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:**	14 August 2025
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Proposed Quality & Safety Governance Arrangements
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Sharon Daniel, Director of Nursing, Quality and Patient Experience
SWYDDOG ADRODD: **REPORTING OFFICER:**	James Severs, Director of Allied Health Professions and Health Science Mark Henwood, Medical Director Andrew Carruthers, Chief Operating Officer

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 share the proposed revised and strengthened quality & safety governance arrangements across the operational arm of the Health Board to manage any potential gaps, inconsistencies or duplication in reporting.

This paper will set out the justification for these proposals, and the changes that have been made to ensure the Quality, Safety and Experience Committee (QSEC) can receive the necessary assurance required from the operational governance arrangements now in place to enable it to approve the dis-establishment of its Quality, Safety and Experience Sub-Committee (QSESC).

Cefndir / Background

It is acknowledged that, for some time, the Quality, Safety & Experience Sub-Committee (QSESC) has not been operating effectively in its current establishment within the assurance arm of the Health Board as a Sub-Committee of Quality, Safety & Experience Committee (QSEC).

Since August 2024, the following 9 groups have reported directly into QSESC, via a Triple A report, every other meeting, however the tendency from these 9 groups has been to report on operational matters, which it is considered would be better managed within the Health Board's operational arm.

- Effective Clinical Practice Advisory Panel
- Medicines Management Operational Group
- Human Tissue Authority Assurance Group
- Mental Capacity Act & Consent Group
- Nutrition & Hydration Group
- RADAR Group
- Medical Devices Group

- Infection Prevention Strategic Steering Group
- Strategic Safeguarding Group

Prior to April 2025, QSESC also received Triple A reports directly from the Acute Directorate, Mental Health & Learning Disabilities Directorate and Primary & Community Services Directorate Quality Governance Groups. These were scheduled to every other QSESC meeting. Again however, the tendency had been to report on operational matters into the assurance arm of the Health Board.

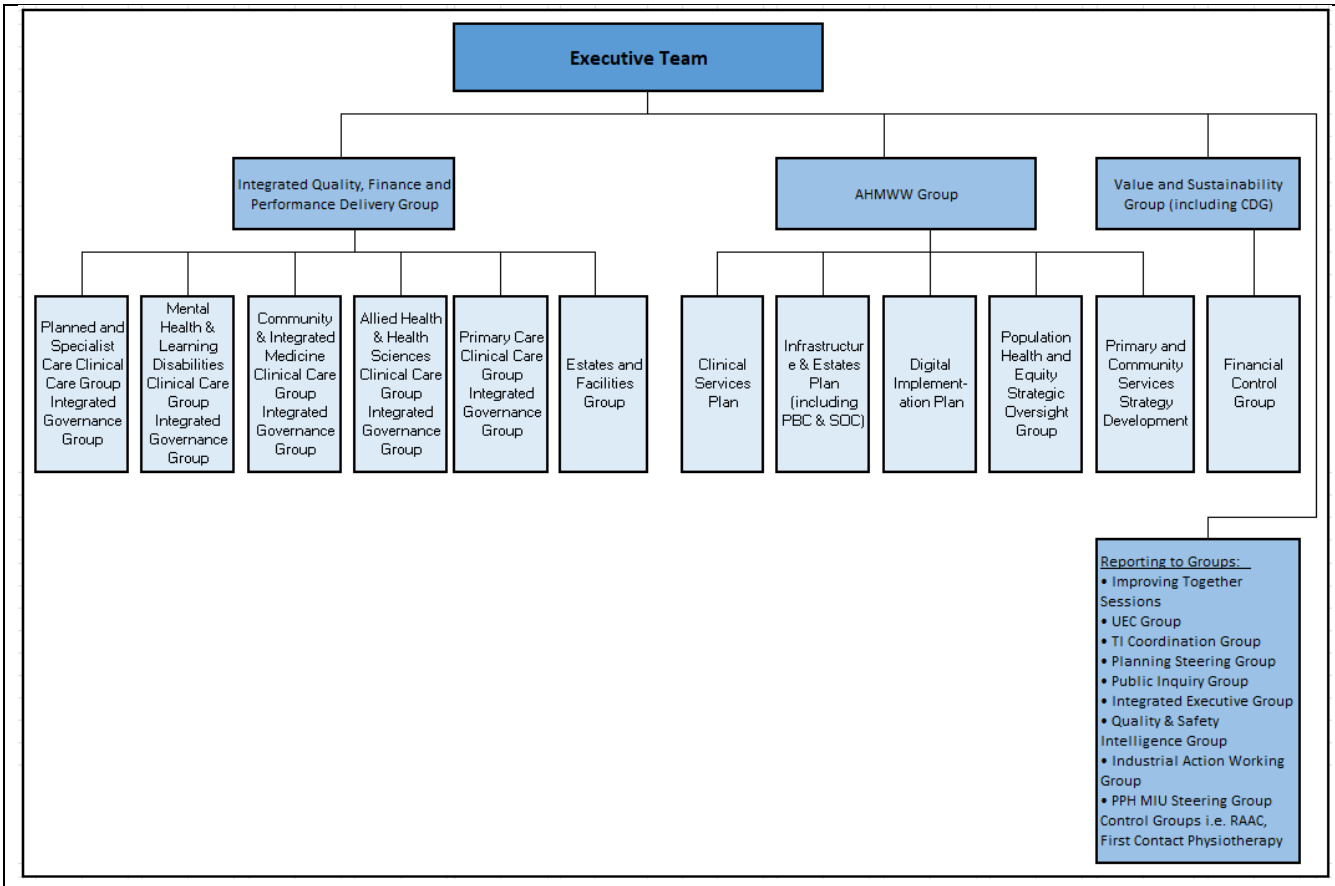
Since the establishment of the new Operational structure within the Health Board from April 2025, 6 Clinical Care Groups have replaced these previous Directorates, and are required, through the operational governance arrangements that have been put in place, to report monthly on their quality and safety arrangements through their Integrated Governance Group meetings to the Integrated Quality, Finance, Performance & Delivery Group (IQFPDG), which in turn reports into Executive Team. In addition to this, the Clinical Care Groups have been requested to provide a Quality Governance Assurance Report to QSESC on a 6 monthly rotational basis on QSESC's agenda.

In light of these new operational governance arrangements, discussions have been held with the Health Board's Clinical Executive Directors, the Chief Operating Officer and the Health Board's wider Executive Team, to inform this proposal which will aim to strengthen and streamline quality & safety governance arrangements across both the operational and the assurance arm of the Health Board, and to ensure there are no gaps, inconsistencies or duplication.

Asesiad / Assessment

New Operational Governance Arrangements Since April 2025

An organogram depicting the reporting arrangements between the 6 Clinical Care Groups Integrated Governance Groups and IQFPDG (and upward to Executive Team) is set out overleaf:



IQFPDG alternates its fortnightly meetings between a focus on business planning, performance & people once a month, and quality, health & safety once a month. It has been agreed that when IQFPDG is focused on quality, health & safety, chairing will be undertaken by a Clinical Executive Director i.e. the Director of Allied Health Professions & Health Science, with the Chief Operating Officer chairing the business planning, performance & people focused IQFPDG meetings.

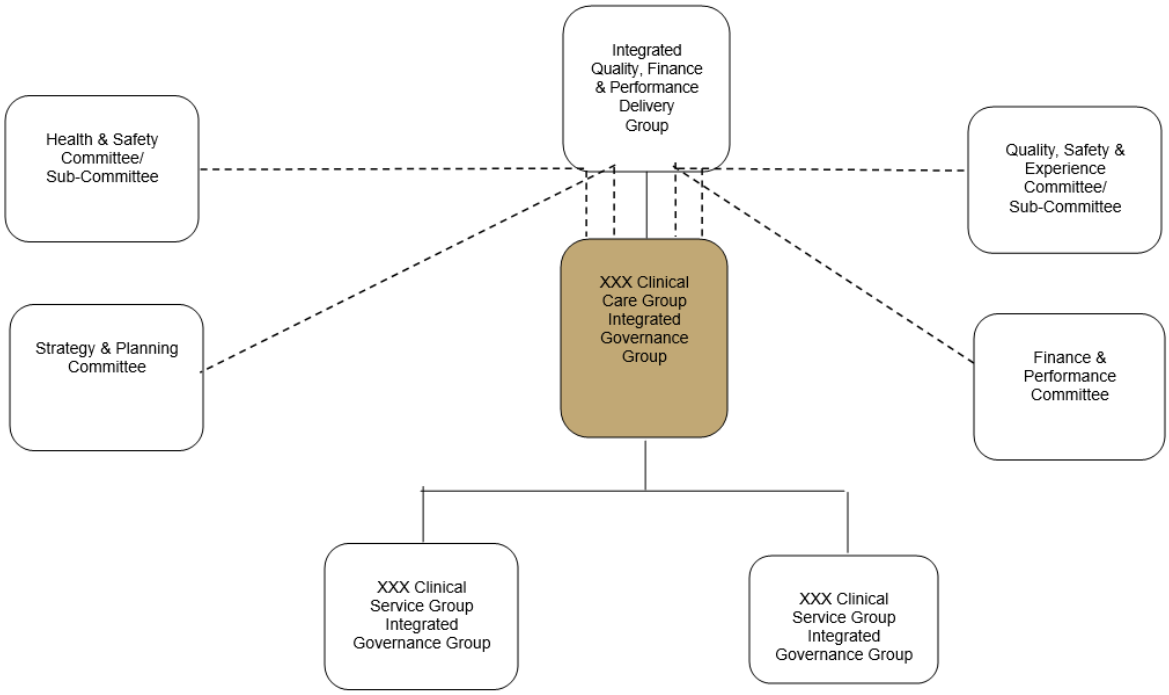
Clinical Care Groups are required to maintain the same meeting rhythm with their Integrated Governance Groups to ensure there is no gap in reporting into IQFPDG. Similar to the chairing arrangements within IQFPDG, chairing of the Clinical Care Groups Integrated Governance Groups, when focused on quality, health & safety, will be undertaken by their Assistant Directors of Nursing, Patient Safety, Quality & Experience/Assistant Director of Quality, Safety and Experience (with the Clinical Care Groups Service Directors chairing their business planning, performance & people focused Integrated Governance Group meetings).

Standard agendas have been issued for Clinical Care Groups to follow for their quality, health & safety Integrated Governance Group meetings, to instruct them on the types of reports they need to include for discussion i.e. a patient story; concerns reports; learning from events; mortality reviews; external audits and regulatory reports; etc. See Appendix A.

While Clinical Care Groups Integrated Governance Groups are directly accountable to the IQFPDG, it is anticipated that elements of their work will also feed into the Health Board's assurance arm. For example, quality and safety matters would be reported to the Quality, Safety & Experience Committee; health and safety matters to the Health & Safety Committee; financial/performance matters to the Finance and Performance Committee; and planning matters or proposed service changes, etc, to the Strategy and Planning Committee.

Where appropriate and when timing allows, IQFPDG will direct where papers will need to be prepared for relevant Committees of the Board, and endorsement from the IQFPDG may be necessary for the progression of a range of operational matters through the Health Board's governance framework and pathways.

See organogram below:



Following the establishment of the Operational structure in April 2025, a revised 'assurance style' reporting template has been introduced for the Clinical Care Groups to submit, on rotation to the Quality & Safety Sub-Committee (QSESC), again placed at 6 monthly intervals, on QSEC's agenda *CCG Quality Report to QSEC* See Appendix B.

Proposed Quality & Safety Governance Arrangements Across the Health Board's Operational and Assurance Arms

Since the introduction of the new operational governance arrangements, discussions have been held with the Health Board's Clinical Executive Directors and Chief Operating Officer to consider how best to address any gaps, inconsistencies or duplication in terms of quality & safety governance arrangements across both the operational and the assurance arm of the Health Board, and to consider where best to hold discussions on quality data.

To this end, and to strengthen operational quality and safety governance arrangements, it has been agreed that the Health Board's Quality & Safety Intelligence Group (QSIG), previously an advisory group reporting into Executive Team, will move to becoming an intelligence–led group reporting into IQFPDG.

It is recognised that the Quality & Safety Intelligence Group, currently comprising HDdUHB's Clinical Executive Directors together with Deputy and Associate Directors, would need to adopt a more formal approach in terms of a maintenance of its monthly meeting rhythms in order that the 'intelligence' from QSIG can be brought regularly to IQFPDG to provide the context for its monthly quality, health & safety focused meetings, through a composite 'intelligence' report, based on the Quality & Safety Dashboard, the monthly escalation levels for functions for the

Quality domain with de-escalation criteria for Clinical Care Groups, and any other concerns or issues related to quality performance with proposed actions for IQFPDG to agree for the CCGs.

This would enable the Clinical Care Groups Service Directors and Assistant Directors of Nursing, Quality and Experience/Assistant Director of Quality, Safety and Experience present at IQFPDG, to be directly informed of the quality & safety issues within their specific areas in order that the service can then operationalise any responses that may be required.

Cross-organisational learning across CCGs will also be facilitated at IQFPDG as a 'home' for discussion and cross-pollination of insights and ideas with the aim of avoiding siloed solutions.

It is anticipated that QSIG would continue to issue 'outcome letters' from its discussions to the Clinical Care Group Service Directors to follow up on any action required within their respective services.

In addition, a summary report of the Quality & Safety intelligence would be reported to Executive Team, appended to the routine IQFPDG Update Report, providing an overview of any issues that needed actions agreed through IQFPDG for Clinical Care Groups to take forward.

It is also proposed that the 9 operational groups currently reporting into QSESC should, more appropriately, report into the operational arm of the Health Board, through the Quality & Safety Intelligence Group, alongside QSIG's current reporting group, the Fragile Services Oversight Group. This would require a change to the reporting arrangements within these 9 operational groups' Terms of Reference, approval of these Terms of Reference at the next scheduled meeting of QSIG, and a conversation with their Chairs on QSIG's expectations of how these reporting groups will operate going forward.

This would also require changes to be made to QSIG's membership in terms of the addition of the Chairs of these 9 reporting groups, as well as including the Chair of the Medical Exposures Group, as identified by the clinical Executive Directors.

QSIG would, in turn, incorporate into their composite intelligence report to IQFPDG, any issues from the 11 operational groups and the proposed actions required for IQFPDG to agree for the Clinical Care Groups.

To manage the additional workload involved for QSIG, and to manage IQFPDG's agenda, it is proposed that the 11 reporting groups maintain their current bi-monthly meeting rhythm and report in, on rotation - 3 groups every 4 months, to QSIG's agenda with 3 of the reporting groups' data reported to IQFPDG once every 4 months.

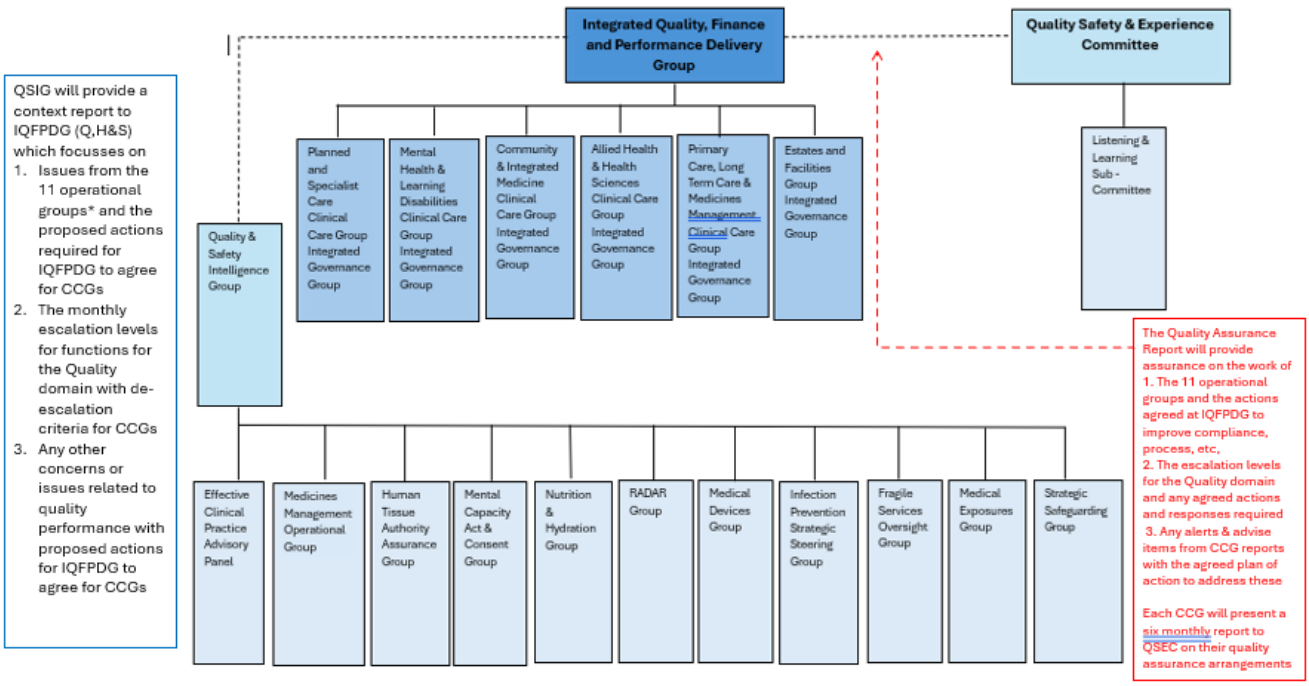
Links into the Health Board's assurance arm would also be made via a quality assurance report to QSEC, constructed by the Interim Assistant Director of Nursing Assurance & Safeguarding, drawing out the key issues from the intelligence provided for the 11 reporting groups (3 times per year) and any alert and advise items from the 6 Clinical Care Group 3As reports with the agreed plan of action to address these. This report would also provide an assurance on the work involved, including an assurance on QIA Panels, and the actions agreed at IQFPDG to improve quality and safety, compliance, etc, as well as the escalation levels for the Quality domain and any agreed actions and responses required.

In respect of safeguarding and infection prevention & control, QSEC will receive additional assurance, on a 6 monthly basis, on both these matters through separate assurance reports which will be added to the QSEC workplan.

As an example of how matters would be reported through these new quality & safety governance arrangements, should the Infection Prevention Strategic Safeguarding Group (IPSSG) raise an issue regarding handwashing compliance, this will be reported up from IPSSG to QSIG where the actions that would need to be taken to address any areas of non-compliance would be included in the composite intelligence report presented to IQFPDG for discussion with the relevant CCG Service Directors and Assistant Directors of Nursing, Quality and Experience/Assistant Director of Quality, Safety and Experience. Once any required operational or management response has been identified, and addressed, this will be included in the 6 monthly infection prevention & control report to QSEC to provide an assurance on any improvements that have been made.

In addition to the Quality Assurance report, QSEC will also receive a six monthly assurance report from each CCG, and Public Health, on their quality governance arrangements. As outlined above, these reports are currently provided to QSESC. This will enable QSEC to gain assurance direct from each CCG.

An organogram illustrating these proposed arrangements is set out below:



Given these proposed Quality & Safety governance arrangements across the Health Board's operational arm, it is proposed to dis-establish QSESC, moving its functions and its 9 reporting groups under QSIG, whose extended remit it is expected will address the likelihood of any gaps associated with QSESC's dis-establishment.

Dis-establishing QSESC will also enable the revised operational governance arrangements to be appropriately supported and implemented, as it is recognised that there would not be sufficient capacity to support both from within current corporate and operational teams.

Should this proposal receive QSEC's approval, these new arrangements are included in the revised QSIG's Terms of Reference at Appendix C.

A comparison undertaken of QSESC's and QSIG's Terms of Reference to determine where QSESC's responsibilities are covered off by either by QSIG, IQFPD, or the CCGs themselves,

has concluded that no gaps will be introduced by dis-establishing QSESC. A table to support this has been crafted to accompany this report (see Appendix D).

A draft agenda and draft annual workplan have been developed for QSIG and are attached, for information, at Appendices E and F.

For QSEC's further assurance, these arrangements will be reviewed by Internal Audit in 2026/27.

Argymhelliad / Recommendation

QSEC is requested to:

- Receive an assurance that QSESC's previous functions have been mapped to the new proposed approach, with due consideration to its governance requirements and accountabilities, with enhanced reporting arrangements to QSEC in place;
- **APPROVE** the dis-establishment of QSESC;
- **NOTE** that, for further assurance, a report will be presented to QSEC in 6 months' time to provide an update on the effective implementation of these new operational quality & safety arrangements.

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 Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	Not Applicable

Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	QSEC Terms of Reference Establishment/Dis-establishment of Committees/Sub-Committees (SOP for the Management of Board and Committees)
Rhestr Termau: Glossary of Terms:	Contained within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	Director of Corporate Governance (Board Secretary) Assistant Director of Assurance and Risk Executive Team Quality & Safety Intelligence Group

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No direct impacts
Ansawdd / Gofal Claf: Quality / Patient Care:	The intention of this report is to improve quality & safety governance arrangements to drive improvements within clinical services
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

Standard Agenda for the XXX Clinical Care Group Integrated Governance Group (focus on Quality, Health & Safety)

Governance

1. Welcome and Apologies
2. Declaration of Interests
3. Notes of the Previous Meeting
4. Table of Actions/Matters Arising

Urgent/Emerging Issues

5.

Safety & Experience

6. Patient Story *Link in with Patient Experience Team.*
7. Harms Dashboard
8. Concerns Report *Overview of incidents, complaints, claims, Medical Examiners concerns, Ombudsman cases, police investigations, coroners' inquests, Regulation 28 – or any other feedback received – with a focus on learning arising from these as well as understanding progress against any action plans, key risks and mitigation arrangements.*
9. Learning from Events (including Serious Concerns, Walkrounds and Observations of Patient Care – improvement and learning action plans To be an agenda item until action plan is fully closed (actions must be SMART). New serious concerns should be included within the Clinical Care Group report to IQFPDG and/or QSEC/QSESC when action plans completed or reported as completed).
10. Mortality Reviews (Clinical Care Group or Clinical Service Group level) *To include learning and actions. May also include morbidity reviews.*
11. Infection, Prevention and Control *Consider any outbreak incidents, outcomes from MRSA/Cdiff reviews. PPE guidance, particularly in light of COVID-19. Review environmental audits associated with IPC.*
12. Safeguarding Update from Clinical Care Group/Clinical Service Groups *Any escalation from Delivery Groups – needing to be considered at IGG.*
13. Population Health and Outcomes

Quality and Effective Clinical Practice

14. Clinical Audit (Clinical Care Group or Clinical Service Group level Consider Clinical Care Group/Clinical Service Group audit plan. Discuss any published National audit recommendations.
15. NICE and other National Guidance (including New Interventional Procedures, INNU and NatSSIP's/LocSSIPs) To include learning and actions. May also include morbidity reviews.

16. Safety Alerts and Safety Notices *To include implementation and monitoring of Safety Alerts relevant to Clinical Care Group/Clinical Service Group.*
17. Welsh Health Circulars (and other national guidance)
18. Quality Impact Assessments/Integrated Impact Assessments
19. R&D Activity Update *E.g. the activity being undertaken at a Clinical Care Group/Clinical Service Group level*

Health & Safety

20. Compliance with legislation and standards in respect of health and safety
21. Staff incidents and RIDDOR
22. Health and Safety Inspection/Audit findings
23. Health and Safety training compliance e.g. Manual Handling, Reducing Restrictive Practice/Violence and Aggression
24. Relevant Health and Safety Executive reports

External Audit and Regulatory Reports *Sign off of draft reports and management responses/action plans will need to be through groups where meetings are missed, Chair's Action will need to be taken and reported to the next meeting.*

25. Audit Reports *Progress against the agreed audit plan and any changes to practice as a consequence.*
26. Healthcare Inspectorate Wales Reviews/Reports *To be an agenda item until action plan is fully closed (actions must be SMART). New HIW reports should be included within the Clinical Care Group/Clinical Service Group report to QSEC/QSESC and when action plans completed reported as completed.*
27. Relevant Care Inspectorate Wales Reports *If relevant to the Clinical Care Group/Clinical Service Group, discuss published reports, outcome from any recent visits.*
28. Getting It Right First Time Reviews (GIRFT) *If relevant to the Clinical Care Group/Clinical Service Group, discuss recommendations.*
29. Peer Reviews *If relevant to the Clinical Care Group/Clinical Service Group, discuss outcome of internal/external published reviews, learning.*
30. Royal College Reports *If relevant to the Clinical Care Group/Clinical Service Group, discuss recommendations.*
31. Other *E.g. accreditation issues, thematic analysis of triangulated information at Clinical Care Group/Clinical Service Group level.*

Risk, Impact and Fragility Assessment

32. Clinical Care Group/Clinical Service Group/Risks Update *To include previously identified risks, their scores, and mitigation, and from any other discussions on concerns, complaints, and incidents – to consider whether these identify any further risks). Inclusive of new risks for consideration of adding to Clinical Care Group/Clinical Service Group Risk Register, risks to be closed.*

33. Quality Impact Assessments/Integrated Impact Assessments

34. Fragility Assessments

Portfolio/Service Assurance Exception Reports

35. Exception reports from individual service areas *To include areas requiring discussion from individual service area e.g. Issues for escalation/discussion. Good Practice, Wider learning.*

For Information

36.

Items for Sharing/Escalation

To agree items for sharing to:

37. XXX Clinical Care Group Integrated Governance Group (focus on Business Planning, Performance & People)
38. Other Clinical Care Groups Integrated Governance Groups

To agree items for escalation to:

39. Integrated Quality, Finance and Performance Delivery Group (IQFPDG) *To include any proposed items for Quality, Safety & Experience Sub-Committee/Committee and/or the Health & Safety Sub-Committee/Committee, following IQFPDG's review.*

40. Effective Clinical Practice Advisory Panel

Any Other (Urgent) Business

Date and Time of Next Meeting

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	Click here to enter a date.
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	*Insert* Clinical Care Group Quality Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	
SWYDDOG ADRODD: **REPORTING OFFICER:**	

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Choose an item.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report details the quality governance arrangements within the *insert* Clinical Care Group in relation to quality, safety and patient experience. It sets out achievements, progress and planned actions to meet our Duty of Quality, and is presented to the Quality, Safety and Experience Committee to provide assurance on the arrangements in place.

Cefndir / Background

An example of what could be included in this section

The *insert* Clinical Care Group – *give a description of what Service Groups are in the* Clinical *Care Group*

The aim of the *insert* Clinical Care Group in summary is to:

- Ensure there is a process in place to continually monitor and review its risk register, acting to mitigate quality and safety risks on an ongoing basis;
- Maintain an open culture of improving quality, safety and patient experience across all teams and all staff;
- Promote a positive culture of staff engagement, development and understanding of everyone's responsibility for safe, quality care and
- Foster a culture of psychological safety within *insert* Clinical Care Group in order to promote collaboration, trust, innovation and personal growth.

Meeting the Duty of Quality is the highest priority for the Clinical Care Group and its governance structures and oversight has developed significantly. The Service Director, Associate Medical Director and Assistant Director of Nursing lead the agenda which is aligned to the six domains of quality as defined by the Duty of Quality Statutory Guidance 2023. This report is set out under each of these domains.

Asesiad / Assessment

This section should be an assessment of the Clinical Care Groups current position. It should be written from the perspective of quality and provide evidence to help inform decision making. Where risks or issues are described it should detail what the Clinical Care Group is doing to address the risks or issues.

Quality Assurance

Please give an assessment of the Clinical Care Group's quality governance arrangements e.g.
The *insert* Clinical Care Group's Integrated Governance Group (focused on Quality, Health & Safety) are planned every month, and are well represented by medical, nursing and managerial staff across all Clinical Service Groups, as well as other multi-disciplinary colleagues from across the Health Board, all of which take an active part in the meetings and shape the overall agenda. The Group's Terms of Reference and Work Plan are reviewed annually and it is supported by sub groups covering ….

Each Clinical Service Group also holds monthly Integrated Governance Group (focused on Quality, Health & Safety), and further work is underway to strengthen this structure and reporting to the Clinical Care Group's Integrated Governance Group (focused on Quality, Health & Safety).

Safe Care

This section should include:

- Incident reporting using graphs from the Our Safety Dashboard (themes, management etc)
- Nationally reportable incidents including an overview of what the Clinical Care Group is currently investigating, what has been learnt on ones closed since the last report and improvement action plans currently open
- Compliance with patient safety notices and alerts
- Peer review relevant to the Clinical Care Group. AMAT graphs can be used
- Safeguarding
- Infection prevention and control
- Mortality reviews
- Inquests including any Reg 28 Prevention of Future Deaths Report
- Claims and redress (relating to safe care)
- Relevant risk recorded on the risk register (high or extreme risks)

Timely

This section should include:

- The issues within each service group e.g. waiting times, access etc. Patient experience feedback should be used to support the issues
- Relevant risk recorded on the risk register (high or extreme risks)

- Claims and redress (relating to timely care)

Effective
This section should include:
- Quality improvement
- Clinical Audit
- Relevant risk recorded on the risk register (high or extreme risks)

Evidence based
This section
- Compliance with national guidelines e.g. NICE, Welsh Government Quality Standards etc. Data graphs from AMAT can be used to support this paragraph.
- Relevant risk recorded on the risk register (high or extreme risks)

Equitable
This section:
- Complaints related to equitable care and actions being taken
- Relevant risk recorded on the risk register (high or extreme risks)

Person Centred
This section should include:
- Person experience (CIVICA data and 'you said, we did' etc)
- Complaints (themes, management etc)
- PSOW
- HIW reports
- Llais reports
- Relevant risk recorded on the risk register (high or extreme risks)

Argymhelliad / Recommendation

(N.B. Only one of the following directions should be identified for the Committee):
- Decision – i.e. reaching a conclusion after the consideration of options
- Assurance – i.e. whether an assurance, or otherwise, can be taken from the report
- Discussion – i.e. examine and consider the implications of a matter
- For Information

The Quality, Safety and Experience Committee is asked to take an assurance on the quality governance arrangements in place within the *insert* Clinical Care Group in relation to quality, safety and patient experience.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Parthau Ansawdd: Domains of Quality	Choose an item. Choose an item.

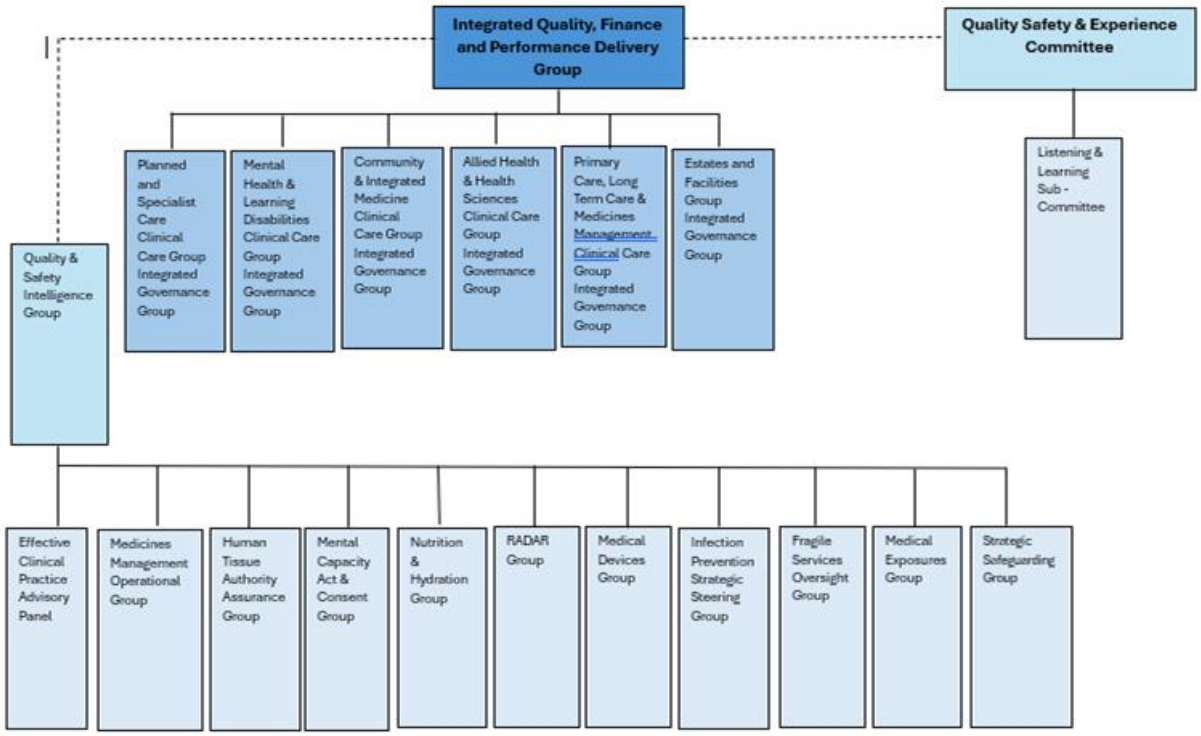
Quality and Engagement Act (sharepoint.com)	Choose an item. Choose an item.
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	Choose an item. Choose an item. Choose an item. Choose an item.
Amcanion Strategol y BIP: UHB Strategic Objectives:	Choose an item. Choose an item. Choose an item. Choose an item.
Amcanion Cynllunio Planning Objectives	Choose an item. Choose an item. Choose an item. Choose an item.
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	Choose an item. Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	e.g. financial impact or capital requirements: (if yes, please complete relevant section of the Integrated Impact Assessment Template available via the link below) Integrated Impact Assessment Template
Ansawdd / Gofal Claf: Quality / Patient Care:	e.g. adverse quality and/or patient care outcomes/impacts: (if yes, please complete relevant section of the Integrated Impact Assessment Template available via the link below) Integrated Impact Assessment Template

Gweithlu: **Workforce:**	e.g. adverse existing or future staffing impacts: (if yes, please complete relevant section of the Integrated Impact Assessment Template available via the link below) Integrated Impact Assessment Template
Risg: **Risk:**	e.g. risks identified and plans to mitigate risks: (if yes, please complete relevant section of the Integrated Impact Assessment Template available via the link below) Integrated Impact Assessment Template
Cyfreithiol: **Legal:**	e.g. legal impacts or likelihood of legal challenge: (if yes, please complete relevant section of the Integrated Impact Assessment Template available via the link below) Integrated Impact Assessment Template
Enw Da: **Reputational:**	e.g. potential for political or media interest or public opposition: (if yes, please complete relevant section of the Integrated Impact Assessment Template available via the link below) Integrated Impact Assessment Template
Gyfrinachedd: **Privacy:**	e.g. potential impact on individual's privacy rights or confidentiality and/or the potential for an information security risk due to the way in which information is being used/shared, etc: (if yes, please complete relevant section of the Integrated Impact Assessment Template available via the link below) Integrated Impact Assessment Template
Cydraddoldeb: **Equality:**	e.g. potential negative/positive impacts identified in the Equality Impact Assessment (EqIA) documentation – follow link below • Has EqIA screening been undertaken? Yes/No (if yes, please supply copy, if no please state reason) • Has a full EqIA been undertaken? Yes/No (if yes please supply copy, if no please state reason) Equality Impact Assessment

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board



TERMS OF REFERENCE

QUALITY AND SAFETY INTELLIGENCE GROUP

Version	Issued to:	Date	Comments
V1.0	Executive Team	November 2021	Approved version
V1.1	Integrated Quality, Finance and Performance Delivery Group (IQFPDG)	12/06/2024	For Approval
V2.0	Executive Team Integrated Quality, Finance and Performance Delivery Group (IQFPDG)	21/08/2024	Approved version
V3.0	Quality, Safety and Intelligence Group		
V3.1	Quality, Safety and Intelligence Group	05/02/2025	For Review
V3.2	Quality and Safety Intelligence Group	07/07/2025	For Review
V3.3	Quality, Safety & Experience Committee	14/08/2025	For Assurance

1. CONSTITUTION

1.1 The Quality and Safety Intelligence Group has been established as an intelligence-led Advisory Group to the Integrated Quality, Finance & Performance Delivery Group (IQFPDG) and constituted from 12th June 2024.

2. PURPOSE

2.1 The Quality and Safety Intelligence Group will monitor the quality and safety arrangements within Operational services, ensuring that the clinical Executive Directors are aware of, and have the opportunity, to review Quality and Safety data and discuss any patient safety related or other significant issues which have the potential to impact on quality and patient safety. This review of data will be linked to the established escalation arrangements to improve the effectiveness of operational services, and ultimately the quality and safety of care.

The Quality and Safety Intelligence Group will:

2.1.1 Discuss significant issues arising or that have the potential to impact on patient safety, particularly those within the Health Board's most fragile services. This may include serious incidents, complaints, and risks that have been reported through the Datix Cymru reporting system, through quality, safety and experience concerns that have been raised by the service, or through other intelligence gathering mechanisms.

2.1.2 Utilising established and developing metrics agree triggers within the Quality and Intelligence data e.g. Medical Examiner, deteriorating patient/Cardiac arrest, hospital acquired Infection, hospital acquired VTE, issues relating to DNACPR.

2.1.3 Review dashboard/dataset and analysis, and identify any areas where immediate action is required to protect the safety of patients and staff

2.1.4 Identify further action required based upon the information available which may require escalations, including investigation, deep dive request to relevant Groups or Sub-Groups, etc.

3. OPERATIONAL RESPONSIBILITIES

The Quality and Safety and Intelligence Group will:

3.1 Ensure oversight of those performance measures that focus on the delivery of quality and safe services within the NHS Wales Performance Framework.

3.2 Oversee and agree the escalation levels for the domain of quality of the internal Improving together framework, providing clear de-escalation criteria and areas of improvement to Clinical Care Groups and Clinical Service Groups classed as providing either 'limited' or 'no assurance.

3.3 Make use of key performance indicators/metrics, including triangulation with patient feedback, surveys and patient stories, to evaluate what is working well and what is not, focusing on exceptions, both positive and negative.

3.4 Request further information/deep dives regarding any issue of concern to inform decision-making.

3.5 Ensure appropriate improvement actions are conveyed where performance is not meeting expectations.

3.6 Detect any trends to mitigate issues before they arise or reduce the impact of risk.

3.7 Provide a Quality and Safety Intelligence Report to the Integrated Quality, Finance and Performance Delivery Group, in regard to all of the above, setting out the improvement actions required.

3.8 Receive updates from each of its reporting groups indicating the Health Board's position against the required legislation or standards, and agreed performance metrics/outcome measures in place, identifying any gaps in achieving these/compliance, and how these will be addressed through any actions required.

3.9 Horizon scan and feedback from national groups to ensure local awareness and development of measures linked to delivery of the quality, safety and experience agenda.

3.10 In respect of areas of concern raised by services the Group will seek to address those concerns raised by services through a variety of sources including, but not limited to the following:

- Quality and Safety Dashboard
- Performance Dashboard
- Listening and Learning Sub-Committee

4. MEMBERSHIP

4.1 The membership of the Quality and Safety Intelligence Group shall comprise:

Title
Director of Nursing Quality, Safety and Experience (Chair)
Director of Allied Health Professions and Health Science (Vice Chair)
Medical Director
Deputy Director of Allied Health Professions
Deputy Director of Health Science
Deputy Medical Director for Acute Services
Deputy Medical Director for Primary Care
Associate Medical Director for Quality & Safety
Assistant Director of Nursing for Assurance, & Safeguarding
Assistant Director for Patient Experience & Legal Services
Assistant Director of Nursing, Quality Improvement
Head of Quality and Governance
Head of Clinical Effectiveness
Chairs of Reporting Groups (Attending on Rotation to Present Update Reports)
Chair, Effective Clinical Practice Advisory Panel
Chair, Medicines Management Operational Group

Chair, Human Tissue Authority Assurance Group
Chair, Mental Capacity Act & Consent Group
Chair, Nutrition & Hydration Group
Chair, RADAR Group
Chair, Medical Devices Group
Chair, Infection Prevention Strategic Steering Group
Chair, Fragile Services Oversight Group
Chair, Medical Exposures Group
Chair, Strategic Safeguarding Group
In Attendance
Secretariat

4.2 The membership of the Group will be reviewed on an annual basis.

5. QUORUM AND ATTENDANCE

5.1 A quorum shall consist of no less than a third of the membership and must include as a minimum two clinical Executive Directors and one deputy Clinical Director, together with the Chair (or representative) of the 3 Reporting Groups required to attend on rotation at each meeting to present their respective update reports.

5.2 Any senior officer of the Health Board may be invited to attend by the Group where it is felt appropriate to do so.

5.3 The Group may also co-opt additional independent external 'experts' from outside the organisation to provide specialist knowledge.

5.4 Should any member be unavailable to attend, they may nominate a deputy to attend in their place, subject to the agreement of the Chair.

5.5 The Group 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 Quality and Safety Intelligence Group's agenda will be standardised and based around identified risks, matters arising from previous meetings. Issues emerging throughout the year and requests from Group members will be added to the agenda as necessary.

6.2 Dashboards and datasets will be utilised and will be available to all members in advance of the meeting.

6.3 The agenda and papers for meetings will be distributed six days in advance of the meeting.

6.4 Draft action notes and tracking log will be circulated to members within seven days to check the accuracy.

6.5 Outcome letters from the Group will be issued to the relevant Clinical Care Group/Clinical Service Group or other Operational service to follow up on any action required.

7. FREQUENCY OF MEETINGS

7.1 The Quality and Safety Intelligence Group will meet monthly. Additional meetings will be arranged as determined by the Chair of the Group.

7.2 The Chair of the Group, in discussion with the Quality Safety and Assurance Team shall determine the time and the place of meetings of the Group and procedures of such meetings.

8. ACCOUNTABILITY, RESPONSIBILITY AND AUTHORITY

8.1 The Quality and Safety Intelligence Group is accountable for its performance in exercising the functions set out in these terms of reference.

8.2 The Group shall embed the University Health Board's vision, corporate standards, priorities and requirements, e.g. equality and human rights, through the conduct of its business.

8.3 The requirements for the conduct of business as set out in the University Health Board's Standing Orders are equally applicable to the operation of the Group.

8.4 The Group's Chair, supported by the Group's Secretary, shall:

8.4.1 Report formally, regularly and on a timely basis to the Integrated Quality, Finance and Performance Delivery Group on the Group's activities through the submission of a Quality Intelligence Report.

8.4.2 Bring to Integrated Quality, Finance and Performance Delivery Group's specific attention any significant matters under consideration by the Group.

9. REPORTING

9.1 The Quality and Safety Intelligence Group may establish reporting groups or task and finish groups to carry out on its behalf specific aspects of the Group's business. The Group will receive an update following each of its reporting groups meetings detailing the business undertaken on its behalf.

9.2 The following Groups report directly to the Quality and Safety Intelligence Group:

9.2.1 Effective Clinical Practice Advisory Panel
9.2.2 Medicines Management Operational Group
9.2.3 Human Tissue Authority Assurance Group
9.2.4 Mental Capacity Act & Consent Group
9.2.5 Nutrition & Hydration Group
9.2.6 RADAR Group
9.2.7 Medical Devices Group
9.2.8 Infection Prevention Strategic Steering Group
9.2.9 Fragile Services Oversight Group
9.2.10 Medical Exposures Group

9.2.11 Strategic Safeguarding Group

9.3 These Groups shall maintain their current bi-monthly meeting rhythm and:

9.3.1 Report, formally, regularly and on rotation (i.e. every 4 months) to the Quality and Safety Intelligence Group on their work programme activities, compliance with legislation/standards and agreed performance metrics/outcomes measures.

10. SECRETARIAL SUPPORT

10.1 The secretariat will be provided by the Quality Assurance and Safety Team.

11. REVIEW DATE

11.1 These terms of reference and operating arrangements shall be reviewed on at least an annual basis by the Quality and Safety Intelligence Group.

Comparison between the Quality, Safety & Experience Sub-Committee Terms of Reference and the revised Quality & Safety Intelligence Group Terms of Reference

Responsibilities from Section 2 of QSESC TORs	**Alignment to QSIG/IQFPDG/CCGs/other arrangements**
2.1 The Quality, Safety & Experience Sub-Committee will, as delegated by the Quality, Safety and Experience Committee, monitor the quality, safety and experience governance arrangements of Acute, Mental Health & Learning Disabilities and Primary and Community services. In doing so, the sub-committee will hold services accountable for the management and mitigation of those quality and safety issues, thus allowing the Quality, Safety and Experience Committee to be strategically focused and provide upward assurance to the Board.	**Section in bold included in the revised QSIG TORs as follows (QSIG will not hold the services accountable as this will be the role of IQFPDG):** 2.1 The Quality and Safety Intelligence Group will **monitor the quality and safety arrangements within Operational services,** ensuring that the clinical Executive Directors are aware of, and have the opportunity, to review Quality and Safety data and discuss any patient safety related or other significant issues which have the potential to impact on quality and patient safety. This review of data will be linked to the established escalation arrangements to improve the effectiveness of operational services, and ultimately the quality and safety of care. The Quality and Safety Intelligence Group will: 2.1.1 Discuss significant issues arising or that have the potential to impact on patient safety, particularly those within the Health Board's most fragile services. This may include serious incidents, complaints, and risks that have been reported through the Datix Cymru reporting system, through quality, safety and experience concerns that have been raised by the service, or through other intelligence gathering mechanisms. 2.1.2 Utilising established and developing metrics agree triggers within the Quality and Intelligence data e.g. Medical Examiner, deteriorating patient/Cardiac arrest, hospital acquired Infection, hospital acquired VTE, issues relating to DNACPR. 2.1.3 Review dashboard/dataset and

	analysis, and identify any areas where immediate action is required to protect the safety of patients and staff 2.1.4 Identify further action required based upon the information available which may require escalations, including investigation, deep dive request to relevant Groups or Sub-Groups, etc.
Responsibilities from Section 3 of QSESC TORs	**Alignment to QSIG/IQFPDG/CCGs/other arrangements**
3.1 Aligned to the Duty of Quality and Health & Care Quality Standards, the sub-committee will monitor the quality, safety and experience of care delivered to patients. **Data triangulation from the Quality & Safety and Performance Dashboards reviewed by the Quality Safety Intelligence Group (QSIG) will inform this alongside patient feedback, surveys and patient stories**. Lack of assurance and resolution is escalated to the Integrated Quality, Planning, Finance and Delivery Group (IQPFD) to inform the Escalation and Directorate Improving Together processes and to Board via the Quality, Safety and Experience Committee.	Section in bold has been included in the revised QSIG TORs as follows: 3.3 Make use of key performance indicators/metrics, **including triangulation with patient feedback, surveys and patient stories**, to evaluate what is working well and what is not, focusing on exceptions, both positive and negative.
3.2 Where re-directed by the Listening & Learning Sub-Committee, monitor concerns (incidents, complaints, and claims) ensuring that they are being managed in a robust and timely manner at service level, agreeing mitigating actions where required.	This is covered by QSIG TORs: 3.10 In respect of areas of concern raised by services the Group will seek to address those concerns raised by services through a variety of sources including, but not limited to the following: • Quality and Safety Dashboard • Performance Dashboard • Listening and Learning Sub-Committee
3.3 Request a deep dive report. • When action plans following investigations into serious incidents and concerns and the identification of lessons learned breach the agreed timescales. Ensuring actions are completed in a robust and timely manner and seek assurance that learning is disseminated and	This is covered by QSIG TORs: 3.4 Request further information/deep dive regarding any issue of concern to inform decision-making.

embedded across all the Health Board's activities as appropriate. • To consider themes arising from triangulated information at service specific level and agree and monitor any action plans required to deliver improvements.	This is covered by QSIG TORs: 3.3 Make use of key performance indicators/metrics, including triangulation with patient feedback, surveys and patient stories, to evaluate what is working well and what is not, focusing on exceptions, both positive and negative.
3.4 Ensure and monitor compliance with recommendations from external reviews and national guidance, including HIW, Royal Colleges, NICE, NSFs, National Confidential Enquiries, outcome reviews and national clinical audits and Health Board clinical written control documents.	This is undertaken by CCGs in their CCG IGG meeting with issues escalated to IQFPDG as part of 3As report Assurances on processes would also be provided to QSEC on a 6 monthly basis in the CCG Quality Governance Arrangements Assurance Report Compliance is also monitored through internal escalation process which would be discussed at QSIG. This is in QSIG TORs: 3.2 Oversee and agree the escalation levels for the domain of quality of the internal Improving together framework, providing clear de-escalation criteria and areas of improvement to Clinical Care Groups and Clinical Service Groups classed as providing either 'limited' or 'no assurance.
3.5 Inform and monitor progress against agreed performance indicators in the Quality & Safety Dashboard and the Performance Dashboard as identified by QSIG.	This would be covered by QSIG TORs: 3.1 Ensure oversight of those performance measures that focus on the delivery of quality and safe services within the NHS Wales Performance Framework. 3.3 Make use of key performance indicators/metrics, including triangulation with patient feedback, surveys and patient stories, to evaluate what is working well and what is not, focusing on exceptions, both positive and negative
3.6 Seek clarification and assurance on the management of operational risks that have been aligned to the Sub-Committee where the risk tolerance is exceeded or where there is a lack of timely action. Lack of assurance and resolution is escalated to the Quality, Safety and Experience Committee.	This is undertaken by CCGs in their CCG IGG meeting with issues escalated to IQFPDG as part of 3As report Assurances on processes would also be provided to QSEC on a 6 monthly basis in the CCG Quality Governance Arrangements Assurance Report

	Risk Register reports would be provided through the Assurance and Risk Report to QSEC
3.7 Aligned to the Domains of the Duty of Quality receive Directorate /Site Exception Risk Reports and seek assurance on new elements of a directorate risk which requires consideration on a broader scale. Any risk escalated should clearly reference the risk as noted on the register	This is undertaken by CCGs in their CCG IGG meeting with issues escalated to IQFPDG as part of 3As report Assurances on processes would also be provided to QSEC on a 6 monthly basis in the CCG Quality Governance Arrangements Assurance Report
3.8 Receive assurance from the Advisory Groups reporting to the Sub-Committee and consider how escalated issues are addressed/resolved.	The advisory groups would report into QSIG in the new arrangements and have been added to the revised QSIG TORs: 3.8 Receive updates from each of its reporting groups indicating the Health Board's position against the required legislation or standards, and agreed performance metrics/outcome measures in place, identifying any gaps in achieving these/compliance, and how these will be addressed through any actions required.
3.9 Receive position reports on: • Quality Impact Assessment Panel • Risk Register • Key Risks associated with preventing harm to patients determined through Triangulation of data.	Assurance on QIA process would be provided in the regular Quality Assurance Report to QSEC Risk Register reports would be provided through the Assurance and Risk Report to QSEC. Risk Registers are also reviewed by CCGs in their CCG IGG meeting with issues escalated to IQFPDG as part of 3As report Assurance on Key Risks would be provided by CCG IGGs with issues escalated to IQFPDG as part of 3As report. Assurances on key risks would also be provided to QSEC on a 6 monthly basis in the CCG Quality Governance Arrangements Assurance Report
3.10 Assure itself that clinical written control documentation, which falls within the remit of the Sub-Committee, has been adopted, developed, or reviewed in line with HDdUHB Policy 190 – Written Control Documentation prior to approving it.	This is undertaken by CCGs in their CCG IGG meeting with issues escalated to IQFPDG as part of 3As report Policy approval would be undertaken by QSEC and is already covered in QSEC TORs: 3.22 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.
3.11 Develop an annual work plan, responding to operational service priorities, consistent with the strategic direction for the organisation, for approval by the Quality, Safety and Experience Committee. Oversee delivery to improve the quality, safety and effectiveness of care delivered and enhance the patient experience.	Not on QSIG TORs but an annual workplan would be developed to inform agendas.
3.12 Inform the work plans for Advisory Groups and vice versa.	Clear direction and guidance would be provided by QSIG on the requirements of these groups This has been added to the revised QSIG TORs: 3.10 Receive updates from each of its reporting groups indicating the Health Board's position against the required legislation or standards, and agreed performance metrics/outcome measures in place, identifying any gaps in achieving these/compliance, and how these will be addressed through any actions required.
3.13 Address any other requirements stipulated by the Quality, Safety and Experience Committee.	These would be fed into QSIG following QSEC meetings by the Clinical Executive Directors
3.14 Agree issues to be escalated to the IQPFD Group	This has been included in the revised QSIG TORs: 3.7 Provide a Quality and Safety Intelligence Report to the Integrated Quality, Finance and Performance Delivery Group, in regard to all of the above, setting out the improvement actions required.

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Quality and Safety Intelligence Group Agenda

Date and time of meeting	XXX
Venue	Via Teams

Time	Item	Presenter
X:XX	**Introduction and Apologies**	
	1. Welcome and apologies (verbal)	Chair
	2. Declaration of interests (verbal)	All
X:XX	**Preliminary Matters**	
	3. Notes of the Previous Meeting held on XX XXXX XXXX	Chair
	4. Matters Arising and Table of Actions from the meeting held on XX XXXX XXXX	Chair
X:XX	**Quality & Safety Intelligence**	
	5. Escalation/Quality Dashboard	Interim Assistant Director of Nursing Assurance & Safeguarding
	6. Fragile Services (linked to Clinical Services Plan)	Director of Nursing, Quality & Patient Experience
	7. Emerging Issues	Director of Nursing, Quality & Patient Experience/All
X:XX	**Updates from Reporting Groups**	
	8. XXXX Group	XXXX Group Chair
	9. XXXX Group	XXXX Group Chair
	10. XXXX Group	XXXX Group Chair
X:XX	**Matters for Escalation/Assurance Reporting**	
	11. IQFPDG Intelligence Report QSIG	Director of Nursing, Quality & Patient Experience

	12. Items to Include in QAST Report for QSEC	Chair/All
X:XX	**Annual Work Plan**	
	13. QSIG Annual Work Plan	Director of Nursing, Quality & Patient Experience
X:XX	**For Information**	
	14.	Chair/All
X:XX	**Any Other Business**	
	15.	All
X:XX	**Date and Time of Next Meeting**	
	X:XX XX XXXX XX	