COMMITTEE UPDATE REPORT/ ADRODDIAD DIWEDDARU'R PWYLLGOR – QUALITY, SAFETY AND EXPERIENCE COMMITTEE

Date of last meeting/ Dyddiad y cyfarfod diwethaf: 12 February 2026

Quoracy/ Cworwm: Met

Report by/ Adroddiad gan: Eleanor Marks, Chair

KEY DISCUSSION POINTS AND MATTERS TO BE ESCALATED FROM THE DISCUSSION AT THE MEETING/ PWYNTIAU TRAFOD ALLWEDDOL A MATERION I'W HUWCHGYFEIRIO O'R DRAFODAETH YN Y CYFARFOD:

Alert[1] (may require discussion)/ **Rhybuddio** (efallai y bydd angen trafodaeth)

The Quality, Safety and Experience Committee had no items of which to **alert** the Board.

Advise[2] (to monitor)/ **Cynghori** (i fonitro)

The Quality, Safety and Experience Committee wishes to **advise** members of the Board that:

- 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 further scrutiny of extreme-level risks is required. A thematic deep dive into the Allied Health Professional and Health Science Corporate level and extreme operational risks and associated mitigations has been scheduled for the next meeting, following concerns raised in relation to diagnostic demand and physiotherapy waiting times.
- The risk associated with providing care in non-designated clinical areas is currently under review. This work 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[3] **(to note)/ Sicrhau (i nodi)**

The Quality, Safety and Experience Committee wishes to **assure** members of the Board that:

- The **Committee Self-Assessment** Report was positively received, with a high number of completed actions noted. Areas identified for improvement included the quality and timing of papers and data quality.

---

[1] *There is a lack of confidence that any action in place is sufficient to address the issue satisfactorily and/or within the scope of the operational team or executive to resolve. Engagement, action or intervention required.*
[2] *There are areas of concern where assurance has been taken on actions in place but requires close monitoring. An early warning of an emerging and potentially serious concern*.
[3] *There is confidence that actions are robust and will be sufficient to address the issue or generally operating effectively. Routine monitoring.*

- The current position against **targeted interventions** was discussed including the scale and ageing profile of open complaints and the inspection positions. The need for stronger evidence-based assurance and consideration of corresponding improvements in risk reduction was highlighted.
- Subject to a further discussion with Members on potential improvements to the role and responsibilities section and an amendment to a legacy position on the Membership, the **QSEC Terms of Reference (Appendix 1)** were approved.
- A powerful **patient story** presentation 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 has** been reformatted following previous Committee feedback. A reduction in complaints was noted, leading to questions about whether this reflected genuine improvement or reduced feedback. The decrease has resulted from an internal re-categorisation exercise, with some issues now recorded as enquiries dealt with at first contact, with the Committee informed that complaint numbers are beginning to rise again. Concerns were raised 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** (Appendix 2) that has been 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 will be shared with the Board for final approval. 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.
- 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 improving customer service processes.
- Detailed information on compliance with statutory safeguarding requirements was shared as part of the **Safeguarding Update Report**. 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 is compliant with statutory requirements, and the extension is to ensure a robust review can be undertaken with the newly appointed Head of Safeguarding starting in post.
- The progress made against recommendations from the Public Services Ombudsman of Wales investigation into the **epilepsy pathway for patients with a learning disability (LD**) was presented. The Committee took assurance from the continued work of the LD Epilepsy Task & Finish Group and agreed to receive

a further update at a future meeting for full assurance on equity, access and variation.

- The **Estates and Facilities Clinical Care Group** has made significant progress in structuring its business, improving governance, and documenting risks comprehensively in the last twelve months. The priority for the coming year is 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 is an organisational change process underway to strengthen rota arrangements to provide a 7 day a week cleaning service and the team is working closely with Trade Unions to support staff as much as possible.
- The significant work underway to implement the Listening to People Regulations was discussed as part of the **Listening and Learning Sub Committee (LLSC)** report. 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** have 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.
- **Policy 429 Management and Distribution of Safety Alerts and Notices** was approved.

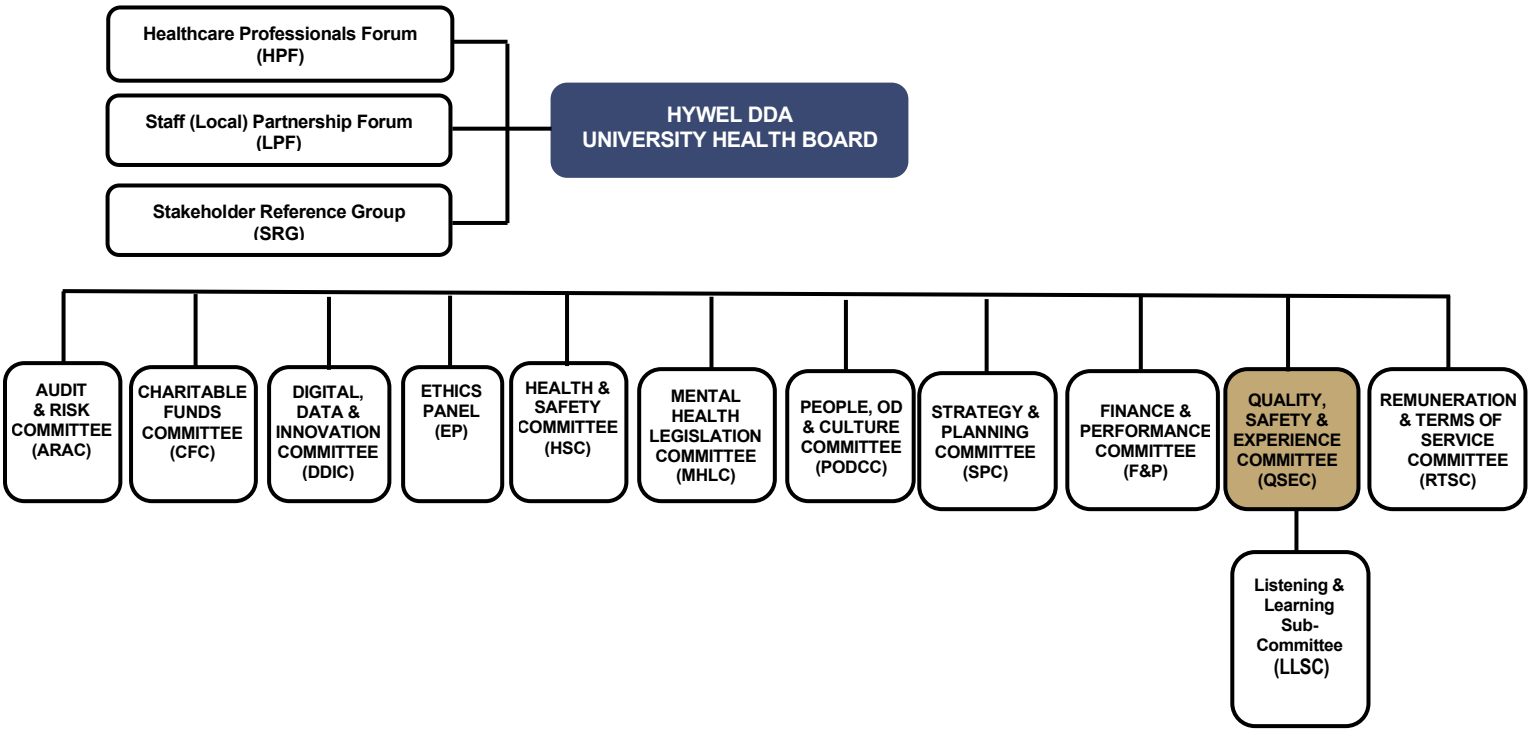
Recommendation/ Argymhelliad

The Board is asked to:

- **Approve** the Terms of Reference (Appendix 1)
- **Approve** the Health Equity Assessment Toolkit (Appendix 2)
- **Note** the items the Committee is advising them of
- **Take assurance** from the items that the Committee is providing assurance on

Date of next meeting/ Dyddiad y cyfarfod nesaf: 9 April 2026

Agenda, papers and minutes are available on our website/ Mae agenda, papurau a chofnodion ar gael ar ein gwefan: Quality, Safety and Experience Committee



TERMS OF REFERENCE

QUALITY, SAFETY & EXPERIENCE COMMITTEE

Version	Issued to:	Date	Comments
V1	Quality Safety & Experience Assurance Committee	16.06.2015	Approved
V2	Hywel Dda University Health Board	30.07.2015	Approved
V3	Hywel Dda University Health Board	26.11.2015	Approved
V4	Quality Safety & Experience Assurance Committee	18.10.2016	Approved
V4	Hywel Dda University Health Board	26.01.2017	Approved
V5	Quality Safety & Experience Assurance Committee	20.02.2018	Approved
V5	Hywel Dda University Health Board	29.03.2018	Approved
V6	Quality Safety & Experience Assurance Committee	05.02.2019	Approved via Chair's Action 20.03.2019
V7	Hywel Dda University Health Board	28.03.2019	Approved

V8	Hywel Dda University Health Board	26.03.2020	Approved
V9	Quality Safety & Experience Assurance Committee	07.04.2020	Approved via Chair's Action on 18.05.2020
V.9	Hywel Dda University Health Board	28.05.2020	Approved
V10	Quality Safety & Experience Assurance Committee	02.02.2021	Approved
V11	Hywel Dda University Health Board	25.03.2021	Approved
V12	Hywel Dda University Health Board	29.07.2021	Approved
V13	Quality Safety & Experience Assurance Committee	22.06.2022	Approved
V13	Public Board	28.07.2022	Approved
V14	Quality, Safety and Experience Committee	13.06.2023	Approved
V14	Hywel Dda University Health Board	27.07.2023	Approved
V15	Quality, Safety and Experience Committee	11.06.2024	Approved
V15	Hywel Dda University Health Board	25.07.2024	Approved
V16	Hywel Dda University Health Board	30.01.2025	Approved (alongside the new governance arrangements)
V17	Quality, Safety and Experience Committee	10.06.2025	Approved
V17	Hywel Dda University Health Board	31.07.2025	Approved
V18	Quality, Safety and Experience Committee	14.08.2025	Alongside the new Quality & Safety Governance Arrangements
V19	Quality, Safety and Experience Committee	12.02.2026	For approval
V19	Hywel Dda University Health Board	26.03.2026	For approval

QUALITY, SAFETY & EXPERIENCE COMMITTEE

1. Constitution

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

2. Principal Duties

The purpose of the Quality, Safety & Experience Committee is to:

2.1 Provide the Board with assurance that care across the Health Board is safe, timely, efficient, effective, equitable and person-centred, aligned to the twelve Health and Care Quality Standards and the strengthened statutory Duty of Quality introduced through the Health and Social Care (Quality and Engagement) (Wales) Act 2020.

2.2 Scrutinise performance and patient and population impact and outcomes, and risks, ensuring that the Health Board continually meets its obligations under the Act to consider, monitor, and improve the quality of health services in all decision-making.

2.3 Offer timely, evidence-based advice, and ensure effective and robust governance, strategies and delivery plans are in place to continuously improve the quality and safety of services in line with organisational objectives and the statutory duties of Quality and Candour established by the Act.

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 risks within the Corporate Risk Register (CRR) and Operational Risk Registers (including for hosted services and through partnerships and Joint Committees as appropriate) aligned to the Committee and its sub-committees, and report any areas of significant concern e.g. where risk tolerance is exceeded, lack of timely action. Where risks cannot be brought within the Health Board's risk appetite/tolerance, recommend acceptance of risks to the Board.

3.3 Receive assurance through Sub-Committee Update Reports and other management/task & finish group 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).

3.4 Ensure the right enablers are in place to promote a positive culture of quality improvement based on best evidence.

3.5 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.

3.6 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.

3.7 Receive assurance on delivery against the areas of targeted intervention, and the required elements for de-escalation, that are aligned to the Committee.

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

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

3.10 Provide assurance to the Board in relation to its responsibilities for the quality and safety of mental health, primary and community care, public health, health promotion, prevention and health protection activities and interventions in line with the Health Board's strategies.

3.11 Ensure that the organisation is meeting the requirements of the Health and Social Care (Quality and Engagement) Act and recommend the Annual Duty of Quality and Duty of Candour Reports to Board for approval as soon as reasonably practicable after the end of each financial year.

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 Seek assurance on the delivery of the requirements arising from the Health Board's auditors, inspectorates and regulators, Welsh Government and professional bodies.

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 annual work plans for any Sub-Committees which has delegated responsibility from the Quality, Safety and Experience Committee and oversee delivery and monitor the impact on patients of the Health Board's services and their quality.

3.26 Refer matters which fall within the remit of other Committees.

3.27 Seek assurance on delivery against all Planning Objectives aligned to the Committee, in accordance with the Board approved timescales, as set out in the Health Board's Annual Plan, considering, and scrutinising the plans and programmes that are developed and implemented, supporting and endorsing these as appropriate.

4. Membership

4.1 The membership of the Committee shall comprise:

Member
Independent Member (Chair)
Independent Member (Vice-Chair)
3 x Independent Members (which will include a Member of the Health and Safety Committee and the People, Organisational Development & Culture

Committee)

4.2 The following should attend Committee meetings:

In attendance
Executive Director of Nursing, Quality & Patient Experience (Lead Executive)
Executive Medical Director (Chair of Listening and Learning Sub Committee)
Chief Operating Officer
Executive Director of Allied Health Professions & Health Science
Executive Director of Public Health
Deputy Director of Nursing Quality & Patient Experience
Head of Quality and Governance
Associate Medical Director Quality & Safety
Assistant Director, Legal Services/Patient Experience
Assistant Director of Nursing, Quality and Assurance
Llais Cymru/ Citizens Voice Body Representative (not counted for quoracy purposes)

4.3 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.

6. Agenda and Papers

6.1 The Committee Secretary is to hold an agenda setting meeting with the Chair and/or Vice Chair and the Lead Director, at least **six** weeks before the meeting date.

6.2 The agenda will be based around the Committee work plan, identified risks, matters arising from previous meetings, issues emerging throughout the year, and requests from Committee members. Following approval, the agenda and timetable for request for papers will be circulated to all Committee members.

6.3 All papers must be approved by the Lead/relevant Director.

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

6.5 A draft Table of Actions will be issued within **two** days of the meeting. The minutes and Table of Actions will be circulated to the Lead Director within **seven** days to check the accuracy, prior to sending to Members (including the Committee Chair) to review within the next seven days.

6.6 Members must forward amendments to the Committee Secretary within the next **seven** days. The Committee Secretary will then forward the final version to the Committee Chair for approval.

7. In Committee

7.1 The Committee can operate with an In Committee function to receive updates on the management of sensitive and/or confidential information.

8. Frequency of Meetings

8.1 The Committee will meet bi-monthly and shall agree an annual schedule of meetings. Any additional meetings will be arranged as determined by the Chair of the Committee in discussion with the Lead Executive.

8.2 The Chair of the Committee, in discussion with the Committee Secretary, shall determine the time and the place of meetings of the Committee and procedures of such meetings.

9. Accountability, Responsibility and Authority

9.1 Although the Board has delegated authority to the Committee for the exercise of certain functions, as set out in these Terms of Reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens, through the effective governance of the organisation.

9.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

9.3 The Committee shall embed the UHB's vision, corporate standards, priorities and requirements, e.g. equality and human rights, through the conduct of its business.

9.4 The requirements for the conduct of business as set out in the UHB's Standing Orders are equally applicable to the operation of the Committee.

10. Reporting

10.1 The Committee, through its Chair and Members, shall work closely with the Board's other Committees, including joint and 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, subject to the approval of the Board, 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 meeting providing an assurance on business undertaken on its behalf. The Sub-Committees reporting to this Committee are:

10.3.1 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 financial year.
10.4.2 Bring to the Board's specific attention any significant matter under consideration by the Committee.
10.4.3 Ensure appropriate escalation arrangements are in place to alert the Health Board 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 Health Board.

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 Director of Corporate Governance/Board Secretary.

12. Review Date

12.1 These terms of reference and operating arrangements shall be reviewed on at least an annual basis by the Committee for approval by the Board.

EQUITY CHECKLIST

	Yes	Unsure	No
DOES THIS PROPOSAL CONSIDER ACCESS FOR...			
			
Populations living in the most deprived communities? (Consider communities in the most deprived 20% of WIMD)			
Those with protected characteristics (Equality Act, 2010)?			
Vulnerable and inclusion health groups *(e.g. homeless, gypsy, Roma and traveller communities, sex workers, people in contact with the justice system*)?			
Rural populations?			
Those who miss appointments on a regular basis?			
Those who access urgent care on a regular basis for conditions that could be managed in the community?			
WILL THIS PROPOSAL ADDRESS PREVENTION...			
			
Through assessing the specific health risks and needs of our most vulnerable groups?			
By raising awareness of the risk factors for certain health conditions, promoting healthy lifestyles, and improving the availability of preventative services (e.g. smoking cessation services, vaccinations)			
Through promoting screening and early detection and addressing disparities in uptake/ coverage between groups.			
Through improving care for those already suffering from chronic conditions (e.g. improving access and support mechanisms, monitoring outcomes in key groups)			
DOES THIS APPROACH OPTIMISE INTERVENTIONS AND ASSESS EFFECTIVENESS...			
			
Through using data to understand key factors in the local population that may contribute to poor health or high service utilisation. *(e.g. an ageing population, areas of deprivation, higher prevalence of lifestyle risk factors)*?			
Through systematically assessing impact on inequalities and monitoring changes over time? (e.g. results from pilot testing, evaluation, research, establishing benchmarks)			
Ensuring the resource /financial implications of the proposal are considered (e.g. workforce demand, skills, training, and programme costs)?			
DOES THIS APPROACH CONSIDER PARTNERSHIPS AND SOCIAL ACCEPTABILITY THROUGH ...			
			
Strengthening and expanding partnerships to enhance health equity? (e.g. multi-sectoral, community working)			
Working with those that are likely to be affected by the proposal? (e.g. Collaboration, coproduction, engagement)			
Making a commitment to health equity through the development of inclusive policy and practice that is fair and transparent?			
Ensuring that organisations and teams understand their responsibilities when tackling inequalities?			
Collecting data to monitor patient/service user experience?			
COULD THIS APPROACH WIDEN INEQUALITIES BY...			
			
Not tackling the full spectrum of causes (e.g. behavioural risk factors, social determinants)?			
Not being co-designed (e.g. engaging stakeholders)?			
Relying on professional led interventions (e.g. can reinforce existing structures & barriers)?			
Not recognising the economic impact of ill health and treatment (e.g. travel cost, time off work)?			
Failing to ensure that health information is delivered in a way that empowers people to make informed decisions to meet their needs? (e.g. Health literacy, communications strategy)			

RECOMMENDATIONS:

Decisions should be based on the nature of the impact (e.g. specific population groups or those with certain conditions are excluded).

Which of the following recommendations apply to your initial assessment using the EQUITY CHECKLIST?

RECOMMENDATION 1. There is likely to be only negligible or small health impacts following the implementation of this proposal. The effect is expected to be small and will not have an impact on equity	**There is no need to adjust the proposal or to proceed to the comprehensive EIA. It may be useful to think about how this proposal will be monitored over time and what actions should be taken if a differences in health outcomes occur.**
RECOMMENDATION 2. There is likely to be some potential effect because of the proposal. There is no need to adjust the proposal or to proceed with a full Health Equity Impact Assessment.	**There is no need to adjust the proposal or to proceed with the comprehensive EIA, however, it is important to think about the key areas where a potential difference in outcomes may occur e.g. some groups have not been fully considered or there has been a lack of engagement with partners/service users). Ensure you develop a strategy to monitor health outcomes and consider what actions should be taken if a difference in health outcomes occur.**
RECOMMENDATION 3. There is likely to be a significant effect on health outcomes. Further analysis should be undertaken to address the difference and identify any unmet needs.	**Go to STEP 4 and complete the comprehensive EQUITY IMPACT ASSESSMENT**