volume of referrals coming through the system are causing backlog challenges. Welsh Government has committed to help support the backlog through procurement to assess 400 waiting patients.

Members welcomed the positive feedback from Audit Wales regarding the Directorate governance arrangements noting that the recommendations are being progressed. An external audit has taken place for the Crisis and Liaison Service for Older Adult Mental Health, with four recommendations to progress.

Referring to the '111' press 2 for Mental Health Services contact line, Members were advised that a piece of work is underway regarding how calls are being managed and options considered related to immediate feedback regarding distress levels, highlighting that a number of those who have accessed this service are already receiving Mental Health Services support and the information requires triangulation.

Public Health Services: The Sub Committee received the key highlights from the Public Health Services Directorate Quality, Safety and Experience Group (QSEG).

- Future reporting of vaccination and immunisation updates through OQSESC to the Quality and Safety Committee have been agreed.
- There are two WHC's within the Directorate on schedule for completion: WHC 027-22 Urgent polio catch-up programme for children under 5 years old and WHC 001-23 Eliminating hepatitis (B and C) as a public health threat in Wales – Actions for 2022-23 and 2023-24
- New risks have been added since the last report to the Public Health QSEG in November 2022. The transition of some risks to the Women and Childrens directorate is in progress. Members noted the two risks relating to the vaccination programme and the two new corporate risks associated with Industrial Action and Power Outage.

Members received assurance that the risks which have passed their review dates have been updated and discussions are underway regarding the Service Risk processes to ensure they are reflective of service position.

Scheduled Care Services: The Sub Committee received three specific updates from the Scheduled Care Services Directorate.

1. **An update from Scheduled Care Services on the Incident Management Group for the Cataract Implants EyeCEE One Lens:** On 26 January 2023, the Health Board received a Field Safety Notice (FSN) in relation to Bousch & Lomb (B&L) EyeCee one lenses. The use of the product was stopped immediately and clinicians were informed. An investigation was conducted by B&L. The Waiting List Support Service received 16 calls on 7 February 2023 regarding a newspaper article stating that all Health Boards and Trusts would be contacting patients that may have been affected by the FSN and the Ophthalmology service were contacted by the WLSS the following day regarding the Medicines and Health Care Products Regulatory Agency (MHRA) alert. Following enquiries, the service was made aware that the MHRA issued a further alert on 1 February 2023 which had not been communicated to the service. An Incident Management Group was established and immediate actions undertaken in response, with the Corporate Team undertaking discussions regarding communication processes with the MHRA. Members received assurance that as of the 1 March 2023, 160 patients have received a repeat pressure check in their Optometric Practice. 158 of patients did not require any further action and pressures were all within range. Two patients required referral to Emergency Eye Casualty for a Consultant review. The service will continue to review the results of patient's pressure checks and escalate any concerns appropriately.

2. **An update on the Welsh Health Circular on School Entry Hearing Screening:** The Sub Committee noted the inconsistencies across Health Boards nationally on how this service is delivered. Hywel Dda University Health Board currently provide this service through the School Nursing team. The WHC proposes that this service should be transferred to Audiology but there is no funding allocation to transfer this service. The annual cost to transfer this to Audiology would be approximately £84k which will be discussed further at the Improving Together Sessions with the Director of Operations and raise the funding requirements through the Operational Planning and Delivery Programme.

3. **Update position report from the Critical Care Services:** The workforce challenges remain within the service with limited success in recruitment. An update will be provided to Public Board in March 2023 relating to the emergency medical take at PPH as part of a fragile services report which will include short and long term goals. Members were pleased to note that the Director of Operations has implemented a Working Group for clinicians in Prince Philip Hospital to continue to monitor the position.

Primary Care Services: The Sub Committee received an update from Primary Care Services noting that whilst recruitment into clinical posts has improved, several attempts at recruitment into the Clinical Lead posts for Neyland and Johnston and Tenby Surgeries have not been successful. An interim arrangement has been made with a GP Locum in Neyland and Johnston and the post for Tenby is currently out to advert. The lack of clinical leadership within the Managed Practices increases the level of risk in supporting the operational clinical teams.

Due to essential estates maintenance work, Trimsaran Surgery was closed in January 2023. Members were pleased to note that the work has successfully concluded in February 2023 and services have resumed. Members were also pleased to note the general update on estates improvements within the Managed Practices.

The Sub Committee requested to be sighted in future reports on updates from Optometry services, highlighting the potential for the transfer of Ophthalmology from Primary to Secondary Care services and the associated impact this will cause.

Resuscitation And RRAILS Group: The Sub Committee received the key highlights from the Resuscitation and RRAILS Group and were advised that attendance at the meetings is being monitored due to clinical pressures.

Members noted Health Education and Improvement Wales (HEIW's) recommendation that junior doctors will no longer be required to undertake Advanced Life Support (ALS) training as juniors were reporting distress undertaking ALS, with feedback that they should not be in a position to oversee a cardiac arrest. A solution suggested to the group was that ALS be offered just before they move on to an F2 post. Presently, due to reduced Resuscitation Team staffing levels and reduced Medical Faculty numbers, it is only possible to deliver ALS to medical staff. Concern was raised regarding whether senior nursing staff should also be prioritised for such courses, as in some instances they have led cardiac arrest response.

Members noted that the volume of Sepsis form submission has reduced and following a snap shot audit at Bronglais Hospital it has been agreed that although no Sepsis cases had been missed, the triage process, and specifically, onward communication, will be reviewed.

Members noted that the Quality Improvement Team are supporting a Resuscitation Survey, which will be widely distributed in order to obtain insight into Resuscitation services and where there is room for improvement.

Nutrition and Hydration Group: The Sub Committee received the key updates from the Nutrition and Hydration Group that took place on 8 February 2023. The development and implementation of a local Nutritional Risk Screening training resource for Mental Health linked to the screening tool was presented. This new training resource aims to support improved nutrition screening practice across Mental Health and is initially being piloted in the Older Adult and Adult Mental Health wards in PPH.

There is a Health Board plan for Nutrition and Hydration Week 13- 19 March 2023, which aims to optimise engagement from staff and the public.

Members noted that the Assistant Director of Legal and Patient Services reported on nutrition and hydration related themes from complaints and concerns, meetings with families, and Ombudsman cases. Feedback included families' experiences of nutrition and hydration at the end of life, palliative care, and prolonged periods nil by mouth. It was agreed to work to undertake improvement work to ensure we are supporting actions that address themes from concerns, and to ensure quality improvement activities are recognised in evidence, action plans and reports.

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Risks (include Reference to Risk Register reference):

Resuscitation and RRAILS Group: Concerns raised regarding Health Education and Improvement Wales (HEIW's) recommendation that junior doctors will no longer be required to undertake Advanced Life Support (ALS) training, which is being raised with HEIW and the Deanery.

Argymhelliad:
Recommendation:

The Quality, Safety and Experience Committee is asked to note the content of the OQSESC Update Report.