

# QUALITY, SAFETY AND EXPERIENCE COMMITTEE

ANNUAL REVIEW REPORT

2025/2026

## 1. Introduction and Chair's summary

In line with Standing Orders the Quality, Safety and Experience Committee (QSEC) must submit an Annual Report to the Board 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 Sub-Committees it has established, setting out how the Committee has met its Terms of Reference during the financial year.

The Board uses this annual report to inform:

- The ongoing development of its governance arrangements, including its structures and processes:
- Its Board Development Programme, as part of an overall Organisation Development framework: and

## 2. Terms of Reference and Workplan

The Terms of Reference (TOR) for the QSEC Committee are reviewed on an annual basis or following any significant changes. The TORs were last reviewed in February 2026.

### [QSEC Terms of Reference March 2026](#)

The QSEC has a work plan to enable forward planning for the forthcoming year. The workplan is produced to incorporate the duties outlined in the Committee's Terms of Reference and any suggested areas of focus identified during the self-assessment process.

The QSEC Committee workplan covers a range of activities including statutory reporting duties, regular items of business and priority planned pieces of work which support Board and Committee's objectives.

The work plan is regularly updated throughout the year to ensure it remains responsive to emerging issues and risks.

### [Work Plan 2025/26](#)

## 3. Sub-Committees

The Listening and Learning Sub-Committee reports into the QSEC with its own terms of reference and workplan for the year. The Sub-Committee's TOR were last reviewed on 12 February 2026.

In line with the Terms of Reference, the Sub-Committee is required to provide a report after each meeting, as well as produce an annual report which are scheduled to be presented to the Committee in June 2026 reporting on activity throughout the year.

#### 4. Table of attendance

Name					Extraordinary meeting		Extraordinary meeting		
Members		08.04.2025	10.06.2025	14.08.2025	15.09.2025	09.10.2025	04.11.2025	04.12.2025	12.02.2026
Anna Lewis	Independent Member - Committee Chair	✓	✓	✓	✓	✓	x	✓	N/A <sup>1</sup>
Eleanor Marks	Independent Member (Committee Vice-Chair)	✓	✓	✓	✓	✓	✓	✓	N/A
Eleanor Marks	Independent Member (Committee Chair)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	✓
Michael Imperato	Independent Member	✓	x	✓	✓	✓	✓	✓	✓
Chantal Patel	Independent Member	✓	✓	✓	✓	✓	✓	✓	✓
Sarah Harraway	Independent Member	N/A	x	✓	✓	✓	✓	✓	N/A
Rhodri Evans	Independent Member	N/A	N/A	N/A	N/A	N/A	N/A	N/A	✓
Neil Prior	Independent Member	N/A	N/A	N/A	N/A	N/A	N/A	N/A	✓
<b>In Attendance</b>									
Sharon Daniel	Director of Nursing, Quality & Patient Experience	✓	✓	✓	✓	✓	✓	✓	✓
Andrew Carruthers	Chief Operating Officer	✓	✓	✓	✓	✓	✓	x	✓
Mark Henwood	Medical Director	✓	x	✓	x	✓	x	✓	✓
Jill Paterson	Director of Primary Care, Community and Long-term Care	✓	✓	✓	x	✓	x	N/A	N/A
James Severs	Director of Therapies and Health Science	✓	✓	✓	✓	✓	✓	✓	✓
Ardiana Gjini	Executive Director of Public Health	✓	✓	✓	✓	✓	x	✓	✓

Louise O'Connor	Assistant Director Legal and Patient Experience	x	✓	✓	x	✓	x	✓	✓
Cathie Steele	Interim Assistant Director of Assurance and Safeguarding	✓	✓	✓	✓	✓	✓	✓	✓
Llais Cymru Representative		✓	x	x	✓	x	x	x	✓
Meeting quoracy		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

(Not Applicable: due to changes in Membership/ Staff leaving posts)

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. Committee Activities – alert, advise and assure.

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

**Alert** – *The following matters were areas where the 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 Board as engagement action or intervention was required.*

- A patient story powerfully illustrated the urgent need for systemic transformation within **Emergency Departments** in June 2025. Key themes included inconsistency in standards of practice for nutrition and hydration processes, poor waiting room conditions, lack of dignity and respect, insufficient patient care due to capacity constraints, and a perceived culture of acceptance amongst staff under pressure. Urgent work was progressing through dedicated accelerated care workstreams, each focusing on specific priority areas.
- Clarification was sought on the approach and frequency with which concerns regarding estate deficiencies and capital investment in June 2025, particularly those affecting infection prevention and control, were raised during discussions with Welsh Government in response to **Targeted Intervention** de-escalation requirements. It was confirmed that such matters, notably ventilation related issues, are regularly addressed during touch point meetings with Welsh Government. A review of the identification of estate deficiencies took place by executive colleagues that reviewed and strengthened how feedback from safety walkarounds was reported and monitored.

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

- The ongoing issues with overcrowding and workforce fragilities at the **Health Board’s Urgent and Emergency Care services** were discussed during a Deep Dive report in April 2025, including the outcome of the Getting it Right First Time (GIRFT) review into the Emergency Departments. While a number of positive changes had been implemented to improve the quality and patient experience, which were shared as part of a *patient story*, it was recognised that necessary improvements would not be achievable without systemic transformation.
- A deep dive into quality matters being managed within the **Mental Health and Learning Disabilities Clinical Care Group** was presented in April 2025 including the processes, practices and frameworks. The Committee noted that a revised national Mental Health and Wellbeing Strategy (2025- 2034) would replace the previous ten-year strategy Together for Mental Health which would impact upon local planning. Innovative pilot opportunities were being actively explored by the Clinical Care Group, and the Committee encouraged the Clinical Care Group to be ambitious with its vision for future services.
- It was recognised in April 2025 that there was work required to strengthen reporting, to evidence the Health Board’s participation with national clinical audits within the **Targeted Intervention Update Report** in April 2025, which was taking place via the recently established operational governance arrangements and would continue to be monitored via the Audit and Risk Assurance Committee.
- In response to concerns raised regarding culture and high sickness rates in Theatres at Glangwili Hospital via the **Targeted Intervention Progress Report** in June 2025, the Committee requested that an improvement plan is scheduled for the People, Organisational Development and Culture Committee (PODCC). PODCC received an update on 17 February 2026 that an improvement plan co-produced with theatre staff was underway, with Band 7 staff taking ownership of leadership and management roles
- Several key highlights were discussed as part of the routine **Quality Assurance Report** during the June 2025 meeting including staff survey results which indicated that some staff felt uncomfortable reporting incidents. The Clinical Care Groups were asked to emphasise the importance of incident reporting during team meetings, in alignment with the Health Board’s ongoing commitment to the Speak up Safely agenda, while PODCC considered themes arising from the survey and other sources of intelligence.
- The serious consequences of stretched services, along with the underlying causes of current shortfalls was discussed in August 2025 as part of the **impact on patient experience and clinical outcomes due to Risk 797: Workforce Pressures in Ultrasound Services** report. The need for strategic changes to the workforce model was emphasised, to maximise staffing and resource use, while reducing demand. The vision set out within the report indicated potential service change which would

integrate scanning into the midwife role, reduce sickness rates linked to hand injuries, and provide a more varied role for the midwives. It is anticipated that the review for midwife sonography will strengthen the current fragile system. The service model redesign and workforce plan, which was in development, was shared for Executive and Board approval in March 2026. Further strengthening of the workforce model, with a clear plan for succession and expansion would help support a more consistent service offer across the Health Board and ensure the best possible outcomes for women and babies.

- In December 2025, the high-risk issue relating to **Sonography Services (Risk 797)** was reviewed, with concern expressed regarding the timeframes for achieving the target risk score, the potential impact on patient safety, and the effectiveness of current mitigations. It was noted that staff absences and recent retirements had increased service fragility, resulting in the risk score rising from 20 to 25. The initiatives include the development of an integrated midwifery sonography service within one to three years, the extension of insourcing arrangements to address national workforce shortages, and the strengthening of radiography leadership through the introduction of new roles.
- The **Assurance and Risk report** was reviewed by the Committee in August 2025. and the following action was agreed:
  - Concern was raised around risks where internal mitigations had been exhausted, and progress was reliant on external factors, particularly associated with Welsh Government (WG) funding. There was a desire to explore options to make stronger representation to the Board and WG on this issue.
- **Risk 664 - Risk to ophthalmology service delivery due to a national shortage Consultant Ophthalmologists and the inability to recruit:** Several developments within primary care optometry services have mitigated the risks, such as the introduction of Glaucoma filtering and monitoring pathways and the expansion of independent prescribing optometrists. These developments have enabled more services to be delivered within the community, thereby alleviating pressure on the ophthalmology service and supporting more timely diagnosis and treatment.
- **Risk 1708 - increasing fragility in primary care contractor services due to external factors** had been de-escalated. While services remain fragile, the Health Board has a statutory duty to ensure their provision, although the delivery model may change. It was noted that this risk was not solely dependent on the development of the Primary Care Strategy. However, as the service moves closer towards redesign through cluster-based arrangements, additional funding would be required to support this shift. Future Board support would be sought for the implementation of the Primary Care Model for Wales and the local cluster-based service delivery, with further requests to be made for support regarding the Eye Health Plan and the Dental Investment Plan.

- During an extraordinary Committee held during September 2025, a deep dive was provided into **Critical Care services**. The Committee was advised that following a reduction in the number of critical care consultants in Carmarthenshire from 8 to 5, an amended pathway and Standard Operating Procedure (SOP) was developed whereby patients were managed remotely from the Intensive Therapy Unit (ITU) at Glangwili Hospital. However following an incident in December 2024, the level of risk aversion had increased that resulted in all Level 2 and Level 3 Intensive Care Unit patients being transferred from ITU at Prince Philip Hospital (PPH) to Glangwili Hospital. The Committee were advised that an assessment of patients being admitted to ITU at PPH had not been able to determine the rationale for a reduction in the number of patients retained at PPH and that there had been no change to the admission and review process for ITU at Prince Philip Hospital.
- During the meeting in September 2025, the **Stroke Services** deep dive provided the current service provision provided by the Health Board at its four acute hospital sites and advised of the fragility of the service due to workforce limitations, in that there was a vulnerability caused by having services supported by one speciality stroke clinician per acute site in two of the four sites.
- None of the four acute sites or rehabilitation units within the Health Board meet the staffing levels recommended by the Royal College Clinical Guidance for Stroke. Work continues towards the development of a regional strategy for the provision of Hyper-Acute Stroke Units. A Programme Plan to develop Comprehensive Regional Stroke Centres across Wales was being consulted on and modelling work being undertaken. The availability of CT Perfusion Scanning was currently not available within the Health Board due to capacity and workforce constraints within the Radiology service. This provides significant benefit to patients and can lengthen the acute-stroke treatment window from 4.5 hours to 9 hours for thrombolysis, increasing the opportunity for clot retrieval treatment. Proposals were being developed for implementation within the Health Board through the All-Wales Optimal Imaging Pathway.
- At the same meeting, the deep dive of **Emergency General Surgery** service showed that the service was considered fragile due to workforce challenges experienced in managing the Emergency General Surgery rotas for Glangwili Hospital and Withybush Hospital. The recruitment of staff to service-specific recruitment as opposed to site-specific recruitment had been made to make the Health Board more attractive to prospective recruits into general surgery.
- In October 2025, a **Public Interest Report** highlighted the Health Board's failure to provide ongoing specialist care for epilepsy for patients with a learning disability, following the cessation of the dedicated service in June 2021. It detailed the significant impact on patients and carers, noting that, four years later, a clear pathway to specialist care had not been implemented. Following Board consideration in November 2025, an update was provided to the Committee in February 2026 on the progress against the recommendations. The Committee took assurance from the

continued work of the task and finish Group and agreed to receive a further update at a future meeting for full assurance on equity, access and variation.

- While there had been no evident change in the number of referrals to the service since the **temporary service changes for access to the Community Mental Health Service (CMHT) in Ceredigion** during October 2025, a localised increase in hospital admissions had been observed. The Committee asked that this is explored further and also sought assurance that local GPs have been engaged with consultations ahead of the report to Board in November 2025. An update was received through the table of actions in December 2025 confirming planned GP attendance at the north and south collaborative meetings in November 2025, with the purpose of engaging with doctors to gather local feedback.
- Partial assurance was provided on progress with the **Occupational Therapies Paediatric Improvement Action Plan** in October 2025 to develop a sustainable model and reduce waiting times below the 14-week target. A programme of service evaluation, which included a detailed demand and capacity analysis was reported and identified an opportunity to increase productivity by 13 new patients per week across the Paediatric Occupational Therapy service, demonstrating the potential to provide the required capacity to meet demand.
- Despite longstanding national consultant workforce shortages, significant efforts are being made by the team to progress actions to mitigate the challenges in providing a quality **Dermatology Service**, while awaiting the outcome of the Clinical Services Plan. At an extraordinary QSEC meeting held in November 2025 it was reported that steps are being taken to explore regional collaborative opportunities, undertake remote medical appointments and upskill GPs for additional service provision. Concerns remained regarding the impact on the service, if the imminent medical recruitment attempts were not successful.
- Significant concerns were raised regarding prolonged **autism spectrum disorder (ASD) diagnostic waiting times for children and young people (Risk 1032)** in December 2025. The target risk score of 16 remained unchanged due to resource limitations and the need for a strategic response. Patient concerns and the requirement for additional resources to support integrated hubs was discussed. Members highlighted the considerable distress experienced by families and emphasised the need for urgent service improvements. Consequently, the Chief Operating Officer carried out a deep dive meeting to review the risk and undertook to initiate discussions at a regional level on the need to develop a regional needs-led approach, to improve the quality, safety and experience of children and young people, to enable them to have improved access to appropriate support and interventions as opposed to the achievement of performance targets.
- In December 2025, the Committee was advised that a comprehensive review of **Waiting List Management** would be undertaken to address identified complexities and inconsistencies in patient communication processes across the Health Board.

The findings would inform a Health Board action plan which would be presented to QSEC in February 2026. In February 2026, the Committee supported the recommendation to form a task and finish group to review governance structures and audit processes related to the management of waiting lists and emphasised the importance of rebuilding trust with the population and improve customer service processes. The Board to receive an update on progress in March 2026.

- In February 2026, a substantial increase in **operational risks** was reported, rising from 389 to 467. Members discussed the likelihood of further deterioration as a result of ongoing financial pressures. While assurance was provided regarding the robustness of the **risk management process**, the Committee agreed that scrutiny of extreme level risks would be required going forward. A thematic deep dive into the Allied Health Professional and Health Science corporate and extreme level operational risks and associated mitigations was scheduled for the next meeting in April 2026, following concerns raised in relation to diagnostic demand and physiotherapy waiting times.

The risk associated with providing **care in non-designated clinical areas** was reported as currently under review during February 2026 and will be led by the Quality, Safety and Assurance Team and will incorporate individual patient risk assessments for all patients cared for in such environments.

**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 April 2025, it was reported that the rates of **Healthcare Acquired Infections (HCAI)** in the community continue to be examined in partnership with Public Health Wales and Local Authorities. Data was regularly reviewed as part of the Healthcare Associated Infections (HCAI) reporting expectations to Welsh Government for C.Difficile, E.coli, and S.Aureus, and targeted action undertaken, where required.
- In April 2025, the ongoing review of incident data and patient feedback did not suggest a harmful impact on patient care following the temporary closure of the **Minor Injuries Unit at Prince Philip Hospital** overnight service. This was subject to proactive monitoring, and the Committee continued to maintain oversight.
- The activity and successes of the **Improvement Strategic Framework 2023- 2026** was presented to the Committee in April 2025, and it was reported that the planning for Cohort 7 of the **Enabling Quality Improvement in Practice Programme (EQliP)** would start in June 2025. It was reported that 550 colleagues had been involved with the EQliP Programme up to April 2025, with 80 projects undertaken and 50 Quality Improvement Coaches across the Health Board.
- An addition had been made to the revised **Fragile Services framework** in June 2025 to include the Fragile Services Register, Improvement Plan and Quality Impact Assessment, to support achievement of the de-escalation criteria actions.

- The key areas of focus which would be prioritised as part of the local cancer transformation programme was shared during a presentation of the **Auditor General Report on Cancer Services** in June 2025.
- The **Duty of Candour Annual Report 2024/25** was presented to the Committee in June 2025 ahead of the Annual General Meeting in September 2025.
- The **Listening and Learning Sub Committee (LLSC) Annual Report 2024/25** was reviewed and approved by the Committee.
- The **Patient Experience Framework** was shared as part of the **LLSC Update Report** in June 2025. This is a tool developed for all NHS services (including commissioned services) to undertake self-evaluation and provide support for the development of improvement plans for improving patient experience.
- A governance review was conducted to evaluate how **Getting it Right First Time (GIRFT) reports** and other external reports in June 2025, to strengthen the process, and integrate it within the Health Board's operational and corporate structures. Revised processes are now in place to ensure these are appropriately tracked and implemented within the organisation.
- The Health Board was reported to be meeting its statutory 'duty to calculate' responsibility in respect of the nurse staffing levels in all wards that fall under the inclusion criteria of Section 25B of the **Nurse Staffing Levels (Wales) Act 2016** in June 2025.
- The **Corporate Risk report** was reviewed in June 2025, and the risk (1810) to **delivering effective and timely cancer service due to a high risk that the current Aseptic Unit at Withybush Hospital (WGH) will be forced to close** before the South-West Transforming Access to Medicines hub is operational, was considered. Actions progressing to mitigate the risks include the purchase of isolators. A demountable unit at WGH is also being progressed which would provide increased production and storage of stock for the future.
- A six-month review of actions following the **Committee self-assessment** was undertaken during February 2025 was shared in August 2025, with six out of the 10 actions completed and progressing within agreed timeframes.
- The Committee approved the proposal to revise the operational quality and safety governance arrangements and disestablish the **Quality, Safety and Experience Sub Committee (QSESC)** in August 2025. The 9 reporting Groups that previously reported to QSESC would report to Quality and Safety Intelligence Group (QSIG) which reports to the Integrated Quality, Finance, Performance & Delivery Group (IQFPD). A report will be presented to QSEC in April 2026 to provide an update on the effective implementation of these new operational quality and safety arrangements.

- It was reported in August 2025 that actions underway in response to the second limited assurance audit outcome regarding **cleaning standards** across the organisation were progressing within the specified timescales. A follow up audit was anticipated within the current financial year. In February 2026, the Committee received an update report advising that the **Estates and Facilities Clinical Care Group** had made significant progress in structuring its business, improving governance, and documenting risks comprehensively in the last twelve months. The priority for the coming year would include implementing a new model of cleaning provision, with extensive staff engagement. The assessment of cleaning resources aims to shift focus from low-risk to high-risk areas, with proposals put forward for winter resilience workforce. There was an organisational change process underway to strengthen rota arrangements to provide a 7 day a week cleaning service and the team was working closely with trade unions to support staff as much as possible.
- Several key highlights were discussed as part of the routine **Quality Assurance Report** in August 2025 including:
  - The Quality Assurance team continues to actively promote the significance of incident reporting with staff. An upward trend in incident reporting provided an early indicator of progress.
  - 240 incidents had been closed where the Duty of Candor had been ‘triggered’, with a discussion on how the learning from these incidents was being implemented across the organisation.
- The Committee received the **Duty of Quality Annual Report 2024/25** in August 2025, ahead of presentation at the Annual General Meeting in September 2025.
- The progress being made to implement a **Women’s Health Hub** in line with the NHS Wales Women’s Health Plan by 31 March 2026 was reported in August 2025 with an update report scheduled for the meeting on 9 April 2026.
- Assurance was received in August 2025 that due process was being followed in collaboration with key stakeholders for the centralised relocation of the **Section 136** place of safety for people experiencing a mental health crisis to Carmarthen, Carmarthenshire.
- The positive work undertaken in establishing the Frailty Assessment Unit was shared as part of a **Staff Story** in October 2025, whereby the Cadog Ward transitioned from a 20-bed frailty ward to a reconfigured model, consisting of a 6-bed assessment unit and 14 short stay frailty beds. This also included the implementation of a pathway to support patients requiring longer-term frailty care. The changes have reduced the need for enhanced patient support, improved outcomes and strengthened patient safety through visible and effective leadership.

- It was reported in October 2025 that appropriate steps were being taken to assess the safety and quality of services in light of the findings from the Independent **Review of Maternity and Neonatal Services** at Swansea Bay University Health Board. A maternity and neonatal assessment report has been scheduled on the QSEC agenda for 9 April 2026.
- Assurance was received in November 2025 during an extraordinary meeting, that significant progress had been achieved in outpatient efficiency, diagnostics and governance within the **Urology Service**. The next steps reported included securing additional theatre sessions, addressing diagnostic bottlenecks and expanding clinical nurse specialist capacity to deliver a sustainable transformation, as part of the Clinical Service Planning process.
- Positive progress was reported in November 2025 in clearing the diagnostic backlog and maintaining high standards of patient experience in **Endoscopy Services as part of the Clinical Services Plan Deep Dives**. Remaining challenges include the prolonged waiting lists, and the potential workforce and financial risks that could impact recovery delivery were noted.
- Mitigations to address **mortuary capacity challenges** (Risk 1552) was reported in December 2025, including short-term measures such as purchasing and renting additional storage units, providing 60 extra spaces to manage winter pressures. Financial support enabled building works at Prince Philip Hospital, adding eight spaces, with further plans to increase freezer capacity by seven. The Committee recognised the risk management efforts.
- The **Listening and Learning Sub Committee** focused on Mental Health and Learning Disabilities during its meeting in December 2025, emphasising person-centred care planning, staff support following adverse incidents, and compliance with HIW recommendations post-discharge. Appreciation was extended to the parents who attended to discuss the loss of their son, for their commitment and determination in helping to drive learning and improvements to mental health services. The Sub Committee reported the progress being made on the implementation of a Health Board wide Listening and Learning from Events Framework.
- The **Clinical Audit Programme 2025/26** was approved which emphasised alignment with organisational priorities through engagement with clinical care groups. Members highlighted the need for a prioritisation process, to be considered by the Executive Team, with suggestions for involving Committee Chairs and incorporating health equity audits. While approving the plan, the Committee expressed interest in greater involvement in audit prioritisation. In March 2026, the Committee were invited to consider what clinical audit projects might be beneficial to the organisation with suggestions to be sent to the Clinical Director for Clinical Audit by the 30 April 2026.

- Deep Dives into **Orthopaedics, Ophthalmology, and Radiology** presented in December 2025 outlined interim measures already in place, and those planned to address current challenges and service fragilities. The actions will remain in place pending the outcome of the Clinical Services Plan and underscore the case for change and the effectiveness of existing mitigations.
- An update report from the **Community Integrated Care and Medicine Clinical Care Group** in December 2025 addressed equitable service access and thematic learning and highlighted both the implementation of audit recommendations and their subsequent impact. Emphasis was placed on the monthly learning panel to embed improvements.
- The updated **guidelines for staff conducting patient-related surveys**, aligned with the new People's Experience Framework and national survey, were approved by the Committee, with assurance that the consultation identified no equality impact.
- A powerful **patient story** presentation during February 2026 illustrated the complexities of caring for vulnerable adults with cognitive impairment, behavioural escalation, safeguarding needs, and significant system pressures impacting flow, staff morale and workload.
- The **Quality Assurance Report** noted a reduction in complaints, leading to questions about whether this reflected genuine improvement or reduced feedback. The decrease had resulted from an internal re-categorisation exercise, with some issues now recorded as enquiries dealt with at first contact, with Committee informed that complaint numbers are beginning to rise again.
- During February 2026, the Committee raised concerns regarding the 75.36% compliance rate for mandatory **infection prevention and control (IPC)** training with actions underway to improve uptake, including reviewing the training offer and collaboration between the IPC Team and Clinical Care Groups. Detailed data continues to be shared through the Infection Prevention Strategic Steering Group, with Clinical Care Groups encouraged to strengthen locality meetings to drive improvements.
- The Committee approved the **Health Equity Impact Assessment toolkit** in February 2026 which was developed as part of the 24-7 model, to ensure that strategic and operational decisions do not impact upon health inequities across the region. This was shared with Board for final approval in March 2026. The tool focuses on socio-economic factors and aims to support equitable access to services, particularly for people facing transport issues and other barriers. The Committee discussed integration of the toolkit into the quality impact assessment process which will be considered by the Executive Team.
- Detailed information on compliance with statutory safeguarding requirements was shared as part of the **Safeguarding Update Report** in February 2026. The report

included background information on various safeguarding activities, such as the management of People in Position of Trust (PiPOT) cases and collaboration with local authorities. In terms of the request for a six month extension to the Corporate Safeguarding Policy, the Committee received assurance that the current policy was compliant with statutory requirements, and the extension was to ensure a robust review can be undertaken with the newly appointed Head of Safeguarding starting in post.

- The significant work underway to implement the Listening to People Regulations was discussed as part of the **LLSC** report in February 2026. The change impact assessment is pending national-level decisions and will be ready to share with the Committee on 9 April 2026. The revised **LLSC Terms of Reference** has been strengthened in terms of membership and scope, focusing on evidencing how feedback leads to learning and improvement. The Committee expressed appreciation for the positive approach to the appreciative inquiry within the Terms of Reference.

## 6. Committee Effectiveness - Feedback from self-assessment process

As stipulated within Standard Orders, the Board introduced a process of regular and rigorous self-assessment and evaluation of the performance of the QSEC.

This year's self-assessment focused on five core areas of governance and assurance:

- Oversight and Impact on Quality & Safety – how the Committee effectively oversees and influences improvements in the organisation's quality and safety outcomes.
- Data, Indicators, and Assurance - quality of papers including accuracy, timeliness, with relevant data to provide assurance on quality and safety experience, impact and outcomes for patients.
- Culture and Accountability – how the Committee promotes a culture of safety, transparency, and learning across the organisation.
- Risk Recognition and Response – how the Committee effectively identifies and responds to emerging quality and safety risks.
- Continuous Improvement and Committee Effectiveness how the Committee evaluates its own performance and takes steps to improve its effectiveness and strategic influence.

The results from which were fed into an action plan, combining information and Auditor/Regulator feedback.

The process was undertaken during the year and reported to the Committee on 12 February 2026 - [Self Assessment Report](#).

The following themes were provided:

What has gone well:

- Effective chairing and strong Independent Member engagement.
- Effective scrutiny through high support and high challenge to those delivering the services.
- A positive culture of professionalism, openness and transparency.
- Continued oversight of areas requiring improvement.
- The revised approach to writing papers using the Domains of Quality (STEEEP) and enablers as outlined in the Duty of Quality support continuous quality improvement.

What to strengthen going forward:

- Operational reporting by focussing on outcomes and impacts to quality, supported by data, with less focus on performance, to avoid risks being reported after they have materialised.
- Operational governance to minimise ‘surprises’ and being proactive in considering urgent service issues/changes.
- Continue to improve quality of data reported to Committee

The Committee will receive an update on progress at the mid-year point in August 2026.

## **7. Conclusion**

The Committee is satisfied that it continues to operate effectively and in line with the Terms of Reference. Issues have been escalated to Board as appropriate, and the Committee uses feedback from the self-assessment process to evolve and continually improve.