UNAPPROVED MINUTES OF THE QUALITY, SAFETY AND EXPERIENCE COMMITTEE MEETING

DATE OF MEETING: **9:30 AM, Thursday 11 June 2026**

VENUE: **Tresaith Meeting Room, Corporate Headquarters, Picton Terrace/Microsoft Teams Meeting**

PRESENT:
Eleanor Marks (Chair of the Committee and Vice Chair of the Health Board)
Michael Imperato (Independent Member)
Chantal Patel (Independent Member)
Neil Prior (Independent Member)

IN ATTENDANCE:
Sharon Daniel (Executive Director of Nursing, Quality and Patient Experience) (Lead Executive Director)
Mark Henwood (Executive Medical Director)
Andrew Carruthers (Chief Operating Officer)
James Severs (Executive Director of Allied Health Professions and Health Science)
Ardiana Gjini (Executive Director of Public Health)
Nadine Gould (Deputy Director of Nursing, Quality and Patient Experience)
Cathie Steele (Interim Assistant Director of Nursing Assurance and Safeguarding)
Miranda Metha (Llais Cymru/Citizens Voice Body Representative) (VC)
Louisa Morris (Clinical Director for Clinical Effectiveness) (VC)
Charlotte Wilmshurst (Assistant Director of Assurance and Risk)

Ian Bebb (Clinical Audit Manager) (VC) (part)
Karen Brown (Associate Medical Director – CIMCG) (VC) (part)
Caroline Burgin (Patient Safety and Assurance Manager) (VC) (part)
Liz Carroll (Service Director – Mental Health and Learning Disabilities Clinical Care Group) (VC) (part)
Anna Chiffi (Assistant Director of Nursing, Patient Safety and Quality) (VC) (part)
Paula Goode (Service Director for Planned and Specialist Care) (VC)
Andrew Homfray (Interim Service Delivery Manager) (VC) (part)
Helen Humpries (Head of Nursing for Professional Standards and Regulation) (VC) (part)
Amorelle Jones (Ophthalmology Service Delivery Manager) (VC) (part)
Bethan Lewis (Assistant Director of Public Health Strategic Business and Operations) (VC) (part)
Julia McCarthy (Head of Long Term Care) (VC) (part)
Miranda Metha (Llais Cymru/Citizens Voice Body Representative) (VC)
Dana Scott (Director of Midwifery and Professional Governance for Women and Children) (VC)
Anne Simpson (Head of Strategic Commissioning) (VC) (part)
Peter Skitt (Clinical Care Group Service Director – Community and Integrated Medicine) (VC) (part)
Rebecca Temple-Purcell (Assistant Director of Nursing, Patient Safety, Quality and Experience) (VC) (part)
Charlotte Wilmshurst (Assistant Director of Assurance and Risk)

John Jenkins (Hywel Dda UHB - Committee Services Officer) (Secretariat)

MINUTES REF.	ITEM	ACTION

QSEC 26 (38) WELCOME AND APOLOGIES

Mrs Eleanor Marks welcomed all those present to the Quality, Safety and Experience Committee (QSEC) meeting.

Apologies had been received from:

- Cllr Rhodri Evans
- Ms Louise O'Connor
- Mr Subhamay Ghosh (Dr Louisa Morris deputising)
- Mrs Joanne Wilson (Ms Charlotte Wilmshurst deputising)

QSEC 26 (39) DECLARATIONS OF INTEREST

There were no declarations of interest.

QSEC 26 (40) MINUTES FROM THE PREVIOUS MEETING AND TABLE OF ACTIONS

The minutes of the QSEC meeting held on 9 April 2026 were reviewed and agreed as an accurate record of proceedings.

The Table of Actions was reviewed, and it was noted that all the actions were complete other than QSEC 26 (22) ('Risk and Assurance Report') where it was advised that an update on overdue Welsh Health Circulars (WHCs) would be presented to the QSEC meeting on 11 August 2026.

Decision: The Quality, Safety and Experience Committee:

- **APPROVED** the minutes of the Quality, Safety and Experience Committee meeting held on the 9 April 2026 as a correct record of proceedings; and
- **REVIEWED** and **NOTED** the Table of Actions from the Quality, Safety and Experience Committee meeting on the 9 April 2026.

QSEC 26 (41) RISK AND ASSURANCE REPORT- EXECUTIVE LEADS

Ms Charlotte Wilmshurst introduced the Risk and Assurance Report to the Committee to provide an oversight on the principal risks, operational risks and review of audits and inspections aligned to the Committee.

Ms Wilmshurst advised that there were a significant number of operational risks aligned to the Committee and that the report sought to provide assurance to the Committee on how the risks were managed and the oversight arrangements in place. The risks have been themed and aligned to the STEEEP principles. The intention from Q2 2026/27 was to develop risk themes aligned to the reporting groups of the Quality and Safety Intelligence Group and share these with the Chairs of each Group and relevant subject matter experts to provide greater assurance on how the risks were managed, to improve the identification of trends and enable greater organisational controls.

In respect of audit and inspections, the Committee noted that there were 29 reports assigned to QSEC, with 62 recommendations (out of 340 recommendations) that have exceeded their original implementation date contained within those reports.

In response to a question from Ms Chantal Patel on how the information relating to how the impact of the risks to patient care was captured, Ms Wilmshurst advised that the risk description recorded the impact with the responsibility to mitigate the potential risk to patient harm.

In response to an observation from Mr Michael Imperato on a number of risks having a target completion date of 2030, Ms Wilmshurst believed that this reflected the level of capacity within the organisation and that management have tried to set realistic completion dates for target risk scores as opposed to repeatedly revising the date. Mr Neil Prior added whilst the risk themes were helpful, the number of risks aligned to the Committee was overwhelming, and some of the target risk scores seemed quite ambitious. In respect of the audit and inspection section of the paper, Mr Prior observed that that a number of these recommendations were overdue, and the paper did not provide assurance that these were going to be resolved which raised questions about ownership and whether these were going to be progressed. Ms Wilmshurst noted that less than a fifth of recommendations were overdue and that this reflected that a number of risks and audit and inspections recommendations were challenging to implement due to capacity and operational pressures. Mr James Severs believed that capacity was not the only barrier to mitigation of risk with capital resource constraints often a barrier to mitigating risk, particularly in respect of those related to the estate infrastructure.

Mrs Sharon Daniel believed that there was a need to ensure that whatever actions arose from audit and inspection

recommendations were SMART (specific, measurable, achievable, relevant and time-bound) and as responsible officers, have a responsibility to influence internal audit recommendations to ensure they are deliverable. In respect of risk, three risks were noted with a risk score of 25 aligned to one Clinical Care Group (CCG) with a significant level of risk relating to Urgent and Emergency Care (UEC) and questioned whether there was training available for staff on risk tolerance and mitigating actions. Ms Wilmshurst advised that risk training was provided, and risks were scored against a risk matrix however risk scoring can be subjective, and further work was needed to ensure risk owners felt psychologically safe to set realistic target risk scores and dates to achieve.

The Committee recognised the potential impact to patients behind these significant risks and audit and inspection recommendations, and recognised Executive's responsibility to challenge management on their perception of the scale and significance of these risks.

In response to a question from Mrs Eleanor Marks on whether there was any challenge to the scoring of risk, Mr Andrew Carruthers advised that the 2025-26 planning cycle was highly risk-focussed which led to much activity on reviewing risk scores and developing new risks. With the new governance structure, assurance was provided that a number of these risks had been escalated for discussion. The CCGs review risks with their service groups on a regular basis, with the most significant risks reported to CCG monthly performance meetings and reported to the Operations Delivery Group, chaired by Mr Carruthers. Mr Carruthers further advised that deep dives were conducted on individual risks, predominantly on the corporate risks, but also on the highest scoring risks.

Whilst acknowledging that the number of risks seemed overwhelming, Mr Carruthers advised that this is reflective of the number of risks that the CCGs are trying to manage across the organisation operationally. A number of these risks were identified as issues that could not be addressed due to resourcing constraints and formed part of our decision making as a Board when approving the Annual Plan for 2026/27. The risks also reflect the geographical spread of the Health Board and the number of services operating across our sites, as the same risk could appear four times on the risk registers due to the same risk occurring at the Health Board's four acute sites. In response to a question from Mrs Marks on whether the four risks could be combined into a single risk, Ms Wilmshurst advised that the mitigation and management at each site would be different mitigations and therefore separate risk assessment would be appropriate.

Mrs Marks believed that the level of risk experienced within secondary care that stretched the capacity of the system would

continue until mitigation was undertaken to move more activity to primary care, with a need to progress work in the public health space in terms of prevention. Dr Ardiana Gjini agreed and noted that the shift into primary and community services and increased focus on preventative public health measures would help to reduce system pressures and level of a number of operational risks across the Health Board, however this would need investment which would need to come from disinvestment in other areas. This may have need a new view of risk appetite and risk tolerance in order to make this shift of moving services out of acute setting, into a community and primary setting.

Mr Carruthers believed significant mitigation would be delivered through the delivery of the primary and community Services strategic plan and the implementation of Community by Design with the challenge for the Health Board on how it makes Community by Design part of the Health Board's core business by realigning resources and configuring our services differently to transform the way we delivery healthcare.

Mr Prior reasserted his concerns that there were overdue recommendations with no barriers noted, and therefore it was unclear why these have not been implemented, which raised questions about the Health Board's commitment to listen to external organisations' feedback on our current delivery, which should be as important as having strategic conversations about service configuration. The Committee agreed the next report on the position of audit and inspection recommendation should not only detail Executive ownership but also provide assurance on the accountability for delivering the oldest, and the most basic recommendations, at pace.

The Committee concluded that it was assured that there was high awareness of the risks within the report, and the processes in place, however, was not yet assured on the ambition and pace to implement them and would continue to challenge this so long as it remained concerned on the risks.

Decision: The Quality, Safety and Experience Committee, in relation to the areas presented in the report: -

RISK MANAGEMENT

- **RECEIVED ASSURANCE** that the principal risks are being refreshed and will be reported to the Board in July; and
- **RECEIVED ASSURANCE** that there are processes in place to oversee operational risks to ensure these are being managed effectively.

AUDITS, INSPECTIONS AND REGULATORY REPORTS

- **RECEIVED PARTIAL ASSURANCE** from the lead Executive Director or Supporting Officer on the management of recommendations raised in audit, inspection and regulatory reports within their area of responsibility, particularly in respect of confirming the full implementation of recommendations, any barriers to delivery and subsequent impacts of non/late delivery, and assurance that the risks associated with these are being managed effectively. The Committee were assured that the governance and oversight arrangements were in place, stronger assurance was requested regarding accountability, the pace of implementation of overdue recommendations, and the delivery of timely and sustainable improvements where recommendations remained outstanding.

- **Update Report to Board**: The Quality, Safety and Experience Committee were **ASSURED** that there were processes in place to oversee the management of the risks aligned to the Committee despite the significant number of principal and operational risks aligned to the Committee however there was only **PARTIAL ASSURANCE** was received on the accountability and the pace of implementation of overdue recommendations, and the delivery of timely and sustainable improvements where recommendations remained outstanding.

QSEC 26 (42) OPHTHALMOLOGY DEEP DIVE

Ms Paule Goode and Ms Amorelle Jones joined the meeting

Ms Amorelle Jones presented a deep dive into Ophthalmology Services to the Committee to provide assurance on the performance of the service and the impact of capacity, workforce and pathway pressures on the quality, safety and timely access to care for patients.

Ms Jones advised that the service utilised the corporate performance dashboard to oversee the risks to the service and noted that the main corporate risk, Risk 1664 ('Risk to ophthalmology service delivery due to a national shortage Consultant Ophthalmologists and the inability to recruit'), was anticipated to be de-escalated shortly due to the imminent onboarding of two Speciality and Specialist (SAS) doctors and a regional vitreoretinal (VR) consultant.

Ms Jones advised that the intravitreal therapy (IVT) pathway was considered fragile as articulated within Risk 2142 ('Risk of being unable to provide consistent IVT service due to lack of specialist staff to allow capacity to meet demand') with the mitigating actions

planned for the outsourcing of patients to ensure the timely and effectiveness of treatment. Ms Jones advised that the additional cost pressure of outsourcing was balanced against the risk of sight loss to patients and the need to restart patients who breach their treatment time at the start of their drug regime carried an additional cost.

Ms Jones noted that the availability and replacement of equipment was a risk to the efficient, safe and effective delivery of care exacerbated as services are provided at multiple locations across the Health Board. Ms Jones advised that while this provided care closer to the location of the patient, it had a consequential impact on staffing with a need to address the longer-term arrangements as outlined in the Clinical Services Plan (CSP).

The Committee were reassured that the number of complaints received within the service had decreased in the preceding 12 months. Whilst this was linked to a revision in the complaints management process ensuring that enquiries were managed in a timelier manner, the number of overdue complaints had remained static. Patient feedback had been positive as a result of the outsourcing of patients to a private provider.

In relation to incidents, on average there are five incidents per month. Nine incidents currently open at present with the longest waiting incident currently at 237 days. Ms Jones advised that monthly deep dives were undertaken with the most recent deep dive resulting in 20 incidents being closed. Most incidents related to delays in care despite progress being made, with 62% of patients seen within target in April 2026 and seven consecutive months of improvement having been delivered. Stage 1 outpatient waiting time had been reduced from a high of 8,915 breaches in June 2024 to 3,368 breaches in April 2026.

In response to a question from Mrs Patel on what level of assurance could be provided beyond the activity metrics that patients were not experiencing deterioration and irreversible harm from waiting for treatment, Ms Jones noted that there were 10,000 R1 patients on the follow-up list with work being undertaken to review each individual patient to ensure those with the longest delay received treatment first, with scans being undertaken within community settings to enable patients to be removed from the follow-up list who did not require a follow-up appointment to free up capacity for those patients with the highest priority.

Ms Paula Goode added that within the CCG, ophthalmology was considered a priority area with clinical urgency based on the prevention of harm. The strategic intent is to focus on the clinical urgency to minimize risk and prevent harm. Ms Goode advised that a redesign of the management team had been undertaken with work undertaken to review each individual patient to clinically validate urgency to prioritise patients and ensure patient visibility.

Mr Imperato noted that the CSP remained the long-term solution and questioned what actions were being undertaken in the interim period to provide a clear line of sight to continuing the positive performance trajectory. Mrs Daniel also questioned what actions were being progressed to strengthen the workforce and develop advanced practice roles and whether the plan was reliant on external recruitment. Ms Jones noted that there was a current senior workforce challenge in the long term however there were actions in progress to 'grow our own' ophthalmology workforce to develop advanced nurse practitioners from within the existing workforce to enable them to provide IVT injections.

In response to a question from Mr Severs on the opportunities in place to maximise the existing workforce, Ms Jones believed that there were opportunities to increase the technician workforce within the service and to undertake a desktop clinical review of patients to prioritise doctor diagnostic capacity.

Mrs Marks questioned the pace and ambition of the delivery of services to patients, to which Ms Jones advised that previously the focus has been on referral to treatment (RTT) however there now needed to be a shift to a focus on R1 compliance for the most clinically important patients.

Ms Jones advised that working within a regional space offered both benefits and challenges with Swansea Bay University Health Board (SBUHB) receiving more benefit from regional recruitment than Hywel Dda University Health Board (HDdUHB), and that she would discuss regional recruitment with Mr Henwood as there was a need for the Health Board to recruit its own consultant as opposed to sharing a regional solution with SBUHB. Ms Goode advised that there was still a need for a regional solution for out-of-hours care to ensure that patients could access urgent eyecare services 24/7. **AJ/MH**

Ms Paula Goode and Ms Amorelle Jones left the meeting

Decision: The Quality, Safety and Experience Committee **RECEIVED ASSURANCE** on the current position of ophthalmology services, including the impact of capacity, workforce and pathway pressures on quality, safety, effectiveness and timely access to care.

Update Report to Board: The Quality, Safety and Experience Committee were **ASSURED** by the current position of the Ophthalmology Service and wished to explore further what additional support Allied Health professions could deliver within the service and the potential that could be realised by regional working with Swansea Bay University Health Board.

QSEC 26 (43) QUALITY ASSURANCE REPORT

Ms Cathie Steele introduced the Quality Assurance Report to the Committee and highlighted the increasing pressures in Nationally Reportable Incident (NRI) closure rates despite a zero-tolerance across the Health Board. System-wide learning was underway to ensure that the Health Board was learning in a timely manner. The objective was to have no overdue NRI closure rates other than those that related to external incidents outside of the control of the Health Board that reduces the ability of the Health Board to investigate such incidents itself. NRIs had been added to the safety dashboard. There is also a focus on complaints and providing a timely response, facilitated by the implementation of the Listening to People Regulations on 1 April 2026, with the aim of closing historic complaints. Ms Steele advised that there had been a significant number of complaints closed relating to waiting times, especially with Emergency Departments (EDs).

The Committee was provided with a strategic overview of infection prevention and control (IP&C) with governance and scrutiny routes standardised with reporting through the CCG structure now established. Ms Steele advised that policies were being reviewed to ensure alignment to the All-Wales policy and the National Infection Prevention and Control manual. The launch of the national Clostridioides difficile (C. diff) campaign has taken place with the aim of shifting the focus to the impact on patients.

Ms Steele presented the Infection Control Improvement Plan to the Committee for approval and advised that the focus was on moving to system-wide learning through all portfolios for the next six months. In response to a question from Mr Prior on how the impact of that learning would be measured and assessed in a year's time, Ms Steele advised that there would be a behavioural science focus with a number of quality improvement projects undertaken with outcomes measured. Projects will be undertaken and overseen by the C. diff Project Group. Action plans will be revised to ensure that they are embedded within the Health Board and are proactive and not reactive. Mrs Daniel advised that the safety dashboard and key performance indicators (KPIs) would be reviewed to triangulate the data to ensure that the level of harm and the level of complaints were reduced to demonstrate that the learning had been successfully implemented.

Ms Dana Scott advised that care reviews were being carried out on wards with self-monitoring and peer monitoring being undertaken and it was anticipated that the standards on wards would be recognised as having improved through inspection. The Quality and Assurance Team are doing spot-check inspections on the same level as inspections undertaken by Health Inspectorate Wales (HIW).

Mr Imperato queried the ability of the Health Board to benchmark against the national context, whereby Ms Steele advised that data was available through an All-Wales dashboard.

In response to a question from Ms Patel on learning and improvement and how the Health Board distinguished between activity and impact and how improvement could be sustained, Ms Steele believed that by taking a proactive and learning system-wide approach it would enable changes to be sustained.

Mr Prior questioned the ownership of overdue inspections, to which Ms Steele advised that ownership lay with the relevant CCG. In response to a further question from Mr Prior on escalation with reference to Child Protection in Pembrokeshire and with how the Health Board professionally escalated issues, Mrs Steele advised that escalation processes were currently being reviewed. Mrs Daniel advised that a report on safeguarding would be presented to the QSEC meeting on 11 August 2026.

Mr Prior questioned the process for ensuring actions were undertaken in a timely manner. Mrs Steele advised that the Quality Assurance and Safety Team followed up Healthcare Inspectorate Wales (HIW) actions and the Risk Team also followed up HIW actions in addition to other actions recorded on the Audit Management and Tracking (AMAT) system with CCGs reporting on their actions plans through the Strategic Safeguarding Steering Group.

Mrs Marks felt that while assurance could be received that there were processes in place to oversee the actions that more work needed to be undertaken to ensure that the actions were carried out. Ms Wilmshurst advised that reports were provided to each function monthly.

Mrs Steele believed that advising those responsible for completing overdue outstanding actions that the matter had been discussed at QSEC would encourage improvement. Mrs Marks suggested that a letter from the Chair of QSEC be prepared to present to those responsible for updating and completing recommendations to encourage progress. **CW**

Decision: The Quality, Safety and Experience Committee:

- **RECEIVED ASSURANCE** that processes are in place to review, monitor and improve the quality of the Health Board's service through:
    - Patient Safety Incidents
    - Nationally reported patient safety incidents
    - Never Events
    - Patient Experience
    - Complaints management
    - Inquests and Regulation 28
    - Infection prevention and control

- Inspections and peer reviews including activity of Healthcare Inspectorate Wales
- **APPROVED** the Infection Prevention and Control Organisational Improvement Plan for 2026-27.

Update Report to Board: The Quality, Safety and Experience Committee were **ASSURED** that processes were in place to review, monitor and improve the quality of the Health Board's services however believed that there was a need to ensure that the actions identified through the Quality Assurance Report were undertaken.

QSEC 26 (44) DUTY OF CANDOUR REPORT 2025/26

Ms Caroline Burgin joined the meeting

Ms Steele introduced the Duty of Candour 2025/26 Annual Report to the Committee. The Health Board is required by the Health and Social Care (Quality and Engagement) (Wales) Act 2020 to produce and present the report for approval by the Board. A Duty of Quality Report is also required under the Act and this will be presented to the QSEC meeting on 11 August 2026.

Ms Steele confirmed that it was intended for the public. In response to an observation from Mr Prior that the report seemed to be written for Board Members as the target audience, Ms Steele advised that the report would be forwarded to the Communications Team to ensure that it was in a format and language that would be better received by a member of public reading the report. **CS**

Mr Imperato asked what the Duty of Candor Annual Report gave a member of the public beyond information and whether there was a sufficiently purposeful ending for the reader, including what they could do next or how the organisation wanted them to engage. Ms Caroline Burgin welcomed the feedback and acknowledged that the current format had been carried over from previous years and that the Duty of Candour framework was still relatively new in Wales. Ms Burgin agreed that the language and presentation needed to become more accessible and accepted that sections describing cases being downgraded might be misinterpreted as minimising issues rather than explaining process.

The Committee was advised that the report was a statutory requirement and that it was to be presented to the Board for approval no later than 6 months following the end of the reporting period.

In response to a question from Ms Patel on whether the Duty of Candor Annual Report resulted in any changes in practice within

the Health Board, Ms Steele believed that it did as it enabled the Health Board to learn, and that near misses were equally as important as actual incidents that caused patient harm.

Decision: The Quality, Safety and Experience Committee:

- **PROVIDED FEEDBACK** on the draft Duty of Candour Annual Report for 2025/26; and
- **RECOMMENDED FOR APPROVAL** to the Board subject to review by the Communications Team to ensure that the report was in a format suited for the public audience.

QSEC 26 (45) QUALITY ASSURANCE REPORT FOR COMMISSIONED SERVICES

Ms Julia McCarthy and Ms Anne Simpson joined the meeting

Ms Anne Simpson presented the Quality Assurance Report for Commissioned Services with SBUHB, Cardiff and Vale University Health Board (CVUHB) and the NHS Wales Joint Commissioning Committee (NWJCC) to the Committee.

Ms Simpson advised that an analysis of the data did not suggest any isolated issues in any single service area so much as repeated system-level themes, adding that SBUHB was a high-volume secondary and tertiary provider for HDdUHB, and that the number of incidents was consistent across both Health Boards with just over 1,000 incidents and 160 complaints from HDdUHB patients within SBUHB services. The main themes identified were within high-volume specialties and often related to delays in communication or information failures. A Commissioning and Contracting Oversight Group has recently been established to monitor and review contract and commissioning arrangement where appropriate.

In relation to waiting times when seen through a quality and safety lens that there were a small number of patients waiting over 52 weeks for treatment aligned to the number of complaints. The Health Board is taking a structured approach with recovery plans in place including patient-specific updates and the use of the appropriate oversight forums.

Ms Simpson highlighted an urgent service risk within paediatric neurology services as a result of the loss of outreach clinics previously provided by CVUHB. There were plans to reinstate the clinics for 6 months which reduced the immediate risk to HDdUHB patients however the service remained fragile.

Ms Julia McCarthy delivered a presentation on the assurance arrangements for commissioned care within nursing homes and advised that HDdUHB commissioned care for 618 residents and a

further 80 individuals in the community who were in receipt of continuing healthcare (CHC). The Health Board maintains active oversight of each of these commissioned arrangements through a programme of overviews and assessments. The Health Board Team undertakes quarterly unannounced monitoring visits to providers. These take place at various times of the day and at weekends and findings are reported to the relevant contract management forums.

The Committee heard that the Health Board sought to build and maintain relationships with the managers of the care homes that it commissioned. A dedicated nurse acts as a single point-of-contact with each provider. Ms McCarthy believed that the aim of the relationship was to promote a partnership approach to the provision of care to the patient.

Ms McCarthy highlighted risk identification and advised that patient safety was paramount. There is timely escalation of any concerns identified with appropriate safeguarding processes in place. Risks are regularly reviewed to reflect that patient need is ever-changing to ensure that individuals receive their care in the most appropriate setting at all times. The Health Board works with the relevant local authority to review the risk. Where risks or concerns were identified, action plans with agreed timescales were implemented with providers. Shared intelligence with local authorities is utilised to identify risk as early as possible. Ms McCarthy advised that contract termination was an option of last resort with a balance struck with the provider between support and challenge that seeks to sustain a strong relationship and ensure accountability. There were regular meetings with care home managers and that the Health Board provided training opportunities to providers in addition to the provision of professional support such as from dieticians and pharmacist support.

In response to a question from Mr Imperato on how the Health Board assessed providers, Ms McCarthy advised that a unified tool was used in conjunction with local authorities for all providers. This ensures a standardised assessment and that any significant concerns identified are escalation and a corrective plan implemented with RAG ratings. Weekly visits are undertaken to review all aspects of the environment such as kitchens, food and menu plans, environmental assessments that included an inspection of mattresses, equipment such as hoists, PAT testing to review the suitability of placements. Ms McCarthy advised that high-cost placements were reviewed more frequently so if the needs of the patient reduced, they were moved to a less high-intensive location so that in addition to saving money it also released capacity for other patients to utilise.

Mrs Marks queries the value judgements of providers, Ms Nadine Gould advised that clinical and non-clinical reviews were undertaken to provide assurance. In response to a question from

Ms Patel on how complaints were assessed to identify areas of emerging concern before they became a significant concern, Ms Simpson advised that the underlying data was triangulated to develop further reporting.

Ms Steele advised that for each commissioned service, the Health Board held regular meetings with other Health Boards such as SBUHB and Powys Health Teaching Board (PHTB) to provide quality assurance data and review Long Terms Arrangements (LTAs) with quality data such as Patient-Recorded Outcome Measures (PROMs) and Patient-Reported Experience Measures (PREMs) to identify early warnings.

Ms Julia McCarthy and Ms Anne Simpson left the meeting

Decision: The Quality, Safety and Experience Committee:

Swansea Bay University Health Board and NHS Wales Joint Commissioning Responsibility

- **NOTED** the overall quality and safety position for commissioned services.
- **ACKNOWLEDGED** that Swansea Bay University Health Board incident, complaints and claims data identify recurring system themes, particularly delays and communication.
- **NOTED** the emerging risk relating to tertiary paediatric neurology provision.
- **RECEIVE ASSURANCE** that issues are being actively monitored and escalated through commissioning arrangements.

Long Term Care Assurance for Commissioned Nursing Homes

- **NOTED** and **RECEIVED ASSURANCE** on the arrangements in place for commissioned nursing homes, including monitoring, escalation, and partnership working, and to take assurance that robust processes are in place to identify concerns, support improvement, and escalate issues through agreed governance and Provider Performance routes where required.

Update for Board:

The Committee were **ASSURED** that the Health Board's commissioning arrangements were being actively monitored and escalated where appropriate to ensure the quality and safety of services for Hywel Dda University Health Board patients through services commissioned through partner organisations.

The Committee were **ASSURED** that the Long Term Care Assurance for Commissioned Nursing Homes report provided useful assurance on the oversight of commissioned services however believed that future reporting should demonstrate more clearly how triangulated intelligence is impacting decision-making and how the Health Board was reflecting on its effectiveness as a commissioning body.

QSEC 26 (46) CLINICAL AUDIT PROGRAMME FOR APPROVAL

Mr Ian Bebb joined the meeting

Mr Ian Bebb presented the Clinical Audit Programme to the Committee for approval and advised that the programme was constructed following requests to senior governance and quality forums within the Health Board and CCGs with the 2026-27 programme having been broadened to include input from the Audit and Risk Assurance Committee (ARAC) and QSEC to ensure that the programme aligned closely with the organisational priorities of the Health Board.

In response to a query from Mr Prior on the nature of the clinical audits, Mr Bebb confirmed that the audits were internal reviews undertaken by the Health Board with recommendations made through the clinical audits followed up with all clinical audits recorded and tracked on the AMaT system and that the audits formed part of the formal clinical audit programme.

Mr Bebb advised that the programme was informed from a range of sources including complaints data, National Institute of Clinical Excellence (NICE) guidance, the risk register and strategic organisational requests.

In response to a question from Mr Severs on the timescales of responses, Mr Bebb advised that most audits were continuous in nature in comparison to regular one-off audits.

Mr Ian Bebb left the meeting

Decision: The Quality, Safety and Experience Committee **DISCUSSED** and **APPROVED** the Clinical Audit Programme for 2026/27.

QSEC 26 (47) NURSE STAFFING LEVELS SPRING CYCLE REPORT

Ms Helen Humpries joined the meeting

Mrs Daniel introduced the Nurse Staffing Levels Spring Cycle report to the Committee to provide assurance that the Health Board was meeting its statutory duty to calculate nurse staffing levels for all wards within the scope of Section 25B of the Nurse Staffing Levels (Wales) Act 2016.

Ms Helen Humpries presented the outcome of the Spring 2026 cycle and advised that there had been a number of changes following the Spring 2026 cycle with an additional 2.72 WTE Registered Nurse (RN) requirement on Ward 10 at Withybush Hospital (WGH) to provide an additional RN on duty over seven days and a reduction of 2.52 WTE Band 4 Assistant Practitioners based on patient acuity.

There had been a change in the proportion of long days being worked by Nursing Support Workers on Cadog Ward at Glangwili Hospital (GGH) and a change in the proportion of long days being worked by RNs and Nursing Support Workers on Angharad Ward at Bronglais Hospital (BGH).

Ms Humpries advised that the changes had been a result of reviews undertaken into ward capacity, specialities, infection control data and national guidance.

The report contained the financial implications of the changes to the nurse staffing levels and that this had been presented to the Executive Team on 3 June 2026. The annual nurse staffing levels assurance report had been reported to Board on 28 May 2026, with a three-year report due to be produced in 2027 that would articulate the impact of nurse staffing on key performance indicators (KPIs).

In response to a question from Ms Patel on how sustainable the nurse staffing levels were, Ms Humpries advised that reviews were undertaken in areas where the nurse staffing level requirements had not been met with any concerns raised with the relevant senior nurse and highlighted within the assurance report. Mitigating measures, such as redeploying staff from other wards, were considered within the assurance report, to inform how to meet the requirements of the Nurse Staffing Levels (Wales) Act.

Ms Helen Humpries left the meeting

Decision: The Quality, Safety and Experience Committee:

- **RECEIVED ASSURANCE** that Hywel Dda University Health Board is meeting its statutory duty to calculate nurse staffing levels for all wards within the scope of Section 25B of the Nurse Staffing Levels (Wales) Act 2016.
- **RECEIVED ASSURANCE** that, by presenting this report Hywel Dda University Health Board is fulfilling its statutory requirement to provide a written update on nurse staffing levels for each relevant ward to the Board (or its delegated

committee) where there has been a service change affecting staffing levels or were deemed necessary by the designated person (Paragraph 12).
- **NOTED** the content of the Annual Assurance Report.

Update Report to Board: The Committee wished to **ASSURE** the Board that the Health Board was compliant with the requirements of the Nurse Staffing Levels (Wales) Act 2016.

QSEC 26 (48) CLINICAL CARE GROUP REPORTS: MENTAL HEALTH AND LEARNING DISABILITIES

Ms Karen Brown, Ms Liz Carroll, Ms Anna Chiffi, Mr Peter Skitt and Ms Rebecca Temple-Purcell joined the meeting

Ms Rebecca Temple-Purcell introduced the Mental Health and Learning Disabilities (MHLD) CCG report to the Committee to provide an update on progress and to provide assurance on the quality improvement work undertaken within the CCG in relation to the publication of a new national Mental Health and Wellbeing Strategy.

Ms Temple-Purcell advised that the aim of the Welsh Government (WG) Mental Health and Wellbeing Strategy (2024-2034) was to align the practices of the Health Board to a clear vision of equitable and patient-centred care and support.

A significant level of improvement work has been undertaken by the CCG to strengthen the governance processes relating to complaints and incidents, with the establishment of a Serious Incident Learning Forum that would provide oversight of performance and outcomes going forward.

Ms Temple-Purcell advised that an overview of the risks aligned to the CCG identified that the themes related to delays to access timely services and workforce gaps and challenges with some areas of the Health Board more affected than others. Ms Temple-Purcell advised that measures to extend the Practice Team and the use of digital pathways were being pursued with the use of outsourced services to address patient waiting times.

Mr Imperato asked what actions were being taken to address the workforce gaps and the impact on delivery and financial impact. Ms Temple-Purcell advised that there the significant gaps within medical staffing were being addressed with a pro-active approach being taken to fill the gaps using innovative measures, such as overseas recruitment and the establishment of a clinical fellowship programme. There was also work being undertaken to develop non-medical roles such as advanced clinical practitioners to support the delivery of care to bridge the medical workforce gaps

and advised of the Workforce Management Group for workforce planning that reported to the Medical Director.

In response to a supplementary question from Mr Imperato on whether the additional measures were working, Ms Temple-Purcell believed that there had been positive feedback on improvements to non-medical vacancies, especially within the Ceredigion county system driven by the provision of training of non-medical roles. Work had also been undertaken to renew the staffing establishment levels within in-patient services to reduce the reliance on bank and agency nursing staffing.

Ms Patel inquired how artificial intelligence (AI) and digital platforms was being used to support assessment that would improve the patient experience. Ms Temple-Purcell responded that HDdUHB was consistent with the practice used in other Health Boards, with work being undertaken to evaluate the possibilities to understand fully how AI and digital solutions were working and not generating additional risk.

Ms Liz Carroll advised that the MHLD service had a specific consultant challenge, which had led to a review being undertaken of the learning disability medical workforce supported by discussions with the Medical Directorate to examine the use of non-medical roles. Mr Henwood advised that a review of the use of variable pay would be presented to the Finance and Performance Committee (FPC) on 30 June 2026.

Ms Rebecca Temple-Purcell left the meeting

Decision: The Quality, Safety and Experience Committee **RECEIVED ASSURANCE** on the quality governance arrangements in place within the Mental Health and Learning Disabilities Clinical Care Group in relation to quality, safety and patient experience.

QSEC 26 (49) CLINICAL CARE GROUP REPORTS: PUBLIC HEALTH

Ms Bethan Lewis joined the meeting

Ms Bethan Lewis presented the Public Health CCG report to the Committee to provide an overview of governance and operational delivery within the Public Health function to protect health, prevent harm and improve wellbeing and believed that the report demonstrated how the governance structure within the Directorate had become more integrated and demonstrated the quality activity within health protection, communicable disease control, immunisation oversight, disease prevention work, smoking cessation and health coaching.

Mrs Marks queried on how staff engagement within the wider community could be promoted, Ms Lewis advised that the Health Board utilised the services of its Community Outreach Team to engage with communities that were traditionally reluctant to engage with the Health Board and access services and sought to embed health protection and health coaching within communities, within GP practices and other community venues, and sought to link in with established 'trusted voices' within communities to encourage an improvement in the update of Health Board services.

Ms Lewis believed that there were a number of good examples within the Health Board such as pop-up clinics within the community, the close linkage between smoking cessation work and the Immunisation Team and representation at community events, strong linkages with third-sector organisations and the deployment of a mobile vehicle across the Health Board.

Ms Marks questioned how the wider Health Board workforce could be encouraged to be health ambassadors within their community, Ms Lewis believed that the 'Make Every Contact Count' programme was an important platform from which to promote health protection and it was being explored how best training for new starters could be utilised to use staff to have health coaching conversations and also to not miss opportunities to speak to out-patients and also to engage with Local Authorities and social care colleagues.

Ms Patel enquired what interventions had the greatest impact from the shift of resources into prevention, Ms Lewis believed that immunisation had the single, greatest impact on population health and advised that HDdUHB had the leading impact in Wales for smoking cessation and vaping and nicotine replacement.

Mrs Daniel highlighted incident reporting and noting the high level of incidents within nurseries within the county of Pembrokeshire, Ms Lewis noted that there had been an outbreak of gastrointestinal symptoms in Pembrokeshire in Winter 2025/26 and that Public Health Wales (PHW) were leading in response with the Health Board engaged with Local Authority Leads through the Quality Health Protection Oversight Group and believed that the Health Board had strong Healthy Schools and Health Pre-School Team. Ms Lewis also believed that the spike in Pembrokeshire could also be attributed to better reporting within the county. Dr Gjini advised that reporting was voluntary and that such self-reporting would inherently be subjective.

Dr Gjini believed that all Health Board staff should be supported to promote health protection and to prevent ill-health and believed that the 'Make Every Contact Count' programme needed to be scaled up with the Health Board's three constituent Local Authorities and Public Service Boards (PSBs) all requesting for 'Make Every Contact Count' training to be expanded. Dr Gjini

advised that all consultant new starters received training and that there was positive engagement with the Medical Education Team and that the Health Board was a leader in medical education development for foundation doctors.

Dr Gjini noted that there had been specific engagement with the farming and fishing communities within the community outreach programme and that the health coaching service had been expanded and had been included within the Health Board's Annual Plan for 2026/27.

Ms Bethan Lewis left the meeting

Decision: The Quality, Safety and Experience Committee **RECEIVED ASSURANCE** on the quality governance arrangements in place within the Public Health Directorate in relation to quality, safety and patient experience.

QSEC 26 (50) CLINICAL CARE GROUP REPORTS: COMMUNITY AND INTEGRATED MEDICINE

Ms Anna Chiffi presented the Community and Integrated Medicine (CIM) CCG report to the Committee and highlighted that incident management within the CCG continued to present a challenge however noted that there had been significant improvement in reducing the number of long-term incidents that had been open for more than 60 days and 120 days.

Ms Chiffi highlighted the on-going safety concerns relating to boarding and care within non-designated clinical areas. Work is being progressed with patient flow initiatives, clinical streaming and assessment models, strengthening discharge coordination and oversight of pathways of care delays through improved senior decision-making at the front door of the acute setting. Ms Chiffi noted that a thematic analysis of complaints indicated the areas of greatest complaints related to communication with patients and families, delays in care and discharge and environmental concerns. The report also acknowledged the workforce challenge within the medical workforce across the Health Board's acute sites.

Ms Chiffi believed that the introduction of the Listening to People framework would strengthen patient feedback and drive service improvement through the triangulation of incidents, complaints and patient experience.

Mr Imperato questioned what changes had been made to the CCG structure to provide quality assurance, Ms Chiffi advised that the structure of the CIM CCG had evolved to establish processes for all three county systems to integrate additional elements into

the system. The organisational change process (OCP) aims to ensure that there is appropriate workforce to ensure an integrated pathway from community to acute settings that was captured by Quality and Safety meetings. Mr Carruthers believed that the OCP would address the historic geographic challenges moving from county or site-specific view to a speciality overview across the Health Board.

Mrs Marks believed that there was a need for the promotion of efficient working to overcome the financial constraints, Mr Peter Skitt believed that workforce gaps caused a financial challenge and created inefficiency with a need to strengthen the substantive workforce to promote efficiency. Mr Carruthers believed that there was an inherent structural inefficiency through the historic organisation of the Health Board.

Ms Karen Brown, Ms Anna Chiffi, and Mr Peter Skitt left the meeting

Decision: The Quality, Safety and Experience Committee: **RECEIVED ASSURANCE** on the governance arrangements in place across Community and Integrated Medicine Clinical Care Group and **NOTED** the progress made in strengthening oversight and improvement activity.

QSEC 26 (51) ESCALATION REPORT

Mrs Daniel presented the Escalation Report to the Committee and believed that the data contained within the report indicated that improvements had been realised in relation to hospital acquired infections. This reduction had not yet become reliable, however the significant improvement exhibited in Q4 2025/26 was noted by the Committee, with acknowledgement that the criteria for de-escalation required three consecutive months of improvement.

The Health Care Associated Quality Improvement Plan would focus on targeted and high impact interventions in areas where the numbers of infections were highest. This would support the delivery of the Health Board's targeted intervention (TI) deescalation criteria.

In response to an observation from Mrs Marks that it was difficult to sustain improvements in relation to hospital acquired infections when the numbers were so low, Mrs Daniel advised that she would be meeting with NHS Wales Performance and Improvement to further understand the de-escalation criteria.

Decision: The Quality, Safety and Experience Committee:

- **NOTED** the current position that infection performance has shown periods of improvement but not sustained compliance;
- **NOTED** that fragile services arrangements are established but not yet fully embedded;
- **NOTED** that further work is required to:
    - embed a consistent fragile services approach
    - provide a consolidated Board-level view of risk and trajectory
- **DISCUSSED** and scrutinised the ongoing variability in:
    - Hospital Acquired Infections (criteria 22–24)
    - Fragile Services (criteria 10–14)
- **RECOGNISED** that system reliability and consistency have not yet been achieved
- **SUPPORTED** strengthening infection prevention reliability and improving training compliance

QSEC 26 (52) **EXTENSION OF 'SERVICE USER ACCESS POLICY – PSYCHOLOGICAL THERAPIES.' POLICY NUMBER: 1133**

Mr Andrew Homfray joined the meeting

Mr Carruthers presented the extension of Policy 1133 ('Service User Access Policy – Psychological Therapies') to the Committee for approval.

Mr Carruthers advised that the request for the extension was to ensure the continuity of the current policy while the development of an all-Wales policy was implemented at a national level.

Mr Carruthers noted that the development of the national policy had been influenced by work undertaken within HDdUHB with the request was not to approve a new local policy however to retain the current policy on an interim basis until the all-Wales policy was confirmed.

Mr Carruthers advised that should the development of the all-Wales policy not be implemented within the next six months then the current policy would be reviewed and updated and presented to the Committee for approval.

Mr Andrew Homfray left the meeting

Decision: The Quality, Safety and Experience Committee is approved the extension of Policy 1133 by 6 months to allow the All-Wales document to be taken through the relevant governance and implemented across Wales.

QSEC 26 (53) QSEC WORK PLAN 2026-27

Mrs Marks presented the Committee Work Plan to the Committee for review.

In response to a question from Mr Prior on the inclusion of a patient or staff story to the QSEC agenda, Mrs Daniel confirmed that it was the intention to include a patient story within the agenda at the Committee meeting on 11 August 2026.

Decision: The Quality, Safety and Experience Committee **REVIEWED** and **NOTED** the Committee Work Plan 2026/27.

QSEC 26 (54) DATE OF NEXT MEETING

The next meeting was noted as scheduled for 11 August 2026 at 9.30.

QUALITY, SAFETY AND EXPERIENCE COMMITTEE (QSEC)/ PWYLLGOR ANSAWDD, DIOGELWCH A PHROFIAD
11/06/2026
TABLE OF ACTIONS/TABL GWEITHREDOEDD

Key: AC-Andrew Carruthers; AJ-Amorelle Jones; CS-Cathie Steele; CW-Charlotte Wilmshurst; MH-Mark Henwood; SD-Sharon Daniel

MEETING DATE	MINUTE REF	ACTION	LEAD	TIME SCALE	PROGRESS
09/04/2026	QSEC (26) 22	Risk and Assurance Report • To provide a status update on the overdue Welsh Health Circulars and ensure there is a risk aligned on the Datix Risk Register	SD, AC	11/08/2026	Complete This will be reported in the August Assurance and Risk Report
11/06/2026	QSEC (26) 43	QUALITY ASSURANCE REPORT • To draft a commication for the Chair of the Committee to send to Executive Directors requesting that risks are updated and completed in a timely manner.	CW	11/08/2026	In progress
11/06/2026	QSEC 26 (42)	OPHTHALMOLOGY DEEP DIVE • To discuss the regional recruitment needs of the Health Board's Ophthalmology Service with Medical Director.	AJ, MH	11/08/2026	Complete
11/06/2026	QSEC 26 (44)	DUTY OF CANDOUR REPORT 2025/26 • To send the Duty of Candour 2025/26 Annual Report to the Communications Team for review to ensure that it is presentable for public consumption.	CS	11/08/2026	Complete The Duty of Candour was subsequently approved by Board on 25 June 2026