Enw'r Pwyllgor / Name of Committee	Quality, Safety and Experience Committee (QSEC)
Cadeirydd y Pwyllgor/ Chair of Committee:	Ms Anna Lewis, Independent Member
Cyfnod Adrodd/ Reporting Period:	Meeting held on 22nd June 2022

Y Penderfyniadau a'r Materion a Ystyriodd y Pwyllgor / Key Decisions and Matters Considered by the Committee:

- **Annual Review of the Terms of Reference:** The Committee received and approved the QSEC Terms of Reference with no changes or additions required, for Board approval.

- **Patient Story Community Paediatrics Services:** The Committee received a patient story from the mother of a patient, providing an account of their experience of the service transition from Children's Services to the Adult Learning Disabilities Service. The overall feedback was positive, highlighting areas for improvement in the lead up to the transition stage such as communication regarding the next steps, resources for the provision of services and appropriate disabled parking facilities for clinical appointments. The patient story commended the nursing staff for their help and advice following the referral to the Adult Learning Disabilities service, noting that the patient's mother felt at ease to come forward with any questions or concerns. The Committee received assurance that the recently established Transition Team has reflected upon the feedback provided and that actions have been taken to address the issues and continue to develop and expand the service.

- **Community Paediatrics Deep Dive Report:** The Committee received a Deep Dive Report from the Community Paediatrics Service, noting the significant concerns raised by the Consultant workforce regarding the high number of patients waiting for an appointment within Community Paediatrics and the associated risks. Correspondence was received from the Lead Community Paediatrics Consultant expressing concern regarding the current service position and the request for a review of the Community Paediatrics Service. The Director of Operations described how the pre –COVID-19 patient waiting lists have not changed significantly, however, children are waiting longer for an initial appointment, some up to four years. The Committee was advised that the national clinical view is that there is an increased level of acuity and complexities for those children on the waiting list. The Committee was assured that an internal, evidence based review of the Community Paediatrics Service will be undertaken by Mr Martin Simmonds, Paediatrics Consultant to identify gaps and areas for improvement and investment. Additionally, a Task and Finish Group is being established to ascertain the demand and capacity position, review the staff skill set and review the criteria for referrals. The Committee requested that the individual impact on the children and families affected is captured during these significant waits including the broader social impact for children and families. The Committee received assurance that a communications plan is in development to capture the patient experience during the waiting periods and feedback will be presented to the QSEC upon completion of the review.

- **Getting It Right First Time (GIRFT) Outcome Report for Orthopaedic Services:** The Committee received the draft GIRFT Outcome Report for Orthopaedic Services and an update on the recommendations made following the service review. The Committee was advised that the overall practice feedback has been positive however, it has indicated a

need for strategic change and reconfiguration, which ties in with the national orthopaedic services report. The Committee received assurance that an Orthopaedic Steering Group will be established to oversee the implementation of the recommendations and deliver Orthopaedic improvements. A response to the draft report will be compiled and an action plan developed, which will be presented to the Committee at a future meeting. The Committee received further assurance that a triangulated approach for learning from complaints will be led by the Head of Quality Governance and will be reported to the Quality Meetings.

- **De-Escalation Of Health Board COVID-19 Infection Prevention Control Measures:** The Committee received an update on the de-escalation of Health Board COVID-19 infection prevention control measures to risk based management, with the majority of Health Board sites reverting to pre COVID-19 substantive practice. Daily risk assessment and COVID-19 position discussions take place between the Director of Nursing, Quality and Safety Experience and Senior Management to ensure patient safety, including lessons learned from patient feedback. The revised guidance has been shared with the Health Board's Community Health Council (CHC) and the intranet's Frequently Asked Questions for consultation. The Committee noted that the patient testing framework is currently being updated and will be presented to the Health Board's Operational Programme Delivery Group.

- **Corporate Risks assigned to QSEC:** The Committee received the Corporate Risks assigned to QSEC report. With reference to *Risk 1032- Timely access to assessment and diagnosis for Mental Health and Learning Disabilities clients,* clarity was requested on the change in timescales for actions with no explanation provided on the demand and capacity work underway. The Committee was advised that further information will be requested from the Mental Health and Learning Disabilities Triumvirate to ensure that achievable timescales are provided and received assurance that an update will be presented to the Committee at its next meeting. With reference to *Risk 1337- Risk of reputational harm if the health board is found to have not managed the Llwynhendy Tuberculosis outbreak as well as it could have*; the Committee noted that the review will be undertaken in Autumn 2022. With reference to *Risk 129- Ability to deliver an Urgent Primary Care Out of Hours Service for HDdUHB patients*; the Committee noted the out of hours response work underway to shape the service to support the workforce position.

- **Quality and Assurance Report:** The Committee received the Quality and Assurance Report, noting key highlights such as the update on the Falls Improvement data, with the Quality Improvement Team tasked with producing a collaborative falls framework in conjunction with key stakeholders for falls prevention. The Committee received an update on patient safety incidents where the harm is severe or catastrophic. The Committee received assurance that those flagged by the Quality Assurance Information System (QAIS) Team are reviewed by the Patient Safety Team and an Incident Management meeting is arranged with the respective Triumvirate, which has been working well. Walkarounds have recommenced following a break due to COVID-19, and a forward scheduling programme has been agreed with Independent Members and the Executive Director. Positive feedback was provided from a recent visit undertaken to Dewi Ward, Glangwili General Hospital (GGH), highlighting that the nursing team had a clear awareness of the falls statistics and communicated the challenges and mitigations in place. The Committee noted that the walk rounds should be scheduled in advance with clinical staff out of courtesy and to provide clarity that the visits are not part of an

inspection, due to the current clinical pressures. The Committee received assurance that feedback from staff regarding challenges accessing online guidance has been fed back to the Director of Communications.

- **Stroke Services Pathway Update:** The Committee received an update on the Stroke Services Pathway, and commended the staff working within Stroke Pathway services who have worked tremendously hard during a challenging period, and highlights that pathway redesign and investment is required for service improvement. The pathway redesign developments were halted due to COVID-19,and have now recommenced with the Carmarthen region arrangements being revised in the first instance. The Committee received an update on recent opening discussions with Swansea Bay University Health Board for limited HDdUHB population access to the Stroke Services Pathway in Morriston Hospital and an update will be provided when available.

- **Welsh Health Specialised Services Committee (WHSCC) Update On Children And Young People's Mental Health Services (CAMHS) Tier 4 Pathway:** The Committee received an update from WHSCC on the commissioned CAMHS Tier 4 Pathway and raised concern regarding the period of time that services have been in escalation and the impact it has had on children and young people. The Committee noted that the recently approved investment for the recruitment of a number of psychologists and therapists, including physiotherapy, dietetics and occupational therapists, is expected to transform the clinical model to a more therapeutic pathway. The Committee raised that the overview report would suggest that Hywel Dda patients are inpatients for longer periods in comparison to other Health Boards and requested that this is explored further to provide assurance on the clinical pathway models in place. In response to a request from the Committee on the anticipated timescale trajectory and contingency planning if the timescales are not met, the Director of Nursing and Quality at WHSCC responded that a contingency planning report and associated timeframes is being prepared for the WHSCC Joint Health Board Committee and an update can be shared with QSEC following the meeting.

- **Maternity Services Action Plan Update:** The Committee received the Maternity Services Action Plan Update, providing an update on the actions underway in response to the Health Board's recommendations following the Ockenden Report. The report also provided an update on the CHC Report and the Welsh Branch Royal College of Midwives (RCM) Staff Survey. The Committee was advised that all health boards in Wales undertook a benchmarking exercise, led by the Maternity and Neonatal Network and Welsh Government. An All Wales Assurance Framework was created and the Health Board requested to report by exception areas identified for improvement by 7th July 2022. A multidisciplinary workshop will be held to review each other's exception reports to identify opportunities for learning and to commence the development of Quality Assurance Indicators of what good looks like to support benchmarking against standards.

- **Planning Objectives Update:** The Committee received an update on the planning objectives assigned to QSEC, noting the development of an implementation group to identify the actions required to respond to the emerging requirements of the Quality & Engagement Act with an update scheduled for the next QSEC meeting on 9th August 2022. With reference to Planning Objective *Planning Objective 5P, Develop and deliver an implementation programme that will ensure effective operational implementation of the Liberty Protection Safeguards (LPS) legislation across the health board by 1st October 2023*, the Committee was advised that Welsh Government has undertaken a national

consultation process in regard to the LPS legislation and the Health Board has provided a response with the internal developments reliant on the national progress.

- **Listening And Learning Sub-Committee Update (ToR):** The Committee received an update from the Listening and Learning Sub-Committee including presentations and individual cases from across the concerns and safeguarding portfolio, with discharge arrangements and communication, which was highlighted as a key theme. The Public Services Ombudsman final reports, which had been received during the relevant period, were also reviewed.

- **Operational Quality, Safety and Experience Sub-Committee (OQSESC) Update Report:** The Committee received an update report from OQSESC, noting the significant risks across services include waiting times, emergency care pressures, staffing resource deficits and the risk to patient experience. The Sub-Committee received an update on the 'red status' Welsh Health Circulars and mitigating actions underway. The Sub-Committee noted that Bronglais General Hospital (BGH) has reported an increase in the numbers of pre-Hospital Cardiac arrests arriving at the Emergency Department (ED) with a similar pattern emerging in the Acute Medical Admissions Unit at Prince Philip Hospital (PPH). The Sub-Committee was advised that this would be monitored through the Rapid Response to Acute Illness (RRAILS) group and requested a review of Medical Emergency Team (MET) calls at both EDs in WGH and GGH. A further review of cases at BGH and PPH will be completed to identify any themes in collaboration with the NHS Welsh Ambulance Service Trust (WAST). The conclusions from the review will be reported at the next RRAILS monitoring group.

- **Strategic Safeguarding Working Group:** The Committee received the Strategic Safeguarding Working Group report and the key areas for consideration, noting the slight decline in the number of Looked After Children (LAC) within the Health Board since the significant increase during the first wave of the pandemic. The pattern has levelled off over the summer and the number has slightly reduced from 814 to 787 LAC at the end of Quarter 2, 2021/22. The Committee noted the increase in Multi Agency Referral Forms and referrals for children and adult safeguarding activity, due to the continuing relaxation of COVID-19 pandemic restrictions and the commencement of face-to-face consultations and contacts. The Committee was reminded to undertake the Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) National Training, which has been developed for Strategic Leaders within Public Sector organisations.

Materion y mae angen Ystyriaeth neu Gymeradwyaeth Lefel y Bwrdd are u cyfer / Matters Requiring Board Level Consideration or Approval:

- Approval of the Quality, Safety and Experience Committee Terms of Reference, appended.

Risgiau Allweddol a Materion Pryder / Key Risks and Issues/ Matters of Concern:

- **Corporate Risks assigned to QSEC:** With reference to *Risk 1027 - Delivery of integrated community and acute unscheduled care services*; the Committee noted the significant levels of emergency demand, due to the broader impacts of COVID-19 and workforce deficits. The Committee acknowledged steps taken to reshape services such as Same Day Emergency Care model and the Mental Health specific 111 telephone service, recognising however that the impact will take time to be realised within the unscheduled

care (USC) system. Therefore, the Committee agreed to escalate this risk to Board. The Committee received assurance that feedback from the upcoming '111' and Out of Hours peer review meeting will be presented to the Committee at a future meeting.

- **Stroke Services Pathway Update:** The challenges in providing effective stroke services in rural locations are significant, with the need to balance multidisciplinary specialist care with care closer to home, and timely assessment and treatment with travel considerations across a wide geographical area. Recognising that the operational risks are being managed within reach, the Committee agreed that the risks remain significant for the HDdUHB population and therefore agreed to escalate the pathway challenges for further discussion at Board.

- **WHSCC Update On CAMHS Tier 4 Pathway:** Highlighting the ongoing quality and safety concerns, the Committee agreed to continue to closely monitor the position and risk and requested an improvement trajectory assurance report be presented to QSEC in the next four to six months.

- **Maternity Services Action Plan Update:** The Committee noted concern raised regarding the fragility of the consultant workforce. The Committee received assurance that routine updates from Maternity Services will be scheduled as part of the QSEC work programme going forward.

Busnes Cynlluniedig y Pwyllgor ar gyfer y Cyfnod Adrodd Nesaf / Planned Committee Business for the Next Reporting Period:

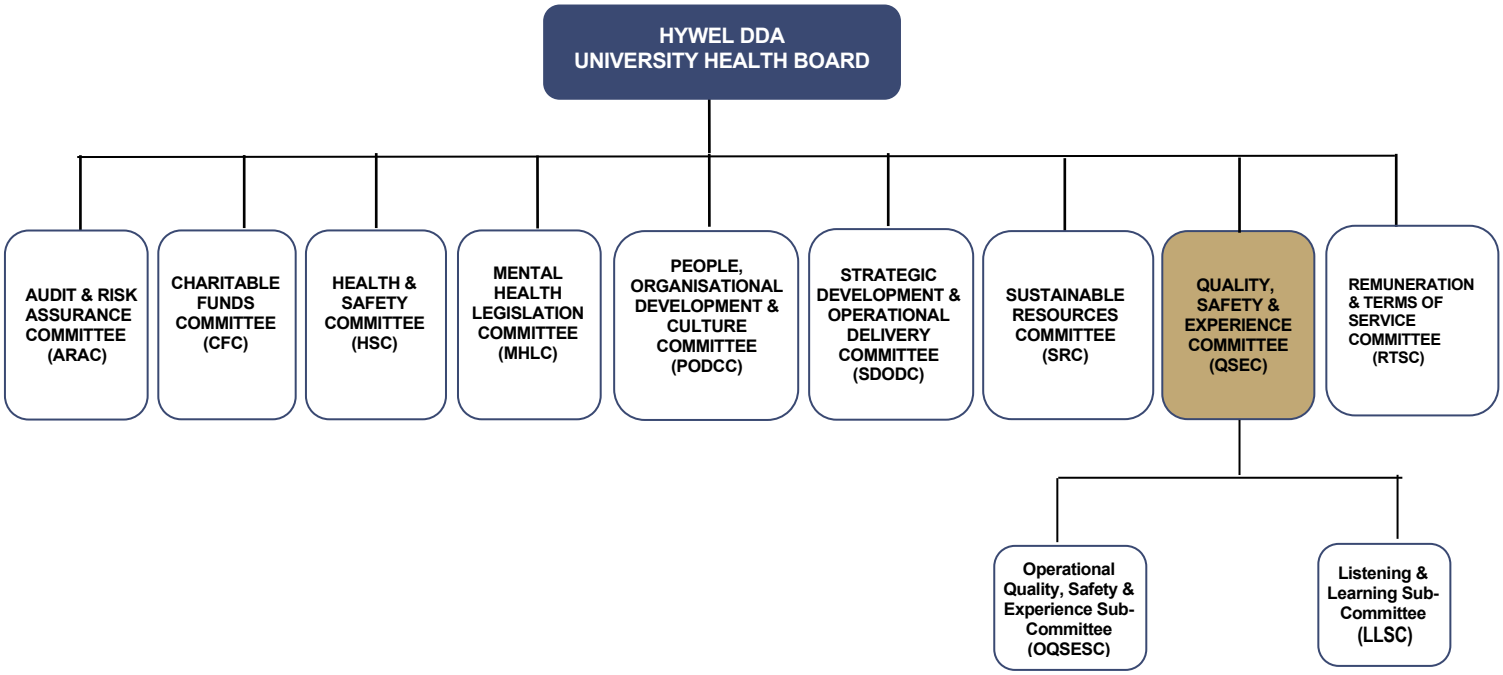
Adrodd yn y Dyfodol / Future Reporting:

In addition to the items scheduled to be reviewed as part of the Committee's Work Programme, the following items will be included on the agenda for the next QSEC meeting:

- Deep Dive and Patient Story: Unscheduled Care Services
- Public Health Update
- Planning Objective 3C: Quality and Engagement Act

Dyddiad y Cyfarfod Nesaf / Date of Next Meeting:

11th October 2022



QUALITY, SAFETY & EXPERIENCE COMMITTEE

TERMS OF REFERENCE

Version	Issued To	Date	Comments
V0.1	Quality Safety & Experience Assurance Committee	16.06.2015	Approved
V0.2	Hywel Dda University Health Board	30.07.2015	Approved
V0.3	Hywel Dda University Health Board	26.11.2015	Approved
V0.4	Quality Safety & Experience Assurance Committee	18.10.2016	Approved
V.04	Hywel Dda University Health Board	26.01.2017	Approved
V.05	Quality Safety & Experience Assurance Committee	20.02.2018	Approved
V.05	Hywel Dda University Health Board	29.03.2018	Approved
V.06	Quality Safety & Experience Assurance Committee	05.02.2019	Approved via Chair's Action 20.03.2019
V.07	Hywel Dda University Health Board	28.03.2019	Approved
V.08	Hywel Dda University Health Board	26.03.2020	Approved
V.09	Quality Safety & Experience Assurance Committee	07.04.2020	Approved via Chair's Action on 18.05.2020
V.09	Hywel Dda University Health Board	28.05.2020	Approved
V.10	Quality Safety & Experience Assurance Committee	02.02.2021	Approved

V.11	Hywel Dda University Health Board	25.03.2021	Approved
V.12	Hywel Dda University Health Board	29.07.2021	Approved
V.13	Quality Safety & Experience Assurance Committee	22.06.2022	Approved
V.13	Hywel Dda University Health Board	28.07.2022	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 1st 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.

2.5 To receive an assurance on delivery against relevant Planning Objectives aligned to the Committee (see Appendix 1), in accordance with Board approved timescales, as set out in HDdUHB's Annual Plan.

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.

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) 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 Seek assurance on delivery against Planning Objectives aligned to the Committee, considering and scrutinising the processes that are developed and implemented, supporting and endorsing these as appropriate.

3.7 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.

3.8 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.

3.9 Provide assurance to the Board that current and emerging clinical risks are identified and robust management plans are in place and any learning from concerns is applied to these risks as part of this management.

3.10 Provide assurance to the Board in relation to improving the experience of patients, including for those services provided by other organisations or in a partnership arrangement. Patient Stories, Patient Charter and Board to Floor Walkabouts will feature as a key area for patient experience and lessons learnt.

3.11 Provide assurance to the Board in relation to its responsibilities for the quality and safety of mental health, primary and community care, public health, health

promotion, prevention and health protection activities and interventions in line with the Health Board's strategies.

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

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

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

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

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

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

3.18 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.

3.19 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.

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

3.21 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.

3.22 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.

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

3.24 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.

3.25 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.

3.26 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.

3.27 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)
6 x Independent Members (including Audit & Risk Assurance 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 & Deputy CEO
Director of Operations
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 Nursing, Quality Assurance, Professional Regulation, and Interim Acute Operational Services (Chair of Operational Quality, Safety & Experience Sub-Committee)
Assistant Director of Therapies and Health Science - Professional Practice, Quality and Safety
Assistant Director, Legal Services/Patient Experience
Hywel Dda Community Health Council (CHC) 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 (Director of Nursing, Quality & Patient Experience) 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 of papers will be circulated to all Committee members.

6.3 All papers must be approved by the Lead/relevant Director, ensuring these are submitted in accordance with the Standard Operating Procedure for the Management of Board and Committees.

6.4 The agenda and papers will be distributed **seven** days in advance of the meeting.

6.5 The minutes and action log will be circulated to members within **ten** days to check the accuracy.

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 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 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 –Planning Objectives aligned to QSEC

PO Ref	Planning Objective	Executive Lead
1E	During 2022/23 roll out the processes developed in 2021/22 to maintain personalised contact with all patients currently waiting for elective care which will: 1. Keep them regularly informed of their current expected wait 2. Offer a single point of contact should they need to contact us 3. Provide advice on self-management options whilst waiting 4. Offer advice on what do to if their symptoms deteriorate 5. Establish a systematic approach to measuring harm – bringing together the clinically assessed harm and harm self-assessed by the patient and use this to inform waiting list prioritisation 6. Offer alternative treatment options if appropriate 7. Incorporate review and checking of patient consent By the end of March 2023 to have this process in place for all patients waiting for elective care in the HB.	Director of Nursing, Quality and Patient Experience
3C	From April 2022, establish an implementation group to identify the actions required to respond to the emerging requirements of the Quality & Engagement Act. The specific actions that will be put in place to support organisational readiness will be informed by the work undertaken to review the Health & Care Standards during 2021/2022 and the receipt of any formal guidance related to the Act.	Director of Nursing, Quality and Patient Experience
5K	Establish a process to ensure effective clinical practice is embedded within individual practice and clinical service areas. The process is part of the Health Board's Quality Management System, alongside Clinical Audit and Quality Improvement, and sits within the Quality and Governance structure, by the end of 2022/23. This will be achieved by: • Supporting the assessment of practice against local and national clinical effectiveness standards and ensuing that findings are used improve the services provided to our patients; • Supporting services to identify, understand and act upon findings from external reviews that are relevant to effective clinical practice e.g. GIRFT, Royal College Peer Reviews	The Medical Director

PO Ref	Planning Objective	Executive Lead
5W	Develop and deliver an implementation programme that will ensure effective operational implementation of the Liberty Protection Safeguards legislation across the health board by 1st October 2023.	The Director of Operations
5X	Develop a plan to introduce a comprehensive quality management system to support and drive quality across the organisation. Implementation to begin by April 2022 and completed within 3 years. The system will be supported by the HBs "Improving Together Framework" and Enabling Quality Improvement In Practice (EQIiP) Programme as delivery vehicles.	Director of Nursing, Quality and Patient Experience