

QUALITY, SAFETY AND EXPERIENCE SUB COMMITTEE

ANNUAL REVIEW REPORT

2024/2025

1. Introduction and Chair's summary

In line with Standing Orders the Quality, Safety and Experience Sub Committee (QSESC) must submit an Annual Report to the Quality, Safety and Experience Committee through the Chair within 6 weeks of the end of the reporting year setting out its activities during the year and including the review of its performance and that of any Groups it has established, setting out how the Sub Committee has met its Terms of Reference during the financial year.

2. Terms of Reference and Workplan

The Terms of Reference (TOR) for the QSESC is reviewed on an annual basis or following any significant changes. The TORs were last reviewed on 15 August 2024. The QSESC has a work plan to enable forward planning for the forthcoming year. The workplan is produced to incorporate the duties outlined in the Sub Committee's Terms of Reference and any suggested areas of focus identified during the self-assessment process.

The workplan covers a range of activities including statutory reporting duties, regular items of business and priority planned pieces of work which support Committee and the Sub Committee's objectives. The work plan is regularly updated throughout the year to ensure it remains responsive to emerging issues and risks.

Reporting Groups

The following reporting groups provide a written report on activity to QSESC on a quarterly basis.

- Recognition of Acute Deterioration and Resuscitation Group (RADAR)
- Nutrition and Hydration Group
- Mental Capacity Act and Consent Group
- Medical Devices Group (including Point of Care Testing and Ultrasound Governance)
- Strategic Safeguarding Group
- Infection Prevention Strategic Steering Group
- Human Tissue Authority Group
- Radiation Protection Group
- Effective Clinical Practice Group
- Acute, Mental Health & Learning Disabilities and Primary and Community services Quality Governance Groups



3. Table of attendance

Members	14 May 24	11 Jul 24	12 Sep 24	14 Nov 24	16 Jan 25	13 Mar 25
Executive Director of Allied Health Professionals and Healthcare Sciences (Chair)	N/A	✓	✓	✓	✓	✓
Executive Medical Director (Vice-Chair)	N/A	N/A	X	X	✓	X
Executive Director of Nursing, Quality and Patient Experience	N/A	N/A	✓	✓	✓	X
Assistant Director of Nursing, Quality and Assurance	✓	✓	✓	✓	✓	✓
Assistant Director, Legal and Patient Support	D	X	X	D	X	D
Clinical Director and Associate Medical Director Primary Care	✓	X	X	X	✓	✓
Deputy Medical Director – Acute Services	✓	X	✓	X	✓	✓
Deputy Medical Director – Primary Care & Community Services	✓	X	X	X	X	✓
Assistant Director of Nursing, Acute Services	✓	X	X	✓	✓	✓
Associate Medical Director, Quality & Safety	✓	X	X	✓	X	X
Head of Quality and Governance	✓	X	✓	✓	✓	✓
Deputy Director of Allied Health Professionals	✓	X	✓	✓	✓	✓
Deputy Director of Health Science	N/A	X	X	✓	✓	✓
Director of Public Health	X	D	D	X	X	D
Director of Midwifery	✓	X	X	✓	X	X
Clinical Director of Pharmacy and Medicines Management	X	✓	✓	D	D	✓
Deputy Chief Operating Officer	N/A	N/A	X	X	X	X
Head of Workforce	X	X	✓	X	✓	✓
Assistant Director of Assurance and Risk	✓	D	✓	✓	✓	✓
Digital Director	X	✓	X	X	X	X
County Directors x 3	✓	✓	✓	X	✓	✓
Senior Nurse, Infection Prevention	X	X	X	✓	✓	✓
Representative from each Triumvirate (Head of Nursing)	✓	✓	✓	✓	✓	✓
Assistant Director of Primary Care	D	X	✓	X	X	✓

Assistant Director of Nursing Mental Health & Learning Disability	✓	✓	✓	X	✓	✓
Chairs of Advisory Groups	✓	✓	✓	✓	✓	✓

N/A: Not applicable as Membership was revised in August 2025.	D: Deputy in attendance	X: Not in Attendance	✓: In Attendance
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A quorum consists 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 Clinical Professions (Medicine, Nursing, Allied Health Professionals and Health Sciences) and each Directorate/Care Group.

Sub Committee Activities – alert, advise and assure.

The Sub Committee is required to report to the Committee after each meeting by presenting a report highlighting the key discussion items at the Sub Committee.

Alert – *The following matters were areas where the Sub Committee was unable to take an assurance or had a lack of confidence that the action in place was sufficient to address the issue satisfactorily and/or it was within the scope of the operational team to resolve, and were alerting the Committee as engagement action or intervention was required.*

- In May 2024, concerns were raised regarding the roll out of the **Death Certification Reform and Medical Examiners** process and the impact of the additional scanning requirements (which became statutory in September 2024) on staffing capacity. Additional resource was being explored to support the implementation of the process. In September 2024, despite there being process in place to ensure compliance with the Medical Examiners (Wales) Regulations, the Sub Committee remained concerned regarding the fragility in the service and impact on body storage capacity. The risk was escalated onto the corporate risk register (CRR) and mitigations enacted resulting in reduction in the level of risk. QSESC continues to monitor the impact and escalate concerns where necessary.

Advise – *The following matters were areas of concern where assurance had been taken on actions in place but required close monitoring.*

- In May 2024, Sub Committee were advised that plans are progressing for the Health Board to meet the requirements for the national implementation of Martha's Rule (**Call for Concern**: a patient safety initiative which was triggered by the death of a teenage girl). A Working Group was established. The Sub Committee were advised in March 2025 that a three-month pilot in Glangwili Hospital had commenced in February 2025 and an evaluation would be shared once completed.

- The Sub-Committee received an update report in May 2024 from the **Estates and Facilities Directorate** and further information on some areas including the roll out of Cook Freeze catering model was requested. In March 2025, the Directorate reported that a Strategic Group for the catering models has been established with operational Quality, Workforce and Procurement subgroups reporting in and there have been delays to the project due in the main to late submission of contract from Cwm Taf University Health Board and critical lack of managerial resource in department which has since improved.
- In May 2024, **Unscheduled Care in Glangwili (GGH) and Prince Philip (PPH) Hospital updates reported** both Emergency Departments in GGH and Acute Medical Assessment Unit (AMAU) in PPH continue to experience significant ambulance handover delays. Task and Finish groups for both PPH and GGH were underway to review further opportunities. The Sub-Group was also informed that the current workforce model was being reviewed due to sickness absence. It was noted that performance in terms of C-Diff infection rates continue to be a concern across the Health Board. Targeted work was also underway at both GGH and PPH to reduce incidences of hospital acquired infection and this continues to be monitored closely.
- Discussion took place on staff receiving timely access to Resuscitation Training via the **Mental Health and Learning Disabilities Update Report** in July 2024. The demand and capacity issues for Resuscitation staff on a Health Board wide basis was highlighted. A review of the level of training needed by different staff via Directorate Leads and ESR is being undertaken. Cascade Training is being provided in a staged approach to train staff to deliver training within their respective services where appropriate.
- An assessment of the requirements for staff and current attendance rates for life support training was shared as part of the **Recognition of Acute Deterioration and Resuscitation (RADAR) Group Update** in January 2025. The impact of 'did not attend' rates on training capacity was highlighted. A training needs analysis has been undertaken and a cascade training process commenced which increases capacity for the delivery of training. The Datix Risk Score has since reduced due to mitigating actions that are being undertaken.
- In response to data shared in January 2025, which showed that Sepsis screening rates dropped during October 2024 at Glangwili Hospital Unscheduled Care Services, the Resuscitation and Quality Improvement team undertook a programme of work to improve processes, led by National Early Warning Score (NEWS) 2 and a Sepsis Task Group. Mitigating actions included changes to the national sepsis guidance, the introduction of NEWS 2 and training undertaken by the Critical Care Outreach team (CCOT) around recognition of the deteriorating patient.

- In January 2025, the Sub Committee were advised that the data relating to staff uptake of Reducing Restrictive Practice Training across Older Adult inpatient wards showed a decrease in compliance from the previous months within the **Mental Health and Learning Disabilities Report**. This was reported as partly due to the availability of ward staff and capacity challenges within the Reducing Restrictive Practice team to deliver training. A recovery plan was developed and shared with Executive Leads.
- A number of significant updates were reported at the meeting in July 2024 from the **Unscheduled Care Directorates** at the three acute hospital sites, and while the one-hour ambulance delays had shown some improvement due to the mitigating actions undertaken, the 12-hour waits within the A&E departments continued, and patient experience within the area was being closely monitored. A Patient Advice and Liaison Service (PALS) Officer and Complaints Officer had been recruited and are based on site which helped to support patients and the timely management of complaints.
- Although progress had been noted in implementing recommendations arising from the **Falls Improvement Audit in November 2024**, concern was raised regarding the pace in developing the Falls Strategy which was agreed will be taken forward by the Task and Finish Group. Progress on the investigation of 989 open incidents relating to falls will be monitored via the Directorate Quality and Safety Experience Groups going forward and reported to QSESC. Falls scrutiny meetings continue across all acute and community sites and the need for timely assessment and investigation through focussed reviews was reinforced.
- In November 2024, options were being explored via the **Radiology Service** for a sustainable service model for the DEXA bone density scanning pathway which is currently commissioned from Swansea Bay University Health Board (SBUHB) due to concerns regarding length of waits and an inequity of service provision across the Hywel Dda region. This was escalated as a Corporate Risk and subsequently monitored via the Quality, Safety and Experience Committee.
- A request was made by the Charitable Funds Committee in September 2024 for assurance that there are appropriate processes in place for the replacement of medical devices across the Health Board via the **Medical Devices Group (MDG)**. Currently the replacement programmes are driven by capital planning as opposed to a specific process for the oversight of a formal rolling replacement scheme for medical devices. The MDG have requested assurance that there is appropriate oversight of all medical devices as part of a rolling replacement scheme.
- The low levels of staff take up of the Influenza/ Covid 19 vaccine during 2024/25 was highlighted during the **Public Health Directorate Report** in March 2025 with 30% of staff having received the vaccinations from 1 October

2025 to 28 February 2025 (not inclusive of bank or locum staff.) Actions are being explored to understand the impact on services and maximise learning opportunities ahead of next year's vaccination Programme.

- A temporary change of pathway was reported via the Mental Health and Learning Disabilities report in March 2025. A pilot is in progress in North Ceredigion due to insufficient workforce capacity of both medical and non-medical practitioner roles in the Community **Mental Health** Team and Crisis Resolution Home Treatment Team. Primary Care leads will temporarily divert non urgent referrals to a 'phone first' pathway via the established 111 press 2 service. Feedback so far has been positive and suggestive of more timely response for patients. If GP's are concerned about patients seeking help not contacting the 111 service, they can make a direct referral where a Mental Health practitioner will contact the person within 72 hours.
- The Risk for non-compliance with the Medical Device Post Market Surveillance Regulations for custom-made devices that come in to force on 16 June was being considered by the **Medical Devices Group (MDG)** in January 2024 as well as mitigations and controls. The Risk will be monitored by the MDG specific Risk Register that is in development.

Assure – *The following matters were areas where there was confidence that robust actions are in place and are sufficient to address the issues to operate effectively.*

- In May 2024, the Sub-Committee received assurance that all outstanding actions identified in the Quality and Safety BGH Unscheduled Care Internal Audit Report, had been given a "reasonable" assurance rating, and that following the report there has been a significant reduction in the number of incidents in the holding area as at 30 November 2023 (reduced from over 550 to 54). Work is undergoing to relocate members of staff to an off-site location to facilitate the chemotherapy day unit building work to commence, a lack of sufficient space is a current risk.
- In May 2024, the Sub Committee received assurance that the Water Group was implementing sustainable provision of free water for people attending **Accident and Emergency (A&E)** units across the Health Board.
- The Sub-Committee was also assured in May 2024 that the remedial work for Reinforced Aerated Autoclave Concrete (RAAC) had been completed at **Withybush Hospital (WGH)**. The Sub-committee noted that a review group had been set up for C-Diff cases across WGH and multi-disciplinary team (MDT) scrutiny of all infection incidents across the site are undertaken regularly, and also that Individual Complaint Support Officers for Accident and Emergency and Patient Advice and Liaison Service (PALS) were now Available.
- In July 2024 the Sub Committee received assurance regarding the work underway to improve **C-Diff Healthcare Acquired Infection** rates. Members noted that while Health Board-wide engagement is improving; there remains

ongoing challenges with the required clinical engagement for the scrutiny reviews and compliance with Start Smart and Stop Audits. Audits were being undertaken by the Infection Prevention Control Teams and improvement plans developed via the monthly multi-disciplinary meetings.

- In October 2024, the Committee were assured that proactive steps are underway to ensure care of patients after death in response to the outcome of the **David Fuller Inquiry** ahead of the anticipated national roll out of improvement requirements from Welsh Government.
- In December 2024, the Sub Committee were pleased to report the positive news story that the Outpatients senior nursing and operational team within **Scheduled Care Services** were winners in the Equitable Care category at the NHS Awards 2024. This quality improvement initiative empowers patients and enhances the patient experience. The prostate cancer rapid diagnosis pathway, PROSTAD team, won the Efficient Care award for improving prostate cancer outcomes and integration of this pathway into routine care.
- An incident that required the immediate temporary closure of Withybush Hospital Kitchen was discussed during the **Estates Directorate** report at the March 2025 meeting which had been resolved. The impact on patient experience, lessons learnt, and business continuity plans will be presented to the Sub Committee meeting due to be held in July 2025.
- Work continues to progress the action plan for the **Internal Cleaning Audit** and updates are being provided via the Infection Prevention Strategic Steering Group. Estates and Facilities will reengage with Internal Audit to discuss the positive progress in advance of the follow up audit in April 2025. The Infection Prevention Strategic Steering Group terms of reference have been recently reviewed and consideration given to providing clarity of the oversight and assurance of action plans in response to reports relating to cleanliness and infection prevention such as internal audit, HIW, and internal environment spot checks. The governance arrangements for the new Clinical Care Groups (CCG) will strengthen the responsibility of the CCG for implementation and oversight of actions where the responsibility sits within the CCG.

Staff and Patient Stories

The Committee received patient and staff stories at each of its meetings during 2024/25 with a focus on the following Services/ Programmes of work:

- Unscheduled Care- Intensive Care Unit
- Hywel Dda rehabilitation service
- NHS Joint Commissioning Committee

Written Control Documents

During 2024/ 25 the Sub Committee approved the following:

- 1158 Cardiac Monitoring Procedure
- 867 All Wales ICD Deactivation Policy and Deactivation of an Implantable Cardiac Defibrillator Procedure
- 811 Mental Capacity Act Guideline
- 309 Long Term Care Operational Care Policy
- The RADAR Terms of Reference
- The Medical Devices Group Terms of Reference
- The Effective Clinical Practice Terms of Reference
- The Human Tissue Authority Assurance Group Terms of Reference

4. Conclusion

The Sub Committee is satisfied that it continues to operate effectively and in line with the Terms of Reference. Issues have been escalated to Committee as appropriate.

QUALITY, SAFETY & EXPERIENCE

SUB-COMMITTEE (QSESC) UPDATE REPORT

Date of last meeting: 13 May 2025

Quoracy: Met

Report by: Mr James Severs, Chair

KEY DISCUSSION POINTS AND MATTERS TO BE ESCALATED FROM THE DISCUSSION AT THE MEETING:

Alert¹ (may require discussion)

There were no matters of which to alert the Committee.

Advise² (to monitor)

The Quality, Safety & Experience Sub-Committee wish to **advise** members of the Committee that:

- The number of Health Board wide concerns relating to practitioners in a position of trust (PIPOT) has continued to rise since 2022 as reported by the **Strategic Safeguarding Working Group (SSWG)**. Steps are being undertaken to prepare a position statement for the organisation and discussions are underway with universities for periodic reminders during training on expectations for professional conduct. The Safeguarding National Service is undertaking national benchmarking, and the Health Board is engaged with this. The Sub Committee asked the Group to consider the methodology for a review of internal workforce Safeguarding Policies with Professional Leads to ensure effective processes are in place to manage PIPOT allegations of misconduct and report the findings back to the Sub Committee within the next Group Update report.
- Concerns regarding Dyson Fans purchased by Welsh Ambulance Services NHS Trust for use in ambulance bay areas was highlighted by the **Infection Prevention Control (IPC) Steering Group** due to potential IPC and safety risks. Discussion took place regarding the decision-making process for the purchasing of the fans and the Sub Committee agreed that further work is required to articulate and establish ownership of this risk which the Group will take forward.
- A comprehensive action plan has been developed to address challenges within Glangwili Hospital (GGH) theatres which include insufficient staffing levels and suboptimal working practices. Quality Improvement plans are being progressed by the **Planned and Specialist Care Clinical Care Group**

¹ There is a lack of confidence that any action in place is sufficient to address the issue satisfactorily and/or within the scope of the operational team or executive to resolve. Engagement, action or intervention required.

² There are areas of concern where assurance has been taken on actions in place but requires close monitoring. An early warning of an emerging and potentially serious concern.

leadership team in collaboration with Infection Prevention Control and Workforce and Organisational Development.

Assure³ (to note)

The Quality, Safety & Experience Sub-Committee wish to **assure** members of the Quality, Safety & Experience Committee that:

- Significant work has taken place to implement the new governance arrangements for the Clinical Care Groups and the Sub Committee received reports from **Mental Health and Learning Disabilities** and **Planned and Specialist Clinical Care Groups**. Going forward reports will align to the six domains of quality as defined by the Duty of Quality Statutory Guidance 2023 and provide a focus on the Safe, Timely, Equitable, Efficient, Evidence Based and Patient Centred (STEEEP) Principles.

Written Control Documents

The Sub Committee reviewed and approved:

- The QSESC Annual Report 2024/25
- The Infection Prevention Control Steering Group Terms of Reference.

Recommendation

- The Quality, Safety & Experience Committee is asked to note the 'advise' items and receive assurance from the 'assure' items.
- The Sub Committee is asked to approve the QSESC Annual Report 2024/25.

³ There is confidence that actions are robust and will be sufficient to address the issue or generally operating effectively. Routine monitoring.