

Y PWYLLGOR ANSAWDD, DIOGELWCH A PHROFIAD QUALITY, SAFETY AND EXPERIENCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	10 June 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Quality, Safety and Experience Committee Terms of Reference
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Sharon Daniel, Executive Director of Nursing, Quality and Patient Experience
SWYDDOG ADRODD: REPORTING OFFICER:	Joanne Wilson, Director of Corporate Governance/Board Secretary Charlotte Wilmshurst, Assistant Director of Assurance and Risk

Pwrpas yr Adroddiad (dewiswch fel yn addas) Purpose of the Report (select as appropriate)

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

The purpose of this paper is to ensure that the Quality, Safety and Experience Committee has clear terms of reference which detail its purpose, boundaries, role, composition and operating arrangements.

The Committee are asked to approve the Quality, Safety and Experience Committee's Terms of Reference for onward ratification by the Board on 31 July 2025.

Cefndir / Background

According to its terms of reference, the Committee must review its terms of reference and operating arrangements on at least an annual basis to ensure they remain fit for purpose. These must be subsequently approved by the Board and will form part of the Health Board's Standing Orders.

The Committee last reviewed its terms of reference and operating arrangements in June 2024, and these were subsequently approved by the Board, on 25 July 2024. The Board also approved the following changes on 28 January 2025 as part of the revised governance arrangements from 1 April 2025.

- 4 x Independent Members per Committee (except Quality, Safety and Experience Committee which will have 5).
- Where Independent Membership has reduced to 4, the quoracy will be amended to 'A quorum shall consist of no less than two of the membership and must include as a minimum the Chairman or Vice-Chairman of the Committee, and one other Independent Member, together with a third of the In Attendance Members.'
- Updated job titles, e.g., from Director to Executive Director, Director of Operations to Chief Operating Officer, where appropriate.

- The Director of Corporate Governance will be removed from the In Attendance section however will attend committees (or nominate a deputy) to provide governance advice and support.
- Other cosmetic amendments required to standardise Board Committee level terms of reference.

Asesiad / Assessment

The Quality, Safety and Experience Committee Terms of Reference and operating arrangements (**Appendix 1**) have been reviewed and updated to include any relevant amendments agreed at Board on 30 January 2025. The table below also details further changes that have been made. These are clearly marked on Appendix 1 and relate to the following:

Section	What has changed?	Why?
2.7	Principal Duties - removed	Wording removed as included within Appendix 1
3.2	Key Responsibilities – section amended	New standard wording agreed by Board in January 2025 for risks in Committee ToRs as follows: <i>“Seek assurance on the management of risks within the Corporate Risk Register (CRR) and Operational Risk Registers (including for hosted services and through partnerships and Joint Committees as appropriate) aligned to the Committee and its subcommittees, and report any areas of significant concern e.g. where risk tolerance is exceeded, lack of timely action. Where risks cannot be brought within the Health Board’s risk appetite/tolerance, recommend acceptance of risks to the Board”</i> .
3.3	Key Responsibilities – section removed	Section removed as covered in section 3.2
New 3.3	Key Responsibilities – section amended	New standard wording agreed by Board in January 2025 for risks in Committee ToRs, as follows: <i>“Receive assurance through Sub-Committee Update Reports and other management/task & finish group reports that risks relating to their areas are being effectively managed across the whole of the Health Board’s activities (including for hosted services and through partnerships and Joint Committees as appropriate)”</i> .
3.4	Key Responsibilities – section added	New standard wording agreed by Board in January 2025, as follows. <i>“Review and approve the annual work plans for any Sub-Committee which has delegated responsibility from the Quality and Safety Committee and oversee delivery”</i> .
3.17	Key Responsibilities – section amended	New standard wording agreed by Board in January 2025, as follows. <i>“Seek assurances on the requirements arising from the Health Board’s regulators, Welsh Government and professional bodies”</i> .
3.27	Key Responsibilities – section amended	Removed reference to specific Committees and reduced narrative as follows: <i>“Refer quality & safety matters which fall within the remit of other Committees”</i> .

3.28	Key Responsibilities – section removed	Section removed as covered in section 10.4.
New 3.28	Key Responsibilities – section amended	New standard wording for PO's agreed by Board in January 2025, as follows: <i>“Seek assurance on delivery against all Planning Objectives aligned to the Committee, in accordance with the Board approved timescales, as set out in the Health Board’s Annual Plan, considering, and scrutinising the plans and programmes that are developed and implemented, supporting and endorsing these as appropriate”</i> .
4.1	Membership - section amended	Following the changes to the membership of Committees as of 1 April 2025, the requirement for the Health and Safety Committee (HSC) Chair to also be a member has been removed. The revised requirement stipulates that <i>“the HSC Vice Chair” is a member of QSEC</i> ”
4.3	Membership - section amended	Amended to reflect the new chairing arrangements for the Sub-Committees to QSEC.
4.4	Membership - section removed	Section removed as the new Sub-Committee Chairs are Executive Directors and are members of the Committee.
10.3.1	Reporting - section amended	Removal of <i>“Operational”</i> following approval to change the Sub-Committee name at QSEC in August 2024.

Argymhelliad / Recommendation

The Committee are asked to approve the Quality, Safety and Experience Committee's Terms of Reference (version 17) for onward ratification by the Board on 31 July 2025.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	10.5 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self assessment and evaluation of the Committee's performance and operation including that of any Sub-Committees established. In doing so, account will be taken of the requirements set out in the NHS Wales Quality & Safety Committee Handbook.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	Not Applicable
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	1. Leadership

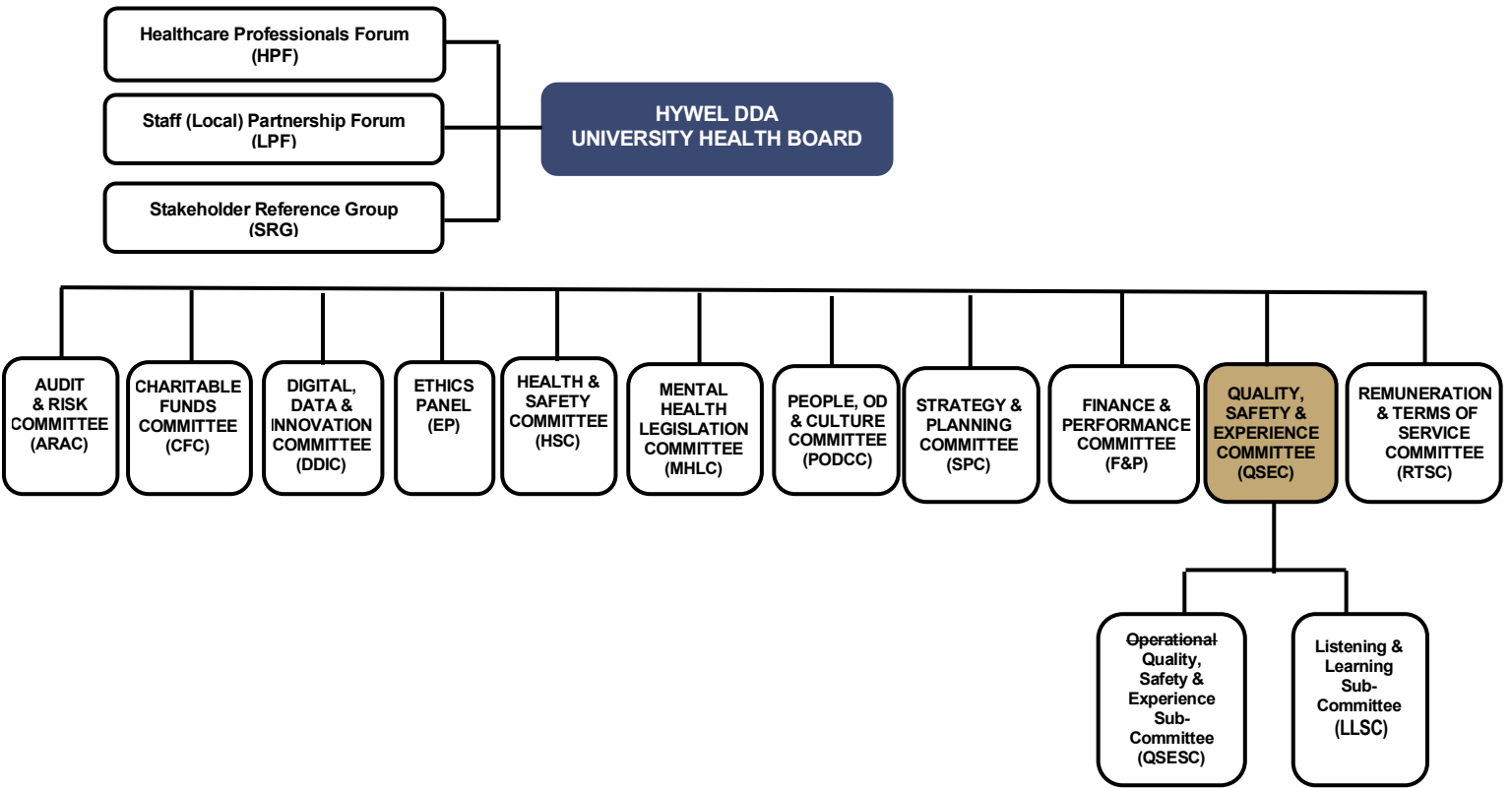
Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable
Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Standing Orders
Rhestr Termau: Glossary of Terms:	Contained within the body of the report
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiad: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	Director of Corporate Governance/Board Secretary Executive Director of Nursing, Quality and Patient Experience

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No direct impacts
Ansawdd / Gofal Claf: Quality / Patient Care:	No direct impacts
Gweithlu: Workforce:	Not applicable
Risg: Risk:	Not applicable
Cyfreithiol: Legal:	Not applicable
Enw Da: Reputational:	Not applicable
Gyfrinachedd: Privacy:	Not applicable

**Cydraddoldeb:
Equality:**

Not applicable



TERMS OF REFERENCE

QUALITY, SAFETY & EXPERIENCE COMMITTEE

Version	Issued to:	Date	Comments
V1	Quality Safety & Experience Assurance Committee	16.06.2015	Approved
V2	Hywel Dda University Health Board	30.07.2015	Approved
V3	Hywel Dda University Health Board	26.11.2015	Approved
V4	Quality Safety & Experience Assurance Committee	18.10.2016	Approved
V4	Hywel Dda University Health Board	26.01.2017	Approved
V5	Quality Safety & Experience Assurance Committee	20.02.2018	Approved
V5	Hywel Dda University Health Board	29.03.2018	Approved
V6	Quality Safety & Experience Assurance Committee	05.02.2019	Approved via Chair's Action 20.03.2019
V7	Hywel Dda University Health Board	28.03.2019	Approved

V8	Hywel Dda University Health Board	26.03.2020	Approved
V9	Quality Safety & Experience Assurance Committee	07.04.2020	Approved via Chair's Action on 18.05.2020
V.9	Hywel Dda University Health Board	28.05.2020	Approved
V10	Quality Safety & Experience Assurance Committee	02.02.2021	Approved
V11	Hywel Dda University Health Board	25.03.2021	Approved
V12	Hywel Dda University Health Board	29.07.2021	Approved
V13	Quality Safety & Experience Assurance Committee	22.06.2022	Approved
V13	Public Board	28.07.2022	Approved
V14	Quality, Safety and Experience Committee	13.06.2023	Approved
V14	Hywel Dda University Health Board	27.07.2023	Approved
V15	Quality, Safety and Experience Committee	11.06.2024	Approved
V15	Hywel Dda University Health Board	25.07.2024	Approved
V16	Hywel Dda University Health Board	30.01.2025	Approved (alongside the new governance arrangements)
V17	Quality, Safety and Experience Committee	10.06.2025	For approval

QUALITY, SAFETY & EXPERIENCE COMMITTEE

1. Constitution

- 1.1 The Quality & Safety Committee was established as a Committee of the Hywel Dda University Health Board (HDdUHB) and constituted from 1 October 2009.

2. Principal Duties

The purpose of the Quality, Safety & Experience Committee is to:

- 2.1 Scrutinise, assess and seek assurance in relation to the patient impact, quality and health outcomes of the services provided by the Board.
- 2.2 Provide evidence based and timely advice to the Board to assist it in discharging its functions and meeting its responsibilities with regard to the quality and safety of health care provided and secured by the University Health Board.



- 2.3 Provide assurance that the Board has an effective strategy and delivery plan(s) for improving the quality and safety of care patients receive, commissioning quality and safety impact assessments where considered appropriate.
- 2.4 Assure the development and delivery of the enabling strategies within the scope of the Committee, aligned to organisational objectives and the Annual Plan/Integrated Medium Term Plan for sign off by the Board.
- 2.5 Provide assurance that the organisation, at all levels, has the right governance arrangements and strategy in place to ensure that the care planned or provided across the breadth of the organisation's functions, is based on sound evidence, clinically effective and meeting agreed standards.
- 2.6 Receive assurance on delivery against the areas of targeted intervention, and the required elements for de-escalation, that are aligned to the Committee (see Appendix 1 for additional detail):
 - i. ~~Planning and service management~~
 - ii. ~~Quality management – clinical governance~~
 - iii. ~~Quality management – complaints and healthcare associated infections (HCAIs)~~

3. Key Responsibilities

The Quality, Safety & Experience Committee shall:

- 3.1 Provide advice to the Board on the adoption of a set of key indicators of quality of care against which the University Health Board's performance will be regularly assessed and reported on.
- 3.2 ~~Seek assurance on the management of risks within the Corporate Risk Register (CRR) and Directorate level risks allocated to the Committee and provide assurance to the Board that risks are being managed effectively and report any areas of significant concern e.g. where risk tolerance is exceeded, lack of timely action.~~ **Seek assurance on the management of risks within the Corporate Risk Register (CRR) and Operational Risk Registers (including for hosted services and through partnerships and Joint Committees as appropriate) aligned to the Committee and its sub-committees, and report any areas of significant concern e.g. where risk tolerance is exceeded, lack of timely action. Where risks cannot be brought within the Health Board's risk appetite/tolerance, recommend acceptance of risks to the Board.**

~~Recommend acceptance of risks that cannot be brought within the UHBs risk appetite/tolerance to the Board through the Committee Update Report.~~
- 3.3 ~~Receive assurance through Sub-Committee Update Reports that risks relating to their areas are being effectively managed across the whole of the Health Board's activities (including for hosted services and through partnerships and Joint Committees as appropriate).~~ **Receive assurance through Sub-Committee Update Reports and other management/task & finish group reports that risks relating to their areas are being effectively managed across the whole of the Health Board's activities (including for hosted services and through partnerships and Joint Committees as appropriate).**

- 3.4 Review and approve the annual work plans for any Sub-Committee which has delegated responsibility from the Quality and Safety Committee and oversee delivery.
- 3.5 Ensure the right enablers are in place to promote a positive culture of quality improvement based on best evidence.
- 3.6 Oversee the development and implementation of strengthened and more holistic approaches to triangulating intelligence to identify emerging issues and themes that require improvement or further investigation.
- 3.7 Provide assurance that all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality and safety of care provided, and in particular that sources of internal assurance are reliable, there is the capacity and capability to deliver, and lessons are learned from patient safety incidents, complaints and claims.
- 3.8 Receive assurance on delivery against the areas of targeted intervention (Appendix 1), and the required elements for de-escalation, that are aligned to the Committee (see Appendix 1 for additional detail):
- 3.9 Provide assurance to the Board that current and emerging clinical risks are identified and robust management plans are in place and any learning from concerns is applied to these risks as part of this management.
- 3.10 Provide assurance to the Board in relation to improving the experience of patients, including for those services provided by other organisations or in a partnership arrangement. Patient Stories, Patient Charter and Board to Floor Walkabouts will feature as a key area for patient experience and lessons learnt.
- 3.11 Provide assurance to the Board in relation to its responsibilities for the quality and safety of mental health, primary and community care, public health, health promotion, prevention and health protection activities and interventions in line with the Health Board's strategies.
- 3.12 Ensure that the organisation is meeting the requirements of the Health and Social Care (Quality and Engagement) Act and recommend the Annual Duty of Quality and Duty of Candour Reports to Board for approval as soon as reasonably practicable after the end of each financial year.
- 3.13 Ensure that the organisation is meeting the requirements of the NHS Concerns, Complaints and Redress Arrangements (Wales) Regulations.
- 3.14 Approve the required action plans in respect of any concerns investigated by the Ombudsman.
- 3.15 Agree actions, as required, to improve performance against compliance with incident reporting.
- 3.16 Provide assurance that the Central Alert Systems process is being effectively managed with timely action where necessary.

- 3.17 ~~Provide assurance on the delivery of action plans arising from investigation reports and the work of external regulators.~~ **Seek assurances on the requirements arising from the Health Board's regulators, Welsh Government and professional bodies.**
- 3.18 Approve the annual clinical audit plan, ensuring that internally commissioned audits are aligned with strategic priorities.
- 3.19 Provide assurance that a review process to receive and act upon clinical outcome indicators suggesting harm or unwarranted variation is in place and operating effectively at operational level, with concerns escalated to the Board.
- 3.20 Consider advice on clinical effectiveness, and where decisions about implementation have wider implications with regard to prioritisation and finances, prepare reports for consideration by the Executive Team who will collectively agree recommendations for consideration through relevant Committee structures.
- 3.21 Provide assurance in relation to the organisation's arrangements for safeguarding vulnerable people, children and young people.
- 3.22 Receive decisions made with regard to significant claims against the Health Board, valued in excess of £100,000, or valued under £100,000, but which raise unusual issues or may set a precedent, and ensure that the learning from such cases is considered, with relevant actions agreed as appropriate.
- 3.23 Approve policies and plans within the scope of the Committee, having taken an assurance that the quality and safety of patient care has been considered within these policies and plans.
- 3.24 Assure the Board in relation to its compliance with relevant healthcare standards and duties, national practice, and mandatory guidance.
- 3.25 Develop a work plan which sets clear priorities for improving quality, safety and experience each year, together with intended outcomes, and monitor delivery throughout the year.
- 3.26 Review and approve annual work plans for any Sub-Committees which has delegated responsibility from the Quality, Safety and Experience Committee and oversee delivery ~~to scrutinise~~ and monitor the impact on patients of the Health Board's services and their quality.
- 3.27 Refer quality & safety matters which **fall within the remit of other Committees.** ~~people, planning and performance to the People, Organisational Development & Culture Committee (PODCC), and the Strategic Development & Operational Delivery Committee (SDODC), and vice versa.~~
- ~~Agree issues to be escalated to the Board with recommendations for action.~~
- 3.28 ~~Seek assurance on delivery against all Planning Objectives aligned to the Committee in accordance with the Board approved timescales, as set out in the Health Board's~~

Annual Plan, considering and scrutinising the plans and programmes that are developed and implemented, supporting and endorsing these as appropriate. **Seek assurance on delivery against all Planning Objectives aligned to the Committee, in accordance with the Board approved timescales, as set out in the Health Board's Annual Plan, considering, and scrutinising the plans and programmes that are developed and implemented, supporting and endorsing these as appropriate.**

4. Membership

4.1 The membership of the Committee shall comprise:

Member
Independent Member (Chair)
Independent Member (Vice-Chair)
3 x Independent Members (including Health and Safety Committee Vice-Chair and People, Organisational Development & Culture Committee Chair)

4.2 Membership must include an Independent Member from the Health and Safety Committee.

4.3 The following should attend Committee meetings:

In attendance
Executive Director of Nursing, Quality & Patient Experience (Lead Executive)
Executive Medical Director (Chair of Listening and Learning Sub Committee)
Chief Operating Officer
Executive Director of Allied Health Professions & Health Science (Chair of QSESC)
Executive Director of Public Health
Director of Primary Care, Community & Long Term Care
Head of Quality and Governance
Associate Medical Director Quality & Safety
Assistant Director of Therapies and Health Science
Assistant Director, Legal Services/Patient Experience (Chair of Listening and Learning Sub Committee)
Assistant Director of Nursing, Quality and Assurance (Chair of Operational Quality, Safety and Experience Sub Committee)
Llais Cymru/ Citizens Voice Body Representative (not counted for quoracy purposes)

~~It is expected that Sub-Committee Chairs will attend QSEC for the purpose of presenting their update reports.~~

4.4 Membership of the Committee will be reviewed on an annual basis.

5. Quorum and Attendance

- 5.1 A quorum shall consist of no less than three of the membership, and must include as a minimum the Chair or Vice Chair of the Committee, and two other Independent Members, together with a third of the In Attendance members.
- 5.2 The membership of the Committee shall be determined by the Board, based on the recommendation of the UHB Chair, taking into account the balance of skills and expertise necessary to deliver the Committee's remit, and subject to any specific requirements or directions made by the Welsh Government.
- 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 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 deputy with full voting rights to attend in their place, subject to the agreement of the Chair.
- 5.6 The Chair of the UHB reserves the right to attend any of the Committee's meetings as an ex officio member.
- 5.7 The Head of Internal Audit shall have unrestricted and confidential access to the Chair of the Quality Safety & Experience Committee.
- 5.8 The Committee can arrange to meet with Internal Audit and External Audit (and, as appropriate, nominated representatives of Healthcare Inspectorate Wales), without the presence of officers, as required.
- 5.9 The Chair of the Quality Safety & Experience Committee shall have reasonable access to Executive Directors and other relevant senior staff.

6. Agenda and Papers

- 6.1 The Committee Secretary is to hold an agenda setting meeting with the Chair and/or Vice Chair and the Lead Director, at least **six** weeks before the meeting date.
- 6.2 The agenda will be based around the Committee work plan, identified risks, matters arising from previous meetings, issues emerging throughout the year, and requests from Committee members. Following approval, the agenda and timetable for request for papers will be circulated to all Committee members.
- 6.3 All papers must be approved by the Lead/relevant Director.
- 6.4 The agenda and papers 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 Lead Director within **seven** days to check the



accuracy, prior to sending to Members (including the Committee Chair) to review within the next seven days.

- 6.6 Members must forward amendments to the Committee Secretary within the next **seven** days. The Committee Secretary will then forward the final version to the Committee Chair for approval.

7. In Committee

- 7.1 The Committee can operate with an In Committee function to receive updates on the management of sensitive and/or confidential information.

8. Frequency of Meetings

- 8.1 The 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 Committee in discussion with the Lead Executive.
- 8.2 The Chair of the Committee, in discussion with the Committee Secretary, shall determine the time and the place of meetings of the Committee and procedures of such meetings.

9. Accountability, Responsibility and Authority

- 9.1 Although the Board has delegated authority to the Committee for the exercise of certain functions, as set out in these Terms of Reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens, through the effective governance of the organisation.
- 9.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.
- 9.3 The Committee shall embed the UHB's vision, corporate standards, priorities and requirements, e.g. equality and human rights, through the conduct of its business.
- 9.4 The requirements for the conduct of business as set out in the UHB's Standing Orders are equally applicable to the operation of the Committee.

10. Reporting

- 10.1 The Committee, through its Chair and Members, shall work closely with the Board's other Committees, including joint and Sub-Committees and groups to provide advice and assurance to the Board through the:
- 10.1.1 Joint planning and co-ordination of Board and Committee business.
 - 10.1.2 Sharing of information



- 10.2 In doing so, the Committee shall contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.
- 10.3 The Committee, may, subject to the approval of the Board, establish Sub-Committees or task and finish groups to carry out on its behalf specific aspects of Committee business. The Committee will receive an update following each meeting providing an assurance on business undertaken on its behalf. The Sub-Committees reporting to this Committee are:
- 10.3.1 ~~Operational~~ Quality, Safety & Experience Sub-Committee
 - 10.3.2 Listening & Learning Sub-Committee
- 10.4 The Committee Chair, supported by the Committee Secretary, shall:
- 10.4.1 Report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes the submission of a Committee update report, as well as the presentation of an Annual Report within **six** weeks of the financial year.
 - 10.4.2 Bring to the Board's specific attention any significant matter under consideration by the Committee.
 - 10.4.3 Ensure appropriate escalation arrangements are in place to alert the Health Board Chair, Chief Executive or Chairs of other relevant Committees of any urgent/critical matters that may compromise patient care and affect the operation and/or reputation of the Health Board.
- 10.5 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self assessment and evaluation of the Committee's performance and operation including that of any Sub-Committees established. In doing so, account will be taken of the requirements set out in the NHS Wales Quality & Safety Committee Handbook.

11. Secretarial Support

- 11.1 The Committee Secretary shall be determined by the Director of Corporate Governance/Board Secretary.

12. Review Date

- 12.1 These terms of reference and operating arrangements shall be reviewed on at least an annual basis by the Committee for approval by the Board.

Appendix 1 – Targeted Intervention areas relating to quality of care intervention and focus

De-escalation Criteria

Clinical Services

- Evidence that the health board has the appropriate mechanism to understand the drivers behind a fragile service through the triangulation of key data points, including staffing levels, staff and patient feedback, concerns, incidents, stakeholder feedback (HIW, Audit Wales, HMC, Royal Colleges, Llais etc), mortality reviews, duty of quality / candour, infection protection control, performance, clinical and medical leadership.
- Fragile services are supported by strong clinical leadership, have an effective integrated improvement plan, project management structure and effective transformation support.
- Evidence that all recommendations from the Royal Colleges, HIW and other reviews specific to Hywel Dda UHB are discharged and either verified or delivered or scheduled for delivery within the health board's longer-term improvement plan.
- Evidence that the Board is sighted on fragile services and has a robust response to these issues that is being addressed by the health board.

Urgent and Emergency Care

- Assessment of health board response and handling of concerns, complaints, incidents and patient experience feedback related to UEC.

Quality of care

- C-Diff: reduce the number of hospital onset infections by 25% and maintain for 3 months (from agreed baseline - No more than 6 cases per month).
- Staph aureus: reduce the number of hospital onset infections by 25% and maintain for 3 months (from agreed baseline - No more than 2 cases per month).
- E-coli: reduce the number of hospital onset infections by 25% and maintain for 3 months (from agreed baseline - No more than 5 cases per month).
- Implicit: Addressing the root cause of HCAs and having effective response mechanisms.

Planned Care

- Assessment of health board response and handling of concerns, complaints, incidents and patient experience feedback related to planned care.

CAHMS

- Demonstrate a prompt response to any HIW inspections, concerns, incidents, never-events, coroners requests and regulation 28s.
- Improved patient and family feedback.