Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	11 June 2024
TEITL YR ADRODDIAD: TITLE OF REPORT:	Quality, Safety and Experience Committee Terms of Reference
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Anna Lewis, Independent Member and Chair
SWYDDOG ADRODD: REPORTING OFFICER:	Sharon Daniel, Interim Executive Director of Nursing, Quality and Patient Experience

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 (QSEC) has clear Terms of Reference which detail its purpose, responsibilities, and operating arrangements.

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

Cefndir / Background

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

The QSEC last reviewed its Terms of Reference and operating arrangements in May 2023, and these were subsequently approved by the Board on 27 July 2023.

Asesiad / Assessment

TERMS OF REFERENCE
The QSEC Terms of Reference have been reviewed and some changes and amendments have been made which are clearly marked in **red** text on Appendix 1. These changes have been made to ensure they align to the model Terms of Reference set out in the model Health Board Standing Orders issued by Welsh Government, and include the Committee's additional responsibilities in relation to targeted intervention.

Argymhelliad / Recommendation

QSEC is requested to:

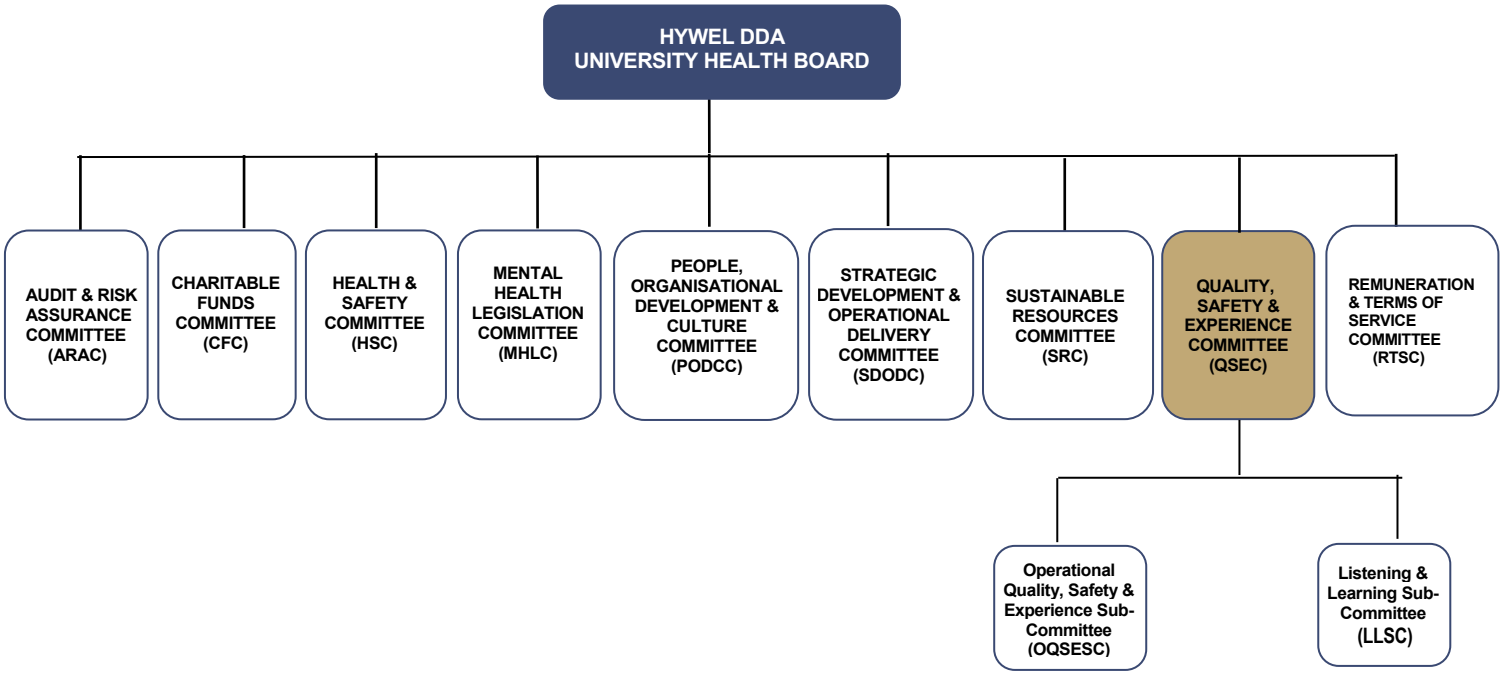
- APPROVE the updated QSEC's Terms of Reference for onward RATIFICATION and approval by the Board at its meeting on 25 July 2024.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference Cyfeirnod Cylch Gorchwyl y Pwyllgor	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.
Cyfeirnod Cofrestr Risg Risk Register Reference:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	QSEC Terms of Reference
Rhestr Termau: Glossary of Terms:	Contained within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg: Parties / Committees consulted prior to Audit and Risk Assurance Committee:	Director of Corporate Governance (Board Secretary) Assistant Director of Assurance and Risk

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:	No direct impacts
Risg: Risk:	No direct impacts
Cyfreithiol: Legal:	No direct impacts
Enw Da: Reputational:	No direct impacts

Gyfrinachedd: **Privacy:**	No direct impacts
Cydraddoldeb: **Equality:**	No direct impacts



QUALITY, SAFETY & EXPERIENCE COMMITTEE

TERMS OF REFERENCE

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	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. Purpose

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.

2.6 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.

2.7 Receive assurance on delivery against the three areas of targeted intervention, and the required elements for de-escalation, related to quality of care (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 ~~principal~~ risks within the ~~Board Assurance Framework (BAF) and~~ 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.

3.3 Recommend acceptance of risks that cannot be brought within the UHBs risk appetite/tolerance to the Board through the Committee Update Report.

3.4 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).

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 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.

3.9 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.

3.10 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.

3.11 Ensure that the organisation is meeting the requirements of the NHS Concerns, Complaints and Redress Arrangements (Wales) Regulations.

3.12 Approve the required action plans in respect of any concerns investigated by the Ombudsman.

3.13 Agree actions, as required, to improve performance against compliance with incident reporting.

3.14 Provide assurance that the Central Alert Systems process is being effectively managed with timely action where necessary.

3.15 Provide assurance on the delivery of action plans arising from investigation reports and the work of external regulators.

3.16 Approve the annual clinical audit plan, ensuring that internally commissioned audits are aligned with strategic priorities.

3.17 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.

3.18 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.

3.19 Provide assurance in relation to the organisation's arrangements for safeguarding vulnerable people, children and young people.

3.20 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.

3.21 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.

3.22 Assure the Board in relation to its compliance with relevant healthcare standards and duties, national practice, and mandatory guidance.

3.23 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.

3.24 Review and approve work plans for Sub-Committees to scrutinise and monitor the impact on patients of the Health Board's services and their quality.

3.25 Refer quality & safety matters which impact on people, planning and performance to the People, Organisational Development & Culture Committee (PODCC) and the Strategic Development & Operational Delivery Committee (SDODC), and vice versa.

3.26 Agree issues to be escalated to the Board with recommendations for action.

4. Membership

4.1 Formal membership of the Committee shall comprise of the following:

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

4.2 The following should attend Committee meetings:

In Attendance
Director of Nursing, Quality & Patient Experience (Lead Executive)
Medical Director
Director of Operations
Head of Quality and Governance
Director of Therapies & Health Science
Director of Public Health
Director of Primary Care, Community & Long Term Care
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)

4.3 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.

5.10 The 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 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/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 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 sub-committee or task and finish group meeting providing an assurance on the 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 end of the financial year.

10.4.2 Bring to the Board's specific attention any significant matters under consideration by the Committee.

10.4.3 Ensure appropriate escalation arrangements are in place to alert the UHB 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 UHB.

10.5 The Director of Corporate Governance/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

The **quality of care intervention and focus** whilst in targeted intervention covers the following three areas and the health board will be required to action and demonstrate areas as highlighted below:

1. Planning and service management
    - Reassess the clinical strategy and support the immediate development of a clinical plan to lead future planning and investment decisions.
    - Review the models for agreed services including clinical leadership, capability regional and service configuration options.
    - Assess patient risk within the ophthalmology pathway, assess whether the clinical risk is being well managed and options for an improved clinical model.
    - Review commissioning arrangements as appropriate.
    - Review the clinical approach for regional delivery models.

2. Quality Management – clinical governance
    - Review current systems and procedures to ensure high quality care, consistent with the Duty of Quality guidance.
    - Review data surrounding incidents complaints, datix, never events to establish any patterns and investigate the extent to which learning is taking place.
    - Overall review and assessment of clinical governance.
    - Assessment of clinical staff capability and overall wellbeing.
    - Review the quality management system linking quality control, assurance, planning and improvement, to include the management of complaints, incidents, claims, safeguarding and other related activities in line with agreed guidelines.
    - Review how patient experience is being used to support quality management.
    - Review safeguarding arrangements.
    - Ensure that there are standard operating procedures for undertaking and responding to:
    - Clinical risk assessment
        - Mortality and Morbidity reviews
        - Incident reporting, investigations and learning
        - Coroner's requests and inquests
        - Capability and capacity issues
        - Record keeping
        - Understanding consent, as well as the fundamentals of care practice

3. Quality Management – complaints and HCAIs
    - Undertake oversight of the PTR process including PTR compliance, inquests and claims management, complaints and serious incidents and external investigation processes.
    - Implement a recovery plan to ensure that complaints are responded to in line with Welsh Government targets.
    - Stabilisation of the increased trajectory of cases of HCAI and evidence of continuous improvement accompanied by a strong QI approach and plan that has

oversight and monitoring by board Quality Safety Committee and Board.

De-escalation criteria for quality of care

1. Stabilisation of the increased trajectory of cases of HCAI and evidence of continuous improvement accompanied by a strong QI approach and plan that has oversight and monitoring by board Quality Safety Committee and Board. The health board to have a clear improvement plan based on a root cause analysis to address the issue of hospital onset HCAIs.
   - C-Diff: reduce the number of hospital onset infections by 25% and maintain for 3 months (from a baseline of the average number of cases in quarter 3 of 8 cases to no more than 6 per month)
   - Staph aureus: reduce the number of hospital onset infections by 33% and maintain for 3 months (from a baseline of the average number of cases in quarter 3 of 3 cases to no more than 2 per month)
   - E-coli: reduce the number of hospital onset infections by 25% and maintain for 3 months (from a baseline of the average number of cases in quarter 3 of 7 cases to no more than 5 per month)

2. 70% of complaints that had final reply (Reg 24)/interim reply (Reg 26) to be closed less than 30 working days of concern received.

3. Effective response from the health board to external reports and reviews including those from Audit Wales, the Ombudsman, Royal Colleges and HIW resulting in sustainable improvements.

4. Demonstrate how service user and staff experience/involvement is being used to improve quality processes and inform service development across the organisation.

5. Demonstrate the progress made against implementing the requirements of the Duty of Candour and Duty of Quality including the embedding of the Care and Quality Standards through the organisation from Board to service area delivery.

6. Oversight of safeguarding arrangements to ensure the board have sufficient, meaningful assurance that organisation is delivering against its safeguarding statutory responsibilities.

7. Use of National Clinical Audit and Outcome Review Programme and Value in Health dashboards to support quality improvement and address unwarranted variation in care (including the use of patient and staff feedback to influence service design).