



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

ChaDate **2025-06-10**
Time **09:30 - 12:30**
Location **Microsoft Teams Meeting/ Ystwyth Boardroom; Ystwyth Board
Room Avocor (Hywel Dda UHB - Generic Account)**

Quality, Safety & Experience Committee Meeting

HDD_Quality, Safety & Experience Committee

NHS Wales

Agenda - 10 June 2025

1 Governance

09:30, 15 min

1.1 Declarations of Interest

Anna Lewis (Hywel Dda UHB - Independent Board Member)

1.2 Minutes from the Previous Meeting and Table of Actions

Anna Lewis (Hywel Dda UHB - Independent Board Member)

1.3 Targeted Intervention Progress Report- Executive Leads

1.4 Patient/ Staff Story- Unscheduled Emergency Care

Louise O'Connor (Hywel Dda Health Board - Assistant Director)

1.5 QSEC Terms of Reference for Annual Review

Anna Lewis (Hywel Dda UHB - Independent Board Member)

2 Risk

15 min

2.1 Corporate Risk Report- Executive Leads

2.2 Occupational Therapies Paediatric Improvement Action Plan - Deferred

Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Angela Bell (Hywel Dda UHB - Assistant Director Quality, Safety + Patient Experience for Allied Health + Health Sciences)

3 Break

10 min

4 Assurance

1 hr 30 min

4.1 Fragile Services Report

Sharon Daniel (Hywel Dda UHB - Executive Director of Nursing, Quality & Patient Experience), Mandy Davies (Hywel Dda UHB - Assistant Director of Nursing & Quality Improvement)

4.2 Auditor General Report on Cancer Services

Paula Goode (Hywel Dda UHB - Service Director for Planned and Specialist Care)

4.3 Quality Assurance Report

Cathie Steele (Hywel Dda UHB - Interim Assistant Director of Nursing Assurance and Safeguarding)

4.4 Duty of Candour Report 2024/25

Cathie Steele (Hywel Dda UHB - Interim Assistant Director of Nursing Assurance and Safeguarding)

4.5 Quality, Safety and Experience Sub Committee and Annual Report 2024/25

James Severs (Hywel Dda UHB - Executive Director of Allied Health Professions and Health Science)

4.6 Listening and Learning Sub Committee Update Report, Annual Report 2024/25 and Patient Experience Framework

Louise O'Connor (Hywel Dda Health Board - Assistant Director)

4.7 CHKS Report

Subhamay Ghosh (Hywel Dda UHB – Associate Medical Director For Quality & Safety)

4.8 Getting it Right First Time Governance Review

Joanne Wilson (Hywel Dda UHB - Director of Corporate Governance/Board Secretary)

4.9 Cleanliness Standards Audit report and Action Plan- Deferred

Simon Chiffi (Hywel Dda UHB - Head of Operations), Elin Brock (Hywel Dda UHB - Head of Research, Innovation & Improvement), James Severs (Hywel Dda UHB - Executive Director of Allied Health Professions and Health Science)

4.10 Nurse Staffing Levels Spring Cycle

Helen Humphreys (Hywel Dda UHB - Head of Nursing for Professional Standards and Regulation), Sharon Daniel (Hywel Dda UHB - Executive Director of Nursing, Quality & Patient Experience)

5 Risks and Matters for Escalation to Board

Anna Lewis (Hywel Dda UHB - Independent Board Member)

6 For Information

6.1 QSEC Work Plan 2025/26

6.2 Joint Commissioning Committee Quality and Safety Highlight Report

7 Date of Next Meeting : 14 August 2025

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1 - Governance

1.1

09:45,

1.1 - Declarations of Interest

*Anna Lewis (Hywel
Dda UHB -
Independent Board
Member)*

1.2

1.2 - Minutes from the Previous Meeting and Table of Actions

*Anna Lewis (Hywel
Dda UHB -
Independent Board
Member)*

Attachments

[2025-04-08 - Quality Safety Experience Committee Meeting - Minutes for a~.pdf](#)

[Table of Actions QSEC 8 April 2025.pdf](#)

Draft Minutes Quality, Safety & Experience Committee

Date of Meeting: **09:30, Tuesday 08 April 2025**
Venue: **Microsoft Teams Meeting/ Ystwyth Boardroom**

Present: Anna Lewis, Independent Member and Chair of the Committee
Eleanor Marks, Vice Chair of the Health Board and Committee
Chantal Patel, Independent Member
Michael Imperato, Independent Member

In Attendance: Amanda Glanville, Assistant Director of People Development
Andrew Carruthers, Chief Operating Officer
Ardiana Gjini, Director of Public Health
Cathie Steele, Interim Assistant Director of Quality and Assurance
James Severs, Director of Allied Health Professions and Health Science
Joanne Wilson, Director of Corporate Services (Board Secretary)
Karen Brown, Clinical Lead Unscheduled Care
Mandy Davies, Assistant Director of Nursing, Quality Improvement
Mark Henwood, Interim Medical Director
Rhian Bond deputising for the Director of Primary Care, Community and Long-Term Care
Peter Skitt, Clinical Care Group Service Director - Community & Integrated Medicine
Rebecca Temple- Purcell, Assistant Director of Nursing, Mental Health and Learning Disabilities
Sam Dentten, Llais Cymru Representative
Sharon Daniel, Director of Nursing, Quality and Patient Experience
Subhamay Ghosh, Associate Medical Director of Quality and Safety

Apologies: Louise O'Connor, Assistant Director of Legal and Patient Experience

Minutes Ref.	Item	Action
	Governance	
	Declarations of Interest	
	No declarations of interest were received.	
QSEC 25 (01)	Minutes from the Previous Meeting and Table of Actions	
	In terms of matters arising, Ms. Anna Lewis passed on heartfelt congratulations to Mrs. Sharon Daniel on her successful appointment into the substantive role as Executive Director of Nursing, Quality and Patient Experience within the Health Board.	

The Committee welcomed Ms Eleanor Marks and Mr Michael Imperato as new Members following a recent reallocation of Committee Membership.

Referring to Action QSEC 24 (97) which is relating to the review of workforce models within the Midwifery Sonography services in order to mitigate risks, Mrs Chantal Patel queried the outcome of the review as the action is marked complete. Mr Carruthers explained that the review of the skill mix and resource allocation is ongoing within the service. The progress of the work will be monitored via the internal Quality, Safety Intelligence Group.

RESOLVED: The minutes of the previous meeting were approved as an accurate record.

QSEC 25 (02) QSEC Annual Report 2023/24

RESOLVED: The QSEC annual report 2024/25 was received and approved by the Committee.

QSEC 25 (03) Targeted Intervention (TI) Progress Report

Mrs. Sharon Daniel presented the TI report which she believes provides a comprehensive update of areas that have been escalated to Targeted Intervention status by Welsh Government and fall under the remit of quality and safety. Mrs. Daniel highlighted that since the previous report, two criteria have been de-escalated from 'alert' to 'advise' status which relate to actions in response to external reviews and recommendations. For the areas that have not de-escalated within the report, sustainable improvement is being monitored prior to decision making on de-escalation.

In terms of the Health Board's participation with national clinical Audits which has been raised as an area of concern within the report, Mrs. Daniel recognised there is a piece of work to do on strengthening reporting in this space. Clinical audits will be reporting via the Clinical Care Groups as part of future reporting requirements and the Audit and Risk Assurance Committee will continue to monitor Clinical Audit activity, including the continuation of the majority of mandatory national audits and escalate when appropriate.

IB/ SD

Highlighting that this has come as somewhat of a surprise to the Committee, Ms. Lewis queried whether audits are generally being overlooked or whether there are concerns that information has been requested from services and not acted upon. Mrs. Daniel felt that capacity issues are regularly raised.

Ms. Lewis asked whether there is a level of confidence that nothing else is being overlooked as part of the TI criteria for de-

escalation and Mrs. Daniel confirmed that TI criteria continues to be monitored by Executive Leads and action undertaken where necessary, and this is helpfully supported by Mr. Shaun Ayres, TI Lead.

Mrs. Chantal Patel queried whether the Health Board has now been de-escalated to 'Enhanced Monitoring' status for quality domains. In response Mrs. Daniel advised that although progress has been recognised in several areas such as complaints management and incidents, the 'quality' domains have not de-escalated. Recent discussions with Welsh Government have suggested there is a need to demonstrate sustainability in a number of areas such as Healthcare Acquired Infection rates.

Referring to Criterion 32, 33, 35, Mr. Imperato sought clarity on the definition of 'Limited evidence of a centralised methodology for integrating disparate elements into a coherent assessment of service vulnerability' highlighting the complexity of how this has been phrased. Mrs. Daniel advised that this relates to the process in place to identify and monitor fragile services. Mrs. Daniel explained that the Health Board are required to evidence that the fragile services monitoring processes are established and effective via the Directorate Improving Together sessions and Mr. Henwood added that the Fragile Services Framework has not yet been finalised by Executive Team. Noting Mr Imperato's point regarding the phrasing within the report, Ms. Lewis commented that the language used within the report is somewhat opaque for those who may not be directly involved with the Targeted Intervention process.

Commenting on the significant remedial work that has taken place in response to Targeted Intervention, Ms. Lewis asked for more information on the plan to transition from this point to a business as usual position, and timescales for this. In response, Mrs. Daniel reflected that a number of processes are already embedded in practice, for example the revised quality metrics 'Safety Dashboard' which monitors complaints and emerging hot spots across services. Highlighting the revised operational governance arrangements, the Clinical Care Groups will monitor performance of areas aligned with the T.I domains, and Integrated Quality Finance Performance Delivery (IQFPD) will escalate any emerging areas of concern.

Drawing attention to the incomplete 'Speak Up Safely' section on the TI report which suggests further work is required in this space, Ms Lewis suggested that the People, Organisational Development and Culture Committee (PODCC) (as the owning Committee) are asked to receive an update and share the outcome with QSEC if necessary. Ms. Marks, as the new Chair of the Committee agreed. On this subject, Mrs. Patel provided feedback from a recent medical conference that the 'Speak up Safely' service is not available during out of hours/ night shifts, and in response Ms. Lewis suggested availability of the service is also clarified within the PODCC report. Ms. Steele provided assurance that as well as

Speak up Safely there are various platforms that allow staff to raise concerns however noted that staff awareness of these mechanisms may need strengthening.

In terms of the Healthcare Acquired Infection data, Ms. Lewis noted the low numbers that the Health Board are reporting and finds it challenging to draw conclusion on what may be an improving position or just a natural fluctuation. In agreement, Mrs Daniel stated that there has been no significant reduction or increase in this space, however the number of outbreaks and whether there are any areas of recurring incidents is continually monitored. Ms. Lewis suggested review of the quality indicators in the TI report to provide a more rounded understanding of improvement or deterioration in this space.

Decision: The Committee received assurance from the report.

QSEC 25 (04) Patient Story- Unscheduled Emergency Care

Ms Karen Brown presented a patient story from the Integrated Unscheduled Emergency Care service. The story provided the experience of a 72-year-old male whose wife called Emergency Services due to him suffering with shortness of breath. The Welsh Ambulance Service Trust (WAST) crew arrived and the patient became stable but needed assessment due to fluid in the legs and lungs. A discussion took place with Same Day Emergency Care (SDEC) clinical Co-ordinator and the patient was accepted for assessment. The patient was treated via the Hospital at Home virtual ward service.

The patient was visited by the Advanced Clinical Practitioner and Physician's Associate from the CATCH team and the patient improved clinically. The patient and wife were happy with the alternative to hospital admission and felt that the wider team listened to their concerns, and felt supported.

The Committee noted that the SDEC service is funded on a fixed term basis via the 6 Goals Programme and is a Monday to Friday, five day a week service.

Decision: The Committee considered the patient story alongside item 2.1 on the agenda.

QSEC 25 (05) Unscheduled Care Deep Dive

Mr Peter Skitt joined Ms Brown to present the Unscheduled Care Deep Dive report. Reflecting upon previous discussion regarding the TI requirements to define fragility, Mr Skitt felt it could reasonably be argued that Unscheduled Care Services is currently the most fragile service across the Health Board, particularly Emergency Departments with the significant overcrowding and workforce challenges. Mr Skitt recognised the value the GP Out of Hours service has played a big part in reducing hospital admissions during evening and weekends however due to the

nature of the service there continue to be capacity challenges where GP home visits may be required. Members noted an improved position for district nursing capacity at weekends which is positive however there is a need to consider the continuation of the SDEC model. Mr Skitt emphasised that while work continues to mitigate the risks being faced at UEC, it is clear that a whole system transformation is needed to make the necessary changes to provide an appropriate service.

Drawing members' attention to the performance trajectory within the report, Mr Skitt highlighted that there was an improved position in waiting times during the winter pressures of 2024, however this was due to the significant work and extra hours undertaken by staff to and reflected that this was more of a holding position as opposed to a true picture of improvement. It was positive to note that more patients are presenting via the SDEC pathway which is having a positive impact on admission levels however community wrap around services need strengthening to give people the confidence to stay at home where possible and not present back to UEC services should deteriorating occur.

Mandy Davies joined the meeting.

In terms of patient flow, Mr Skitt advised that the report also provides information on the revised Hospital Flow framework with several measures introduced such as discharge toolkits for staff.

Mr Skitt drew attention to the Getting it Right First Time Reports and action plans following review of the Health Board ED departments. The findings, although upsetting to absorb, have not been surprising, and work continues to address fragilities, particularly around the staffing position for ED Consultants, and overcrowding issues. Multi agency regional stakeholder meetings are underway to try and develop an approach for whole system transformation which will include strengthening community models.

On behalf of Llais Cymru, Mr Samuel Dentten shared wholehearted support for the transformation proposals in this space and highlighted that it is positive to see a whole system response to this systemic issue. Mr. Dentten highlighted that as transformation unfolds communication with the public will be essential to ensure there is a common understanding that the healthcare model is going to look different in the future to what people are used to, and Llais will be keen to collaborate with colleagues on this journey.

In agreement, Mr Carruthers commented that it is widely recognised that the standard of service currently being provided to patients is not acceptable and requires change. Mr. Carruthers updated Members that the previous week the Health Board experienced two of the busiest days in the Glangwili Accident and Emergency department, with 184 attendances the previous Friday. Mr Carruthers advised that a more focused approach is

being considered over the next twelve months collectively between Executive Leads, to gain traction in the transformation space and there will be involvement required from all services. Ms Lewis raised the immediate concern while the transformational work is undertaken, regarding the current clinical impact on patients due to the challenges with the UEC model.

In response to Ms Lewis' question regarding patient outcomes in the meantime, Ms Karen Brown shared the national statistic that patients who spend more than 12 hours in ED are twice as likely to die than those treated or transferred or discharged within 2 hours as there is a risk of not knowing the level of acuity of unwell patients due to workforce challenges and overcrowding. Ms Brown emphasised that the challenges in ED are part of wider system pathway challenges and agreed with Mr Carruthers that all services need to be involved with change. Ms Lewis highlighted that this type of local statistical data, aligned with research evidence, will be compelling and is likely to amplify the Board's appetite for strategic change.

In terms of the service impact due to challenges in A&E, Mr. Peter Skitt felt that the wider Multi-Disciplinary Team 'Big Room discussions' that are being undertaken on a regular basis are proving to be helpful, with learning being actively shared. The meetings have been valuable for MDT solutions for issues. The way the teams are working together has been encouraging and shows engagement in the change process.

Mr Carruthers reflected upon a service visit undertaken to Urgent Care Services in Denmark, and felt there are opportunities for learning from this model as significant elements of the service configuration were consistent with what Hywel Dda aims to achieve. Mr. Carruthers feels that the step change needs to be bold and brave and based on learning undertaken.

Reflecting on the current challenges, Mr Imperato commented that the strategic and immediate answer to the challenges is to reduce patient presentation at ED's, and communicating this to the population is key given the significant pressures. **AC/PS**

Dr Gjini noted Ms Lewis' suggestion for more tangible statistical data to be shared with Board for strategic change discussions, however issued caution that as the statistic Ms Brown shared comes from a Health Care service in England, collating similar data for a smaller demographic may make the outcome less reliable and it may be more impactful to share national research information. In response to Mr Imperato's point regarding reducing footfall at A&E, Dr Gjini explained that the Social Model for Health Charter will strengthen community resilience, provide alternative options and empower the public to make appropriate choices for health care.

Noting Dr Gjini's comment regarding clinical outcome data, Ms Lewis agreed that if the reliability of the sample size is found to not

be sufficient, then this can be accepted as a legitimate outcome of the enquiry, however Ms Lewis would encourage exploring this further. Ms Lewis felt it will be a helpful shift from hearing the big national headlines, to an understanding of the local clinical outcomes for the West Wales population which is likely to gain local support and momentum for the need for change.

Ms Brown informed the Committee that an internal audit has been undertaken during the busiest day of the year in 2023 following the journey of approximately 500 patients. The findings showed that 50% of patients would have been supported better in an alternative healthcare pathway and more concerningly half of those patients were directed to A&E by healthcare professionals. Ms Lewis felt it will be helpful to pull the key headlines from these findings when the strategic direction of UEC is discussed at Public Board. Ms Lewis asked that the timescales for the revised strategic approach are provided at the next meeting via the Table of Actions.

PS

Decision: The Committee agreed to advise Board.

Assurance

**QSEC 25
(05)**

Mental Health and Learning Disabilities (MHL) Deep Dive

Ms Temple Purcell presented a deep dive into the MHL service. Members noted that the revised Mental Health and Wellbeing Strategy (2024- 2034) is being published during April 2025 to replace the previous ten year Together for Mental Health Strategy and will include plans for delivery. Ms. Purcell shared that the Directorate are heavily engaged with the national strategic discussions and highlighted that a national Patient Safety Programme has been introduced for adult inpatient wards across Wales.

In terms of the Health Boards internal escalation framework, the MHL Clinical Care Group is currently at Level 3 escalation for both quality and governance domains. The areas for improvement identified include complaints management and the length of time complaints are open, which is an ongoing piece of work for improvement. In terms of the incident data within the report, Ms Purcell explained that incidents are often linked with the Serious Untoward Incidents procedure and the investigation process takes place which can cause delays. Action plans are in place to improve the quality of care provided and robustness of governance mechanisms to meet expected standards. The Clinical Care Group is developing a quality dashboard which will include a wider range of quality metrics and more targeted breakdown of incident categories.

Providing an update on closure of overdue actions from external audits, reviews, inspections and peer review reports, Ms Purcell advised that the Clinical Care Group currently has 9 open

improvement plans, in response to recommendations generated from a range of external inspections/reviews. Many actions relate to strategic developments that have been delayed due to service capacity challenges, but work continues to make improvements.

Ms Purcell noted the risk relating to adults' access to psychological therapies. The Health Boards performance to ensure that 80% of adults referred for psychological therapy begin treatment within 26 weeks remains below target and this is undergoing regular scrutiny and monitoring. Some significant improvements have been noted however the target is not being met and this is under review for improvement.

Thanking Ms Temple Purcell for the comprehensive report, Ms Lewis queried more generally, whether the national vision for Mental Health services could be more ambitious. Providing feedback from a recent national conference event she attended with Mental Health leads, Ms Purcell was in fact struck by the level of ambition shared from peers across Wales. Ms Purcell advised that it is widely recognised that in terms of the strategic vision, Health is only one part of the wider picture, and success will depend on the strengthening of community and person-centered support mechanisms that will support people to avoid reaching crisis point. A number of approaches are being looked at including peer support and recovery colleges for example. Dr Gjini reiterated that the Social Model for Health Charter aims to build resilience in communities.

Ms Purcell is keen to champion Hywel Dda taking forward innovative pilot opportunities and is actively engaging with national leads around this. Providing an example of innovative areas being considered, Ms. Purcell shared the benefits of a user friendly shared digital platform used in Australia that is a portal for accessing different support options for service users. Discussion took place regarding the significant work undertaken in 2018 on Transforming Mental Health (TMH), and there was a lack of understanding about why the Programme did not reach its maximum potential and a need to ensure the learning from this has not been lost. Ms Lewis urged the service to be ambitious and innovative in its transformation agenda rather than waiting for national direction. Mr Carruthers shared that learning from the TMH Programme is being fed through the current review of UEC model, for example the success of the NHS 111 press 2 for Mental Health service.

Ms Lewis noted the helpful update and quality impact assessment shared relating to the Ceredigion Community Mental Health Team temporary service changes, and a further discussion will take place with the Lead Executive for the Committee on how the impact on quality, safety and experience will be monitored by QSEC going forward.

Decision: The Committee received assurance from the information presented in this report.

QSEC 25 (06) Primary Care Quality and Safety and Experience Deep Dive

Ms Rhian Bond presented the key highlights from the Primary Care Update Report including the following:

- A new Contract Assurance Framework for General Medical Services (GMS) has been developed nationally to provide assurance of delivery of the GMS Unified Contract.
- Concern has been raised regarding the increase of community pharmacy closures. Seven out of the eight breaches considered at the most recent Formal Breaches panel relate to one Pharmacy Contractor. A meeting has been arranged with the Contractor's Superintendent Pharmacist to understand the reason why locum cover has not been put in place and agree a way forward to avoid future closures due to patient impact.
- Ongoing challenges with emergency access pressures for dental care. 17,260 of appointments currently provided are in relation to urgent care which accounts for 20% of all appointments.
- 40% of Dental Practices report Dentist vacancies; with a reported trend of Dentists choosing to work privately. The Dental Commissioning Plan has been prepared and is aligned to the developing Primary Care and Community Services Strategic Plan and the HEIW Dental Workforce Plan. The Dental plan includes an investment of £1.672m in 2025/26 and £2.775m in 2026/27.
- The Health Board is participating in a pilot to extend the use of CIVICA into Primary Care. The pilot will take place in the Carmarthenshire Managed Practices in the first instance and the findings will be monitored.

In terms of the Health Board acquiring GMS contracts, Mrs Chantal Patel queried whether opportunities are occasionally revisited. Ms Rhian Bond confirmed that this has taken place for Tenby Surgery and Ashgrove Surgery but unfortunately this has been unsuccessful. Ms Bond updated Members that the Strategic Plan for GMS will be refreshed as part of the Primary and Community Strategy. On a positive note, Ms Bond updated Members that all staff at Tenby and Ashgrove Surgery are NHS salaried staff and there is no longer a regular reliance on locum GPs.

Thanking Ms Bond for the improvements in the level of intelligence contained within the report since a similar update was presented to Quality, Safety and Experience Sub Committee, Mr Severs offered constructive challenge for the Directorate to progress local metrics rather than waiting for national guidance for quality, safety and experience data collation such as the monitoring the compliance of screening programs etc. Mr Severs

offered support as Chair of the Sub Committee in changing the focus of the content from contract and performance to quality, safety focused metrics and asked that this is undertaken via Integrated Quality Finance and Performance Delivery Group. Thanking Mr Severs for the feedback, Ms Bond informed the Committee that a number of Enabling Quality Improvement in Practice Projects have been identified, and the team are progressing these initiatives. Members also noted that the quality, safety and governance structures are being strengthened.

Mr Imperato reflected upon the content of the report, and in terms of the community pharmacies closure information asked whether it would be possible for future reporting to include pharmacy coverage, and also what services are provided for a more rounded understanding of the impact (noting that different pharmacies provide different levels of care). Ms Bond replied that they can share this information, however the current data only provides a snapshot of individual patient visits and not if patients have visited more than one pharmacy due to closures.

Ms Eleanor Marks raised concern regarding future access to NHS dental services in the community, particularly the impact on long-term health and care for children and young people. Ms Marks asked whether there is an indication of public response to the proposals from Welsh Government which would mean that they will no longer be registered with one dentist, and queried how the Health Board are positioned for these potential changes. Acknowledging the challenging question to answer during the period of uncertainty, Ms Bond explained that a consultation questionnaire has been released by Welsh Government and noted that it is quite challenging to get clear feedback from the public. Generally, it is recognised that the majority of Dental Professionals are not happy with the direction of travel, and it is likely that more NHS dentists will opt to provide private services if the changes are enacted. It is expected that the majority of Health Board's across Wales will be in the same position.

Ms. Marks reiterated concerns regarding inflated patient charges that will be unattainable for preventative care for patients, and this causes inequity for the population. The risk to reducing routine dental care for children and young people is likely to have longer term economic and health implications. In agreement, Ms Lewis confirmed that as the position evolves the Committee will expect to monitor the local impact on the population.

QSEC 25 (07) Auditor General Report on Cancer Services- Deferred.

QSEC 25 (08) Infection Prevention and Control in the Community

Dr Ardiana Gjini presented an update on Infection Prevention Control in the Community following concerns raised that the Health Board report a higher rate of healthcare acquired infections compared to other Welsh Health Boards. A piece of work was

undertaken by the Health Protection Oversight Group which found that whilst for some infections the rates for the Health Board population were higher, on the whole rates of infections and the number of community incidents were not significantly higher than other Health Boards.

Referring to the data in the report, Dr Gjini has asked for a detailed analysis of S.Aureus bacteraemia for an understanding of age standardisation as the data within the report shows higher rates in the older population. Further data collection on these and other bacteraemia, including age standardised rates across the full year (April to April) is taking place and will give a better understanding of infection rates by August 2025.

Highlighting to Members that the appendix report is duplicated within the Committee papers within the Quality Assurance Report, Ms Steele commented that it will be important that this work is undertaken as part of the Infection Prevention Control Steering Group due to the scope of work requiring involvement of the Infection Prevention Control Team.

MH/CS

Thanking Dr Gjini for the helpful report, Ms Anna Lewis commented that the data has been a welcome piece of work in response to previous concerns raised by the Committee relating to community and hospital acquired infection rates. Mrs Daniel also asked, if there is an opportunity, to carry out an analysis of sepsis rates in comparison with blood counts undertaken to benchmark and ascertain whether the Health Board is an outlier in this space.

CS/AG

The Committee noted thanks to Dr Gjini and to Dr Megan Harries for the report and to Public Health Wales colleagues.

Decision: The Committee received assurance from the information above and agreed to receive longer and more detailed feedback of the age standardised rates of community infection in August 2025.

QSEC 25 (09) Quality Assurance Report

Ms Steele presented the Quality Assurance Report.

Drawing attention to the Health Inspectorate Wales tracker, which was appended to the report, Mrs Patel highlighted that there are a high number of overdue/ partially completed actions that span over a number of years. Ms Steele advised that the spreadsheet provides an overview of partially opened actions and there is work underway with the Mental Health and Learning Disabilities (MHL) Directorate to look at how these can be resolved. Providing further context, Mrs Sharon explained that a number of the actions have been superseded by national programmes of work. In terms of the Ionising Radiation (Medical Exposure) Regulations actions, Ms Steele advised that a risk assessment

has been undertaken and Audit and Risk Assurance Committee requested that these continue to be monitored.

Ms Steele provided assurance that the team have recently undertaken a piece of work to ensure the actions are aligned to the appropriate Clinical Care Group for monitoring and escalation where appropriate.

Ms Lewis noted the Welsh Risk Pool Concerns report and action plan in place and commented that this is a strong assessment report.

The Welsh Health Circulars will be reported via the Clinical Care Groups and the approach to monitor these via QSEC is under review.

Decision: The Committee received assurance from the report.

QSEC 25 (10) Minor Injuries Unit- Prince Philip Hospital

The Committee noted the Minor Injuries Unit Prince Philip Hospital update report and took assurance that patient care has not been affected since the temporary closure of the overnight service and this is evidenced by patient engagement and feedback.

Decision: The Committee took assurance from the report that patient care has been maintained at Prince Philip Hospital during the temporary change

QSEC 25 (11) Update Report on the Improvement Strategic Framework 2023- 2026

Ms Mandy Davies presented an update on the Improvement Strategic Framework 2023-26, highlighting that this is the third year of the second phase of the Framework, and soon work will commence on revamping the 2026/ 29 Enabling Quality Improvement in Practice Programme (EQliP), therefore this is a good opportunity to reflect on next steps.

Members noted that Cohort 7 is due to start in June 2025. So far, 550 colleagues have been involved with the EQliP Programme, which has undertaken 80 projects and there are not 50 Quality Improvement Coaches across the Health Board.

Ms Davies reflected on the evolution of the Programme, which started with a focus on Quality Improvement methodology, and has now evolved and focuses on leadership and empowering staff such as the developments in the staff psychological safety initiatives. The Programme is under constant review and every step includes a Plan, Do, Study Act (PDSA) approach.

Members attention was drawn to slide 11 which highlights the range of disciplines that have been engaged with the Programme

since it started and there is an increase in projects becoming Health Board wide which provides an opportunity for spread and scale activity and shared learning. The Institute for Healthcare Improvement framework is being utilised to strengthen team working. A Quality Improvement and Service Transformation (QIST) internal SharePoint page has been developed for staff to access information and enquire about getting support. Ms Davies updated Members that workshops have taken place in each county to support with Primary Care projects. In terms of Patient Safety, Ms Davies highlighted the targeted work undertaken for the most common incident themes such as medicine management, pressure damage and falls. Ms. Davies highlighted that deconditioning is a big part of the Optimal Patient Flow Programme work and the team have been advised that morning that four additional projects have been confirmed.

While recognising the significant achievements undertaken by the team, Mrs Daniel noted the need to spread and scale more widely across the Organisation. This is being considered as part of the review of Chief Executive Objectives to look at quality improvement and service transformation more broadly, aligning with the Value Based Health Programme.

Thanking Ms Davies and Ms Daniel for the helpful update, Ms Lewis commended the extraordinary journey and exceptional leadership that has been integral to the successes of the Quality Improvement Framework. As the capability grows in the organisation, Ms Lewis queried at what point the quality improvement mindset will become embedded in day-to-day business within services. Ms Lewis also urged that the Quality Improvement Framework is aligned with transformational discussions undertaken relating to Unscheduled Emergency Care to ensure an alignment of strategic planning.

Noting the vast amount of work undertaken and learning, Mrs Patel queried whether an evaluation of the impact of the 50 quality improvement coaches has been undertaken. Ms Davies confirmed that the review of the impact of the coaches forms part of the next stages of the Programme. Early reflections have been that the coaches help make service improvements sustainable with their support. Ms Davies agreed that work is needed to evidence how the quality improvement activities undertaken by the coaches (outside of EQliP) are having an impact on quality, safety and experience. Mrs Patel added that it will be useful, as service transformations progress, for an understanding of how the coaches will be involved and support the change.

Mrs Eleanor Marks commended the slides and stated that she feels positive about the actions underway and appreciates the inclusion of patients' feedback. Ms Marks shared feedback from a recent visit to Social Care services at Eastgate, Llanelli, with the Welsh Government Minister for Social Care, who was very impressed with the revised approach to discharge management

and the successes with partnership working between Health and Local Authority.

Referring to the nutritional risk assessment data which suggests that the completion timescales differ across sites, Ms Marks queried whether improvements are being explored in this space. Mrs Daniel confirmed that risk assessments are undertaken at the appropriate point of admission, and these figures continue to be monitored by the Senior Nurse Manager Team and at the Nutrition and Hydration Group. Ms Davies also felt that the process is working well and the completion of assessments continue to show an improving trajectory. Ms Marks commented that while it is pleasing to note that there has been some increase, the data suggests that further improvement work needs consideration in this space.

MD

Noting that the Community Hub appears to be a growing service, Ms Eleanor Marks sought assurance that the service is operating efficiently. Ms Davies agreed that the service has become more popular and believes it is working effectively and this can be evidenced by the level of activity. The fundamental principle that there is a person answering the phone to co-ordinate responses in a timely way has received positive feedback and due to the success, continues to grow. Ms Davies invited Ms Marks to undertake a visit to the Communications Hub which was gratefully accepted.

Decision: The Committee noted the Update Report on the Improvement Strategic Framework 2023- 2026

QSEC 25 (11) Quality, Safety and Experience Sub Committee

Mr James Severs presented the Quality, Safety and Experience Sub Committee update report and highlighted that the revised operational governance structure will strengthen reporting arrangements over the coming months with the revised Clinical Care Group updates feeding in. Mr Severs stated that Clinical Executives are in the process of clarifying future reporting for the Health Board Advisory Groups.

Decision: The Committee noted the update report

QSEC 25 (12) Listening and Learning Sub Committee Update Report-Deferred

QSEC 25 (13) Risks and Matters for Escalation to Board

QSEC 25 (14) For Information

QSEC 25 (15) JCC Quality, Safety and Outcomes Sub-Committee Highlight Report

QSEC 25 (16) Patient Experience Report

QSEC 25 (17) Date of Next Meeting: 9:30am 10 June 2025

**TABLE OF ACTIONS FROM
QUALITY, SAFETY & EXPERIENCE COMMITTEE (QSEC) MEETING
HELD ON 8 APRIL 2025**

Reference	Item	Responsible	Timescale	Update
QSEC 25 (03)	Targeted Intervention (TI) Progress Report: <ul style="list-style-type: none"> To provide assurance on the Health Board's National Clinical Audit participation and findings at its next meeting. 	IB/ SD	June 2025	<p>Complete: Assurance on Health Board participation with national clinical audits are shared via the Audit and Risk Assurance Committee.</p> <p>The revised TI monitoring and escalation process requires all parties to provide relevant updates for their respective areas. This will reduce duplication.</p>
QSEC 25 (04)	Unscheduled Emergency Care (UEC) Deep Dive <ul style="list-style-type: none"> To consider developing local data that provides a focus on clinical outcomes/ potential harm for patients due to the current UEC service configurations challenges e.g waiting times/ overcrowding. 	AC/ PS	May 2025	<p>A local UEC Dashboard is in development to cover all aspects of Emergency Department (ED) provision as a live operational tool for in real time management.</p> <p>The 6 Goals Programme and Getting it Right First Time (GIRFT) (SEDiT data) does give an overall assessment of long waits in ED.</p> <p>The development of the accelerated approach to 6 Goals will require a further review of ED waits to enable progress before next Winter.</p> <p>In order to support the Accelerated UEC Transformation Programmes, the Executive Director of Nursing is leading a piece of work to develop a set of quality and outcome metrics for UEC, set against the Safe, Timely, Effective, Efficient, Equitable, and Patient-centred (STEEP) principles.</p>

QSEC 25 (04)	Unscheduled Care Deep Dive <ul style="list-style-type: none"> To schedule a progress update on the Emergency Department Getting it Right First Time (GIRFT) action plan on the Committees Forward Work Programme. 	PS/ KL	April 2025	Complete: Scheduled on the forward work Programme.
QSEC 25 (08)	Community Infection Prevention Update <ul style="list-style-type: none"> To engage with the Infection, Prevention and Control Steering Group (IPSSG) regarding the analytical work being undertaken on age standardisation for community infections. 	MH/ CS	April 2025	Complete: The report is scheduled as part of the IPSSG forward work Programme
QSEC 25 (08)	Community Infection Prevention Update <ul style="list-style-type: none"> To consider undertaking an analysis of local sepsis rates and number of blood counts taken against national datasets to assess whether Hywel Dda are an outlier in this space. 	AG/ MH/ RR	April 2025	Complete: The report is scheduled as part of the IPSSG forward work Programme

AC: Andrew Carruthers	CS: Cathie Steele	PS: Peter Skitt	AG: Ardiana Gjini	MH: Megan Harris	RR: Rebecca Richards
IB: Ian Bebb	SD: Sharon Daniel	KL: Katie Lewis			

1.3

1.3 - Targeted Intervention Progress Report- Executive Leads

Attachments

[QSEC - De-escalation Criteria Progress Update.pdf](#)



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**Quality, Safety and Experience Committee
De-escalation Criteria Progress Update
Tuesday 10th June 2025**

Purpose



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This paper provides the Quality, Safety and Experience Committee (QSEC) with an update on pertinent points from the Welsh Government targeted intervention and enhanced monitoring criteria for 2025/26. The information presented represents key extracts from the new targeted intervention tracker system currently under development, with the complete tracker scheduled for presentation to the next Committee. However, in the meantime the information in this presentation alongside the escalation tracker focuses on a number of key areas requiring attention.

The paper encompasses both active targeted intervention criteria where the Health Board remains under formal intervention status, and enhanced monitoring requirements for areas where de-escalation has been achieved but continued oversight is required to demonstrate sustained performance.

Important Context and Limitations



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The Committee should note that whilst the Health Board is undertaking and achieving progress across many of these criteria, there are areas where evidence gaps exist within the formal tracker documentation. This situation reflects the timing challenges between the final tracker framework being agreed with Welsh Government in May 2025, the definition of all de-escalation criteria, and the subsequent requirement to update all supporting evidence and documentation.

Some aspects of this report therefore focus on areas where evidence may not be fully documented within the tracker system. This does not necessarily mean that the relevant work, processes, or achievements do not exist within the Health Board, but rather that for the purposes of our escalation assessment, evidence must be formally contained within the tracker system to satisfy Welsh Government requirements. Without this documented evidence, the Health Board cannot formally demonstrate compliance against specific criteria, regardless of actual operational activity.

Given that the revised framework was only recently agreed, the Health Board faces particular challenges in demonstrating comprehensive evidence across all criteria within the short timeframe available. For hospital acquired infections, where targeted intervention status continues, factual performance updates can be provided as this represents ongoing monitoring with established data collection systems. However, for other domains, particularly those requiring demonstration of new processes or enhanced documentation, the evidence compilation proves more challenging given the limited time between framework agreement and this Committee meeting.

This context is provided to ensure the Committee understands that evidence gaps in the tracker do not necessarily reflect gaps in operational performance or organisational capability but rather reflect the practical challenges of documenting comprehensive evidence within compressed timescales following framework finalisation (notwithstanding there may be a number of areas or issues that may result in an on-going challenge).

The Health Board has made progress in several areas, particularly *C. difficile* reduction and the elimination of 104-week waits. However, significant challenges remain in *S. aureus* infection control, patient communication, and mental health service capacity. Immediate action is required in these areas to achieve de-escalation criteria.

Background and Oversight Framework

The Welsh Government targeted intervention framework for 2025/26 represents a continuation and evolution of the monitoring arrangements established during 2024/25, with most elements carrying forward whilst incorporating learning from the previous year's implementation. The Health Board's targeted intervention status has evolved during this period, with successful de-escalation achieved in planned care, mental health and learning disabilities and governance and leadership domains, whilst enhanced monitoring arrangements continue for these areas.

However, the Health Board remains under targeted intervention specifically for hospital acquired infections, which forms the primary focus of this Committee's ongoing oversight responsibilities. This targeted approach reflects the progress made in some quality domains whilst maintaining intensive support and monitoring for areas where sustained improvement is still required.

The de-escalation criteria examined in this paper therefore represent both the continuing hospital acquired infection requirements where targeted intervention status remains, and the enhanced monitoring criteria for planned care and mental health services where the Health Board has achieved de-escalation but continues to demonstrate sustained performance under the enhanced monitoring framework.

Key Messages



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The escalation tracker system has been developed to manage this more complex monitoring landscape, building upon existing reporting mechanisms to provide comprehensive tracking across both active targeted intervention criteria and enhanced monitoring requirements. This evolution recognises the need for differentiated oversight approaches that reflect the Health Board's varying progress across different quality domains.

The QSEC maintains its established oversight responsibilities for hospital acquired infection criteria where targeted intervention status continues, whilst also receiving relevant updates on enhanced monitoring elements that fall within its quality and safety remit.



C. difficile Reduction (Target: ≤ 6 cases per month for 3 consecutive months)

Status: Partially Achieved

March 2025 performance achieved the target threshold with six cases. February recorded four cases, demonstrating that interventions are having measurable impact. However, the three-month sustained performance required for de-escalation has not yet been achieved.

Recent performance shows November 2024 eight cases, December 2024 six cases, January 2025 eight cases, February 2025 four cases, and March 2025 six cases. The improvement trajectory indicates that sustained achievement is possible with continued focus.

Key interventions implemented include hydrogen peroxide vapour decontamination at Prince Philip Hospital, systematic environmental auditing programmes, and safety dashboard dissemination to all services. Regional analysis shows variation across counties with Carmarthenshire recording forty-seven cases, Ceredigion eighteen cases, and Pembrokeshire thirteen cases over the twelve-month period.

S. aureus Reduction (Target: ≤ 2 cases per month for 3 consecutive months)

Status: Not Achieved

Performance remains consistently above target with four cases recorded in each of March, February and January 2025 against a target of two cases monthly. This represents no improvement from previous months and indicates current interventions are insufficient.

Infection source analysis reveals device-related infections account for ten cases, wound infections sixteen cases, and musculoskeletal infections twenty-three cases. Thirty-nine cases have unknown sources, indicating investigation protocols require strengthening.

Aseptic Non-Touch Technique compliance stands at 80.6 per cent against a target of 95 per cent. Enhanced monitoring and intervention programmes are being implemented across high-risk clinical areas.

E. coli Reduction (Target: ≤ 5 cases per month for 3 consecutive months)

Status: Inconsistent Achievement

Hospital-onset E. coli infections show significant month-to-month variation. March 2025 recorded eight cases, well above the five-case target, following February's achievement of five cases and January's exceptional performance of zero cases.

Analysis of all E. coli infections shows fifty-nine hospital-onset cases against 321 community-onset cases over twelve months. Primary infection sources include urinary tract infections and biliary complications, providing clear targets for prevention strategies.



Waiting Times Achievement

The Health Board has achieved the complete elimination of 104-week referral-to-treatment waiters in March 2025, representing a significant milestone in planned care access. This achievement demonstrates the organisation's capacity to deliver against challenging targets when resources are appropriately focused.

Cancer pathway performance shows 63.5 per cent achievement against the sixty-two day target. The Health Board has achieved the required sixty per cent threshold for two consecutive months. One additional month at this performance level will satisfy the targeted intervention de-escalation criteria but still requires significant improvement to meet the annual plan 80% target by March 2026.

Service Pressures

Glangwili Hospital theatres face significant challenges with a twenty-five whole-time equivalent staffing shortfall and sickness rates exceeding 12.5%. These pressures have resulted in two Healthcare Inspectorate Wales enquiries and directly impact both planned procedures and emergency surgery capacity.

Prince Philip Hospital (PPH) Critical Care does not meet national standards for intensive care provision. Interim arrangements have been implemented to maintain patient safety whilst longer-term solutions are developed.

Paediatric services experience medical rota fragility with reduced junior doctor post uptake. The service requires regional collaboration to ensure sustainable provision across all sites.



Patient Communication Requirements

Current evidence shows limited documentation of patient communication strategies for waiting list management, service changes, and support access. The de-escalation criteria require demonstration of effective patient engagement regarding service changes, waiting time policies, and provision of appropriate support.

Specific requirements include waiting list communication protocols, patient involvement in service redesign, clear guidance on support access points, and effective communication of new pathway benefits including straight-to-test and see-on-symptoms approaches. Whilst, through the Clinical Services Plan (CSP) and the PPH Minor Injury Unit (MIU) there has been significant engagement (with supporting evidence), there needs to be evidence across all domains to satisfy this criteria (please note, that when the 25/26 escalation tracker is fully complete, a full appraisal will then be possible to understand the current gap).

Performance Against Targets

Current performance falls significantly short of required standards. Only 15% of children wait less than twenty-six weeks for autism assessment, with 3,058 children waiting beyond twenty-six weeks. Adult psychological therapies achieve 63.81% performance against an eighty per cent target.

The Local Primary Mental Health Support Services requires 80% of assessments within twenty-eight days and 70% of therapeutic interventions to commence within twenty-eight days of assessment. Current capacity constraints prevent achievement of these standards.

Response to External Scrutiny

The Mental Health Clinical Care Group manages nine open improvement plans from external reviews. Sixty-one recommendations have been closed since September 2024, demonstrating systematic attention to external scrutiny.

Recent Healthcare Inspectorate Wales activity includes inspection of Bryngolau Ward generating forty recommendations. Monthly operational meetings review progress with clear tracking mechanisms in place.

Patient Feedback and Engagement

Current patient engagement mechanisms focus primarily on complaints management, with an average of thirteen new complaints monthly. Patient experience integration into quality improvement work includes Person-Centred Safety Planning projects on adult mental health wards.

However, evidence of meaningful engagement regarding service changes, waiting time policies, and support provision requires strengthening to meet de-escalation criteria expectations.



Several areas present immediate risks to de-escalation achievement. *S. aureus* infections show no improvement trend and require urgent intervention. Patient communication gaps across planned care services represent a fundamental requirement for de-escalation that currently lacks adequate evidence.

Mental health service capacity constraints indicate that achieving performance targets may require service model transformation rather than incremental improvement within existing approaches.

Theatre staffing pressures at Glangwili Hospital create risks to both planned care sustainability and patient safety that require immediate strategic and operational attention.

Recommendations

- The Committee is asked to note progress in *C. difficile* reduction and planned care waiting time elimination whilst recognising the urgent action required for *S. aureus* infection control.
- The Committee should receive detailed improvement plans for patient communication strategy development across planned care services, as this represents a critical requirement for multiple de-escalation criteria.
- Mental health service capacity challenges may require consideration of alternative service delivery models to achieve the scale of improvement needed against current demand levels.
- Regular monitoring of theatre staffing solutions at Glangwili Hospital should be maintained given the impact on both patient safety and service sustainability.



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SAFE | SUSTAINABLE | ACCESSIBLE | KIND



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1.4

1.4 - Patient/ Staff Story- Unscheduled
Emergency Care

*Louise O'Connor
(Hywel Dda Health
Board - Assistant
Director)*

1.5

1.5 - QSEC Terms of Reference for Annual Review

*Anna Lewis (Hywel
Dda UHB -
Independent Board
Member)*

Attachments

[QSEC ToRs SBAR June 25.pdf](#)

[QSEC Terms of Reference.V16.Board.for QSEC approval 10.06.25.pdf](#)

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	10 June 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Quality, Safety and Experience Committee Terms of Reference
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Sharon Daniel, Executive Director of Nursing, Quality and Patient Experience
SWYDDOG ADRODD: REPORTING OFFICER:	Joanne Wilson, Director of Corporate Governance/Board Secretary Charlotte Wilmshurst, Assistant Director of Assurance and Risk

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

Ar Gyfer Penderfyniad/For Decision

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

The purpose of this paper is to ensure that the Quality, Safety and Experience Committee has clear terms of reference which detail its purpose, boundaries, role, composition and operating arrangements.

The Committee are asked to approve the Quality, Safety and Experience Committee's Terms of Reference for onward ratification by the Board on 31 July 2025.

Cefndir / Background

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

The Committee last reviewed its terms of reference and operating arrangements in June 2024, and these were subsequently approved by the Board, on 25 July 2024. The Board also approved the following changes on 28 January 2025 as part of the revised governance arrangements from 1 April 2025.

- 4 x Independent Members per Committee (except Quality, Safety and Experience Committee which will have 5).
- Where Independent Membership has reduced to 4, the quoracy will be amended to 'A quorum shall consist of no less than two of the membership and must include as a minimum the Chairman or Vice-Chairman of the Committee, and one other Independent Member, together with a third of the In Attendance Members.'
- Updated job titles, e.g., from Director to Executive Director, Director of Operations to Chief Operating Officer, where appropriate.

- The Director of Corporate Governance will be removed from the In Attendance section however will attend committees (or nominate a deputy) to provide governance advice and support.
- Other cosmetic amendments required to standardise Board Committee level terms of reference.

Asesiad / Assessment

The Quality, Safety and Experience Committee Terms of Reference and operating arrangements (**Appendix 1**) have been reviewed and updated to include any relevant amendments agreed at Board on 30 January 2025. The table below also details further changes that have been made. These are clearly marked on Appendix 1 and relate to the following:

Section	What has changed?	Why?
2.7	Principal Duties - removed	Wording removed as included within Appendix 1
3.2	Key Responsibilities – section amended	New standard wording agreed by Board in January 2025 for risks in Committee ToRs as follows: <i>“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 subcommittees, 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”</i> .
3.3	Key Responsibilities – section removed	Section removed as covered in section 3.2
New 3.3	Key Responsibilities – section amended	New standard wording agreed by Board in January 2025 for risks in Committee ToRs, as follows: <i>“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)”</i> .
3.4	Key Responsibilities – section added	New standard wording agreed by Board in January 2025, as follows. <i>“Review and approve the annual work plans for any Sub-Committee which has delegated responsibility from the Quality and Safety Committee and oversee delivery”</i> .
3.17	Key Responsibilities – section amended	New standard wording agreed by Board in January 2025, as follows. <i>“Seek assurances on the requirements arising from the Health Board’s regulators, Welsh Government and professional bodies”</i> .
3.27	Key Responsibilities – section amended	Removed reference to specific Committees and reduced narrative as follows: <i>“Refer quality & safety matters which fall within the remit of other Committees”</i> .

3.28	Key Responsibilities – section removed	Section removed as covered in section 10.4.
New 3.28	Key Responsibilities – section amended	New standard wording for PO's agreed by Board in January 2025, as follows: <i>“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”</i> .
4.1	Membership - section amended	Following the changes to the membership of Committees as of 1 April 2025, the requirement for the Health and Safety Committee (HSC) Chair to also be a member has been removed. The revised requirement stipulates that <i>“the HSC Vice Chair” is a member of QSEC</i> ”
4.3	Membership - section amended	Amended to reflect the new chairing arrangements for the Sub-Committees to QSEC.
4.4	Membership - section removed	Section removed as the new Sub-Committee Chairs are Executive Directors and are members of the Committee.
10.3.1	Reporting - section amended	Removal of <i>“Operational”</i> following approval to change the Sub-Committee name at QSEC in August 2024.

Argymhelliad / Recommendation

The Committee are asked to approve the Quality, Safety and Experience Committee's Terms of Reference (version 17) for onward ratification by the Board on 31 July 2025.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	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.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	Not Applicable
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	1. Leadership

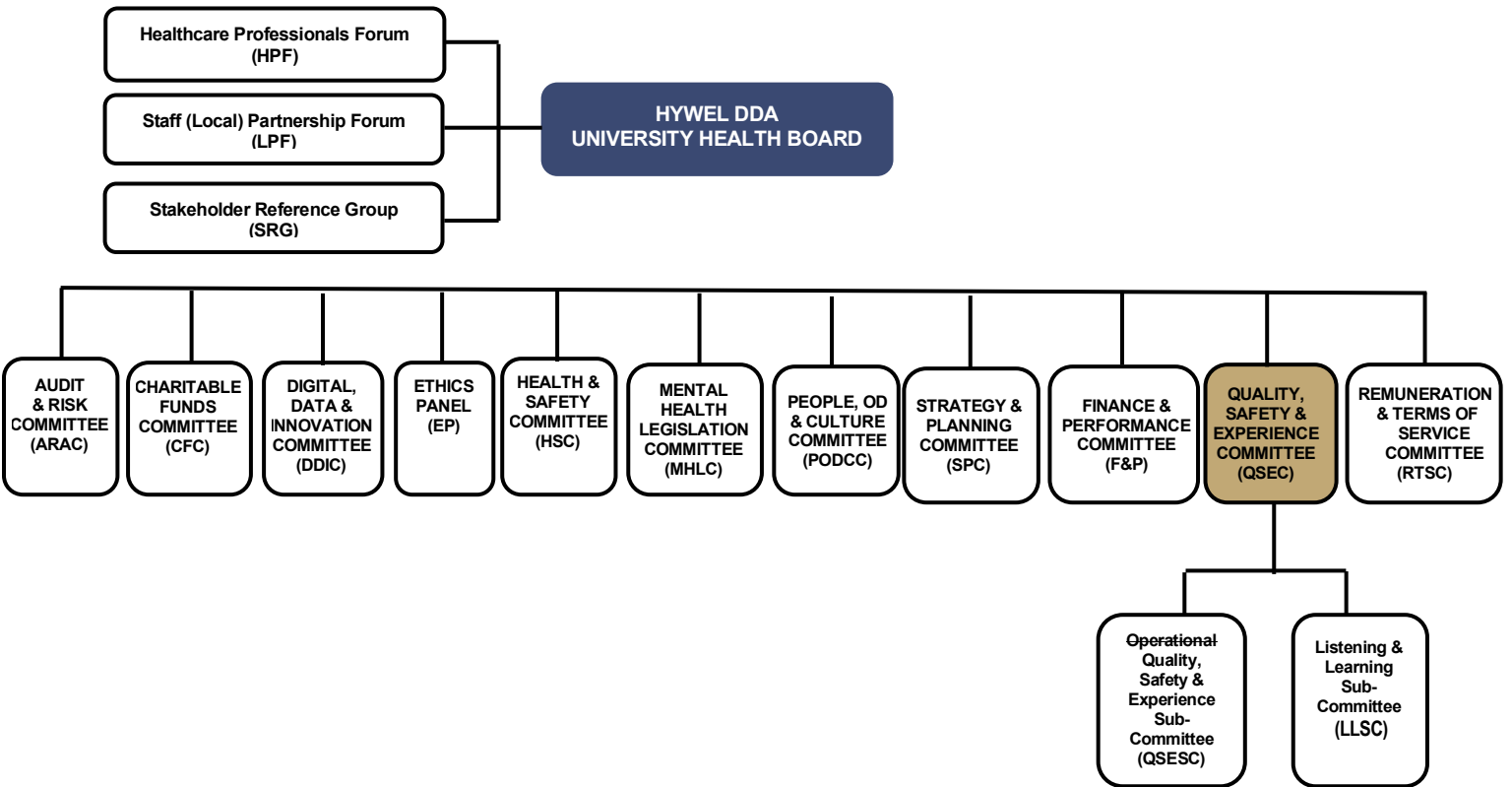
Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable
Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Standing Orders
Rhestr Termau: Glossary of Terms:	Contained within the body of the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiad: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	Director of Corporate Governance/Board Secretary Executive Director of Nursing, Quality and Patient Experience

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No direct impacts
Ansawdd / Gofal Claf: Quality / Patient Care:	No direct impacts
Gweithlu: Workforce:	Not applicable
Risg: Risk:	Not applicable
Cyfreithiol: Legal:	Not applicable
Enw Da: Reputational:	Not applicable
Gyfrinachedd: Privacy:	Not applicable

**Cydraddoldeb:
Equality:**

Not applicable



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	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 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 Provide assurance that the organisation, at all levels, has the right governance arrangements and strategy in place to ensure that the care planned or provided across the breadth of the organisation's functions, is based on sound evidence, clinically effective and meeting agreed standards.
- 2.6 Receive assurance on delivery against the areas of targeted intervention, and the required elements for de-escalation, that are aligned to the Committee (see Appendix 1 for additional detail):
 - i. ~~Planning and service management~~
 - ii. ~~Quality management – clinical governance~~
 - iii. ~~Quality management – complaints and healthcare associated infections (HCAIs)~~

3. Key Responsibilities

The Quality, Safety & Experience Committee shall:

- 3.1 Provide advice to the Board on the adoption of a set of key indicators of quality of care against which the University Health Board's performance will be regularly assessed and reported on.
- 3.2 ~~Seek assurance on the management of risks within the Corporate Risk Register (CRR) and Directorate level risks allocated to the Committee and provide assurance to the Board that risks are being managed effectively and report any areas of significant concern e.g. where risk tolerance is exceeded, lack of timely action.~~ **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.**

~~Recommend acceptance of risks that cannot be brought within the UHBs risk appetite/tolerance to the Board through the Committee Update Report.~~
- 3.3 ~~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).~~ **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 Review and approve the annual work plans for any Sub-Committee which has delegated responsibility from the Quality and Safety Committee and oversee delivery.
- 3.5 Ensure the right enablers are in place to promote a positive culture of quality improvement based on best evidence.
- 3.6 Oversee the development and implementation of strengthened and more holistic approaches to triangulating intelligence to identify emerging issues and themes that require improvement or further investigation.
- 3.7 Provide assurance that all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality and safety of care provided, and in particular that sources of internal assurance are reliable, there is the capacity and capability to deliver, and lessons are learned from patient safety incidents, complaints and claims.
- 3.8 Receive assurance on delivery against the areas of targeted intervention (Appendix 1), and the required elements for de-escalation, that are aligned to the Committee (see Appendix 1 for additional detail):
- 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 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.
- 3.13 Ensure that the organisation is meeting the requirements of the NHS Concerns, Complaints and Redress Arrangements (Wales) Regulations.
- 3.14 Approve the required action plans in respect of any concerns investigated by the Ombudsman.
- 3.15 Agree actions, as required, to improve performance against compliance with incident reporting.
- 3.16 Provide assurance that the Central Alert Systems process is being effectively managed with timely action where necessary.

- 3.17 ~~Provide assurance on the delivery of action plans arising from investigation reports and the work of external regulators. Seek assurances on the requirements arising from the Health Board's regulators, Welsh Government and professional bodies.~~
- 3.18 Approve the annual clinical audit plan, ensuring that internally commissioned audits are aligned with strategic priorities.
- 3.19 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.
- 3.20 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.
- 3.21 Provide assurance in relation to the organisation's arrangements for safeguarding vulnerable people, children and young people.
- 3.22 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.
- 3.23 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.
- 3.24 Assure the Board in relation to its compliance with relevant healthcare standards and duties, national practice, and mandatory guidance.
- 3.25 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.
- 3.26 Review and approve annual work plans for any Sub-Committees which has delegated responsibility from the Quality, Safety and Experience Committee and oversee delivery to scrutinise and monitor the impact on patients of the Health Board's services and their quality.
- 3.27 Refer quality & safety matters which ~~fall within the remit of other Committees. people, planning and performance to the People, Organisational Development & Culture Committee (PODCC), and the Strategic Development & Operational Delivery Committee (SDODC), and vice versa.~~
- ~~Agree issues to be escalated to the Board with recommendations for action.~~
- 3.28 ~~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. **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 (including Health and Safety Committee Vice-Chair and People, Organisational Development & Culture Committee Chair)

4.2 Membership must include an Independent Member from the Health and Safety Committee.

4.3 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 (Chair of QSESC)
Executive Director of Public Health
Director of Primary Care, Community & Long Term Care
Head of Quality and Governance
Associate Medical Director Quality & Safety
Assistant Director of Therapies and Health Science
Assistant Director, Legal Services/Patient Experience (Chair of Listening and Learning Sub Committee)
Assistant Director of Nursing, Quality and Assurance (Chair of Operational Quality, Safety and Experience Sub Committee)
Llais Cymru/ Citizens Voice Body Representative (not counted for quoracy purposes)

~~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.

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 ~~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 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.

Appendix 1 – Targeted Intervention areas relating to quality of care intervention and focus

De-escalation Criteria

Clinical Services

- Evidence that the health board has the appropriate mechanism to understand the drivers behind a fragile service through the triangulation of key data points, including staffing levels, staff and patient feedback, concerns, incidents, stakeholder feedback (HIW, Audit Wales, HMC, Royal Colleges, Llais etc), mortality reviews, duty of quality / candour, infection protection control, performance, clinical and medical leadership.
- Fragile services are supported by strong clinical leadership, have an effective integrated improvement plan, project management structure and effective transformation support.
- Evidence that all recommendations from the Royal Colleges, HIW and other reviews specific to Hywel Dda UHB are discharged and either verified or delivered or scheduled for delivery within the health board's longer-term improvement plan.
- Evidence that the Board is sighted on fragile services and has a robust response to these issues that is being addressed by the health board.

Urgent and Emergency Care

- Assessment of health board response and handling of concerns, complaints, incidents and patient experience feedback related to UEC.

Quality of care

- C-Diff: reduce the number of hospital onset infections by 25% and maintain for 3 months (from agreed baseline - No more than 6 cases per month).
- Staph aureus: reduce the number of hospital onset infections by 25% and maintain for 3 months (from agreed baseline - No more than 2 cases per month).
- E-coli: reduce the number of hospital onset infections by 25% and maintain for 3 months (from agreed baseline - No more than 5 cases per month).
- Implicit: Addressing the root cause of HCAs and having effective response mechanisms.

Planned Care

- Assessment of health board response and handling of concerns, complaints, incidents and patient experience feedback related to planned care.

CAHMS

- Demonstrate a prompt response to any HIW inspections, concerns, incidents, never-events, coroners requests and regulation 28s.
- Improved patient and family feedback.

2 - Risk

2.1

2.1 - Corporate Risk Report- Executive Leads

Attachments

[QSEC Corporate Risk Report - May 2025 - V6.pdf](#)

[Appendix 2 - Quality Safety and Experience Committee Corporate Risks May-25.pdf](#)



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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	10 June 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Corporate Risks Assigned to the Quality, Safety and Experience Committee (QSEC)
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Andrew Carruthers, Chief Operating Officer Jill Paterson, Director of Primary Care, Community & Long Term Care Mark Henwood Medical Director Sharon Daniel, Director of Nursing, Quality & Patient Experience
SWYDDOG ADRODD: REPORTING OFFICER:	Joanne Wilson, Director of Corporate Governance Charlotte Wilmshurst, Assistant Director of Assurance and Risk

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

Er Sicrwydd/For Assurance

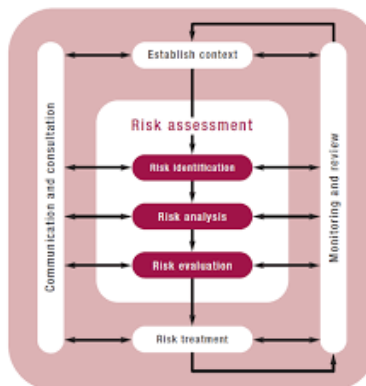
**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

The Quality, Safety and Experience Committee (QSEC) is asked to request assurance from Executive Directors that the corporate risks in the attached report are being managed effectively.

Cefndir / Background

Effective risk management requires a ‘monitoring and review’ structure to be in place to ensure that risks are effectively identified and assessed, and that appropriate controls and responses are in place.



(Risk Management Process, ISO 31000)

The Board’s Committees are responsible for the monitoring and scrutiny of risks within their remit. They are responsible for:

- Seeking assurance on the management of risks on the Corporate Risk Register (CRR) and providing assurance to the Board that risks are being managed effectively and report areas of significant concern, for example, where risk appetite is exceeded, lack of action, etc.
- Reviewing corporate risks over tolerance and, where appropriate, recommend the 'acceptance' of risks that cannot be brought within Hywel Dda University Health Board's (HDdUHB) risk appetite/tolerance to the Board.
- Identify through discussions any new/emerging risks and ensure these are assessed by management.
- Signposting any risks outside of its remit to the appropriate HDdUHB Committee.
- Using risk registers to inform meeting agendas.

The Board has delegated a proportion of its role of scrutiny of assurances to its Committees to make the most appropriate and efficient use of expertise. Therefore, Committees should also ensure that assurance reports relevant to the principal risks are received and scrutinised, and an assessment made as to the level of assurance it provides, taking into consideration the validity and reliability i.e., source, timeliness, methodology behind its generation and its compatibility with other assurances. This will enable the Board to place greater reliance on assurances, if they are confident that they have been robustly scrutinised by one of its' Committees; and provide them with greater confidence regarding the likely achievement of strategic objectives, as well as providing a sound basis for decision-making. It is the role of Committees to challenge where assurances in respect of any component are missing or inadequate. Any gaps should be escalated to the Board.

A revised approach to risk tolerance was agreed by the Board at its meeting in March 2025 to reflect the organisation's readiness to bear the risk after risk treatment, in order to achieve its objectives. This supersedes the previous approach agreed in September 2018 which set the tolerance levels for risk aligned to risk impact domains.

The revised approach utilises the target risk score (TRS) of risks in order to demonstrate the lowest level of risk exposure that the Health Board is willing to tolerate, following the completion of all planned actions aligned to each risk. The TRS represents the ultimate level of risk achievable given the available means and resource. Once the TRS is achieved, if the risk continues to exist, it should then be tolerated / accepted unless further actions are identified or made possible (e.g., additional resources). If achieving the TRS is deemed unacceptable (i.e., the TRS is too high), further discussion or escalation is required. The TRS should be quantified, and where possible aligned to performance targets (including quality metrics), with a set timescale for achieving the reduction of the Current Risk Score to the TRS.

Risks will be 'treated' until a discussion to 'tolerate' a risk is triggered – this would be when the Executive Risk Owner for corporate risks does not support the TRS. The Board will be asked to accept any risks where the Health Board is unable to treat within its available means.

These risks have been identified by individual Directors via a top down and bottom-up approach and are either:

- Associated with the delivery of the Health Board objectives; or
- Significant operational risks escalated that are of significant concern and require corporate oversight and management.

Each risk on the CRR has been mapped to a Board level Committee to ensure that risks on the CRR are being managed appropriately, taking into account the gaps, planned actions and agreed tolerances, and to provide assurance to the Board through their update report on the management of these risks.

The Board has delegated a proportion of its role of scrutiny of assurances to its Committees to make the most appropriate and efficient use of expertise. Therefore, Committees should also ensure that assurance reports relevant to the principal risks are received and scrutinised, and an assessment made as to the level of assurance it provides, taking into account the validity and reliability i.e. source, timeliness, methodology behind its generation and its compatibility with other assurances. This will enable the Board to place greater reliance on assurances, if they are confident that they have been robustly scrutinised by one of its Committees; and provide them with greater confidence regarding the likely achievement of strategic objectives, as well as providing a sound basis for decision-making. It is the role of Committees to challenge where assurances in respect of any component are missing or inadequate. Any gaps should be escalated to the Board.

The process for risk reporting and monitoring within the UHB is outlined at Appendix 1.

Asesiad / Assessment

The QSEC Terms of Reference reflect the Committee’s role in providing assurance to the Board that corporate risks are being managed effectively by the risk owners (Executive Leads).

The Terms of Reference state that:

- 3.2 Seek assurance on the management of risks within the Corporate Risk Register (CRR) and Directorate level risks allocated to the Committee and provide assurance to the Board that risks are being managed effectively and report any areas of significant concern e.g., where risk tolerance is exceeded, lack of timely action.
- 3.3 Recommend acceptance of risks that cannot be brought within the UHBs risk appetite/tolerance to the Board through the Committee Update Report.
- 3.4 Receive assurance through Sub-Committee Update Reports that risks relating to their areas are being effectively managed across the whole of the UHB’s activities (including for hosted services and through partnerships and Joint Committees as appropriate).

There are 9 risks currently aligned to QSEC (out of the 21 that are currently on the CRR) as the potential impacts of the risks relate to the safety of patients, quality of services and patient outcomes.

Each of these risks have been entered onto a ‘risk on a page’ template, which includes information relating to the strategic objective, controls, assurances, performance indicators and action plans to address any gaps in controls and assurances. These can be found at Appendix 2.

Changes since the previous report to QSEC (December 2024):

The Committee is requested to seek assurance from risk owners (Executive Directors) that each risk is being managed effectively and will be brought within the UHB tolerance.

Below is a summary of changes since the previous report to QSEC:

Total Number of Open Risks	9	
New Risks Being Reported	0	
De-escalated/Closed Risks	1	See note 1
Increase in Risk Score ↑	0	
Decrease in Risk Score ↓	3	See note 2
No Change in Risk Score →	6	See note 3

The 'heat map' below includes the risks currently aligned to QSEC:

HYWEL DDA RISK HEAT MAP					
	LIKELIHOOD →				
IMPACT ↓	RARE 1	UNLIKELY 2	POSSIBLE 3	LIKELY 4	ALMOST CERTAIN 5
CATASTROPHIC 5			1531 (↓) 1859 (↓)	1027 (→)	
MAJOR 4				684(→) 1708 (→) 1664 (↓)	797 (→) 1032 (→)
MODERATE 3					1810 (→)
MINOR 2					
NEGLIGIBLE 1					

Note 1 – Risk de-escalated/closed:

The following risk has been de-escalated to Operational Level since the previous meeting:

Risk Reference & Title	Date risk identified	Lead Director	Update
1812 - Risk of non-compliance with Medical Examiners (Wales) Regulations due to the failure to fully resource internal processes	16/11/21	Executive Medical Director	Risk de-escalated to operational level for ongoing monitoring and review at Formal Executive Team meeting held 8 January 2025, as mitigating actions in place to manage compliance, with no specific concerns raised by the Medical Examiners Service to date.

Note 2 – Decrease in risk score:

The following risk has decreased in score since the previous meeting:

Risk Reference & Title	Date risk identified	Lead Director	Previous Risk Score	Current Risk Score	Update	Target Risk Score
1664 - Risk to ophthalmology service delivery due	23/05/23	Chief Operating Officer	4x5=20	4x4=16 (Reviewed 25/04/25)	Increased demand and reduced capacity continues to be a challenge. Balancing Eye Care Measures for R1	5x2=10

<p>to a national shortage Consultant Ophthalmologists and the inability to recruit</p>					<p>patients (high risk) with Ministerial Measures for longest waiting patients presents a conflicting priority to the service with limited capacity.</p> <p>The service has provided additional Age-Related Macular Degeneration (AMD) sessions on a weekend, however these additional sessions have not been enough to meet the demand across all counties in the Health Board (HB). Patient delays continue across the Health Board. AMD continues to be prioritised impacting on the provision of general clinics, having an impact on the wider ophthalmology service and patient experience.</p> <p>The current non-medical workforce establishment is not aligned to service needs. Recently the service has transferred Glaucoma funding to the Intra Vitreal Injection Therapy (IVT) service to create a new Band 7 post for IVT. The additional staffing needed for Wet AMD have been identified in the Eye Care Measures SBAR, which identifies the R1 delivery at 35%. The Welsh Government (WG) target for R1 delivery is 95%.</p> <p>The service as at April 2025 are expected to reach waiting times of stage 1 52 weeks and all stages 104 weeks with a robust plan in place to</p>	
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				<p>reach this by the end of quarter one. 7612 patients have been 100% delayed for their follow up appointment.</p> <p>The current impact has been scored as 4 because patients suffering irreversible sight loss is a reality and the current likelihood has been scored 4 as ophthalmology is a fragile service. It is unlikely that this risk will be able to be significantly reduced without considerable investment or a regionally agreed solution.</p> <p>The workforce challenges have led to an impact on the Health Board's ability to deliver services within the ophthalmology referral to treatment (RTT) plan, which has been sustained through non recurrent funding secured for the out-sourcing of cataract procedures and IVT patients. Waiting list initiatives have been utilised for additional out-patient appointments. This is in direct conflict with the Health Board's ability to comply with WG Eye Care Measures (ECMs) which is the delivery of timely care for the high risk (R1) category of patients. There are delays to the delivery of R1 appointments for both Glaucoma and the delivery of Intravitreal injections for the Wet</p>	
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				<p>AMD pathway, which affects the National Institute for Health and Care Excellence (NICE) 14-day pathway for AMD appointments, impacting on the ability to provide timely diagnosis and treatment and directly impacting on patient safety, with the potential for sight loss and long-term lifestyle impacts.</p> <p>Recruitment difficulties have led to the Consultant on-call rota being covered by 4 substantive Consultants with a gap of 2. This gap is filled by the substantive consultants working additional duty hours to ensure the delivery of the ophthalmology on call service. This is an on-call structure which is impacted by sickness and annual leave. However it is now more stable than previously reported.</p> <p>The service has been able to reduce the impact score of this risk as whilst the consequences to the patient remains high, an SBAR for the recovery of the R1 Eye Care Measures target has been produced which demonstrates a trajectory for recovery if the required investment is secured. This would allow the service to recover to a 65% R1 delivery target allowing the likelihood score to be reduced to a 3 which would reduce the overall</p>	
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					<p>score to 15. If the investment was secured in April 2025 the service could recover to 65% by September 2026. Further development would be required to reach a 95% R1 delivery score, which would reduce the likelihood to a 2.</p> <p>With the required investment in Glaucoma and IVT with the additional workforce and focused management of the waiting lists, the HB will potentially reduce the likelihood score on this risk to a 2. The service also will meet their ministerial measures targets by the end of quarter 1.</p>	
1859 - Risk of poor patient outcomes and experience due to inability to effectively recognise and manage acute deterioration	01/05/24	Director of Nursing, Quality & Patient Experience	4x5=20	3x5=15 (Reviewed 25/04/24)	<p>There are specific concerns relating to Glangwili General Hospital (GGH) and Worthybush General Hospital (WGH) in relation to cardiac arrests and unplanned admissions. There was an increase in cardiac arrest rates in GGH in the period January - December 2024 (35) compared to the same period January - October 2023 (15). GGH senior management team have agreed to Datix all cardiac arrests and establish bi-monthly meetings to review cases and identify themes and learning opportunities.</p> <p>There has been an increase (22%) in unplanned admissions at WGH, with 92 noted in 2024 (71 noted for</p>	

					<p>2023). Following the recent WGH Recognition of Acute Deterioration and Resuscitation (RADAR) meeting it was agreed that the Treatment Escalation Plan (TEPs) task & finish group in WGH would be re-established.</p> <p>There are also concerns across the Health Board relating to the National Early Warning Scores (NEWS), and appropriate escalation where required as part of observation processes. Currently working with Clinical Audit to develop an audit tool on the Audit Management and Tracking (AMaT) system to audit on a monthly basis NEWS charts on wards and identify good practice and areas for improvement. A National Safe Care Collaborative meeting held in Cardiff in October 2024 began exploring the possibility of establishing a National Acute Deterioration Clinical Reference Group which will provide an opportunity to benchmark the position of Hywel Dda on an all Wales basis.</p> <p>As of January 2025, compliance rates for Level 2 and Level 3 Resuscitation Training are at 49% and 46% respectively, an increase on the previous figure noted of 40% at November 2024. While there is no set compliance target,</p>	
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				<p>compliance has never been greater than 60%. Staff availability to attend resuscitation training is problematic due to operational pressures and demand, therefore, need to identify the most appropriate training level and method to deliver to meet mandatory requirements.</p> <p>As at February 2025, all actions are being processed within set dates / timeframes although many remain long term. Current controls are managing the risk and the increasing awareness of gaps in assurance and local actions to mitigate and manage the risk have been established.</p> <p>The full implementation of the actions noted in the risk action plan will support the reduction in the likelihood and impact score of this risk to a target risk of 10. With recruitment into the Resuscitation Team and the establishment of a supported cascade training process the aim will be to see an increase in training compliance in both level 2 & level 3 training by October 25 to >60%. This will enable the risk to be reduced to the Target Risk Score of 10, >85% would enable the risk score to be reduced further to 5. We will aim to see a reduction in cardiac arrest rates across all 4 sites and unplanned</p>	
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					admissions into Intensive Therapy Unit (ITU) from ward areas by October 2025.	
1531 - Risk of being unable to safely support the Consultant on-call rota at Withybush General Hospital (WGH) and Glangwili General Hospital (GGH) due to workforce pressures	10/11/22	Chief Operating Officer	4x5=20	3x5=15 (Reviewed 24/04/25)	<p>Whilst this risk is relating to workforce issues, the domain for the risk is patient safety. The reason for this decision is that, although the rota in WGH has been stabilised, gaps in the service remain e.g. Upper Gastrointestinal (GI).</p> <p>The risk to emergency Upper GI patients at WGH is due to no Upper GI specialists on site and no Endoscopic Retrograde Cholangiopancreatography (ERCP) service on the site. An SBAR has been populated, highlighting the risk to emergency Upper GI patients in WGH. The recommendation from the senior clinical team is for these patients to be admitted directly to GGH. This SBAR was presented at Acute Leadership Group (ALG) on 25/09/2024, at the Quality, Safety and Experience Committee (QSEC) on 08/10/2024 and at the Scheduled Care Quality, Safety and Experience (QSE) meeting on 29/01/2025.</p> <p>The concern is that the GGH clinical team have absorbed the patients that cannot be treated at WGH, without additional resource and this is currently exacerbated by the rota gaps on the</p>	1x5=5

					<p>GGH consultant on-call rota. As this situation has not changed, the current risk score remains the same.</p> <p>The consultant on-call rota at WGH remains a 1:4 with 2 substantive consultants and 2 NHS locum consultants on the rota, 1 of which is an internal associate specialist upgraded to a locum consultant. At GGH, the consultant on-call rota is a 1:8 with one gap and one consultant only participating in 50% of the rota. The 1 full gap is currently being covered by a Medacs agency locum consultant and interviews are taking place for an NHS locum colorectal consultant to fill this gap. The 50% gap is being covered by an internal locum at the health board card rate. There are 3 NHS locum consultants participating in this rota.</p> <p>An options appraisal was presented to board in November 2024 and there was an urgent meeting between the Clinical Care Group and Executives in early 2025. The outcome of this was the approval to advertise the posts to fill the gaps. This supersedes the content of a previous SBAR presented at various Executive committees as the plan is no longer to amalgamate rotas, at least in the short term.</p>	
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					<p>Following the Scheduled Care Escalation Meeting in March 2025, where the immediate risk of the GGH rota collapsing was highlighted, due to the internal consultants withdrawing from covering the 1 gap on the rota, an urgent executive meeting was arranged for 12 March 2025. The outcome of the meeting was to appoint a substantive colorectal consultant to the GGH rota and for 2 substantive Upper GI consultants in a dual location role across WGH and GGH. It was recognised that this would take some time, there was an agreement that the service would recruit a Medacs locum consultant immediately, to cover the upcoming gap in April and in parallel, advertise an NHS locum colorectal consultant to GGH. On the appointment of the locum consultant, the agency locum will be terminated. On the appointment of the substantive consultant, the NHS locum will be terminated.</p> <p>An NHS locum colorectal consultant was successfully appointed on 30 April 2025, to commence in post in August 2025. The job descriptions and adverts for the 3 substantive consultant posts have been approved by the Medical Director and are</p>	
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					now with the Royal College. The aim is that they will be ready to go out to advert by 23 May 2025.	
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Note 3 - No change in risk score:

There have been no changes to the risk scores of the risks included in the table below since the previous meeting:

Risk Reference & Title	Date risk identified	Lead Director	Current risk score	Update	Target Risk Score
797 - Risk to the ability to deliver ultrasound services due to workforce pressures	07/11/19	Chief Operating Officer	5x4=20 (Reviewed 30/04/25)	<p>Despite best efforts, the service remains fragile. As of January 2025, remaining vacancies have been advertised and appointed as training posts under Annex 21 posts, with trainees expected to qualify in September 2026.</p> <p>If all vacancies were recruited to, the Health Board would still not have the capacity to meet current demand (as at end March 2025) there were 1,110 patients waiting 8 weeks plus for non-obstetric ultrasound (February 2024:1288, March 2024:917, April 2024:962, May 2024:731, June 2024 608, July 2024 555, December 2024: 1,960, Jan 2025: 2,301). Reduction in 2025 due to insourcing ultrasound services</p> <p>Long term vacancies exist in WGH with maternity leave which started in summer of 2024 impacting the fragility further. There are 2 potential retirements at Prince Philip Hospital (PPH) in the near future and a number expected in Bronglais General Hospital (BGH), which constitute a significant percentage of the workforce. There will be an inability to secure high-cost agency staff due to the current financial climate of the Health Board. However, in the event</p>	3x4=12

				<p>of recovery monies being made available we will be able to re-initiate the current ultrasound insourcing contract</p> <p>3 Radiographer sonographers and 2 Midwife sonographers commenced training in January 2024, however training takes 2 years to complete for Radiographer Sonographers and 1 year for midwife sonographers (obstetric only).</p> <p>Only 13.82% of Urgent Suspected Cancer (USC) ultrasounds carried out and reported in 7 days, 37.53% carried out and reported in 14 days at end March 2025.</p>	
1027 - Risk to delivery of timely urgent and emergency care due to demand exceeding current capacity	19/11/20	Chief Operating Officer	<p>4x5=20 (Reviewed 21/05/25)</p>	<p>Levels of urgent and emergency pathway capacity pressures continue at significantly escalated levels. Workforce deficits, handover delays, 4- and 12-hour performance, bed occupancy rates and significant pressures on wider community and social care capacity are all demonstrating lack of sustainable improvement. The situation remains at high levels of risk escalation across our acute sites on a daily basis.</p> <p>Whilst some positive progress has been achieved in reducing ambulance handover delays and pathways of care delays, Glangwili Hospital (GGH), Bronglais (BGH) and Worthybush (WGH) remain a major pressure in the Unscheduled Emergency Care (UEC) system.</p> <p>Whilst recent experience suggests early signs of improvement against key UEC metrics, these remain outside target requirements. Data for</p>	2x4=8

				<p>April 2025 highlighted that the number of ambulance handovers taking over one hour was 866, although this is an improvement in comparison to April 2024 (1103) it is not meeting the Targeted Intervention (TI) target of 605 which needs to be maintained for 3 months.</p> <p>Breaches were also noted with the number of patients spending 12 hours or more in Accident & Emergency (A&E) / Minor Injuries Unit (MIU), with actual figure of 1,372 (9%) in April 2025 (compared to 1,543 in November 2024) exceeding the target of 1,137 (7%) TI target. The median time to assessment by a clinical decision maker in April 2025 was 79 minutes (November 2024 87minutes), exceeding the national target of 60 minutes. The Health Board were also over target in April 2025 in relation to Pathway of Care Delays, with actual figure of 223 (November 2024, 204) exceeding the target of 165. As such, the current risk score remains unchanged as at May 2025, pending further review.</p> <p>Recent external reviews (NHS Executive Same Day Emergency Care (SDEC) Review, NHS Executive Emergency Department (ED) Review and Getting It Right First Time (GIRFT) Review on ED) continue to identify concerns with patient flow and quality of service, with a Ministerial Advisory Group (MAG) review received in March 2025.</p>	
1032 - Risk of timely diagnosis and treatment of	02/11/20	Chief Operating Officer	5x4=20 (Reviewed 21/05/25)	The service is experiencing significant waiting times as a result of increasing demand levels which are exceeding	5x4=20

MH&LD clients due to demand and capacity				<p>pre-pandemic levels, compounded by the longer term impacts of COVID-19. Due to increasing demand, there is an impact on the services' ability to see the same volume of service users as they were previously able to. Some posts continue to be funded on a fixed term basis which can make staff retention challenging along with having to train new incoming staff.</p> <p>Recommendations received from NHS Executive in relation to Children's Neurodevelopmental services are in the process of being implemented. The Clinical Care Group is working with the Children, Women and Family Clinical Service Group to implement these.</p> <p>For Autism Spectrum Disorder (ASD), a meeting took place with the Delivery Unit (DU) to establish trajectories, along with the commissioned service which since have been agreed in March 2023. The DU were unable to provide trajectories, therefore the Health Board has agreed to a 1% monthly improvement trajectory.</p>	
1708 - Risk of increasing fragility in primary care contractor services due to external factors	07/07/23	Director of Primary Care, Community & Long Term Care	4x4=16 (Reviewed 30/04/25)	8 dental contracts have been returned to the Health Board in the last 12 months, of which 4 contracts (totalling £958,500) confirmed as being awarded by NHS Wales Shared Services Partnership (NWSSP) Procurement Services in May 2024. In addition, a further 8 dental practices have not signed up to the contract reform and are signalling that they will return contracts once reform negotiations have concluded.	2x4=8

				<p>The number of complaints received from the public has increased due to returned contracts, and while the Health Board is currently containing the demand for urgent dental care, it is recognised that patients who do not fall into this category but require a level of dental care are detrimentally impacted, and that any further contracts returned will exacerbate this situation. The capacity of the Health Board in terms of staffing to absorb further contract reform will impact on the ability to effectively deliver services, and a detrimental impact on staff welfare. There has been increased demand in urgent dental appointments resulting in appointments for the week being booked up early within the same week.</p> <p>The Dental Access Portal (DAP) was successfully rolled out in Hywel Dda in November 2024.</p> <p>2 General Medical Service (GMS) contracts have been returned to the Health Board in the last 12 months. However, from previous contract terminations, 2 of the 3 GMS contracts have become Health Board managed practices, resulting in additional financial pressures as the workforce is salaried. The third practice has been awarded as of 1 April 2024 after a successful procurement process. The outcome of the contract which was returned in April 2024 was presented and agreed by Board in July 2024, with decision made to manage list dispersal. It is recognised that</p>	
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				<p>any further managed practices would likely have a negative impact on the GMS budget.</p> <p>Implementation plans are in place with Ophthalmology to support the transition of patients into Welsh General Optometric Service (WGOS4) (clinical pathways for Glaucoma, Hydroxychloroquine Retinopathy (HCQ) and Medical Retina) as part of the new Optometry contract implementation which commenced in September 2024.</p>	
684 – Risk to the timely investment and replacement of Radiology equipment and supporting infrastructure	04/01/19	Chief Operating Officer	4x4=16 (Reviewed 08/04/25)	<p>The Health Board's stock of aged imaging equipment routinely breaks down causing disruption to diagnostic imaging services across all sites, which has a significant impact on the Health Board's ability to meet its Referral to Treatment (RTT) target and the impact to patients can include delays in diagnosis and treatment. Computed Tomography (CT) and Magnetic Resonance Imaging (MRI) scanners have been replaced and has reduced the frequency of machine downtime compared to previous experience.</p> <p>The risk score is assessed as 16, reflecting that some equipment has been installed and is operational, however further investment is required given recent breakdowns of key imaging equipment. A costed plan along with a rolling programme for the installation of additional equipment is in place. There is a continuous process locally by which equipment is prioritised for replacement.</p>	2x4=8

				<p>The gamma camera at WGH is the only scanner of its nature in the Health Board and experienced a series of breakdowns in 2023 and 2024 due to intermittent failures which resulted in several Healthcare Inspectorate Wales (HIW) reportable Ionising Radiation Medical Exposure Regulations (IRMER) incidents. This item of equipment is on the current priority list of items to replace and business continuity plans are being explored.</p> <p>While a new CT scanner has been obtained and installed at GGH, the original CT scanner has had a number of breakdowns. The technology on this scanner is also now out of date and impacts directly on the resilience of the service at our major trauma site in the Health Board. Like-for-like replacement of existing equipment is not necessarily a cost-effective method of maintaining services and in certain circumstances does not meet updated regulatory compliance or meet the requirements of maintenance warranty agreements. This means there will need to be upgraded infrastructure such as air handling units, water chiller systems and the size/accommodation for modalities at an initial increased cost but representing long term savings and service resilience overall.</p> <p>The Dual-energy X-ray Absorptiometry (DEXA) unit at BGH is aged and with the advent of trabeculae bone scoring, any new scanner will have a larger footprint</p>	
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				<p>compared with the current scanner and along with necessary shielding required, this may mean that the current DEXA room will be unsuitable to accommodate any new scanner. The technology gap has widened between the services provided at Swansea University Health Board (SBUHB) with concerns raised by referring clinicians.</p> <p>The Health Board's only Nuclear Medicine Single-photon Emission Computed Tomography (SPECT) scanner is overdue for replacement and remains a significant risk to continuity of service provision. The equipment replacement task & finish team are currently looking into options and specifications in readiness for potential funding which was discussed at the National Imaging Equipment and Capital Priorities (NIECP) Group review panel on 2 April 2025.</p>	
1810 - Risk to delivering effective and timely cancer service due to Aseptic Unit facilities being non-compliant with Quality Assurance of Aseptic Preparation Services (QAAPS).	01/02/24	Director of Primary Care, Community & Long Term Care	3x5=15 (Reviewed 22/04/24)	<p>Withybush Aseptic unit is the only functional unit that can manufacture cancer treatments remaining in the Health Board. The facilities of Withybush Aseptic unit are currently non-compliant with regulatory standards. An audit by the National Pharmacy Quality Assurance Lead was performed in February 2024 which confirmed the facilities were a high risk to patient safety, and the unit is at risk of forced closure.</p> <p>Short term control measures have been implemented by the Health Board's aseptic team to reduce the risk of immediate forced closure (see control measures). The</p>	1x5=5

				<p>controls are currently successfully minimising the amount of microbial contamination present within the unit, demonstrated by ongoing daily/weekly/monthly environmental monitoring. However, as the unit and equipment are beyond their useful expected life, there will come a time where the control measures will no longer be sufficient to allow the safe running of the unit. If the stringent controls fail at limiting the amount of microbial contamination, the unit may be forced to close.</p> <p>As part of the Transforming Access to Medicines (TrAMS) project programme, a regional manufacturing hub will be built in South West Wales that will prepare cancer therapy for Hywel Dda patients. The hub was originally estimated to open during 2028, however there have been delays to the project plan and the opening date is currently unknown.</p> <p>There is therefore a high risk that the current Aseptic unit at Witybush will be forced to close before the South West TrAMS manufacturing hub is operational. In this case, there would be no means of obtaining certain cancer therapy for Hywel Dda patients to be administered within the Health Board locality</p>	
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Argymhelliad / Recommendation

The Committee is requested to seek assurance that:

- All identified controls are in place and working effectively.
- All planned actions will be implemented within stated timescales and will reduce the risk further and/or mitigate the impact, if the risk materialises.
- Challenge where assurances are inadequate.

This in turn will enable the Committee to provide the necessary assurance to the Board, through its Committee Update Report, that the UHB is managing these risks effectively.

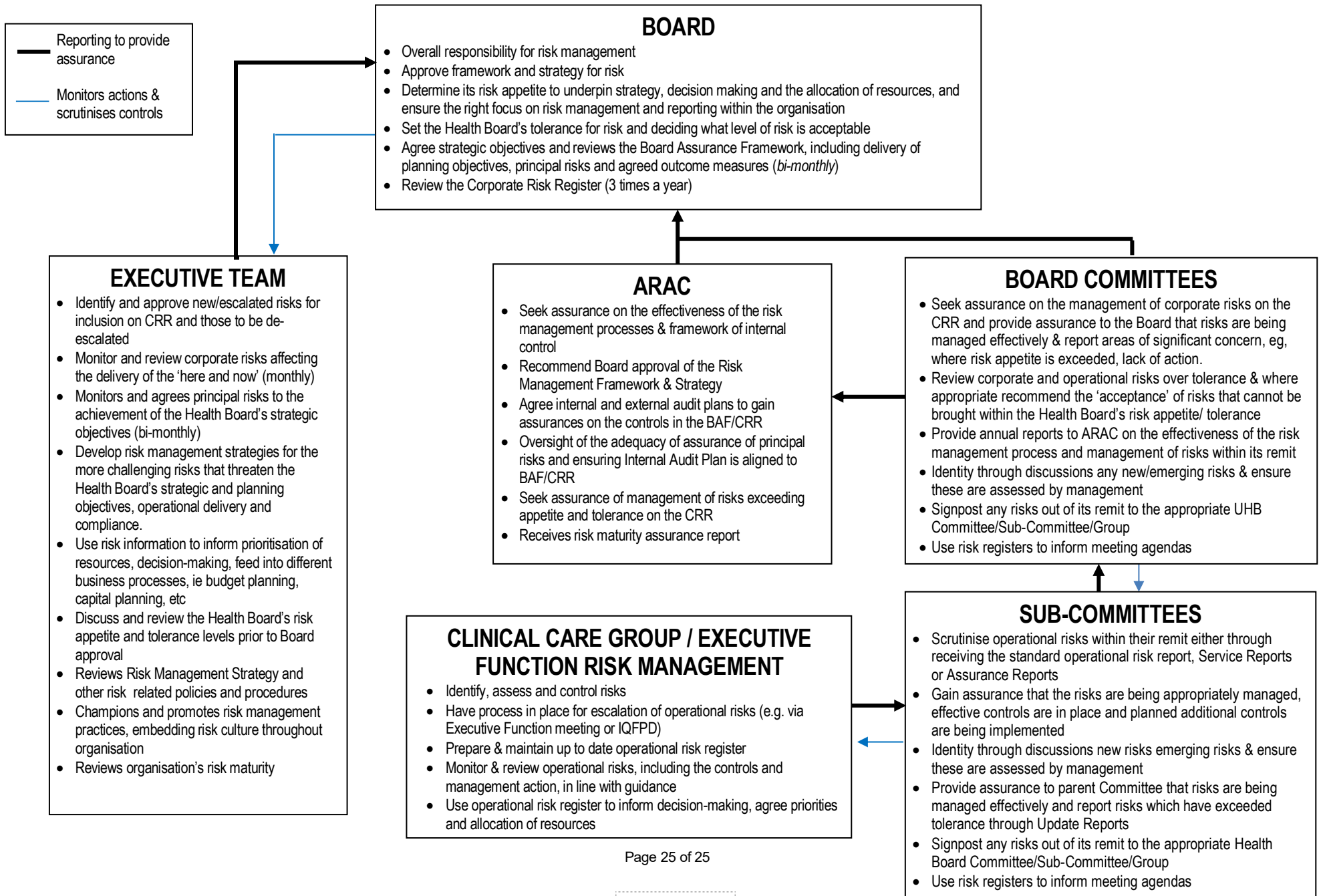
Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.2 Seek assurance on the management of principal risks within the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) allocated to the Committee and provide assurance 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 UHB's activities (including for hosted services and through partnerships and Joint Committees as appropriate).
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Contained within the body of the report
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Underpinning risk on the Datix Risk Module from across the UHB's services reviewed by risk leads/owners
Rhestr Termiau: Glossary of Terms:	Current Risk Score - Existing level of risk taking into account controls in place.

	<p>Target Risk Score - The ultimate level of risk that is desired by the organisation when <u>planned</u> controls (or actions) have been implemented.</p> <p>Tolerable risk – this is the level of risk that the Board agreed for each domain in September 2018 – Risk Appetite Statement</p>
<p>Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:</p>	N/A

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No direct impacts from report however impacts of each risk are outlined in risk description.
Ansawdd / Gofal Claf: Quality / Patient Care:	No direct impacts from report however impacts of each risk are outlined in risk description.
Gweithlu: Workforce:	No direct impacts from report however impacts of each risk are outlined in risk description.
Risg: Risk:	No direct impacts from report however organisations are expected to have effective risk management systems in place.
Cyfreithiol: Legal:	No direct impacts from report however proactive risk management including learning from incidents and events contributes towards reducing/eliminating recurrence of risk materialising and mitigates against any possible legal claim with a financial impact.
Enw Da: Reputational:	Poor management of risks can lead to loss of stakeholder confidence. Organisations are expected to have effective risk management systems in place and take steps to reduce/mitigate risks.
Gyfrinachedd: Privacy:	No direct impacts
Cydraddoldeb: Equality:	Has EqIA screening been undertaken? No Has a full EqIA been undertaken? No




Appendix 1 – Committee Reporting Structure



Risk Ref	Risk (for more detail see individual risk entries)	Executive Director	Domain	Tolerance Level	Previous Risk Score	Risk Score May-25	Trend	Target Risk Score	Expected Date of achieving Target Risk Score	Risk on page no...
1032	Risk of timely diagnosis and treatment of MH&LD clients due to demand and capacity	Carruthers, Andrew	Safety - Patient, Staff or Public	6	5×4=20	5×4=20	→	5×4=20		3
797	Risk to the ability to deliver ultrasound services due to workforce pressures	Carruthers, Andrew	Safety - Patient, Staff or Public	6	5×4=20	5×4=20	→	3×4=12		8
1027	Risk to delivery of timely urgent and emergency care due to demand exceeding current capacity	Carruthers, Andrew	Safety - Patient, Staff or Public	6	4×5=20	4×5=20	→	2×4=8	31/03/2026	12
1708	Risk of increasing fragility in primary care contractor services due external factors	Carruthers, Andrew	Service/Business interruption/disruption	6	4×4=16	4×4=16	→	3×4=12		18
1664	Risk to ophthalmology service delivery due to a national shortage Consultant Ophthalmologists and the inability to recruit	Carruthers, Andrew	Safety - Patient, Staff or Public	6	4×5=20	4×4=16	↓	2×5=10		24
684	Risk to the timely investment and replacement of Radiology equipment and supporting infrastructure	Carruthers, Andrew	Service/Business interruption/disruption	6	4×4=16	4×4=16	→	2×4=8		29
1859	Risk of poor patient outcomes and experience due to inability to effectively recognise and manage acute deterioration	Daniel, Sharon	Safety - Patient, Staff or Public	6	4×5=20	3×5=15	↓	2×5=10	13/12/2025	36
1810	Risk to delivering effective and timely cancer service due to Aseptic Unit facilities being non-compliant with QAAPS.	Carruthers, Andrew	Service/Business interruption/disruption	6	3×5=15	3×5=15	→	1×5=5		46
1531	Risk of being unable to safely support the Consultant on-call rota at WGH & GGH due to workforce pressures	Carruthers, Andrew	Safety - Patient, Staff or Public	6	4×5=20	3×5=15	↓	1×5=5		50

Assurance Key:

3 Lines of Defence (Assurance)		
1st Line	Business Management	Tends to be detailed assurance but lack independence
2nd Line	Corporate Oversight	Less detailed but slightly more independent
3rd Line	Independent Assurance	Often less detail but truly independent

Key - Assurance Required		<i>NB Assurance Map will tell you if you have sufficient sources of assurance not what those sources are telling you</i>
	Detailed review of relevant information	
	Medium level review	
	Cursory or narrow scope of review	

Key - Control RAG rating	
LOW	Significant concerns over the adequacy/effectiveness of the controls in place in proportion to the risks
MEDIUM	Some areas of concern over the adequacy/effectiveness of the controls in place in proportion to the risks
HIGH	Controls in place assessed as adequate/effective and in proportion to the risk
INSUFFICIENT	Insufficient information at present to judge the adequacy/effectiveness of the controls

Date Risk Identified:	Nov-20
Strategic Objective:	5. Safe and sustainable and accessible and kind care

Executive Director Owner:	Carruthers, Andrew	Date of Review:	May-25
Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Jun-25

Risk ID:	1032	Corporate Risk Description:	<p>There is a risk to the delivery of timely diagnosis to those on the ASD waiting lists within required timescales - Welsh Government performance standard of 26 weeks.</p> <p>This is caused by an increase in referrals, with demand outstripping capacity and lack of sustainable external funding. This could lead to an impact/affect on those currently awaiting diagnosis and intervention, resulting in delays in care and appropriate support and signposting in a timely manner which may lead to poorer patient outcomes, and delayed adjustments to educational needs. There will also be an impact on the ability of the Health Board to meet Welsh Government targets (diagnosis of ASD within 26 weeks) and the ability to meet the Health Board agreed trajectory of 1% improvement per month which could lead to increased scrutiny from regulators, and escalation from Welsh Government. This in turn could result in adverse publicity and a reduction in stakeholder confidence.</p>
Does this risk link to any Directorate (operational) risks?			138, 1249, 1286, 1287, 1392, 1455, 1422, 1524, 1290, 1260, 1699, 1745, 1414

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	5x4=20
Current Risk Score (L x I):	5x4=20
Target Risk Score (L x I):	5x4=20
Expected Date To Achieve TRS:	

Trend:	
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Rationale for CURRENT Risk Score:

The service is experiencing significant waiting times as a result of increasing demand levels which are exceeding pre-pandemic levels, compounded by the longer term impacts of Covid. Due to increasing demand there is an impact on the services' ability to see the same volume of service users as they were previously able to. Some posts continue to be funded on fixed term basis which can make staff retention challenging along with having to train new incoming staff.

Recommendations received from NHS Executive in relation to Children's ND services are in the process of being implemented. The Clinical Care Group is working with the Children, Women and Family Clinical Service Group to implement these.

For Autism Spectrum Disorder (ASD), a meeting took place with the Delivery Unit to establish trajectories, along with the commissioned service which since have been agreed in March 2023. The DU were unable to provide trajectories, therefore Health Board has agreed to a 1% monthly improvement trajectory.

Rationale for TARGET Risk Score:

The Directorate is prioritising implementation of WPAS in key areas within MHLD and this will enable improved reporting and waiting list management and enable forward trajectories of improvement in waiting times to be determined.

The target risk score will be dependent on securing recurring funding for Children's ND service as well as having access to appropriate clinical venues and other agencies being able to undertake their associated assessments, digital solutions and review of clinical pathways.

While trajectory plans are in place as of March 2025, there is recognition that the Health Board will not achieve WG targets. The end of procurement contracts with external providers will further negatively impact trajectories.





Unable to provide a target risk date.

The target risk score has been increased.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	How and when the Gap in control be addressed	By Who	By When	Progress
<p>Use of IT/virtual platforms such as Attend Anywhere when appropriate.</p> <p>Clinical prioritisation regarding assessment and treatment of service users by engaging in a dynamic process of reviewing waiting lists in line with any other referrals that may be received in respect of that service user.</p> <p>Additional WG funding received in 2022/23/24/25 for ND services - currently awaiting confirmation for the next three year cycle.</p> <p>Services are in contact with individuals to provide information regarding mainstream/Tier 0 support, wellbeing at home and guidance should their situation deteriorate.</p> <p>Process in place to ensure individuals on waiting lists are being contacted periodically through the wait for assessment/treatment to monitor any alteration in presentation.</p> <p>Autism Advice Hubs and pre-assessment workshops in place for Children Neurodevelopmental Service.</p> <p>Rolling programme of workshops offering advice and support around neuro-divergence for parents of children aged 2-11 years and 12 years and over awaiting diagnostic assessment.</p> <p>Monthly meetings to meet recommendations of NHS Executive's Action Plan in respect of CYP ND services in place.</p> <p>ND Service Delivery Manager appointed and in place.</p> <p>All posts recruited in to Children's ASD service. With the exception of clinical psychology in adult autism services, all clinical substantive posts recruited in to, with no retention issues.</p>	<p>Although dedicated premises have been sourced for ASD services, there is limited clinical space and Estate issues remain a challenge as identified in the risk narrative.</p> <p>Information not currently included on Health Board website or QR codes due to IT difficulties.</p> <p>Additional funding received in 2022/23 for ND service on fixed term annual basis until 2025.</p> <p>Current resource does not provide sufficient capacity to meet demand.</p>	<p>Identify alternative venues/space/ virtual to hold clinics (Integrated Psychological Services).</p>	<p>Homfray, Andrew</p>	<p>Completed</p>	<p>Integrated Psychological Therapies Service de-escalated by NHS Executive from Targeted Intervention.</p>
	<p>Current procurement exercise to outsource portion of diagnostic assessments to external provider for children and adult services ends March 2025 and will further negatively impact trajectory.</p> <p>Rapid Design Event to achieve critical, systemic and needs led transformation of children's ND services held on 27th and 28th of November 2024. Awaiting outcome report from Welsh Government.</p> <p>Keeping in Touch letters not being sent as of May 2025 - there is a contract</p>	<p>Development of a MH/LD essential training framework to reflect training needs across MH/LD services based on a systematic Training Needs Analysis that can be reviewed at regular intervals and monitored for compliance.</p>	<p>Temple-Purcell, Rebecca</p>	<p>30/11/2023 31/12/2024 31/03/2025</p>	<p>In progress, working with Workforce to develop a training needs and analysis tool. MH&LD to act as a pilot for this pending further roll out across the HB. Ongoing.</p>

<p>Workforce Management Group has been established which meets monthly.</p> <p>Trajectories have been agreed for Children's ND by NHS Executive and there are systems in place to monitor waiting lists at service level performance-management meetings, IPAR and Directorate service review meetings.</p> <p>Monthly meetings with Estates to look at accessing/leasing/enhancing the current MH estates with a view to increase MH estate footprint.</p> <p>Use of HB Third Party Contractor to send out Keeping in touch letters and sent to those on ASD waiting lists on a 3-4 monthly basis confirming place on waiting list and signposting to sources of support including access to ND services while waiting.</p> <p>Service Leads secured outsourcing for ASD services up to 2025. Commissioned external provider for ASD services across all ages.</p> <p>Additional NDIP funding secured to outsource a further portion of diagnostic assessments for Children and Young People for previous financial year.</p> <p>Quarterly meetings with the NHS Executive, Welsh Government and Service Leads at the Health Board.</p> <p>SMS functionality in place for ND to improve attendance and decrease instances of non attendance.</p> <p>Support workers recruited in to Children's ND service.</p>	<p>monitoring meeting taking place as they haven't been meeting the standards set.</p> <p>Dedicated website being launched imminently but the availability of resources for parent/carers are limited due to digital accessibility laws.</p>	<p>ND specific HB internet and intranet pages in development to give guidance and support whilst neuro-divergent individuals and parent carers are waiting.</p>	<p>vaughan, Catherine</p>	<p>31/10/2024 31/12/2024 31/03/2025 30/09/2025</p>	<p>Series of meetings held with Communications team and ND services prioritised to include children's ADHD, Adult ADHD, Integrated Autism Service and Children's ASD service</p> <p>Website remains in development, although all material ready. Adult IAS and Childrens ND content now ready. Awaiting final go live.</p> <p>Children's ADHD and Adult ADHD website has been launched. Digital accessibility issues are being worked through. Due to go live September 2025.</p>
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<p>Current staff received relevant training, and processes in place to assess training needs on induction for any new starters.</p> <p>"Rapid Access" developed to diagnosis (service improvement initiative) currently being piloted in Children's ND. Started in April 2025.</p> <p>Developed an Early Years pathways for Health Visitors.</p> <p>Social Care and Education Interface Meeting with Carmarthenshire Local Authority to stem the flow (promoting a needs led approach).</p> <p>Fixed term contracts have been agreed for staff until the end of March 2026.</p> <p>Additional resource for admin cover to ND services for a 12 month period.</p>		<p>Grow your own' scheme is coming into place with funding provided in academic year 23/24 for 3 places on the Clinical Psychologist programme (3 year programme).</p>	<p>Carroll, Mrs Liz</p>	<p>31/12/2024 31/12/2027</p>	<p>Three year training programme with graduates during 2027.</p>
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ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance  Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Welsh Government performance indicators along with internal monitoring arrangements will be used to ensure the actions are having the desired effect or whether there is more that needs to be done.	Management monitoring of referrals	1st			Update - Risk 1032: Mental Health and Learning Disabilities Waiting Lists - QSEC (Oct21) MHLD progress update on Planning Objective 5G - Board (Mar22) Papers have been presented	System to improve analysis of patient experience				
	Monthly MH&LD Business Planning and Performance Group overseeing performance	2nd								

MH&LD QSE Group overseeing patient outcomes	2nd			at the Quality Safety and Experience Assurance Committee				
Update - Risk 1032: Mental Health and Learning Disabilities Waiting Lists - QSEC	2nd			with a further update paper provided for the December 2021 meeting				
W-PAS Internal Audit (reasonable assurance)	3rd			outlining control measures to manage the waiting times that the Directorate have at present. A paper was presented at Board Seminar in June 2022 to provide assurance on current waiting times and control measures.				
An update was requested by the Chair and provided for the August Quality, Safety, Assurance Committee.								
An updated paper was submitted to the December 2024 meeting of the Integrated Quality Finance Performance Delivery Group.								
Rapid Access Pilot Steering Group (add as action - look at other pathway options/digital)								

Date Risk Identified:	Nov-19
Strategic Objective:	

Executive Director Owner:	Carruthers, Andrew	Date of Review:	Apr-25
Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	May-25

Risk ID:	797	Corporate Risk Description:	<p>There is a risk of being unable to provide a full range of ultrasound services including obstetric and non-obstetric ultrasound across the Health Board. This is caused by workforce pipeline and retention: the retirement and resignation of current sonography staff, low availability of sonographers UK wide, and the inability to recruit to due national shortages of qualified staff, and the inability release existing workforce to train and develop to meet both current and future service demands. Current pressures are also leading to existing staff harm due to repetitive strain injuries (RSI).</p> <p>demand and capacity: there is a gap between funded establishment and demand for ultrasound services</p> <p>This could lead to an impact/affect on patient safety: delays in diagnosis which could result in detrimental outcomes for patients, inability to meet diagnostic targets and cancer pathway targets, and an inability to hold clinics to meet demand in ante natal screening services within required timescales and to implement national scanning guidance.</p> <p>workforce: An impact on staff health and wellbeing in terms of the volume of patients examined within a shift/overtime, which could lead to increased incidents of staff stress and burnout. This could ultimately lead to increased errors when performing the dynamic diagnostic test. This could also lead to increased RIDDOR reporting due to the harm being caused to staff.</p> <p>compliance and litigation: increased instances of RIDDOR and health and safety reporting could trigger monitoring actions by relevant regulator. In the case of obstetric ultrasound, this could lead to failure to detect in utero anomalies, life long, limiting or changing duration which places the Health Board at significant risk of litigation</p>
Does this risk link to any Directorate (operational) risks?		1557, 1349, 1658, 1936	

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	5x4=20
Current Risk Score (L x I):	5x4=20
Target Risk Score (L x I):	3x4=12
Expected Date To Achieve TRS:	
Tolerable Risk:	6

Trend:	↔
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Rationale for CURRENT Risk Score:

Despite best efforts, the service remains fragile. As of January 2025, remaining vacancies have been advertised and appointed as training posts under Annex 21 posts, with trainees expected to qualify in September 2026

If all vacancies were recruited to, the Health Board would still not have the capacity to meet current demand (as at end March 2025) there were 1,110 patients waiting 8 weeks plus for non-obstetric ultrasound (February 2024:1288, March 2024:917, April 2024:962, May 2024:731, June 2024 608, July 2024 555, December 2024: 1,960, Jan 2025: 2,301).

Reduction in 2025 due to insourcing ultrasound services

Long term vacancies exist in Withybush with maternity leave which started in summer of 2024 impacting the fragility further. There are 2 potential retirements at PPH in the near future and a number in BGH, which constitute a significant percentage of the workforce. There will be an inability to secure high cost agency staff due to the current financial climate of the Health Board. However, in the event of recovery monies being made available we will be able to re-initiate the current ultrasound insourcing contract

Three Radiographer sonographers and two Midwife sonographers commenced training in January 2024, however training takes two years to complete for Radiographer Sonographers and 1 year for midwife sonographers (obstetric only).

Only 13.82% of ultrasound USC's carried out and reported in 7 days, 37.53% carried out and reported in 14 days at end March 2025.

Rationale for TARGET Risk Score:

The actions below will not in themselves reduce this risk significantly. Demand and capacity and the current establishment review is being undertaken by the Ultrasound control group via a needs assessment which was due to be completed by the end of Autumn 2024. It is likely that these reviews will lead to a need for further investment and additional funding to establish a sustainable service model to include a robust perpetual training programme, that will enable the Health Board to meet expected diagnostic waiting times targets.

Radiology wide demand and capacity work has been undertaken by the Radiology Department which has included the non-obstetric element and has been described in the 2025-2026 annual plan and as of 24/01/2025 an accompanying paper for Board consideration requesting workforce investment in Radiology was submitted on 11/02/2025 and describes the plan for recruitment and expansion of training in all areas of Radiology, including Ultrasound. The annual plan was approved at the March Board meeting and Radiology are working with executives as of April 2025 to answer queries in relation to the agreed investment.

Improvement has been seen during Q4 of 2024 and Q1 2025 due to the insourcing at additional cost.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	How and when the Gap in control be addressed	By Who	By When	Progress
<p>Process in place for the movement of staff across the Health Board to maintain capacity where possible.</p> <p>Conversion of room to increase capacity @ GGH</p> <p>Employment of Physiotherapists and Midwives to undertake scanning within scope of expertise</p> <p>Utilising insourced ultrasound service to reduce backlogs of patients waiting >8weeks (recovery funded).</p> <p>Rolling bank adverts for sonographers.</p> <p>Clinical Educator in post, facilitating the expansion of training across site.</p> <p>Monitoring of cancer patient pathways with ultrasound requirements via weekly Cancer Watchtower, and monthly Cancer and Radiology escalation meetings. Meetings chaired by General Manager of Planned Care and Cancer Services.</p> <p>Continuous recruitment and training of sonographers within current establishment</p> <p>Annex 21 process in place, commencing in January of each year, to train over a period of 2 years sonographers</p>	<p>Inability to recruit and retain sufficient numbers of trained staff.</p> <p>Whilst staff are on the Annex 21 programme, they are not fully qualified until completion of 2 years training and preceptorship (these gaps are covered by insourcing during this period of time)</p> <p>While process in place regarding the movement in staff, due to current staffing levels and pressures, this is not being implemented, however the teams across sites are collaborating and look at all possibilities when gaps in rota arise and are foreseen.</p> <p>Whilst an Ultrasound Control Group is in place, meetings are infrequent due to availability of attendees.</p>	<p>Further action necessary to address the controls gaps</p> <p>Develop and implement a plan to help alleviate pressures through increasing the number of growth scan checks undertaken by midwives.</p>	<p>Llewellyn, Cerian</p>	<p>31/12/2022 31/10/2023 31/01/2024 30/06/2024 31/01/2025 31/01/2026</p>	<p>The date of completion of this action has been changed to 31/01/2026 as the midwife identified for training did not start until Jan 2025 due to lack of process to support the clinical aspects and a change in maternity management.</p> <p>Maternity and child health are required to advise of the plan to utilise the skills of the trainee midwife sonographer and also any plans to train more staff.</p>
		<p>Train members of staff to become sonographers, the number of which dependant on capacity to take training.</p>	<p>Roberts-Davies, Gail</p>	<p>31/03/2020 31/12/2022 01/02/2023 30/09/2024 31/01/2026</p>	<p>08/04 update. Approval of annual plan, however additional recovery funding has not yet been sourced. Current phasing when signed off will allow the recruitment of 1 additional Sonographer due to the need to fund recovery from recurrent monies.</p>
			<p>Await outcome of Radiology Annual Plan and request for additional workforce investment to enact next phase of recruitment to train.</p>	<p>Roberts-Davies, Gail</p>	<p>Completed</p>

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Non-Obs ultrasound - longest wait 53 weeks as at end March 2025 with 1,110 patients waiting over 8 weeks. Radiology Dashboard IPAR Reports WG Cancer PTL, reported monthly	Management review of sonography and SCP diagnostic waiting times	1st			Sonography Report to Acute Leadership Group (ALG) and Operation Planning and Delivery Programme meeting					
	Monthly review of USC performance undertaken monthly (13.82% of ultrasound USC's carried out and reported in 7 days, 37.53% carried out and reported in 14 days at end March 2025), included in the IPAR & reported to WG	1st								
	Performance monitored at Executive Improving Together Sessions	2nd								
	Performance monitored via IPAR, overseen SDODC & Board	2nd								
	Ultrasound Services Internal Audit, July 2024 reasonable assurance provided	3rd								

Date Risk Identified:	Nov-20
Strategic Objective:	5. Safe and sustainable and accessible and kind care

Executive Director Owner:	Carruthers, Andrew	Date of Review:	May-25
Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Jun-25

Risk ID:	1027	Corporate Risk Description:	<p>There is a risk to the consistent delivery of timely and high quality urgent and emergency care.</p> <p>This is caused by significant fragility across the urgent and emergency care (UEC) system (acute, primary care (including out of hours), community and social care services), related to workforce compromise and increasing levels of demand and acuity. This could lead to an impact/affect on the quality of care provided to patients, significant clinical deterioration, delays in care and poorer outcomes, increased incidents of a serious nature relating to ambulance handover delays and overcrowding at Emergency Departments (ED) and delayed ambulance response to community emergency calls, increasing pressure of adverse publicity/reduction in stakeholder confidence and increased scrutiny from regulators.</p>
Does this risk link to any Directorate (operational) risks?		1649, 1406, 1548, 1210, 750, 205, 86, 820, 232, 1298, 1281, 906, 1380, 1116, 878, 839, 1167, 1223, 111, 114, 199, 523, 136, 200, 1115, 1078, 572, 1295, 1231, 966, 967, 565, 852, 1295, 1435, 1377, 1083, 180, 1424, 1417, 1309, 291, 118, 925, 119, 1245, 695	

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	5x5=25
Current Risk Score (L x I):	4x5=20
Target Risk Score (L x I):	2x4=8
Expected Date To Achieve TRS:	31/03/2026
Tolerable Risk:	6

Trend:	↔
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Date	Current Risk Score	Target Risk Score	Tolerance Level
Dec-20	15	12	6
May-21	15	12	6
Jan-22	20	12	6
Jun-22	25	12	6
Dec-22	20	12	6
May-23	20	12	6
Oct-23	20	12	6
Feb-24	20	12	6

Rationale for CURRENT Risk Score:

Levels of urgent and emergency pathway capacity pressures continue at significantly escalated levels. Workforce deficits, handover delays, 4- and 12-hour performance, bed occupancy rates and significant pressures on wider community and social care capacity are all demonstrating lack of sustainable improvement. The situation remains at high levels of risk escalation across our acute sites on a daily basis.

Whilst some positive progress has been achieved in reducing ambulance handover delays and pathways of care delays, Glangwili Hospital (GGH), Bronglais (BGH) and Worthybush (WGH) remain a major pressure in the UEC system.

Whilst recent experience suggests early signs of improvement against key UEC metrics, these remain outside target requirements. Data for April 2025 highlighted that the number of ambulance handovers taking over one hour was 866, although this is an improvement in comparison to April 2024 (1103) it is not meeting the TI target of 605 which needs to be maintained for 3 months.

Breaches were also noted with the number of patients spending 12 hours or more in A&E / MIU, with actual figure of 1,372 (9%) in April 2025 (compared to 1,543 in November 2024) exceeding the target of 1,137 (7%) TI target. The median time to assessment by a clinical decision maker in April 2025 was 79mins (November 2024 87mins), exceeding the national target of 60 minutes. The Health Board were also over target in April 2025 in relation to Pathway of Care Delays, with actual figure of 223 (November 2024, 204) exceeding the target of 165. As such, the current risk score remains unchanged as at May 2025, pending further review.

Recent external reviews (NHS Executive Same Day Emergency Care (SDEC) Review, NHS Executive ED Review and GIRFT Review on ED) continue to identify concerns with patient flow and quality of service, with a Ministerial Advisory Group (MAG) review received in March 2025.

Rationale for TARGET Risk Score:

The Target Risk Score of 8 reflects the confidence in the delivery of 6 Goals Programme to address the significant issues across the health and care system.

Plans for improvement during 2025/26 are reflected in the HB's Annual Plan, approved by the Board in March 2025, and are informing next year's Annual Plan. The 6 goals plan has been approved by WG in March 2025.

TI measures such as ambulance handovers and 12 hour delays in ED will need to improve in order to reduce the current risk score, for a consecutive period of three months.

UEC Transformation Acceleration Group (TAG) meeting weekly and reporting fortnightly into Formal Executive Team.

An expected date of March 2026 has been noted to achieve the target risk score of 8, to allow the transformation change to embed.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	How and when the Gap in control be addressed	By Who	By When	Progress
<p># Live Operational Dashboard in place and twice HB wide escalation meeting.</p> <p># Reviews of patients admitted to surged areas to ensure patient acuity and dependency is monitored and controlled. Surge and boarding recorded on the twice a day escalation report.</p> <p># Frontier system in place for recording DPOC and red days flagging required assessments to support discharge.</p> <p># Surge beds continue as per escalation and risk assessment of site demand and acuity (where staffing allows). A daily review of the use of surge beds via patient flow meetings to facilitate step down of beds.</p> <p># Regular reviews of long stay patients over 7 days at weekly meetings across all hospital sites with associated actions in collaboration with social care partners.</p> <p># Regular advice on discharge planning and complex care management is provided to ward based staff through Community Discharge Liaison teams, social services and the Long Term Care Team support.</p> <p># Discharge arrangements are in place on all sites with a strategic review underway.</p> <p># Standardised board rounds processes in place on all sites and D2RA processes are embedded with a 77% D2RA rate (Sep24).</p> <p># Criteria-led discharge guidance and principles piloted across HB (Sep24).</p> <p># Integrated Regional Winter Plans developed to manage whole system pressures over the winter period.</p> <p># An operationally focussed 6 Goals Urgent and Emergency Care (UEC) programme with governance structure agreed where all UEC improvement is coordinated.</p> <p># Welsh Ambulance Services NHS Trust involved in all 6 Goals UEC workstreams.</p> <p># 111 and 111 press 2 (MH) implemented across Hywel Dda.</p>	<p># Fragility of Care Home Sector such as financial viability, staffing deficits, recruitment and retention of workforce.</p> <p># Significant paucity of domiciliary care/social care availability due to recruitment and retention of staff.</p> <p># Inability to handover ambulances to release them back for use within community due to lack of flow in acute sites.</p> <p># Need to have better understanding of ED presentations to ensure development of alternative pathways in primary care / community to prevent ED attendance.</p> <p># Ability to influence public mind set / expectation and culture in terms of use of NHS resource and 'Home First' Ability.</p> <p># Gap in communication between secondary and primary care that could lead to poor discharge outcomes.</p> <p># Clarity regarding roles and responsibilities for discharge planning and coordination.</p> <p># The inability to risk stratify for people at moderate to high risk of admission in the community to implement proactive anticipatory care plans to support avoidance of exacerbation / decompensation and hence increased</p>	<p>Delivery of 6 Goals Programme and Plan via the workstreams and closer working with WAST and primary care</p> <p>1. Development of Regional Clinical Streaming Hub (CSH) for Health Professionals & Care Homes delivering 24/7 urgent care advice & support and onward referral to local deliver/resource hubs where appropriate</p> <p>Develop a consultant led ED medical provision that is fit for purpose and meets the D&C requirements utilising all professions.</p> <p>Winter Communication Plan for UEC to include advising the public on community pharmacy provision and avoiding falls</p> <p>Utilise the risk stratification data set across the system proactively with the population</p> <p>Review of Community bed based hospital capacity, with a view to ensuring proactive case load management and estate as part of the Alternative Care Model work. Develop & implement strategy for Alternative Care Community (ACP) Provision across the West Wales region.</p>	<p>Skitt, Peter</p> <p>Skitt, Peter</p> <p>Skitt, Peter</p> <p>Skitt, Peter</p> <p>Skitt, Peter</p>	<p>31/10/2025</p> <p>31/03/2025 30/09/2025</p> <p>Completed</p> <p>30/04/2025 31/10/2025</p> <p>31/10/2025</p>	<p>Piloting a 7 day model on the CSH across the Health Board as part of winter planning (utilising overtime and additional shifts) with an evaluation being finalised by end of May 2025. The plan to produce a business case for substantive arrangements is including in the Accelerated UEC Transformation work to be delivered by October 2025.</p> <p>Discussions have started, with a lead for the discussion appointed.</p> <p>Lead ED Consultant had gone out to advert as of May 2025 (closing June 2025) following previous advertisement unsuccessful. advised appointment date of September 2025.</p> <p>Communications engagement leads contacted, with a plan in place and social media communications active.</p> <p>Part of First Home Hub plan and work is underway. Data is being used in primary care multi-disciplinary team meetings across the Health Board and WGH, and requires further embedding to ensure the impact within acute sector is realised.</p> <p>Initial planning and audit of capacity has been completed. Length of stay data being gathered by County Leads.</p>

<p># Regional Integration Fund projects in place across Regional Partnership Board (RPB) footprint, along with Further Faster projects to ensure alignment with Ministerial objectives.</p> <p># Whole system approach to deploy HB staff to ensure continuity of patient care.</p> <p># Care Home Risk & Escalation Policy to support failing care homes to be applied as required.</p> <p># Domiciliary Care Risk and Escalation Policy approved by Integrated Executive Group and implemented across the RPB region.</p> <p># Establishment of a Discharge to Recover and Assess (D2RA) Group which reports to the the 6 Goals Programme with a detailed D2RA improvement plan in place.</p> <p># Establishment of a D2RA Escalation Transfer panel which provides senior oversight of delays at county level, assesses risk of the delay to the patient and organisation in terms of flow compromise</p> <p># SRO in place to lead agreed 6 Goals for UEC programme.</p> <p># Agreed SDEC model in place to maximise impact on admission avoidance. NHS Executive review with associate actions are part of the 6 goals UEC programme.</p> <p># Local streaming (Home First) hubs developed with a HB wide approach agreed with clinical triage and screening systems in place, including APP Navigator in place.</p> <p># Direct referral into SDEC in place.</p> <p># OOH Pilot clinical streaming via GP route ongoing as of January 2025 with a view to full completion at the end of the month</p> <p># Clinical Care Group structure in place where this risk is discussed at the quality meeting.</p> <p>#UEC Transformation Acceleration Group (TAG) meeting weekly and reporting fortnightly into Formal Executive Team.</p>	<p>risk of hospital admission.</p> <p># Optimising our bedded facilities in the community.</p> <p># Need to develop 24/7 integrated urgent primary care service aligned to Home First hubs.</p> <p># Insufficient IPC single rooms across community and acute sites, negatively impacting on patient flow.</p> <p># Lack of level 1 / 2 falls response service during out of hours across the Health Board.</p> <p># Fragility of senior medical cover at EDs across the acute sites.</p> <p># Need to create a Health Board wide Frailty approach and appoint a Clinical Lead for Frailty.</p> <p># 7 day services within the Community are required, particularly around Clinical Streaming Hubs and level 1 / 2 Falls.</p>	<p>Enhancements to local delivery / resource hubs to support the CSH providing access to enhanced community care services, third sector services and other pathways to provide safe alternatives to admission. Integration with GP OOHs and APP resources</p> <p>Development & implementation of consistent approach to Front Door Streaming / Assessment Units focused on our Frail Elderly cohort based on good practice and lessons learnt from Withybush Puffin / South Pembrokeshire model.</p> <p>Development and implementation of HDUHB optimal SDEC model following on from lessons learnt from peer review and alignment with CSH and local resource hubs.</p> <p>Continued implementation of Optimal Flow Framework including Community sites supported by Frontier digital platform.</p> <p>Continuing education at ward level to ensure consistent approach to Board Rounds and Safety Patient Huddles utilising Frontier platform to capture and report information.</p> <p>Implementation of 7 focused areas within ED Quality statement.</p>	<p>Skitt, Peter</p> <p>Skitt, Peter</p> <p>Skitt, Peter</p> <p>Skitt, Peter</p> <p>Skitt, Peter</p> <p>Skitt, Peter</p>	<p>31/10/2025</p> <p>31/12/2025</p> <p>31/10/2025</p> <p>31/10/2025</p> <p>Completed</p> <p>31/03/2026</p>	<p>Discussions ongoing on providing a single clinical streaming hub across the Health Board footprint, with response resources locally based at cluster level as a phased approach to introducing the care at home blueprint, as described during the 6 Goals review meetings. This will feature strongly in the Accelerated USC Transformation work.</p> <p>SDEC services available on all sites for medical patients. Surgical SDECs piloted in Glangwili and Bronglais (with further expansion during the next 6 months). Ongoing discussion with Glangwili relating to frailty provision, and further work required in Bronglais (nurse-led frailty team at the front door).</p> <p>An SBAR has been developed to standardise the approach across the Health Board, which is to be discussed at the CCG July 2025 meeting.</p> <p>On track with roll out plan, and ensuring that all sites are using the framework is ongoing. This work will also feed in to the E-Obs and patient flow project going forward.</p> <p>This action links with the management actions as noted in the Discharge Management internal audit issued. This is now complete and evidence to be uploaded to AMaT.</p> <p>Clinical lead for ED post currently out to advert.</p> <p>ED Quality Statement Action group in place, who report 6 weekly to Welsh Government. Action plan developed and in place, forming the basis of updates to WG, based around the national toolkit.</p>
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	Develop West Wales Hospital @ Home model to ensure consistent approach and delivery.	Skitt, Peter	30/09/2025	Phased approach to the delivery of the model, with strategic document currently being developed, to be agreed by clinical leads and 6 Goals advisory group.
	Establishment of a regional Discharge Strategy Group to provide oversight of all current work streams and actions being undertaken around discharge as well as work around national and local policies - Discharge and Transfer of Care Policy, Reluctant Discharge Policy, Care Home of Choice policy.	Skitt, Peter	Completed	POCD group and Trusted Assessor group in place, and Discharge Strategy group to provide oversight and actions, chaired Assistant Director of Nursing. This work will align with the delivery of the management actions of the internal audit on Discharge Management, which is being monitored by the Health Board via AMAT. Action complete and toolkits available.
	Establish regional POCD group to focus on reviewing of trends and themes to develop robust regional or local action plans to deliver improvement.	Skitt, Peter	Completed	In place as at January 2025, and regular monthly meetings with Welsh Government, and onward submission of data. Monitored via the 50 Day Challenge Care Action Committee (CAC) group.
	Develop robust regional Trusted Assessor (TA) Model to ensuring consistent approach to assessment across the region - residents can be an inpatient at any of the 4 x general hospital sites.	Skitt, Peter	31/10/2025	Trusted Assessor regional group in place focussing on the model and reporting required to Welsh Government, aligned to further faster monies. A National Audit is to take place in Summer 2025 on Trusted Assessors across the West Wales region.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Ambulance handovers within 15 minutes	Medically optimised and ready to transfer patients are reported 3 times daily on situation reports	1st				None identified.				
Ambulance handovers over 1 hour	Daily performance data overseen by service management	1st								
Ambulance handovers over 4 hours	Workstream Delivery Plans overseen by 6 Goals Programme	2nd								
4 & 12 hour waits in A&E	6 Goals Programme / UEC IQFPD 3As report into IQFPD	2nd								
Time to triage in A&E	Bi-annual reports to SDODC on progress on delivery plans and outcomes (and to Board via update report)	2nd								
Time to see a Doctor in A&E	IPAR Performance Report to SDODC & Board	2nd								
Pathway of care delays	IA review on Transforming Urgent and Emergency Care	3rd								
	NHS Executive Same Day Emergency Care (SDEC) Review	3rd								
	NHS Executive ED Review	3rd								
	GIRFT Review on ED	3rd								
	MAG review	3rd								

Date Risk Identified:	Jul-23
Strategic Objective:	

Executive Director Owner:	Carruthers, Andrew	Date of Review:	Apr-25
Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	May-25

Risk ID:	1708	Corporate Risk Description:	There is a risk of increasing fragility in Primary Care Contractor services. This is caused by several factors including pay-affecting Government decisions, which impacts on succession planning for contractor professions. There are further challenges in relation to premises not being fit for purpose, and not having the capacity to flex to a more modern approach to service delivery e.g. MDT working. In addition, contract reform against the background of significant pressures on the wider system, and exacerbated by financial pressures for the independent contractor business model. This could lead to an impact/affect on undermining the independent contractor model, and therefore the ability for patients to access timely and local primary care services, with potential for demand exceeding capacity. If service users are unable to access these services, this may lead to additional pressures on other primary care services, and wider Health Board services such as Out of Hours and Urgent and Emergency Care. As a result of contract terminations, there will be a detrimental impact on the financial position of the directorate relating to dental contracts.
Does this risk link to any Directorate (operational) risks?		1688, 1451, 1403, 1164, 1660, 933, 800. 912, 1823, 1869, 1109, 1851, 1823, 1993	

Risk Rating:(Likelihood x Impact)	
Domain:	Service/Business interruption/disruption
Inherent Risk Score (L x I):	4x4=16
Current Risk Score (L x I):	4x4=16
Target Risk Score (L x I):	3x4=12
Expected Date To Achieve TRS:	
Tolerable Risk:	6
Trend:	↔

Date	Current Risk Score	Target Risk Score	Tolerance Level
Aug-23	16	8	6
Nov-23	15	8	6
Feb-24	15	8	6
May-24	15	8	6
Jul-24	15	8	6
Sep-24	15	8	6
Dec-24	15	8	6
Feb-25	15	12	6

Rationale for CURRENT Risk Score:

8 dental contracts have been returned to the Health Board in the last 12 months, of which four contracts (totalling £958,500) confirmed as being awarded by NWSSP Procurement Services in May 2024. In addition, a further 8 dental practices have not signed up to the contract reform, and signalling that they will return contracts once reform negotiations have concluded. The number of complaints received from the public has increased due to returned contracts, and while the Health Board is currently containing the demand for urgent dental care, it is recognised that patients who don't fall in to this category but require a level of dental care are detrimentally impacted, and that any further contracts returned will exacerbate this situation. The capacity of the Health Board in terms of staffing to absorb further contract reform will impact on the ability to effectively deliver services, and a detrimental impact on staff welfare. There has been increased demand in urgent dental appointments resulting in appointments for the week being booked up early within the same week. The Dental Access Portal (DAP) pilot commenced in Powys in June 2024, with roll out at Hywel Dda commencing in November 2024.

2 GMS contracts have been returned to the Health Board in the last 12 months. However from previous contract terminations, 2 of the 3 GMS contracts have become Health Board managed practices, resulting in additional financial pressures as the workforce is salaried. The third practice has been awarded as of 1st April 2024 after a successful procurement process. The outcome of the contract which was returned in April 2024 was presented and agreed by Board in July 2024, with decision made to manage list dispersal. It is recognised that any further managed practices would likely have a negative impact on the GMS budget.



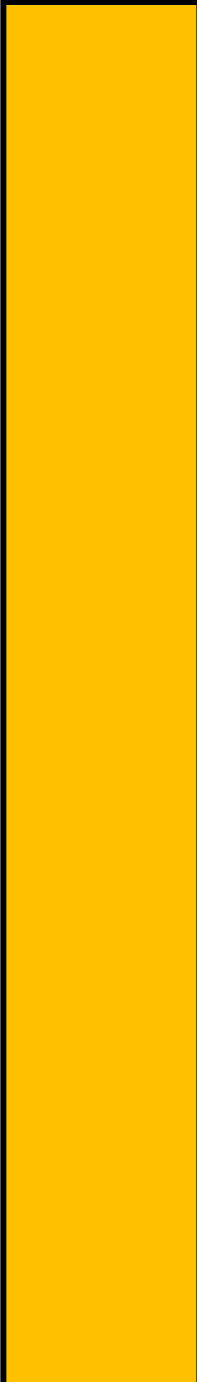


Implementation plans are in place with Ophthalmology to support the transition of patients into Welsh General Optometric Service (WGOS4) (clinical pathways for Glaucoma, HCQ and Medical Retina) as part of the new Optometry contract implementation which commenced in September 2024.

Rationale for TARGET Risk Score:

Achievement of the target score is subject to the development and agreement of a Primary Care Strategy at Board alongside successful national contract negotiations and subsequent implementation across the Primary Care contractor professional groups. There is a high dependency on external factors which make the reduction of the risk score challenging. It is unlikely that the risk score will reduce to the target risk score within 12 months without the approval of the Primary Care Strategy. Successful conclusion of contract negotiations with professional contractor groups also required.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	How and when the Gap in control be addressed	By Who	By When	Progress
<p>Primary Care Academy in place, which looks at workforce planning, training and development needs and opportunities</p> <p>5 Facet Survey completed in 2022 to establish a baseline for the GMS estate</p> <p>GMS and Dental Practices undertake annual reporting which includes reviews of statutory compliance requirements</p> <p>0.25 FTE Primary Care Development Manager for estates in post but with a focus on GMS</p> <p>Escalation tool for GMS and Community Pharmacy (SITREP)</p> <p>Continue effective engagement with struggling practices to support with their issues through close working relationships developed with practices.</p> <p>Programme of practice visits to review Estates provision, and if remedial action is required</p> <p>Requests sent to contractors to assess potential risk of RAAC, with outcomes reported to WG</p> <p>Nationally agreed Breach Management process in place for Community Pharmacies.</p> <p>Requests for contract variation (termination, merger, branch surgery closure etc) are considered in line with national guidance, with panels convened as stipulated. Recommendations are taken through the Primary Care Contract Review Group with papers to Board when required.</p> <p>Strategic Programme for Primary Care (SPCC) bids approved for 2024/25 and 2025/26 to support workforce initiatives</p> <p>A series of patient facing videos have been developed with Pocket Medic to support patient education in accessing Primary Care Services</p> <p>Whilst Community Pharmacy Breach Management process in place, which has been reviewed in light of appeals process.</p> <p>GMS contract management review process in place, reviewing escalation status, sustainability assurance framework and business continuity plans. Data is</p>	<p>Requests for support on addressing the GMS sustainability agenda are with the Strategic Programme for Primary Care as a result of a review paper across all Health Boards on their sustainability pressures.</p> <p>National work on the development of the escalation tool for Dental and Optometry is ongoing but not live.</p> <p>Five Facet Survey and annual reporting of practices has highlighted non-compliance with statutory requirements such as Health and Safety, Fire and IP&C which have now all been completed, however this is a statutory requirement for the practices to complete.</p> <p>Limited requirements for practices to disclose information to the Health Board about their sustainability pressures, and rare for practices to disclose financial details (reliant on engagement and good will as this is not a contractual requirement).</p> <p>Insufficient resources to support the estates development across all Primary Care services, particularly with independent contractors. Due to national review of Premises Directions, there is no improvement grant funding for 2024/25.</p> <p>Whilst Community Pharmacy Breach Management process in place, which has been reviewed in light of appeals process.</p>	<p>Further action necessary to address the controls gaps</p> <p>Establish workforce plan and recruitment strategy in line with the development of the national Primary Care Workforce Strategy and as a component of the Primary Care Strategy.</p> <p>To develop the Primary Care Strategy in consultation with statutory stakeholders and consultees, to cover areas including:</p> <ul style="list-style-type: none"> •Workforce •Sustainable provision of Primary Care services •Estates •Managing contractual change •Developing pathways and new services •Improving access to services across all contractor professions 	<p>Hughes, Samantha</p> <p>Bond, Rhian</p>	<p>31/03/2024 31/03/2025 30/09/2025</p> <p>30/09/2024 31/03/2025 30/09/2025</p>	<p>Workforce planning continues. GP Practice workforce plans using data from Welsh National Workforce Reporting System (WNWRS) have been pulled together at Cluster level for Collaborative consideration. This information now needs to inform and align to the Primary Care Workforce Strategy. Support is being provided to the Directorate with this work from colleagues in Workforce, and is also discussed via the Primary Care Academy. Through Strategic Programme for Primary Care (SPPC) fund, a Primary Care Workforce Planner has been appointed on a fixed term basis until March 2026, who will commence work on the workforce plan. Whilst contact has been made with GP Practices to start this work the initial uptake of the offer of support has been low, however that could be attributed to the end of year contractual submissions taking priority.</p> <p>Paper submitted to Board in September 2023 setting out the scope of the Primary Care Strategy, with papers presented to Board at regular intervals.</p> <p>A further paper was presented to SDODC in October 2024. Work is ongoing to establish a mechanism to develop a Clinical Reference Group to secure views from across the contractor professions as well as community service staff.</p>

reviewed and challenged where necessary by Primary Care Service Managers.	<p>Whilst RAAC declarations were requested, these were not mandatory for contractors to respond, and therefore effectiveness of responding to outcomes.</p> <p>Whilst challenge is provided via GMS contract reviews, feedback not consistently addressed by practices.</p>	<p>Consider the potential to deliver a wider range of salaried NHS Dental Services through the Community Dental Service.</p>	Owens, Mary	30/04/2024 30/06/2024 31/10/2024 31/03/2025 30/09/2025	<p>As of April 2025 Welsh Government have issued a public consultation document on the future of NHS dental services provision. The Health Board will be seeking to provide a robust response. To enact the proposed changes of an integrated dental service there is the potential to need to consider an OCP in the current CDS service to ensure that the delivery model can be flexible to the demands of the service.</p>
		<p>Implement the Managed Practice Strategy plan will give greater system resilience.</p>	Swinfield, Anna	30/04/2024 30/10/2024 31/01/2025 31/03/2025 30/09/2025	<p>The tender process for Neyland and Johnston concluded without a contract award. Re-procurement exercise completed in September 2024 with no success. Review of Managed Practice Strategy to be undertaken in line with the development of the Primary and Community Services Strategic Plan.</p> <p>The introduction of a locum rate card in Autumn 2024 has seen an increase in salaried GP posts with two of the six managed practices operating with minimal locum reliance.</p>

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance  Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Sustainability Matrix Contract performance to monitor volume metrics (identifies if dental practices have issues in service delivery), with Primary Care Service Managers reviewing the escalation statuses of practices which is a contractual requirement. Those practices escalated to Level 4 are contacted requesting assurance around their reported level, to identify the potential for any support and where appropriate to challenge the reported level of escalation. Monthly assurance reports and Dental	GMS practices are asked to complete a WG sustainability matrix every 6 months to track the main risk areas and this contributes to a heatmap. Practices are also asked to report regularly on operational pressures	1st			OQSEC Primary Care Exception Report	Varying levels of engagement from practices in the regular reporting of operational pressures.				
	Dental Management Team undertake annual reviews	1st								
	GMS Practices are part of a rolling visiting programme, based on their annual return which is risk assessed against a framework of any other issues or concerns identified	1st								

Assurance Framework - Business Service Authority dashboards, to identify outliers	PCSMs tasked with regular discussions with Practices that report L4 to understand the issues	1st										
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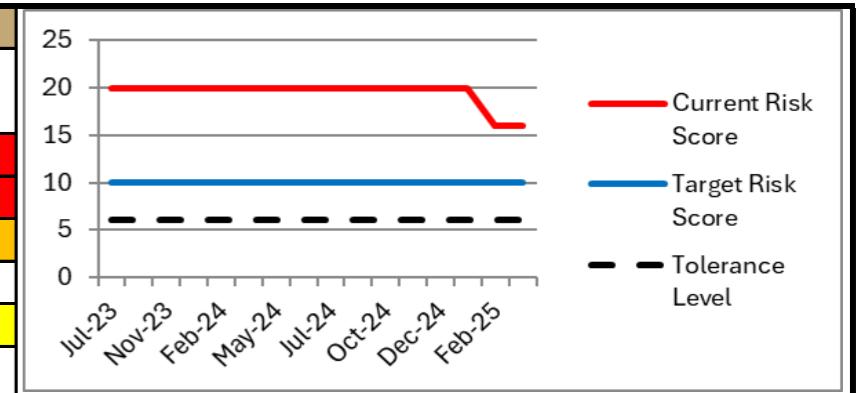
Date Risk Identified:	May-23
Strategic Objective:	5. Safe and sustainable and accessible and kind care

Executive Director Owner:	Carruthers, Andrew	Date of Review:	Apr-25
Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	May-25

Risk ID:	1664	Corporate Risk Description:	<p>There is a risk to service sustainability in Ophthalmology across the Health Board, and the inability to provide timely care to patients with Glaucoma, wet Age Related Macular Degeneration (wAMD), Vitreoretinal and Cataracts. This is ongoing 25/04/2025 This is caused by a national shortage of Consultant Ophthalmologists and the inability to recruit to vacancies. The workforce position is exacerbated by nursing and medical staffing constraints and a reduction in service capacity due to lack of physical space, and long-term funding. Recruitment difficulties are leading to the Consultant on-call rota being covered by four substantive Consultants with 2 gaps in the rota. To ensure the delivery of the Ophthalmology service the Consultants undertake additional duty hours. This is a fragile on call structure which is impacted by sickness and annual leave. This could lead to an impact/affect on ability to deliver services within the Ophthalmology Referral to Treatment (RTT) plan, and the ability of the Health Board to comply with Welsh Government Eye Care Measures (ECMs). This impacts the ability to provide timely diagnosis and treatment, directly impacting on patient safety, with the potential for sight loss and long-term lifestyle impacts. The Health Board's ability to progress with the implementation of recommendations raised by various regulators and inspectorates is affected by the recruitment and estates issues, which in turn could lead to adverse publicity and reduction in stakeholder confidence, with increased scrutiny/escalation from Welsh Government.</p> <p>The service have undertaken successful recruitment of one consultant and specialty Drs which has improved capability and capacity in part. Regional conversation has been commenced reagrding 2 Regional substantive Consultant posts.</p>
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Does this risk link to any Directorate (operational) risks?

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	4x4=16
Current Risk Score (L x I):	4x4=16
Target Risk Score (L x I):	2x5=10
Expected Date To Achieve TRS:	
Tolerable Risk:	6



Trend:

Rationale for CURRENT Risk Score:

Increased demand and reduced capacity continues to be a challenge. Balancing Eye Care Measures for R1 patients (high risk) with Ministerial Measures for longest waiting patients presents a conflicting priority to the service with limited capacity.

The service has provided additional Age-Related Macular Degeneration (AMD) sessions on a weekend, however these additional sessions have not been enough to meet the demand across all counties in the Health Board (HB). Patient delays continue across the Health Board. AMD continues to be prioritised impacting on the provision of general clinics, having an impact on the wider ophthalmology service and patient experience.

The current non-medical workforce establishment is not aligned to service needs. Recently the service has transferred Glaucoma funding to the Intra Vitreal Injection Therapy (IVT) service to create a new Band 7 post for IVT. The additional staffing needed for Wet AMD have been identified in the Eye Care Measures SBAR, which identifies the R1 delivery at 35%. The Welsh Government (WG) target for R1 delivery is 95%.

The service as at April 2025 are expected to reach waiting times of stage 1 52 weeks and all stages 104 weeks with a robust plan in place to reach this by the end of quarter one. 7612 patients have been 100% delayed for their follow up appointment.

The current impact has been scored as 4 because patients suffering irreversible sight loss is a reality and the current likelihood has been scored 4 as ophthalmology is a fragile service. It is unlikely that this risk will be able to be significantly reduced without considerable investment or a regionally agreed solution.

The workforce challenges have led to an impact on the Health Board's ability to deliver services within the ophthalmology referral to treatment (RTT) plan, which has been sustained through non recurrent funding secured for the out-sourcing of cataract procedures and IVT patients. Waiting list initiatives have been utilised for additional out-patient appointments. This is in direct conflict with the Health Board's ability to comply with WG Eye Care Measures (ECMs) which is the delivery of timely care for the high risk (R1) category of patients. There are delays to the delivery of R1 appointments for both Glaucoma and the delivery of Intravitreal injections for the Wet AMD pathway, which affects the National Institute for Health and Care Excellence (NICE) 14-day pathway for AMD appointments, impacting on the ability to provide timely diagnosis and treatment and directly impacting on patient safety, with the potential for sight loss and long-term lifestyle impacts.

Recruitment difficulties have led to the Consultant on-call rota being covered by 4 substantive Consultants with a gap of 2. This gap is filled by the substantive consultants working additional duty hours to ensure the delivery of the ophthalmology on call service. This is an on-call structure which is impacted by sickness and annual leave. However it is now more stable than previously reported.

The service has been able to reduce the impact score of this risk as whilst the consequences to the patient remains high, an SBAR for the recovery of the R1 Eye Care Measures target has been produced which demonstrates a trajectory for recovery if the required investment is secured. This would allow the service to recover to a 65% R1 delivery target allowing the likelihood score to be reduced to a 3 which would reduce the overall score to 15. If the investment was secured in April 2025 the service could recover to 65% by September 2026. Further development would be required to reach a 95% R1 delivery score, which would reduce the likelihood to a 2.






Rationale for TARGET Risk Score:

the service has been able to reduce the impact score of this risk as whilst the consequences to the patient remains high, however an SBAR for the recovery of the R1 Eye Care Measures target has been produced which demonstrates a trajectory for recovery if the required investment is secured. This would allow the service to recover to a 65% R1 delivery target allowing the likelihood score to be reduced to a 3 which would reduce the overall score to 15. If the investment was secured in April 2025 the service could recover to 65% by September 2026. Further development would be required to reach a 95% R1 delivery score, which would reduce the likelihood to a 2.

With the required investment in Glaucoma and IVT with the additional workforce and focused management of the waiting lists, the HB will potentially reduce the likelihood score on this risk to a 2. The service also will meet their ministerial measures targets by the end of quarter 1.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	How and when the Gap in control be addressed	By Who	By When	Progress
<p>The service is included within the Health Board's Clinical Service Plan (CSP). This will produce efficiency gains but will not secure additional resources.</p> <p>Active recruitment to vacancies, grow your own initiatives to secure Substantive Consultants and develop Consultants for the future.</p> <p>Regional discussion around 2 Regional Substantive posts.</p> <p>Collaborative working with Swansea Bay to deliver a Regional solution to address the workforce and estates constraints. Sub groups to be formulated to address, Glaucoma, AMD, Vitreoretinal and cataract pathways.</p> <p>Additional capacity has been funded for the delivery of Wet Age related Macular Degeneration (AMD). and has reduced the breach from 10 weeks to 8 weeks by March 2025. IVT outsourcing commenced in February 2025 and continues. Eye Care Measures SBAR submitted to board for approval to further develop IVT service delivery.</p> <p>Additional capacity has been funded for the delivery of Cataract surgery to maintain the 104 week wait for 2025/2026.</p> <p>Continued Identification of patients suitable to undergo transfer out to the community to Wales General Ophthalmic Services (WGOS) for Glaucoma and Medical Retina.</p> <p>Continued Validation of waiting lists to remove any patients who no longer require treatment through the scheduled Care validation team.</p> <p>Eye Care Collaborative Group meets quarterly to oversee performance against eye care standards.</p> <p>Eye Care Measures co-ordinator in place to oversee and manage the management of all R1 referrals.</p> <p>Review of data quality inclusive of Health Risk Factor (HRF) code and clinical</p>	<p>Whilst recurring money has been invested into glaucoma and cataract services previously, there still remains areas of the service (e.g. Glaucoma, AMD, Cataract, Paediatrics, Corneal and VR) that require investment. The ARCH programme closed, with a regional conversation around a regional clinical workshop to consider opportunities for a long-term regional model. Central investment in Estates, Infrastructure and Workforce is required to develop a sustainable service.</p>	<p>Roll out and implementation of National Electronic Patient Record for Ophthalmology.</p>	<p>Barreiro, Marta</p>	<p>30/07/2021 31/03/2022 31/05/2022 30/09/2022 31/10/2023 31/12/2023 31/03/2024 15/07/2024 31/03/2027</p>	<p>Issues identified in the planning phase around data governance. DHCW are working to resolve issues. Update provided by the DHCW in September 2024 outlining options available and potential funding required to deliver. Regional planning scoped and aligned programme now proposed with Swansea Bay UHB, but is unlikely to be implemented before 2027. Further funding may be required from each HB to implement this model.</p>
	<p>Long-term funding required in order to continue with current delivery of IVT, included within the Directorate's annual plans for 2025/26.</p> <p>Recovery funding is non-recurring and reviewed annually, this restricts delivery planning.</p>	<p>Refurbish and establish a nursing team in the Outpatient Department in Amman Valley Hospital to provide intravitreal treatment for the patients currently attending the day theatre area for their treatment. This will ensure continuity of care for those patients when cataract surgery activity is returned to day theatre.</p>	<p>Coppack, Victoria</p>	<p>Completed</p>	<p>Capital bid was secured and work to improve physical space at Amman Valley Hospital (AVH) was completed in March 2022. IVT recovery SBAR presented to the Board with associated workforce and drug costs identified. Long term funding is being considered as part of the annual plan.</p>
	<p>There are concerns in data quality due to referral processes and system use.</p>	<p>Remodelling the capacity and demand associated with Wet AMD and Amman Valley</p>	<p>Coppack, Victoria</p>	<p>Completed</p>	<p>Remodelling exercise complete. Ongoing costs associated with additional activity. SBAR to outline recovery of IVT service has been presented to Board with short term funding secured, with findings being incorporated in to annual planning process for 2025/26.</p>

<p>codes ongoing to improve data quality.</p> <p>Highly trained Optometrists working collaboratively with the Secondary Care Eye Service to reduce referrals to secondary care.</p> <p>Ongoing training of Optometrists within secondary care to continue to develop this service for continued delivery of WGOS.</p> <p>Ongoing arrangement of Optometrists enrolling in prescribing training to develop further Independent prescribers in the community.🔗</p> <p>GIRFT review undertaken on the Ophthalmology service with progress made against recommendations raised monitored and updated via AMAT.</p> <p>Performance dashboards in place to monitor performance daily.</p> <p>The service albeit still requires investment and continued work with Swansea Bay ref Regional working which is in its infancy in development</p>	<p>Implement virtual review clinics for patients undergoing Hydroxychloroquine (HCQ) treatment.</p>	<p>Coppack, Victoria</p>	<p>30/09/2022 31/10/2023 30/11/2023 31/03/2024 30/06/2024 30/09/2024 31/03/2026</p>	<p>Validation of HCQ patient commenced in November 2023. Longest wait HCQ patients have been identified for tech review, however workforce pressures are negatively impacting on service delivery. Clinic spaces to be secured for patient review. This is an interim measure until WGOS 4 for HCQ can be rolled out. This will follow the roll out of Glaucoma and Medical Retina. HCQ qualified Optometrists will need to be in place in the community to proceed.</p>
	<p>Alignment in the Delivery of Eye Care Measures and Ministerial Measures and effective management of Ophthalmology waiting lists.</p>	<p>Coppack, Victoria</p>	<p>31/03/2027</p>	<p>A Regional Programme Board has now been established. Ophthalmology has commenced a Regional Eye Care Programme. The Regional Eye Care Programme will meet bi-monthly to monitor and progress a Regional solution to the challenges faced in HDUHB and SBUHB, this will be fed to the Regional Programme Board. Identified first steps are to form sub-groups for the review of Paediatric Ophthalmology, Glaucoma, AMD and on call out of hours delivery.</p>
	<p>Long-term investment required for IVT and Glaucoma Delivery to recover R1 position</p>	<p>Jones, Keith -</p>	<p>31/01/2026</p>	<p>New action - progress update to be provided at next risk review.</p>
	<p>Regional solutions to workforce gaps and estates to be explored through Regional programme</p>	<p>Coppack, Victoria</p>	<p>31/03/2027</p>	<p>2nd Regional meeting booked February 2025 Update 18/02/2025 - meeting rescheduled to 14/03/2025</p>
	<p>Orthoptist posts to be recruited into</p>	<p>Coppack, Victoria</p>	<p>30/04/2025</p>	<p>Band 6 Orthoptist is now onboarding after successful interview. Band 8A JD is being review prior to submitting to Agenda For Change (A4C) panel.</p>

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance  Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Eye care measures monthly report. GIRFT review Cataracts. GIRFT review Glaucoma. Weekly RTT Optimisation to review Ministerial Measures.	WPAS	1st			SBAR for IVT Service Delivery & SBAR for recovery of R1 position (October 2024) Revised RISK SBAR to condense risks submitted to Board for decision.					
	GIRFT action plan cataracts	1st								
	GIRFT action plan Glaucoma	1st								
	WPAS, scheduled care performance indicators	1st								

Date Risk Identified:	Jan-19
Strategic Objective:	N/A - Operational Risk

Executive Director Owner:	Carruthers, Andrew	Date of Review:	Apr-25
Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	May-25

Risk ID:	684	Corporate Risk Description:	<p>There is a risk to the radiology service provision from breakdown of key radiology imaging equipment and associated infrastructure to enable equipment to function. This is caused by equipment not being replaced in line with RCR (Royal College of Radiologists) and other guidelines.</p> <p>This could lead to an impact/affect on patient flows resulting from delays in diagnosis and treatments, delays in discharges, increased waiting times on cancer pathways, increased staffing costs to minimise the impact on patients when breakdowns occur and increased number of SCP breaches and breaches over 8 weeks due to increased downtime. Increased risk of IR(ME)R notifiable radiation incidents due to increased breakdowns as a result of malfunctions during exposures.</p>
Does this risk link to any Directorate (operational) risks?			925, 114, 1668, 1785

Risk Rating:(Likelihood x Impact)	
Domain:	Service/Business interruption/disruption
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	4×4=16
Target Risk Score (L x I):	2×4=8
Expected Date To Achieve TRS:	
Tolerable Risk:	6
Trend:	↔

Date	Current Risk Score	Target Risk Score	Tolerance Level
Sep-22	16	8	6
Jan-23	12	8	6
Jun-23	12	8	6
Sep-23	16	8	6
Nov-23	16	8	6
Feb-24	16	8	6
May-24	16	8	6
Jul-24	16	8	6
Oct-24	16	8	6
Dec-24	16	8	6
Feb-25	16	8	6

Rationale for CURRENT Risk Score:	Rationale for TARGET Risk Score:
<p>The Health Board's stock of aged imaging equipment routinely breaks down causing disruption to diagnostic imaging services across all sites which has a significant impact on the Health Board's ability to meet its Referral to Treatment (RTT) target and impact to patients can include delays in diagnosis and treatment. CT and MR scanners have been replaced and has reduced the frequency of machine downtime compared to previous experience.</p> <p>The risk score is noted as 16 reflecting that some equipment has been installed and is operational, however further investment is required due to recurrent breakdowns of aged key imaging equipment. A plan and rolling programme for the installation of additional equipment is in place. There is a continuous process locally by which equipment is prioritised for replacement.</p> <p>Gamma camera at Withybush General Hospital is the only scanner of its nature in the Health Board, and has experienced a series of breakdowns in 2023 and 2024 due to intermittent failures which resulted in several HIW reportable IRMER incidents. This item of equipment is on the current priority list of items to replace as at February 2025.</p> <p>While a new CT scanner has been obtained and installed at Glangwili, the original CT scanner is having regular breakdowns. The technology on this scanner is also now out of date and impacts directly on the resilience of the service at our major trauma site in the Health Board.</p> <p>Like-for-like replacement of existing equipment is not necessarily a cost effective method of maintaining services and in certain circumstances does not meet updated regulatory compliance or meet the requirements of maintenance warranty agreements. This means there will need to be upgraded infrastructure such as air handling units, water chiller systems and the size/accommodation for modalities at an initial increased cost but representing long term savings and service resilience overall.</p> <p>April 2025</p> <p>The DEXA unit at BGH is aged and with the advent of trabeculae bone scoring, any new scanner will have a larger footprint compared with the current scanner and along with necessary shielding required, this may mean that the current DEXA room will be unsuitable to accommodate any new scanner. The technology gap has widened between the services provided at Swansea with concerns raised by referring clinicians.</p> <p>The only HB Nuclear Medicine SPECT scanner is overdue for replacement and remains a significant risk to continuity of service provision. The equipment replacement T&F team are currently looking into options and specifications in readiness for potential funding which was discussed at the NIECP review panel on 02/04/2025.</p>	<p>WG funding has been secured to replace a fluoroscopy unit and a CR x-ray unit at WGH along with a much needed MRI upgrade at PPH during the 24-25 financial year.</p> <p>With more modern equipment, breakdowns will be less likely and less significant in terms of downtime together with a reduced impact on the diagnostic services at the remaining hospital sites. Improved business continuity plans will also help reduce the impact of equipment breakdown across the UHB.</p> <p>Due to the nature of the release of funding which is usually in Q3/Q4 of the financial year it is difficult to plan large installations due to the speed at which the replacement need to be completed. This means that sometimes equipment of lesser priority is replaced before the bigger installations which have a greater need.</p> <p>The number 1 replacement priority in the Health Board is to replace the Nuclear Medicine SPECT scanner. This is a service risk as it is the only scanner in the HB (Risk 1706, score 20) and has suffered frequent breakdowns since June 2023. A specific task and finish group has been convened to forward plan the replacement in anticipation of WG funding. The second CT scanner at GGH is a second priority as this is relied upon to undertake outpatient work and as a back up scanner. This is aged and is having increasing breakdown outages with long lead time to source parts.</p> <p>In addition to this the variation between the DEXA services provided via the SBUHB SLA and at BGH has been made worse by the fact that the Swansea scanner now undertakes Trabecular Bone Scoring (TBS) which is a new and very important way of assessing bone structure. The BGH scanner is unable to do this and there have been a few recent cases of patients who have recently had a DXA in BGH who are now having another DXA in the SBUHB mobile unit because we need obtain the TBS results. The version of windows which this scanner runs on is no longer supported and so is a further risk to the Health Board.</p> <p>Once the Nuclear Med SPECT-CT scanner, the 2nd CT scanner at GGH and the DEXA scanner at BGH have been replaced we would look to seek permission to reduce this risk score and to move the risk directorate level. This is dependent on WG funding, and may not be complete until the end of the 26-27 financial year due to the additional infrastructure required.</p>

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	How and when the Gap in control be addressed	By Who	By When	Progress
<p># Service maintenance contracts in place and regularly reviewed to ensure value for money is maintained.</p> <p># The difficult to source spares can be obtained through bespoke manufacture but this invariably results in inherent delays in returning equipment to service.</p> <p># Regular quality assurance checks (eg daily checks).</p> <p># Use of other equipment/transfer of patients across UHB during times of breakdown.</p> <p># Ability to change working arrangements following breakdowns to minimise impact to patients.</p> <p># Site business continuity plans in place.</p> <p># Disaster recovery plan in place.</p> <p># Replacement programme has been re-profiled by risk, usage and is influenced by service reports.</p> <p># Escalation process in place for service disruptions/breakdowns.</p> <p># National Imaging and Capital Priorities Group ensures there is a robust governance process to support a national, sustainable clinically focused capital equipment programme across Wales. This will ensure that all HB's in Wales agree to a prioritisation process which will allow for timely equipment procurement and delivery to support healthcare demands across Wales.</p> <p># All equipment at main sites are now DR and so will be compliant with the RISP project</p> <p># Additional WGH EOY funding was secured (23-24 financial year) and replaced aged US units and upgraded the software on MRI scanners at BGH and WGH providing latest technology.</p>	<p>Limitation of spare parts for some older equipment leading to extended outages. This issue has been compounded by Brexit.</p> <p>Increased use of site contingency plans puts pressures on patient flows, discharges, diagnosis at other sites.</p> <p>Reliance on AWCP for replacement of equipment.</p> <p>Inability to undertake specific replacements at this time due to the additional infrastructure required</p> <p>National Imaging and Capital Priorities Group outcomes do not always align with the Health Board priorities, and is subject to negotiations within the group.</p>	<p>Further action necessary to address the controls gaps</p> <p>Installation of replacement Gamma Camera, WGH</p>	<p>Roberts-Davies, Gail</p>	<p>31/07/2024 30/06/2025 31/03/2026</p>	<p>Gamma camera is 9 years old and the only scanner in the Health Board providing a regional service. Recurrent breakdowns are resulting in HIW reportable incidents.</p> <p>Awaiting confirmation of funding as at December 2023. No funding allocated as of 09/02/2024 This will not be replaced in the 24/25 financial year. A specific T&F group is due to be set up as of June 24 to plan the necessary accommodation improvements required. July 2024 update- the T&F group has been set up and meets weekly Feb 2025 update - there is a draft plan for replacement. Business continuity plans being explored</p> <p>Following a National Equipment Capital Priorities Group Meeting held on 02/04/2025, The CT replacement of the aged at GGH has been recommended, however funding has not yet been formally agreed.</p>

Replacement of aged CT Scanner at GGH	Procter, Sarah	31/03/2024 31/07/2024 30/06/2025 31/07/2026	<p>Awaiting confirmation of funding as at December 2023.</p> <p>No funding allocated as of 09/02/2024</p> <p>This will not be replaced in the 24/25 financial year.</p> <p>Following a National Equipment Capital Priorities Group Meeting held on 02/04/2025, The CT replacement of the aged at GGH has been recommended, however funding has not yet been formally agreed.</p>
Replacement of Fluoroscopy room, WGH	Whitecross, Faith	31/03/2024 31/07/2024 31/03/2025 31/08/2025	<p>Additional infrastructure required to replace this piece of equipment and so will not be completed until the 2025-2026 financial year.</p> <p>Update feb 25: funding approved for installation of fluoroscopy equipment 25/26 financial year.</p>
Replacement of CR X-ray Room 1, WGH	Roberts-Davies, Gail	31/03/2024 31/07/2024 31/03/2025 30/04/2025	<p>Ageing equipment.</p> <p>In order to remain in service, this replacement must be completed by August 2026 due to the end of current Fuji contract.</p> <p>This will not be replaced in the 2023/24 financial year</p> <p>Confirmation that this piece of equipment will be replaced in the 24/25 financial year was received late May '24- action will be closed when this piece of equipment is operational.</p> <p>Equipment replacement complete as of 08/04/2025- awaiting acceptance testing.</p>

Replacement of CR X-Ray room, Llandoverly Hospital	Osell, Fiona	31/03/2024 31/07/2024 30/06/2025 01/12/2025	<p>Equipment on site is incompatible with the incoming PACS system, and interim solution required.</p> <p>X Ray room continues to be in use one day per week (Tuesdays) staffed by 1 Radiographer (B5 or B6). Regular maintenance of equipment continues and required QA testing.</p> <p>In order to remain in service, this replacement must be completed by August 2026 due to the end of current Fuji contract.</p> <p>Awaiting confirmation of funding as at April 2024.</p> <p>This will not be replaced in the 2024/2025 financial year.</p> <p>Progression of this project reliant upon the outcome of the clinical services plan which may see the closure of this x-ray department which is expected in November 2025.</p>
Replacement of Mammography Units, BGH and WGH	Roberts-Davies, Gail	31/03/2024 31/07/2024 30/06/2025 31/03/2027	<p>Ageing equipment, exacerbated by the failure of Securview.</p> <p>These will not be replaced in the 23/24 financial year</p> <p>These will not be replaced in the 2024/2025 financial year</p> <p>These will not be replaced in the 2025/2026 financial year</p>

	Upgrade or replacement of MRI scanner, GGH	Procter, Sarah	31/03/2024 30/06/2025 31/03/2026	<p>Ageing equipment with increasing failures, with new technologies now available.</p> <p>Awaiting confirmation of funding as at April 2024. This will not be replaced in the 24/25 financial year.</p> <p>Following a National Equipment Capital Priorities Group Meeting held on 02/04/2025, The MRI upgrade of the aged scanner at GGH has been recommended, however funding has not yet been formally agreed.</p>
	To replace the DEXA scanner at BGH and ensuring suitable accommodation is found to meet regulatory compliance for a larger more modern scanner.	Edwards, David	31/03/2024 30/09/2024 30/09/2025 31/03/2026	<p>Unit is 17 years old, and previously funded via charitable funds</p> <p>This has been added to the imaging priorities list and end of year additional funding projects as relative replacement costs are not high, however the infrastructure enablement costs are additional and a suitable location to accommodate a larger scanner needs to be found.</p> <p>Following a National Equipment Capital Priorities Group Meeting held on 02/04/2025, The replacement of the aged DEXA scanner at BGH has been recommended, however funding has not yet been formally agreed.</p>

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance  Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Reduction of waiting times to under 8 weeks. No SCP diagnostic breaches.	Monthly reports on equipment downtime and overtime costs	1st			Radiology Equipment SBAR - Executive Team - Mar19 Further updates CEIMT Feb20 Further updates CEIMT Sep20 Radiology Diagnostic Imaging update to Capital Sub-Committee presented September 2024	Lack of process of formal post breakdown review.				
	IPAR report	2nd								

Date Risk Identified:	May-24
Strategic Objective:	

Executive Director Owner:	Daniel, Sharon	Date of Review:	Apr-25
Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	May-25

Risk ID:	1859	Corporate Risk Description:	There is a risk that patients are at increased risk of poor outcomes, and a poor patient experience. This is caused by the Health Board's inability to effectively recognise and manage acute deterioration. This could lead to an impact/affect on increased length of stays, increased admissions to Critical Care, increased risk of cardiac arrests for patients, and poorer patient outcomes who may experience permanent injuries or irreversible health effects.
Does this risk link to any Directorate (operational) risks?			1758

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	5x5=25
Current Risk Score (L x I):	3x5=15
Target Risk Score (L x I):	2x5=10
Expected Date To Achieve TRS:	31/12/2025
Tolerable Risk:	6
Trend:	↔

Month	Current Risk Score	Target Risk Score	Tolerance Level
Jun-24	20	5	6
Jul-24	20	5	6
Aug-24	20	5	6
Sep-24	20	5	6
Oct-24	20	5	6
Nov-24	15	5	6
Dec-24	15	10	6
Jan-25	15	10	6
Feb-25	15	10	6
Apr-25	15	10	6

Rationale for CURRENT Risk Score:

There are specific concerns relating to Glangwili General Hospital (GGH) and Withybush General Hospital (WGH) in relation to Cardiac Arrests and unplanned admissions. There was an increase in Cardiac Arrest rates in GGH in the period Jan - Dec 2024 (35) compared to the same period Jan - Oct 2023 (15). GGH senior management team have agreed to Datix all cardiac arrests and establish bi-monthly meetings to review cases and identify themes and learning opportunities.

There has been an increase (22%) in unplanned admissions at WGH, with 92 noted in 2024 (71 noted for 2023). Following the recent WGH Recognition of Acute Deterioration and Resuscitation (RADAR) meeting it was agreed that the Treatment Escalation Plan (TEPs) task & finish group in WGH would be re-established.

There are also concerns across the Health Board as a whole relating to the National Early Warning Scores (NEWS), and appropriate escalation where required as part of observation processes. Currently working with Clinical Audit to develop an audit tool on AMAT to audit on a monthly basis NEWS charts on wards and identify good practice and areas for improvement. A National Safe Care Collaborative meeting held in Cardiff in October 2024 began exploring the possibility of establishing a National Acute Deterioration Clinical Reference Group which will provide an opportunity to benchmark the position of Hywel Dda on an All Wales basis. First meeting scheduled on 24Mar25 focussing on NEWS, PEWS and MEWS and NEWTS).

As of January 2025, compliance rates for Level 2 and Level 3 Resuscitation Training are at 49% and 46% respectively, an increase on the previous figure noted of 40% at November 2024. While there is no set compliance target, compliance has never been greater than 60%. Staff availability to attend resuscitation training is problematic due to operational pressures and demand, therefore, need to identify the most appropriate training level and method to deliver to meet mandatory requirements.

As at February 2025, all actions are being processed within set dates / timeframes although many remain long term. Current controls are managing the risk and the increasing awareness of gaps in assurance and local actions to mitigate and manage the risk have been established.

Rationale for TARGET Risk Score:

The full implementation of the actions noted in the risk action plan will support the reduction in the likelihood and impact score of this risk to a target risk of 10. With recruitment into the Resus Team and the establishment of a supported Cascade Training process the aim will be to see an increase in training compliance in both Level 2 & Level 3 training by October 25 to >60%. This will enable the risk to be reduced to the Target Risk Score of 10, >85% would enable the risk score to be reduced further to 5. We will aim to see a reduction in Cardiac Arrest rates across all 4 sites and unplanned admissions into ITU from ward areas by October 2025.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	How and when the Gap in control be addressed	By Who	By When	Progress
<p>Governance structures in place eg RADAR Group (Recognition of Acute Deterioration and Resuscitation).</p> <p>Increased awareness of gaps in assurance and local actions in place to manage and mitigate the risk.</p> <p>T&F Group chaired by HB RADAR Lead with focus on Sepsis, DNA/CPR group chaired by Deputy Medical Director.</p> <p>RADAR directly reports to Operational QSE.</p> <p>Local RADAR groups (across all sites, counties, MHL and Paediatrics) which report to HB wide RADAR group - chaired by a commission.</p> <p>Mechanisms in place across all sites to monitor cardiac arrest rates.</p> <p>Health Board Resus policy in place (currently out of date requiring updating - however waiting on national guidance)</p> <p>All Wales DNA/CPR policy in place</p> <p>Lead for Acute Deterioration</p> <p>Dedicated Resuscitation Team in place, consisting of 6.2WTE across the Health Board (acute, community, mental health and primary care) plus 1WTE admin support</p>	<p>No treatment escalation plans in place</p> <p>No call for concern in place</p> <p>Training demand outstrips capacity to deliver the mandatory level of training recommended by the Resus Council</p> <p>Inconsistent application of policies and processes eg DNA/CPR, , sepsis assessment tool, National Early Warning Score (NEWS).</p> <p>Reliance on manual / paper based documentation to record patient deterioration and subsequent escalation</p> <p>Critical Outreach Services not in place at PPH / BGH</p> <p>Inability to release staff to complete L2 and L3 training</p> <p>High number of newly qualified new nurses to the HB including overseas</p>	<p>Health Board Recognition of Acute Deterioration and Resuscitation (RADAR) group to develop a workplan to address gaps in control to improve the recognition and management of acute deterioration across the Health Board.</p>	<p>Davies, Mandy</p>	<p>30/09/2024 30/11/2024 30/04/2025 30/09/2025</p>	<p>Quarterly meetings in place, and sub-groups being established to report to Recognition of Acute Deterioration and Resuscitation (RADAR) group on sepsis, NEWS, treatment escalation plans, call for concern (Martha's Law) DNA/CPR, acute kidney injury (AKI). Agenda at August meeting didn't allow for discussion on the development of a workplan.</p> <p>Plan is to confirm RADAR Action Plan at next meeting 20Mar25, with risk actions to be updated accordingly.</p> <p>Update as of April 2025: Health Board RADAR Lead has stepped down and awaiting a replacement to be identified. No scheduled meetings planned at the current time in respect of an overarching Health Board group as awaiting new Lead.</p>

<p>Networks in place across the wider HB, including support from QIST</p> <p>Organisational training plan in place, including mandatory training</p> <p>Critical Outreach Services in GGH and WGH (not in place at PPH / BGH), managed by Planned Care Directorate (i.e not fully linked to Acute Deterioration resource)</p> <p>New Acute Kidney Injury (AKI) Lead appointed for GGH (12 months)</p> <p>Dedicated resource in Quality Improvement Team monitoring AKI alerts for the Health Board</p> <p>Bi-monthly scrutiny meetings have been set up in GGH to review Cardiac arrests.</p> <p>Cardiac arrest reviews presented at Medical Education sessions</p> <p>Review of feedback from any Medical Examiner reviews, highlighting issues relating to resuscitation/cardiac arrests and lessons learned.</p>	<p>requiring support to develop their expertise in recognising acute deterioration</p>	<p>Develop an organisation-wide training needs analysis to appropriately identify staff across all staff groups complete the most appropriate level of training to improve recognition and management of acute deterioration.</p>	<p>Wastell, David</p>	<p>Completed</p>	<p>The directorate is working with ESR to ensure that staff training attendance is accurately recorded. Work is ongoing with individual line managers to identify the training needs of all their staff groups across all four sites and community. Meetings commenced with all senior nurse managers to discuss current training uptake and training needs to identify the most appropriate training for each staff group across acute and community. Meetings are to be arranged with Heads of Service for other clinical services.</p> <p>As at June 2024, it has been identified that 84 ILS sessions are required in order to ensure compliance with targets for GGH alone. Heads of Nursing requested to discuss training attendance with all ward sisters, and to appropriately prioritise.</p> <p>Monthly analysis of training available, and attendance to be shared with Heads of Service and Senior Nurse Managers. The provision of training continues at current levels, given current resource availability.</p> <p>TNA taken to QSESC advising in January 2025, with further discussion at SNMT and QSESC on cascading this.</p>
		<p>To implement an electronic observations systems across the Health Board to capture real-time bedside capture of patient assessments and monitoring, in line with the Health Board's Digital Plan</p>	<p>Williams, Carolyn</p>	<p>30/09/2025</p>	<p>Tender process completed. Business case presented to Board in July 2024, with a view to implement on a site by site basis over in 18 months, in line with the current Digital Plan. Board approved the business case in Sept 24 however funding has not yet been identified to enable the project to proceed.</p>

As part of the Quality Dashboard, agree the matrix needed for patient deterioration. Include these matrix in the Health Board Quality Dashboard to inform escalation and create a specific dashboard for RADAR (Recognition of Acute Deterioration and Resuscitation).	Wastell, David	30/05/2025	<p>Meeting of 25th July 2024 has identified the following supporting metrics for the dashboard: sepsis, AKI, NEWS audits, cardiac arrests, number of MET calls, treatment escalation plans are in place, call for concern rates and training compliance for ILS and BLS for each Directorate.</p> <p>Senior Nurse for Resuscitation and Acute Patient Deterioration is working with Performance Team to agree the process for data collection to inform the Dashboard, and identifying methods to prioritise the dashboard data via a RAG system.</p>
Put in place process for Health Board compliance with Martha's Rule by establishing a Task and Finish Group to implement Call for Concern	Wastell, David	31/03/2025 31/12/2025	<p>Task and Finish Group is in place, chaired by Ceri Griffiths.</p> <p>SOP Patient leaflet is being developed and a pilot was due to commence in GGH in Feb25.</p> <p>This pilot will test the process to roll out across the organisation for Adult Inpatients. Pilot scheme at GGH is aiming to be completed by March 2025, with a view to rolling out to other three acute sites by December 2025.</p>

Put in place All Wales Policy for treatment escalation plans to enable safe and effective care management when patient deteriorating.	Wastell, David	31/12/2024 30/06/2025 30/09/2025	<p>Discussed at Health Board Recognition of Acute Deterioration and Resuscitation (RADAR) group Group (March 2024) - no agreement to move forward with proposed pilot in Withybush. Discussed at Withybush RADAR meeting in July 2024 where agreement reached for pilot. Task and Finish group being established by Lead for Critical Care Outreach in Withybush to devise an implementation plan. RADAR to review following evaluation and consider roll out across other sites.</p> <p>As of January 2025, the situation remains unchanged. TEPS sub group meetings have been held at WGH but there is no set plan at the moment to implement or trial.</p>
Implement a model for CASCADE training for basic life support and monitor impact on basic life support training compliance rates.	Wastell, David	Completed	<p>Model devised by Resuscitation Team - first training session held. 6 Cascade Trainers from across the Health Board Community Teams, trained in July 2024. Training will continue. Training session for Midwife Cascade Trainers in development, with plans for health visitors and school nurses for February 2025.</p>

<p>Following assessment and interpretation of the All Wales Direction, the Health Board is engaging in National work, namely roll out of NEWS2 and Call 4 Concern and contribute to the National Improvement for Acute Deterioration being led through the Safe Care Partnership.</p>	<p>Wastell, David</p>	<p>30/09/2024 30/03/2025 30/09/2025</p>	<p>Launch of this initiative on 17th September 2024 (World Patient Safety Day). WHCs have been received in relation to NEWS2 and Call 4 Concern. A group led by the Assistant Director of Nursing for Acute Inpatient Services is designing a first phase approach to pilot Call 4 Concern from November 2024. All Wales Safe Care Partnership meeting held on 22 October 2024 to design a national improvement programme for acute deterioration, which the Health Board are engaged in and are contributing towards. National group not yet established as of November 2024. Advised at national level NEWS2 will be launched September 2025.</p>
<p>Work to improve compliance with Sepsis Bundles at the front door.</p>	<p>Wastell, David</p>	<p>31/12/2025</p>	<p>Ongoing quality improvement in place. Has demonstrated improvements in Glangwili and Prince Phillip and now being used in Withybush. Reviewing process for assessing impact on patient outcomes as a result of the response and management of sepsis.</p>

Improve compliance with DNACPR National Guidance	Steele, Cathie	30/10/2024 31/05/2025	DNACPR Review Group formed and actions identified including development of a SharePoint page (which is now complete) and undertaken an improvement project through EQliP (underway). Annual audits undertaken by junior doctors, and reviews of medical examiner reports and cardiac arrest to identify learnings. Training needs have been identified in relation to DNACPR and patients who are considered having learning disabilities, or diagnosed with dementia. Work is commencing with the MHLD directorate to progress this. A full action plan as been agreed in response to the HIW National Report on DNACPR (see AMAT)
Development of an Acute Deterioration Sharepoint page for all advice, guidance, updates, for staff on issues relating to resuscitation, DNACPR, sepsis, call for concern, MET calls, training, etc.	Wastell, David	31/05/2025	Senior nurse for acute deterioration is working with Interim ADN for Quality and Safety to develop SharePoint page.☑
Trial starting in October 2024 for 3 months re NEWS Audit, NEWS Charts - 5 charts every ward, every month on every site utilising the AMaT system. To review compliance and whether escalation processes are being followed with outcomes being fed back to wards.	Wastell, David	31/01/2025 31/03/2025 30/09/2025	Training plan developed and was rolled out in March 2025 with 1st audits completed in March and April. The full audit will now start in May on all wards on all four acute sites. Meeting with Clinical Audit on 30th April 2025 to look at developing action plans on AMaT.
Acute Deterioration E-learning modules - topics include NEWS, sepsis, DNACPR and A-E assessment being developed by the Lead Nurse for Acute Deterioration in conjunction with NHS Executive and other leads. Work to develop a process for using these modules with clinical areas in response to issues of concern.	Wastell, David	31/01/2025 30/06/2025	Currently awaiting national updates in order to progress with this action.

	Review efficacy of local RADAR groups, and frequency of meetings being held	Davies, Mandy	30/06/2025	Support being given to Chair of RADAR to liaise with Chairs of local RADAR groups delays due to limited availability and operational pressures.☒
	Develop standardised template to report into Health Board RADAR group	Wastell, David	Completed	Template developed following meetings with Chairs of local RADAR.
	To develop mechanisms to review and monitor the Acute Deterioration position via Escalation Framework via the Quality domain (including the implementation of the Safety Dashboard)	Davies, Mandy	30/06/2025	<p>Meeting of 25th July 2024 has identified the following supporting metrics for the dashboard: sepsis, AKI, NEWS audits, cardiac arrests, number of MET calls, treatment escalation plans are in place, call for concern rates and training compliance for ILS and BLS for each Directorate.</p> <p>Senior Nurse for Resuscitation and Acute Patient Deterioration is working with Performance Team to agree the process for data collection to inform the Dashboard, and identifying methods to prioritise the dashboard data via a RAG system.☒</p>

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES					
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress	
Training compliance via ESR Cardiac Arrest Audits	RRAILS Audits undertaken by ward staff monthly, and inform the Nursing dashboards	1st			RADAR Group Update to QSESC, Feb-24 and Jan-25	Ward based NEWS audits in place but may be unreliable as self assessed.	Once dashboards in place, to develop a monthly audit process to address key hotspots / areas of concern relating to RAILS	Wastell, David	30/09/2025	Next RADAR meeting scheduled for 20 March 2025.	
	Review of DATIX incidents, complaints, cardiac arrest reports and Medical Examiners reports relating to acute deterioration	1st									
	Outreach review all unplanned admissions to Intensive Care	1st									
	RADAR Group	2nd									
	T&F Group chaired by HB RADAR Lead with focus on Sepsis	2nd									
	DR/CPR group chaired by Deputy Medical Director	2nd									

Date Risk Identified:	Feb-24
Strategic Objective:	

Executive Director Owner:	Carruthers, Andrew	Date of Review:	Apr-25
Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	May-25

Risk ID:	1810	Corporate Risk Description:	<p>There is a risk that the Health Board will be unable to continue manufacturing cancer treatments for our patients. This is caused by the facilities of the Pharmacy Aseptic Unit being non-compliant with Quality Assurance of Aseptic Preparation Services (QAAPS) standards 5th edition (published 2016) and therefore at risk of closure.</p> <p>This could lead to an impact/affect on the Health Board's ability to provide all the cancer treatments currently offered. The Health Board would be entirely reliant on outsourcing cancer therapy from commercial suppliers. A fully outsourced service would cost an additional c£1 each year. Some therapies cannot be outsourced, meaning Hywel Dda could not offer over 500 cancer treatments each year. This would have a significant negative impact on patient care as patients would either be required to travel further from home to neighbouring Health Boards to receive their treatment (dependant on their capacity to absorb the additional demand) or would be offered less clinically appropriate treatments at Hywel Dda, negatively affecting clinical outcomes. The closure of the Aseptic unit would directly impact the ability of the Health Board to achieve ministerial priorities and targets such as the Single Cancer Pathway, A Healthier Wales, etc.</p>
Does this risk link to any Directorate (operational) risks?		2004, 374, 1350, 716	

Risk Rating:(Likelihood x Impact)	
Domain:	Service/Business interruption/disruption
Inherent Risk Score (L x I):	5x5=25
Current Risk Score (L x I):	3x5=15
Target Risk Score (L x I):	1x5=5
Expected Date To Achieve TRS:	
Tolerable Risk:	6

Trend:	↔
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Rationale for CURRENT Risk Score:

Withybush Aseptic unit is the only functional unit that can manufacture cancer treatments remaining in the Health Board. The facilities of Withybush Aseptic unit are currently non-compliant with regulatory standards. An audit by the National Pharmacy Quality Assurance Lead was performed in February 2024 confirmed the facilities were a high risk to patient safety, and the unit is at risk of forced closure.

Short term control measures have been implemented by the Health Board's aseptic team to reduce the risk of immediate forced closure (see control measures). The controls are currently successfully minimising the amount of microbial contamination present within the unit, demonstrated by ongoing daily/weekly/monthly environmental monitoring. However, as the unit and equipment are beyond their useful expected life, there will come a time where the control measures will no longer be sufficient to allow the safe running of the unit. If the stringent controls fail at limiting the amount of microbial contamination, the unit may be forced to close.



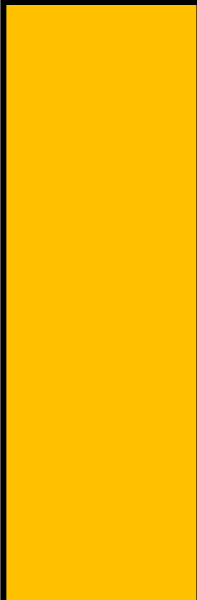


As part of the Transforming Access to Medicines (TrAMS) project programme, a regional manufacturing hub will be built in South West Wales that will prepare cancer therapy for Hywel Dda patients. The hub was originally estimated to open during 2028, however there have been delays to the project plan and the opening date is currently unknown. There is therefore a high risk that the current Aseptic unit at Withybush will be forced to close before the South West TrAMS manufacturing hub is operational. In this case, there would be no means of obtaining certain cancer therapy for Hywel Dda patients to be administered within the Health Board locality

Rationale for TARGET Risk Score:

The target risk score is based on the premise that funding for a new aseptic unit is approved by Welsh Government. The unit would be compliant with regulatory standards and once operational, it would be extremely unlikely for the unit to be forced to close. A new unit would allow the Health Board to continue to safely prepare cancer therapy until the TrAMS South West manufacturing hub is operational.

On approval of the Business Justification Case, it is anticipated that the target risk score of 5 would be achieved within 18 months.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	How and when the Gap in control be addressed	By Who	By When	Progress
<p>Transfer of the radiopharmacy service to Singleton Hospital in October 2022; this means less overall activity through the Withybush Aseptic unit reducing the risk of contamination and errors.</p> <p>More time and resource provided to the Quality System (i.e. internal audits, investigation of near misses and microbial growths, maintaining SOPs).</p> <p>Increased training of aseptic staff to develop their skills and knowledge.</p> <p>Increase outsourcing from commercial suppliers; this limits the volume of products prepared within the unit, allowing products that must be made in-house to be prepared safely.</p> <p>New pharmaceutical isolators have been procured to replace the existing isolators that are beyond their working life of 10 years. The new isolators will be stored with the intention of installing into the demountable unit (if funding is secured) or will be installed into the existing unit if the current isolators fail mitigating the risk of equipment failure causing prolonged service disruption.</p> <p>Removal of outsourced dispensing from the Aseptic unit; this minimises the risk of contamination and potential for error.</p> <p>Preparation of products near to the time of use; this limits the pre-administration storage time.</p> <p>More stringent gowning process; this minimises contamination risk.</p> <p>More stringent cleaning and monitoring programmes; this minimises contamination risk and allows early detection of microbial growth.</p> <p>Oversight and steer from Capital Sub-Committee.</p>	<p>Controls are reliant on a key group of skilled staff (i.e to maintain Quality System, to follow cleaning and monitoring procedures) therefore subject to key person dependencies.</p> <p>Limited accommodation to employ additional staff to expand workforce within the existing unit at WGH.</p> <p>Limited accommodation to store starting materials and finished products or to perform the associated tasks that are required to safely supply cancer treatments. Between 2021 and 2023, the number of cancer treatments requiring aseptic preparation at Hywel Dda increased from 12,718 to 16,648 (average of 14% increase each year).</p> <p>There is limited space within the Pharmacy at WGH to manage this increase in demand.</p> <p>Lack of funding to build a new unit at WGH.</p> <p>Progress dependent on feedback received from Welsh Government</p>	<p>To submit revised business case for demountable unit to Welsh Government (estimated £2.89m).</p> <p>To work with estates and capital planning team to source temporary accommodation at Withybush to increase the storage capacity for outsourced cancer therapy. This will help the aseptics service to meet the increasing demand for cancer therapy and will allow cost efficiencies related to outsourcing to be achieved whilst the business case for a demountable aseptic unit is being developed.</p>	<p>Morgan, Cerith</p> <p>Morgan, Cerith</p>	<p>Completed</p> <p>Completed</p>	<p>As part of the tendering process, no suppliers had submitted a bid for the contract for the demountable aseptic unit as of 03/09/2024. The tender was repackaged to the principal contractor of the project (Lewis Construction) noting the following specialist cleanroom subcontractors; Angstrom, Enbloc, Scitech, T-squared, Cleanroom projects. The quality of the submissions was scored by members of the project team and representatives from NWSSP on 20.11.2024. As no suppliers submitted a bid during the original tender return, this may have an impact on the project timelines. The BJC was presented at Public Board 30th January and approved for submission to WG for scrutiny. WG provided BJC scrutiny comments to the HB on 20th March 2025 with the HB responding on 15th April. Awaiting WG response to HB's scrutiny return.</p> <p>Capital bids proforma submitted to Health Board capital planning team 11/06/2024. Ratification paper signed off and contract awarded to Portakabin on 02/08/2024. 05.09.2024, awaiting for contract to be signed by the Head of Service - Procurement before order can be placed. Portacabin has now been installed and now awaiting fittings to be installed by the company before unit is operational.</p>

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance  Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Audit Reports from annual audits detailing areas of non-compliance KPI Dashboard in place to provide continuous oversight of unit performance, updated monthly.	Annual Audits by Lead Quality Assurance Pharmacist (NWSSP) .	3rd			Capital Sub Committee (22nd January 2024). MMOG report to QSEC for Feb 2024. BJC Board January 2025.					
	Quarterly self-assessments undertaken by Lead Aseptic Pharmacist, with outcomes fed back to Lead Quality Assurance Pharmacist at NWSSP	1st								
	Bi-monthly Senior Pharmacist Leads Business Meeting .	2nd								

Date Risk Identified:	Nov-22
Strategic Objective:	

Executive Director Owner:	Carruthers, Andrew	Date of Review:	Apr-25
Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	May-25

Risk ID:	1531	Corporate Risk Description:	There is a risk of being unable to provide a safe and sustainable general surgery consultant on-call rota at WGH and GGH. This is caused by Unsustainable and fragile rotas, with a difficulty to recruit into substantive posts. This could lead to an impact/affect on on the ability to provide an emergency general surgery service at WGH and GGH affecting patient experience, causing clinical delays and poor outcomes for patients. The wellbeing of remaining consultants who are already working to full capacity is also affected and there is an increased expenditure on agency locum consultants and internal locum rates above the HB card rate. Consultants working additional on call locum weeks is resulting in a reduction in elective activity in OPD, endoscopy and theatre. This could have a negative impact on RTT and SCP targets.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	4x5=20
Current Risk Score (L x I):	3x5=15
Target Risk Score (L x I):	1x5=5
Expected Date To Achieve TRS:	
Tolerable Risk:	6
Trend:	↔

Date	Current Risk Score	Target Risk Score	Tolerance Level
Oct-23	20	5	6
Dec-23	15	5	6
Apr-24	20	5	6
Feb-25	15	5	6

Rationale for CURRENT Risk Score:	Rationale for TARGET Risk Score:
<p>1531 - Risk of being unable to safely support the Consultant on-call rota at Withybush General Hospital (WGH) and Glangwili General Hospital (GGH) due to workforce pressures. Chief Operating Officer. 10/11/22. 3x5=15</p> <p>(Reviewed 24/04/25) Whilst this risk is relating to workforce issues, the domain for the risk is patient safety. The reason for this decision is that, although the rota in WGH has been stabilised, gaps in the service remain e.g. Upper Gastrointestinal (GI).</p> <p>The risk to emergency Upper GI patients at WGH is due to no Upper GI specialists on site and no Endoscopic Retrograde Cholangiopancreatography (ERCP) service on the site. An SBAR has been populated, highlighting the risk to emergency Upper GI patients in WGH.</p> <p>The recommendation from the senior clinical team is for these patients to be admitted directly to GGH. This SBAR was presented at Acute Leadership Group (ALG) on 25/09/2024, at the Quality, Safety and Experience Committee (QSEC) on 08/10/2024 and at the Scheduled Care Quality, Safety and Experience (QSE) meeting on 29/01/2025.</p> <p>The concern is that the GGH clinical team have absorbed the patients that cannot be treated at WGH, without additional resource and this is currently exacerbated by the rota gaps on the GGH consultant on-call rota. As this situation has not changed, the current risk score remains the same.</p> <p>The consultant on-call rota at WGH remains a 1:4 with 2 substantive consultants and 2 NHS locum consultants on the rota, 1 of which is an internal associate specialist upgraded to a locum consultant.</p> <p>At GGH, the consultant on-call rota is a 1:8 with one gap and one consultant only participating in 50% of the rota. The 1 full gap is currently being covered by a Medacs agency locum consultant and interviews are taking place for an NHS locum colorectal consultant to fill this gap. The 50% gap is being covered by an internal locum at the health board card rate. There are 3 NHS locum consultants participating in this rota.</p> <p>An options appraisal was presented to board in November 2024 and there was an urgent meeting between the Clinical</p>	<p>The target risk score is based on the work currently being undertaken as part of the Clinical Services Plan to identify and approve a more sustainable solution in order to reduce the likelihood of rota collapse and reduce the risk of not being able to provide a safe and sustainable emergency general surgery service to patients in the south of the Health Board. The effectiveness of revised rota arrangements will depend on several factors including availability of a labour market.</p> <p>The risk score will reduce on the appointment of consultants.</p> <p>Achievement of the target risk score is dependant on the outcomes of the Clinical Services Plan which will inform future plans or the successful appointment of substantive upper GI consultants to the current model at WGH.</p>

Care Group and Executives in early 2025. The outcome of this was the approval to advertise the posts to fill the gaps. This supersedes the content of a previous SBAR presented at various Executive committees as the plan is no longer to amalgamate rotas, at least in the short term.


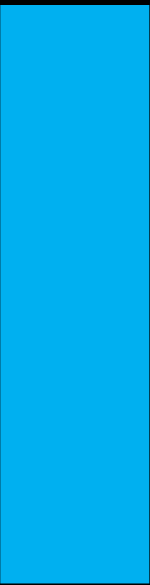
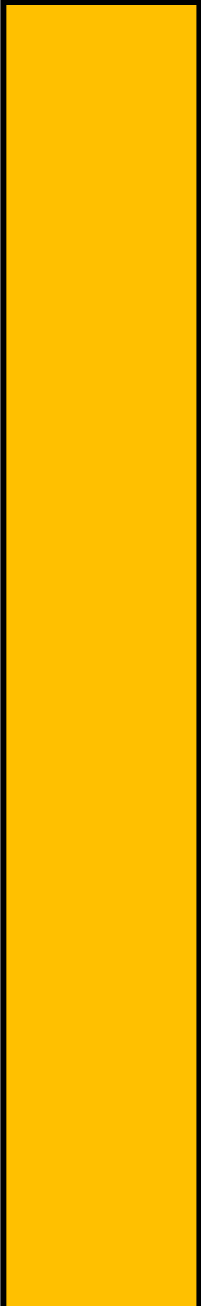
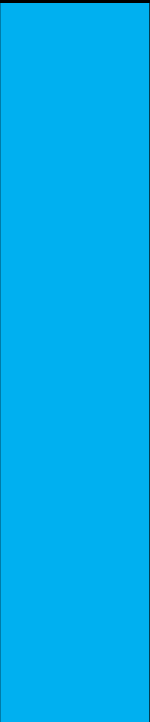
Proposals relating to service changes and the amalgamation of the rotas were presented to ALG in October 2024, with the requirement to engage with relevant stakeholders noted as an action. An options appraisal paper was presented to Board in November 2024 via the Clinical Service Plan (CSP).

Following the Scheduled Care Escalation Meeting in March 2025, where the immediate risk of the GGH rota collapsing was highlighted, due to the internal consultants withdrawing from covering the 1 gap on the rota, an urgent executive meeting was arranged for 12 March 2025. The outcome of the meeting was to appoint a substantive colorectal consultant to the GGH rota and for 2 substantive Upper GI consultants in a dual location role across WGH and GGH. It was recognised that this would take some time, there was an agreement that the service would recruit a Medacs locum consultant immediately, to cover the upcoming gap in April and in parallel, advertise an NHS locum colorectal consultant to GGH. On the appointment of the locum consultant, the agency locum will be terminated. On the appointment of the substantive consultant, the NHS locum will be terminated.

An NHS locum colorectal consultant was successfully appointed on 30 April 2025, to commence in post in August 2025. The job descriptions and adverts for the 3 substantive consultant posts have been approved by the Interim Medical Director and are now with the Royal College. The aim is that they will be ready to go out to advert by 23 May 2025.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	How and when the Gap in control be addressed	By Who	By When	Progress
<p>Rotas monitored daily by the service delivery team</p> <p>When there is sickness or unexpected leave, due to emergency circumstances, the management team work to cover as follows:</p> <ol style="list-style-type: none"> 1. Internal Additional Hours (ADH) on the site with the gap. 2. Internal ADH from the other sites across the health board. 3. In the event of steps 1 & 2 being unsuccessful, the service would escalate for agreement on transferring the surgical out of hours on call take to another site. (WGH to GGH) 4. Ensuring that all stakeholders are aware, including site teams, medical teams, WAST, any supporting services as appropriate. <p>Proactive sickness management</p> <p>Escalation to clinical leads</p> <p>On appointment, new consultants undertake an induction with Hospital Director at WGH and Clinical Director for Scheduled Care.</p> <p>SOP in place for the transfer and repatriation of patients</p> <p>Engagement with WGH Medical Staff Committee and public on changes to services</p>	<p>Potential inability to recruit to all 3 substantive consultant posts scheduled for April 2025.</p> <p>The Consultants at GGH also provide the support to the junior and SAS level doctors at PPH for the elective pathway.</p> <p>The NHS locum in place at WGH is only on a 6 month fixed term contract.</p> <p>No rota co-ordinator in place at GGH to support rota management, and currently undertaken by Service Manager</p> <p>There is a risk of consultants requesting rates that are higher than the HB card rate, going forward as they have been covering multiple gaps on the rota for a prolonged time.</p>	<p>Review the longer term sustainability of general surgery on-call rotas across Hywel dda (recommendation from Getting it Right First Time (GIRFT) review in Jan23)</p>	<p>Lewis, Caroline</p>	<p>Completed</p>	<p>The senior consultant leads for general surgery have suggested that the WGH and GGH on call rotas are amalgamated to one site. This would provide an increase of consultants on the rota to either a 1:10 (the 3 WGH consultants and the 7 GGH consultants) or a 1:12 (the 3 WGH consultants, 7 GGH consultants and 2 newly recruited posts). This recommendation is in line with the GIRFT report. SBAR's have been drafted by the service to describe the fragility of the rotas.</p>
		<p>To develop an options appraisal paper with all relevant stakeholders, including WAST, Primary Care, and site teams</p>	<p>Hire, Stephanie</p>	<p>Completed</p>	<p>A discussion was due to be held live at the health board planning session on 09/1/25, this did not take place due to the clinical lead and clinical director not being able to attend. The EGS situation is regularly reviewed and appropriate action is taken by the service as and when required. It also forms part of the fragile services, which is discussed at escalation. We are awaiting confirmation as to when or if the stakeholder discussion will take place. Following the executive meeting on 12/03/2025 and the agreement to recruit substantive consultants into the gaps on the rotas, this options appraisal paper is no longer required. This will need to be reviewed, if the service is unable to recruit suitable candidates.</p>
		<p>To hold interviews to appoint NHS locum consultant</p>	<p>Lewis, David</p>	<p>30/05/2025</p>	<p>Interviews have been scheduled for 30/04/2025.</p>

		To agree job descriptions and advertise for three substantive consultant posts	Lewis, David	30/06/2025	Job descriptions have been sent for Royal College approval in April 2025.
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ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance  Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
	WGH Medical Staff Committee established to develop models of sustainability	1st			Management team have presented an SBAR to Acute Leadership Group (Feb23)	Assurance to Board on communication and repatriation arrangements				
	Reported to monthly General Surgery Business Meetings on each site (BGH/GGH/WGH)	2nd			SBAR to Executive Team and OPDP to agree 1:3 rota (Mar23)					
					General Surgery Report to Board (Mar23)					
					Management team to present updated SBAR to Acute Leadership Group (Oct23 & Nov23)					
					Management team to present updated SBAR to Corporate Directorate Group (Apr24)					

<p>Reported to bi-monthly Scheduled Care Quality, Safety and Experience Group through exception reporting</p>	<p>2nd</p>			<p>Upper GI service SBAR presented at ALG (Sep24)</p> <p>Upper GI service SBAR presented at Quality, Safety and Experience committee Meeting (Oct24)</p> <p>Updated SBAR to Executive Team (Nov24)</p> <p>Upper GI service SBAR presented at scheduled care directorate QSEAC (Jan25)</p>					
<p>Assurance to be reported to the Board following introduction of temporary rota</p>	<p>2nd</p>								
<p>GIRFT report on General Surgery which raised the sustainability of general surgery across 3 sites in Hywel Dda - final report awaited</p>									

2.2

2.2 - Occupational Therapies Paediatric Improvement Action Plan - Deferred

**Andrew Carruthers
(Hywel Dda UHB -
Chief Operating
Officer), Angela Bell
(Hywel Dda UHB -
Assistant Director
Quality, Safety +
Patient Experience
for Allied Health +
Health Sciences)**

3 - Break

4 - Assurance

4.1

4.1 - Fragile Services Report

Sharon Daniel (Hywel Dda UHB - Executive Director of Nursing, Quality & Patient Experience), Mandy Davies (Hywel Dda UHB - Assistant Director of Nursing & Quality Improvement)

Attachments

[Fragile Services Update QSEC Final.pdf](#)



Fragile Services Update Report

Quality, Safety and Experience Committee

June 2025



The purpose of this report is to provide the Quality, Safety and Experience Committee (QSEC) with an update on development of the Fragile Services Framework with reference to the de-escalation criteria within the NHS Wales oversight and escalation framework .

The Quality, Safety & Experience Committee (QSEC) are asked to note amendments to the Framework.

Papers to QSEC June 2023, June 2024 and December 2024:

Purpose:

Develop a definition of what is meant by fragility in the context of services delivered by the Health Board together with a set of criterion/triggers that could be used to enable the organisation to identify and prioritise services that are classified as fragile. Underpinned by the Health Board:

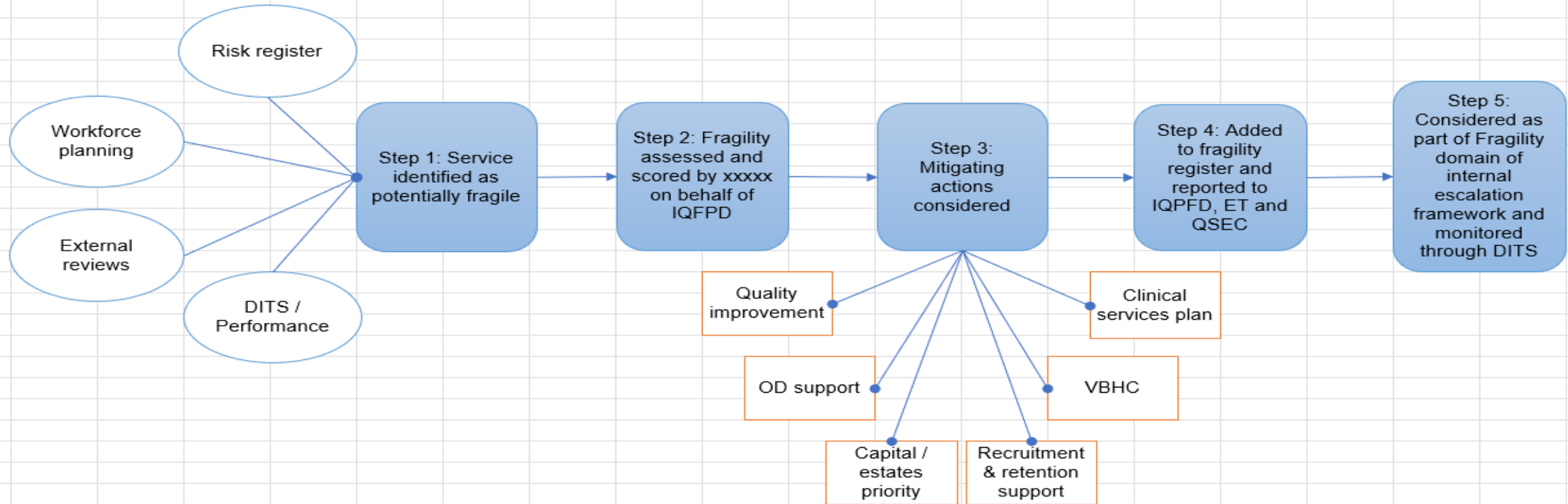
- [Risk matrix.docx \(sharepoint.com\)](#)
- [Quality Management System \(sharepoint.com\)](#)
- [A Framework for Safe, Reliable, and Effective Care | Institute for Healthcare Improvement \(ihi.org\)](#).
- To identify and prioritise services classified as fragile the methodology presented to QSEC built on:
 - The traditional risk management (5x5 risk matrix: likelihood x impact) approach.
 - A set of criterion/triggers developed and subsequently adapted in June 2024 following a thorough review of the existing risks and available literature.
- The purpose of the triggers/criterion, in addition to the risk score, was to facilitate prioritisation of service fragility, to enable teams to develop a shared vision of the risks that exist, and to inform the controls/mitigating actions thus building on traditional risk management approaches

- The NHS Wales oversight and escalation framework, sets out the process by which Welsh Government maintains oversight of NHS bodies and gains assurance across systems. Under the Fragile Services Domain the Health Board is required to have:
 - *“Effective process to recognise and respond to services that are at risk of becoming fragile”*
- The Health Board Fragile Services Framework will:
 - Identify and prioritise services that are classified as fragile
 - Articulate the level of risk each service holds so that the Board is sighted.
 - Assess the degree of fragility, to identify opportunities and inform decisions on appropriate action to aid service sustainability
 - Inform requirement for service change
 - Identify opportunities for consolidation/regionalisation of services
- The Framework was tested against risk:
 - 1609: Risk of avoidable harm due to fragile Medical Diabetes Service at Withybush Hospital: The workforce challenges identified were mitigated by a recruitment exercise reducing the Risk Score to 16 and level of fragility.
 - 1557: Risk of non-adherence to national guidance on ultrasound scanning requirements during pregnancy: The process highlighted demand management opportunities initiating a review of “Grow 2.0 and the pathway for low gestational age” to further mitigate this risk.
- Fragile Services Oversight Group established

Identification and corporate process



Flowchart for Fragile Services



- Criterion 1: Quality and safety** - there is evidence that the outcomes for patients are significantly below comparator providers; or there are significant patient safety concerns; or service does not meet minimum volumes of activity to maintain high standards
- Criterion 2: Patient experience and performance** - there is no viable prospect of the service meeting professional standards, including delivery of timely services
- Criterion 3: Workforce and culture** - the workforce required to safely and sustainably deliver the service is not available because it cannot be recruited, developed, or retained - or can only be delivered by a dependency on agency or locum staff
- Criterion 4: Professional Consensus:** There is professional consensus on the merits of reconfiguring the services to deliver an enhanced or new service model
- Criterion 5: Public support:** There is significant public support or democratic mandate for the service model

Weighting Criteria:



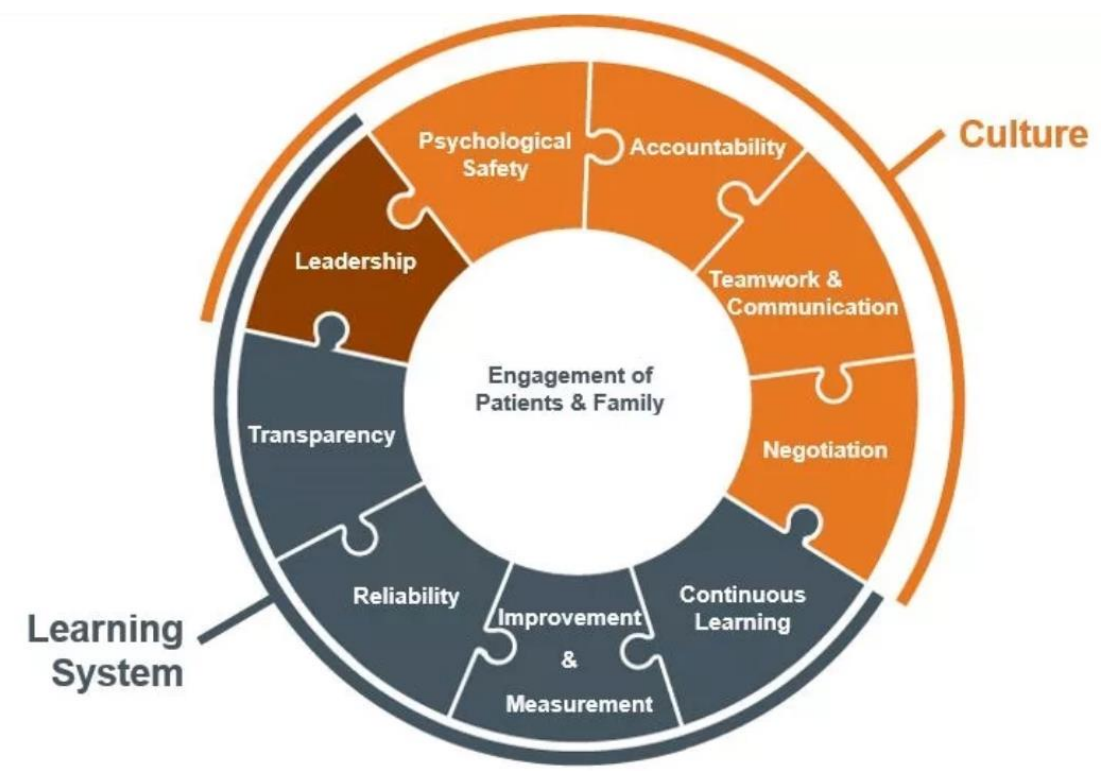
Criteria	Weighting
<p>Criterion 1: Quality and safety - there is evidence that the outcomes for patients are significantly below comparator providers; or there are significant patient safety concerns; or service does not meet minimum volumes of activity to maintain high standards</p>	
<p>Criterion 2: Patient experience and performance - there is no viable prospect of the service meeting professional standards, including delivery of timely services</p>	
<p>Criterion 3: Workforce and culture - the workforce required to safely and sustainably deliver the service is not available because it cannot be recruited, developed, or retained - or can only be delivered by a dependency on agency or locum staff</p>	
<p>Criterion 4: There is professional consensus on the merits of reconfiguring services to deliver an enhanced pathway or a new service model.</p>	
<p>Criterion 5: There is significant public support or democratic mandate to change a service model.</p>	

Safe Reliable and Effective care Framework self-assessment. Institute for Healthcare Improvement (IHI)



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Quality Impact Assessment



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A check of the impact of the proposed strategic decision is undertaken.

Each quality standards must be considered also whether the change links to a quality enabler.

The quality standards are Safe, Timely, Effective, Efficient, Evidence Based, Timely and Person Centred

The quality enablers are Leadership, Workforce, Culture, Information, Learning improvement and research, and Whole-system perspective

Health & Care Quality Standard	Possible considerations for this standard	Risk Score (current risk before change)			Tick impact			Does this impact link with a Quality Enabler? If yes, which enabler? (Leadership, Workforce, Culture, Information, Learning improvement and research, Whole-system perspective)	Risk Score (after proposed change)			Description of impact
		Likelihood 1-5	Impact 1-5	Overall score	Positive	Neutral	Negative		Likelihood 1-5	Impact 1-5	Overall score	
Safe	Does this decision have a positive, neutral or negative impact on ensuring that: a) our health care system is a high quality, highly reliable and safe system that avoids preventable harm, maximising the things that go right and learning from when things go wrong to prevent them occurring again? b) people's health, safety and welfare are actively promoted and protected? Do the risks that have been identified have a positive, neutral or negative impact on safety?			0						0		
Timely	Does this decision have a positive, neutral or negative impact on ensuring that: a) people have access to the high-quality advice, guidance and care they need quickly and easily, in the right place, first time? b) we care for those with the greatest health need first, and where treatment is identified as necessary, we treat people based on their identified and agreed clinical priority?			0						0		
Effective	Does this decision have a positive, neutral or negative impact on ensuring that: a) care and treatment reflects evidence-based best practice, and b) people receive the right care to achieve the optimal outcomes possible for them and that matter to them?			0						0		



Fragile Services Register



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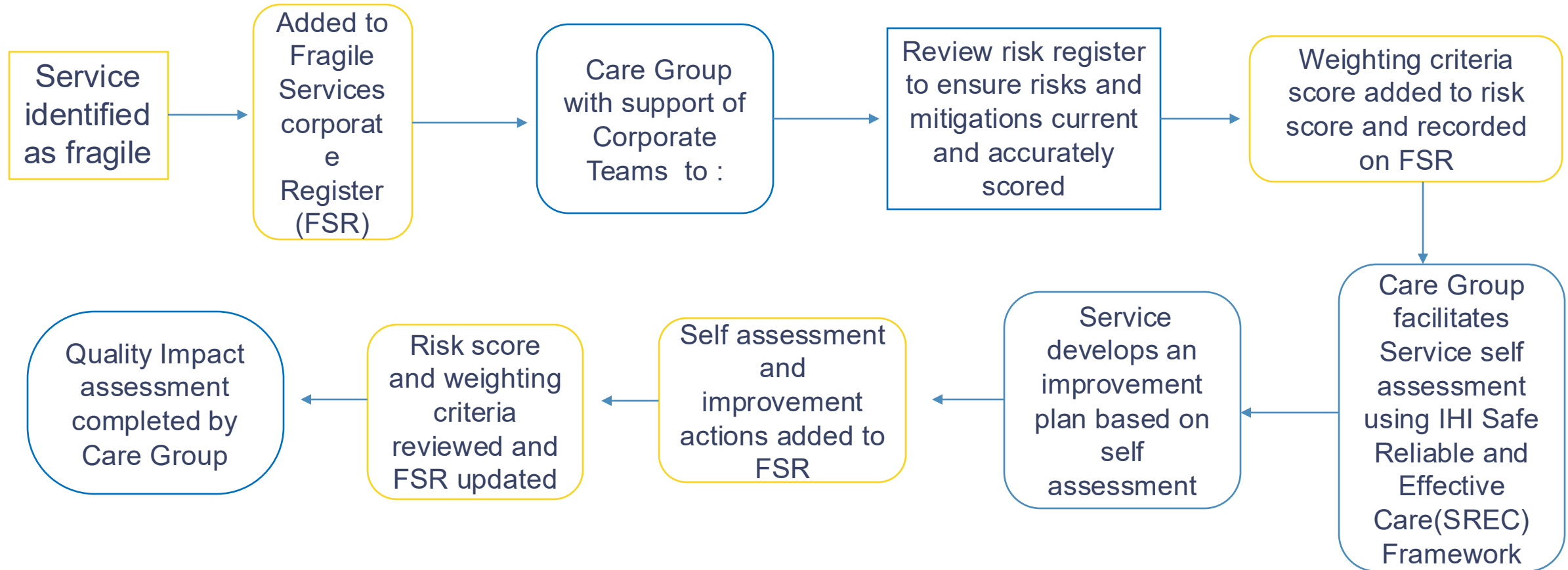
• Fragile Service Sharepoint

Microsoft Lists

Ellen Dzebo (Hywel Dda UHB - PA to QIST Team)'s list
Fragile Services

Service Identified as Fragile	Directorate	Source - How/...	Managerial Le...	Clinical Leads ...	Fragile Service...	Discussed at F...	Review of Risk...	Weighting Tool	Initial Weighti...	IHI Safe reliabl...	Completed Sel...	Quality Impac...	Completed QIA	Escalation Ne...	Improvement...
Cellular Pathology	Pathology	DITS						Criteria & Weighting	6	IHI Self Assessment Template		Quality Impact Assessment Template			✓
Clinical Haematology	Pathology	DITS						Criteria & Weighting		IHI Self Assessment Template		Quality Impact Assessment Template			✓
Planned Care PPH	Planned Care	DITS						Criteria & Weighting		IHI Self Assessment Template		Quality Impact Assessment Template			✓
Emergency General Surgery (WGH & GGH)	Planned Care	DITS						Criteria & Weighting		IHI Self Assessment Template		Quality Impact Assessment Template			✓
Ophthalmology Consultant On-Call	Planned Care	DITS						Criteria & Weighting		IHI Self Assessment Template		Quality Impact Assessment Template			✓
Rota, Anaesthetics & Medical Workforce	Planned Care	DITS						Criteria & Weighting		IHI Self Assessment Template		Quality Impact Assessment Template			✓
Trauma Unit at GGH	Planned Care	DITS						Criteria & Weighting		IHI Self Assessment Template		Quality Impact Assessment Template			✓
Agency Nurses and Medical Locums	BGH	DITS						Criteria & Weighting		IHI Self Assessment Template		Quality Impact Assessment Template			✓
ED Department	GGH	DITS	Caryl Bowen (Hywel D)			✓	Yes	Criteria & Weighting	19	IHI Self Assessment Template		Quality Impact Assessment Template			✓
Respiratory Service	WGH	DITS						Criteria & Weighting		IHI Self Assessment Template		Quality Impact Assessment Template			✓
Bronglais Paediatrics	Women & Children	DITS						Criteria & Weighting		IHI Self Assessment Template		Quality Impact Assessment Template			✓
Contract Returns	Primary Care	DITS						Criteria & Weighting		IHI Self Assessment Template		Quality Impact Assessment Template			✓
Aseptic Facilities	Medicines Management	DITS						Criteria & Weighting		IHI Self Assessment Template		Quality Impact Assessment Template			✓
Staffing Levels	Finance	DITS						Criteria & Weighting		IHI Self Assessment Template		Quality Impact Assessment Template			✓
Critical Care PPH	Planned Care							Criteria & Weighting		IHI Self Assessment Template		Quality Impact Assessment Template			✓
MIU PPH	Carmarthenshire USC							Criteria & Weighting		IHI Self Assessment Template		Quality Impact Assessment Template			✓
Medical Staffing Ceredigion	MH&LD	Escalation Meet...				✓	Yes	Criteria & Weighting							✓

Operational Process





De-escalation Criteria:

Evidence that the Health Board has the appropriate mechanism to understand the drivers behind a fragile service through the triangulation of key data points, including staffing levels, staff and patient feedback, concerns, incidents, stakeholder feedback (HIW, Audit Wales, HMC, Royal Colleges, Llais etc), mortality reviews, duty of quality / candour, infection protection control, performance, clinical and medical leadership.

Action:

The fragile services intervention and focus whilst in level 4 will alter over time in response to workforce and estate challenges.

At this point the focus will be on the nine clinical areas identified in the clinical services plan.



De-escalation Criteria:

Fragile services are supported by strong clinical leadership, have an effective integrated improvement plan, project management structure and effective transformation support.

Progress is being made towards key performance metrics.

Action:

For each service, the health board will be expected to produce a summary document setting out the issues of concern, and action plans with agreed outcomes and access targets.

For each service, the health board will be expected to produce a summary document setting out the issues of concern, and action plans with agreed outcomes and access targets.



De-escalation Criteria:

Evidence that all recommendations from the Royal Colleges, HIW and other reviews specific to Hywel Dda UHB are discharged and either verified or delivered or scheduled for delivery within the health board's longer-term improvement plan.

Evidence that the Board is sighted on fragile services and has a robust response to these issues that is being addressed by the health board.

Action:

Focus on identifying issues and creating action plans for fragile services, which would implicitly involve addressing recommendations

Focus on identifying issues and creating action plans for fragile services with Board



The Quality and Safety and Experience Committee is asked to **NOTE** the addition of the Fragile Services Register, Improvement Plan and Quality Impact Assessment as part of the revised Fragile Services Framework to support achievement of the de-escalation criteria actions.



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The Duty of Candour

Openness and honesty should be at the heart of every relationship between those providing treatment and care and those experiencing it.



DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG
SAFE | SUSTAINABLE | ACCESSIBLE | KIND

4.2

4.2 - Auditor General Report on Cancer Services

Paula Goode (Hywel Dda UHB - Service Director for Planned and Specialist Care)

Attachments

[Cancer Services Quality Safety Experience Committee 10.6.25 final.pdf](#)

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	10 June 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Health Board Response to the Auditor General Report on Cancer Services
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Paula Goode- Service Director for Planned & Specialist Care
SWYDDOG ADRODD: REPORTING OFFICER:	Lisa Humphrey General Manager Planned Care & Cancer/ Debra Bennett- Service Delivery Manager Cancer Services & Cancer Performance

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

In January 2025 Audit Wales published a report on Cancer Services in Wales - A review of the strategic approach to improving the timeliness of diagnosis and treatment.

<https://www.wao.gov.uk/publication/cancer-services-wales>

It exposed significant gaps in the implementation of cancer services in Wales, with confusion over national leadership and delays in meeting targets contributing to poor outcomes for patients. No health board has met the target of starting treatment for 75% of cancer patients within 62 days of point of suspicion since 2020.

Overall conclusions:

- Overall, it was found that despite increased investment, there is a continuing failure to meet the national performance targets for cancer with a minority of patients facing unacceptably long waits for diagnosis and/ or treatment.
- Cancer outcomes in Wales have improved over recent years but are still poor compared to other countries. Stronger and clearer national leadership is urgently needed to help drive the necessary improvements in the timeliness and sustainability of cancer diagnosis and treatment.

This paper aims to provide assurance that the Health Board have robust leadership, oversight and governance arrangements that are integrated across our wider system and informed by our patient experience and national programmes as a framework for continual improvement.

Cefndir / Background

The report looked for evidence that the NHS is sustainably meeting demand to diagnose and treat cancer; whether it is meeting the national performance targets for timeliness of cancer

diagnosis and treatment; and for evidence that outcomes for cancer patients are improving and compare well internationally.

It also looked at evidence of a clear strategic direction for improving cancer outcomes and services, and for reducing demand for cancer services by preventing cancer occurring in the first place. They also looked for evidence of appropriate and clear leadership structures to direct, oversee and support improvement and tackle barriers at a national level.

The report also concluded that the Cancer Improvement Plan has not been sufficiently integrated into the wider strategic approach for improving cancer services. There is also a lack of clarity as to who is responsible and accountable for driving system wide improvements to cancer services.

The report highlighted significant gaps in data, which obscure the true scale of the challenges facing cancer services.

Early detection through screening is essential, yet the report found shortcomings in this area. While the Bowel Screening programme has been expanded and uptake is good, breast and cervical screening rates remain below target. A national lung screening programme, recommended by the UK National Screening Committee in 2022, has yet to be implemented in Wales, despite a successful pilot in Cwm Taf Morgannwg University Health Board.

Workforce shortages are a key barrier to improving cancer care, with critical gaps in radiologists, oncologists and histopathologists. This situation is compounded by outdated equipment and a shortage of modern diagnostic scanners, which hinder efforts to increase capacity.

The report calls for stronger leadership, better data systems, and an urgent focus on prevention, as an estimated 40% of cancers in Wales are preventable through lifestyle changes.

Suspected cancer referrals create demand for NHS services even though the vast majority of those referrals (over 84%) go on to find out that they do not have cancer. The number of suspected cancer referrals increased by 14% from June 2019 to August 2024 equivalent to around 3% growth each year.

The number of newly diagnosed cancer patients has also increased over time (by 22% from 2002 to 2021). Numbers of newly diagnosed cancers increased in 2021 but have not yet returned to pre-pandemic levels.

As part of its vision for quality cancer care, the Welsh Government wants to see the waiting list volume return to pre-pandemic levels. It has also set a target that 80% of cancer patients start treatment within 62-days by March 2026. However, the waiting list for diagnosis and/ or treatment has continued to increase, and it is difficult to see how that target will be achieved.

It is clear that without a significant increase in activity to diagnose and treat more patients the waiting list is unlikely to return to previous levels. Much of the capacity the NHS uses to diagnose and treat cancer patients is also used for other non-cancer patient pathways. Delays at diagnostic stage are one of the main reasons for poor performance against the 62-day cancer target.

Screening plays a vital role in early detection. Public Health Wales NHS Trust (PHW) runs Wales's three cancer screening programmes: Breast Test Wales, Bowel Screening Wales and Cervical Screening Wales.

Data on patient experience is collected via the annual Wales Cancer Patient Experience Survey commissioned by the Cancer Network and Macmillan Cancer Support.

Cancer survival improved between 2002 and 2020. 54% of patients diagnosed with cancer from 2002-2006 survived their cancer at five years compared to 62% of patients diagnosed between 2016 and 2020.

Workforce capacity is a significant challenge and there is an absence of information on the availability and condition of equipment

Overall conclusions:

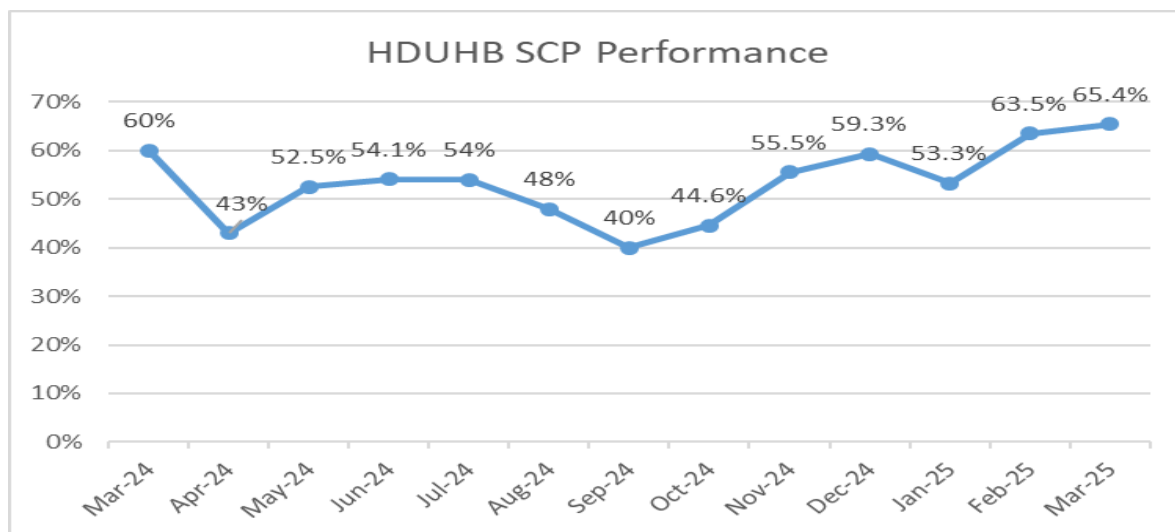
- Overall, it was found that despite increased investment, there is a continuing failure to meet the national performance targets for cancer with a minority of patients facing unacceptably long waits for diagnosis and/ or treatment.
- Cancer outcomes in Wales have improved over recent years but are still poor compared to other countries. Stronger and clearer national leadership is urgently needed to help drive the necessary improvements in the timeliness and sustainability of cancer diagnosis and treatment.

Asesiad / Assessment

Single Cancer Pathway (SPC) Performance

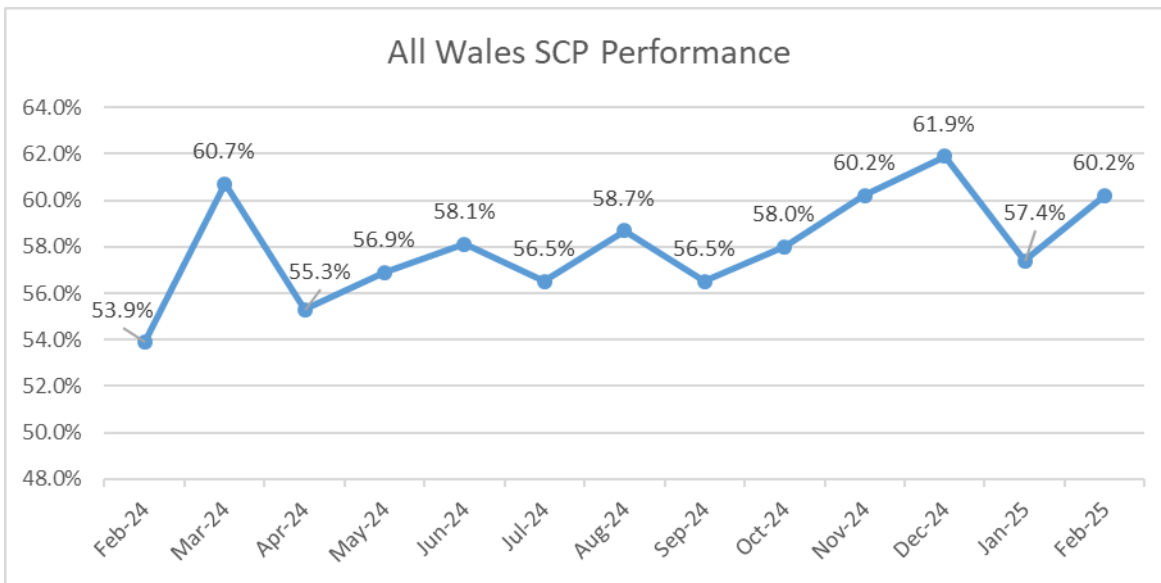
Cancer services within the Health Board are undergoing a number of developments to improve diagnostic and treatment capacity, ensuring timely access to care and driving sustainable improvements in patient outcomes. The ambition for the next financial year is to build on existing service improvements, strengthening cancer pathways to achieve a step change in performance. The most recent performance data (March 2025) can be seen in the following graphs:

Since November 24 the health board compliance with the Single Cancer Pathway has increased with February 25 performance at 63.5% and March 25 performance at 65.4%.



The focus now is on sustaining performance above 60% for at least three months, ensuring consistent improvements in access to care.

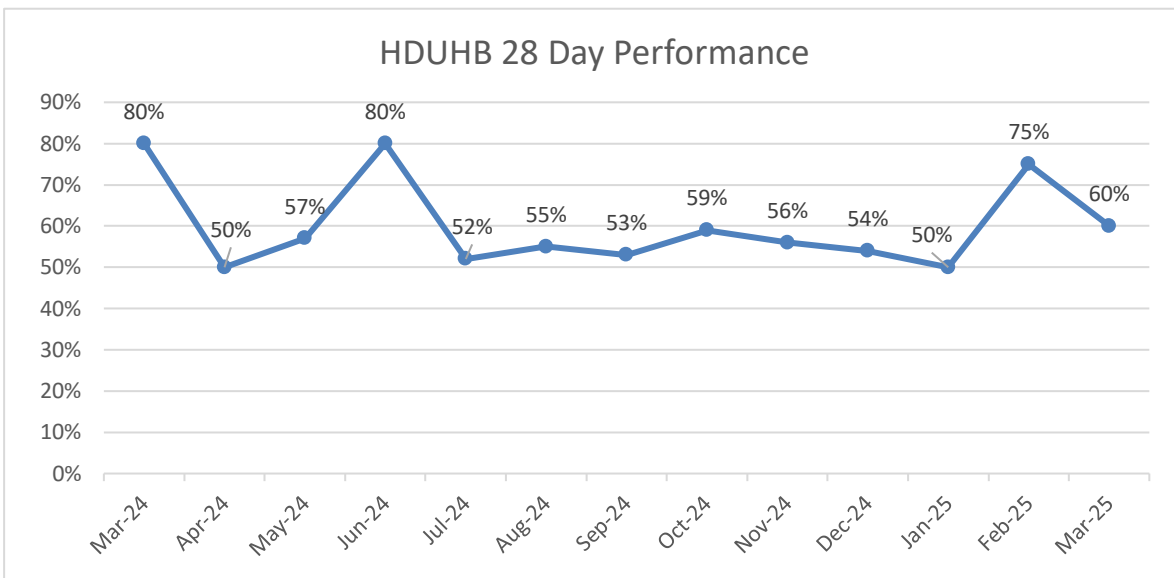
Hywel Dda University Health Board SCP performance for 24/25 broadly mirrors the Welsh average range of 50- 60%.



The trajectory for the rest of the year aims to achieve 80% compliance by March 2026, with a continued reduction in backlog volumes and more timely diagnoses. While monthly treatment activity is expected to remain stable at around 270–280 patients, Targeted Interventions by tumour site will ensure these numbers are maintained, with additional capacity introduced where needed.

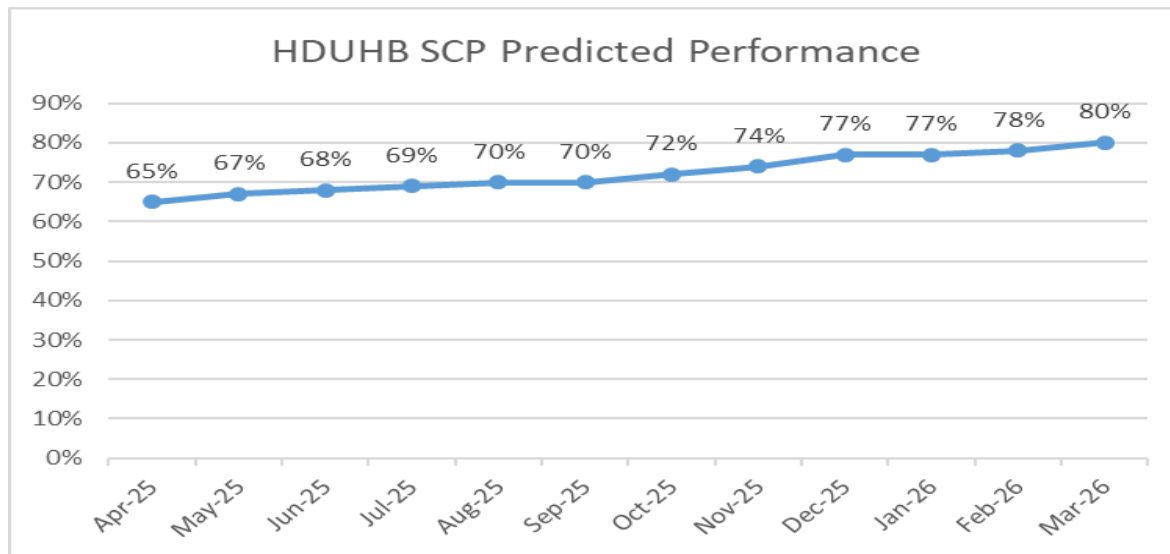
28 Day Performance Compliance

The emphasis for improvement is on improvement of and delivery of the 28 day target to inform all patients whether they have a diagnosis of cancer or not from point of suspicion.



Whilst the health board use the national dashboards to inform planning and delivery there are constraints in accessing Business Intelligence (BI) locally. Access to enhanced cancer BI tools is a key enabler and therefore, an objective for the clinical care group.

SCP Predicted Performance April 25 – Mar 26



Diagnostics

A fundamental assumption underpinning these improvements is the successful implementation of the Health Board's agreed investment into radiology for 2025/27. Given that timely access to imaging is a critical dependency for cancer pathways, any constraints within radiology have the potential to impact the delivery of this plan. Diagnostic capacity improvements particularly in MRI, CT, and endoscopy are essential to meeting SCP compliance targets and reducing treatment delays. Therefore, targeted investment in radiology will remain a central enabler for cancer service improvements and will require close alignment with the broader workforce and infrastructure planning processes.

Agreed Radiology Investment Plan - By the end of 2025/26 for diagnostics we will have:

- Provided an additional CT scanning capacity for 480 patients per month
- Deployed a mobile MRI service creating capacity for 560 additional patients monthly
- Introduced insourcing for non-obstetric ultrasound for 300 additional scans per month
- Cleared the Single Cancer Pathway imaging backlog by September 2025
- Subject to additional funding cleared 8-week diagnostic breaches
- Implemented a new digital phlebotomy booking service

A key focus is ensuring that access to diagnostics and specialist input is both timely and effective. Investment in service redesign, additional workforce, and infrastructure improvements will enable the Health Board to reduce waiting times and deliver a more responsive service.

A recurrent allocation of £3.4m has been earmarked for 2025/26, enabling essential groundwork to be laid particularly in backlog clearance and meeting SCP requirements. This core investment will be complemented by efforts to secure an additional £2.0m £2.4m non-recurrent bridging arrangement in quarter 1 2025/26 from Welsh Government, aiming for a total of £5.4m–£5.8m to fully address workforce and capacity needs.

A principal driver for this investment is to improve the SCP and support the national ambition of achieving a 7-day turnaround for urgent scanning and reporting. The immediate priority is to

clear the Radiology Unscheduled Care (USC) backlog by the end of Quarter 2 (2025/26), thus ensuring that critical imaging does not delay treatment decisions.

The Health Board also recognises the need to balance service expansion with the challenge of ensuring a sustainable backlog reduction. This will require careful management of diagnostic demand, prioritisation of treatment capacity, and embedding long-term solutions that prevent future delays. A structured, system-wide approach is being taken to align these improvements with national frameworks, ensuring that cancer services remain fit for the future.

Across the Health Board, work is ongoing to refine cancer pathways, improving efficiency and access to care using the evidence based National Optimal Pathways as a framework for improvement and to inform the Health Board Cancer Improvement Plan currently in development. Elements of the improvement plan are included below:

Lower Gastrointestinal (Lower GI)

In Lower Gastrointestinal (Lower GI) services, the introduction of Faecal Immunochemical Testing (FIT) within Primary Care is expected to eliminate delays of between 14 and 21 days from the traditional referral pathway. This will be supported by full adoption of the National Optimal Pathway (NOP) for lower GI, ensuring diagnostic capacity is used efficiently and that patients progress effortlessly from referral to diagnostic testing. Further investment in endoscopy services, including additional capacity for Bowel Screening Wales (BSW) colonoscopies, is expected to strengthen performance, particularly as the screening programme expands by 25%. Full implementation of FIT testing in primary care will be completed by the second quarter of 2025/26, with additional colonoscopy capacity aligning to the screening expansion.

Gynaecology

In Gynaecology, the introduction of one-stop clinics at Glangwili and Withybush hospitals will provide a more streamlined diagnostic service, doubling the number of 'see-scan-biopsy' slots available and significantly reducing delays. Plans are also in place to establish an improved triage system for urgent referrals, ensuring that women with suspected ovarian and endometrial cancers are prioritised effectively. These clinics will be fully operational by quarter 2 of 2025/26.

Urology

In Urology, the focus is on ensuring stable outpatient capacity while introducing measures to improve access to Magnetic Resonance Imaging (MRI) through the PROSTAD pathway. This will reduce the time taken to reach biopsy decisions, shortening referral-to-diagnosis times by up to four weeks.

Increased provision of local anaesthetic trans-perineal (LATP) biopsies will help meet growing demand, while additional nurse-led cystoscopy services will provide a 30% uplift in capacity, enabling patients to be seen more quickly. Increased MRI access and expanded LATP biopsy capacity will be in place by the end of quarter 2 2025.

Head and Neck

In Head and Neck cancer, investment in Trans-nasal Oesophagoscopy equipment will allow for more rapid assessment and reduce the need for theatre-based diagnostic procedures. A dedicated neck lump clinic will provide same-day ultrasound and biopsy, improving patient flow and reducing delays. This service will be fully functional by quarter 3 of 2025/26.

Lung

In Lung Cancer services, the introduction of radial endobronchial ultrasound

(rEBUS) will significantly reduce reliance on CT-guided biopsies, cutting diagnostic waiting times and improving access for those requiring radical treatment.

Dermatology

In Dermatology, targeted teledermoscopy sessions will improve triage for urgent suspected skin cancer, reducing in-person clinic pressure while maintaining diagnostic accuracy. The model will be continuously monitored through weekly and quarterly demand-and-capacity Reviews to adjust capacity as needed.

The Health Board has a strong commitment to prevention, aiming to reduce avoidable illness, lessen the strain on urgent and emergency care, and support healthier communities throughout mid and west Wales. We intend to build on current successes and address ongoing challenges, including improving vaccination coverage, expanding smoking cessation services, strengthening support for substance misuse recovery, and embedding a social model of health.

Screening

At the heart of our plan is a set of tangible improvements that reflect local and national Priorities. By the end of 2025/26, we aspire to see significant progress in preventing avoidable illness and promoting better health outcomes. This means raising HPV vaccination from 78% to 80%. We also intend to ensure that at least 5% of adult smokers in our region attempt to quit, with CO-validated quit rates moving from 8% to 20%, and to maintain high treatment completion rates of over 93% for individuals accessing substance misuse services. Additionally, we will uphold our commitment to accessible and timely screening programmes, aiming to maintain over 90% of eligible patients being offered an index Colonoscopy within four weeks of booking their Specialist Screening Practitioner assessment appointment.

The table below is the most up to date published data available.

Screening Programme Data Hywel Dda Position – tables formulated with most recent data available. [Screening - Public Health Wales \(nhs.wales\)](https://www.nhs.uk/public-health-wales/)

	Cervical Screening	Bowel Screening	Breast Screening
	Minimum Service Standard 70%	Minimum Service Standard 60%	Minimum Service Standard 70%
Health Board			
Hywel Dda UHB Coverage/Uptake %	As at March 2022 coverage 68.4%	2022 – 2023 uptake 66.9%	As at May 2021 uptake 73.4%
Wales Coverage/Uptake %	As at March 2022 coverage 69.6%	2022/23 uptake 65.9%	As at May 2021 uptake 72.3%

All screening programmes and in all regions of Wales see an inequality gradient in terms of uptake, with those in less affluent areas taking up the offer of screening less frequently.

Across Hywel Dda we meet and exceed the minimum service standard for uptake of bowel and breast cancer screening, but do not hit this uptake for cervical. This will therefore be a focus area in the coming year.

Patient experience

In May 2023 Hywel Dda sent a patient recorded experience measure (PREM) out to 1670 patients, across all tumour sites, who had a confirmed cancer diagnosis and had received their first definitive treatment within the preceding 12 month period. The PREM itself had been developed by the Wales Cancer Network Patient Experience Team, tested and validated at NHS Executive level, and handed to local cancer teams. Hywel Dda Cancer Services Team

and the Value Based Healthcare Team partnered and hosted the PREM on the DrDoctor platform and it was delivered to patients electronically via SMS and email. The PREM was open for 1 week and in that time 437 (26%) responses were received. The PREM was a mixture of scored responses and free text opportunities.

Key themes from the feedback were:

- The importance of the Cancer Key Worker role (CNS) and a positive patient experience where this role was visible and responsive
- Examples of poor communication particularly around breaking bad news
- Patients described feeling poorly supported in the first 2 weeks of their diagnostic pathway, from USC appointment with GP to first outpatient appointment, though recognised this was a short, but anxious period.

Actions resulting from the PREM:

- Each tumour site team was given a filtered summary of their patients responses for local action plans to be made
- One patient commented he would like to meet to discuss his experience in more detail and this was facilitated and a patient story collected and used in a service improvement plan
- The Cancer Services Team partnered with the Waiting List Support Service to start providing a point of support to patients on a USC pathway from referral to a confirmed or excluded cancer diagnosis
- Cancer Support Senior Coordinator for CaPS (Cancer Psychological Support Service) delivered teaching on breaking bad news to the Health Board wide Grand Round
- The Cancer Services Team started a Person-Centred Care Cancer Group to continue to monitor elements such as Key Worker support, Holistic Needs Assessment compliance, psychological support etc.

Next Steps:

- The PREM was adjusted based on learning from 1st cohort and was re issued to non-responders from cohort 1 in February 2024.
- The ambition is that the PREM will be issued to all new cancer patients every quarter – this has been delayed due to a change in PREM platform in the Value Based Health CareTeam from DrDoctor to Promptly following a tender process. However we are nearly ready to re-host on the new platform and are aiming for another PREM to be issued around September 2025.
- Every patient with a confirmed cancer (RIP filtered and excluded) will be given the opportunity once to complete feedback.
- PREM reports will be fed back to clinical cancer teams for learning and service improvement.

Cancer Survival

The latest net cancer survival estimate for Wales shows that for people diagnosed from 2017 to 2021, 63.1% survived cancer five years from diagnosis, on average.

Long-term historic improvement in five-year net cancer survival has stagnated since the 2014-2018 diagnosis period. This stalling in improvement started before the Covid-19 pandemic and has continued beyond it.

One-year net cancer survival stopped improving appreciably each year of diagnosis from 2014 to 2019, then dipped to 71.9% in 2020, the first full year of the pandemic. This improved significantly to 75.2% in 2021 but only returned survival to the pre-pandemic level

Welsh Cancer Surveillance Intelligence Unit (WCSIU) have been contacted to request Hywel Dda 1 & 5 Year survival data but are still awaiting a response.

Clinical Care Group

With the formation of the new operational structures of the Clinical Care Groups there is a strengthened leadership, oversight and governance on the delivery of cancer care in the Health Board. Assurance, risk, governance, performance and improvement will be closely monitored by the established Cancer Transformation Task and Finish group which reports into the Clinical Care Group (CCG) transformation hub. The Transformation hub will report into the Integrated Quality, Financial Performance and Delivery group (IQFPD), Strategy and Planning Committee, the Quality, Safety and Experience Committee and the Public Board.

Whilst structured, evidence-informed, and patient-centred steps are being taken, improvements are conditional on addressing known risks such as data limitations, workforce constraints, and funding dependencies.

Argymhelliad / Recommendation

The Quality, Safety and Experience Committee receives assurance from the content of the report relating to the Health Board's Response to the Auditor General Report on Cancer Services.

Amcanion: (rhaid cwblhau)	
Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.16 Provide assurance on the delivery of action plans arising from investigation reports and the work of external regulators.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Risk 1350
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	4 Planned care, diagnostics and cancer Recovery

Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply
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Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Link to report
Rhestr Termiau: Glossary of Terms:	Contained within the body of the report
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	Audit Risk & Assurance Committee (ARAC)

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Contained within the body of the report
Ansawdd / Gofal Claf: Quality / Patient Care:	Contained within the body of the report
Gweithlu: Workforce:	Contained within the body of the report
Risg: Risk:	Contained within the body of the report
Cyfreithiol: Legal:	Not Applicable
Enw Da: Reputational:	Not applicable
Gyfrinachedd: Privacy:	Not applicable
Cydraddoldeb: Equality:	Not applicable

4.3

4.3 - Quality Assurance Report

***Cathie Steele (Hywel
Dda UHB - Interim
Assistant Director of
Nursing Assurance
and Safeguarding)***

Attachments

[3.1 QS Assurance Report June2025 v2.0.pptx](#)

[App 1 Overdue actions as at 27-05-2025.pdf](#)



Quality and Safety Assurance Report

Quality, Safety and Experience Committee

June 2025



The purpose of this report is to provide the Quality, Safety and Experience Committee (QSEC) with an overview of quality and safety across the Health Board.

Within the Health Board's Quality Management System, a number of assurance processes and quality improvement strategies are used to ensure high quality care is delivered to patients.

This report provides information on:

- Patient safety incidents
- Nationally reported patient safety incidents
- Duty of Candour
- Patient Experience
- Infection, prevention and control
- Inspections and peer reviews including activity of Healthcare Inspectorate Wales (HIW)
- Quality Impact Assessments
- Nursing Staffing Levels (Wales) Act 2016

Patient Safety Incident Reporting



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

There were 14,937 incidents reported on Datix Cymru in the Health Board between 1st April 2024 and 31st March 2025. Of these, 12,316 were Patient Safety Incidents.

Of the 12,316 patient safety incidents reported, 10,269 have been closed. 114 (1.1%) were closed as moderate, severe or catastrophic harm.

The top 3 incident classifications (incidents reported between 01/04/2024 and 31/03/2025 and closed as moderate, severe or catastrophic harm) were pressure damage; accident or injury; and treatment and procedure. This can be broken down further into the categories.

Pressure ulcer developed or worsened during care in this clinical care area/caseload	24
Slip, trip or fall	17
Treatment or procedure issues	13

Patient Safety Incidents by month of occurrence



Incident Reporting: exploring the reduction in reporting

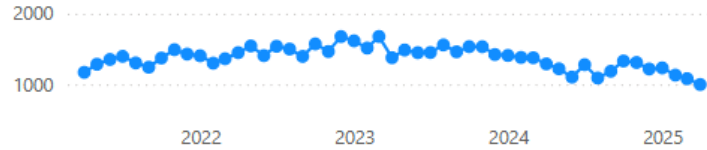
A downward trend in reporting can be seen when comparing the number of incidents reported for 2024/25 compared to the previous financial years.

The reduction is seen in incidents where the person affected is a patient or a service user. An exploration of the top classifications and categories shows that the reduction is in pressure and moisture damage incidents



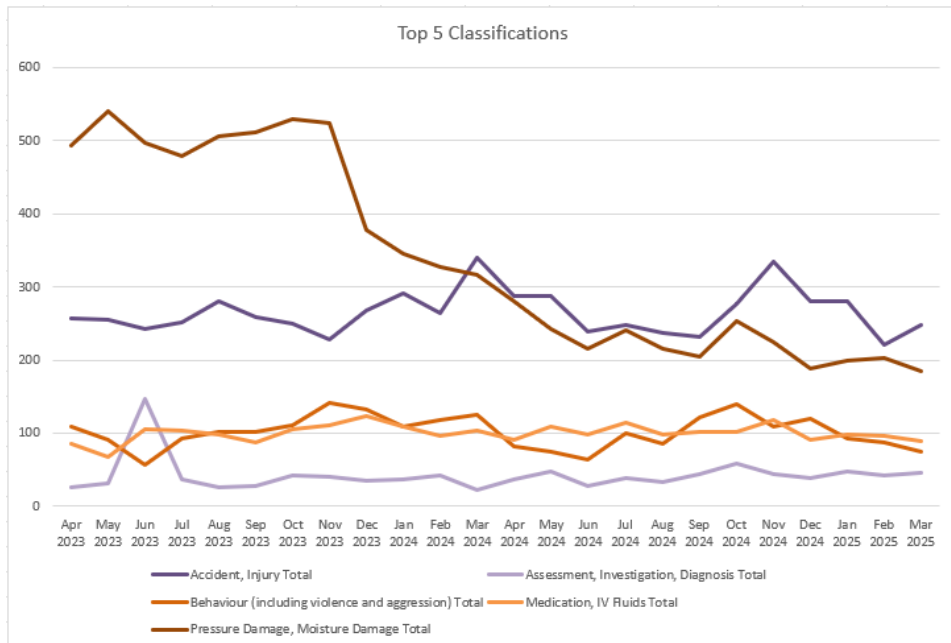
Incidents by month of occurrence

As at 30/04/2025



	Organisation	Patient/Service User	Public/Visitor	Staff/Contractor	Total
2021/2022	791	14077	52	1615	16535
2022/2023	893	16128	47	1589	18657
2023/2024	1021	15046	51	1707	17825
2024/2025	963	12141	58	1553	14715
Total	3675	57506	208	6482	67871

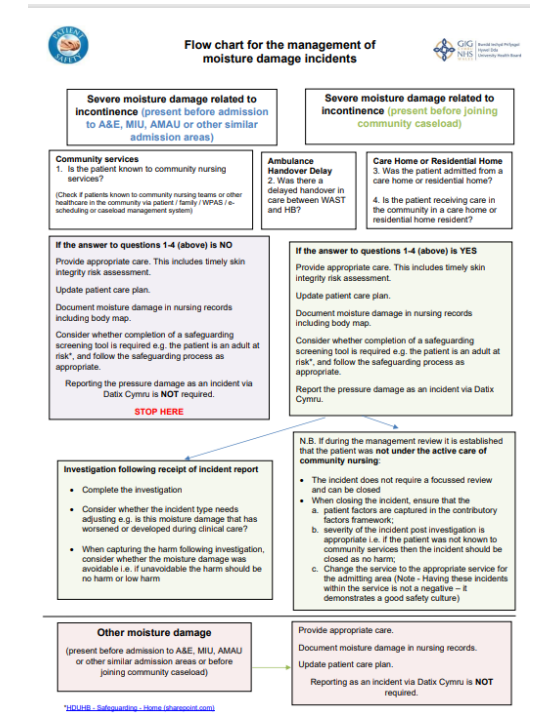
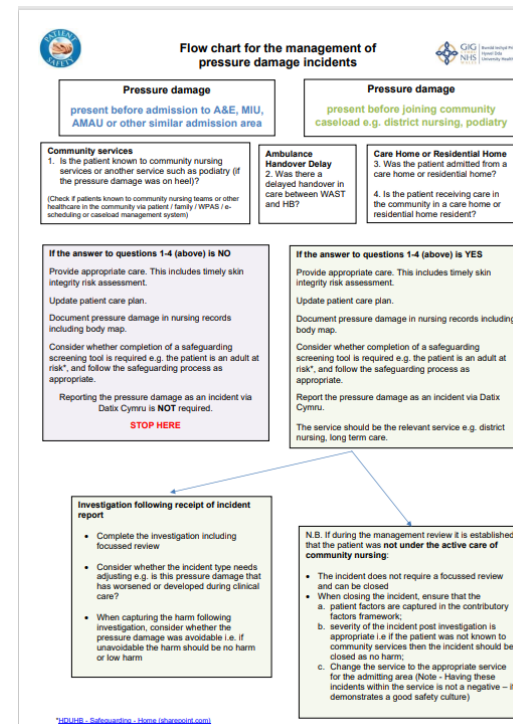
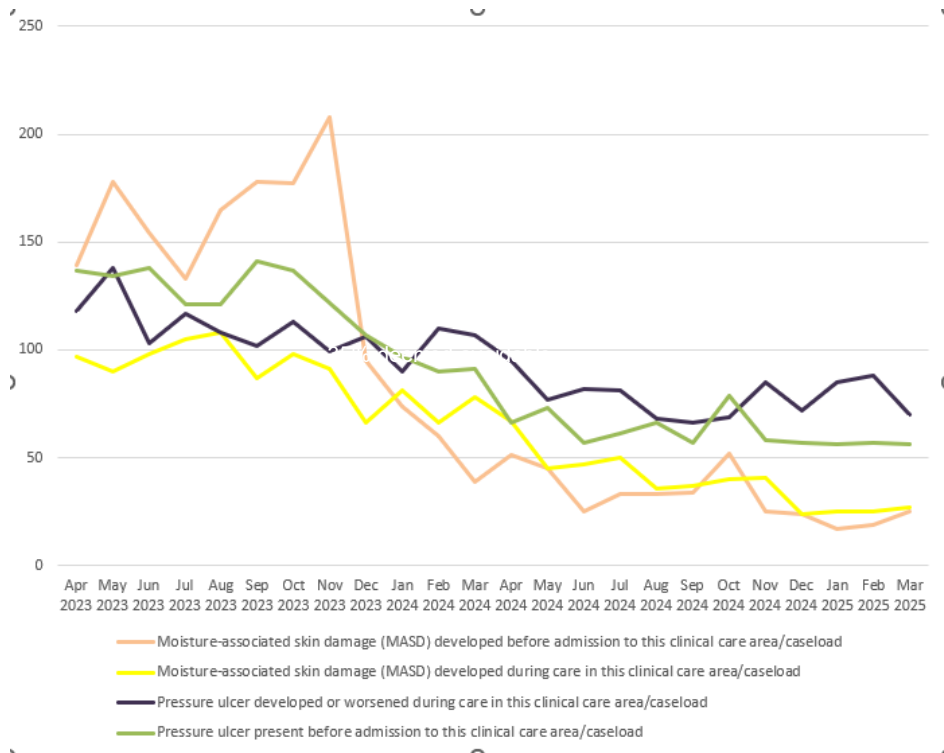
Patient Safety Incidents by month of occurrence



Pressure and moisture damage

The reduction is due to two pieces of targeted work:

- Removing the duplicate incidents e.g.
 - Patient admitted to Ward A – pressure damage reported.
 - Patient then moved to Ward B – pressure damage reported again by second ward
- Improve understanding about reporting of pressure damage identified on admission. A new process was rolled out Health Board wide in November 2023 which clarified the importance of clinical documentation of pressure damage on admission rather than incident reporting if the patient was not known to health services prior to admission. As part of the work the requirement for reporting of moisture damage was clarified.



Incident Reporting: the picture without pressure damage incidents

Community & Integrated Medicine



Planned and Specialist Care



Mental Health and Learning Disabilities



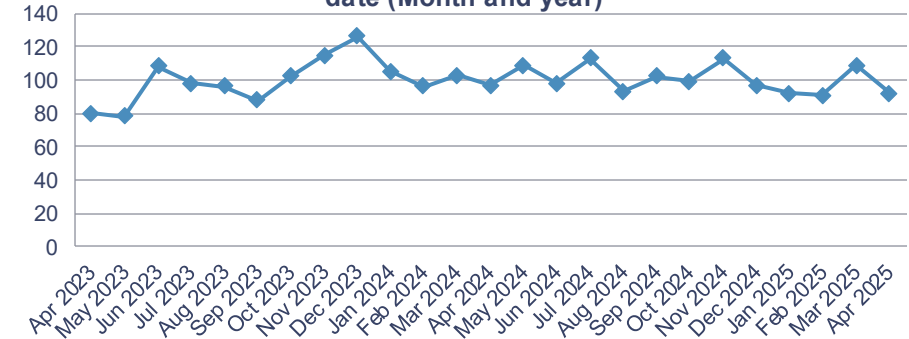
Primary Care, Community Strategy



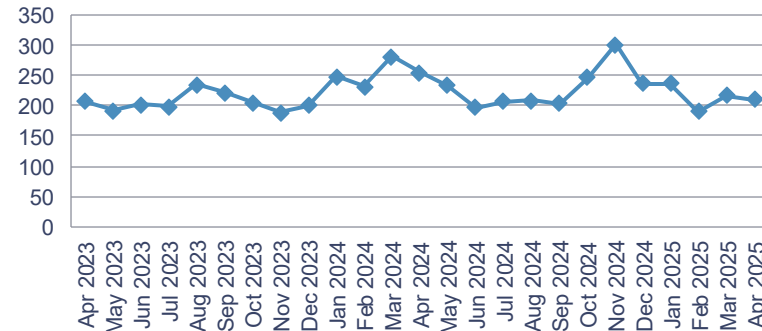
Operational Allied Health and Health Science



Medication related Patient Safety Incidents by Incident date (Month and year)



Patient Slips, Trips and Falls (all harm) by Incident date (Month and year)



Patient Slips, Trips and Falls by post investigation harm and incident date



*Not including pressure damage or moisture damage in view of change in reporting requirement

Incident Reporting: improving reporting

In the staff survey, within the patient safety theme, it was highlighted that:

- staff feel unsafe in reporting errors, near misses or incidents.
- there is a perception that those that do report are treated unfairly and there is little feedback after doing so.

The Quality Assurance and Safety Team are:

- Considering additional areas for inclusion in newsletters and 7-minute briefings;
- Reminding investigation managers of the importance of documenting within the relevant section in the Datix Incident Module the feedback to the reporter which shows that the time taken by the reporter is valued; and
- Working with Clinical Service Groups (where reporting levels are lower than expected) to develop trigger lists for incident reporting;
- Working with Clinical Service Groups to refocus the Scrutiny Panels to become Learning from Events Panels; and
- Working with acute hospital pharmacy colleagues to consider how medication prescription errors identified before administration (near miss incidents) can be captured as these are captured within pharmacy systems rather than in Datix Cymru

The Clinical Care Groups, Clinical Service Groups and Departments have been reminded that:

Sharing of learning and actions through Clinical Care Groups and Clinical Service Group Integrated Governance Group meetings and through department meetings is key to improving perception; and

Timely investigation and closure of incidents will assist in improving staff perception regarding feedback

The 'Speak Up' agenda will need to continue to be embedded, and the workforce educated in the importance of speaking up at micro and meso levels of culture.



Nationally Reportable Incidents



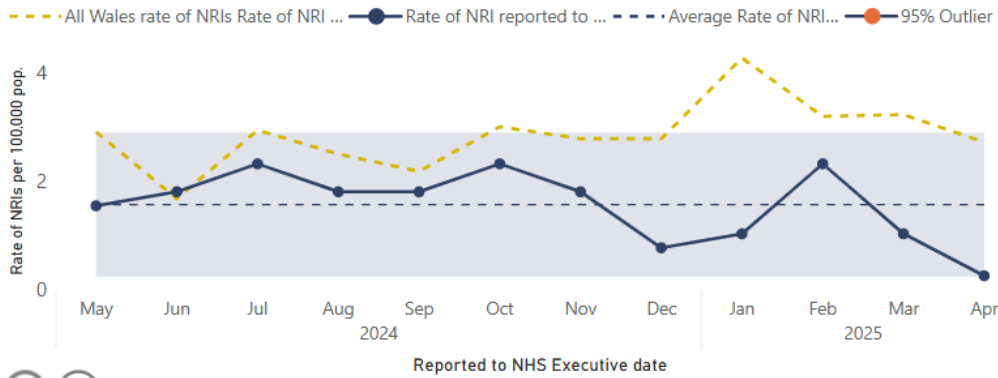
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University Health Board

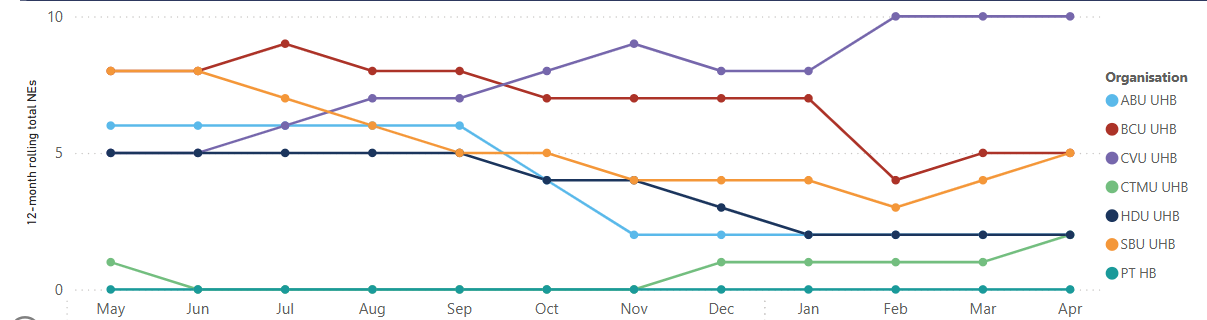
There were 81 Patient Safety Incidents reported to the NHS Executive between 1st April 2024 and 31st March 2025.

In May 2023, an updated [NHS Wales National Policy on Patient Safety Incident Reporting and Management](#) was published. The Policy provides clear guidance on what types of incident should be nationally reported, and how this should occur. There are 5 principles for reporting; must reports; outcome/harm; number of patients or service users involved; learning opportunities; and joint decision making around reporting and investigation

HDU UHB rate of NRIs reported to NHS Executive per 100,000 population as of 02/05/2025



All Wales 12-month rolling total Never Events occurring (by incident date) as of 02/05/2025



HDU UHB Never Events reported to NHS Executive (May-24 to Apr-25) as of 02/05/2025

Year	2024					2025						
	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Administration of medication by the wrong route	1	0	0	0	0	0	0	0	0	0	0	0
Retained foreign object post procedure	0	0	0	1	0	0	0	0	0	0	0	0
Total	1	0	0	1	0	0	0	0	0	0	0	0

NRI category	Total
Unexpected death	14
Pressure ulcer developed or worsened during care in this clinical care area/caseload	9
Clinical assessment, clinical diagnosis	6
Neonate	4
Treatment or procedure issues	3
Healthcare Acquired Infection (community, primary care or hospital)	2
Medical devices	2
Self-harm / self-injurious behaviour	2
Administration errors	1
Assessing and recognising patient/service user deterioration	1
Communication issues	1
Maternal	1
Pressure ulcer present before admission to this clinical care area/caseload	1



The Quality Assurance and Safety Team arrange incident management groups (IMG) when severe or catastrophic harm is reported. Consideration of reporting is given during the IMG.

The team have also added an additional check in their validation of incidents closed by Clinical Care Groups

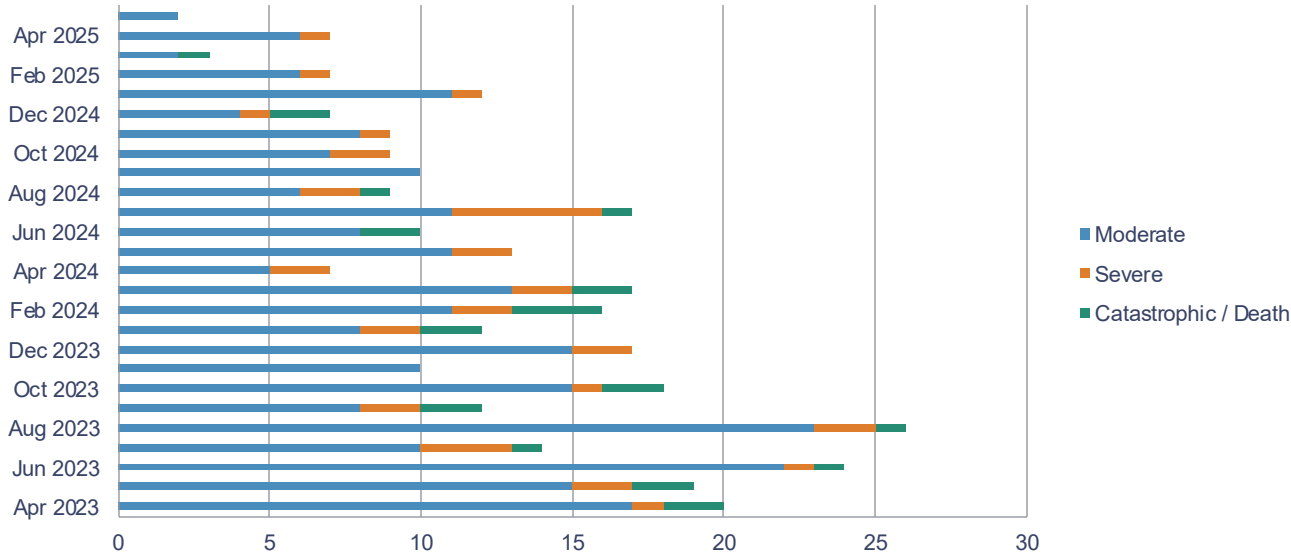
Duty of Candour



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Incidents by Incident date (Month and year) and Manager's interim harm assessment



219 incident records have been closed where duty of candour had been triggered during the manager's initial assessment.

		Harm post investigation					Total
		None	Low	Moderate	Severe	Catastrophic / Death	
Manager's interim harm assessment	Moderate	14	42	126	2	1	185
	Severe	1	6	3	10	3	23
	Catastrophic / Death	2	4	1	2	2	11
	Total	17	52	130	14	6	219

Top 3 incident classifications

Incidents occurring after 01/04/2023 where duty of candour has triggered, and investigation has been closed.

Pressure Damage, Moisture Damage	51
Pressure ulcer developed or worsened during care in this clinical care area/caseload	45
Pressure ulcer present before admission to this clinical care area/caseload	2
Pressure from medical device present before admission to this clinical care area/caseload	4
Accident, Injury	38
Slip, trip or fall	36
Patient injury	2
Maternity adverse occurrence	27
Maternity adverse occurrence - Neonate	15
Maternity adverse occurrence - Maternal	12



Learning identified:

- Importance of clear documentation and patient involvement
- Critical role of monitoring in safe prescribing including confirming monitoring has been completed before issuing repeat prescription
- Patients with capacity can refuse treatment even if the treatment is in their best interest



We continue to receive many positive stories and comments about the services provided by our caring and compassionate staff. We are continually sharing and celebrating these achievements across the organisation.

All Wales People Experience Survey 1,480 service users completed the 'Your NHS Wales Experience' survey of which 10% responded with poor or very poor rating for their overall experience. Concerns related to waiting times and care provided in corridors in A&E. A higher number of service users completed the survey during this period and more were satisfied with the care received.

212 compliments were received direct to wards, departments or Corporate Office. These frequently highlight the professionalism and compassionate care provided by healthcare teams. *"Jassmin was very supportive and advocated for me as I am a breastfeeding. After 2 days in A&E/CDU with not many opportunities of privacy to feed, she ensured I was moved to an appropriate ward with privacy and open access for my baby to come and feed. This saved our breastfeeding journey which is very important to me. Thank you"*.

Complaints and enquires: 894 new cases were received into Patient Support Services. Of these, 492 were received as new complaints and 402 as enquiries. The main reasons for enquiries/early resolutions related to appointments / waiting list queries, communication inefficiencies. During the period a total of 451 complaints were closed. 180 were responded to within 5 working days through the early resolution process.



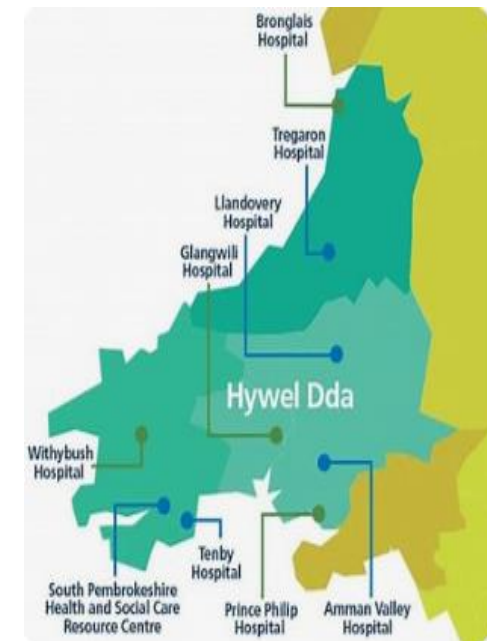
Friends and Family Test

46,343 individuals received our friends and family patient experience survey, in which 7058 responded following their attendance, representing a 15% response rate. 94.6% reported a positive experience which has improved from the previous period.

Public Services Ombudsman

There has been one new investigation and 11 decisions not to investigate. In the same period, there were 5 early resolution agreements made between the Health Board and the Ombudsman. There were also 3 final reports issued by the Ombudsman following investigations. Two of the final reports were upheld one not upheld.

1203 calls were made to the 0300 0200 159 Patient support number.



Friends and Family test

This feedback is provided by patients following a visit to one of our outpatient clinics, telephone/video call appointment or hospital admission.

Many responses did not include detailed reasons for the ratings; however feedback highlighted positive aspects such as professional and caring staff, clear explanations, and efficient service. Negative feedback mentioned issues including long waiting times, lack of communication, and inadequate facilities.

Accident and Emergency

Comments highlighted the efficiency of the service and the care provided during their visits. However, long waiting times and lack of communication are areas needing improvement.

Acute Internal Medicine

Patients praised the nursing staff for being attentive and assuring. The doctors were also commended for their thorough explanations and care, but some patients felt that the service could be more streamlined.

Adult Mental Illness

Patients and their families appreciated the care and attention provided but felt better communication was needed.

Cardiology/Gastroenterology/Gynaecology

Many appreciated the clear explanations, and the care provided during their visits. Some people were not happy with long waiting times and the need for better coordination between departments.

Ophthalmology/Pain Management/Dermatology

Positive views expressed about the care received, patients appreciated clear explanations and the thoroughness of the procedures. Waiting times were an issue, along with follow up appointments.

Physiotherapy/Respiratory Medicine

Patients were very positive about the care and professionalism of the staff. Long waiting times and the need for better coordination between departments were highlighted.

Further information can be found in the papers for the May Board meeting

<https://duhb.nhs.wales/about-us/your-health-board/board-meetings-2025/board-agenda-and-papers-29-may-2025/board-agenda-and-papers-29-may-2025/11-improving-people-and-community-experience-report-pdf/>

Healthcare Acquired Infection



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Monthly Infections Report

C. difficile - April 2025

Trends

15 patients diagnosed this period

Onset

For the period Apr 25

10 Hospital onset
5 Community onset
2 COCA; 3 COHA

Carmarthenshire

For the period Apr 25

4 Hospital onset
3 Community onset

Ceredigion

For the period Apr 25

4 Hospital onset
1 Community onset

Pembrokeshire

For the period Apr 25

2 Hospital onset
1 Community onset

Monthly Infections Report

E. coli bacteraemia - April 2025

Trends

26 patients diagnosed this period

Onset

For the period Apr 25

6 Hospital onset
20 Community onset
20 COCA; 0 COHA

Source Apr 25

Urinary **13** CAUTI **2** Biliary **4** Other **1** TBC **2** Unknown **4**

Carmarthenshire

For the period Apr 25

4 Hospital onset
11 Community onset

Ceredigion

For the period Apr 25

0 Hospital onset
4 Community onset

Pembrokeshire

For the period Apr 25

2 Hospital onset
5 Community onset

Monthly Infections Report

S. aureus bacteraemia - April 2025

Trends

10 patients diagnosed this period

Onset

For the period Apr 25

3 Hospital onset
7 Community onset
4 COCA; 3 COHA

Source Apr 25

Wound **3** Line/devices **0** Other **0** Unknown **1**
1 MSK 5 TBC

Carmarthenshire

For the period Apr 25

1 Hospital onset
5 Community onset

Ceredigion

For the period Apr 25

1 Hospital onset
1 Community onset

Pembrokeshire

For the period Apr 25

1 Hospital onset
1 Community onset

Quality Planning

- Organisation Annual Plan
- Annual Infection Prevention and Control (IP&C) work plan
- Infection Prevention Strategic Steering Group (IPSSG) work plan
- Welsh Health Circulars (WHC) relating to IP&C and Public Health
- WHC Antimicrobial Resistant (AMR) & Healthcare Acquired Infection (HCAI) Improvement Goals 2024/25
- Working with the Public Health team and primary care/ community services to prevent infection in high-risk populations/ community settings

Quality Assurance

- All Clinical Care Groups (CCGs) and Clinical Service Groups (CSGs) to monitor the data on the Health Board's Safety Dashboard (and review cases)
- Review of monthly data from HARP with internal health board analysis and scrutiny
- [Asceptic Non Touch Technique \(ANTT\)](#) 80.6% compliance with health board critical care and other inpatient areas seeking accreditation
- Level 1 mandatory training at 86.5% compliance. Level 2 mandatory training at 74.1%
- Deep cleaning and hydrogen peroxide vapour (HPV) for PPH on all wards continues
- Refurbishment of Derwen Ward GGH continues (increased rate of VIM Pseudomonas prior to refurbishment)
- Work has commenced on review of community onset infections- working with managed practices and analysis of HCAs

Quality Control

- Standardisation of assurance/ scrutiny groups in progress
- Reports from CCG / Subgroups of IPSSG
- Review of health board's IPC policies
- Self-assessment against C.diff Framework for Wales and attendance at Wales C. diff Focus Forum Meeting.
- Review of data sets against TI reduction expectations- disseminated to all services and use of safety dashboards
- Review by AMG and antibiotic pharmacists of compliance to SSTF for each acute site

Quality Improvement

- Scrutiny meetings held-all hospital onset/ HCAI are discussed and learning obtained/ action plans implemented, themes derived
- Working with managed practices- presenting infographics for infections/ sources/ learning
- Environmental audit programme re-established for high risk areas. Working with clinical audit team to establish this on AMat
- Observational audits conducted and action plans produced
- Review of Synbiotix scores in relation to IPC audit programme
- Trail of HPV machines in GGH/ BGH
- Deep clean and HPV of PPH linked to C.diff clusters
- Capital bids [successful](#) for SESN 24/18 - Welsh Government (Capital, Estates & Facilities) Targeted ESTATES FUND in relation to supporting IPC and cleaning using new technologies- purchasing of equipment in planning stage

Health Inspectorate Wales (HIW) / Care Inspectorate Wales) CIW / Human Tissue Authority (HTA) inspection activity: 01/02/2025 – 20/05/2025



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There has been 1 inspection (Maternity Glangwili 13th and 14th May 2025) but no new reports published by HIW or the HTA relating to the Health Board in the period 1st February to 20th May 2025.

The feedback from the Maternity Glangwili inspection was mostly positive, with no immediate actions arising. The Health Board awaits the draft report in due course.

The Health Board have received the following letters from HIW requesting assurance :

Date of letter	HIW ref	Matter
16/01/2025	12474	Emergency Department staffing, GGH
30/01/2025	12589	Ceredig Ward, BGH – care of patient
14/02/2025	12702	Cwm Seren – care of patient
14/02/2025	12734	Staff behaviour in Radiology, GGH
25/02/2025	12858	Theatre Department staffing, GGH
18/03/2025	12994	PPH Bryngolau – care of patient
20/03/2025	12997	Ward 12 staffing, WGH

Date of letter	HIW ref	Matter
11/04/2025	13271	Paediatric Medical Workforce
12/04/2025	13272	Mental health services provision in north Ceredigion
12/04/2025	13274	Member of staff St Nons Ward, Bro Cerwyn
30/04/2025	13391	Critical care provision in Carmarthenshire
02/05/2025	13274	Member of staff St Nons Ward, Bro Cerwyn - additional query
20/05/2025	13271	Paediatric Medical Workforce – request for update regarding recruitment progress
	13272	Mental health services provision in north Ceredigion – request for further information
	13274	St Non’s Ward – request for update

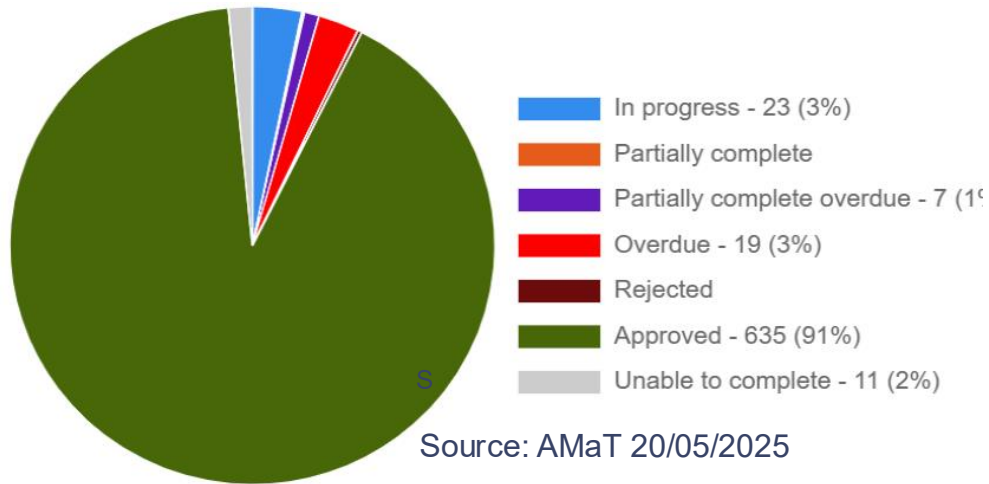
Clinical Care Groups are expected to monitor open HIW reports through the Information Governance Groups (IGGs) until closure of action plan is confirmed. Clinical Service Groups are actively supported to utilise Audit Management and Tracking System (AMaT) and supported and engaged during an inspection to develop a SMART action plans within a realistic timeframe. HIW expect an update to all action plans on a 3 monthly basis until completion.

In the letters from HIW requesting assurance on specific matters, HIW set a date (not later than) two days ahead of the deadline to allow for Executive review and approvals.

response must be received. The Corporate Team request the draft response from the CCG

HIW Quality Checks/Inspections: Reviews and inspections

Improvement Actions relating to HIW reviews



In comparison to the position in February 2024, there has been improvement in closure of actions.

	Position Feb 2024	Position as at 20 May 2025
Overdue	51	19
Partially complete (overdue)	17	7
Partially complete	1	1
In progress	119	23

See appendix for list of overdue actions

Open HIW inspections

No. of inspections	MD	SD	WN	PIR	Actions							
					In progress	Partially complete	Partially complete (Overdue)	Overdue	Unable to complete	Completed (awaiting approval)	Rejected	Completed
7	91/146 (62%)	1/1 (100%)	0	0	23	1	7	19	5	0	2	143

Completed HIW inspections

No. of inspections	MD	SD	WN	PIR	Actions							
					In progress	Partially complete	Partially complete (Overdue)	Overdue	Unable to complete	Completed (awaiting approval)	Rejected	Completed
27	248/248 (100%)	18/18 (100%)	0	0	0	0	0	0	6	0	0	492

HIW Quality Checks/Inspections: Open reviews and inspections

Code	Title	Type	Date of inspection	Origin	Recommendations	Action
Healthcare Inspectorate Wales (HIW)/2024/395	Bryngolau Ward, Prince Philip Hospital	New	02/09/2024	Healthcare Inspectorate Wales (HIW)	40	51
Healthcare Inspectorate Wales (HIW)/2024/396	HIW Children and Young People Mental Health Review	New	05/02/2024	Healthcare Inspectorate Wales (HIW)	9	23
Healthcare Inspectorate Wales (HIW)/2022/19	HIW GGH IRMER Inspection (Nov 2022)	New	15/11/2022	Healthcare Inspectorate Wales (HIW)	21	36
Healthcare Inspectorate Wales (HIW)/2024/302	HIW Glangwili Hospital – Morlais Ward inspection	New	01/07/2024	Healthcare Inspectorate Wales (HIW)	9	18
Healthcare Inspectorate Wales (HIW)/2023/29	HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)	New	07/03/2023	Healthcare Inspectorate Wales (HIW)	40	33
Healthcare Inspectorate Wales (HIW)/2024/86	HIW IRMER Diagnostic Imaging x-ray department Withybush Hospital January 2024	New	31/01/2024	Healthcare Inspectorate Wales (HIW)	9	14
Healthcare Inspectorate Wales (HIW)/2023/69	HIW St Non, St Caradog, Canolfan Bro Cerwyn WGH	New	16/10/2023	Healthcare Inspectorate Wales (HIW)	19	25

HIW Operation Plan 2025/06

HIW have launched their [Operational Plan 2025-2026](#).

The 2025–2026 Operational Plan builds on the strong foundations of their existing [Strategy](#), which they have extended by one year. Over the coming year, they will continue to focus on key priorities that help them achieve their goal of improving healthcare for everyone in Wales.

This plan outlines how HIW aims to achieve their strategic objectives. They have committed to:

1. focus on the quality of healthcare provided to people and communities as they access, use and move between services.
2. adapt our approach to ensure we are responsive to emerging risks to patient safety
3. work collaboratively to drive system and service improvement within healthcare.
4. support and develop our workforce to enable them, and the organisation, to deliver our priorities.

HIW have stated that they will continue to take a balanced, risk-based approach to their work, prioritising areas where patient safety is most at risk. Their inspection and assurance programme will remain flexible and responsive, ensuring that they check the right services, in the right place, at the right time. They have stated that they will continue to deliver our statutory responsibilities, including their work under the Mental Health Act, the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R), and independent healthcare regulations.





Peer reviews may be undertaken by professional bodies such as the networks within the NHS Wales Executive, the Royal College of Physicians, and the Royal College of Nursing.

There has been one peer review since the last report to QSEC. Representatives from the Royal College of Nursing visited the Emergency Departments in Bronglais General Hospital, Glangwili General Hospital and Withybush General Hospital to undertake a workplace inspection. The report of the findings was received on 16th April and an action plan is being developed. The actions will be recorded on AMaT and implementation monitored through the Community and Integrated Medicine Clinical Care Group Integrated Governance meeting.

The Quality Impact Assessment Panel has met on 5 occasions since the last report to QSEC in December 2025. The following Quality Impact Assessments have been considered:

- Agency / locum staff usage within:
 - Dietetics
 - Physiotherapy
 - EUCC BGH
 - Surgical junior doctor rota in WGH
 - Surgical speciality doctor rota in WGH
 - Consultant cover in general surgery at WGH and GGH
- Savings Plans
 - Dietetics
 - Occupational therapy
 - Physiotherapy
 - Speech and Language Therapy
 - Podiatry
 - Cancer therapy service
- Podiatry vascular service initiative
- Adferiaid funded Long COVID, ME and chronic fatigue syndrome service
- Podiatry - location for service provision in north Ceredigion
- Audiology PIFU follow up
- Audiology advance practitioner
- Audiology associate practitioner
- Hydrotherapy Pentre Awel
- Biomedical Science in BGH
- Respiratory and sleep service
- HEIW policy on transcription of medication
- Physiotherapy referral for imaging
- GP referral pathway for Mental Health assessments in north Ceredigion
- Childrens Autism Spectrum Disorder service – pilot of rapid referral pathway
- National joint registry - data collection
- National Audit of inpatient falls – data collection expansion
- National hip fracture audit – data collection
- Redirection policy



Nurse Staffing Levels (Wales) Act 2016: extent to which the Nurse Staffing Levels have been maintained within S25B wards



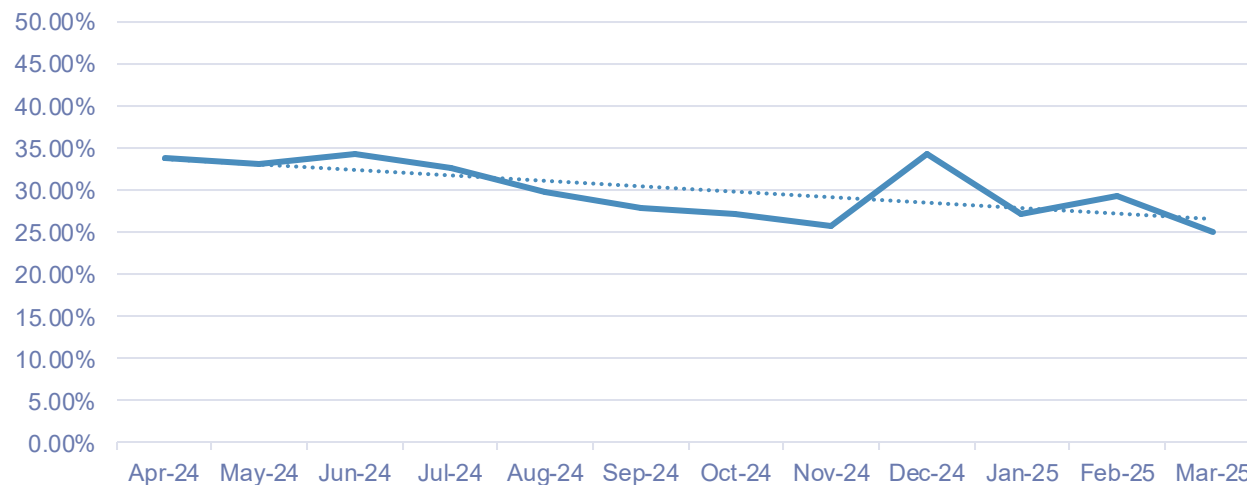
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For the period 6th April 2024 to the 5th April 2025 the extent to which the planned roster has been maintained within S25B adult medical and surgical wards is set out below – the data reflects a point in time on the shift and may not be representative of the whole shift)

Month	Total number of shifts	Shifts where planned roster met and appropriate		Shifts where planned roster met but not appropriate		Shifts where planned roster not met but appropriate		Shifts where planned roster not met and not appropriate		Data completeness	Shifts where planned roster met but no appropriateness recorded		Shifts where planned roster not met and no appropriateness recorded	
		%	Count	%	Count	%	Count	%	Count		%	Count	%	Count
ADULT	38370	45.84%	17589	19.04%	7306	19.47%	7471	8.39%	3220	92.74%	5.00%	1917	2.25%	865

Percentage of shifts deemed to be not appropriate (Adult)



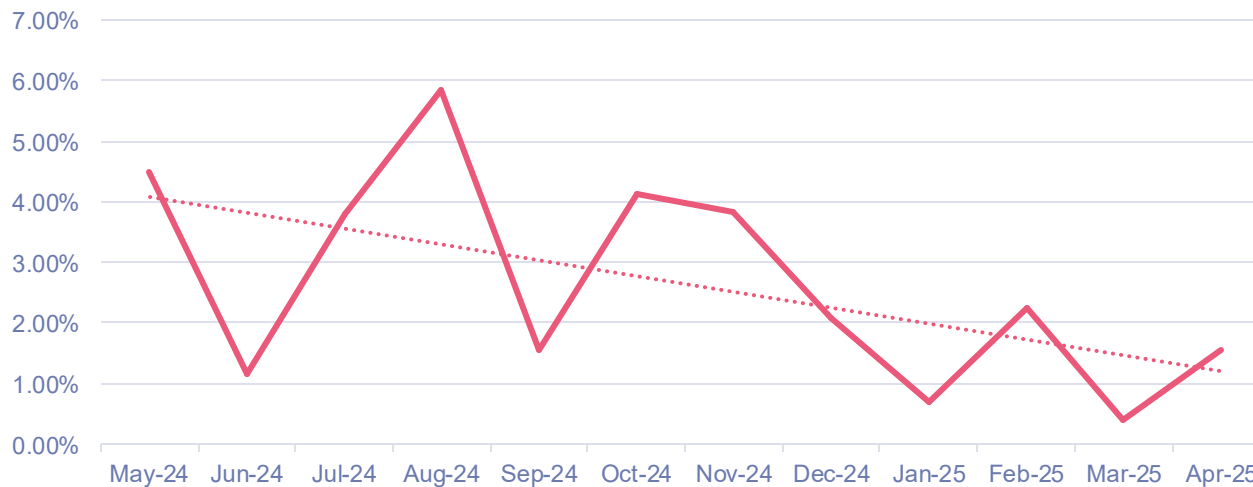
Appropriate/Not Appropriate: the data shows that there is an average of 29.75% of shifts where the nurse in charge deemed that the number of nurses on duty was not appropriate to meet the needs of the patients on the ward at the time irrespective of whether the roster was met or not met (a low of 25.03% in March 2025 to a high of 34.18% in December 2024).

Nurse Staffing Levels (Wales) Act 2016: extent to which the Nurse Staffing Levels have been maintained within S25B wards

For the period 6th April 2024 to the 5th April 2025 the extent to which the planned roster has been maintained within S25B Paediatric wards is set out below – the data reflects a point in time on the shift and may not be representative of the whole shift)

Month	Total number of shifts	Shifts where planned roster met and appropriate		Shifts where planned roster met but not appropriate		Shifts where planned roster not met but appropriate		Shifts where planned roster not met and not appropriate		Data completeness	Shifts where planned roster met but no appropriateness recorded		Shifts where planned roster not met and no appropriateness recorded	
		%	Count	%	Count	%	Count	%	Count		%	Count	%	Count
TOTAL	3282	55.27%	1814	1.25%	41	39.09%	1283	1.43%	47	97.04%	1.25%	41	1.68%	55

Percentage of shifts deemed to be not appropriate (Paeds)



Appropriate/Not Appropriate: the data shows that there is an average of 2.68% of shifts where the nurse in charge deemed that the number of nurses on duty was not appropriate to meet the needs of the patients on the paediatric wards at the time irrespective of whether the roster was met or not met (0.40% in March 2025 to 5.86% in August 2024). The number of shifts ranges from a low of one March 2025) to a high of 17 in August 2024).

Nurse Staffing Levels (Wales) Act 2016:

extent to which the Nurse Staffing Levels have been maintained within S25B wards

Analysis of the narrative:

- The inability to secure additional staff to care for high acuity patients or patients requiring enhanced patient support are the main reasons why the number of staff on duty is deemed to be not appropriate. There are systems in place whereby risk assessments are undertaken, taking into consideration patients' needs (acuity) versus the available staff (both substantive and temporary), staff's knowledge and team. Work is ongoing to review how patients requiring enhanced patients support are managed and cared for. An All Wales enhanced patient care risk assessment is being developed and is awaiting Executive Directors of Nursing Peer Group sign off before being implemented within the HB.
- The inability to secure additional staff when the ward is using surged beds is also a reason the number of staff on duty is deemed to be not appropriate.
- Staff's understanding of professional judgement is variable and novice and less experienced RNs often make different professional judgment decisions than more experienced staff. Education and training are available to new users and to those requiring updates.

Actions being taken:

- Staff can raise a 'red flag' in the event of the number of nurses on duty not being appropriate to meet the needs of the patients on the ward at that time and evidence what actions were taken. Further work is required to embed the practice of raising a 'red flag' for these situations and suite of training sessions developed around Safecare includes a session on 'red flags.'
- All reasonable steps" are taken to maintain the nurse staffing levels as per the requirements of the Act and the nationally agreed adult ward operational guidance document. Operational teams apply their professional judgment to ensure that the staffing levels wherever possible, are maintained – and, where not possible, that risks are mitigated, whilst also having regard for the health board's overarching duty of "providing sufficient nurses to allow the nurses time to care for patients sensitively."



The Quality, Safety and Experience Committee (QSEC) is asked to note the contents of this report.

The Quality, Safety and Experience Committee is asked to take assurance that processes are in place to review, monitor and improve the quality of our service through:

- Patient safety incidents
- Nationally reported patient safety incidents
- Duty of Candour
- Patient Experience
- Infection, prevention and control
- Inspections and peer reviews including activity of Healthcare Inspectorate Wales (HIW)
- Quality Impact Assessments
- Nursing Staffing Levels (Wales) Act 2016



Collation of report: Cathie Steele, Interim Assistant Director of Nursing, Assurance and Safeguarding

Sections:

1. Patient Safety Incident Reporting – Cathie Steele, Interim Assistant Director of Nursing, Assurance and Safeguarding
2. Nationally reportable incidents – Cathie Steele, Interim Assistant Director of Nursing, Assurance and Safeguarding
3. Duty of Candour – Cathie Steele, Interim Assistant Director of Nursing, Assurance and Safeguarding
4. Patient experience and patient feedback – Louise O’Connor, Assistant Director for Legal Services and Patient Experience
5. Infection Prevention and Control – Rebecca Richards, Head of Infection Prevention and Control
6. Healthcare Inspectorate Wales and other peer reviews – Caroline Burgin, Patient Safety and Assurance Manager and Cathie Steele, Interim Assistant Director of Nursing, Assurance and Safeguarding
7. Quality Impact Assessments - Cathie Steele, Interim Assistant Director of Nursing, Assurance and Safeguarding
7. Nurse Staffing Levels (Wales) Act 2016 – Helen Humphries, Head of Nursing for Professional Standards and Regulation



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The Duty of Candour

Openness and honesty should be at the heart of every relationship between those providing treatment and care and those experiencing it.



DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG
SAFE | SUSTAINABLE | ACCESSIBLE | KIND

HIW Overdue Actions
As at 27/05/2025

Inspection Title	Recommendation	Reference Number	Action	Service	Original Due Date	Current Due Date	Progress Status
Bryngolau Ward, Prince Philip Hospital	The health board must ensure patients are provided with relevant, up-to-date and accessible information to support their care.	Healthcare Inspectorate Wales (HIW)/2024/395/MD6/1	Review information on display and its accessibility and assure the following information points are present and accessible: <ul style="list-style-type: none"> • Advocacy Services and contact details • Role of HIW and contact details • Mental Health Act information • MHA name and contact • Available and appropriate legal representatives for detained patients (list in office) • How to raise a concern or complaint (putting things right) • QR Code Patient Satisfaction • Infection Board: staff images, role, uniform and name. 	Mental Health and Learning Disabilities	31/01/2025	31/01/2025	Partially complete (Overdue)
Bryngolau Ward, Prince Philip Hospital	The health board should consider the staff feedback about suggestions for training and implement regular, individualised training needs assessments.	Healthcare Inspectorate Wales (HIW)/2024/395/MD33/1	Develop and deliver bespoke Older Adult Mental Health Clinical Risk training specifically around self-harm and suicidality, to all OAMH Wards.	Mental Health and Learning Disabilities	31/03/2025	31/03/2025	Partially complete (Overdue)
HIW GGH IRMER Inspection (Nov 2022)	The employer is required to provide HIW with details of the action taken to improve the ratification process for locally produced documentation so that information does not conflict with the employer's written procedure	Healthcare Inspectorate Wales (HIW)/2022/19/MD15/2	To source a document control system.	Radiology	30/09/2023	30/09/2023	Overdue
HIW Glangwili Hospital – Morlais Ward inspection	The health board must ensure that the outstanding actions identified following the fire safety audit in February 2024 are completed and sustained.	Healthcare Inspectorate Wales (HIW)/2024/302/MD6/1	To review the recommendations from the fire safety audit and agree an implementation plan.	Estates	31/12/2024	31/12/2024	Partially complete (Overdue)
HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)	The health board must ensure that full and comprehensive mental health assessments and physical health assessments are always being completed in a timely manner, in line with the Mental Health (Wales) Measure 2010 under the Mental Health Act 1983.	Healthcare Inspectorate Wales (HIW)/2023/29/MD1/1	a) Develop of standards for physical health screening to be incorporated into Service Specifications.	Mental Health and Learning Disabilities	29/09/2023	29/09/2023	Partially complete (Overdue)
HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)	The health board must ensure the inpatient ward round structure and arrangements in place allow for sufficient time for patients to be adequately discussed.	Healthcare Inspectorate Wales (HIW)/2023/29/MD6/1	e) Produce a set of standards to underpin Ward MDT Review process to include a plan for implementation (including consistent approach to enabling service user and carer views within this process and consistent approach to documentation and communication of outcomes from ward reviews and discharge planning) and monitoring.	Mental Health and Learning Disabilities	29/09/2023	29/09/2023	Overdue
HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)	The health board must ensure that all relevant staff complete training for timely and effective communication and information sharing relating to the patient discharge process.	Healthcare Inspectorate Wales (HIW)/2023/29/MD8/1	h) Develop a training resource to provide guidance to all relevant staff on standards associated with the discharge planning and process.	Mental Health and Learning Disabilities	31/10/2023	31/10/2023	Overdue
HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)	The health board must take action to manage the risks of insufficient staff numbers and temporary staffing needs on inpatient mental health wards.	Healthcare Inspectorate Wales (HIW)/2023/29/MD25/3	p) Pilot application of the SAFECARE tool across an individual mental health inpatient ward to inform an approach to full implementation.	Mental Health and Learning Disabilities	30/11/2023	30/11/2023	Overdue

HIW Overdue Actions
As at 27/05/2025

Inspection Title	Recommendation	Reference Number	Action	Service	Original Due Date	Current Due Date	Progress Status
HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)	The health board must take action to manage the risks of insufficient staff numbers and temporary staffing needs on inpatient mental health wards.	Healthcare Inspectorate Wales (HIW)/2023/29/MD25/4	q)Development of MH/LD targeted actions through the MH/LD Workforce Group to feed into board wide recruitment and retention plans.	Mental Health and Learning Disabilities	31/12/2023	31/12/2023	Overdue
HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)	The health board must provide HIW with an update on how it is assured that community teams within its mental health services have sufficient capacity to meet their patient caseloads.	Healthcare Inspectorate Wales (HIW)/2023/29/MD26/2	s)Undertake evaluation of the current caseload weighting tool in place across community mental health teams to determine use and effectiveness.	Mental Health and Learning Disabilities	30/09/2023	30/09/2023	Overdue
HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)	The health board must consider undertaking a training needs analysis for inpatient and community mental health staff, to identify any training gaps and help ensure all staff have the appropriate knowledge and skills to effectively undertake their role.	Healthcare Inspectorate Wales (HIW)/2023/29/MD32/1	u)Development of a MH/LD essential training framework to reflect training needs across MH/LD services based on a systematic TNA that can be reviewed at regular intervals and monitored for compliance.	Mental Health and Learning Disabilities	30/11/2023	30/11/2023	Overdue
HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)	The health board should ensure there is adequate and consistent engagement with all staff around the audit arrangements in place across its mental health services, and that staff are made aware of all audit result and any actions required for improvement.	Healthcare Inspectorate Wales (HIW)/2023/29/MD34/1	w)Develop a Directorate audit framework and plan, with the support of the Clinical Audit Team, that reflects local ward/team based audits and wider Health Board requirements to include:- -Testing assurance of consistent implementation of CAT and Physical Health Screening	Mental Health and Learning Disabilities	31/12/2023	31/12/2023	Partially complete (Overdue)
HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)	The health board should ensure there is adequate and consistent engagement with all staff around the audit arrangements in place across its mental health services, and that staff are made aware of all audit result and any actions required for improvement.	Healthcare Inspectorate Wales (HIW)/2023/29/MD34/2	x)Develop a plan to engage frontline staff on the delivery and contribution of the clinical audit programme.	Mental Health and Learning Disabilities	31/12/2023	31/12/2023	Overdue
HIW IRMER Diagnostic Imaging x-ray department Wthybush Hospital January 2024	The Employer is required to provide HIW with details of action taken to ensure that all written documentation in place include the required level of detail as set out within the employer's procedure for Quality Assurance programme document control.	Healthcare Inspectorate Wales (HIW)/2024/86/MD4/1	1. A document control system needs to be sourced	Radiology	31/12/2024	31/12/2024	Overdue
HIW St Non, St Caradog, Canolfan Bro Cerwyn WGH	The Health Board must address the environmental issues and resolve them in a prompt and timely manner: 1) Mould and poor ventilation in both laundry rooms 2) Glass window cracked in St Non's leading into the courtyard requires replacing; 3) Sluice macerator on both wards needs to be fixed or replaced as both currently not working , 4) Occupational therapy room needs to be decluttered and tidied up and not used as a storage room; 5) Wrong signage on some doors in St Caradog which could pose a risk if fire alarms locations are activated; 6) Review of handrails in the ward area and bathrooms on St Non ward to ensure handrails are available, appropriate, and safe for the patient group; 7) Thermostats covers in some patient rooms on St Non are missing and need replacing.	Healthcare Inspectorate Wales (HIW)/2023/69/MD10/4	Handrails are in place in courtyard and corridors on st Non Ward. Review of handrail needs in bedrooms and bathrooms and how these can be addressed	Estates	31/01/2024	31/01/2024	Partially complete (Overdue)
HIW St Non, St Caradog, Canolfan Bro Cerwyn WGH	The health board must ensure that safe holds are described in detail and that patient observations are recorded post any restraint or medical intervention in patient notes	Healthcare Inspectorate Wales (HIW)/2023/69/MD13/1	To undertake a Directorate wide audit of Rapid Tranquillisation against standards for physical health monitoring within the Health Boards Rapid Tranquillisation Policy.	Mental Health and Learning Disabilities	31/03/2024	31/03/2024	Overdue

HIW Overdue Actions
As at 27/05/2025

Inspection Title	Recommendation	Reference Number	Action	Service	Original Due Date	Current Due Date	Progress Status
IRMER Regulations	Software delivering an exposure, controlling or influencing the extent of an exposure directly assisting in the clinical evaluation of an exposure must be included on the radiation equipment inventory.	Healthcare Inspectorate Wales (HIW)/2024/498/MD1/1	Software must be added to the radiation equipment inventory	Radiology	09/05/2025	09/05/2025	Overdue
IRMER Regulations	Interventional procedures are now explicitly listed in 12 (3)(c)	Healthcare Inspectorate Wales (HIW)/2024/498/MD5/1	Clarify the diagnostic reference levels apply to interventional procedures	Radiology	09/05/2025	09/05/2025	Overdue
IRMER Regulations	Employer's procedure to cover required action on audit findings	Healthcare Inspectorate Wales (HIW)/2024/498/MD7/1	Clinical Audits must be undertaken and their findings acted upon	Radiology	09/05/2025	09/05/2025	Overdue

4.4

4.4 - Duty of Candour Report 2024/25

***Cathie Steele (Hywel
Dda UHB - Interim
Assistant Director of
Nursing Assurance
and Safeguarding)***

Attachments

[QSEC DoC Annual Report 2024-25 cover paper v1.0.pdf](#)

[Duty of Candour Annual report 2024-25 v0.1.pdf](#)

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	10 June 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Duty of Candour Annual Report: How we met the Duty of Candour in 2024/2025
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Sharon Daniel, Executive Director of Nursing, Quality and Patient
SWYDDOG ADRODD: REPORTING OFFICER:	Cathie Steele, Interim Assistant Director of Nursing Assurance and Safeguarding

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Ar Gyfer Penderfyniad/For Decision

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

All NHS organisations are required to publish an Annual Duty of Candour Report as part of the organisation's annual reporting process.

The purpose of this report is to share with the Quality, Safety and Experience Assurance Committee the current draft *Duty of Candour* Annual Report for 2024 to 2025 (appendix 1).

Cefndir / Background

The Quality and Engagement Act became law on 1 June 2020 and came into force on 1 April 2023.

The Act:

- Ensures that NHS bodies and ministers think about the quality of health services when making decisions;
- Ensures NHS bodies and primary care services are open and honest with patients, when something may have gone wrong with their care; and
- Creates a new Citizen Voice Body to represent the views of people across health and social care.

There are two main duties under the Act which the Health Board must consider.

The Duty of Quality

Quality is more than just meeting service standards; it is a system-wide way of working to provide safe, effective, person-centred, timely, efficient, and equitable care in the context of a learning culture. To help achieve this, the Act:

- Places an overarching duty of quality on the Welsh Ministers; and
- Reframes and broadens the existing duty on NHS bodies.

This ensures the concept of "quality" is used in its broader definition, not limited to the quality of services provided to an individual or to service standards.

NHS bodies are placed under a duty to report on the steps they have taken to comply with the duty of quality on an annual basis.

The Duty of Candour

A culture of openness, transparency and candour is widely associated with good quality care. To help achieve this, the Act places a duty of candour on providers of NHS services (NHS bodies and primary care) – supporting existing professional duties.

The duty requires NHS providers to follow a process when a service user suffers an adverse outcome which has or could result in unexpected or unintended harm that is more than minimal, and the provision of health care was or may have been a factor. There is no element of fault, enabling a focus on learning and improvement, not blame.

The duty seeks to promote a culture of openness and improves the quality of care within the health service by encouraging organisational learning, avoiding future incidents.

Under the duty, NHS Bodies will be required to report annually on compliance with the duty and publish their reports. Local Health Boards will be required to collate this information from those primary care providers with whom they enter into a contract or arrangements for services and publish a combined report.

When reporting, NHS Bodies will be required to specify if the duty of candour has been triggered in the reporting year (defined as each period of 12 months ending on 31st March, (each financial year), and if it has:

1. state how often the duty of candour has been triggered during the reporting year.
2. give a brief description of the circumstances in which the duty was triggered; and
3. specify any steps taken by the body with a view to preventing similar circumstances from arising in the future.

The report must be prepared as soon as practicable after the end of each financial year.

Asesiad / Assessment

Preparation of the Duty of Candour Annual Report

Duty of Candour data within DatixCymru was also validated and information gathered in preparation for the report.

Attached as appendix 1, is the proposed annual report for 2024/25.

Developing Always on Reporting

Information on the duty of candour and duty of quality has been provided regularly to QSEC through the quality assurance report. It is proposed that this regular reporting mechanism continue.

Next Steps

The finalised Duty of Candour annual report will be presented to the Annual General Meeting in September 2024.

Argymhelliad / Recommendation

The Quality, Safety and Experience Assurance Committee is asked to:

- Provide comment on the draft report for 2024/25
- Note and support the proposed next steps.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	5.22 Monitor progress of and assure the Board in relation to its compliance with relevant healthcare standards and duties, national practice, and mandatory guidance.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	No corresponding risk identified on organisational risk register
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply Choose an item. Choose an item. Choose an item.
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply Choose an item. Choose an item. Choose an item.
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable Choose an item. Choose an item. Choose an item.
Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply Choose an item. Choose an item. Choose an item.
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	DatixCymru EQliP Programme
Rhestr Termiau: Glossary of Terms:	Contained within the body of the report
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	N/A

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	This annual requires resource in the form of staff time to produce it. This comes principally from the Director of Nursing, Quality and Patient Experience's budget. Resource will also be required from other areas such as Communications.
Ansawdd / Gofal Claf: Quality / Patient Care:	This annual report reports on the quality of HDdUHB services to the public, and is an important part of the Health Board's Annual Reporting process.
Gweithlu: Workforce:	Development of staff through pooling of skills and integration of knowledge
Risg: Risk:	This annual report as reputational risks if it is not published, or if the information within it is inappropriate or inaccurate. These are mitigated through review by Committees/Groups of the Health Board and by the Board Secretary, as well as audit by Internal Audit.
Cyfreithiol: Legal:	This annual report has legal risks if it is not published, or if the information within it is inappropriate or inaccurate. These are mitigated through review by Committees/Groups of the Health Board and by the Board Secretary, as well as audit by Internal Audit.
Enw Da: Reputational:	This annual report has reputational Risks if it is not published, or if the information within it is inappropriate or inaccurate. These are mitigated through review by Committees/Groups of the Health Board and by the Board Secretary, as well as audit by Internal Audit.
Gyfrinachedd: Privacy:	N/A
Cydraddoldeb: Equality:	This annual report reports on services only. It aims to cover as many areas of service as possible, but it is not possible to cover everything within the report.



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Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

DUTY OF CANDOUR ANNUAL REPORT

How we met the Duty of Candour between April 2024 and March 2025

Welcome from the Chair of the Quality, Safety and Experience Committee and Executive Director of Nursing, Quality and Patient Experience

We are delighted to bring you this report for 2024 to 2025 which shows how we, Hywel Dda University Health Board (the Health Board), are fulfilling our requirements under the Health and Social Care (Quality and Engagement) (Wales) Act 2020 (the Act) to meet the Duty Candour.

This report provides you with a summary of what is in place to ensure the Health Board is able to meet its obligations under the Act in relation to the Duty of Candour, how often the Duty has been triggered and what the themes are.

We continuously monitor our systems and processes so that we can learn and improve to ensure safe and high-quality care. We welcome your feedback in the form of complaints, concerns and compliments and provide a variety of ways in which you can do that. We work together with Healthcare Inspectorate Wales and Llais who give us independent feedback in light of visits to the Health Board and ensure that we act upon their recommendations.



Anna Lewis, Independent Member – Community and Chair of the Quality, Safety and Experience Committee



Sharon Daniel, Executive Director of Nursing, Quality and Patient Experience

The Health and Social Care (Quality and Engagement) (Wales) Act 2020

Welcome to our Duty of Candour Annual Report for 2024 to 2025. This report is intended for our population, as well as our Board. It gives us the opportunity to share with you how we are fulfilling our requirements under Duty of Candour which is a statutory duty within the Health and Social Care (Quality and Engagement) (Wales) Act 2020 (the Act).

The Health and Social Care (Quality and Engagement) (Wales) Act became law on 1 June 2020 with its full implementation completed April 2023. Its intention is to:

- Ensures that NHS bodies and ministers think about the quality of health services when making decisions;
- Ensures NHS bodies and primary care services are open and honest with patients, when something may have gone wrong with their care; and
- Creates a new Citizen Voice Body to represent the views of the people across health and social care.

There are two main duties under the Act which the Health Board must consider.

The Duty of Quality

Quality is more than just meeting service standards; it is a system-wide way of working to provide safe, effective, person-centred, timely, efficient and equitable health care in the context of a learning culture.

Significant progress has been made to improve the quality of health services in Wales but we still have challenges and changes that we must make to achieve better outcomes for patients across Carmarthenshire, Ceredigion, Pembrokeshire and the borders.

The Duty of Candour

The key intention of the Duty of Candour is to promote a culture of openness, learning and improving that is owned at organisational level, whether a person receives care from the NHS, or from a regulated provider of health care services, and that person can be assured that they will be dealt with in an **open and honest** way by their care provider.



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Meeting the Duty of Candour: how we are ensuring we are open and transparent

The Health Board recognise the importance of the Duty of Candour in promoting a culture of openness and ensuring that there is learning and improving that is owned at organisational level.

Even when the Health Board does its very best to prevent harm, people may experience harm. This is why the duty of candour is in place. If the care provided has caused moderate harm, severe harm or death to a patient, this means that the organisations health and care professionals must tell its patients or someone acting on their behalf that harm has been caused.

By being open and honest, it will give people confidence and trust in the care and treatment they received from the Health Board.

Organisational Requirements

NHS bodies are required to follow a procedure when the duty of candour is triggered. The Act also requires NHS providers to report annually about when the duty has come into effect, how often the duty has been triggered, a description of the circumstances leading to the event and the steps taken by the provider with view to preventing any further occurrence. Triggering the duty does not mean an NHS body accepts any fault or blame.

Triggering the Duty of Candour

The Duty of Candour comes into effect if it appears to the NHS body that both of the following conditions are met:

- The first condition is that a person (the 'service user') to whom health care is being, or has been, provided by the body has suffered an adverse outcome which is more than minimal harm;
- The second condition is that the provision of the health care was, or may have been, a factor in the service user suffering that outcome.

For the purpose of the first condition, a service user is to be treated as having suffered an adverse outcome if the user experiences, or if the circumstances are such that the user could experience, any unexpected or unintended harm that is more than minimal.

The [Duty of Candour Statutory Guidance 2023](https://www.gov.wales/sites/default/files/publications/2023-03/duty-of-candour-statutory-guidance.pdf)¹ prescribe the actions that must be taken and supports the existing processes for 'Putting Things Right' (the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011) with updates made to the 'Putting Things Right' (PTR) Regulations to include the Candour Guidance.

¹ <https://www.gov.wales/sites/default/files/publications/2023-03/duty-of-candour-statutory-guidance.pdf>

More than minimal harm

“More than minimal harm” is not defined in the Act. However, for the purposes of this guidance “more than minimal harm” is considered to constitute moderate harm, severe harm and death.

Moderate harm: is any significant but not permanent harm or harm that requires a ‘moderate increase in treatment’ relating to the incident. A moderate increase in treatment is defined as an unplanned return to surgery, an unplanned readmission, a prolonged episode of care, extra time in hospital or as an outpatient or transfer to another treatment area such as intensive care
Severe harm: is the permanent lessening of the bodily, sensory, motor, physiologic or intellectual functions, including the removal of the wrong limb or organ or brain damage, which is related directly to the incident and not related to a natural course of the service user’s illness or underlying condition.

Death: A death caused or contributed to by a patient safety incident, as opposed to a death which occurs as a direct result of the natural course of the patient’s illness or underlying condition

Harm that is ‘unintended’ or ‘unexpected’

For Duty of Candour to be triggered, the harm must be unintended or unexpected. It can be as a result of either an actual intervention/treatment, or an omission in care, for example, a missed cancer diagnosis.

Medical or surgical treatment and all care interventions may of course come with inherent risks or may in itself cause a temporary increase in symptoms.

Harm which is caused by the treatment itself (e.g. impairments in function as a result of surgery,) would not necessarily be notifiable. These may fall into the category of a known risk, which may have been explained to, and accepted by, the patient as part of the consenting process.

How are we assessing patient safety incidents

Each directorate and service have processes to manage patient safety incidents. This includes an initial review by a designated manager of the incident report. If a patient safety incident is categorised, by the manager undertaking the initial review of the report, as moderate or above and health care was, or may have been, a factor, the Duty of Candour is triggered, and the procedure must be followed. The Datix Cymru system is used to record all activity relating to the patient safety incident including key dates relating to the Duty of Candour.

Dashboards are available within the Datix Cymru system for each directorate and service to ensure the Candour procedure is followed and performance indicators are met.

Candour performance is validated by the Quality Assurance and Safety Team and is reported through the Directorate Improving Together meetings.

We would like to take this opportunity to thank our staff who strive for improvements to the quality of care provided to our patients, who continue to be open and honest and learn from concerns when things do not go as well as we would wish. Staff have embraced the Duty of Candour and are aware of the processes to comply with the requirements of the Act. There is further work to do to support staff to comply in a timelier manner with the reviews and responses to concerns, and we are committed to make improvements in this area.

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Health Board Performance

During 2024/2025², 2,247 patient safety incidents were reported where the reporter said their initial harm assessment was moderate or above. Of these incidents, following the Manager's Interim Harm Assessment, 1,688 patient safety incidents were downgraded to low harm, no harm or the incident occurred prior to the introduction of the Duty. This shows an 75% downgrade rate across the Health Board (in 2023/2024, we reported a downgrade rate of 79%).

During the reporting period, Datix Cymru is reporting as showing 132 patient safety incidents graded by the reporter as no or low harm which, following 'Manager's Interim Harm Assessment', were re-graded as moderate harm or above.

There can be a difference between the reporter's harm grading and the manager's interim harm assessment. The reporter may give the outcome for the person affected with no consideration as to whether there was an act or inaction in the healthcare or they may report on what they expect the harm will be for the person affected rather than the actual harm.

This data suggests further work is required to ensure staff are aware of the classification of harm to be record when reporting an incident.

Duty of Candour Triggered

During 2024/25, both conditions³ were met and the duty of candour was triggered in 132 patient safety incidents⁴.

The manager's interim harm assessment was recorded as moderate harm in 104 incidents, severe harm in 19 incidents and catastrophic harm / death in 9 incidents.

Moderate	Severe	Catastrophic / Death
104	19	9

The manager undertaking the initial assessment is asked to provide information as to the rationale for triggering the Duty of Candour. The high level themes are:

- In-patient slips, trip or fall (20%)

² Patient safety incidents reported between 01.04.24-31.03.25 where the reporter has stated their initial assessment of harm is moderate, severe or catastrophic/death

³ The Duty of Candour comes into effect if it appears to the NHS body that both of the following conditions are met:

- The first condition is that a person (the 'service user') to whom health care is being, or has been, provided by the body has suffered an adverse outcome which is more than minimal harm;
- The second condition is that the provision of the health care was, or may have been, a factor in the service user suffering that outcome.

⁴ Patient safety incidents where the duty was triggered between 01.04.24-31.03.25

- Pressure Damage developed or worsened whilst receiving healthcare (11%)
- Complication of treatment (7%)
- Delay in care / treatment / procedure (17%)
- Delay in diagnosis (16%)
- Delay in referral to other professional for assessment / treatment (9%)
- Healthcare acquired infection (4%)
- Treatment / Procedural issues (5%)
- Inappropriate monitoring and / or escalation (8%)
- Medication error / delay / omission (4%)

Post investigation harm

Of the 132 patient safety incidents where the duty was triggered between 01/04/2024 and 31/03/2025, 75 incidents have been investigated and the record closed. Post investigation harm assessment shows that 25 (33%) did not cause moderate harm or above as a result of healthcare.

		Harm post investigation					
		None	Low	Moderate	Severe	Catastrophic / Death	Total
Manager's interim harm assessment	Moderate	7	14	43	2	0	66
	Severe	1	3	0	4	1	9
	Catastrophic / Death	0	0	0	0	0	0
	Total	8	17	43	6	1	75

Learning identified

Of the patient safety incidents where the duty was triggered and the investigation has concluded, the learning includes:

- Ensuring required training has been completed and competency assessed
- CT contrast must only be administered via a line that is clearly labelled as pressure injectable.
- A clear escalation policy for radiology needs to be developed
- A health board wide contrast media policy needs to be developed
- Use of cannula care bundle and recording of Visual Infusion Phlebitis (VIP) score
- Peer review of pressure damage to confirm grading.

- Use of body map for pressure damage
- Adherence to the 'Care after a death' policy and updating to reflect recent changes to how to request portering services for transfer of deceased patient.
- Importance of environment and patient safety huddles.
- Importance of assessing overall clinical picture
- Consideration of clinical impression when reviewing radiological imaging
- Notification of senior clinician when trauma call made
- Cognitive bias and clinical assessment and diagnosis
- Importance of arranging scans and documenting appropriate management plans when women present with reduced fetal movements.
- Importance of the completion of care plans around the management of second trimester loss for patients, in line with good practice.
- Unplanned reattendances within 72 hours need to be seen by a consultant or senior registrar as this is a high-risk group (as per RCEM guidelines).
- Importance of completing NEWS correctly and escalating accordingly.
- Engagement with specialty team e.g. any problem with an overlying a graft should be referred to the vascular team and is likely to require an angiogram

Contracted Services – Primary Care

Contractors within the Primary Care setting, which includes Community Pharmacists, General Medical Practitioners, General Dental Practitioners and Optometrists, are required to submit data to the Health Board relating to the Duty of Candour in September 2025.

Concerns Management

High quality, safe and compassionate care is at the heart of health care being delivered by our staff. Despite these intentions, inevitably from time to time our patients may suffer harm due to challenging and / or complex situations. When harm does occur, being open and honest should feel like the right thing to do.

Dealing with these situations quickly, sensitively and openly is of great importance and can make a difference to a patient's ongoing relationship with the Health Board.

Throughout 2024/25 at our Board meetings, we have reported how we are improving our people's experience which includes our concerns management and patient experience survey data. An example from the Board meeting in March 2024, can be found through the following link <https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2025/board-agenda-and-papers-27-march-2025/board-agenda-and-papers-27-march-2025/13-improving-people-and-community-experience-report-pdf/>

Listening and Learning Sub-Committee

The Listening and Learning Sub-Committee is a sub-committee of the Health Board's Quality, Safety and Experience Committee. The sub-committee provides clinical teams across the Health Board with a forum to share and scrutinise learning from concerns (incidents, complaints, and claims) and other quality areas such as external inspections, and to share innovation and good practice.

During 2024/25, the Listening and Learning Sub-Committee considered the following themes. This was in addition to the Learning from Events Reports (LfER) relating to Redress payments and claims and recommendations made by the Public Services Ombudsman for Wales. A summary of the Sub-committee can be found in the agenda and papers for the Quality, Safety and Experience Committee.

- Falls
- Sensory loss
- Do Not Attempt Cardiopulmonary Resuscitation
- Maternity
- Cancer experience

4.5

4.5 - Quality, Safety and Experience Sub Committee and Annual Report 2024/25

***James Severs (Hywel
Dda UHB - Executive
Director of Allied
Health Professions
and Health Science)***

Attachments

[QSESC Annual Review 2425.pdf](#)

[QSESC Update Report May25.pdf](#)

QUALITY, SAFETY AND EXPERIENCE SUB COMMITTEE

ANNUAL REVIEW REPORT

2024/2025

1. Introduction and Chair's summary

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

2. Terms of Reference and Workplan

The Terms of Reference (TOR) for the QSESC is reviewed on an annual basis or following any significant changes. The TORs were last reviewed on 15 August 2024. The QSESC has a work plan to enable forward planning for the forthcoming year. The workplan is produced to incorporate the duties outlined in the Sub Committee's Terms of Reference and any suggested areas of focus identified during the self-assessment process.

The workplan covers a range of activities including statutory reporting duties, regular items of business and priority planned pieces of work which support Committee and the Sub Committee's objectives. The work plan is regularly updated throughout the year to ensure it remains responsive to emerging issues and risks.

Reporting Groups

The following reporting groups provide a written report on activity to QSESC on a quarterly basis.

- Recognition of Acute Deterioration and Resuscitation Group (RADAR)
- Nutrition and Hydration Group
- Mental Capacity Act and Consent Group
- Medical Devices Group (including Point of Care Testing and Ultrasound Governance)
- Strategic Safeguarding Group
- Infection Prevention Strategic Steering Group
- Human Tissue Authority Group
- Radiation Protection Group
- Effective Clinical Practice Group
- Acute, Mental Health & Learning Disabilities and Primary and Community services Quality Governance Groups



3. Table of attendance

Members	14 May 24	11 Jul 24	12 Sep 24	14 Nov 24	16 Jan 25	13 Mar 25
Executive Director of Allied Health Professionals and Healthcare Sciences (Chair)	N/A	✓	✓	✓	✓	✓
Executive Medical Director (Vice-Chair)	N/A	N/A	X	X	✓	X
Executive Director of Nursing, Quality and Patient Experience	N/A	N/A	✓	✓	✓	X
Assistant Director of Nursing, Quality and Assurance	✓	✓	✓	✓	✓	✓
Assistant Director, Legal and Patient Support	D	X	X	D	X	D
Clinical Director and Associate Medical Director Primary Care	✓	X	X	X	✓	✓
Deputy Medical Director – Acute Services	✓	X	✓	X	✓	✓
Deputy Medical Director – Primary Care & Community Services	✓	X	X	X	X	✓
Assistant Director of Nursing, Acute Services	✓	X	X	✓	✓	✓
Associate Medical Director, Quality & Safety	✓	X	X	✓	X	X
Head of Quality and Governance	✓	X	✓	✓	✓	✓
Deputy Director of Allied Health Professionals	✓	X	✓	✓	✓	✓
Deputy Director of Health Science	N/A	X	X	✓	✓	✓
Director of Public Health	X	D	D	X	X	D
Director of Midwifery	✓	X	X	✓	X	X
Clinical Director of Pharmacy and Medicines Management	X	✓	✓	D	D	✓
Deputy Chief Operating Officer	N/A	N/A	X	X	X	X
Head of Workforce	X	X	✓	X	✓	✓
Assistant Director of Assurance and Risk	✓	D	✓	✓	✓	✓
Digital Director	X	✓	X	X	X	X
County Directors x 3	✓	✓	✓	X	✓	✓
Senior Nurse, Infection Prevention	X	X	X	✓	✓	✓
Representative from each Triumvirate (Head of Nursing)	✓	✓	✓	✓	✓	✓
Assistant Director of Primary Care	D	X	✓	X	X	✓

Assistant Director of Nursing Mental Health & Learning Disability	✓	✓	✓	X	✓	✓
Chairs of Advisory Groups	✓	✓	✓	✓	✓	✓

N/A: Not applicable as Membership was revised in August 2025.	D: Deputy in attendance	X: Not in Attendance	✓: In Attendance
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A quorum consists of no less than a third of the membership, one of whom must be the Chair or Vice Chair of the Sub-Committee, together with representation from Clinical Professions (Medicine, Nursing, Allied Health Professionals and Health Sciences) and each Directorate/Care Group.

Sub Committee Activities – alert, advise and assure.

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

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

- In May 2024, concerns were raised regarding the roll out of the **Death Certification Reform and Medical Examiners** process and the impact of the additional scanning requirements (which became statutory in September 2024) on staffing capacity. Additional resource was being explored to support the implementation of the process. In September 2024, despite there being process in place to ensure compliance with the Medical Examiners (Wales) Regulations, the Sub Committee remained concerned regarding the fragility in the service and impact on body storage capacity. The risk was escalated onto the corporate risk register (CRR) and mitigations enacted resulting in reduction in the level of risk. QSESC continues to monitor the impact and escalate concerns where necessary.

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

- In May 2024, Sub Committee were advised that plans are progressing for the Health Board to meet the requirements for the national implementation of Martha's Rule (**Call for Concern**: a patient safety initiative which was triggered by the death of a teenage girl). A Working Group was established. The Sub Committee were advised in March 2025 that a three-month pilot in Glangwili Hospital had commenced in February 2025 and an evaluation would be shared once completed.

- The Sub-Committee received an update report in May 2024 from the **Estates and Facilities Directorate** and further information on some areas including the roll out of Cook Freeze catering model was requested. In March 2025, the Directorate reported that a Strategic Group for the catering models has been established with operational Quality, Workforce and Procurement subgroups reporting in and there have been delays to the project due in the main to late submission of contract from Cwm Taf University Health Board and critical lack of managerial resource in department which has since improved.
- In May 2024, **Unscheduled Care in Glangwili (GGH) and Prince Philip (PPH) Hospital updates reported** both Emergency Departments in GGH and Acute Medical Assessment Unit (AMAU) in PPH continue to experience significant ambulance handover delays. Task and Finish groups for both PPH and GGH were underway to review further opportunities. The Sub-Group was also informed that the current workforce model was being reviewed due to sickness absence. It was noted that performance in terms of C-Diff infection rates continue to be a concern across the Health Board. Targeted work was also underway at both GGH and PPH to reduce incidences of hospital acquired infection and this continues to be monitored closely.
- Discussion took place on staff receiving timely access to Resuscitation Training via the **Mental Health and Learning Disabilities Update Report** in July 2024. The demand and capacity issues for Resuscitation staff on a Health Board wide basis was highlighted. A review of the level of training needed by different staff via Directorate Leads and ESR is being undertaken. Cascade Training is being provided in a staged approach to train staff to deliver training within their respective services where appropriate.
- An assessment of the requirements for staff and current attendance rates for life support training was shared as part of the **Recognition of Acute Deterioration and Resuscitation (RADAR) Group Update** in January 2025. The impact of 'did not attend' rates on training capacity was highlighted. A training needs analysis has been undertaken and a cascade training process commenced which increases capacity for the delivery of training. The Datix Risk Score has since reduced due to mitigating actions that are being undertaken.
- In response to data shared in January 2025, which showed that Sepsis screening rates dropped during October 2024 at Glangwili Hospital Unscheduled Care Services, the Resuscitation and Quality Improvement team undertook a programme of work to improve processes, led by National Early Warning Score (NEWS) 2 and a Sepsis Task Group. Mitigating actions included changes to the national sepsis guidance, the introduction of NEWS 2 and training undertaken by the Critical Care Outreach team (CCOT) around recognition of the deteriorating patient.

- In January 2025, the Sub Committee were advised that the data relating to staff uptake of Reducing Restrictive Practice Training across Older Adult inpatient wards showed a decrease in compliance from the previous months within the **Mental Health and Learning Disabilities Report**. This was reported as partly due to the availability of ward staff and capacity challenges within the Reducing Restrictive Practice team to deliver training. A recovery plan was developed and shared with Executive Leads.
- A number of significant updates were reported at the meeting in July 2024 from the **Unscheduled Care Directorates** at the three acute hospital sites, and while the one-hour ambulance delays had shown some improvement due to the mitigating actions undertaken, the 12-hour waits within the A&E departments continued, and patient experience within the area was being closely monitored. A Patient Advice and Liaison Service (PALS) Officer and Complaints Officer had been recruited and are based on site which helped to support patients and the timely management of complaints.
- Although progress had been noted in implementing recommendations arising from the **Falls Improvement Audit in November 2024**, concern was raised regarding the pace in developing the Falls Strategy which was agreed will be taken forward by the Task and Finish Group. Progress on the investigation of 989 open incidents relating to falls will be monitored via the Directorate Quality and Safety Experience Groups going forward and reported to QSESC. Falls scrutiny meetings continue across all acute and community sites and the need for timely assessment and investigation through focussed reviews was reinforced.
- In November 2024, options were being explored via the **Radiology Service** for a sustainable service model for the DEXA bone density scanning pathway which is currently commissioned from Swansea Bay University Health Board (SBUHB) due to concerns regarding length of waits and an inequity of service provision across the Hywel Dda region. This was escalated as a Corporate Risk and subsequently monitored via the Quality, Safety and Experience Committee.
- A request was made by the Charitable Funds Committee in September 2024 for assurance that there are appropriate processes in place for the replacement of medical devices across the Health Board via the **Medical Devices Group (MDG)**. Currently the replacement programmes are driven by capital planning as opposed to a specific process for the oversight of a formal rolling replacement scheme for medical devices. The MDG have requested assurance that there is appropriate oversight of all medical devices as part of a rolling replacement scheme.
- The low levels of staff take up of the Influenza/ Covid 19 vaccine during 2024/25 was highlighted during the **Public Health Directorate Report** in March 2025 with 30% of staff having received the vaccinations from 1 October

2025 to 28 February 2025 (not inclusive of bank or locum staff.) Actions are being explored to understand the impact on services and maximise learning opportunities ahead of next year's vaccination Programme.

- A temporary change of pathway was reported via the Mental Health and Learning Disabilities report in March 2025. A pilot is in progress in North Ceredigion due to insufficient workforce capacity of both medical and non-medical practitioner roles in the Community **Mental Health** Team and Crisis Resolution Home Treatment Team. Primary Care leads will temporarily divert non urgent referrals to a 'phone first' pathway via the established 111 press 2 service. Feedback so far has been positive and suggestive of more timely response for patients. If GP's are concerned about patients seeking help not contacting the 111 service, they can make a direct referral where a Mental Health practitioner will contact the person within 72 hours.
- The Risk for non-compliance with the Medical Device Post Market Surveillance Regulations for custom-made devices that come in to force on 16 June was being considered by the **Medical Devices Group (MDG)** in January 2024 as well as mitigations and controls. The Risk will be monitored by the MDG specific Risk Register that is in development.

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 May 2024, the Sub-Committee received assurance that all outstanding actions identified in the Quality and Safety BGH Unscheduled Care Internal Audit Report, had been given a "reasonable" assurance rating, and that following the report there has been a significant reduction in the number of incidents in the holding area as at 30 November 2023 (reduced from over 550 to 54). Work is undergoing to relocate members of staff to an off-site location to facilitate the chemotherapy day unit building work to commence, a lack of sufficient space is a current risk.
- In May 2024, the Sub Committee received assurance that the Water Group was implementing sustainable provision of free water for people attending **Accident and Emergency (A&E)** units across the Health Board.
- The Sub-Committee was also assured in May 2024 that the remedial work for Reinforced Aerated Autoclave Concrete (RAAC) had been completed at **Withybush Hospital (WGH)**. The Sub-committee noted that a review group had been set up for C-Diff cases across WGH and multi-disciplinary team (MDT) scrutiny of all infection incidents across the site are undertaken regularly, and also that Individual Complaint Support Officers for Accident and Emergency and Patient Advice and Liaison Service (PALS) were now Available.
- In July 2024 the Sub Committee received assurance regarding the work underway to improve **C-Diff Healthcare Acquired Infection** rates. Members noted that while Health Board-wide engagement is improving; there remains

ongoing challenges with the required clinical engagement for the scrutiny reviews and compliance with Start Smart and Stop Audits. Audits were being undertaken by the Infection Prevention Control Teams and improvement plans developed via the monthly multi-disciplinary meetings.

- In October 2024, the Committee were assured that proactive steps are underway to ensure care of patients after death in response to the outcome of the **David Fuller Inquiry** ahead of the anticipated national roll out of improvement requirements from Welsh Government.
- In December 2024, the Sub Committee were pleased to report the positive news story that the Outpatients senior nursing and operational team within **Scheduled Care Services** were winners in the Equitable Care category at the NHS Awards 2024. This quality improvement initiative empowers patients and enhances the patient experience. The prostate cancer rapid diagnosis pathway, PROSTAD team, won the Efficient Care award for improving prostate cancer outcomes and integration of this pathway into routine care.
- An incident that required the immediate temporary closure of Withybush Hospital Kitchen was discussed during the **Estates Directorate** report at the March 2025 meeting which had been resolved. The impact on patient experience, lessons learnt, and business continuity plans will be presented to the Sub Committee meeting due to be held in July 2025.
- Work continues to progress the action plan for the **Internal Cleaning Audit** and updates are being provided via the Infection Prevention Strategic Steering Group. Estates and Facilities will reengage with Internal Audit to discuss the positive progress in advance of the follow up audit in April 2025. The Infection Prevention Strategic Steering Group terms of reference have been recently reviewed and consideration given to providing clarity of the oversight and assurance of action plans in response to reports relating to cleanliness and infection prevention such as internal audit, HIW, and internal environment spot checks. The governance arrangements for the new Clinical Care Groups (CCG) will strengthen the responsibility of the CCG for implementation and oversight of actions where the responsibility sits within the CCG.

Staff and Patient Stories

The Committee received patient and staff stories at each of its meetings during 2024/25 with a focus on the following Services/ Programmes of work:

- Unscheduled Care- Intensive Care Unit
- Hywel Dda rehabilitation service
- NHS Joint Commissioning Committee

Written Control Documents

During 2024/ 25 the Sub Committee approved the following:

- 1158 Cardiac Monitoring Procedure
- 867 All Wales ICD Deactivation Policy and Deactivation of an Implantable Cardiac Defibrillator Procedure
- 811 Mental Capacity Act Guideline
- 309 Long Term Care Operational Care Policy
- The RADAR Terms of Reference
- The Medical Devices Group Terms of Reference
- The Effective Clinical Practice Terms of Reference
- The Human Tissue Authority Assurance Group Terms of Reference

4. Conclusion

The Sub Committee is satisfied that it continues to operate effectively and in line with the Terms of Reference. Issues have been escalated to Committee as appropriate.

QUALITY, SAFETY & EXPERIENCE

SUB-COMMITTEE (QSESC) UPDATE REPORT

Date of last meeting: 13 May 2025

Quoracy: Met

Report by: Mr James Severs, Chair

KEY DISCUSSION POINTS AND MATTERS TO BE ESCALATED FROM THE DISCUSSION AT THE MEETING:

Alert¹ (may require discussion)

There were no matters of which to alert the Committee.

Advise² (to monitor)

The Quality, Safety & Experience Sub-Committee wish to **advise** members of the Committee that:

- The number of Health Board wide concerns relating to practitioners in a position of trust (PIPOT) has continued to rise since 2022 as reported by the **Strategic Safeguarding Working Group (SSWG)**. Steps are being undertaken to prepare a position statement for the organisation and discussions are underway with universities for periodic reminders during training on expectations for professional conduct. The Safeguarding National Service is undertaking national benchmarking, and the Health Board is engaged with this. The Sub Committee asked the Group to consider the methodology for a review of internal workforce Safeguarding Policies with Professional Leads to ensure effective processes are in place to manage PIPOT allegations of misconduct and report the findings back to the Sub Committee within the next Group Update report.
- Concerns regarding Dyson Fans purchased by Welsh Ambulance Services NHS Trust for use in ambulance bay areas was highlighted by the **Infection Prevention Control (IPC) Steering Group** due to potential IPC and safety risks. Discussion took place regarding the decision-making process for the purchasing of the fans and the Sub Committee agreed that further work is required to articulate and establish ownership of this risk which the Group will take forward.
- A comprehensive action plan has been developed to address challenges within Glangwili Hospital (GGH) theatres which include insufficient staffing levels and suboptimal working practices. Quality Improvement plans are being progressed by the **Planned and Specialist Care Clinical Care Group**

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.

leadership team in collaboration with Infection Prevention Control and Workforce and Organisational Development.

Assure³ (to note)

The Quality, Safety & Experience Sub-Committee wish to **assure** members of the Quality, Safety & Experience Committee that:

- Significant work has taken place to implement the new governance arrangements for the Clinical Care Groups and the Sub Committee received reports from **Mental Health and Learning Disabilities** and **Planned and Specialist Clinical Care Groups**. Going forward reports will align to the six domains of quality as defined by the Duty of Quality Statutory Guidance 2023 and provide a focus on the Safe, Timely, Equitable, Efficient, Evidence Based and Patient Centred (STEEEP) Principles.

Written Control Documents

The Sub Committee reviewed and approved:

- The QSESC Annual Report 2024/25
- The Infection Prevention Control Steering Group Terms of Reference.

Recommendation

- The Quality, Safety & Experience Committee is asked to note the 'advise' items and receive assurance from the 'assure' items.
- The Sub Committee is asked to approve the QSESC Annual Report 2024/25.

³ There is confidence that actions are robust and will be sufficient to address the issue or generally operating effectively. Routine monitoring.

4.6

4.6 - Listening and Learning Sub Committee Update Report, Annual Report 2024/25 and Patient Experience Framework

*Louise O'Connor
(Hywel Dda Health
Board - Assistant
Director)*

Attachments

[LLSC May 2025 final.pdf](#)

[PES English FINAL March 2025 \(2\).pdf](#)

[People Experience Framework \(E\) WEB FINAL March 2025 \(1\).pdf](#)

[LLSC Annual Review 2425.pdf](#)

[SUEF - Self Assessment tool.pdf](#)

GROUP UPDATE REPORT/ ADRODDIAD DIWEDDARU'R LISTENING AND LEARNING SUB COMMITTEE

Date of last meeting/ Dyddiad y cyfarfod diwethaf: May 2025

Report by/ Adroddiad gan: Mark Henwood (Chair)

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

Alert¹ (may require discussion)/ **Rhybuddio** (efallai y bydd angen trafodaeth)

The Sub Committee had no items of which to alert the Committee

Advise² (to monitor)/ **Cynghori** (i fonitro)

The Sub Committee wish to **advise** members of the Committee that:

- A range of feedback relating to the experience of service users and their families following attendance at the A&E departments across the Health Board area was considered. This included feedback from patient experience; complaints and Ombudsman cases; redress cases and inquests.

The Sub-Committee listened to two stories from patients, one from a staff member who attended the A&E Department with her husband in 2022; the second from a patient who attended a few months ago – both sharing similar concerns and experiences. Concerns were raised that lessons were not being learned.

The theme in both stories related to nutrition and hydration, waiting room conditions, (including seating, lack of blankets, toilet facilities), dignity and respect; lack of attention/care to patients waiting due to capacity, and a perceived growing culture of acceptance amongst staff due to continued pressures.

The stories would be presented to the Clinical Care governance Group and the Quality, Safety and Experience Committee. It was agreed that the patient and user experience feedback would be incorporated not the Unscheduled Emergency Care (UEC) Accelerated Transformation Group.

- Royal College of Emergency Medicine – a recommendation that patients making an unscheduled return to the Emergency Departments (ED) with the same condition, within 72 hours of discharge should be escalated to a consultant or senior doctor. This was raised in a Public Interest Report relating

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.

to another Health Board in October 2023 and escalated to the Quality, Safety and Experience Committee at that time, as Hywel Dda University Health Board was not able to comply with this recommendation due to availability of consultants. To date, no evidence has been shared to provide assurance this is now being complied with. The Sub-Committee suggested that assurance be sought that whilst this target may be a problem to achieve 24/7, there should be a commitment to this when consultants are in the department or a senior doctor (min ST4).

- A redress cases from 2014 had highlighted issues in achieving the 15-minute timeframe for undertaking **electrocardiogram (ECG's) in the Emergency Department** for patients presenting with chest pain. There were also concerns raised about the quality of the interpretations of the readings. Further cases had highlighted similar issues and an audit undertaken for Welsh Risk Pool assurance had demonstrated a total of 639 patients were identified during the period; 93 patients (15%) received an ECG within the RCEM-recommended 15-minute target. The remaining 546 (85%) experienced delays beyond the standard, with the following time distributions: Among those who experienced delays 219 patients (34.2%) waited between 1-2 hours for an ECG, 140 patients (21.9%) waited over 2 hours, 14 patients (2%) had an ECG performed more than 6 hours after arrival. Welsh Risk Pool has requested to know what improvement plans are in place. Concern was raised by the Sub-Committee that initial cases were reported in 2014 and there was no improvement in 2025.
- Following review of a paediatric case an experience of attending A&E, it was highlighted that there is a lack of **paediatric nurses working within the A&E** department. The Royal College of Paediatrics and Child Health (RCPCH) recommends that every emergency department treating children must have at least two registered nurses on duty per shift. The nurses must hold the appropriate qualifications and competencies as required by the Nursing and Midwifery Council.

These issues would be forwarded to the Care Group Triumvirate for consideration and would be scheduled for further discussion at the Sub-Committee in the Autumn.

Assure³ (to note)/ Sicrhau (i nodi)

The Sub-Committee wish to assure members of the Committee that:

- The Sub Committee annual review report was approved via Chair's Action.

³ There is confidence that actions are robust and will be sufficient to address the issue or generally operating effectively. Routine monitoring.

- Public Services Ombudsman for Wales (PSOW) – Two final reports were received by the Sub-Committee as follows:

- PSOW 11712 &13937

There was a delay in oncology review, caused by a delayed biopsy and miscommunication which made the patients pathway less clear. Recommendations sit with Cancer Services and include a review of the Health Board's approach to carrying out biopsies of urgent suspected cancers and refresher training on ECOG performance status scale (Eastern Cooperative Oncology Group).

- PSOW 13891

Concerns around care and treatment in respect of an ectopic pregnancy were not upheld.

- **A Public Interest Report** issued to Betsi Cadwaladr Health Board and involving two English Trusts where care had been commissioned was discussed. The report discussed concerns about colorectal and gynaecology services. The report would be shared with the relevant governance leads for the Care Groups.

The report also highlighted serious concerns about the consenting process so the report would also be shared with the Consent Lead as it was noted by the Sub-Committee that consenting issues were also becoming more apparent within the complaints received.

- The new Welsh Health Circular enclosing the updated **People's Experience Framework**, and new People's Experience Survey was received by the Sub-Committee. A self-assessment process was reviewed and endorsed. This would be issued to all Care Groups and corporate teams during June, for completion. This would inform the Health Board's self-assessment process which would be reported back to the Quality, Safety and Experience Committee in due course.

Sharing of learning/ Rhannu dysgu

- Contained within the report

Recommendation/ Argymhelliad

- The Committee is asked to discuss the issues and proposed action relating to the advise section and be assured on the items that the Committee is providing assurance on.
- The Committee is asked to approve the LLSC Annual Review Report 2024/25

People's Experience Survey (PES)

Your NHS Wales Experience

The experience that you have of care is important to us. This might be an appointment with your doctor or health visitor, a hospital stay, an outpatient visit or something else. We would be grateful if you could complete this survey so that we can understand this better.

The questions are based on the things that patients have said matter most. We will ask you questions about your latest experience of healthcare. Please help us by giving your honest opinion.

The questions mostly have four options and you are asked to tick the answer that you feel best describes how you feel.

How recent was the experience you are thinking of?

- In the last week
- Between 1 month and 6 months ago
- Between a week and a month ago
- More than 6 months ago

Thinking about this experience:

1. Was the time you waited:

- Much shorter than expected
- A bit shorter than expected
- About right
- A bit longer than expected
- Much longer than expected

2. Did you feel well cared for?

- Always
- Usually
- Sometimes
- Never

3. Were you treated with dignity and respect?

- Always
- Usually
- Sometimes
- Never

4a Which language would you prefer to communicate in?

- | | | |
|-----------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Welsh | <input type="checkbox"/> Urdu | <input type="checkbox"/> Gujarati |
| <input type="checkbox"/> English | <input type="checkbox"/> Portuguese | <input type="checkbox"/> Italian |
| <input type="checkbox"/> Polish | <input type="checkbox"/> Spanish | <input type="checkbox"/> British Sign Language |
| <input type="checkbox"/> Romanian | <input type="checkbox"/> Arabic | <input type="checkbox"/> Other, please specify |
| <input type="checkbox"/> Panjabi | <input type="checkbox"/> Bengali | _____ |

4b Were you able to communicate in your preferred language?

- Always Usually Sometimes Never

5. Did you feel that you were listened to?

- Always Usually Sometimes Never

6. Were you involved as much as you wanted to be in decisions about your care?

- Always Usually Sometimes Never

7. Were things explained to you in a way that you could understand?

- Always Usually Sometimes Never

Thinking of your overall experience

8. How would you rate your overall experience?

- Very poor Poor Neither good nor poor Good Very good

9. Was there anything particularly good about your experience you would like to tell us about?

10. Was there anything particularly bad about your experience you would like to tell us about?

Thank you for taking the time to answer these questions



Llywodraeth Cymru
Welsh Government



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People's Experience Framework

Review date: August 2028

gov.wales

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Aim

This framework is a self-assessment maturity matrix, aimed at empowering organisations to evaluate their current position and to develop

an ambitious improvement plan for people's experience through a Value lens.

Scope

This framework will encompass all services provided by NHS Wales organisations, including commissioned services. Quality and experience indicators must be integrated into all commissioned services arrangements and the data gathered used as part of contractual monitoring and compliance.

The People's Experience Framework aligns with various regulations and acts, including the Health and Social Care (Quality and Engagement) (Wales) Act 2020, the National Health Service (Concerns, Complaints, and Redress Arrangements) (Wales) Regulations 2011, the Public Services Ombudsman (Wales) Act 2019, the Well-being of Future Generations (Wales) Act 2015, the Equality Act 2010, the Value Based Health Care Strategy and the Socio-economic Duty. Listening and learning from people's experiences is an integral element of these regulations.

What is 'People's Experience'?

People's experience is 'the sum of all interactions, shaped by the culture of the organisation, staff and systems'. People's experience can be described as how people feel when using any services and programmes offered by NHS in Wales. Whether it be in a hospital ward, outpatient appointment, participation in national screening programs, engagement with primary care services (such as GP, Optometrist, Pharmacist, Dentist), interaction with health promotion practitioners, or attendance at any event hosted by an NHS Wales Organisation.

In essence, the definition of People's Experience is fundamental to Person and Population-centredness.

The integration of all strands of experience feedback relies on local expertise and resources. However, the triangulation of experience feedback data alongside other metrics, e.g. outcomes, as depicted on the Listening and Learning Tree is indicative of an organisation committed to quality.

Health and Care Quality Standards

To help us understand what excellent quality means and how we can apply it in practice, 12 Health and Care Quality Standards have been developed.

The Standards include the six domains of quality and six quality enablers. The Health and Care Quality Standards are intended to apply broadly to the wide range of services provided by the NHS in Wales.



Duty of Quality – Person Centred quality standard

Our health care system meets people's needs and ensures that their preferences, needs and values guide decision-making that is made in partnership between individuals and workforce. We care about the well-being of individuals, their families, carers and our staff. We ensure that everyone is always treated

with kindness, empathy and compassion and we respect their privacy, dignity and human rights. We are committed to working better together to put people and their families at the centre of decisions, seeing them as experts collaborating with professionals to get the best outcome and experience.

People's Experience principles should be considered in line with the Duty of Quality

- All people who use NHS Wales services, programmes or functions have the right to provide anonymous feedback quickly and easily when they want to.
- 'People's experience' is a continuous feedback stream.
- At times of distress there may be sensitivities in gathering feedback. However, people should still be able to give feedback if they choose to.
- The feedback should be used to celebrate and build on what is working well, and to identify areas where improvements could be made.
- People's experience feedback should be made readily available to the public in an accessible format.
- Information should show that feedback is being listened to and acted upon, e.g. 'You said, we did' and the Duty of Quality report.

The use of and the difference between People's Experience, Engagement, Patient Reported Experience Measurements (PREMS), Patient Reported Outcome Measurements (PROMs)

Engagement with people is different from People's experience and feedback. Although the two activities are related and overlap, engagement is the active participation of members of the public, communities or other stakeholders in service planning, delivery, and evaluation.

To ensure the prioritisation of people's experience, it is recommended that all NHS Wales organisations have in place a People's Experience Strategy.

Use of Patient Reported Experience Measurements (PREMs)

PREMs (Patient Reported Experience Measures) use a series of questions which require an overall rating or another quantifiable value. PREMs can be classified as either relational or functional. Relational PREMs show the patient's experience of their relationships during treatment, and can be disease specific e.g., did they feel listened to? Functional PREMs examine more practical issues, such as the facilities available.

As an example, the CARE measure, a relational questionnaire, is an example of a PREMs tool. PREMs require a large sample of respondents, to generate standardised aggregated and validated measurements and a supporting system which enables clinicians to view and react to individual PREMs feedback. Alongside People's Experience feedback, PREMs also support clinical effectiveness, safety, and quality improvement, and can support a Value-Based approach by combining specific disease specific PREMs with PROMs, but should not be viewed as a replacement for the 'How it felt to use any of the services, functions, and programs of NHS in Wales,' conversation.

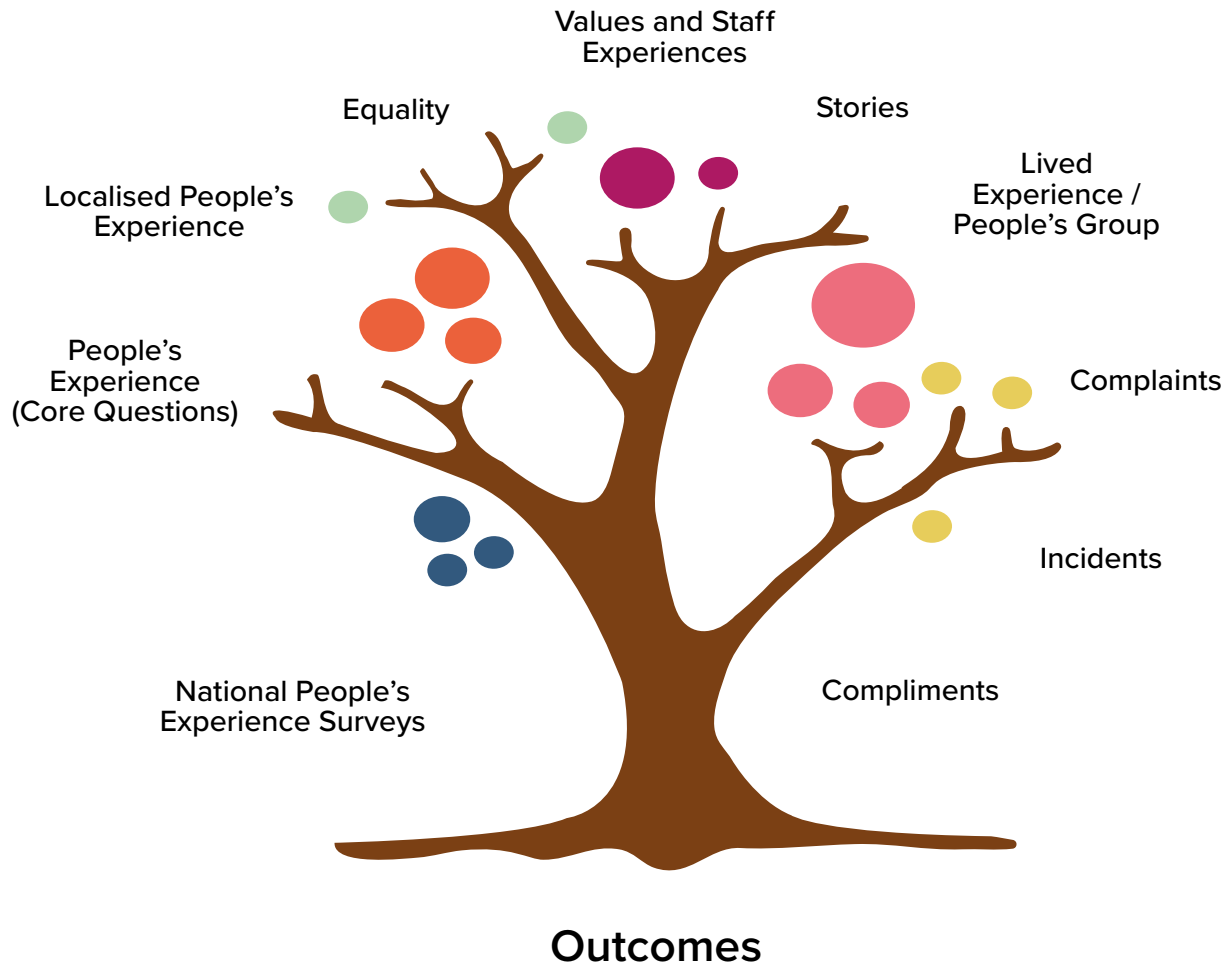
Patient Reported Outcome Measurements (PROMs)

PROMs (Patient reported outcome measures) assessments are essentially a structured communication assessment between a person receiving care and their clinical team, delivering standardised responses about symptom burden and quality of life. PROMs are one of the tools used within a wider toolkit, to evidence Value-Based healthcare, to better understand outcomes which matter most to people and

patients. PROMs are designed and evaluated for symptoms relating to specific conditions or around general health and quality of life.

In addition to PREMs and PROMs there is ongoing development of added measures including CROMs (Clinician Reported Outcome Measures) and SROMs (Staff Reported Outcome Measures).

Listening, Learning and Improving Tree



National People's Experience Surveys

National surveys are developed at the request of clinical areas of work and in conjunction with the NHS Wales Executive Team. There is an approval process set up, (please see Appendix A) to support the development and inclusion of national surveys within the Once for Wales Experience System. Where applicable, all organisations will engage in the national survey approach in line with the Duty of Quality 'always-on' reporting and share with people and communities via local websites, the feedback received and any service improvements that have been undertaken because of the feedback.

Information collected via national surveys will remain the responsibility of clinical areas and organisations supporting the collection. The information will also be used to populate the NHS Wales Executive Quality Dashboard.

People's Experience (core questions)

A Welsh people's experience core set of questions has been developed. Every effort should be made to use the people's experience core set of questions in all experience and feedback surveys, the core set of questions are listed below. In circumstances where people in receipt of services cannot directly provide feedback, consideration should be made for the views of family, friends, and carers (unpaid) to be gathered.

1. How would you rate your overall experience?

- Very poor
 Poor
 Neither good nor poor
 Good
 Very good

2. Was there anything particularly good about your experience you would like to tell us about?

3. Was there anything particularly bad about your experience you would like to tell us about?

4a Which language would you prefer to communicate in?

- Welsh
 Urdu
 Gujarati
 English
 Portuguese
 Italian
 Polish
 Spanish
 British Sign Language
 Romanian
 Arabic
 Other, please specify
 Panjabi
 Bengali

4b Were you able to communicate in your preferred language?

- Always
 Usually
 Sometimes
 Never

Scoring and benchmarking

An All-Wales scoring structure has been agreed upon for the Likert-based question 1, which organisations should use to benchmark, learn from each other, and make publicly available in the spirit of the Duty of Quality.

Response	Weight
Very good	10
Good	7.5
Neither good nor poor	5
Poor	2.5
Very poor	0
I don't know (if included)	N/A

Localised People's Experience Feedback (Service Specific)

Locally requested surveys should reference the National People's Experience question set, included in Appendix B (where appropriate). At a minimum, all local experience and feedback surveys are required to include the people's experience (core questions) question set.

Carers/Families

Carers/Families play a valuable role in the health and well-being of their loved ones and their contribution often goes beyond the cared for and impacts wider society and services. The contribution and role the carers play in the health and well-being of a loved one is sometimes not fully acknowledged. It is often the carer who organises appointments, arranges transportation, plays a role in explaining

information to the patient, assists with medication, as well as helping with a host of other important tasks. This level of involvement places carers in a unique position to share their experiences of services and People's Experiences surveys should be developed to allow carers to offer their feedback.

In addition, the impact of a patient's illness on a carer/family member's own health and well-being has proven to be both widespread and severe and organisations should consider the availability of a FROM (Family Reported Outcomes Measure) type questionnaire. The development and availability of such questionnaires should always be linked to the organisational ability to provide signposting and support.

Equality Monitoring

Health outcomes and experiences are often influenced by the protected characteristics of our people and communities. To support the identification of varying experiences, **all** experience and feedback surveys across NHS Wales should include a nationally agreed set of demographic and diversity (through a quality lens) questions which are included in Appendix C.

These questions should not be compulsory to answer and a clear explanation of how the data will be used and stored should be set out in the survey/questionnaire introduction. Robust processes to support the analysis of information should be developed at a local level and ensure the information provided does not affect individual access to services or care.

Organisations should also develop processes which help the capture of the demographic and diversity information of those people who have raised a complaint (at a time most appropriate).

It is expected that each organisation will have processes in place to support the analytics of information being collected to provide an extra layer to the experience data and be used to support wider quality, improvement, and engagement of communities.

Values and staff experiences

People's experience is 'the sum of all interactions, shaped by the culture of the organisation, staff and systems. The same definition can be applied to staff and put simply, staff and people's experiences are two sides of the same coin. Organisational culture and staff experiences are intrinsically linked to people's experiences. Staff are proud to work for the organisation and speak highly of the culture. Staff throughout the organisation feel able to raise concerns and believe they will be listened to and supported.

We understand that asking people 'What matters to you' instead of 'What's the matter with you' makes a significant difference to their overall experiences of NHS Wales services. How much more difference could we make if we started asking our staff a similar question: 'What matters most to you?' We should remind ourselves that this relationship could be one of the most important moves the NHS Wales makes to drive better productivity and improve experiences of care for the entire population of Wales.

The expectation is that organisations will work with Human Resources, Finance Organisational Development and Planning, Value-Based Healthcare and Data and Analytical teams to establish a work programme, which includes triangulation of data to drive improved outcomes and experiences for people through improving staff experience.

Stories

We cannot ignore the importance of conversations and narrative-based contributions in supporting quality and improvement. The use of people, communities and staff narratives should be embedded across all NHS Wales organisations.

There is an expectation that organisations will have processes in place to allow them to capture and listen to people's stories. These stories should be shared at Committees and Board meetings, in addition to being used as part of staff training and organisational awareness.

To support the collection and thematic analysis of stories from across NHS Wales, it is expected that all organisations contribute to the All-Wales NHS Digital Story Library. To support organisations the NHS Wales Digital Story toolkit is included in Appendix D.

Lived experience/people's groups

Lived experience refers to the unique and personal encounters, perspectives, and insights that individuals gain through direct involvement in particular situations or circumstances. It encompasses the real-life experiences, emotions, challenges, and lessons learned by individuals as they navigate various aspects of their lives. Lived experience is deeply subjective and can be influenced by a person's background, culture, beliefs, and personal circumstances. In various contexts, such as healthcare, social services, or advocacy, lived experience is valued for its authenticity and its potential to offer valuable insights and inform decision-making processes.

It is expected that all organisations consult with their lived experience/people's groups, and this is triangulated as part of their people's experience feedback.

Complaints

Complaints are a part of the experience feedback family and are an expression of dissatisfaction, which is significant enough to prompt the person to raise the matter.

An exemplary organisation will include experience and other sources of feedback so that action can be taken quickly where required. Hotspots can be easily shown and reported to senior leadership, Committees, Board meetings and the public in an accessible format.

Complaints are managed through the robust policy framework and processes of 'Putting Things Right Regulations'. The principles of 'Always on' should be aligned to the sphere of complaints.

Incidents

Clinical incidents refer to unintended or unexpected events that occur during the provision of healthcare services and have the potential to cause harm to patients, staff, or visitors. These incidents can range from errors in medication administration to communication breakdowns, equipment malfunctions, or adverse reactions to treatments. Clinical incidents are typically analysed to understand their causes, prevent recurrence, and improve patient safety and quality of care. Incident reporting and investigation systems are commonly used in healthcare settings to find and address clinical incidents promptly. Incidents should be considered in the triangulation of feedback methods.

Compliments

Compliments are an unsolicited expression of gratitude. People invest their time to leave a compliment in the hope that the behaviours they experience are repeated and routinely available to others. The comparison of compliment and complaint numbers in isolation from the contextual narrative has minimal benefit when looking to support quality and improvements. To support a mutual understanding of what constitutes a compliment and to ensure all NHS Wales Bodies maximise the capturing of compliments, common definition of a compliment is provided below:

'A positive or appreciative statement about any individual NHS Wales staff member, services, programme, or function, which includes the expression of praise, admiration, or congratulations which goes beyond common courtesy. This can be received through a variety of means including verbal and written'.

It is expected that all NHS Wales Bodies develop and implement a robust 'Always on' system for the collection of compliments within easy reach for all people and communities. Organisations should also develop processes which support learning from compliments, processes to recognise areas and staff who are mentioned in the compliment, processes to share good practices highlighted within compliments wider in the organisation.

Good Practice Local Self-Assessment Tool Recommendation

It is recommended that all NHS Wales Bodies complete a local self-assessment Red Amber Green (RAG) rating score for each element of the framework as a basis for local quality and improvements.

National assurance is overseen by NHS Executive Wales.

1. Review each criteria statement and identify the range of evidence available which supports each statement. Ask yourself questions such as:

a. How embedded is the process which supports this criterion?

b. Are we consistent across the organisation/ service as a whole?

2. Then judge the strength of the evidence through a RAG rating –

Red No / insufficient evidence.

Amber Evidence available but may need further development.

Green Sufficient relevant evidence.

Where you have judged the evidence available to support the criteria as **Red**, then this is an area for development/exploration and should be included in your organisation's development plan. The **Amber** criteria will also need to be addressed before assessment, **but if you have ten or more Red criteria focus on these first before adding the Amber criteria to your improvement plan.**

Criteria	Name of person/team completing the self-assessment	Date self-assessment undertaken	What we have in place	Our Rating Red Amber Green	Areas for focus/improvement in next 12 months	Date of reassessment	Name of group/committee to receive self-assessment outcome
Leadership							
Capacity and capability to effectively collect feedback							
Analysis and triangulation							
Using people's feedback to drive quality improvement and learning							
Reporting and publication							

Areas for Local Self-Assessment

Leadership

The Board and senior leadership show their dedication to prioritising people's experience in all their initiatives. They work towards enhanced collaboration, ensuring that all individuals play a crucial role in the decision-making processes, to achieve the best possible outcomes and experiences.

Leadership promotes a culture defined by compassion, empathy, and kindness while upholding principles of privacy, dignity, and human rights. These values and behaviours are actively embraced by all members of the workforce.

Characteristics	Suggested requirement needed to meet the characteristic	What will good look like?
The organisation has a strategically endorsed document by the Board aimed at enhancing people's experiences. This document advocates for a system-wide strategy emphasising quality, continuous improvement, and ongoing learning.	<p>The organisation has a People's Experience Document, collaboratively developed with input from individuals and communities, with consultations involving all staff and relevant stakeholders.</p> <p>This document undergoes approval through the organisation's governance process.</p> <p>The People's Experience Framework is designed to be seamlessly aligned with and integral to the Duty of Quality, Health and Care Quality Standards, and Duty of Candour. This approach reflects a commitment to value-based healthcare.</p>	<p>The organisation aims to establish an approved document outlining people's experiences. This document should be easily comprehensible for individuals, communities, and staff.</p> <p>The People's Experience Document is expected to exhibit harmony with other essential policy documents and plans, such as the Quality Strategy, Equality Plan, and others.</p>
The Board can show evidence of actively listening to feedback from individuals and undertaking measures where appropriate to enhance both the experience and the quality of service.	<p>A variety of feedback and engagement methods are in place, actively promoted and widely disseminated.</p> <p>Every staff member is involved, contributing their insights to the development of services and efficiency changes, with a focus on understanding how these changes impact individuals, communities, and staff.</p>	Evidence in public reports of listening, reporting, and acting upon feedback e.g., 'you said, we did,' in line with the Duty of Quality.

Characteristics	Suggested requirement needed to meet the characteristic	What will good look like?
<p>People's experience is integrated into all leadership development initiatives, encompassing efforts by everyone involved. This fosters a culture dedicated to continuous learning and improvement, prioritising quality, safety, and experience.</p>	<p>All leaders and senior managers actively contribute to an efficient quality management system, possessing the requisite skills, knowledge, and values to provide person-centred services. In addition, leaders and senior managers take proactive steps to incorporate learning, quality, and experience into leadership development, staff objectives, appraisals, and other relevant processes.</p>	<p>The organisation can show the use of Peoples Experience feedback in decision-making and planning and delivery of services.</p> <p>The organisation can provide tangible evidence of incorporating people's experience into the decision-making process and the planning, and delivery of services.</p>
<p>The senior leadership team is visible, with a designated Executive Director taking accountability for leading quality, and people's experience to ensure that the organisation fulfils its Duty of Quality and obligation to promote active listening and learning from experiences and feedback.</p>	<p>The Executive Lead or nominated deputy for people's experience consistently helps discussions on experience and regularly presents comprehensive reports to the Board. Proactively taking charge of this domain within the organisation, the nominated lead ensures that people's experiences (including stories) become a routine feature in various meetings, including those held by the Board and its sub-committees.</p>	<p>People's experiences and the corresponding actions are disclosed in the Board and other published reports.</p> <p>People's experience reports cross-reference various experience/ feedback sources, including compliments, general feedback, satisfaction ratings, complaints, and Value-Based healthcare. Information e.g. (PROMS/PREMS), incorporating both goals and shared decision making tools</p> <p>Lived experiences of people along with associated learnings and actions, are shared both internally and externally. This information is balanced with staff experiences and stories.</p>
<p>The organisational development strategy and implementation plans are underpinned by a commitment to improve people's experiences.</p>	<p>People's experience is integrated into the organisational development strategies. This should also include ensuring that our staff are trained and equipped to engage and work collaboratively with our public and communities.</p>	<p>There is recognition that staff experience is critical to people's experience and service quality. This should be referenced in key documents such as IMTPs, and Patient Experience (People's Experience) Strategies.</p>

Characteristics	Suggested requirement needed to meet the characteristic	What will good look like?
<p>The organisation values and celebrates innovation by staff that demonstrates a consistent approach to people's experience and quality improvements.</p>	<p>Staff are supported by senior managers and colleagues to listen and act locally as a response to feedback and the organisation routinely captures, analyses and reports on the outcomes from any quality improvement work.</p> <p>Monitoring takes place against the results of the staff and people experience surveys.</p> <p>Staff behaviour is compassionate, involves people and communities in decision-making and provides good emotional support to people.</p>	<p>Innovations are recognised within a wide range of policies, procedures, and reports to the Board.</p> <p>Also celebrated and recognised at staff awards; appraisal; Research and quality improvement programmes.</p> <p>There are opportunities for shared learning throughout the organisation and wider, including the opportunity to share good practices and learn from mistakes.</p> <p>Staff training includes opportunities to understand and embed:</p> <ul style="list-style-type: none"> • compassionate leadership and culture within the organisation • positive feedback – learning from compliments. <p>People and communities are involved in staff training through a variety of means including lived experience stories to delivering the training. Active involvement of people and communities at NHS Wales meetings can positively impact outcomes and contribute towards raising staff awareness.</p>

Characteristics	Suggested requirement needed to meet the characteristic	What will good look like?
<p>Organisational culture and staff experiences are intrinsically linked to people's experiences. Staff are proud to work for the organisation and speak highly of the culture. Staff throughout the organisation feel able to raise concerns and believe they will be listened to and supported.</p>	<p>The organisation has developed, with people and staff, a set of values, articulated through all corporate documents, which reflect the values of NHS Wales.</p> <p>The organisation has a process for ensuring values are owned by staff.</p> <p>The organisation has in place a values-based recruitment and appraisal system.</p>	<p>Organisations have an agreed and published Values and Behaviour Framework that has been developed with staff, people, communities, and all relevant stakeholders.</p> <p>Person-centred care/provision (population-centredness) is a core element of the organisation's values and promotes a co-productive way of working.</p> <p>Standards for values and behaviours are part of recruitment, interview processes, staff Job descriptions, role profiles and appraisal.</p>
<p>The organisation expresses its commitment to engaging with people and communities through all its communications. This is per the Duty of Quality.</p>	<p>The organisation's website and other externally facing communications are accessible and clear and people would judge them to be user-friendly. They also articulate a commitment to person or population-centred services and programmes.</p> <p>People and communities are actively involved in the development, production, and review of all public-facing health (including promotion) and well-being information.</p> <p>People and communities can access correspondence relating to their health or care in an accessible format suitable for their needs.</p>	<p>Communication is available bilingually in a range of formats (Welsh and English) but should also include user-friendly and jargon-free easy-to-read information, BSL, audio and language of choice. Organisational websites are designed to use language that is clear in meaning and jargon-free.</p> <p>Public-facing information relating to an individual's or community's health and well-being is developed in line with good practice and is subject to stakeholder review before publication. Stakeholder review is inclusive and relevant to the people and communities who would access the information.</p>

Characteristics	Suggested requirement needed to meet the characteristic	What will good look like?
		<p>Organisations compliance in line with the Accessible Information and Health Care and Quality Standards. Every organisation shows how they will implement, comply, and monitor the Accessible Information Standards.</p> <p>Feedback from staff, people and communities is routinely gathered and includes feedback on whether information and communication are accessible.</p>

Capacity and Capability to effectively collect feedback

The organisation has several routes through which People and Communities can provide feedback.

Characteristics	Suggested requirement needed to meet the characteristic	What will good look like?
<p>The organisation ensures that people's experiences and overarching themes are at the core of all surveys, including post-discharge surveys. It collaborates with teams to devise and execute rapid, real, or near-real time feedback processes.</p>	<p>The organisation fully adheres to all mandated mechanisms and has a comprehensive programme dedicated to looking for rapid, real-time experience and feedback from individuals, utilising the most up to date technology available to them.</p>	<p>A unified system for Wales should facilitate benchmarking across organisations and support real-time feedback through various channels, such as SMS, IVR, online platforms, paper, etc.</p> <p>Organisations are encouraged to consider reframing the question from 'What's the matter?' to 'What matters to you?' This shift in focus aims to prioritise and address the individual's concerns and preferences.</p>

Characteristics	Suggested requirement needed to meet the characteristic	What will good look like?
<p>The organisation has established an accessible experience and feedback process that aligns with national guidance and regulations.</p>	<p>The organisation has implemented accessible and user-friendly feedback processes, enabling individuals to easily submit compliments, provide feedback, or raise concerns in their language of choice. Information related to these processes is prominently displayed and accessible across all locations and formats (website and display screens etc).</p> <p>Organisations have in place a systematic process for capturing experiences, feedback, and concerns specifically about how complaints are handled and the overall process. There is unambiguous evidence that feedback is consistently collected, and the organisation has implemented changes in practice.</p> <p>Moreover, these improvements have been sustained over time.</p>	<p>There is robust national guidance and widespread awareness of experience and feedback systems throughout the organisation, both internally and externally, with a particular focus on reaching seldom-heard communities. Clear visibility is ensured through the availability of leaflets and posters in bilingual formats (Welsh and English), and other languages in line with local population needs. In addition accessible formats, including Easy Read, British Sign Language (BSL), audio should also be made available.</p> <p>The organisation can provide evidence of collecting experience and feedback regarding the concerns process. Furthermore, they can demonstrate tangible improvements made because of the gathered experience and feedback.</p> <p>Feedback is systematically collected monthly, and there is documented evidence of improvement (where appropriate). This information is presented within the organisation and externally to the public.</p>
<p>All staff take ownership of and promptly address feedback and concerns at the earliest opportunity. Clear information is provided, and support is extended when individuals express a desire to provide feedback or raise a concern.</p>	<p>All staff are supported by their colleagues in addressing concerns raised by individuals, and there is a structured process for teams and the broader organisation to share and learn from these experiences.</p>	<p>All staff are empowered to reflect on all feedback and receive support to enhance the experiences of individuals. The organisation has clear processes in place to escalate, share, and learn from all feedback.</p>

Characteristics	Suggested requirement needed to meet the characteristic	What will good look like?
<p>Duty of Candour</p>	<p>Staff comprehend and act upon the Duty of Candour as outlined in the Health and Social Care (Quality and Engagement) (Wales) Act 2020.</p> <p>The significance of experience and feedback is integrated into the organisation's approach to staff training.</p>	<p>All staff members, including those who are front facing or involved in service development, have completed Duty of Candour training.</p> <p>The organisation can provide evidence of being open and honest with people and communities when things go wrong.</p> <p>Training on experience feedback is incorporated into all sides of the organisation, including induction processes, leadership development programs, and staff appraisals.</p>
<p>People are provided with information about the various avenues via which they can leave feedback, encompassing paper-based surveys, comment cards, web platforms, text messages, devices, kiosks, and apps.</p> <p>Staff support individuals in utilising these approaches, ensuring consideration for the needs of those who may be less able or less willing to provide feedback.</p>	<p>The organisation disseminates information to individuals in multiple ways to provide feedback. People are informed about various avenues available to them as routes for sharing their experiences and feedback.</p> <p>The organisation utilises a variety of methods to collect feedback from people, tailoring these approaches based on individuals' needs and preferences.</p> <p>Staff members are well-versed in these methods and actively encourage and support people in providing feedback.</p> <p>Organisations are encouraged to establish experience/feedback Quality Indicators (QIs) for all public-facing services, and programmes in alignment with the People's Experience Framework. These should support quality improvements and be reported internally within the organisation while also being made available externally to the public.</p>	<p>The organisation can demonstrate it has in place various accessible methodologies and routes for the capture of people's experiences.</p> <p>Organisations can demonstrate a quality improvement approach to introducing new routes for capturing people's experience and evidence learning which has resulted in improvements.</p> <p>Staff can direct people and communities to a variety of feedback routes.</p> <p>The QIs along with all performance-related information should be made available on websites and in reports in a format which is easily understood. Also, in the case of online, the information should be easy to find.</p>

Analysis and Triangulation

The Organisation has a systematic and consistent approach to analysing and making sense of feedback (qualitative and quantitative) and considers it alongside safety and outcomes data.

Characteristics	Suggested requirement needed to meet the characteristic	What will good look like?
<p>The organisation has implemented a systematic method for analysing feedback and experiences gathered in various forms.</p> <p>Additionally, the organisation has dedicated analytics and intelligence support for its experience data, generating clear and helpful reports.</p>	<p>The organisation routinely and systematically analyses all forms of feedback and experience, consolidating all strands and identifying themes upon which it acts.</p>	<p>The organisation employs real-time sentiment analysis to identify opportunities for early resolutions.</p> <p>All forms of feedback and experience undergo triangulation with various other outcome measures and are included in quality and assurance reports across the organisation, as well as in other public reports. Quantitative data, when available, is graphically plotted over time to provide a visual representation of trends.</p> <p>Demographic and diversity information is analysed aligned to the experiences themes to identify any variation and support improvement or engagement work (as required). The data is translated into business intelligence, informing meaningful quality improvement actions and engagement (where appropriate).</p>
<p>The organisation generates reports displaying the correlation between enhancing outcomes, safety, and the experience of people. This information is routinely triangulated with data from staff surveys, providing a comprehensive perspective on overall performance.</p>	<p>Reports explicitly highlight themes where people's experiences correlate with other quality measures.</p> <p>Organisational reports clearly articulate these relationships and outline the quality improvement actions that result from the analysis.</p>	<p>All forms of feedback and experience undergo triangulation with a variety of other outcome measures and are incorporated into organisational quality and assurance reports. This information is also included in other public reports.</p> <p>A robust relationship is maintained with services and teams to ensure that feedback, wherever feasible, translates into improvements. This collaboration involves staff from a range of disciplines across the organisation.</p>

Characteristics	Suggested requirement needed to meet the characteristic	What will good look like?
<p>The organisation adeptly employs experience data to efficiently identify and pinpoint areas of deteriorating performance, facilitating prompt action to address the underlying causes.</p>	<p>The organisation proficiently utilises experience and feedback data as an early warning system for declining standards. This enables leaders at various levels to detect concerns and implement quality improvement approaches promptly.</p> <p>The organisation utilises data related to experience and engagement to comprehend variations.</p> <p>Experience is fully aligned with and integral to quality improvement efforts.</p>	<p>Trend graphs are employed to identify abnormal activity within the feedback system. Additionally, alerts are set up to trigger actions promptly in response to key concerns. This system helps in staying vigilant to emerging issues and taking timely corrective actions.</p> <p>All quality improvement processes unequivocally demonstrate the utilisation of experience data. The insights derived from the data play a leading role in shaping and enhancing the organisation's quality improvement initiatives.</p>
<p>Experience and feedback information is routinely taken into consideration and acted upon by all teams. When a larger scale service redesign is necessary, such feedback is appropriately escalated and incorporated into the decision-making process.</p>	<p>Services, programmes, and functions receive feedback promptly and in a format that is suitable for their users.</p> <p>Organisations regularly engage in discussions about the data and leverage it for quality improvements.</p> <p>The organisation has an effective approach to celebrating and sharing local learning.</p>	<p>The organisation should have access to a quality management system where data is live and in real-time, providing them with immediate and up-to-date insights. The quality management system should encompass all sources of experience and feedback.</p>

Using People's Feedback to Drive Quality Improvement and Learning

The organisation actively and consistently seeks experiences and feedback from people to foster a learning culture underpinned by quality and service improvement initiatives.

Characteristics	Suggested requirement needed to meet the characteristic	What will good look like?
<p>The organisation actively and consistently seeks people's experiences to foster a learning culture underpinned by quality and service improvement initiatives.</p> <p>There is evidence that the organisation uses these experiences and feedback, and staff are aware that people's experiences are central to influencing quality improvement. Moreover, people are actively engaged as equal partners in the decision-making processes, service plans and evaluation.</p>	<p>Staff demonstrate a good understanding of the theory and practice of shared decision-making with people, and its principles are reinforced through education and training programmes.</p> <p>People are actively involved in all aspects of their health and possess an understanding of the expectations related to their health and well-being.</p> <p>The organisation has a mechanism in place to capture whether people felt involved in decisions about their own or their communities' health and well-being.</p> <p>The organisation has a mechanism in place to capture whether people felt involved in service, programme design or evaluation.</p>	<p>Staff, including those who are front-facing or involved in planning, service development or quality improvement, have undergone education and training for shared decision-making.</p> <p>Public information incorporates health decision information.</p> <p>Clinical and public information are designed to reflect shared decision-making principles, emphasising collaboration between healthcare professionals and the public in the decision-making process.</p> <p>The organisation can evidence and make public, people's involvement right from the outset, highlighting a commitment to hearing and listening.</p>

Characteristics	Suggested requirement needed to meet the characteristic	What will good look like?
<p>The organisation employs quality improvement methodology and tools as part of an ongoing process to enhance services, programmes, and functions continuously.</p>	<p>Staff actively engage in quality improvement skills to identify problems, carry out tests of change, measure their impact, and act on the results.</p> <p>The organisation empowers all staff by providing the opportunity to contribute and act on ideas for quality improvement, with a clear process for measuring their impact through experiences and feedback.</p> <p>The organisation actively benchmarks and can demonstrate the utilisation of people's experience to make informed decisions.</p> <p>This involves comparing its practices and outcomes to identify areas for improvement and implement informed decision-making processes. (e.g., National People's Experience Surveys, Core Questions or Lived Experiences/People's groups).</p>	<p>There is evidence of education and training courses designed to support Quality Indicators (QI's) in service improvement, in line with the Duty of Quality.</p> <p>Organisations should have a process in place to ensure the public is informed about how their experiences and feedback have influenced change. This involves transparent and accessible communication to demonstrate the impact of public input on organisational decisions, evaluations, and improvements.</p> <p>Organisations can evidence how their Lived Experience or People's groups have supported the identification of shared learning and quality improvements. This should be included in the Duty of Quality report, and all other appropriate reports and made available to the public in an easy-to-find and accessible format.</p>

Reporting and Publication

The organisation regularly reports and publishes its people's experience data and co-produces its quality improvement plans with a range of stakeholders including the public, statutory and voluntary organisations, and the organisation's staff group.

Characteristics	Suggested requirement needed to meet the characteristic	What will good look like?
People's experience should be a key component of organisational reports in line with the Duty of Quality.	Relevant reports include information about people's experiences and how the organisation has encouraged feedback, listened to, and is responding to people's experiences, including examples of improvements.	The organisation's Annual Quality report, Improvement, engagement, equality report, Duty of Candour and Putting Things Right reports include examples of how the organisation responds to experiences and feedback. In the case of Incidents/Complaints/Duty of Candour/Inquests, this would include the post-experiences of the handling process.
The organisation routinely publishes transparent and publicly accessible information within easy reach (e.g. 2 clicks) about people's experiences and the organisation's response to feedback (and ensures this information is accessible through multiple routes).	Information is available and accessible via a range of formats and platforms. This should include the accessibility requirements of seldom-heard communities and communities with low socio-economic backgrounds and communities with sensory loss.	The Annual Quality reports, Improvement, Engagement, Equality report, Duty of Candour and Putting Things Right reports should be available via a range of appropriate formats and platforms.
The organisational reports reflect the feedback offered via all external bodies e.g., Llais (Citizens Voice Body), Health Inspectorate Wales, Public Service Ombudsman Wales, and any other regulatory/ statutory body.	Reporting demonstrates that representations made on behalf of the public and feedback to the organisation have been incorporated and considered.	The organisation will review its communication channels to ensure it promotes the role of all regulatory/ statutory bodies in producing reports.

Appendix A: National Surveys Process Document

National Surveys are overseen by the NHS Executive in line with the national survey road map. The governance process for national surveys is facilitated by the Once for Wales Concerns Management System Central (OfWCMS) team.

- The person or group proposing the national survey is responsible for liaison and engagement with the appropriate Executive Director in each organisation to gain support for the national survey to be undertaken.
- The person or group proposing the national survey will attend the Safety & Learning WRP People's Experience Feedback Network meeting to present their survey.
- A national survey request form must be completed and submitted, with the relevant survey questions, to the Once for Wales Concerns Management System Central (OfWCMS) team via email: OnceForWales.CMS@wales.nhs.uk.
- The OfWCMS team will acknowledge receipt of the request form and survey and arrange for the person or representative of the group proposing the national survey to attend a National Editorial Board meeting.
- All proposed national surveys will be presented to the National Surveys Editorial Board.
- Once approved by the National Surveys Editorial Board the national survey request form will be signed by the National System lead for Experience Feedback Wales System and stored by the OfWCMS Central team.
- The person or group proposing the national survey will need to have the survey translated into Welsh and any other language that they wish the survey to be deployed.
- The OfWCMS Central team will liaise with Feedback Experience System Leads and the supplier to progress the various stages required.
- The person or group proposing the national survey will be responsible for identifying and liaising with the teams within the organisations who will roll out the survey locally.
- The teams who will roll out the survey locally will be responsible for liaising with the Feedback Experience system lead within the organisations to ensure weekly feedback reports are set up correctly.
- The OfWCMS Central team, Feedback Experience System Leads, supplier, the person or group proposing the national survey and the teams responsible for the roll out of the survey locally, will agree a launch date.
- The supplier will, at an agreed time, facilitate the transfer of the data received from the survey held in organisations systems, to the national analytical tool.
- Access to the national analytical tool and to the data generated from this system will be managed by the OfWCMS Central team in accordance with the arrangements agreed by the National Surveys Editorial Board and following GDPR Principles.
- The OfWCMS Central team, will work with the Feedback Experience System Leads, supplier, the person or group proposing the national survey and the teams responsible for the roll out of the survey locally, to agree data sets for national reports to be generated both in the national analytical tool and in local systems.

Appendix B: People's Experience Survey

Your NHS Wales Experience

The experience that you have of care is important to us. This might be an appointment with your doctor or health visitor, a hospital stay, an outpatient visit or something else. We would be grateful if you could complete this survey so that we can understand this better.

The questions are based on the things that patients have said matter most. We will ask you questions about **your latest experience of healthcare**. Please help us by giving your honest opinion.

The questions mostly have four options and you are asked to tick the answer that you feel best describes how you feel.

How recent was the experience you are thinking of?

- In the last week
 Between 1 month and 6 months ago
 Between a week and a month ago
 More than 6 months ago

Thinking about this experience:

1. Was the time you waited:

- Much shorter than expected
 A bit shorter than expected
 About right
 A bit longer than expected
 Much longer than expected

2. Did you feel well cared for?

- Always
 Usually
 Sometimes
 Never

3. Were you treated with dignity and respect?

- Always
 Usually
 Sometimes
 Never

4a. Which language would you prefer to communicate in?

- | | | |
|-----------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Welsh | <input type="checkbox"/> Urdu | <input type="checkbox"/> Gujarati |
| <input type="checkbox"/> English | <input type="checkbox"/> Portuguese | <input type="checkbox"/> Italian |
| <input type="checkbox"/> Polish | <input type="checkbox"/> Spanish | <input type="checkbox"/> British Sign Language |
| <input type="checkbox"/> Romanian | <input type="checkbox"/> Arabic | <input type="checkbox"/> Other, please specify |
| <input type="checkbox"/> Panjabi | <input type="checkbox"/> Bengali | <input type="text"/> |

4b. Were you able to communicate in your preferred language?

- Always Usually Sometimes Never

5. Did you feel that you were listened to?

- Always Usually Sometimes Never

6. Were you involved as much as you wanted to be in decisions about your care?

- Always Usually Sometimes Never

7. Were things explained to you in a way that you could understand?

- Always Usually Sometimes Never

Thinking of your overall Experience

8. How would you rate your overall experience?

- Very poor Poor Neither good nor poor Good Very good

9. Was there anything particularly good about your experience you would like to tell us about?

10. Was there anything particularly bad about your experience you would like to tell us about?

Thank you for taking the time to answer these questions

Appendix C

Equality Monitoring

We are committed to ensuring that everyone receives fair and equal respect.

Whatever your age, disability, ethnicity, faith, gender reassignment or sexual identity, you can expect to be treated with dignity. We can only achieve this with your help by providing the information below.

Data will be used for monitoring purposes only and held in strictest confidence. Your identity will not be disclosed to anyone.

1. What is your age?

- | | | | |
|--------------------------------------|--------------------------------------|--------------------------------------|--|
| <input type="checkbox"/> 0-15 years | <input type="checkbox"/> 35-44 years | <input type="checkbox"/> 55-64 years | <input type="checkbox"/> 75+ years |
| <input type="checkbox"/> 16-24 years | <input type="checkbox"/> 45-54 years | <input type="checkbox"/> 65-74 years | <input type="checkbox"/> I prefer not to say |

2. What is your gender?

- | | | | |
|-------------------------------|---------------------------------|--------------------------------|--|
| <input type="checkbox"/> Male | <input type="checkbox"/> Female | <input type="checkbox"/> Other | <input type="checkbox"/> I prefer not to say |
|-------------------------------|---------------------------------|--------------------------------|--|

3. At birth, were you described as:

- | | | | |
|-------------------------------|---------------------------------|--------------------------------|--|
| <input type="checkbox"/> Male | <input type="checkbox"/> Female | <input type="checkbox"/> Other | <input type="checkbox"/> I prefer not to say |
|-------------------------------|---------------------------------|--------------------------------|--|

4. Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months?

- | | | | |
|-------------------------------------|--|-------------------------------------|--|
| <input type="checkbox"/> Yes, a lot | <input type="checkbox"/> Yes, a little | <input type="checkbox"/> Not at all | <input type="checkbox"/> I prefer not to say |
|-------------------------------------|--|-------------------------------------|--|

5. Which of the following options best describes how you think of yourself?

- | | | | |
|---|---|-----------------------------------|--------------------------------|
| <input type="checkbox"/> Heterosexual or straight | <input type="checkbox"/> Gay or lesbian | <input type="checkbox"/> Bisexual | <input type="checkbox"/> Other |
| <input type="checkbox"/> I prefer not to say | | | |

6. What is your religion?

(Please choose one option that best describes your religion)

- | | | | |
|--|---------------------------------|---------------------------------|--|
| <input type="checkbox"/> No religion | <input type="checkbox"/> Hindu | <input type="checkbox"/> Muslim | <input type="checkbox"/> Any other religion |
| <input type="checkbox"/> Christian (all denominations) | <input type="checkbox"/> Jewish | <input type="checkbox"/> Sikh | <input type="checkbox"/> I prefer not to say |
| <input type="checkbox"/> Buddhist | | | |

7. What is your ethnic group?

(Please choose one option that best describes your ethnic group or background)

White:

- | | | |
|---|---|---|
| <input type="checkbox"/> Welsh | <input type="checkbox"/> English | <input type="checkbox"/> Scottish |
| <input type="checkbox"/> British | <input type="checkbox"/> Irish | <input type="checkbox"/> Northern Irish |
| <input type="checkbox"/> Gypsy or Irish Traveller | <input type="checkbox"/> Any other white background | |

Mixed / multiple ethnic groups

- | | |
|--|---|
| <input type="checkbox"/> White and Black Caribbean | <input type="checkbox"/> White and Black African |
| <input type="checkbox"/> White and Asian | <input type="checkbox"/> Any other Mixed / multiple ethnic background |

Asian / Asian British

- | | | |
|----------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Indian | <input type="checkbox"/> Pakistani | <input type="checkbox"/> Bangladeshi |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Any other Asian background | |

Black / African / Caribbean / Black British

- | | | |
|----------------------------------|------------------------------------|---|
| <input type="checkbox"/> African | <input type="checkbox"/> Caribbean | <input type="checkbox"/> Any other Black / African / Caribbean background |
|----------------------------------|------------------------------------|---|

Other ethnic group

- | | | |
|-------------------------------|---|--|
| <input type="checkbox"/> Arab | <input type="checkbox"/> Any other ethnic group | <input type="checkbox"/> I prefer not to say |
|-------------------------------|---|--|

Thank you for taking the time to answer these questions

Appendix D

The Digital Stories Toolkit – Using Stories to Improve Quality

In September 2021 it was agreed by the Welsh Directors of Nursing that digital storytelling would form a keyway of capturing feedback and learning to improve our services. This toolkit covers the methodology and information needed by everyone who is digitally recording stories, related to individual feedback and personal experiences of any of the health services provided via NHS Wales.

This toolkit has been developed in partnership with all NHS Wales organisations. It is for use across all programmes, services, and functions provided under the NHS Wales umbrella where quality and improvement are a priority.

This toolkit can be accessed via the following link: [Digital Story Toolkit \(sharepoint.com\)](#)

LISTENING AND LEARNING SUB COMMITTEE

ANNUAL REVIEW REPORT

2024/2025

1. Introduction

In line with Standing Orders the Listening and Learning Sub Committee (LLSC) must submit an Annual Report to the Quality, Safety and Experience Committee through the Chair within 6 weeks of the end of the reporting year, setting out its activities during the year and how the Sub Committee has met its Terms of Reference during the financial year.

2. Terms of Reference and Workplan

The Terms of Reference (TOR) for the LLSC is reviewed on an annual basis or following any significant changes. The TORs were last reviewed on 4 November 2024. The LLSC has a work plan for the forthcoming year which is fairly dynamic, in response to experience feedback and any emerging themes and trends arising from internal and external sources. The workplan reflects the requirements of the Sub-Committee as established by its Terms of Reference.

The LLSC meetings are organised according to a theme which reflects the experience and feedback for the service area, as well as regular items of business and priority planned pieces of work. It is recognised that the work plan is fluid, and responsive to issues and risks.

Reporting Groups

The LLSC does not have any sub-groups or reporting groups.

3. Table of attendance

The sub-committee has been quorate during the financial year. A quorum consists of a minimum of 8 members, one of whom must be the Chair or Vice Chair.

The sub-committee is always well-attended; however, it is recognised that consistency in membership fluctuates, as clinical staff capacity and commitments allow.

The Chair of the Sub-Committee changed in February 2025 from C Patel, Independent Member, to M Henwood, Executive Medical Director. Independent membership also changed from March 2025 from C Patel to M Imperato.

Sub Committee Activities – alert, advise and assure.

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

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

Changes to the NHS (Concerns, Complaints and Redress) Regulations (Wales) 2011.

In October 2024, the Committee was alerted to the revised process for complaints, incidents, concerns, claims and redress cases. The Welsh Government is keen that health bodies maximise every opportunity to resolve concerns as early as possible and is keen to see improvement in this area as soon as possible. Concerns were discussed around capacity and risks to implementation due to significant changes in process, particularly in relation to the NHS Redress Scheme.

As part of the preparedness for implementation, the Listening and Learning Sub-Committee agreed that the current timeframe of 2 working days for an early resolution be increased to 5 working days, leading to 10 in advance of the formal implementation date of the new Regulations (date to confirmed). The Quality, Safety and Experience Committee endorsed this decision which will affect a complaint handling policy change for the remainder of the financial year. A review would be undertaken of the impact prior to increasing the timeframe to 10 working days.

Equality, Diversity and Inclusion

In response to an Ombudsman's thematic report 'Equality Matters' which identified lack of reasonable adjustments; poor communication and outdated policies and procedures across public bodies in Wales, the Sub-Committee held a thematic meeting reviewing the report findings and associated recommendations, as well as organisational data and feedback. It was noted that organisations were not fulfilling their duty under the Equality Act 2010 and the Ombudsman reminded bodies that a failure to make a reasonable adjustment for a person with a protected characteristic is a form of discrimination.

Of particular note within the concerns thematic discussion, was the struggle that people with neuro-divergent conditions had in accessing and communicating with the health service. These communication challenges often resulted in relationships breaking down, restrictions being applied in accessing services then leading to complex complaints. There is an increasing prevalence of neuro-divergent conditions in the population and the workforce.

There was a significant amount of quality improvement work being undertaken across the Health Board, led by the Integrated Autism Service; Diversity and Inclusion and Community Outreach Teams, and the Quality Improvement Team.

It was suggested by the Neurodevelopmental service that a special interest group be established on neuro-divergence, supported by a Learning and Development Strategy. It was noted there had been many expressions of interest in this approach. This has been proposed to the newly formed Equality, Diversity and Inclusion Taskforce.

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.

Cancer Services – In July 2024, the Sub-Committee received assurance from the Lead Cancer Nurse on the improvements that had been to respond to the concerns and themes being raised through feedback and advised of a number of important initiatives to improve access, the environment of care and improving the experience of patients and family members. This included:

- Cancer Services Intranet Page to improve information and quality of referrals from GPs
- Cancer Services Triage Line – this is a 24/7 support & advice line for cancer patients who become unwell. Triage supports patients who: have or are receiving systemic anticancer therapy; received any other type of anticancer treatment, including radiotherapy and bone marrow graft; may be suffering from disease/treatment - related immunosuppression (e.g. acute leukaemia, corticosteroids).
- The triage team also communicate directly with the patients Oncologist and CNS team to keep them informed about changes with their patients. This is very important with our Oncologists being based at Swansea Bay. More feedback from patients who have accessed the service can be found below.
- Improving access for patients who need urgent care, by utilising Same Day Emergency Care facilities.
- Establishment of Patient Reported Experience Measure, to help us monitor how people feel about their experience and accessing the cancer services within the Health Board.
- Heads Up!” initiative across the whole of HDdUHB with the aim of improving the patient experience of cancer treatment related hair loss. HDdUHB is the first health board in Wales to deliver a service of this nature.
- CaPS Cancer Services Counselling Service for patients diagnosed with cancer (2 year pilot project)

Maternity Services - In October 2024 – a review of the maternity services response to all feedback, demonstrated improvement in the following areas to enhance the service user experience:

- Accessibility of information in Welsh English and other languages.
- Educational videos to inspire.
- Birthing Environment – Galaxy lighting in the Obstetrics’ room.
- Biomechanics Video – Visually demonstrate equipment for greater understanding and managing expectations.
- Video created to talk patients through procedures;
- Planned family approach to Caesarean births.
- The Matterport project simulation was created.

Management of Inpatient Falls – In December 2024, the Sub-Committee reviewed the improvement plans surround the management of inpatient falls. Key improvements were noted in the following areas:

- Falls training, including a plan for a multi professional full day training on falls management.
- Use of Red and Green tape on mobility aids to inform staff of a patient’s mobility status, the red tape indicating that someone should not be mobilising alone.
- Roll out of the Bay watch scheme and 1-1 cohort nursing.
- Ensuring lying and standing blood pressure checks are taken following a fall
- Implementation of the Corridor watch scheme
- Fortified milkshakes to be provided for those at nutritional risk of falls
- Provision of lunch clubs and activities to prevent deconditioning
- Falls packs available on wards with clear guidance on what to do post fall.
- Provision of chair and bed alarms in appropriate circumstances.


A number of actions were agreed for review at the Inpatient Falls Group, as a result of discussion at the Listening and Learning Sub-Committee:

- Review of the ways to measure the data to evidence impact of the improvements;
- Review of the Enhanced Support Policy, in particular the definition of 1:1 nursing; and
- Development of a thematic, MDT and Health Board wide Inpatient Falls action plan for review by Welsh Risk Pool.

An update on the improvement plan and on the actions discussed by the Sub-Committee was provided in March 2025 where it was identified that good progress had been made in implementing the actions.

Welsh Risk Pool (WRP) Putting Things Right / Concerns Management Assessment

In February 2025, the outcome of the WRP Assessment process was reported to the Sub-Committee. The report provided assurance to the Quality, Safety and Experience Committee that substantial assurance had been received as follows:

Management of Concerns (Incidents)	REASONABLE ASSURANCE	
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Management of Concerns (Complaints & Enquiries)	SUBSTANTIAL ASSURANCE	
Redress Case Management	SUBSTANTIAL ASSURANCE	
Claims Case Management	SUBSTANTIAL ASSURANCE	
Inquest Case Management	SUBSTANTIAL ASSURANCE	
Organisational Learning & Learning from Events	SUBSTANTIAL ASSURANCE	
WRP Reimbursement Process	SUBSTANTIAL ASSURANCE	

Staff and Patient Stories

The Committee received patient stories at each of its meetings during 2024/25 according to the theme of the meeting.

Written Control Documents

During 2024/25 the Sub Committee approved the following:

July 2024 : 018 Inquest Guidance

307 Production of Patient and Carer Information

4. Conclusion

The Sub Committee is satisfied that it continues to operate effectively and in line with the Terms of Reference. Issues have been escalated to Committee as appropriate.



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WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

GOOD PRACTICE SELF-ASSESSMENT TOOL RECOMMENDATION

It is recommended that all Services/CCG's complete a local self-assessment rag rating score for each element of the framework as a basis for local quality and improvements.

National assurance is overseen by NHS Executive Wales.

1. Review each criteria statement and identify the range of evidence available which supports each statement. Ask yourself questions such as

a. How embedded is the process which supports this criterion?

b. Are we consistent across the CCG/service as a whole?

2. Then judge the strength of the evidence through a RAG rating – **Red** – no / insufficient evidence, **Amber** – evidence available but may need further development, **Green** – sufficient relevant evidence.

Where you have judged the evidence available to support the criteria as **Red**, then this is an area for development/ exploration and should be included in your improvement plan. The **Amber** criteria will also need to be addressed before assessment, but if you have ten or more **Red** criteria focus on these first before adding the **Amber** criteria to your improvement plan.

Criteria	Name of person/team completing the self- assessment	Date self- assessment undertaken	What we have in place	Our Rating	Areas for focus/ improvement in next 12 months	Date of reassessment	Name of group/committee to receive self- assessment outcome	
				Red				
				Amber				
				Green				
Leadership			Leadership	Not Entered				
Capacity and capability to effectively			Collecting Feedback	Not Entered				
Analysis and Triangulation			Analysis and Triangulation	Not Entered				
Using people's feedback to drive			Improvement and Learning	Not Entered				
Reporting and Publication			Reporting and Publication	Not Entered				



LEADERSHIP

The senior leadership show their dedication to prioritising people’s experience in all their initiatives. They work towards enhanced collaboration, ensuring that all individuals play a crucial role in the decision-making processes, to achieve the best possible outcomes and experiences. Leadership promotes a culture defined by compassion, empathy, and kindness while upholding principles of privacy, dignity, and human rights. These values and behaviours are actively embraced by all members of the workforce.

Characteristics	Suggested requirement needed to meet the Characteristic	What will good look like?	What does this look like for the Service	CCG's Rating	Change Ideas	After Improvements Rating
The Service has included within plans, objectives focussed on enhancing people’s experiences. This involves a directorate/ service wide plan for emphasising quality, continuous improvement, and ongoing learning in line with the Health Board’s People and Communities Improving Experience Charter.	<p>The service has a plan for how the Improving Charter and People's Experience Framework will be embedded, involving all staff and relevant stakeholders.</p> <p>This plan is reviews and monitored as part of the governance process.</p> <p>The People’s Experience Framework is designed to be seamlessly aligned with and integral to the Duty of Quality, Health and Care Quality Standards, and Duty of Candour. This approach reflects a commitment to value-based healthcare.</p>	The Service aims to establish an approved plan outlining people’s experiences. This document should be easily comprehensible for individuals, communities, and staff.		Not Entered		Not Entered

Characteristics	Suggested requirement needed to meet the Characteristic	What will good look like?	What does this look like for CCG's?	CCG's Rating	Change Ideas	After Improvements Rating
The Service can show evidence of actively listening to feedback from individuals and undertaking measures where appropriate to enhance both the experience and the quality of service	<p>A variety of feedback and engagement methods are in place, actively promoted and widely disseminated.</p> <p>Every staff member is involved, contributing their insights to the development of services and efficiency changes, with a focus on understanding how these changes impact individuals, communities, and staff.</p>	Evidence in service improvement plans, governance and committee reports of listening, reporting, and acting upon feedback e.g., ‘you said, we did.’ in line with the Duty of Quality.		Not Entered		Not Entered

Characteristics	Suggested requirement needed to meet the Characteristic	What will good look like?	What does this look like for CCG's?	CCG's Rating	Change Ideas	After Improvements Rating
People’s experience is integrated into all leadership development initiatives	All leaders and senior managers actively contribute to an efficient quality management system, recognising the requisite	The service can show the use of Peoples Experience feedback in decision-making and planning and delivery of services.		Not Entered		Not Entered

all leadership development initiatives, encompassing efforts by everyone involved. This fosters a culture dedicated to continuous learning and improvement, prioritising quality, safety, and experience.	efficient quality management system, possessing the requisite skills, knowledge, and values to provide person-centred services. In addition, leaders and senior managers take proactive steps to incorporate learning, quality, and experience into leadership development, staff objectives, appraisals, and other relevant processes.	The service can provide tangible evidence of incorporating people's experience into the decision-making process and the planning, and delivery of services. This would include the use of evidence from experience data gathered to inform equality impact assessments.		Not Entered		Not Entered
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Characteristics	Suggested requirement needed to meet the Characteristic	What will good look like?	What does this look like for CCG's?	CCG's Rating	Change Ideas	After Improvements Rating
The senior leadership team is visible, with a designated senior manager, taking accountability for leading quality, and people's experience to ensure that the organisation fulfils its Duty of Quality and obligation to promote active listening and learning from experiences and feedback.	The Executive or nominated deputy for people's experience consistently helps discussions on experience and regularly presents comprehensive reports upwards through the Board's governance structures. Proactively taking charge of this domain within the service, the nominated lead ensures that people's experiences (including stories) become a routine feature in various meetings, including governance meetings and relevant sub-committees.	People's experiences and the corresponding actions are disclosed in the reports.		Not Entered		Not Entered
		People's experience reports cross-reference various experience/ feedback sources, including compliments, general feedback, satisfaction ratings, complaints, and Value-Based healthcare. Information e.g. (PROMS/PREMS), incorporating both goals and shared decision-making tools.		Not Entered		Not Entered
		Lived experiences of people along with associated learnings and actions, are shared both internally and externally. This information is balanced with staff experiences and stories.		Not Entered		Not Entered

Characteristics	Suggested requirement needed to meet the Characteristic	What will good look like?	What does this look like for CCG's?	CCG's Rating	Change Ideas	After Improvements Rating
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Any service development or improvement strategy and implementation plans are underpinned by a commitment to improve people's experiences.	People's experience is integrated into the service development strategies. This should also include ensuring that our staff are trained and equipped to engage and work collaboratively with our public and communities.	There is recognition that staff experience is critical to people's experience and service quality. This should be referenced in key documents such as IMTP's, clinical service plans.		Not Entered		Not Entered
Characteristics	Suggested requirement needed to meet the Characteristic	What will good look like?	What does this look like for CCG's?	CCG's Rating	Change Ideas	After Improvements Rating
The organisation values and celebrates innovation by staff that demonstrates a consistent approach to people's experience and quality improvements.	<p>Staff are supported by senior managers and colleagues to listen and act locally as a response to feedback and the organisation routinely captures, analyses and reports on the outcomes from any quality improvement work.</p> <p>Monitoring takes place against the results of the staff and people experience surveys.</p> <p>Staff behaviour is compassionate, involves people and communities in decision-making and provides good emotional support to people.</p>	<p>Innovations are recognised within a wide range of policies, procedures, and governance reports. Also celebrated and recognised at staff awards; appraisal; Research and quality improvement programmes.</p>		Not Entered		Not Entered
		<p>There are opportunities for shared learning throughout the organisation and wider, including the opportunity to share good practices and learn from mistakes.</p>		Not Entered		Not Entered
		<p>Staff training includes opportunities to understand and embed:</p> <p>Compassionate Leadership and culture within the organisation.</p> <p>Positive feedback. - Learning from Compliments/ appreciative inquiry</p>		Not Entered		Not Entered

		People and communities are involved in training or service developments through a variety of means including lived experience stories to delivering the training. Active involvement of people and communities at meetings can positively impact outcomes and contribute towards raising staff awareness.		Not Entered		Not Entered
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Characteristics	Suggested requirement needed to meet the Characteristic	What will good look like?	What does this look like for CCG's?	CCG's Rating	Change Ideas	After Improvements Rating
The organisation expresses its commitment to engaging with people and communities through all its communications. This is per the Duty of Quality.	Information for public and communities, ie for the website and other externally facing communications is accessible and clear and people would judge them to be user- friendly. They also articulate a commitment to person or population-centred services and programmes. People and communities are actively involved in the development, production, and review of all public- facing health (including promotion) and well-being information.	Communication is available bilingually in a range of formats (Welsh and English) but should also include user-friendly and jargon-free easy-to- read information, BSL, audio and other languages to reflect community demographics and need. Organisational websites are designed to use language that is clear in meaning and jargon-free.		Not Entered		Not Entered
	People and communities can access correspondence relating to their health or care in an accessible format suitable for their needs.	Public-facing information relating to an individual's or community's health and well-being is developed in line with good practice and is subject to stakeholder review before publication. Stakeholder review is inclusive and relevant to the people and communities who would access the information.		Not Entered		Not Entered

		compliance in line with the accessible Information and Health Care and Quality Standards. Every service to demonstrate how they will implement, comply, and monitor the Accessible Information Standards.		Not Entered		Not Entered
		Feedback from staff, people and communities is routinely gathered and includes feedback on whether information and communication are accessible.		Not Entered		Not Entered

CAPACITY AND CAPABILITY TO EFFECTIVELY COLLECT FEEDBACK

The organisation has several routes through which People and Communities can provide feedback.

Characteristics	Suggested requirement needed to meet the Characteristic	What will good look like?	What does this look like for CCG's?	CCG's Rating	Change Ideas	After Improvements Rating
The organisation ensures that people's experiences and overarching themes are at the core of all surveys, including post-discharge surveys. It collaborates with teams to devise and execute rapid, real, or near-real-time feedback processes	The organisation fully adheres to all mandated mechanisms and has a comprehensive program dedicated to looking for rapid, real-time experience and feedback from individuals, utilising the most up-to-date technology available to them.	A unified system for Wales should facilitate benchmarking across organisations and support real time feedback through various channels, such as SMS, IVR, online platforms, paper, etc.		Not Entered		Not Entered
		Organisations are encouraged to consider reframing the question from 'What's the matter?' to 'What matters to you?' This shift in focus aims to prioritise and address the individual's concerns and preferences.	As well as considering "what matters" to the patient, the same approach should be used to inform discussions with carers and family members.	Not Entered		Not Entered

Characteristics	Suggested requirement needed to meet the Characteristic	What will good look like?	What does this look like for CCG's?	CCG's Rating	Change Ideas	After Improvements Rating
The organisation has established an accessible experience and feedback process that aligns with national guidance and	The organisation has implemented accessible and user-friendly feedback processes, enabling individuals to easily submit compliments, provide feedback, or raise concerns in their language of choice. Information related to these processes is prominently displayed and accessible across all locations and formats (website and display screens etc).	There is robust national guidance and widespread awareness of experience and feedback systems throughout the organisation, both internally and externally, with a particular focus on reaching seldom heard communities. Clear visibility is ensured through the availability of leaflets and posters in bilingual formats (Welsh and English), and other languages in line with local population needs. In additional accessible formats, including easy-read, British Sign Language (BSL), audio should also be made available.	Services have information for patients and carers in a variety of formats and languages and actively support requests to provide information in less common languages, making full use of interpretation and translation services, including the Insight App.	Not Entered		Not Entered

regulations.	Organisations have in place a systematic process for capturing experiences, feedback, and concerns specifically about how complaints are handled and the overall process. There is unambiguous evidence that feedback is consistently collected, and the organisation has implemented changes in practice. Moreover, these improvements have been sustained over time.	The organisation can provide evidence of collecting experience and feedback regarding the concerns process. Furthermore, they can demonstrate tangible improvements made because of the gathered experience and feedback.		Not Entered		Not Entered
		Feedback is systematically collected monthly, and there is documented evidence of improvement (where appropriate). This information is presented within the organisation and externally to the public.		Not Entered		Not Entered

Characteristics	Suggested requirement needed to meet the Characteristic	What will good look like?	What does this look like for CCG's?	CCG's Rating	Change Ideas	After Improvements Rating
All staff take ownership of and promptly address feedback and concerns at the earliest opportunity. Clear information is provided, and support is extended when individuals express a desire to provide feedback or raise a concern.	All staff are supported by their colleagues in addressing concerns raised by individuals, and there is a structured process for teams and the broader organisation to share and learn from these experiences.	All staff are empowered to reflect on all feedback and receive support to enhance the experiences of individuals. The organisation has clear processes in place to escalate, share, and learn from all feedback.		Not Entered		Not Entered

Characteristics	Suggested requirement needed to meet the Characteristic	What will good look like?	What does this look like for CCG's?	CCG's Rating	Change Ideas	After Improvements Rating
	Staff comprehends and acts upon the Duty of Candour as outlined in the Health and Social Care (Quality and Engagement) (Wales) Act 2020.	All staff members, including those who are front facing or involved in service development, have completed Duty of Candour training.		Not Entered		Not Entered
		The organisation can provide evidence of being open and honest with people and communities when things go wrong.		Not Entered		Not Entered

Duty of Candour	The significance of experience and feedback is integrated into the organisation's approach to staff training.	Training on experience feedback is incorporated into induction processes, leadership development programs, and reviewed during staff appraisals. Targeted training is undertaken in areas needing performance improvement, with clear measurement of feedback and impact of interventions.		Not Entered		Not Entered
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Characteristics	Suggested requirement needed to meet the Characteristic	What will good look like?	What does this look like for CCG's?	CCG's Rating	Change Ideas	After Improvements Rating
<p>People are provided with information about the various avenues via which they can leave feedback, encompassing paper-based surveys, comment cards, web platforms, text messages, devices, kiosks, and apps.</p> <p>Staff support individuals in utilising these approaches, ensuring consideration for the needs of those who may be less able or less willing to provide feedback.</p>	<p>The service disseminates information to individuals in multiple ways to provide feedback.</p> <p>People are informed about various avenues available to them as routes for sharing their experiences and feedback.</p> <p>The service utilises a variety of methods to collect feedback from people, tailoring these approaches based on individuals' needs and preferences. There are staff training in each service to access Civica data regularly and ensure this is used to share widely across the service and inform improvements such as you said/we did.</p> <p>Staff members are well-versed in these methods and actively encourage and support people in providing feedback.</p>	The service can demonstrate it has in place various accessible methodologies and routes for the capture of people's experiences and staff trained and accessing information from the Civica system		Not Entered		Not Entered
		Organisations can demonstrate a quality improvement approach to introducing new routes for capturing people's experience and evidence learning which has resulted in improvements.		Not Entered		Not Entered
		Staff can direct people and communities to a variety of feedback routes.		Not Entered		Not Entered

Characteristics	Suggested requirement needed to meet the Characteristic	What will good look like?	What does this look like for CCG's?	CCG's Rating	Change Ideas	After Improvements Rating
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	<p>Services are encouraged to establish experience/feedback Quality Indicators (QIs)</p> <p>for all public-facing services, and programmes in alignment with the People's Experience Framework. These should support quality improvements and be reported internally within the organisation while also being made available externally to the public.</p>		<p>The QIs along with all performance-related information should be made available on websites.</p> <p>Reports should be in a format which is easily understood. Also, in the case of online, the information should be easy to find.</p>	Not Entered		Not Entered
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ANALYSIS AND TRIANGULATION

The Organisation has a systematic and consistent approach to analysing and making sense of feedback (qualitative and quantitative) and considers it alongside safety and outcomes data.

Characteristics	Suggested requirement needed to meet the Characteristic	What will good look like?	What does this look like for CCG's?	CCG's Rating	Change Ideas	After Improvements Rating
<p>The organisation has implemented a systematic method for analysing feedback and experiences gathered in various forms.</p> <p>Additionally, the organisation has dedicated analytics and intelligence support for its experience data, generating clear and helpful reports.</p>	<p>The organisation routinely and systematically analyses all forms of feedback and experience, consolidating all strands and identifying themes upon which it acts.</p>	<p>The organisation employs real-time sentiment analysis to identify opportunities for early resolutions.</p>		<p>Not Entered</p>		<p>Not Entered</p>
		<p>All forms of feedback and experience undergo triangulation with various other outcome measures and are included in quality and assurance reports across the organisation, as well as in other public reports. Quantitative data, when available, is graphically plotted over time to provide a visual representation of trends.</p>		<p>Not Entered</p>		<p>Not Entered</p>

		Demographic and diversity information is analysed aligned to the experiences themes to identify any variation and support improvement or engagement work (as required). The data is translated into business intelligence, informing meaningful quality improvement actions and engagement (where appropriate), and is used to inform equality impact assessments.			Not Entered		Not Entered
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Characteristics	Suggested requirement needed to meet the Characteristic	What will good look like?	What does this look like for CCG's?	CCG's Rating	Change Ideas	After Improvements Rating
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The organisation generates reports displaying the correlation between enhancing outcomes, safety, and the experience of people. This information is routinely triangulated with data from staff surveys, providing a comprehensive perspective on overall performance.	Organisational reports clearly articulate these relationships and outline the quality. improvement actions that result from the analysis.	All forms of feedback and experience undergo triangulation with a variety of other outcome measures and are incorporated into organisational quality and assurance reports. This information is also included in other public reports.		Not Entered		Not Entered
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		A robust relationship is maintained with services and teams to ensure that feedback, wherever feasible, translates into improvements. This collaboration involves staff from a range of disciplines across the organisation.		Not Entered		Not Entered
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Characteristics	Suggested requirement needed to meet the Characteristic	What will good look like?	What does this look like for CCG's?	CCG's Rating	Change Ideas	After Improvements Rating
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<p>The service can efficiently identify and pinpoint areas of deteriorating performance, facilitating prompt action to address the underlying causes.</p>	<p>The service proficiently utilises experience and feedback data as an early warning system for declining standards. This enables leaders at various levels to detect concerns and implement quality improvement approaches promptly.</p>	<p>Trend graphs are employed to identify abnormal activity within the feedback system. Additionally, alerts are set up to trigger actions promptly in response to key concerns. This system helps in staying vigilant to emerging issues and taking timely corrective actions.</p>			Not Entered	Not Entered
	<p>The service utilises data related to experience and engagement to comprehend variations.</p> <p>Experience is fully aligned with and integral to quality improvement efforts.</p>	<p>All quality improvement processes unequivocally demonstrate the utilisation of experience data. The insights derived from the data play a leading role in shaping and enhancing the organisation's quality improvement initiatives.</p>			Not Entered	Not Entered

Characteristics	Suggested requirement needed to meet the Characteristic	What will good look like?	What does this look like for CCG's?	CCG's Rating	Change Ideas	After Improvements Rating
<p>Experience and feedback information is routinely taken into consideration and acted upon by all teams. When a large-scale service redesign is necessary, such feedback is appropriately escalated and incorporated into the decision- making process.</p>	<p>Services, programmes, and functions receive feedback promptly and in a format that is usable for them.</p> <p>Services regularly engage in discussions about the data and leverage it for quality improvements.</p> <p>The Service has an effective approach to celebrating and sharing local learning.</p>	<p>The service should have access to a quality management system where data is live and in real-time, providing them with immediate and up-to-date insights. The quality management system should encompass all sources of experience and feedback.</p>		Not Entered		Not Entered

USING PEOPLE'S FEEDBACK TO DRIVE QUALITY IMPROVEMENT AND LEARNING - CCG AND DIRECTORATE SELF ASSESSMENT

The organisation actively and consistently seeks experiences and feedback from people to foster a learning culture underpinned by quality and service improvement initiatives.

Characteristics	Suggested requirement needed to meet the Characteristic	What will good look like?	What does this look like for CCG's?	CCG's Rating	Change Ideas	After Improvements Rating
<p>The service actively and consistently seeks people's experiences to foster a learning culture underpinned by quality and service improvement initiatives. There is evidence that the organisation uses these experiences and feedback, and staff are aware that people's experiences are central to influencing quality improvement. Moreover, people are actively engaged as equal partners in the decision-making processes, service plans and evaluation.</p>	<p>Staff demonstrate a good understanding of the theory and practice of shared decision-making with people, and its principles are reinforced through education and training programs.</p>	<p>Staff, including those who are front-facing or involved in planning, service development or quality improvement, have undergone education and training for shared decision-making.</p>		<p>Not Entered</p>		<p>Not Entered</p>
	<p>People are actively involved in all aspects of their health and possess an understanding of the expectations related to their health and well-being.</p>					
	<p>The organisation has a mechanism in place to capture whether people felt involved in decisions about their own or their communities' health and well-being.</p>					
	<p>The organisation has a mechanism in place to capture whether people felt involved in service, programme design or evaluation.</p>	<p>Public information incorporates health decision information.</p>		<p>Not Entered</p>		<p>Not Entered</p>
		<p>Clinical and public information are designed to reflect shared decision-making principles, emphasising collaboration between healthcare professionals and the public in the decision-making process.</p>		<p>Not Entered</p>		<p>Not Entered</p>

		The organisation can evidence a robust approach to public people's involvement right from the outset, highlighting a commitment to hearing and listening to the views of people in our communities, including those who face disadvantage. This information is used to inform equality impact assessments.		Not Entered		Not Entered
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Characteristics	Suggested requirement needed to meet the Characteristic	What will good look like?	What does this look like for CCG's?	CCG's Rating	Change Ideas	After Improvements Rating
The Service employs quality improvement methodology and tools as part of an ongoing process to enhance services, programs, and functions continuously.	<p>Staff actively engage in quality improvement skills to identify problems, carry out tests of change, measure their impact, and act on the results.</p> <p>The organisation empowers all staff by providing the opportunity to contribute and act on ideas for quality improvement, with a clear process for measuring their impact through experiences and feedback.</p> <p>The organisation actively benchmarks and can demonstrate the utilisation of people's experience to make informed decisions. This involves comparing its practices and outcomes to identify areas for improvement and implement informed decision-making processes. (e.g., National People's Experience Surveys, Core Questions or Lived Experiences/ People's group</p>	<p>There is evidence of education and training courses designed to support Quality Indicators</p> <p>(QI's) in service improvement. In line with the Duty of Quality</p>		Not Entered		Not Entered

		<p>Service should have a process in place to ensure it's patient population is informed about how their experiences and feedback have influenced change. This involves transparent and accessible communication to demonstrate the impact of public input on organisational decisions, evaluations, and improvements, as well as using the information to inform equality impact assessments.</p>		Not Entered		Not Entered
		<p>Services can evidence how their Lived Experience or People's groups have supported the identification of shared learning and quality improvements. This should be included in the Duty of Quality report, and all other appropriate reports and made available to the public in an easy-to- find and accessible format.</p>		Not Entered		Not Entered

Characteristics	Suggested requirement needed to meet the Characteristic	What will good look like?	What does this look like for CCG's?	CCG's Rating	Change Ideas	After Improvements Rating
Carers / Families	<p>Carers and family members are in a unique position to share their experiences of services when the person they care for is accessing healthcare. People's Experiences surveys should be developed to allow carers to offer feedback on their own experience, distinct from patient feedback.</p> <p>Services should demonstrate that they have clear mechanisms in place to identify carers, involve them in discharge planning (with patient consent) and actively signpost carers to support services.</p>	<p>Carer Experiences surveys are undertaken on a regular basis and form part of the review of People's experience data.</p> <p>All staff members will complete the Carer Awareness e-learning module on ESR to increase their knowledge about the role of unpaid carers, supplementing this with service specific training accessed via the Carers Team.</p> <p>Services will have in place clear mechanisms for routinely identifying unpaid carers and signposting them to support services e.g. Carer Officers. Exemplary practice will be demonstrated through active engagement in the Investors in Carers scheme.</p>		Not Entered		Not Entered

Characteristics	Suggested requirement needed to meet the Characteristic	What will good look like?	What does this look like for CCG's?	CCG's Rating	Change Ideas	After Improvements Rating
Values and Staff Experience	The expectation is that organisations will work with colleagues across Workforce & Organisational Development, Finance, Planning, Value-Based Healthcare and Data and Analytical teams to establish a work programme, which includes triangulation of data to drive improved outcomes and experiences for people through improving staff experience.			Not Entered		Not Entered

Characteristics	Suggested requirement needed to meet the Characteristic	What will good look like?	What does this look like for CCG's?	CCG's Rating	Change Ideas	After Improvements Rating

Equality monitoring	<p>Equality monitoring questions should be included in all People's Experience and feedback surveys.</p> <p>Services should also develop processes which help the capture of the demographic and diversity information of those people who have raised a complaint (at a time most appropriate).</p> <p>It is expected that each organisation will have processes in place to support the analytics of information being collected to provide an extra layer to the experience data and be used to support wider quality, improvement, and engagement of communities.</p>	<p>Equality monitoring questions are routinely included in all People's Experience and feedback surveys and the data is analysed to increase understanding of the characteristics of people accessing services to inform quality improvements or to support equality impact assessments.</p>			Not Entered	Not Entered
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Characteristics	Suggested requirement needed to meet the Characteristic	What will good look like?	What does this look like for CCG's?	CCG's Rating	Change Ideas	After Improvements Rating
Lived Experience / People's group	It is expected that all Services will consult with individuals and groups who have lived experience of using the service, and this is triangulated as part of their people's experience feedback.			Not Entered		Not Entered

Characteristics	Suggested requirement needed to meet the Characteristic	What will good look like?	What does this look like for CCG's?	CCG's Rating	Change Ideas	After Improvements Rating
Digital stories	<p>There is an expectation that services will have processes in place to allow them to capture and listen to people's stories. These stories should be shared at directorate and service meetings, in addition to being used as part of staff training and organisational awareness.</p> <p>These can be supported by the Patient Experience Team who will support the collection and thematic analysis of stories from across the organisation. It is expected that all organisations contribute to the All-Wales NHS Digital Story Library. To support organisations the NHS Wales Digital Story toolkit.</p>			Not Entered		Not Entered

Characteristics	Suggested requirement needed to meet the Characteristic	What will good look like?	What does this look like for CCG's?	CCG's Rating	Change Ideas	After Improvements Rating
Compliments	It is expected that all services support the always on reporting system for the collection of compliments via Civica. Services should also develop processes which support learning from compliments, processes to recognise areas and staff who are mentioned in the compliment, and processes to share good practices highlighted within compliments wider in the organisation.			Not Entered		Not Entered

REPORTING AND PUBLICATION

The organisation regularly reports and publishes its people's experience data and co-produces its quality improvement plans with a range of stakeholders including the public, statutory and voluntary organisations, and the organisation's staff group.

Characteristics	Suggested requirement needed to meet the Characteristic	What will good look like?	What does this look like for CCG's?	CCG's Rating	Change Ideas	After Improvements Rating
People's experience should be a key component of organisational reports in line with the Duty of Quality.	Relevant reports include information about people's experiences and how the organisation has encouraged feedback, listened to, and is responding to people's experiences, including examples of improvements.	The organisation's Annual Quality report, Improvement, engagement, equality report, Duty of Candour and Putting Things Right reports include examples of how the organisation responds to experiences and feedback. In the case of Incident/Complaints/ Duty of Candour/ Inquests, this would include the post experiences of the handling process.		Not Entered		Not Entered

Characteristics	Suggested requirement needed to meet the Characteristic	What will good look like?	What does this look like for CCG's?	CCG's Rating	Change Ideas	After Improvements Rating
The service routinely publishes transparent and publicly accessible information about their services, as part of the organisational wide response to feedback. (and ensures this information is accessible through multiple routes).	Information is available and accessible via a range of formats and platforms. This should include the accessibility requirements of seldom-heard communities, communities with low socio-economic backgrounds and communities with sensory loss.	The service will review its communication channels to ensure it promotes the role of all regulatory/ statutory bodies in producing reports.		Not Entered		Not Entered

4.7

4.7 - CHKS Report

***Subhamay Ghosh
(Hywel Dda UHB –
Associate Medical
Director For Quality
& Safety)***

Attachments

[QSEC update report CHKS June 2025.pdf](#)

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	10 June 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Caspe Health Knowledge Systems (CHKS) update report Hywel Dda Annual Overview Report 2023-2024
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Mark Henwood
SWYDDOG ADRODD: REPORTING OFFICER:	Professor Subhamay Ghosh, Associate Medical Director for Quality & Safety Donna Edwards, Head of Effective Clinical Practice and Quality Improvement

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Gwybodaeth/For Information

ADRODDIAD SCAA

SBAR REPORT

Sefyllfa / Situation

CHKS provide an annual report on key performance indicators to each of the Health Boards in Wales. CHKS is a leading provider of healthcare intelligence and quality improvement services. They help to develop hospital benchmarking and performance management solutions for healthcare organisations. In January 2025 they produced their annual report for 2023 – 2024.

Quality and Patient Safety

- Across several diagnosis groups the rate of readmissions is higher than the peer and higher than would be expected for these patients.
- Antepartum complication rates are higher than the upper quartile for the peer group and outside the confidence limits.

Efficiency and improvement

- Elective length of stay is shorter than the peer group however there are a handful of patient groups where Hywel Dda do have longer stays.
- Hywel Dda have lower outpatient new to follow-up ratios than peers and Did Not Attend (DNA) rates are also low. There are some specialties where new to follow-up rates are higher than peers.
- Generally non-elective length of stay is shorter than the peer however there are several specialties where Hywel Dda exceed the peer norms.

Cefndir / Background

CHKS use patient activity data to provide a benchmarking analysis service built around the comparative performance across a suite of indicators to suitable organisational peer groups. In this 2023 - 2024 report, analysis is structured around four key themes.

- Mortality
- Quality and patient safety
- Efficiency and service improvement
- Data quality

Comparative peer data is included from the other health boards in Wales for the same periods including:

- Aneurin Bevan University Health Board
- Betsi Cadwaladr University Health Board
- Cardiff and Vale University Health Board
- Cwm Taf Morgannwg University Health Board
- Swansea Bay University Health Board

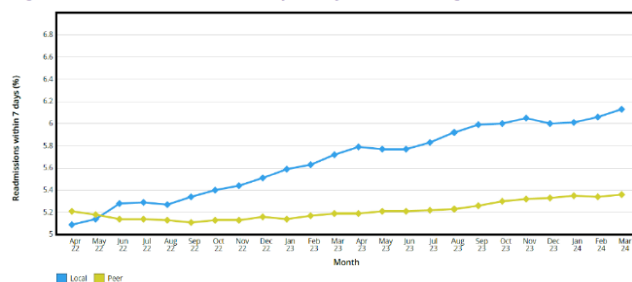
Scorecards are at the core of the CHKS benchmarking system (iCompare) and conveniently group together indicators to areas of interest and are used extensively in the annual reports.

Asesiad / Assessment

Quality and Safety (page3):

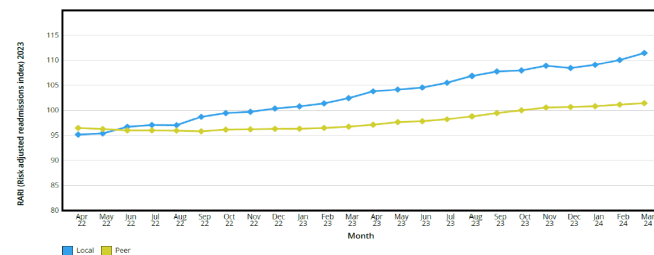
Readmissions within 7 days and the risk adjusted readmission rate are both higher than the peer upper quartile and outside the confidence limits. Both rates are shown to be increasing across 2023/24 and are higher than the peer.

Figure 6b: Readmissions within 7 days two-year trend rolling 12 months



6.2 The two-year rolling 12 month time series in Figure 6b shows that readmissions within 7 days are increasing compared to peer

Figure 6c: RARI two-year trend rolling 12 months



6.3 The risk adjusted readmission rate shown in figure 6c also indicates and increasing readmission rate which should be reviewed in more detail.

Reasons for high readmission rates include

- Medical and Surgical Same Day Emergency Care (SDEC) attendances are recorded as admissions and reattendances each time they return for further review.
- Potential coding issues.
- Patient transfers between Health Board hospital sites, not always transferred but discharged from one hospital and readmitted to another.
- Patient repatriation from other Health Boards post treatment/ procedure.

- Early discharge with poor communication or discharge summary regarding expectations/requirements with families/ GP's leads to readmissions.
- Inability to access appropriate advice through 111 can lead to readmission.

Actions undertaken/ in progress:

- A group has been set up to review this data in greater detail comprising of Mortality team, Clinical Effectiveness, Informatics and Maternity leads. Initial discussion has already taken place.
- Meetings and communications have been had with service leads, Clinical Directors and Quality Improvement leads.
- Meeting is in the diary (9th June 2025) with CHKS to discuss the issues with accuracy and completeness of clinical coding.

Antepartum complication rates are higher than the upper quartile for the peer group and outside the confidence limits.

Figure 6h: Antepartum complications scorecard

Description	Local Numerator	Apr 23 - Mar 24	Apr 22 - Mar 23	Change	Peer Value	Performance	Alert
Antepartum haemorrhage; not elsewhere classified	309	4.21%	4.79%	-12.22%	3.32%		Amber
False labour	241	3.28%	3.59%	-8.53%	1.01%		Red
Other disorders of amniotic fluid and membranes	40	0.54%	0.81%	-32.65%	1.26%		-
Placenta praevia specified as without haemorrhage	12	0.16%	0.09%	85.21%	0.18%		-
Placenta praevia with haemorrhage	36	0.49%	0.22%	122.25%	0.33%		Amber
Placental disorders	13	0.18%	0.13%	32.76%	0.51%		-
Polyhydramnios	74	1.01%	1.57%	-35.96%	1.32%		-
Premature rupture of membranes	368	5.01%	5.22%	-4%	5.29%		-
Premature separation of placenta [abruptio placentae]	12	0.16%	0.21%	-20.62%	0.16%		-
Prolonged pregnancy	274	3.73%	2.62%	42.55%	1.61%		Red

6.8 The antepartum complication rate has triggered a red alert (see appendix 1). Figure 6h shows a breakdown of these complications and this shows that the incidence of false labour and prolonged pregnancy are higher than the peer group and should be reviewed further.

Reasons for prolonged pregnancy: The Health Board have a higher number of pregnant people who choose to birth outside of guidance and actively decline induction of labour (NICE Guidance prolonged pregnancy is 42 weeks: [Recommendations](#) | [Inducing labour](#) | [Guidance](#) | [NICE](#)).

Despite the above the numbers remain higher than expected and consideration should be given for:

- Is there a data collection issue with an incorrect Expected Date of Delivery recorded.
- Reported numbers are inconsistent with clinical expectations

Actions undertaken/ in progress:

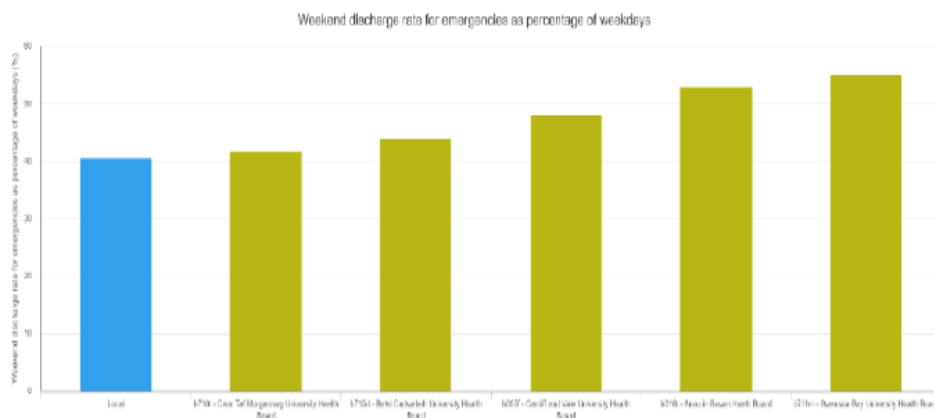
- A group has been set up to review this data in greater detail comprising of Mortality team, Clinical Effectiveness, Informatics and Maternity leads. Initial discussion has already taken place.

- Meetings and communications have been had with service leads, Clinical Directors and Quality Improvement leads.
- Meeting is in the diary (9th June 2025) with CHKS to discuss the issues with accuracy and completeness of clinical coding.

Non-elective Efficiency and Improvement (page 24):

Hywel Dda has the lowest proportion of patients discharged at a weekend.

Figure 8j: Weekend discharge rate for emergencies peer distribution



8.5 Figure 8j shows that Hywel Dda has the lowest proportion of patients discharged at a weekend across Wales. A lower discharge rate at weekends may be contributing to increased length of stay.

Reasons for lower weekend discharge rates in the Health Board than other peers include:

- Lack of Specific Allied Health Professionals such as Physiotherapy cover over the weekend delaying discharges particularly in orthopaedics, including fracture neck of femur care.
- Lack of weekend trauma theatre capacity for surgical specialities.
- Lack of criteria led discharge in place in absence of responsible team.
- Poor handover communication to out of hours team regarding weekend discharges.

The Health Board appears to be an outlier in Cardiology:

- Readmissions: likely to be impacted by managing cases via SDEC therefore recounting attendances as readmissions.
- Longer length of stay for cardiac conditions: likely to be impacted by in patient delays in transferring patients to Morriston for their procedures/ interventions.

Actions undertaken/ in progress:

- Meetings and communications have been had with service leads, Clinical Directors and Quality Improvement leads to understand the data.

The Health Board appears to be an outlier in Stroke Services:

- Longer length of stay for stroke: likely to be influenced by social issues and paucity of community provision including social care. This has been highlighted in the stroke issues paper for Clinical Services Plan (CSP)

- In line with the time period published also influenced by transition of therapists into retirement/ sickness and absence management leading to lack of available therapists. This is also reflective of availability of therapists in the community.
- Limited resources across the stroke multi-disciplinary team (MDT).

Actions undertaken/ in progress:

- Meetings and communications have been had with service leads, Clinical Directors and Quality Improvement leads to understand the data.
- Service changes have been revised and introduced since data reported in the annual report, through the stroke steering group including early supported discharge health board wide which is developing.
- Stroke length of stay meetings held in Prince Philip Hospital (PPH) is leading to changes in ground practice.
- Weekly Stroke MDT meetings have been replaced by daily 30-minute MDT board rounds which show improvement despite being in early stages.

The Health Board also appears to be an outlier in Urology:

- Relating to retention of foreign body after operation: the numbers reported appear to be high, however it depends on how they have been reported. It is recognised that there were a group of patients who had encrusted stents due to delayed operations which has already been highlighted. These patients required multiple operations to remove the stents which appears to be the reason for the data provided by CHKS.
- Extended length of stay: likely to impact is the sociodemographic and aging population within our population including the availability of community resources including social services.

Actions undertaken/ in progress:

- Discussions are being had with clinical directors and service leads.
- Meeting with CHKS to discuss the issues with accuracy and completeness of clinical coding, particularly in areas like comorbidity recording.

Argymhelliad / Recommendation

The Committee are asked to note the content of the report and take assurance that further actions are being undertaken to understand the data accurately, to identify and address any areas of improvement that are required.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.6	Provide assurance on the delivery of action plans arising from investigation reports and the work of external regulators.
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Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	3. Data to knowledge 4. Learning, improvement and research
Amcanion Strategol y BIP: UHB Strategic Objectives:	
Amcanion Cynllunio Planning Objectives	6 Clinical services plan 10 Population health
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	4. Improve Population Health through prevention and early intervention, supporting people to live happy and healthy lives

Gwybodaeth Ychwanegol:

Further Information:

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

Effaith: (rhaid cwblhau)

Impact: (must be completed)

Ariannol / Gwerth am Arian: Financial / Service:	Not Applicable
Ansawdd / Gofal Claf: Quality / Patient Care:	Contained within the body of the report.

Gweithlu: Workforce:	Not Applicable
Risg: Risk:	Not Applicable
Cyfreithiol: Legal:	Not Applicable
Enw Da: Reputational:	Contained within the body of the report
Gyfrinachedd: Privacy:	Not Applicable
Cydraddoldeb: Equality:	Not Applicable

4.8

4.8 - Getting it Right First Time Governance Review

*Joanne Wilson
(Hywel Dda UHB -
Director of Corporate
Governance/Board
Secretary)*

Attachments

[QSEC SBAR GIRFT Report May 2025.pdf](#)

[Appendix 1 Management Response Template May 2025.pdf](#)



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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	10 June 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Receipt of Getting it Right First Time (GIRFT) Reports Governance Review
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Joanne Wilson, Director of Corporate Governance/Board Secretary
SWYDDOG ADRODD: REPORTING OFFICER:	Joanne Wilson, Director of Corporate Governance/Board Secretary

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA

SBAR REPORT

Sefyllfa / Situation

To report to the Quality, Safety & Experience Committee on the findings and recommendations following a governance review of how Getting it Right First Time (GIRFT) reports and other external reports that do not have a pre-defined process are received into the operational and corporate structures of Hywel Dda University Health Board and subsequently tracked and implemented within the organisation.

Cefndir / Background

In September 2024, a Getting it Right First Time (GIRFT) Report on Emergency Department Medicine, Glangwili Hospital (GGH), undertaken in June 2024, was received into the Health Board in September 2024.

The report concluded that ‘The Emergency Department at Glangwili Hospital is currently putting patients at risk of harm and is distressing for staff. It was one of the two EDs in Wales which caused the most concern to the GIRFT team.’

The first time this particular GIRFT report came to the appropriate assurance Committee of the Health Board, the Quality, Safety & Experience Committee (QSEC), was 13 February 2025. This was submitted as a late paper to the In Committee session of the meeting following discussion at Executive Team (ET) on 5 February 2025 where concerns had been raised regarding the operational governance of the report and the quality of the management response.

It was agreed, through the Chair of QSEC, that the report would be presented to the In Committee session of QSEC whilst the operational governance concerns were worked through and the management response prepared.

These operational governance concerns have provided the impetus for this review following In Committee QSEC’s request that an exercise be undertaken into how GIRFT reports and other

external reports that do not have a pre-defined process are received into the operational and corporate structures and subsequently tracked and implemented within the organisation.

Asesiad / Assessment

Timeline of Events

- GIRFT Report on Emergency Department Medicine (EDM) received into the Health Board in September 2024 by the operational services involved with the review;
- GIRFT EDM (GGH) report initially discussed at the Acute Leadership Group (now superseded by the Community and Integrated Medicine Clinical Care Group);
- GIRFT EDM (GGH) report placed on the Integrated Quality, Finance & Performance Delivery Group (IQFPDG) agenda on 23 October 2024;
- GIRFT EDM (GGH) report discussed each month at IQFPDG within the Six Goals section of the agenda given the similarity of the report's findings and recommendations regarding waiting times, patient flow and medical challenges;
- At IQFPDG on 22 January 2025, the Chief Operating Officer was tasked with submitting the GIRFT EDM (GGH) report to Executive Team (ET) for consideration of the recommendations and the management response
- The GIRFT EDM (GGH) report was presented to ET on 5 February 2025 with the outcome that the Chief Operating Officer work with the Community and Integrated Medicine Clinical Care Group Service Director *'to improve the report ahead of presentation to QSEC though the inclusion of actions undertaken and the response to the GIRFT Report'*.
- The GIRFT EDM (GGH) report was submitted (as a late paper following discussion with the QSEC Chair) to In Committee QSEC for its 13 February 2025 meeting

Whilst a documented process for the receipt of GIRFT reports and the drafting of management responses as developed by the Health Board's Assurance & Risk Team was in place at the time the GIRFT EDM (GGH) report was received by the Health Board, it would appear that this was not followed by the service involved.

The process, which had been approved at the Operational Performance, Governance and Planning (OPGP) meeting in December 2023 by the Chief Operating Officer and also made available to staff within the Health Board via the Assurance and Risk Sharepoint site, required that:

'On receipt of a GIRFT report, service leads are to complete a proforma to confirm if the recommendations have been accepted or not, with management responses provided in the form of an action plan detailing how they will be implemented, who will own the recommendations, and with realistic completion dates assigned.

The completed action plan would then need to be reviewed and signed off by the General Manager/Directorate lead as well as the Director of Secondary Care (where appropriate). An SBAR should then be submitted to the OPGP for final approval by the Chief Operating Officer, detailing any concerns with the report content or recommendations and a proposal for which Board Committee the report should be aligned to.

Once approved at OPGP, finalised action plans to be sent to the Head of Assurance and Risk for addition to the Health Board's central Audit & Inspection tracker, prior to then forwarding to the relevant Committee Services Officer for inclusion at the next Board Committee meeting.

*Progress against recommendations would be requested from the service lead by the Assurance and Risk Team and reported to the **Audit & Risk Assurance Committee (ARAC)** on a bi-monthly basis, as well as in Directorate Improving Together sessions.*

In addition, progress against the implementation of GIRFT recommendations is reported to the Audit and Risk Assurance Committee on a bi-monthly basis in the Health Board-wide Audit Tracker paper and to the relevant assurance Committee at appropriate junctures.'

The potential for GIRFT reports to become 'lost in the system' is acknowledged, stemming from the fact that GIRFT reviews are essentially peer reviews and, once prepared, they are issued to whoever the GIRFT reviewers have been dealing with at a service level, rather than the Chief Executive or relevant Executive Director concerned.

The Health Board has tried to influence this to ensure these reports are received more formally into the organisation rather than directly to operational services albeit with little success. In addition, and despite numerous requests, these reports are not always shared with Corporate teams for tracking.

Whilst IQFPDG had been sighted on the GIRFT EDM (GGH) report at a number of its meetings, this may have been by default as it was linked in with the work on the Six Goals, a standing item on IQFPDG's agenda, whereas a GIRFT report on a different subject matter may have been overlooked; it would also appear that an Action Plan in response to this GIRFT report was only latterly presented to IQFPDG.

Given the recent revisions to the Health Board's Operations structure, the Assurance & Risk Team has developed a new process for the management of GIRFT reports as well as for peer reviews or reports that are received by the Health Board that do not have a pre-defined process which is also made available to staff via the Assurance & Risk Sharepoint site - [Assurance](#) (see Appendix 1)

This new process requires the following:

'Within one month of receipt of report, please complete the table below to confirm:

- a) If the recommendation is accepted or not (justification must be documented if not accepted);*
- b) A management response to accepted recommendations detailing
 - a. how it will be implemented, ie the actions that will be undertaken to fully implement the recommendation. Consideration must be given to what is within the means and capacity of the service in order to deliver, with any barriers to its implementation, or additional resource requirements clearly documented*
 - b. who will own this recommendation**
- c) A realistic and achievable completion date, taking into account your capacity;*
- d) The evidence/documentation that will demonstrate the recommendation has been fully implemented as this will need to be uploaded to [AMAT](#)-before it will be fully approved as completed; and*
- e) Any recommendation that cannot be fully implemented must be escalated through the relevant management structure and action plans must be signed off by the relevant Clinical Care Group.*

After sign off by Clinical Care Group/Director, action plans must be reviewed by IQFPDG prior to onward submission to Formal Executive Team for approval. Once approved, action plans should be sent to the Head of Assurance and Risk for initial upload to the Audit Management & Tracking (AMaT) system.

The report and action plans will then be presented to QSEC (or other Board level Committee) at its next meeting to provide assurance that the management response will address the areas of concern/improvement detailed in the report.

Progress against recommendations must be regularly provided on AMaT by the relevant recommendation owners, with monitoring of their delivery undertaken by the relevant Clinical Service Group, with oversight from the Clinical Care Group. Any exceptions to the implementation of recommendations are required to be reported to IQFPDG.

Non-compliance of implementing recommendations within agreed timescales is one of the criteria considered within the Governance domain within the Health Board's Improving Together Framework

This new process will be tested on the next anticipated GIRFT report in relation to Critical Care to ascertain how well the process is working within the new Operations structure.

The GIRFT Critical Care management response and action plan, when subsequently presented to QSEC, will include a summary of its passage through the operational governance arrangements required by the new process to provide further assurance to the Committee.

Argymhelliad / Recommendation

To receive assurance from the governance review undertaken into how GIRFT reports and other external reports that do not have a pre-defined process are received into the operational and corporate structures of HDdUHB, and the revised processes in place to ensure these are appropriately tracked and implemented within the organisation.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	Not Applicable
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	4. Learning, improvement and research
Amcanion Strategol y BIP: UHB Strategic Objectives:	5. Safe sustainable, accessible and kind care

Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:

Ar sail tystiolaeth: Evidence Base:	GRIFT Review Papers and Agenda from various meetings Risk and assurance sharepoint
Rhestr Termiau: Glossary of Terms:	Not Applicable
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiad: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	Health Board Chair Quality Safety and Experience Committee Chair Chief Operating Officer Chief Executive Officer Deputy Chief Executive Officer Executive Director of Nursing, Quality and Patient Experience.

Effaith: (rhaid cwblhau) Impact: (must be completed)

Ariannol / Gwerth am Arian: Financial / Service:	Not Applicable
Ansawdd / Gofal Claf: Quality / Patient Care:	It is essential external reviews are received and actioned appropriately within the Health Board.
Gweithlu: Workforce:	Not applicable
Risg: Risk:	Compliance with internal guidance on receipt of GRIFT reports would reduce the risk.
Cyfreithiol: Legal:	Not applicable

Enw Da: Reputational:	Potential for media interest from the findings of the GRIFT review.
Gyfrinachedd: Privacy:	Not applicable
Cydraddoldeb: Equality:	Not Applicable

ACTION PLAN / DEVELOPMENT OF MANAGEMENT RESPONSES

Process

Within one month of receipt of report, please complete the table below to confirm:

- a) If the recommendation is accepted or not (justification must be documented if not accepted);
- b) A management response to accepted recommendations detailing
 - a. how it will be implemented, ie the actions that will be undertaken to fully implement the recommendation. Consideration must be given to what is within the means and capacity of the service in order to deliver, with any barriers to its implementation, or additional resource requirements clearly documented
 - b. who will own this recommendation
- c) A realistic and achievable completion date, taking into account your capacity;
- d) The evidence/documentation that will demonstrate the recommendation has been fully implemented as this will need to be uploaded to [AMAT](#) before it will be fully approved as completed; and
- e) Any recommendation that cannot be fully implemented must be escalated through the relevant management structure and action plans must be signed off by the relevant Clinical Care Group.

After sign off by Clinical Care Group/Director, action plans must be reviewed by IQFPDG prior to onward submission to Formal Executive Team for approval. Once approved, action plans should be sent to the Head of Assurance and Risk for initial upload to AMaT.

The report and action plans will then be presented to QSEC (or other Board level Committee) at its next meeting to provide assurance that the management response will address the areas of concern/improvement detailed in the report.

Progress against recommendations must be regularly provided on AMaT by the relevant recommendation owners, with monitoring of their delivery undertaken by the relevant Clinical Service Group, with oversight from the Clinical Care Group. Any exceptions to the implementation of recommendations are required to be reported to IQFPDG.

Non-compliance of implementing recommendations within agreed timescales is one of the criteria considered within the Governance domain within the Health Board's Improving Together Framework

Report:

Issued By:

Issued On:

Lead Officer:

Suggested Overseeing Committee:

Recommendation	Management Response	Recommendation Owner (name, job title and CCG)	Completion Date - Please enter a specific implementation date for your action. For recommendations that are reliant on factors external to the Health Board, please note as "External"	Expected Evidence of Implementation
			Click or tap to enter a date.	
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			Click or tap to enter a date.	

Prepared By:

Prepared On:

Approved By:

Approved On:

4.9

4.9 - Cleanliness Standards Audit report and Action Plan- Deferred

Simon Chiffi (Hywel Dda UHB - Head of Operations), Elin Brock (Hywel Dda UHB - Head of Research, Innovation & Improvement), James Severs (Hywel Dda UHB - Executive Director of Allied Health Professions and Health Science)

4.10

4.10 - Nurse Staffing Levels Spring Cycle

***Helen Humphreys
(Hywel Dda UHB -
Head of Nursing for
Professional
Standards and
Regulation), Sharon
Daniel (Hywel Dda
UHB - Executive
Director of Nursing,
Quality & Patient
Experience)***

Attachments

[Spring 2025 Nurse Staffing Levels Calculation Cycle - QSEC SBAR May 2025.pdf](#)

[Annual Presentation to QSEC S25B Nurse Staffing Levels Spring 2025.pdf](#)

[Appendix 1 Annual Presentation NSL Spring 2025 .pdf](#)

[Appendix 1 Annual Presentation NSL Spring 2025 2.pdf](#)

[Appendix 1 Annual Presentation NSL Spring 2025 3.pdf](#)

[Cadog QSEC slides.pdf](#)

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	10 June 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Nurse Staffing Levels (Wales) Act 2016: Annual Presentation of Nurse Staffing Levels
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Sharon Daniel, Executive Director of Nursing, Quality and Patient Experience
SWYDDOG ADRODD: REPORTING OFFICER:	Janice Cole Williams, Assistant Director of Nursing Helen Humphreys, Head of Nursing, Professional Standards and Regulation Catrin Jones, Nurse Staffing Programme Lead

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

Er Sicrwydd/For Assurance

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

The statutory guidance issued in support of the Nurse Staffing Levels (Wales) Act 2016 (NSLWA) requires that there is an annual presentation of the nurse staffing levels to the respective Health Board (in November each year) and a written update of the nurse staffing level of each individual ward (to which sections 25B to 25E of the Act pertain) when there is a change of use/ service that has resulted in a changed nurse staffing level, or if the designated person deems it necessary.

The Quality, Safety and Experience Committee, on behalf of the Board is asked to receive the outcome of the Spring 2025 Nurse Staffing Levels Report and Appendix 1, which contains detail of the nurse staffing levels for all Section 25B wards, and tracks adjustments made to the staffing levels within those wards since the autumn 2024 calculation cycle and aims to assure the Committee that all the legislative requirements associated with the 'duty to calculate' nurse staffing levels within acute adult medical and surgical wards and paediatric wards (since 1 October 2021) are being maintained.

Cefndir / Background

The Nurse Staffing Levels (Wales) Act 2016 (the Act) The Act has five sections:

- I. Section 25A of the Act relates to the overarching responsibility placed upon each Health Board, requiring Health Boards and Trusts to ensure they have robust workforce plans, recruitment strategies, structures, and processes in place to ensure appropriate nurse staffing levels across their organisations. This duty came into effect in April 2017.
- II. Section 25B requires Health Boards/ Trusts to calculate and take reasonable steps to maintain the nurse staffing level in all adult acute medical and surgical wards (since 2018) and paediatric in-patient wards (since October 2021). Health Boards/ Trust are also required to inform patients of the nurse staffing level.

- III. Section 25C requires Health Boards/Trusts to use a specific method to calculate the nurse staffing level in all adult acute medical and surgical wards (since 2018) and paediatric in-patient wards (since October 2021).
- IV. Section 25D of the Act required that Welsh Government devised statutory guidance to support the NSLWA. The initial statutory guidance document was issued in 2017 with a revised document issued in February 2021
- V. Section 25E requires Health Boards/Trusts to report their compliance in maintaining the nurse staffing level for all wards to which Section 25B pertains.

The Board's specific responsibilities under the 2016 Act are to:

- Identify a Designated Person (or provide a description of such a person). The Designated Person should be registered with the Nursing and Midwifery Council, and it was agreed by the Chief Nursing Officer of Wales and the Executive Directors of Nursing (EDON) across Wales that the Designated Person in each organisation would be the Executive Director of Nursing, who is responsible for calculating the nurse staffing levels on behalf of the Chief Executive Officer of the Health Board/Trust.
- Determine which ward areas where Section 25B applies.
- Receive and agree written reports from the 'designated person' on the nurse staffing level that has been calculated for each ward to which Section 25B pertains.
- Ensure that operational systems are in place to record and review every occasion when the number of nurses deployed varies from the planned roster.
- Agree the operating framework which will specify the systems and processes to ensure that all reasonable steps are taken to maintain the nurse staffing level on both a long term and a shift-by-shift basis; and specify the arrangements for informing patients of the nurse staffing.
- Make arrangements to inform patients of the nurse staffing level.

There are two key reporting requirements under the Act and/or the statutory guidance which should be undertaken within a Health Board:

1. The Board receives an annual presentation of the Nurse Staffing Levels which have been calculated for wards where Section 25B pertains (which this report pertains to).
2. Every third year, the Board provides a three yearly assurance report to Welsh Government. To support the accuracy of this report, the Board has agreed to receive an annual assurance report, using the nationally agreed template.

Asesiad / Assessment

The outcome of the Spring 2025 Nurse Staffing Level report sets out the detail of the process, output, conclusions, and further actions to be undertaken arising from the recent (Spring 2025) nurse staffing levels review and recalculation cycle of the adult medical and surgical wards and the paediatric inpatient wards.

The process has been led by the Executive Director of Nursing, Quality and Patient Experience. All Senior Sisters/Charge Nurses of all wards where Section 25B pertains, all Senior Nurse Managers and all acute site Heads of Nursing have participated in the process.

In line with the requirements of the Act, the statutorily prescribed, triangulated methodology for calculating the nurse staffing levels for the adult medical and surgical wards and the paediatric inpatient wards has been fully and rigorously applied. The core information discussed included:

- Current ward bed numbers and speciality, including any proposed service and/or patient pathway changes.

- Current nurse staff provision, including those that are not included in the core roster (e.g. supervisory ward manager, frailty/rehabilitation support workers, ward administrators etc).
- Patient acuity data for the previous 6 months. All S25B wards within the health board are now using the SafeCare module of the rostering system to capture the acuity data (SafeCare is the nationally agreed system for capturing this data).
- Care quality indicator data for the previous 12 months –consideration has been given to the pressure ulcers, medication errors and falls incidents in all wards as well as infiltration/extravasation injuries in the paediatric wards. In addition, complaints, and positive patient experience data was reviewed.
- Infection prevention and control data.
- Finance/workforce-related data - expenditure/utilisation of permanent/temporary staff.
- Staffing related metric data – Performance & Development Review (PADR) compliance, mandatory training compliance and sickness.
- National care standards, where they exist.
- Patient flow/activity related data for the previous 12 months.
- The extent to which the planned rosters have been met over the previous 6 months.

Please see the attached powerpoint slides for an example of some of the data reviewed as part of the nurse staffing level calculation discussion.

It is noted that the table below includes the financial and workforce impact of both the spring 2024, autumn 2024 and spring 2025 calculation cycles, as the outcome of the spring 2024 and autumn 2024 cycles has not yet been transacted into the budget or into the rosters. The Executive team took the decision in November 2024 to not transact the changes of the spring 2024 and autumn 2024 but to provide authorisation for the relevant wards to continue to use temporary staff. This was pending the outcome of a ward modelling review in GGH assessed against the domains of the Duty of Quality as set out in the Health & Social Care (Quality and Engagement) (Wales) Act 2020, to ensure provision of a safe, timely, effective, efficient, equitable, person centred model of care to our patients. This modelling review is ongoing.

Table 1: breakdown of uplift requirements							
	Additional requirements £		RN £	HCSW & Other £		RN WTE	HCSW & Other WTE
1a. Adult inpatient wards (BGH, GGH, PPH)	164,551		-68,885	233,436		-1.33	5.97
1b. Service change: Picton – HCSW Padarn Band 4 role Y Banwy – ward clerk	283,754		10,834	272,920		0.00	7.33
1c.– Service Change – Enhanced Care Unit/Rhiannon BGH	70,102		2,948	67,154		0.05	1.77
1d. Adult inpatient wards WGH	-89,262		- 129,834	40,572		-2.69	1.04
2. Paediatric inpatient wards	433,348		- 144,020	577,369		-2.53	13.43

1. Adult inpatient wards

1a Bronglais Hospital (BGH), Prince Philip Hospital (PPH) and Glangwili Hospital (GGH): As previously noted, the changes agreed in the Spring 2024 and Autumn 2024 calculation cycles have not been transacted into the budgets. The Executive Team took the

decision to not transact the changes but to provide authorisation for the relevant wards to continue to use temporary staff.

For those adult inpatient wards where the uplift requirements is via the 'nurse staffing funding' allocation, there is an **additional £164,551** required following the Spring 2025 cycle.

- A reduction of 1.33wte because of changes to the proportion of long days worked by our RN workforce.
- An additional 2.72wte on Steffan agreed in Spring 2024 due to patient acuity.
- an additional 2.72wte on Padarn ward, GGH, agreed in Autumn 2024 due to patient acuity.
- the additional 0.52wte HCSW is because of the change to the proportion of long days worked by our HCSW workforce.

The Director of Nursing, Quality & Patient Experience is due to meet with the relevant Clinical Care Group to discuss the finance and workforce implications of the Spring 2025 cycle.

As part of the spring 2025 cycle, consideration was given to a change in the HCSW roster on one ward with a request that the twilight shift be changed to a night shift instead, however, additional information has been requested to support the rationale for this change and the nurse staffing levels on this ward will be for an 'early review' in July 2025.

There are established processes in place whereby operational teams are applying their professional judgment to ensure that the staffing levels wherever possible, are maintained – and, where not possible, that risks are mitigated:

- Systems in place whereby risk assessments are undertaken taking into account patients' needs (including acuity and dependency) versus the available staff (both substantive and temporary), staff knowledge and skills and team stability.
- Deployment of staff from other areas within the organisation.

The risks of not transacting the additional requirements into the budget and rosters would be:

- Patient care: The intention underpinning the Act is to ensure safe, effective, and quality patient care. There are two wards (Steffan and Padarn wards) which required an uplift to their Health Care Support Worker (HCSW) establishment and there may be a negative impact on care quality if the outcome of the calculation cycle is not responded to operationally which could result in limiting in-patient numbers to the available staffing.
- There are financial and workforce risks associated with the outcome of the work described in this report. The risks relate to the ability to both finance and recruit a sufficient workforce of HCSWs. Both Steffan and Padarn are incurring variable pay using bank HCSWs.
- The 'duty to maintain the nurse staffing level' requires the finance and the workforce required to be transacted, and this poses a more significant challenge than the duty to calculate described in this report.

1b. Service Change

There are three wards who require additional resources due to a change in the service being provided: an **additional** £283,754.

- Picton ward, GGH – additional HCSW on night duty because of changes to the gynaecology emergency pathway during the Covid 19 pandemic, which remains unfunded.
- Padarn – the role of the Band 4 Assistant Practitioner who supports the respiratory treatment room activity.
- Y Banwy – the funding of the Band 7 ward manager and the funding of the ward clerk which do not appear to have ever been funded roles.

The Director of Nursing, Quality & Patient Experience is due to meet with the relevant Clinical Care Group to discuss the outcome of the Spring 2025 cycle and this will include the finance and workforce implications of these service changes.

1c. Service Change - Enhanced Care Unit (PACU) Rhiannon Ward, BGH – although additional funding was allocated to the Enhanced Care Unit during 2024/25, there is still a deficit between the require establishment and the funded establishment of £70,102 (0.05wte RN and 1.77wte HCSW).

The Director of Nursing, Quality & Patient Experience is due to meet with the relevant Clinical Care Group to discuss the finance and workforce implications of the Spring 2025 cycle.

1d. WGH: The changes required to the rosters/required establishments for the adult inpatient wards in WGH show that there is a **reduction** of £89,262 required. The WGH position is set out separately to the other adult wards as WGH Unscheduled Care underwent a planned change in services during Q3 of 2024/25 and some of the changes have been picked up as part of the Spring 2025 calculation cycle. The changes in the Spring 2025 cycle include:

- There is a reduction of 5.45wte in the RN requirements on Ward 12, WGH
- There is an increase of 2.72wte in the RN requirements on Ward 4, WGH

The funding of the planned programme of changes is being met by the Care Group and the Director of Nursing, Quality & Patient Experience is due to meet with the Clinical Care Group to discuss the outcome of the Spring 2025 cycle.

2. Paediatric inpatient wards

An **additional** £433,348 is required following the spring 2025 calculation cycle for the paediatric wards. Since Section 25B of the Act came into effect for the paediatric wards (October 2021), the funding of the additional requirements has been met from within the Women and Children Directorate.

The Director of Nursing, Quality & Patient Experience is due to meet with the relevant Clinical Care Group to discuss the finance and workforce implications of the Spring 2025 cycle.

Argymhelliad / Recommendation

The Quality, Safety and Experience Committee is asked on behalf of the Board is requested to take assurance that:

- The Health Board is meeting its statutory 'duty to calculate' responsibility in respect of the nurse staffing level in all wards that fall under the inclusion criteria of Section 25B of the Nurse Staffing Levels (Wales) Act 2016.
- By presenting this report to QSEC, the Health Board is meeting its statutory duty to provide a written update of the nurse staffing level of each individual ward (to which sections 25B to 25E of the Act pertain) to the Board (or delegated committee which received the nurse staffing levels updates on behalf of the Board) when there is a change of use/ service that has resulted in a changed nurse staffing level, or if the designated person deems it necessary (Paragraph 12).

Amcanion: (rhaid cwblhau)	
Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	NA
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	NA
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	1. Safe 3. Effective 4. Efficient 6. Person-Centred
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	1. Leadership 2. Culture and valuing people 3. Data to knowledge Choose an item.
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	1 Workforce Stabilisation 2 Financial recovery and route map
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	2. Develop a skilled and flexible workforce to meet the changing needs of the modern NHS 5. Offer a diverse range of employment opportunities which support people to fulfill their potential

Gwybodaeth Ychwanegol:	
Further Information:	
Ar sail tystiolaeth: Evidence Base:	The evidence underpinning the triangulated approach to calculating the nurse staffing levels has been articulated through the working papers of the all Wales Nurse Staffing Group

<p>Rhestr Termiau: Glossary of Terms:</p>	<p>S25B – Section 25B of the Nurse Staffing Levels (Wales) Act 2016 WGH – Worthybush General Hospital BGH – Bronglais General Hospital GGH – Glangwili General Hospital PPH – Prince Phillip Hospital CCU – Coronary Care Unit WTE – whole time equivalent HDdUHB – Hywel Dda University Health Board WG – Welsh Government NIV – Non-invasive ventilation HCSW – Health Care Support Worker AP – Assistant Practitioner RN – Registered Nurse ECU – Enhanced Care Unit PACU – Paediatric Ambulatory Care Unit QI data – quality indicator data</p>
<p>Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofïod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:</p>	<p>Sisters/Charge Nurses, Senior Nurse Managers and Heads/Deputy Heads of Nursing of each S25B.</p>

<p>Effaith: (rhaid cwblhau) Impact: (must be completed)</p>	
<p>Ariannol / Gwerth am Arian: Financial / Service:</p>	<p>The financial impact of the Autumn 2024 and Spring 2025 calculation cycle is set out in the Report and Appendix 1</p>
<p>Ansawdd / Gofal Claf: Quality / Patient Care:</p>	<p>The intention underpinning the Act is to ensure safe, effective, and quality patient care.</p> <p>One of the key requirements of the Act is to monitor the impact of nurse staffing levels on care quality. Page 2-3 of the report refers to the information reviewed as part of the triangulated methodology set out in the Act and which is used when implementing the ‘duty to calculate’. There are wards which required an uplift to their RN or HCSW establishment and there may be a negative impact on care quality if the outcome of the calculation cycle is not responded to operationally which could result in limiting in-patient numbers to the available staffing.</p>
<p>Gweithlu: Workforce:</p>	<p>This paper relates to adjustments to the staffing levels which have been calculated as being required across the acute adult medical and surgical wards and paediatric inpatient wards. The potential impact on the workforce of the calculations referenced within this paper are detailed in Appendix 1. It is anticipated that the Act will enable a positive impact on staff well-being</p>
<p>Risg: Risk:</p>	<p>There are financial and workforce risks associated with the outcome of the work described in this paper. The risks relate to the ability to both finance and recruit a sufficient workforce of RN/HCSWs. Alternatively, there is a risk of providing insufficient inpatient facilities to meet the</p>

	<p>population need if the number of in-patient beds is reduced to the levels that the current workforce/budgets can deliver: Having met the 'duty to calculate the nurse staffing level' as described within this paper, the risk now shifts to how best to respond to the revised calculations</p>
<p>Cyfreithiol: Legal:</p>	<p>The Act sets out the Board's overarching responsibilities and the Designated Person's specific responsibilities to calculate and maintain nurse staffing levels in S25B wards,</p> <p>The legal risk associated with calculating the nurse staffing levels relates not to the issues described within this paper (which relate to the duty to calculate the nurse staffing levels) but rather to the potential of noncompliance with the 'duty of maintaining the nurse staffing levels'. The 'duty to maintain the nurse staffing level' requires the financial and the workforce risks detailed above to be addressed, and this poses a more significant challenge than the duty to calculate described in this paper</p>
<p>Enw Da: Reputational:</p>	<p>The reputation of the nursing services and the effectiveness of the collaboration within the Health Board is enhanced through the level of engagement shown between the operational and corporate teams in ensuring that the statutory requirements relating to the Act are met.</p>
<p>Gyfrinachedd: Privacy:</p>	<p>Currently no impact in relation to privacy identifiable within this work</p>
<p>Cydraddoldeb: Equality:</p>	<p>No negative EqIA impacts identified</p>

Presentation of the Nurse Staffing Levels for Section 25B wards – Spring 2025 calculation Cycle

Health Board/Trust:	Hywel Dda UHB		
Period being reported on:	This report covers the changes that have been made to nurse staffing levels for wards covered by Section 25B (S25B) of the Nurse Staffing Levels (Wales) Act 2016 between Autumn 2024 and Spring 2025		
Number and identity of section 25B wards during the reporting period.	Appendix 1 of this report lists the nurse staffing levels for all wards that have been included under S25B of the NSLWA following the spring 2025 calculation cycle		
	Adult acute <u>medical</u> inpatient wards	Adult acute <u>surgical</u> inpatient wards	Paediatric inpatient wards
	18	12	2
	<ul style="list-style-type: none"> It is noted that although the number of medical wards included in this report is the same for Spring 2025 as to the number review in Autumn 2024, there has been a change to the configuration of one of the wards which impacts on some of the information within this report. During the Autumn 2024 calculation cycle Dyfi ward, BGH was a 28 bedded ward which included the Cardiac Monitoring Unit (CMU), however, the ward has now been split into a 16 bedded ward and a 12 bedded Cardiac Monitoring Unit (CMU). Section 25B of the Act does not apply to the CMU which now falls under Section 25A of the Act. Whilst Section 25B of the Act does not apply to CMU, a review of the nurse staffing levels has been undertaken following the triangulated methodology set out in the Act, but the workforce and finance implications are not included in this report. It is noted that there are two medical ward, (Ward 12, WGH and Y Banwy, BGH) who were included in the nurse staffing calculation in autumn 2024, but due to a change in the primary function of the ward, Section 25B of the Act no longer applies to these wards and although they are included in the finance calculations set out in this paper, will not be included in the workforce or finance calculations for any future reports. 		
	<p>In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster". It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment, however, these staff are not included within the data for this report.</p> <p>Although there is a process by which the budgets for the S25B wards are reset, where required, following each cycle has been agreed so that the changes from each cycle can be realised in a timely manner both in terms of the finance and workforce adjustments required 'in-year', which will ensure both budgetary and rostering stability and allow local 'grip and control' at team level. The changes agreed in the Spring 2024 and Autumn 2024 calculation cycles have not been transacted into the budgets. The Executive team took the decision to not transact the changes but to provide authorisation for the relevant wards to continue to use temporary staff.</p> <p>There was no change to the planned roster and required establishment for 27 of the adult medical/surgical wards and both paediatric wards, following the Spring 2025 calculation cycle.</p>		
	Adult acute medical inpatient wards	Adult acute surgical inpatient wards	Paediatric inpatient wards
Number of Wards	20	12	2

	RN (WTE)	HCSW (WTE)	RN (WTE)	HCSW (WTE)	RN (WTE)	HCSW (WTE)
Required establishment (WTE) calculated Autumn 2024 calculation cycle	361.61	368.84	213.82	215.13	57.68	22.55
WTE of required establishment funded following Autumn 2024 calculation cycle			212.32	202.23	57.68	22.55
Required establishment (WTE) calculated during Spring 2025 calculation cycle	343.72	362.8	212.99	215.96	57.68	22.55
WTE of required establishment funded following Spring 2025 calculation cycle					57.68	22.55
WTE Supernumerary band 7 sister/charge nurse (funded but excluded from planned roster)(Spring 2025 cycle)	18			12	3 (2 Supernumerary Band 7 on 1 ward)	

- During the Autumn 2024 calculation cycle Dyfi ward, BGH was a 28 bedded ward which included the Cardiac Monitoring Unit (CMU), however, the ward has now been split into a 16 bedded ward and a 12 bedded Cardiac Monitoring Unit (CMU). Section 25B of the Act does not apply to the CMU which now falls under Section 25A of the Act. Whilst Section 25B of the Act does not apply to CMU, a review of the nurse staffing levels has been undertaken following the triangulated methodology set out in the Act, but the workforce and finance implications are not included in this report.
- The variation between the calculated required establishment and the funded required establishment:
 - For the medical wards is
 - For the surgical wards is linked to a service change on Picton Ward due to changes to the gynae emergency pathway, the remaining HCSW requirement on the Enhanced Care Unit on Rhiannon Ward, BGH and the changes required to the required establishment because of changes in the proportion of long days worked.

Using the triangulated approach to calculate the nurse staffing level on section 25B wards

For each inpatient ward (both adult and paediatric) where S25B applies (i.e. defined by the Nurse Staffing Levels (Wales) Act (2016) as an adult acute medical/surgical inpatient ward or paediatric inpatient ward) a systematic process has been undertaken to review and recalculate the nurse staffing levels.

As with previous cycles, the Spring 2025 process has included detailed professional discussions with the nursing management structure (Senior Sister/Charge Nurse, Senior Nurse Manager and Head/Deputy Head of Nursing) for each ward to ascertain the total number of staff required to provide sufficient resource to deploy a staffing level appropriate to the individual ward, regardless of whether there was a proposed increase, decrease, or no change to the ward roster or required establishment. The core information discussed included:

- Current ward bed numbers and speciality, including any proposed service and/or patient pathway changes.
- Current nurse staff provision, including those that are not included in the core roster (e.g. supervisory ward manager, frailty/rehabilitation support workers, ward administrators etc).
- Patient acuity data for the previous 6 months. All S25B wards within the health board are now using the SafeCare module of the rostering system to capture the acuity data (SafeCare is the nationally agreed system for capturing this data).
- Care quality indicator data for the previous 12 months –consideration has been given to the pressure ulcers, medication errors and falls incidents in all wards as well as infiltration/extravasation injuries in the paediatric wards. In addition, complaints, and positive patient experience data was reviewed.

	<ul style="list-style-type: none"> • Infection prevention and control data. • Finance/workforce-related data - expenditure/utilisation of permanent/temporary staff. • Staffing related metric data – Performance & Development Review (PADR) compliance, mandatory training compliance and sickness. • National care standards, where they exist. • Patient flow/activity related data for the previous 12 months. • The extent to which the planned rosters have been met over the previous 6 months. <p>Workforce data relating to the proportion of staff working the 'long day' shift pattern is reviewed each calculation cycle as this impacts on the total establishment required against the planned roster and this, together with the 26.9% uplift required to manage absences related to annual leave, sickness and study leave, has been factored into the financial and workforce calculations required.</p> <p>Discussions with Designated Person: A summary for each ward was present by the Ward Manager, supported by the relevant Senior Nurse Manager and Head/Deputy Head of Nursing to the Designated Person, the Director of Nursing, Quality and Patient Experience (or nominated deputy) to ensure that the calculation made by the Designated Person was informed by the registered nurses within the ward and the nursing management structure where the nurse staffing level applies.</p> <p>The discussions with the Designated Person (or nominated deputy) took place between the 8th and 30th April 2025 (the specific date of each discussion is noted in the table in Appendix 1).</p> <p>The planned rosters set out in Appendix 1 are those agreed with the Designated Person as part of the Spring 2025 nurse staffing calculation cycle.</p>
Name of Designated Person:	Sharon Daniel , Director of Nursing, Quality and Patient Experience
Signature:	
Date:	

Finance and workforce implications.	<p>The Corporate Nursing Directorate facilitate the nurse staffing levels calculation process for S25B wards, on behalf of the Designated Person, who is responsible for calculating the number of nurses appropriate to provide patient-centred care that meets all reasonable requirements in that situation. A summary of the finance and workforce implications of the Spring 2025 calculation cycle are set out in this report.</p> <p>It is noted that there was no change to the nurse staffing levels (i.e. the planned roster and required establishment) for 27 of the adult medical/surgical wards and both paediatric wards, following the Spring 2025 calculation cycle (when compared to the planned rosters/required establishments agreed during the Autumn 2024 calculation cycle).</p> <p>The Spring 2025 calculation cycle has identified the following financial and workforce uplift requirements. The figures set out below includes the uplift required to deliver the roster as well the establishment for non-rostered staff who support the delivery of care e.g. e.g. supervisory ward manager, frailty/rehabilitation support workers, ward clerks.</p>
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Table 1: breakdown of uplift requirements							
	Additional requirements £		RN £	HCSW & Other £		RN WTE	HCSW & Other WTE
1a. Adult inpatient wards (BGH, GGH, PPH)	164,551		-68,885	233,436		-1.33	5.97
1b. Service change: Picton – HCSW Padarn Band 4 role Y Banwy – ward clerk	283,754		10,834	272,920		0.00	7.33
1c.– Service Change – Enhanced Care Unit/Rhiannon BGH	70,102		2,948	67,154		0.05	1.77
1d. Adult inpatient wards WGH	-89,262		-129,834	40,572		-2.69	1.04
2. Paediatric inpatient wards	433,348		-144,020	577,369		-2.53	13.43

1. Adult inpatient wards

1a BGH, PPH and GGH: As previously noted, the changes agreed in the Spring 2024 and Autumn 2024 calculation cycles have not been transacted into the budgets. The Executive team took the decision to not transact the changes but to provide authorisation for the relevant wards to continue to use temporary staff.

For those adult inpatient wards where the uplift requirements is via the 'nurse staffing funding' allocation, there is an **additional £164,551** required following the Spring 2025 cycle.

- A reduction of 1.33wte because of changes to the proportion of long days worked by our RN workforce.
- An additional 2.72wte on Steffan agreed in Spring 2024 due to patient acuity.
- an additional 2.72wte on Padarn ward, GGH, agreed in Autumn 2024 due to patient acuity.
- the additional 0.52wte HCSW is because of the change to the proportion of long days worked by our HCSW workforce.

As previously mentioned, the workforce data relating to the proportion of staff working the 'long day' shift pattern is reviewed each calculation cycle as this impacts on the total establishment required against the planned roster. There were five wards which required an amendment to the required establishment because of the proportion of long days' work following the Spring 2025 calculation cycle. The financing arrangements for the nurse staffing establishments must remain flexible enough to be able to respond to this ever-changing position as the balance between 'long day' and the more traditional 'early/late' shift pattern being worked is dependent on what our substantive staff choose to work.

The Director of Nursing, Quality & Patient Experience is due to meet with the relevant Clinical Care Group to discuss the finance and workforce implications of the Spring 2025 cycle.

1b. Service Change

There are three wards who require additional resources due to a change in the service being provided: an **additional** £283,754.

- Plcton ward, GGH – additional HCSW on night duty because of changes to the gynaecology emergency pathway during the Covid 19 pandemic, which remains unfunded.
- Padarn – the role of the Band 4 Assistant Practitioner who supports the respiratory treatment room activity.
- Y Banwy – the funding of the Band 7 ward manager and the funding of the ward clerk which do not appear to have ever been funded roles.

The Director of Nursing, Quality & Patient Experience is due to meet with the relevant Clinical Care Group to discuss the outcome of the Spring 2025 cycle and this will include the finance and workforce implications of these service changes. .

1c. Service Change - Enhanced Care Unit (PACU) Rhiannon Ward, BGH – although additional funding was allocated to the Enhanced Care Unit during 2024/25, there is still a deficit between the require establishment and the funded establishment of £70,102 (0.05wte RN and 1.77wte HCSW).

The Director of Nursing, Quality & Patient Experience is due to meet with the relevant Clinical Care Group to discuss the finance and workforce implications of the Spring 2025 cycle.

1d. WGH: The changes required to the rosters/required establishments for the adult inpatient wards in WGH show that there is a **reduction** of £89,262 required. The WGH position is set out separately to the other adult wards as WGH Unscheduled Care underwent a planned change in services during Q3 of 2024/25 and some of the changes have been picked up as part of the Spring 2025 calculation cycle. The changes in the Spring 2025 cycle include:

- There is a reduction of 5.45wte in the RN requirements on Ward 12, WGH
- There is an increase of 2.72wte in the RN requirements on Ward 4, WGH

The funding of the planned programme of changes is being met by the Care Group and the Director of Nursing, Quality & Patient Experience is due to meet with the Clinical Care Group to discuss the outcome of the Spring 2025 cycle.

2. Paediatric inpatient wards

An **additional** £433,348 is required following the spring 2025 calculation cycle for the paediatric wards. Since Section 25B of the Act came into effect for the paediatric wards (October 2021), the funding of the additional requirements has been met from within the Women and Children Directorate.

The Director of Nursing, Quality & Patient Experience is due to meet with the relevant Clinical Care Group to discuss the finance and workforce implications of the Spring 2025 cycle.

Conclusion & recommendations

The Quality, Safety and Experience Committee is asked Board is requested to take assurance that:

- Hywel Dda University Health Board (HDdUHB) is meeting its statutory 'duty to calculate' responsibility in respect of the nurse staffing level in all wards that fall under the inclusion criteria of Section 25B of the Nurse Staffing Levels (Wales) Act 2016.
- By presenting this report to QSEC, HDdUHB is meeting its statutory duty to provide a written update of the nurse staffing level of each individual ward (to which sections 25B to 25E of the Act pertain) to the Board (or delegated committee which received the nurse staffing levels updates on behalf of the Board) when there is a change of use/ service that has resulted in a changed nurse staffing level, or if the designated person deems it necessary (Paragraph 12).

Date summary presented to Quality, Safety & Experience Committee (on behalf of the Board)	Presented to Quality, Safety and Experience Committee on behalf of the Board 10 th June 2025
Date of annual presentation to the Board	

The number of staff per shift needs to be entered. The information should reflect the information on the informing patient template.

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within the data for this report. Further information is provided within the annual assurance report [INSERT HYPERLINK] on the additional multi-professional staff that contribute to the coordination and delivery of patient care.

Paediatric inpatient wards

The wards highlighted in yellow have seen a change to either their planned roster and/or required establishment during this calculation cycle (autumn 2024 cycle)

Name of Ward	Planned roster as stated within the annual presentation to the Board report - Autumn 2024				Required Establishment as stated within the annual presentation to the Board report (Autumn 2024) including uplift 26.9%		TOTAL WTE Band 7 supernumerary ward sister/Charge nurse	Planned roster as stated within the annual presentation to the Board report - Spring 2025				Required Establishment as stated within the annual presentation to the Board report (Spring 2025) including uplift 26.9%		TOTAL WTE Band 7 supernumerary ward sister/Charge nurse	Date designated person calculated the nurse staffing level	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of the biannual calculation cycle, and reasons for any changes made			
	Shift	RN (band 5 & 6)	HCSW Band 4	HCSW Band 2	TOTAL WTE RN (bands 5 & 6)	TOTAL WTE HCSW (bands 2,3 & 4)		Shift	RN (band 5 & 6)	HCSW Band 4	HCSW Band 2	TOTAL WTE RN (bands 5 & 6)	TOTAL WTE HCSW (bands 2,3 & 4)			Completed	changed	rationale	Completed (Yes/No)	Date	Changed	Rationale
WOMEN AND CHILDREN – PAEDIATRIC WARDS																						
Cilgeran/ HDU CGH	E				46.31 (including 16.34 Band 6)	18.29	2	E				46.31 (including 16.34 Band 6)	18.29	2	28.4.2025JCW on behalf of the designated person	yes	no					
	L							L														
	LD	9M-W10T&F 8S&S	1	2				LD	9M-W10T&F 8S&S	1	2											
	TW			1				TW			1											
N	8	1	2 (1S&S)	N	8	1	2 (1S&S)															
Angharad Ward, BGH	E				11.37 (including 5.69 WTE Band 6)	4.26	1	E	2			12.79 (including 6.4 WTE Band 6)	4.26	1	28.4.2025JCW on behalf of the designated person	yes	no					
	L							L	2													
	LD	2		1				LD			1											
	TW							TW														
N	2		1	N	2		1															

Total	57.68	22.55	3
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total	59.1	22.55	3
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The number of staff per shift needs to be entered. The information should reflect the information on the informing patient template.

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are Not included within the data for this report. Further information is provided within the annual

Adult inpatient Medical wards

The wards highlighted in yellow have seen a change to either their planned roster and/or required establishment during this calculation cycle

Name of Ward	Planned roster as stated within the annual presentation to the Board report -Autumn 2024				Required Establishment as stated within the annual presentation to the Board report (Autumn 2024) including uplift 26.9%		TOTAL WTE Band 7 supernumerary ward sister/Charge nurse	Planned roster as stated within the annual presentation to the Board report -Spring 2025				Required Establishment as stated within the annual presentation to the Board report (Spring 2025) including uplift 26.9%		TOTAL WTE Band 7 supernumerary ward sister/Charge nurse	Date Designated Person calculated the nurse staffing level	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of the biannual calculation cycle, and reasons for any changes made			
	Shift	RN (band 5 &6)	HCSW Band 4	HCSW Band 2	TOTAL WTE RN (bands 5 &6)	TOTAL WTE HCSW (bands 2,3 &4)		Shift	RN (band 5 &6)	HCSW Band 4	HCSW Band 2	TOTAL WTE RN (bands 5 &6)	TOTAL WTE HCSW (bands 2,3 &4)			Completed	changed	rationale	Completed (Yes/No)	Date	Changed	Rationale
Dyfi BGH Medical	E	2		2	31.51	20.61	2	E	1		1	14.45	17.06	1	28.4.2025 JCW on behalf of the designated person	yes	no	ward split june 2024				
	L	2		2																		
	LD	4		2																		
	TW																					
	N	5		3																		
Meurig BGH Medical	E	1		1	14.45	11.61	1	E	1		1	14.45	11.61	1	28.4.2025 JCW on behalf of the designated person	yes	no					
	L	1		1																		
	LD	2		1																		
	TW																					
	N	2		2																		
Ystwyth BGH Medical	E	1		2	19.9	19.54	1	E	1		2	19.9	19.54	1	30.4.2025 JCW on behalf of the designated person	yes	no	In addition to the roster, Ward has 3 WTE Rehab Support Worker				
	L	1		2																		
	LD	3		1																		
	TW			1																		
	N	3		3																		
Cadog GGH Medical	E	1		2	11.73	23.45	1	E	1		2	11.73	23.45	1	11.4.2025	yes	no	In additional to the roster ward has 3 WTE Frailty worker				
	L	1		2																		
	LD	1	1	2																		
	TW																					
	N	2		3																		
Dewi GGH Medical	E	1		2	14.45	20.73	1	E	1		2	14.45	20.73	1	14.4.2025 JCW on behalf of the designated person	yes	no	propotion of hcsw LD ^ spring 2025				
	L	1		2																		
	LD	2		2																		
	TW																					
	N	2		3																		
Gwenllian GGH Medical	E	1		1	17.17	22.62	1	E	1		1	17.17	22.62	1	14.4.2025 JCW on behalf of the designated person	yes	no	In addition to the roster, ward has 3 WTE Rehab Support Worker				
	L	1		1																		
	LD	2	1	3																		
	TW																					
	N	3		3																		
Padarn GGH Medical	E	1		1	14.45	17.17	1	E	1		1	14.45	17.17	1	14.4.2025 JCW on behalf of the designated person	yes	no	Spring 2022 - Changed to Service Model - 19 beds respiratory patients with up to 4 CPAP patients and procedure room (cost pressure) In addition to the roster there is 1 WTE Band 4 AP to support the treatment room. Autumn 2024 additional hcsw night				
	L	1		1																		
	LD	2		2																		
	TW																					
	N	2		3																		

The number of staff per shift needs to be entered. The information should reflect the information on the informing patient template.

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within the data for this report. Further information is provided within the annual assurance report [INSERT HYPERLINK] on the additional multi-professional staff that contribute to the coordination and delivery of patient care.

Adult inpatient surgical wards

The wards highlighted in yellow have seen a changed to either their planned roster and/or required establishment during this calculation cycle

Name of Ward	Planned roster as stated within the annual presentation to the Board report - Autumn 2024				Required Establishment as stated within the annual presentation to the Board report (Autumn 2024) including uplift 26.9%		TOTAL WTE Band 7 supernumerary ward sister/Charge nurse	Planned roster as stated within the annual presentation to the Board report - Spring 2025				Required Establishment as stated within the annual presentation to the Board report (Spring 2025) including uplift 26.9%		TOTAL WTE Band 7 supernumerary ward sister/Charge nurse	Date Designated Person calculated the nurse staffing level	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of the biannual calculation cycle, and reasons for any changes made				
	Shift	RN (band 5 & 6)	HCSW Band 4	HCSW Band 2	TOTAL WTE RN (bands 5 & 6)	TOTAL WTE HCSW (bands 2,3 & 4)		Shift	RN (band 5 & 6)	HCSW Band 4	HCSW Band 2	TOTAL WTE RN (bands 5 & 6)	TOTAL WTE HCSW (bands 2,3 & 4)			Completed	Changed	rationale	Completed (Yes/No)	Date	Changed	Rationale	
Ceredig BGH Surgery	E	1		1	21.67	21.67	1	E	1		1	21.67	22.5	1	28.4.2025 JCW on behalf of the designated person	yes	no						
	L	2		1				L	2		1												
	LD	3		3				LD	3		3												
	TW		1					TW															
	N	3		3				N	3		4												
Rhiannon BGH Surgery	E	1		1	11.61	11.61	1	E	1		1	11.61	11.61	1	28.4.2025 JCW on behalf of the designated person	yes	no						
	L	1		1				L	1		1												
	LD	1		1				LD	1		1												
	TW							TW															
	N	2		2				N	2		2												
Teifi GGH Surgery	E	2		2	23.45	34.35	1	E	1		2	22.62	34.35	1	9.4.2025 JCW on behalf of the designated person	yes	no	proportion of RN LD spring 2025					
	L	2		2				L	1		2												
	LD	2	1	4				LD	3	1	4												
	TW							TW															
	N	4		5				N	4		5												
Cleddau GGH Surgery	E	1	1	1	12.67	18	1	E	1	1	1	12.67	18	1	9.4.2025 JCW on behalf of the designated person	yes	no	funded establishment is for 17 beds. Service Change for the ward to work at 21 beds + 2 triage spaces. Total WTE includes 3.55 WTE Band 4 See below comment entered for Derwen					
	L		1	1				L		1	1												
	LD	2		3				LD	2		3												
	TW							TW															
	N	2		2				N	2		2												
Derwen GGH Surgery	E	1		1	17.17	19.9	1	E	1		1	17.17	19.9	1	9.4.2025 JCW on behalf of the designated person	yes	no	In additional to the roster ward has 3 WTE Frailty worker to work across Derwen & Cleddau					
	L	1		1				L	1		1												
	LD	2	1	2				LD	2	1	2												
	TW							TW															
	N							N															
Merlin GGH Surgery	E	1		1	19.9	11.73	1	E	1		1	19.9	11.73	1	14.4.2025 JCW on behalf of the designated person	yes	no						
	L	1		1				L	1		1												
	LD	3		1				LD	3		1												
	TW							TW															
	N	3		2				N	3		2												
Preseli GGH Surgery	E	1		1	11.73	11.73	1	E	1		1	11.73	11.73	1	11.4.2025	yes	no						
	L	1		1				L	1		1												
	LD	1		1				LD	1		1												
	TW							TW															
	N	2		2				N	2		2												
Picton GGH Surgery	E	1		1+(1x 9-5 Thu)	11.98	9.2	1	E	1		1+(1x 9-5 Thu)	11.98	9.2	1	28.4.2025 JCW on behalf of the designated person	yes	no						
	L	1		1				L	1		1												
	LD	1		1				LD	1		1												
	TW	1x 9-5 Thu						TW	1x 9-5 Thu														
	N							N															

Acuity

- On May 13th 2024 the Frailty Pathway became operational, and the acuity levels reduced to Level 1/2/3

Cadog Ward

- The speciality changed from general Frailty Ward to a 6 bedded Frailty Assessment Unit (FAU) and Cadog Short Stay Frailty Ward.



November / December 2024 saw increase in Level 4/5 patients



Lack of longer stay frailty beds due to complex Discharge to Assess Pathway.



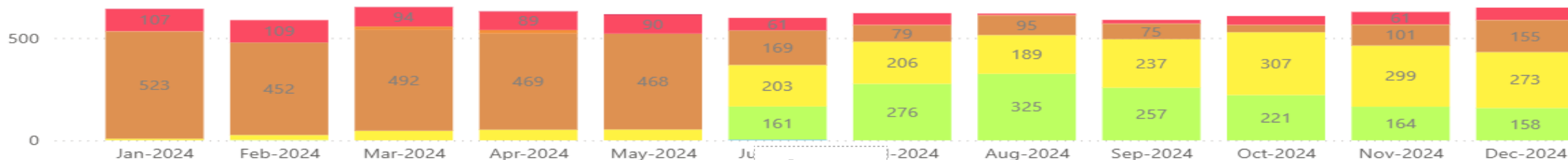
Patients of varying acuity levels admitted to FAU/Cadog ward at times of site escalation



Standard Operating Procedure under review

Number of Patients Receiving Level 1-5 Care

● Level 1 ● Level 2 ● Level 3 ● Level 4 - HCSW ● Level 4 - RN ● Level 5 - HCSW ● Level 5 - RN



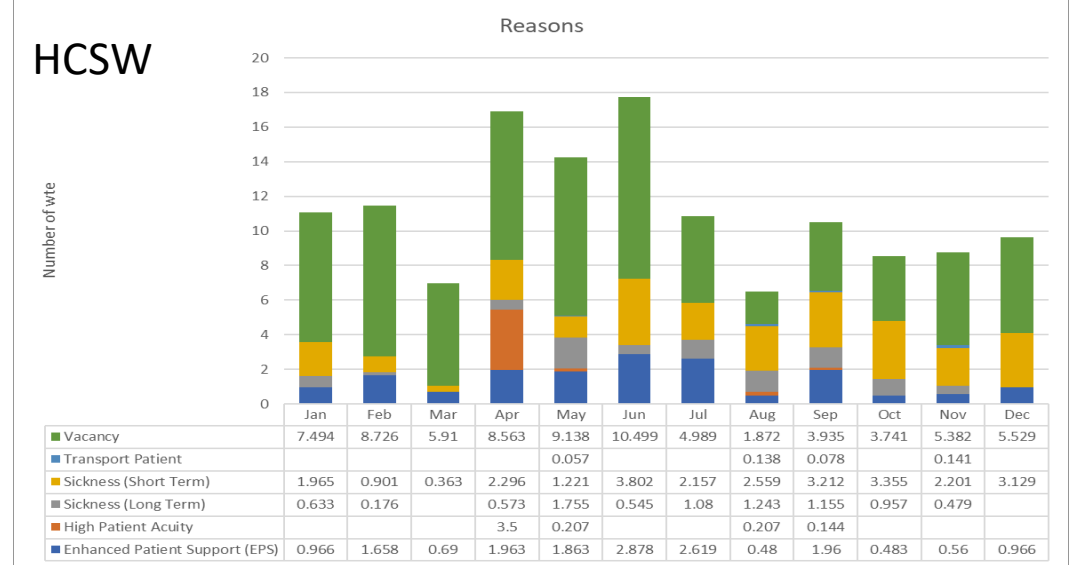
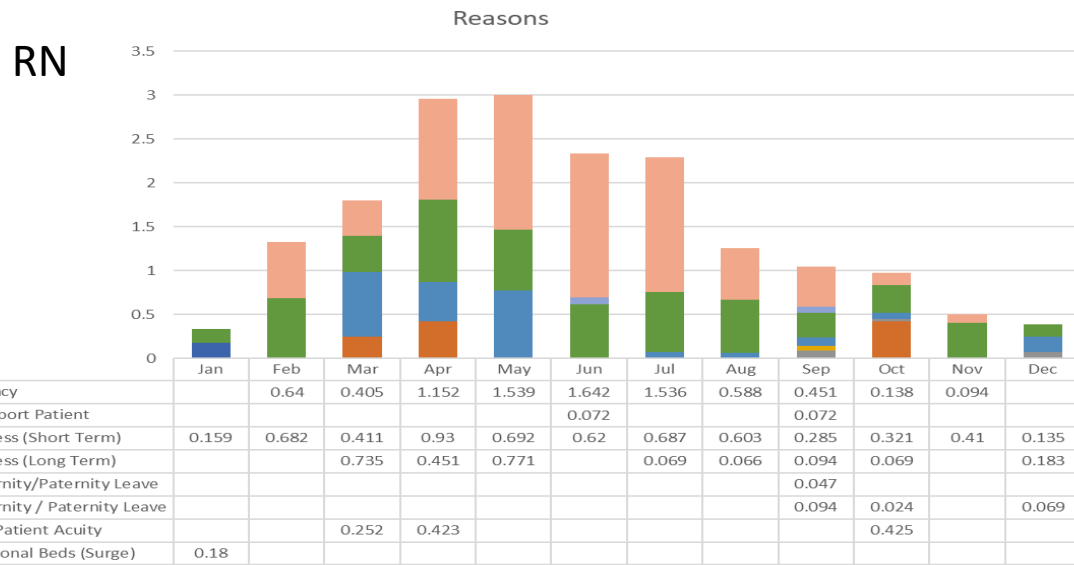


• Actions

- Staff have undergone training using safe care system, WLOC & red Flags .
- Working in New Ways to maintain patient safety eg change of Ward routine
- The booking of temporary staff Standard Operating Procedure (SOP)
- Using Red flags to highlight staffing deficits appropriately and actions recorded.
- Risk assessment and redeployment of staff.
- Staff training in Frailty & Reducing restrictive Practice – Reduced Enhanced Patient Support required.
- Signposting to SNM & CSM escalation process
- Signposting to Critical Care Outreach Team if escalation required .
- Staff from adjusted Ward Supporting .
- Escalate in twice daily Patient Flow Meetings .

Month	Total number of shifts	Shifts where planned roster met and appropriate	Shifts where planned roster met but not appropriate	Shifts where planned roster not met but appropriate	Shifts where planned roster not met and not appropriate	Data completeness	Shifts where planned roster met but no appropriateness recorded	Shifts where planned roster not met and no appropriateness recorded					
Planning total	1191	35.68%	425	26.45%	315	9.49%	0%	299	96.73%	2.69%	32	0.59%	7

Significant reduction in RN agency/bank use & HCSW bank use for enhanced patient support



Fully recruited in all staff groups

Very successful recruitment and development of international nurses

Student Nurse Management placement

Pathway four work experience student

Apprenticeship Programme

Grow your own Nursing Students

Work Experience

Staff development e.g. STAR, LEAP, Frailty

Retention – Flexible Working Policy, Staff Wellbeing, PDR & Managing Attendance Policy

Patient Flow – Length of Stay (LOS)

Average length of stay

Cadog – 13.09 days

FAU – 6.82 days

-
- Frailty Pathway
 - TUEC – Goal 5 - Discharge Planning From Day 1
 - Actions to Prevent Deconditioning
 - Early MDT involvement
 - Board Rounds
 - Criteria Lead Discharge
 - Impacted by long stay frailty bed availability



Spring 2025

PD	2
Falls	25
Medication	3

Autumn 2024

PD	1
Falls	86
Medication	5

Ward initiatives

- ✓ Baywatch
- ✓ Reducing restrictive practice
- ✓ Exercise Station

Reducing Deconditioning

- ✓ Arts for Dementia patient Sessions
- ✓ Daytime Activities eg VE day celebrations
- ✓ Cwtch Cadog (Nutrition & Hydration)
- ✓ Milkshake rounds & Hydration & Snack Station
- ✓ Volunteers
- ✓ Team around





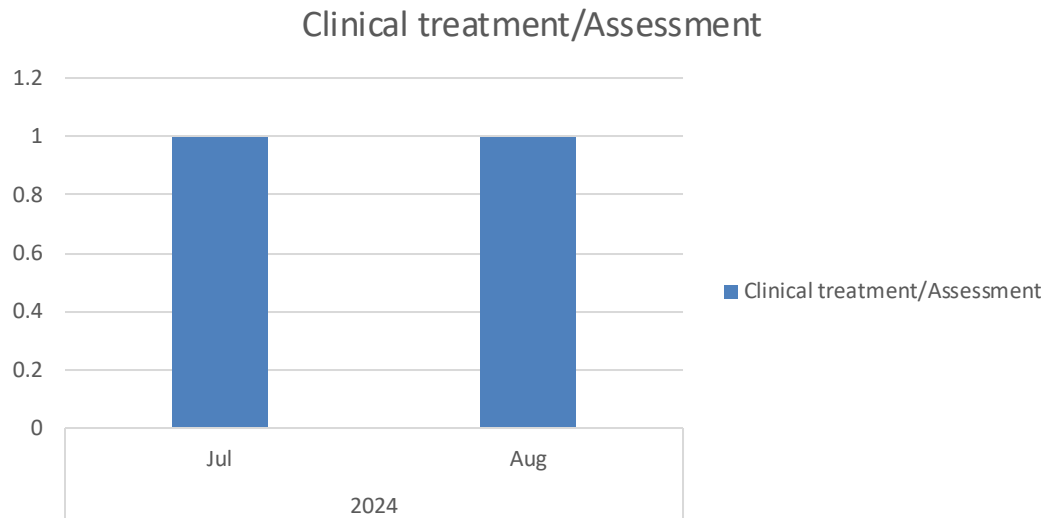
Team Around The Patient

- Frailty support worker role development
- Introduction of assistant practitioner role
- Frailty ANP
- Frailty Consultant
- Therapies
- MDT Board Rounds , Safety Huddles and daily Frailty meetings

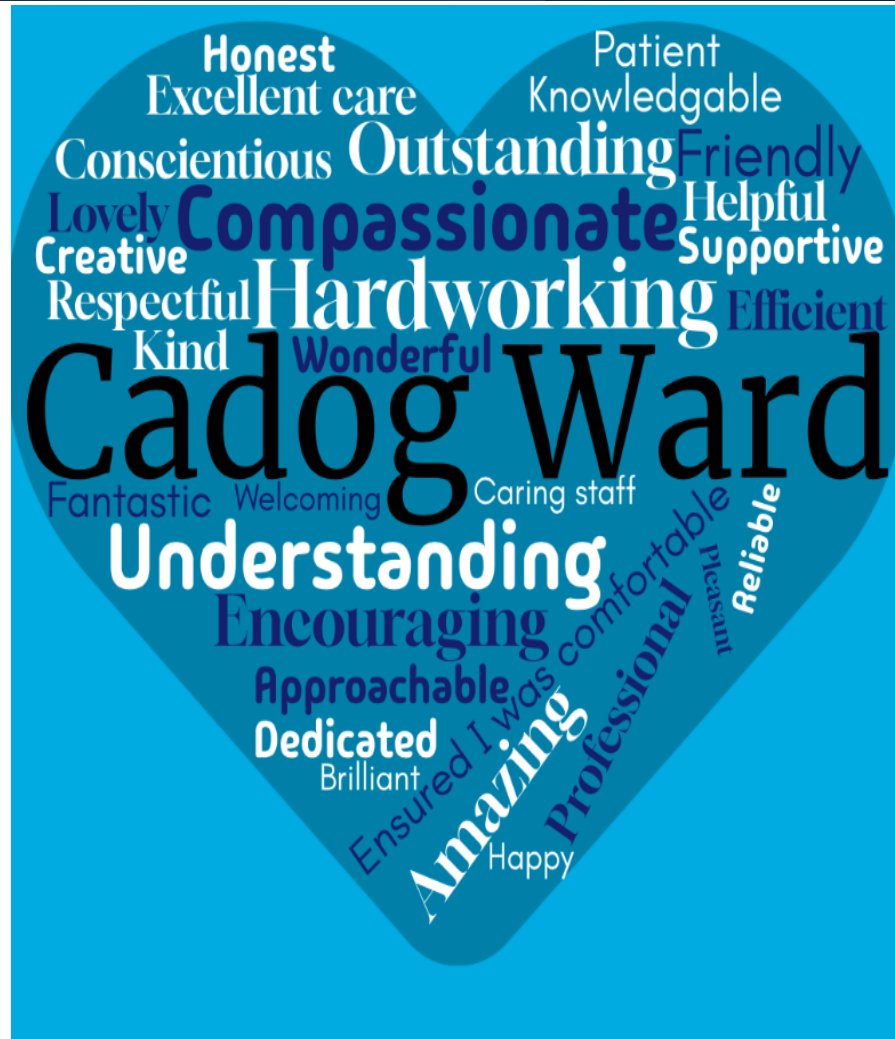


Concerns & Compliments

We really can't express how much the ward's support meant to us as a family



- Visible leadership .
- 7 day Sister Cover.
- Team Around The Patient Approach .
- Early Resolution.



So grateful to staff that worked tirelessly to ensure our mother went home to receive end of life care as per her wishes it

Staff are wonderful despite the pressure they are under



Electronic Staffing Record (ESR) data (as of 30.4.25)

Staff Sickiness

RN

Department, Ward or Team	Staff Headcount	Latest in-month sickness	Latest long term sickness	Latest short term sickness	12 month rolling sickness
CAR GGH Cadog Ward	15	9.8%	6.4%	3.4%	6.1%

HCSW

Department, Ward or Team	Staff Headcount	Latest in-month sickness	Latest long term sickness	Latest short term sickness	12 month rolling sickness
CAR GGH Cadog Ward	32	8.0%	0.7%	7.3%	10.9%

PADR

RN

Location	Staff	PADR
GGH Cadog Ward	15	93.3%

Location	Headcount	Core skills
GGH Cadog Ward	15	94.4%

HCSW

Location	Staff	PADR
GGH Cadog Ward	31	64.5%

Location	Headcount	Core skills
GGH Cadog Ward	32	88.5%

Working with ESR team to update individuals who are on ESR but have left the ward – of the number currently working on Cadog, 4 out of a total of 49 staff members are currently due/overdue a PADR

ROYAL COLLEGE OF NURSING IN WALES
NURSE OF THE YEAR
AWARDS

Registered Nurse - Adult Award

Winner



Donna Major

Senior Ward Sister
Hywel Dda University Health Board



Sponsored by Powys Teaching Health Board



**RCN
Nurse of the Year
(RN)**

Achievements

**Welsh
Language
Award**



**Nutrition &
Hydration
Winner**



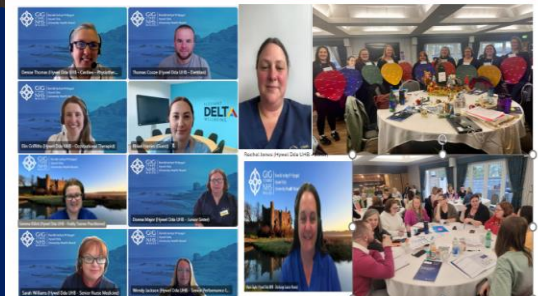
**Education
Award**



EQiP



Meet the Project Team



5 - Risks and Matters for Escalation to Board

*Anna Lewis (Hywel
Dda UHB -
Independent Board
Member)*

6

6 - For Information

6.1

6.1 - QSEC Work Plan 2025/26

Attachments

[Draft QSEC Work Programme 2025 26 \(3\).pdf](#)

QUALITY SAFETY & EXPERIENCE COMMITTEE WORK SCHEDULE APRIL 2025 – MARCH 2026

Currently, Quality Safety & Experience Committee (QSEC) meets bi-monthly. Based on this, the following table represents a proposal to incorporate the duties as outlined in the Committee's Terms of Reference into a basic work programme April 2025 – March 2026

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2025	10 June 2025	15 August 2025	8 October 2025	5 December 2025	13 February 2026
Governance								
Welcome and Apologies	Chair	All	✓	✓	✓	✓	✓	✓
Declarations of Interests	Chair	CSO	✓	✓	✓	✓	✓	✓
Minutes from Previous Meeting and Matters Arising not on Agenda	Chair	CSO	✓	✓	✓	✓	✓	✓
Table of Actions (ToA)	Chair	CSO	✓	✓	✓	✓	✓	✓
Review of Terms of Reference (TORs)	Chair	CSO		✓				
Annual Review of Sub Committees TORs	Chair	CSO		✓				
Self-Assessment - Six month review of actions August 2026	Chair	JW			✓			
Patient/Staff Story	LOC/ Service Leads		✓ Urgent and Emergency Care	✓	✓	✓	✓	✓

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2025	10 June 2025	15 August 2025	8 October 2025	5 December 2025	13 February 2026
Policies for Approval (as required)	All	All		✓	✓	✓	✓	✓
Targeted Intervention Progress Report - TBC	SA	Executive Leads	✓	✓	✓	✓	✓	✓
Assurance								
Annual Report on Committee's Activity	AL/SD	All	✓					
Annual Report from Sub-Committees	SD	SD LOC		✓				
Fragile Service Update Report (TI 32, 33, & 35)	SD	SG/CS			✓			
Clinical Audit Outcome Reviews	SD	TBC						
Patient Experience Framework	SD	LOC		✓				
Learning Framework Report (TI 48)	SD	CS			✓			
Allied Health Services Deep Dive	AC	SQ		✓				
Getting it Right First Time Governance Review	JW	JW		✓				

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2025	10 June 2025	15 August 2025	8 October 2025	5 December 2025	13 February 2026
Duty of Quality Assurance Report incorporating: <ul style="list-style-type: none"> • External Inspection and peer reviews (TI34 & 52) • Nurse Staffing Act Assurance (every 6 months) • Walkrounds (a thematic review on 6 month basis) • Quality Improvement outcomes (TI 53) • Quality Impact Assessments (TI 32, 33) • Putting things right (TI 51) • HCAI (TI 50) • Duty of Candour (TI 54) • Learning from significant events • Speaking Up reports on quality themes (every 6 months) • Paediatrics Service Changes BGH • WHC's overview (every other meeting) (TI 52) 	SD	CS	✓	✓	✓	✓	✓	✓
Unscheduled Emergency Care Deep Dive including GIRFT Reports and Action Plans	AC	PS	✓			✓		
Mental Health and Learning Disabilities Deep Dive	AC	RTP	✓					
Primary Care Quality and Safety and Experience Deep Dive	JP	RB	✓					
Auditor General Report on Cancer Services	AC	LH		✓				
Infection Prevention and Control in the Community	AG	MH	✓		✓			

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2025	10 June 2025	15 August 2025	8 October 2025	5 December 2025	13 February 2026
Update Report on the Quality Improvement Strategic Framework 2023- 2026	SD	MD	✓					
Duty of Candour Annual Report 2024/25	SD	CS		✓				
Duty of Quality Annual Report 2024/25					✓			
Nurse Staffing Levels (Wales) Act: Assurance Reports (as required) –Annual Report 2024/25 and Spring Calculation Cycle	SD	HH		✓		✓		
Nurse Staffing Levels Impact of Reduction of Agency and Bank Staff on quality, safety and patient experience annual review report	SD	HH			✓			
CHKS Report	MH	MH		✓				
Cleanliness Standards Audit report and Action Plan	JS	SC/ EB		D	✓			
Outcome from Maternity Business Care – Date tbc	AC	CL						
Occupational Therapies Paediatric Improvement action plan	AC	PG		D	✓			
Risks								
Corporate Risks Assigned to QSEC	Executive leads	RW (report author)		✓	✓		✓	

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2025	10 June 2025	15 August 2025	8 October 2025	5 December 2025	13 February 2026
Sub Committee Update Reports								
Quality, Safety and Experience	✓	✓	✓	✓	✓ TOR for Annual Review	✓	✓	✓
Listening and Learning:	✓	✓	✓	✓	✓	✓	✓ TOR for Annual Review	✓
For Information								
HIW Annual Report							✓	
JCC Quality Safety Outcomes Sub Committee			✓	✓	✓	✓	✓	✓
Work plan 2025/26			✓	✓	✓	✓	✓	✓
Patient Experience Report			✓	✓	✓	✓	✓	✓
Agenda setting meeting with Chair and Exec Lead to include discussion on deep dives on new risks (at least 6 weeks before the meeting)								
Agenda setting meeting with Chair and Exec Lead to include discussion on deep dives on new risks (at least 6 weeks before the meeting)	CSO	CSO	✓	✓	✓	✓	✓	✓
Draft agenda to go to Executive Team prior to being issued.	CSO	CSO	✓	✓	✓	✓	✓	✓
Call for papers (at least 4 weeks before the meeting to receive papers at least 14 days before the meeting)	CSO	CSO	✓	✓	✓	✓	✓	✓
Disseminate agenda and papers 7 days prior to the meeting	CSO	CSO	✓	✓	✓	✓	✓	✓
Type up minutes and TOA within 7	CSO	CSO	✓	✓	✓	✓	✓	✓

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2025	10 June 2025	15 August 2025	8 October 2025	5 December 2025	13 February 2026
days of the meeting								
Circulate minutes and TOA to Committee for comments, points of accuracy and matters arising within 10 days of the meeting	CSO	CSO	✓	✓	✓	✓	✓	✓
Check and send final version of minutes to the Committee Chair following comments received.	CSO	CSO	✓	✓	✓	✓	✓	✓
Chase updates on TOA before the next meeting and RAG rate	CSO	CSO	✓	✓	✓	✓	✓	✓
Record and track the TOA as part of the decision tracker	CSO	CSO	✓	✓	✓	✓	✓	✓
Produce written update report for QSEC and Board	CSO	CSO	✓	✓	✓	✓	✓	✓
Prepare schedule of meetings	CSO	CSO					✓	
QSEC Annual Work Programme	CSO	CSO	✓	✓	✓	✓	✓	✓

Initials

SD- Sharon Daniel	CSO-Katie Lewis	AL- Anna Lewis	LOC- Louise O'Connor	MH- Mark Henwood
AC- Andrew Carruthers	CL: Cerian Llewellyn	CS- Cathie Steele	SG- Subhamay Ghosh	JS- James Severs
HH- Helen Humphreys	CG- Ceri Griffiths	KJ- Keith Jones	RW- Rachel Williams	AG- Ardiana Gjini
KG- Kathy Greaves	GRD- Gail Roberts Davies	CL- Caroline Lewis	Ps: Peter Skitt	SC: Simon Chiffi
BL- Bethan Lewis	LC- Liz Carroll	SA- Shaun Ayres	MD- Mandy Davies	LH- Lisa Humphreys

6.2

6.2 - Joint Commissioning Committee Quality and Safety Highlight Report

Attachments

[6.2.1 QSO Highlight Report March 2025.pdf](#)

Agenda Item

6.2.1

Joint Commissioning Committee

Quality Safety and Outcomes Sub-Committee Highlight Report

Dyddiad y Cyfarfod / Date of Meeting	20/05/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Maxine Evans, Interim Corporate Governance Officer
Cyflwynydd yr Adroddiad / Report Presenter	Mandy Rayani, Lay Member
Noddwr yr Adroddiad / Report Sponsor	Carole Bell, Director of Nursing and Quality

Pwrpas yr Adroddiad / Report Purpose	For Noting Choose an item.
---	-------------------------------

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
N/A		Choose an item.

1. SITUATION/BACKGROUND

This report had been prepared to provide a summary of the key issues considered by the Joint Commissioning Committee Quality, Safety and Outcomes sub-committee at its meeting on 31 March 2025.

Key highlights from the meeting are reported in Section 3.

2. PURPOSE

The Purpose and Role of the Joint Committee and the sub-committees are set out in Paragraphs 2.18 and 2.20 of the JCC [Standing Orders](#).

The Quality and Safety Outcomes Committee Terms of Reference can be found [here](#).

3. HIGHLIGHT REPORT

RAG Rating	Highlight
Alert / Escalate	<ul style="list-style-type: none"> Members commented on the importance of developing a video tour for the Mother and Baby Unit and agreed to highlight this in the Chairs report, and to provide feedback to the HB that provides this service.
Advise	<ul style="list-style-type: none"> Members were advised that further work was being undertaken on the Quality Newsletter to align it with the JCC communications strategy. This was close to being completed and will be referred to as a Quality Bulletin. Members received an update on the escalation status of the Paediatric Critical Care Unit (PCCU) and the Neonatal Intensive Care Unit (NICCU) at the Children’s Hospital for Wales. The following points were noted: <ul style="list-style-type: none"> Improvements in the governance structure including key appointments and regular meetings to ensure clearer oversight and accountability. Introduction of a dashboard to accurately capture activity and cot availability. Key improvements demonstrated in neonatal mortality and national benchmarking in areas such as retinopathy, prematurity screening and infection rates. Positive feedback from patient and families highlighting the improvements in care and the importance of ongoing work to maintain these improvements. Clear expectations and requirements for de-escalation improved understanding of what was being asked and once established the service was able to provide the necessary information and assurance. Members received the Welsh Kidney Network (WKN) report which provided a briefing on the current Quality and Patient Safety issues within the WKN commissioned services. The following points were noted: <ul style="list-style-type: none"> Oxa 48 e-coli infection identified on a kidney ward and the challenges related to this outbreak. Although this primarily affects kidney patients, it may become a broader infection control concern. It was noted that the environment had been a contributing factor. An

RAG Rating	Highlight
	<p>infection prevention and control meeting is arranged to discuss and agree a consistent approach across Wales.</p> <ul style="list-style-type: none"> ○ The WKN meetings with the three providers of BCUHB, CVUHB and SBUHB and how the wider JCC will be made aware and kept informed of this issue. This would be highlighted in the QSO Chairs report to the JCC. ○ The diversity of dialysis providers and whether this poses any challenges in terms of applying a uniform approach to protocols and standards. It was confirmed that the renal community work very closely, sharing clinical input and that infection prevention and control issues are driven by the clinical teams within the renal centres. <ul style="list-style-type: none"> ● The Director of Commissioning for Specialised Services provided updates on various specialist services including: <ul style="list-style-type: none"> ○ The continued challenges in engagement with Salford Royal Hospital obesity services. This will continue to be escalated. Meanwhile, additional capacity has been secured in South Wales. ○ Improvements in plastic surgery waiting times, the data for March 2025 was still pending, but the target of 104 weeks is likely to be achieved. There was insufficient capacity to make any significant in-roads into achieving 52 weeks targets. ○ Prostate-Specific Membrane Antigen (PSMA) due to the ongoing production challenges with Positron Emission Tomography Imaging Centre (PETIC) in CVUHB. A clinical update was provided advising that undertaking clinical revalidation with all the PMSA PET requests has been agreed with a view to shared decision making, noting that these scans were not mandated according to NICE guidance, therefore, the suggested triage involves categorising patients into high, intermediate, and lower risk groups. This positive progress was welcomed. ○ South Wales Specialist Auditory Implant Device Service and the continued lack of progress. This will form part of a broader conversation however there was an action plan in place and the requirements were more visible. ● A report for the Commissioning for Ambulance and 111 services was received. The quality and safety dashboard, which includes high-level reports on quality domains was highlighted. In addition: <ul style="list-style-type: none"> ○ The establishment of a new clinically led 'National Ambulance Patient Handover Improvement Implementation Group.' The work of this group will be

RAG Rating	Highlight
	<p>a key enabler in supporting the JCC in reducing its emergency ambulance services associated risks around utilisation of capacity.</p> <ul style="list-style-type: none"> ○ The new ambulance performance framework and introduction of new categories was noted which included a purple category for incidents of cardiac and respiratory arrest. ○ High rate of 111 call abandonments and whether the service can cope with demand. The JCC has yet to assess whether it provides sufficient or effective call handling and clinical capacity as a formal strategic demand and capacity review of the 111 system has not yet been conducted. A detailed analysis of the GDPR breaches within the Ambulance and 111 report was requested to understand the causes. ○ A deep dive on Ambulance services, including a patient story, was scheduled for June 2025 where several issues can be addressed. <ul style="list-style-type: none"> ● The Director for Mental Health and Vulnerable Groups report was presented. The following points were highlighted: <ul style="list-style-type: none"> ○ Improvements in High Secure services through the introduction of positive interaction program (PIP) at Ashworth, reducing long-term segregation numbers, noting that Broadmoor and Rampton were implementing similar strategies. ○ Environmental issues at Caswell Medium Secure Unit and Ty Llewellyn, including lack of seclusion facilities. SBUHB has appointed an independent assessor to undertake an independent review of their mental health services. The JCC needs to stay cited on the work of this review to help with informing strategic commissioning decisions. ○ Inpatient numbers have risen within eating disorder services. Noting ongoing discussions to enhance gatekeeping processes. ○ Plans for two newly commissioned perinatal beds for North Wales patients located in Chester, by October 2025.
Assure	<ul style="list-style-type: none"> ● Members heard a story from a patient's specific experience of the Tonna Mother and Baby Unit stating the challenges she faced as a mother with physical health disabilities. It was noted that the Unit worked hard to address the environment and accessibility issues and the staff's willingness to listen and adapt. To minimise anxiety for patients, the Unit is now planning to produce booklets with

RAG Rating	Highlight
	<p>photographs of the unit and to introduce phone calls between staff and patients prior to admission to discuss and prepare for their stay. A video tour was also planned, however due to resources this has not been possible. The Chair thanked her for her sharing her personal story and wished her well for the future.</p> <ul style="list-style-type: none"> • Members received the risk register as at 31 January 2025, highlighting the risks relating to the Quality Safety and Outcomes assigned for monitoring and scrutiny purposes. The following areas were highlighted: <ul style="list-style-type: none"> ○ Cardiac Device Services, the Chair inquired whether this risk was specific to North Wales or if it represented a broader issue concerning engagement within the service. It was clarified that the service was safe, and the engagement issues relate to the provider. The risk was likely to be resolved by the next meeting. ○ Paediatric Intensive Care Beds and Neonatal Infection Control which had been covered in the earlier presentation. Whilst these remain on the Risk Register as risks scoring 20, these should also be updated by the time of the next meeting. It was noted however there appeared to be some underlying issues that could be related to the environment. The infections rates appeared to be higher than national averages despite good compliance with infection control measures. ○ Neurosurgery Sustainability, noting that this risk had been de-escalated from 16 to 8. It was queried if this was premature as the funding had been allocated but the overall sustainability of the service was dependent on successful recruitment. The matter around when a risk is mitigated from a commissioner perspective and becomes a provider risk/issue was discussed. It was suggested that this topic could be addressed in a JCC strategy session since the JCC still needed to conclude their discussions around risk appetite. ○ C&VUHB Neurosciences Staffing issues/level was queried as the description around the risk being addressed by the rehabilitation strategy was due for consideration by the JCC in Quarter three 2024/2025 but this has now passed. It was agreed to review this outside of the meeting and provide an update at the next meeting.
Inform	<ul style="list-style-type: none"> • The forward plan of business for the next twelve months was presented noting that it was a work in progress and would be used to support Agenda planning for future meetings.

RAG Rating	Highlight
	<ul style="list-style-type: none"> A report outlining recent incidents and concerns reported to the JCC from provider and commissioned services covering the period January 2025 – February 2025 was received. An update on the Regulator Report (Healthcare Inspectorate Wales (HIW) / Care Quality Commission (CQC) regulatory activity was provided noting the ongoing collaboration with HIW to improve reporting and assurance processes.
Appendices	None

4. ASSESSMENT

Objectives / Strategy	
Dolen i Amcan (au) Strategol CBC Link to JCC Strategic Objectives(s)	Improve Equity and Population Health
	Ensure Quality
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	A More Equal Wales
Dolen i Hwyluswyr Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality</i> (Duty of Quality Statutory Guidance (gov.wales))	Whole-systems Perspective
	If more than one applies please list below:
Dolen i Feysydd Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality</i>	Person Centred
	If more than one applies please list below: Equitable

(Duty of Quality Statutory Guidance (gov.wales))	
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
	Outcome:	If no, please include rationale below: N/A
Cydraddoldeb <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /</i> Equality <i>Have you undertaken an Equality Impact Assessment Screening?</i>	Yes: <input checked="" type="checkbox"/>	No: <input checked="" type="checkbox"/>
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please include rationale below: N/A
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Joint Committee as a result of the activity outlined in this report.	
Effaith Adnoddau <i>(Pobl /Ariannol) /</i> Resource Impact <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.	

5. RECOMMENDATIONS

The Joint Committee is asked to:

- **Note** the highlights outlined in Section 3 of this report.

7

7 - Date of Next Meeting : 14 August 2025