Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	12 February 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Estates and Facilities Clinical Care Group Quality Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	James Severs, Executive Director of Allied Health Professions and Health Science
SWYDDOG ADRODD: REPORTING OFFICER:	Simon Chiffi, Head of Operations (Estates & Facilities Clinical Care Group)

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report details the quality governance arrangements within the Estates and Facilities Clinical Care Group (CCG) in relation to quality, safety and patient experience. It sets out achievements, progress and planned actions to meet our Duty of Quality, and is presented to the Quality, Safety and Experience Committee to provide assurance on the arrangements in place.

The Estates and Facilities CCG is currently at Level 2 escalation for Quality and Level 3 for Finance, Population Health and Performance and Outcomes domains. Since the last report in July 2025 the CCG has improved to Level 1 for Governance and to Level 2 in Workforce domains, a significant improvement on last year's position. As part of the escalation process, focused efforts are being made to address areas with action plans aimed at improving both the quality of care provided and financial mechanisms to meet expected standards. This report provides detailed insights into performance trends, highlighting areas that require improvement and actions in place to support this.

Cefndir / Background

The Estates and Facilities CCG consists of 5 service areas, covering the full acute, community and managed practice estate:

- Facilities Operations inclusive of Portering, Domestics and Catering
- Estates Operations Maintenance & Engineering
- Estates Risk & Compliance
- Health, Safety & Security

Functions previously covering Property, Estates Information and Capital delivery now located within the Planning Directorate.

The aim of the Estates and Facilities CCG is to:

- Ensure there is a process in place to continually monitor and review its risk register, acting to mitigate quality and safety risks on an ongoing basis.
- Maintain an open culture of improving quality, safety and patient experience across all teams and all staff.
- Promote a positive culture of staff engagement, development and understanding of everyone's responsibility for safe, quality care and
- Foster a culture of psychological safety within Estates and Facilities Care Group in order to promote collaboration, trust, innovation and personal growth.
- Be a positive enabler for the Health Board by providing a safe and effective Estates for Healthcare provision.

Meeting the Duty of Quality is the highest priority for the CCG and its governance structures and oversight has developed significantly. The Service Director (post currently vacant) and Head of Service areas highlighted above lead the agenda which is aligned to the six domains of quality as defined by the Duty of Quality Statutory Guidance 2023. This report is set out under each of these domains.

Asesiad / Assessment

The CCG has reviewed its operational governance structures in line with the Health Boards restructure and introduction of Clinical Care Groups. The below table gives examples of structures and processes in place, underpinning the quality management system across the Estates and Facilities CCG.

Quality Planning	Quality Improvement
Planning Objectives, workplans and priorities. Development and review of service specifications. Development of feedback sources and use of Civica for example in the Catering Service. Patient stories Review of complaints through Heads of Service Reports.	Current improvement areas: Transforming the way in which we clean to manage Health Board expectations against Welsh Government (WG) standards of cleanliness by reviewing rotas and processes across the Facilities function. Embedding of key digital platforms to improve data capture and organisational flow (e.g. CAFM and Synbiotix) Engagement with NHS Wales Shared Services Partnership (NWSSP) for audits of processes in line with key Welsh Health

Staff feedback from Culture and Stabilisation workshops leading to culture and organisational development plan. Close engagement with all CCGs to ensure alignment with planning objectives.	Technical Memorandum (WHTM) areas and feedback loop. Collaboration with WG over a Corporate Landlord approach to change the way in which we manage property and make key decisions based with evidence.
Quality Control	**Quality Assurance**
Oversight of quality, safety and experience through Estates and Facilities internal service area groups and forums that report into Health Board wide Groups and Committees. For example, Quality, Safety and Experience Committee, Health & Safety Committee, Integrated Quality Finance, Performance and Delivery Group (IQFPDG), Infection Prevention and Control. Risk escalation processes. Regular schedule of site visits and walkabouts with key leads. Active use of Audit Management and Tracking System (AMaT) tracking system Planned Preventative Maintenance (PPMs) system of scheduling key statutory checks to the Estates, logged and on a dynamic CAFM system. Submission of all policies through CCG and to the Written Control Document Group. All papers, decisions and challenges are first brought to the Estates & Facilities CCG for approval before sending to respective groups for scrutiny.	Staffing Reviews. Weekly/Monthly Care Group review meetings of: - Audit and Inspection Tracker - Incident Management Groups/Closure Group - Complaints - Risk Register - Datix Incidents - Cleaning Standards Audit Action Plan Accreditation processes for Maintenance & Engineering including Approved Persons for High Voltage & Low Voltage approved via NWSSP. Monthly reviews on Health Inspectorate Wales (HIW) reports and any open reports through direct meetings with Risk manager and in Estates and Facilities Care Groups discussions.

Quality Assurance

The Estates and Facilities CCG Quality Governance meetings have been in place since May 2025 and have taken place monthly to include both Quality, Health & Safety domains and also Business Planning, People and Performance to directly align with IQFPDG.

The Group Terms of Reference are in place and being followed, both will be reviewed annually. Membership is planned to ensure representation of workforce, finance and managerial staff across all Service Groups, as well as other multi-disciplinary colleagues from across the Health Board, all of which will take an active part in the meetings and shape the overall agenda. We have identified areas to improve our governance by linking with other Service Directors before

escalating to IQFPDG to ensure close working relationships can resolve issues before alerting inappropriately. This will be discussed at the next Clinical Group meeting.

Each Service Group holds monthly Quality and Safety meetings, and further work is underway to strengthen this structure and reporting to the CCG Quality Governance meeting.

Quality, Governance and Performance Areas of Escalation

Quality - Areas for improvement identified through the Health Boards escalation framework relate to 2 areas.

- Internal Audit Actions to be completed including closure of reports and recommendations
- Health Inspectorate Wales (HIW), closure of overdue actions.

Governance - Areas for improvement identified through the Health Boards escalation framework relate to 2 areas.

- Audit/Inspection recommendations implemented within timescales (above 80%)
- Outcome and implementation of recommendations from governance review required to provide assurance

Performance & Outcomes - Areas for improvement identified through the Health Boards escalation framework relate to 1 area.

- Consistent cleaning audits across sites (includes acute and community) and risk categories and at least amber achieved for all audits, sustained for three months.

Updates in relation to these areas are contained under relevant Safe, Timely Equitable, Efficient, Effective Principles (STEEEP) domains of the report. A targeted plan with defined actions, timescales and improvement trajectories has been shared and approved at Estates CCG and trajectories demonstrated at Audit and Risk Assurance Committee (ARAC) and Executive Improving Together Sessions (EITS) and Executive Recovery meetings.

Safe Care

Incident Management

Over the last 6 months trends in a number of incidents reported across the CCG have kept at the same level, alongside monthly closures throughout the same period and the overall numbers of incidents that remain open. The number of incidents reported has fluctuated throughout the period.

Whilst the overall number of open incidents has reduced to 24 over the reporting period, the rate of new incidents reported remains consistent. Closures on a monthly basis has increased showing an improved position.

The team has agreed to report this data into the CCGs monthly Quality Governance meeting to enable monitoring of trends as data is not currently available in this format through the existing performance or safety dashboards.

A high proportion of open incidents located within Facilities services where there are much higher rates of reporting due to the continual operation and its purpose for providing patient care to individuals with highest levels of clinical risk and need. The data shows us that the main type of incidents are related to behaviours including slips, trips and falls, violence and aggression which are predominantly reported by portering services. Further work is planned

for more detailed analysis of incidents of violence and aggression and the CCG is working with colleagues in Health and Safety teams to develop a bespoke quality dashboard which will include a wider range of quality metrics and more targeted breakdown of incident categories. This has now been completed and is shared with all CCG's by the Health & Safety Manager.

Due to merging of the Health & Safety Team into this CCG, figures appear concerning from the last period due to an absence in the role of Head of Health & Safety. This is reported into the monthly Estates & Facilities CCG to monitor.

The remaining overdue incidents over 120 days had been inappropriately assigned to members of the Health and Safety Team to investigate and manage rather than the reporters line manager. All incidents have now been either closed or reassigned to the most appropriate person.

Snapshot of open incidents across the CCG as of 31 Dec 2025 by Incident Type

Actions to support improvement:

- Monthly incident trend reports to be provided to the CCG by the site leads to be added to monthly Risk Management Meetings and reported through Integrated Governance Group (focus on Quality and Health and Safety) meetings when appropriate.

- Continued liaison by the Assurance and Risk Officer at monthly site and Estates CCG meetings with operational leads and focus on older cases.
- Prioritisation/protection of time to be actioned by Heads of Service areas for review of proportionate review reports at final stages for approval at CCG level to be built into improvement trajectory.
- Facilitation of weekly protected time for leads to undertake incident review work to be built into improvement trajectory with noted potential to impact on temporary staffing requirement/variable pay.
- Replacement of key retired leads underway to support growth in Facilities area with significant number of reports open greater than 120 days.

Reducing Restrictive Practice Training

Detailed recovery plans to address low uptake of reducing restrictive practice training across Facilities Portering Groups are underway in partnership with Restrictive Practice Trainer Lead and were expected to see full compliance by the end of 2025. A huge step change in engagement has seen significant improvements as can be seen in the table. We now expect all staff to be compliant by March 2026.

Reducing Restrictive Practice Training

Current Training Compliance

RRP Training	No. of staff	No. of staff Trained	Compliance
GGH	23	18	82%
PPH	23	21	100%
WGH	31	6	64%
BGH	18	0	81%

Timely

Areas of exception that relate to timely access to services:

Risks

There are 149 risks on the register.

20 Extreme scoring risks
107 High scoring risks
22 Moderate scoring risks.

As of today, 90% of all risks have been reviewed within timeframe.

Currently a risk stratification exercise is being conducted by the Health and Safety and Risk teams to review our accepted risk appetite and tolerance, with potential for a number of risks to be downgraded to managed items. This will be reported in the next Estates CCG and approved prior to amendment.

Ongoing actions continue to be taken by the CCG to improve performance:

- Risk stratification paper to be completed by Health and Safety Team and collaboration with Estates and Facilities Risk team to review all risks.

- Monthly risk meetings are held to review all risks on the register, to scrutinise actions, confirm that mitigations are current and effective, and to ensure all recommendations are fully closed.
- As of June 2025, all risks identified for closure, along with open reports have been submitted to the Estates & Facilities CCG for approval.
- Weekly AmaT sessions are held to ensure there is a full understanding of the assigned actions.

Effective

Internal Audit on Standards of Cleanliness 2024-25

A recent internal audit was completed by NWSSP at GGH/WGH on the Standards of Cleanliness. This was a follow up report from 2023/24 with a "Limited Assurance". The 2024/25 fieldwork was completed in March – April 2025 and an action plan was developed to implement necessary improvements. The Quality, Safety and Experience Committee can gain assurance that the management actions assigned to the Facilities Team have been completed and progress is being made to prepare for a follow-up audit in February / March 2026.

Scope & Assurance Summary

Below is a summary of recommendations from the 2024-25 audit from the Health Board's Audit Management and Tracking System:

Recommendation	Action	Service	Person Responsible	Progress Status
R1. Reporting to County Infection Prevention Groups (IPGs) Cleaning audit results are not being consistently reported to County IPGs with scheduled meetings not taking place and poor attendance by Soft Facilities at several meetings. We found some instances of scheduled meetings not taking place and occasions where there were no minutes available (e.g. April, October and December 2024 PPH County IPG meetings).	Review the governance for IPC to align with the new CCG Structure, including a review of the terms of reference and reporting arrangements for the Environmental Hygiene Group.	Executive Allied Health Professions & Health Sciences	Mrs Cathie Steele	Partially complete (Overdue)
R2. Domestics Training	Training compliance plans are being	Executive Allied Health	Elin Brock	Fully complete

A central database of staff training has recently been set up and refresher training for staff has commenced however this will take some time to complete.	developed for each site, this will identify the training to be provided and timescales for achieving compliance. Compliance will be monitored through the Estates Facilities CCG governance structures.	Professions & Health Sciences		(Approved)
R3. New Model of Cleaning Provision The Organisational Change Process has commenced and the rollout is in the early stages. The revised working arrangements have been reinstated at a number of wards in GGH and PPH, and this is likely to take some time to fully roll out and embed.	A plan and trajectory for rolling out the new model of cleaning provision across all sites will be developed.	Executive Allied Health Professions & Health Sciences	Elin Brock	Fully complete (Approved)
R4. Cleaning Schedules We found limited use of cleaning schedules at wards in WGH and GGH, with documentation often incomplete or inappropriately completed.	Spot checks will be undertaken as part of the cleaning audit process to ensure compliance with the cleaning schedules. The CCG will continue working towards a digital cleaning schedule for all wards on Synbiotix.	Executive Allied Health Professions & Health Sciences	Elin Brock	Fully complete (Approved)
R5. Frequency of Audits and Audit Scores At GGH very high-risk areas continue to be undertaken on a monthly rather than the recommended weekly basis. since February 2025, high	Following the successful trial of a designated auditing supervisor at PPH this is now being implemented at the other three acute hospital sites. New model of cleaning provision (see key finding 3) will seek to	Executive Allied Health Professions & Health Sciences	Elin Brock	Fully complete (Approved)

risk areas have been audited on a weekly basis at WGH.	improve cleaning standards and audit scores.			
R6. Operational Performance Delivery (Synbiotix) meetings The live Synbiotix dashboard is discussed at the monthly Operational Performance Delivery meetings, however meetings did not take place during October, November and December 2024 or February and March 2025. There are no Terms of Reference for this group. Action notes lack a detailed account of discussions or conclusions reached during the meetings.	As per key finding 1, governance structures and reporting arrangements will be reviewed to align with the new CCG structure. We will seek to incorporate the role of the existing Synbiotix meetings into the Environmental Hygiene Group and include Estates representation on this group. This links to key finding 1 – review of the governance arrangements.	Executive Allied Health Professions & Health Sciences	Elin Brock	Fully complete (Approved)

Whilst progress has been made to complete the management actions above, there is still a substantial amount of work to be undertaken to achieve the desired outcomes. A summary of our priorities to provide assurance to the Committee are listed below:

Quality Governance

The service has strengthened the quality governance arrangements to provide assurance to the Board that cleaning standards are being adhered to and where not, that appropriate interventions are being put in place to improve.

The Environmental Hygiene Group (EHG) has been established to support all aspects of the Health Board's Environmental Cleaning and Disinfection programme, and to provide assurance to the Board that the extant national minimum standards of environmental cleaning are being delivered. Its membership has recently been reviewed to provide greater accountability and ownership. The Group has a clear and deliverable workplan for the year that is monitored on a monthly basis.

The Environmental Hygiene Group reports to the Facilities Integrated Governance Group and provides a monthly Quality Assurance report to the Group. The Head of Facilities is also required to provide a 3As update to Infection Prevention Steering Group on a monthly basis.

Quality Planning

Work has been underway to agree Annual Plan objectives for 2026-27. With regard to the facilities service, the following objectives have been agreed:

1. Implement a new model of cleaning provision so that the Health Board has assurance that standards can be achieved and delivery can be sustained.

2. Undertake a review of the portering and catering functions so that improvements can be identified and a standardised approach can be implemented.

3. Review the leadership and supervisory model across the facilities service to strengthen capacity and capability.

4. Develop performance metrics for the facilities service; enabling data driven decision-making and key areas of focus to be identified.

5. Explore technological / digital advancements across facilities functions so that opportunities to improve efficiency, sustainability, cost effectiveness can be identified and progressed.

6. Develop a plan for standardising the facilities service so that a systematic approach can be taken to improving the effectiveness and efficiency of the service across all sites.

A Facilities Planning Workshop has been arranged for February 2026 to ensure operational plans are developed that are aligned with annual plan objectives that stretch our ambition and ability as a service.

Quality improvement

There are 2 main directions of travel for Cleaning Services within the Health Board.

Implementation of the Cleaning Strategy outlined in the Cleaning Paper 2022. (Utilisation of extra £1.3M funding)
This equates to an extra 42 Whole Time Equivalent (WTE) of additional cleaning posts across the Health Board.

Redesign of current cleaning rosters. (Utilising current staff resource more efficiently)
Replacing current inefficient historic rosters to a consistent 3-week roster across the Health Board. PPH & GGH rosters have been drafted, headline benefits include:

- Efficient relief pool to reduce variable pay / bank usage.
- Current unfunded public areas (toilets & corridors) are staffed.
- Deep Clean Team available to Soft FM managers to deploy for extra cleans (infection risk based, curtain changes etc.)

Delivery of both elements are essential to fulfil the strategy outlined in the paper.

Progress of delivering the cleaning strategy has been slowed down to enable more staff engagement to take place, before a formal organisational change is initiated. The work is now continuing at pace within the team; a revised timeline has been developed along with an Equality Impact Assessment.

Strengthening leadership and capability

Four Facilities Managers have been appointed, with three have already in post, and the fourth due to commence in February 2026. Strengthening site-based leadership is of significant importance to the service to enable better staff engagement, stronger team dynamics and visionary and curious thinking to drive change. Strengthened leadership also presents opportunities to review services and ways of working, which is a focus for the service during 2026.

Appropriate leadership at our acute sites also enables better engagement with system partners to achieve positive working relationships. We will recognise, facilitate the sharing of, and celebrate excellent practice and meaningful learning, to support continuous improvement across the Hywel Dda system.

Supervisory Review

Ensuring capacity and capability across our supervisory level is critical to ensuing operational service delivery. A review of how our supervisory team functions, their roles and responsibilities and expectations is about to commence. This will be a root and branch review to ensure that our supervisory staff have a clear Learning and Development plan, have clarity over their duties and responsibilities and can proactively plan their work. Ensuring the culture is supportive and empowering is also important, driven by the ambition to achieve excellent standards.

Quality Assurance

We are working on developing a Quality Assurance plan to enable further improvements across the cleaning service. The Facilities Integrated Governance Group will review and oversee this. This plan will detail the essential elements needed to achieve quality service delivery, including training and development, inspection and auditing processes, and actions needed when compliance cannot be met.

National considerations

The new National Standards for Cleaning in NHS Wales are due imminently in early 2026. It is anticipated that the frequency of cleaning will increase in some areas, which could potentially create further gaps in assurance and outcomes for patients. Once the new standards have been received, a gap analysis will be undertaken, to understand the difference between our current provision and what is required in the new standards.

Evidence based

Progress with closure of overdue actions (external audit, review, inspection and peer review reports)

Total number of recommendations	Total number of Amber recommendations	Total number of Green recommendations	Total number of External recommendations	Total number of overdue (Red) recommendations	%age of overdue recommendations
808	141	508	1	158	20%

Estates CCG has 57 open reports on the system (98 previously reported)

All AMAT Audit recommendations to be reviewed during newly formed meeting structure, this takes place weekly with Monthly checkpoints with the Risk Team. It is for noting that some of the Audit recommendations placed on the AMAT system require significant funding to resolve,

these are subject to capital funding requests. This can lead to lengthy timescales to complete. Risk mitigations are implemented where possible.

The CCG has continued to demonstrate strong progress, maintaining escalation level 1 within the Governance & Risk domain.

The CCG continues to hold monthly meetings to operationally review progress with actions and identify escalation of actions held by other Health Board departments outside of the CCG.

Regular reports are received from the Assurance and Risk Team to CCG operational meetings to ensure governance and oversight of this work.

A regular report on Estates owned actions has been instigated to report into the Clinical Care Groups Accommodation Steering Group to support escalation of estates led overdue actions.

Equitable

No additional updates.

Person Centred

Complaints Management

There are no complaints within the Estates & Facilities CCG at this time and this has been the case for 8 months in succession.

Key Risks across the Estates & Facilities Clinical Care Group

The CCG currently has 149 open risks on its risk register (an increase of 22 since July 2025). An overview of risk scores can be found below:

Impact	Rare 1	Unlikely 2	Possible 3	Likely 4	Almost Certain 5
Catastrophic 5	1516 2035 1382	1596 1873 1539 1096 471 2062 2085 2042 1 ...	2078 813 1745 1049	975	
Major 4		1969 1135 1665 1864 2055 212 1040 551 93 ...	1966 1753 2016 1875 2014 1667 1101 1331 ...	1134 1263 1968 1962 1071 1759	
Moderate 3		1874 1148 1149 1155 1264 1029 1007 547 1 ...	1920 1961 1964 1872 474 476 430 1965 195 ...	1940 2076 461 1976 2008 1493 2052 2015 1 ...	1832 1948 1934
Minor 2		473 1236 936 1095	482 1270 1261 1503 1123	481 947 1353 991	
Negligible 1					

The Clinical Care Groups five highest scoring risks are as follows:

- 975 Risk of failure to remain within allocated HB Budget.
- 1745 Risk of not being able to safely deliver services due to ageing estate and infrastructure.
- 2078 Risk of falling concrete panels in WGH.
- 1049 Risk of service disruption due to lack of second standby generator
- 813 Risk of non-compliance with Regulatory Reform Fire Safety Order 2005 due to ageing infrastructure

The CCG is acting to both mitigate current risk and to develop transformational approaches that aim to sustainably improve services. These areas of improvement can be cross referenced to priorities and objectives described within the CCG's annual plan. The full risk register is included for reference.

Argymhelliad / Recommendation

The Quality, Safety and Experience Committee is asked to **receive assurance** on the quality governance arrangements in place within the Estates and Facilities Clinical Care Group in relation to quality, safety and patient experience.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	2.1 Scrutinise, assess and seek assurance in relation to the patient impact, quality and health outcomes of the services provided by the Board.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	All risks held on the Estates & Facilities Care Group risk register. Datix references contained within the main body of 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	1 Workforce Stabilisation 8 Estates plans
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	8. Transform our communities through collaboration with people, communities and partners

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Not Applicable
Rhestr Termau: Glossary of Terms:	Not Applicable
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	Though information has come straight from Estates CCG Quality Health and Safety Meeting

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: **Financial / Service:**	Not relevant
Ansawdd / Gofal Claf: **Quality / Patient Care:**	No
Gweithlu: **Workforce:**	Not at this time
Risg: **Risk:**	Aligned to risk register
Cyfreithiol: **Legal:**	No
Enw Da: **Reputational:**	No
Gyfrinachedd: **Privacy:**	No
Cydraddoldeb: **Equality:**	Not Applicable