Date	**12/02/2026**
Time	**09:30 - 12:30**
Location	**Microsoft Teams; Picton Terrace Meeting Room; HDD Picton - Dolau Cothi**

Quality, Safety & Experience Committee Meeting

HDD_Quality, Safety & Experience Committee

NHS Wales

Agenda - 12 February 2026

1 Governance

09:30, 30 min

1.1 Declarations of Interest

Eleanor Marks (Hywel Dda UHB - HDUHB Vice Chair)

1.2 Minutes from the Previous Meeting on 4 November 2025 and 4 December 2025 and Table of Actions

Eleanor Marks (Hywel Dda UHB - HDUHB Vice Chair)

1.3 Committee Self Assessment Report

Eleanor Marks (Hywel Dda UHB - HDUHB Vice Chair)

1.4 Targeted Intervention Progress Report

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

1.5 QSEC Terms of Reference for Review

Eleanor Marks (Hywel Dda UHB - HDUHB Vice Chair)

2 Unscheduled Emergency Care Accelerated Work Programme Update and Patient Story

20 min
Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Anna Chiffi (Hywel Dda UHB - Assistant Director of Nursing, Patient Safety, Quality)

3 Assurance

1 hr 30 min

3.1 Equity Impact Assessment Tool

Ardiana Gjini (Hywel Dda UHB - Executive Director of Public Health), Jo McCarthy (Hywel Dda UHB - Consultant in Public Health)

3.2 Management of Waiting Lists/DNAS/ Appointments:

Marilize Preez (Hywel Dda UHB - Improvement and Transformation Lead), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)

3.3 Quality Assurance Report

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

3.4 Safeguarding Update Report

Cathie Steele (Hywel Dda UHB - Interim Assistant Director of Nursing Assurance and Safeguarding), Sharon Daniel (Hywel Dda UHB - Executive Director of Nursing, Quality & Patient Experience)

4 Risk

20 min

4.1 Assurance and Risk Report- Executive Leads

4.2 Epilepsy in Learning Disabilities Update on Public Interest Report

Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Dana Scott (Hywel Dda UHB - Director of Midwifery & Professional Governance for Women & Children)

5 Sub Committee and Group Updates

20 min

5.1 Estates and Facilities Clinical Care Group

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

5.2 Listening and Learning Sub Committee and Terms of Reference for Review

Mark Henwood (Hywel Dda UHB - Executive Medical Director), Louise O'Connor (Hywel Dda Health Board - Assistant Director)

6 Policies for Approval

5 min

6.1	**Safety Alerts Policy** *Caroline Burgin (Hywel Dda UHB - Patient Safety and Assurance Manager)*	

7	**For Information**	

7.1	**QSEC Work Plan 2026-27**	

8	**Date of Next Meeting : 9 April 2026**	

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12/02/2026 09:30 - 12:30

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09:30, 30 Mins

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1 - Governance

1.1 **10:00,**

1.1 - Declarations of Interest

Eleanor Marks (Hywel Dda UHB - HDUHB Vice Chair)

1.2

1.2 - Minutes from the Previous Meeting on 4 November 2025 and 4 December 2025 and Table of Actions

Eleanor Marks (Hywel Dda UHB - HDUHB Vice Chair)

For approval

Attachments

2025-11-04 - Extraordinary Quality, Safety Experience Committee Meeting ~.pdf

2025-12-04 - Quality, Safety Experience Committee - Minutes.pdf

Table of Actions QSEC 4 December 2025.pdf

DRAFT MINUTES OF THE QUALITY, SAFETY & EXPERIENCE COMMITTEE

Date of Meeting: **13:00, Tuesday 04 November 2025**
Venue: **Microsoft Teams Meeting**

Present:
Eleanor Marks (Vice Chair)
Chantal Patel (Independent Board Member) Part
Michael Imperato (Independent Board Member)
Sarah Harraway (Independent Board Member)

In Attendance:
Bethan Lewis (Assistant Director of Public Health Strategic Business and Operations) deputising on behalf of Dr Ardiana Gjini
Caroline Burgin (Patient Safety and Assurance Manager)
Cathie Steele (Interim Assistant Director of Nursing Assurance and Safeguarding)
Ceri Wisdom (Service Delivery Manager)
Charlotte Wilmshurst (Assistant Director of Assurance and Risk) deputising on behalf of Mrs Joanne Wilson
Gareth Cottrell (Deputy Chief Operating Officer)
James Severs (Hywel Dda UHB - Executive Director of Allied Health Professions and Health Science)
Jonathan Arthur (Deputy Director of Health Sciences)
Katie Lewis (Committee Services Officer)
Neil Griffiths (Service Delivery Manager of Urology and Rheumatology)
Olwen Morgan (Assistant Director of Nursing)
Paula Goode (Service Director for Planned and Specialist Care)
Sara Jones (Service Delivery Manager - Endoscopy & Gastroenterology) (Part)
Sharon Daniel (Executive Director of Nursing, Quality & Patient Experience)
Subhamay Ghosh (Associate Medical Director For Quality & Safety)

Minutes Ref.	Item	Action
QSEC 25 (69)	**Welcome, Apologies and Matters Arising**	

Ms Eleanor Marks opened the meeting and informed the Committee that the Chair, Mrs Anna Lewis, had sent her apologies and would not be chairing any further meetings of the Quality, Safety and Experience Committee as her tenure had come to an end. The Committee expressed their sincere appreciation to Mrs Lewis for her outstanding leadership, kindness and vision throughout her time as Chair. Members acknowledged her measured approach, insightful contributions, and the quality of her questioning, all of which have greatly benefited the work of the Committee.

The Committee recorded their heartfelt thanks and best wishes to Mrs Lewis for the future, noting that she will be greatly missed.

Apologies were noted from:

- Amanda Glanville (Assistant Director of People Development)
- Ardiana Gjini (Executive Director of Public Health)
- Joanne Wilson (Director of Corporate Governance/Board Secretary)
- Louise O'Connor (Assistant Director)
- Mark Henwood (Executive Medical Director)

QSEC 25 (70) **Minutes of the extraordinary meeting that was held on 15 September 2025 and Table of Actions**

Decision: The draft minutes from the meeting held on 15 September 2025 were approved as an accurate record.

QSEC 25 (71) **Urology Deep Dive**

Mr Neil Griffiths presented an update on the Urology Service, supported by a slide deck outlining service fragilities, mitigation actions during the development of the Clinical Services Plan.

Mr Griffiths reported that the service continues to experience sustained pressures due to workforce gaps, diagnostic bottlenecks and theatre constraints. Despite these challenges, there has been consistent improvement in performance, including a reduction in the waiting list from approximately 8,000 to just over 5,600 patients over the past three years. Referral to Treatment (RTT) performance and outpatient throughput have also improved during this period.

A prostate pilot undertaken since 2023 has informed transformation plans for the prostate cancer diagnostic pathway and highlighted the need to expand the Clinical Nurse Specialist (CNS) team to enhance patient experience and pathway coordination. Short-term actions include MRI outsourcing and expansion of Local Anaesthetic Transperineal (LATP) biopsy capacity. Longer-term, the Clinical Services Plan aims to establish a dedicated Urology Investigation Unit to improve service sustainability.

Mr Griffiths advised that the service now has zero patients waiting over 52 weeks, with a Did Not Attend (DNA) rate of 1.1% for follow-ups, among the lowest in Wales. Improvements were attributed to better scheduling, enhanced patient engagement, and pathway efficiency.

Plans are in place to address ongoing diagnostic and theatre capacity challenges, including additional theatre sessions to reduce the ureteroscopy backlog, outsourcing MRI scans, and expanding LATP capacity. These measures are expected to improve cancer pathway performance from 25% to 68% compliance by March 2026. The team is also working to increase

Clinical Nurse Specialist (CNS) posts to support prostate and bladder cancer pathways, with discussions underway regarding potential funding from Prostate Cymru.

Mr Griffiths noted further actions to strengthen quality and safety, including expanded transfusion training following a recent ward incident, and the introduction of PKB and remote monitoring pathways for PSA patients by March 2026.

Mrs Sharon Daniel welcomed the reduction in open complaints over the past 20 months however queried the recent minor increase. Mr Griffiths explained that the rise was mainly associated with follow-up capacity pressures, which are being addressed through redesign of outpatient appointments. He confirmed that weekly meetings are held to review complaints and that themes identified have led to actions such as enhanced consent training.

In response to queries from Mrs Daniel and Mrs Patel regarding CNS workforce development, Mr Griffiths confirmed that plans focus on dedicated prostate and bladder CNS roles, with robust governance arrangements being developed to ensure appropriate supervision and collaboration within MDT structures.

Mrs Patel commended the operational recovery achieved to date but expressed concern regarding long-term sustainability. Mr Griffiths acknowledged ongoing reliance on diagnostic and theatre capacity across services and reiterated that the proposed Urology Investigation Unit will be key to delivering sustainable improvement.

Mr Michael Imperato queried whether a single metric could best demonstrate service stability. Mr Griffiths advised that the key indicators relate to the achievement of RTT targets and the 28-day diagnostic target for USC patients.

Ms Harraway sought clarification on the timelines for increased theatre capacity for patients awaiting ureteroscopy with stents in situ. Mr Griffiths advised that additional sessions are being pursued through the scheduled care planning process, with improvements anticipated by March 2026.

Mr Andrew Carruthers provided assurance that short-term actions are being implemented to support the cancer pathway and that improvements in access are expected by February 2026. He noted ongoing challenges with recruitment and funding for theatre capacity.

In response to queries from Mrs Patel and Ms Marks, Mr Griffiths confirmed that collaborative discussions are taking place with Swansea Bay University Health Board regarding resource sharing. He also explained that references to ‘fragmented communication’ relate primarily to system-wide capacity and outsourcing challenges.

Ms Marks highlighted the CNS expansion supported by Moondance funding and queried whether internal charitable funds had been considered. Mr Griffiths confirmed that charitable funds had historically supported service developments, including expansion of LATP capacity at Withybush Hospital, and that further use of charitable resources was being explored.

Mr Griffiths concluded that significant progress has been achieved in outpatient efficiency, diagnostics and governance. The next steps include securing additional theatre sessions, addressing diagnostic bottlenecks, expanding CNS capacity, and delivering sustainable transformation through the Clinical Services Plan. Ms Marks thanked Mr Griffiths for an informative and constructive presentation.

Decision: The Committee received assurance from the update.

QSEC 25 (72) **Dermatology Deep Dive**

Ms Ceri Wisdom presented an update on the Dermatology Service, supported by a slide deck, to provide assurance regarding the quality, safety, and experience aspects of the service during development of the Clinical Services Plan.

Ms Wisdom outlined significant service fragilities, primarily resulting from a national shortage of dermatology consultants and under-resourcing compared with Swansea Bay UHB, despite serving a similar population. The service currently operates mainly from Prince Philip Hospital with limited clinical space, having lost treatment rooms during the COVID-19 Pandemic and RAAC periods of work.

The service has worked to maintain stability despite workforce pressures, relying heavily on insourcing to meet demand. Dermatology remains one of the most highly referred specialties from Primary Care, receiving approximately 250 referrals per week. Demand is projected to increase by 32% for melanoma and 43% for non-melanoma cancers over the next 20 years, driven by population ageing and increased awareness.

Challenges were also highlighted in administrative capacity, resulting in delays to patient correspondence. While patient feedback is generally positive, negative feedback relates primarily to access and waiting times.

A patient story was shared illustrating the impact of service capacity constraints, where a patient was unable to access treatment in a timely manner and was subsequently treated via A&E and paediatric collaboration. The example emphasised the potential for harm arising from capacity limitations.

To stabilise and improve efficiency, Ms Wisdom emphasised that

the recruitment of at least two substantive consultant dermatologists is required. A recruitment campaign in December 2024 was unsuccessful, but the posts will be re-advertised. Three rooms within Day Services at Prince Philip Hospital have been identified for potential use, including one treatment room to reduce reliance on insourcing. Additional administrative capacity is being sought to address correspondence backlogs.

Ms Wisdom advised that establishing a dedicated dermatology hub would improve recruitment and retention by making the service more attractive to candidates. Upskilling of GPs continues to be progressed as part of service resilience planning.

Mrs Sharon Daniel queried the 800 complaints referenced in the slides, noting this does not seem to align with reported incident numbers, and sought assurance on the incident reporting culture. Ms Wisdom explained that the complaints data reflects activity since implementation of the Datix system in 2022 and confirmed ongoing efforts to strengthen incident reporting and learning. Mrs Daniel requested future reporting of complaint trends and outcomes to provide greater insight into patient experience.

Mr Michael Imperato asked about contingency plans and potential innovative solutions, such as remote consultant opportunities, to attract candidates. Ms Wisdom acknowledged reputational challenges linked to service fragility and advised that advertising both consultant posts simultaneously may encourage applicants through peer support. Nurse consultant roles are also being explored, although medical leadership remains essential.

Ms Harraway queried the shortage of administrative staff and noted the impact of delayed communication on patient experience. Ms Wisdom confirmed that the backlog is linked to increased activity from insourcing and that overtime is being used to address delays, but additional substantive administrative posts are required.

Ms Eleanor Marks queried whether regional solutions were being explored. Ms Wisdom confirmed ongoing collaboration with Swansea Bay UHB, including a shared plastic surgery post supporting skin cancer services. Ms Paula Goode added that the exploration of additional space at Prince Philip Hospital or the new Cross Hands development could facilitate greater regional working.

Ms Marks commended the increased engagement of GPs in dermatology and asked whether this could be expanded through the GP cluster arrangements. Ms Wisdom confirmed that two GPs currently work within secondary care, with interest from a third, and discussions with Workforce are underway to establish a formal training process to support wider GP participation.

Ms Marks thanked Ms Wisdom for a comprehensive and informative report. Members recognised the significant efforts of

the team in maintaining service delivery despite longstanding workforce shortages. However, the Committee expressed concern regarding the fragility of the service and the risk that recruitment efforts may not be successful.

Mr Imperato and Mrs Harraway emphasised that while technological solutions and GP upskilling are encouraging, these measures are unlikely to resolve the immediate challenges. Members agreed that the scale of fragility and risk should be formally highlighted to the Board.

The Committee commended the team for their commitment and proactive mitigations in extremely challenging circumstances.

Decision: The Committee noted the update and received partial assurance from the actions underway to mitigate risks ahead of Clinical Services Plan.

QSEC 25 (73) **Endoscopy Deep Dive**

Ms Sara Jones presented an update on the Endoscopy Service, supported by a slide deck, to provide assurance on how care is being delivered against the Safe, Timely, Effective, Efficient, and Patient-Centred principles (STEEEP) while awaiting the outcome of the Clinical Services Plan.

Ms Jones explained that many of the challenges currently faced by the service originated during the COVID-19 pandemic, when activity was paused and capacity reduced. This led to significantly extended waiting times for endoscopy procedures, compounded by ageing equipment and workforce shortages in key areas.

These combined factors created a substantial waiting list backlog. Recovery initiatives and workforce investment have since been implemented, resulting in diagnostic waiting times being restored to within ministerial standards and the diagnostic backlog fully cleared. However, approximately 1,300 patients remain on the surveillance waiting list. A recovery plan is in place, with full recovery expected by October 2026.

The service's inclusion in the Clinical Services Programme aims to ensure the ongoing maintenance of Joint Advisory Group (JAG) accreditation; and sustain delivery of waiting times and quality standards through service expansion.

Three of the four endoscopy units remain JAG-accredited and have maintained this status for 18 years. Prince Philip Hospital is not accredited solely due to environmental layout issues, although all other standards are met. Accreditation has been deferred twice in recent years owing to waiting time pressures; however, improvement trajectories are in place, and compliance against all other standards has been maintained.

The service undertakes monthly Endoscopy Quality and Safety meetings with multidisciplinary representation to promote learning,

review incidents, and identify trends. A downward trend in reported incidents has been noted since 2023.

Patient feedback mechanisms include written booklets, QR-code surveys, and a “critical friend” process through which staff follow up directly with patients (where consent is given) to explore themes in more depth. Patient satisfaction scores for safety, dignity, and comfort consistently range between 90–100%, reflecting high-quality care.

Ms Jones reported that diagnostic waiting times, which peaked at 100 weeks in 2023, have been reduced to 8 weeks since March 2025. The approved recovery plan, funded in June 2025, is being implemented and includes enhanced clinical validation and additional activity to address the surveillance backlog. Capital replacement of ageing endoscopy equipment remains a key focus, alongside ongoing workforce planning and demand–capacity modelling.

In response to a query from Ms Sarah Harraway regarding learning from the risk stratification process, Ms Jones advised that five patients are currently subject to a Root Cause Analysis to determine whether harm resulted from delayed surveillance procedures. Reviews are being undertaken with clinical leads, and findings will be reported through the governance framework once complete.

Ms Jones provided assurance that the service follows NICE and British Society of Gastroenterology (BSG) guidance to ensure patients are appropriately listed and prioritised, and that validation work has identified patients who no longer require follow-up procedures based on updated criteria.

Responding to a question from Mrs Daniel on the level of confidence in maintaining JAG accreditation, Ms Jones explained that annual evidence is submitted to the JAG assessors. The most recent review (September 2025) confirmed compliance against all standards except waiting times, which are affected by the surveillance backlog. Ms Jones expressed confidence that the agreed recovery trajectory will deliver compliance, with no more than 500 patients waiting by March 2026 and none overdue by October 2026.

Ms Jones noted that maintaining progress is dependent on continued access to enhanced staff payment rates (PARR rates) for weekend activity, as withdrawal of these rates could reduce staff participation and impact recovery. This risk is currently being monitored.

The Committee welcomed the positive progress made in clearing the diagnostic backlog and maintaining high standards of patient experience. Members noted the remaining challenge of the surveillance waiting list and the potential workforce and financial risks that could impact recovery delivery.

The Committee recognised the robust plans in place and the continued commitment of the Endoscopy team to delivering safe and timely care within available resources.

Decision: The Committee received assurance from the actions underway to mitigate risks ahead of CSP.

Date of Next meeting- 4 December 2025

Draft Minutes of the Quality, Safety & Experience Committee

Date of Meeting: **09:30, Thursday 04 December 2025**
Venue: **Microsoft Teams Meeting**

Present:
Anna Lewis (Independent Board Member) (Committee Chair)
Eleanor Marks (HDdUHB Vice Chair)
Sarah Harraway (Independent Board Member)
Chantal Patel (Independent Board Member)
Michael Imperato (Independent Board Member)

In Attendance:
Angela Bell (Assistant Director Quality, Safety and Patient Experience for Allied Health and Health Sciences) *(Part)*
Anna Chiffi (Assistant Director of Nursing, Patient Safety, Quality) *(Part)*
Ardiana Gjini (Executive Director of Public Health)
Caroline Burgin (Patient Safety and Assurance Manager)
Cathie Steele (Interim Assistant Director of Nursing Assurance and Safeguarding)
Craig Baker, (Cellular Pathology Services Manager)
Jo Bradburn (Deputy Director of Allied Health Professions) Deputising for Mr James Severs, (Executive Director of Allied Health Professions and Health Sciences)
Joanne Wilson (Director of Corporate Governance/Board Secretary)
Lianne Gregory (Service Delivery Manager) *(Part)*
Louise O'Connor (Assistant Director of Legal, Patient Experience)
Marilize Preez (Improvement and Transformation Lead) *(Part)*
Mark Henwood (Executive Medical Director)
Olwen Morgan (Assistant Director of Nursing)
Paula Goode (Service Director for Planned and Specialist Care)
Philip Kloer (Chief Executive)
Rebecca Richards (Head of Infection Prevention)
Sharon Daniel (Executive Director of Nursing, Quality and Patient Experience)
Subhamay Ghosh (Associate Medical Director for Quality & Safety)
Victoria Coppack (Service Delivery Ophthalmology & Neurology)
Katie Lewis (Committee Services Officer)
Louisa Morris (Clinical Director for Clinical Effectiveness) (Observing)

Apologies: Andrew Carruthers (Chief Operating Officer)

James Severs (Executive Director of Allied Health Professions and Health Science)

Minutes Ref.	Item	Action
QSEC 25 (69)	The Chair, Mrs Anna Lewis welcomed all to the meeting. Mrs Lewis acknowledged the retirement of Mr Sam Dentten (Llais Cymru), thanked him for his significant contributions to the quality, safety and experience agenda, and welcomed Ms Danielle Barisha as his successor. The Committee also expressed appreciation to Ms Jill Patterson for her long-standing service and expertise in Primary Care.	
QSEC 25 (70)	**Declarations of Interest** No declarations were made by the attendees.	
QSEC 25 (71)	**Minutes from the Previous Meeting that was held on 10 October 2025 and Table of Actions** Mrs Lewis invited comments on the accuracy of the minutes from the previous meeting. No points of accuracy were raised, and the minutes were approved. Discussion on the table of actions ensued, focusing on the progress of patient experience initiatives relating to action QSEC 25 (55). Mrs Lewis emphasised the importance of providing clear commitments and detailed updates at the next meeting to support the continued progress of this agenda. The table of actions was approved with the understanding that certain items will require follow-up. **Decision:** The minutes of the previous meeting were **approved**.	**LOC**
QSEC 25 (72)	**Assurance and Risk Report** Mrs Lewis acknowledged the challenge of providing broad assurance from the Assurance and Risk report and suggested adopting a risk-by-risk approach. In terms of QSEC 25 (57), relating to Corporate Risk Reference 797 - The ability to deliver ultrasound Sonography services due to workforce pressures, Mrs Joanne Wilson highlighted that this risk was discussed at length by the Executive Team the previous day. Despite ongoing mitigations, the risk score will remain high. Mrs Chantal Patel expressed concern regarding the inconsistencies presented in the report and the need for clarity between areas of improvement and those that are static or deteriorating. The Committee expressed concern with the proposed timescale of achieving the target score	

by 2030 and the Chair requested that the Board is alerted to the position. The Chair also requested a brief ahead of Board from the Lead Executive on how this is being managed **(AC)** and what the data is evidencing in terms of impact on patient safety and the mitigations in place.

The discussion shifted to the challenge of care in the corridor concerns, with Mrs Patel questioning whether this should be set out as an explicit risk. Mrs Sharon Daniel responded, outlining a task and finish group has been established to focus on non-designated clinical areas and related risk assessments. Mr Mark Henwood and Mrs Wilson further elaborated on the upcoming 45-minute handover risk assessment required by Welsh Government (WG). Ms Eleanor Marks and Ms Paula Goode contributed to the discussion, highlighting the multifactorial nature of corridor care risks, including safety, staffing levels, and health and safety concerns. The Committee agreed to keep the matter under active review and focusing on clearly articulating it within the risk management framework.

The Committee then addressed the urgent and emergency care risk, with Mrs Patel seeking clarity on the mitigations to reduce the risk score. Ms Goode provided examples of fast-tracking patients to appropriate departments, while Mark Henwood highlighted the upcoming paper on seven-day streaming services to direct patients to suitable pathways. Mrs Lewis acknowledged the complexity of the challenge and the need for continued discussion.

Mr Craig Baker outlined the mitigations to address the mortuary capacity (Risk 1552). He detailed the short-term measures, including purchasing and rental of additional body storage units, which provided 60 extra spaces to manage winter pressures. Financial support funded building works at Prince Philip Hospital, adding eight spaces, with further works planned to increase freezer storage capacity by seven spaces. Mr Baker emphasised the medium-term solutions to manage the Christmas and winter period, with plans to discuss long-term solutions early next year. The matter had been escalated to WG, highlighting a national concern regarding body storage capacity. Mrs Patel questioned whether the temporary mitigations were reflected in the current risk score. Mr Baker confirmed that the score had not been reviewed since they were implemented, advising that a review is planned to follow the completion of building works.

Mrs Louise O'Connor added that delays in body storage had caused distress to families, although provided assurance that the situation had improved recently. A new care after death bereavement manager had been appointed to establish a Health Board-wide service,

ensuring equity across hospital sites and proactive communication with families.

Mr Henwood reported that work is ongoing with performance monitoring in place, noting that death certification currently averages seven days. Efforts also focused on strengthening communication with religious groups and funeral directors, alongside discussions with the General Medical Council (GMC) regarding eligibility to sign death certificates.

Mr Baker highlighted improvements in the death certification process however expressed concerns regarding delays in collection by funeral directors, which are contributing to a storage backlog.

Mrs Lewis acknowledged the extensive efforts to manage the risk and will consider a request for further updates on the emotional impact on families.

The discussion moved to changes in Continuing Health Care (CHC) funding arrangements, with Mr Michael Imperato and Mrs Wilson noting the lack of national guidance and the anticipated impact of expected developments in April 2026. The Committee recognised the need for a prompt response once guidance is available.

The discussion concluded with Risk 1032 Autism Spectrum Disorder (ASD) diagnostics. Mrs Lewis questioned why the target risk score of 16 remains the same as the current score. Mrs Marks and Mrs Wilson highlighted resource constraints and the need for a strategic approach to address this high risk area. Dr Ardiana Gjini suggested a social model approach to ASD, while Mrs O'Connor highlighted the ongoing concerns from patients and the need for more resource for integrated hubs. Mrs Lewis emphasised the significant distress experienced by families and the need for intervention to enhance the service. The Committee agreed to escalate the issue to the Executive Team for a full review and future Board discussion. **(AC)**

No comments were made regarding the Welsh Health Circulars and Ministerial Directions relating to the Committee.

Decision: The Committee **received assurance** that risk management processes and identified controls are in place and working effectively.

QSEC 25 (72) **Targeted Intervention (TI) Progress Report**

Mrs Daniel presented the TI Progress Report, highlighting the two alert items within the report, proposing that these should be discussed later on the agenda under items 2.6 and 4 where key members of the respective services will be present.

Ms Olwen Morgan provided an update on the work to protect trauma capacity within theatres, noting that timely operations could reduce morbidity and mortality among frail, older patients.

The Committee took assurance from the action points, and Mrs Daniel raised additional points regarding the fragile service review and the escalation criteria for trauma services. The Committee acknowledged the extensive work by Ms Goode, Mrs Morgan, and Dr Ihab Abbassi, Associate Medical Director, Planned Care. The Committee expressed gratitude for the team's efforts and agreed to take assurance from the review.

Decision: The Committee **noted** the Targeted Intervention TI Progress Report.

QSEC 25 (73) **Listening and Learning Sub Committee (LLSC) Update Report**

Mrs O'Connor provided an overview of the LLSC's recent activities which provided a focus on the Mental Health and Learning Disabilities service. Matters discussed highlighted the importance of person-centred patient care planning, staff support following adverse incidents, and compliance with Health Inspectorate Wales (HIW) recommendations post-discharge review. A special thank you was made to the parents of Kieran, who attended the meeting to discuss the loss of their son and exhibited strength and determination to implement learning and improvements to mental health services. Mrs Lewis echoed the Committee's gratitude towards Kieran's parents for their dignity and grace in sharing their experiences despite their grief.

The discussions at LLSC also touched upon the public interest report for epilepsy and learning disability access, which will be revisited in the January 2025 Board meeting.

Mrs O'Connor shared a heartwarming story about Finley, a patient whose holistic care plan, including music and surf therapy, significantly improved his wellbeing and confidence, leading him to pursue training as a mental health nurse.

As previously discussed at Board, Mrs O'Connor highlighted the Sub Committee's intention to strengthen its terms of reference (ToRs) and membership to improve

assurance outcomes, with plans to present the revised ToRs for consideration at QSEC in February 2026.

Decision: The Committee noted the items that the Sub Committee advised them of.

QSEC 25 (74) **Listening and Learning from Events Framework**

Ms Cathie Steele updated the Committee on the progress of the Listening and Learning from Events Framework, which has been published on SharePoint and includes a learning library. The framework has been scrutinised by internal audit, with findings presented to the Audit and Risk Assurance Committee (ARAC). Ms Steele emphasised the need for a structured approach to learning, using various methods to share learning across departments and creating a culture of accountability for continuous improvement.

Mrs Marks raised a question about ensuring that learning experiences are implemented across the organisation, to which Ms Steele responded with examples of successful initiatives in response to learning such as the Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) project and the Message in a Bottle Programme. Mrs Daniel emphasised the need for spread and scale techniques to enhance the dissemination of improvements. Professor Philip Kloer highlighted the importance of routine listening and learning from service users, suggesting that the patient experience framework will help embed proactive communication into services.

Decision: The Committee **received assurance** on the implementation of the Health Board's Listening and Learning from Events Framework.

QSEC 25 (75) **Clinical Audit Programme**

Mr Henwood presented the clinical audit programme, describing its three strands: national clinical audits, local clinical audits, and nursing audits. The programme currently includes 94 audits, with a focus on sharing learning across the Health Board. Mr Henwood highlighted the new record-keeping audit programme and the engagement with clinical care groups to align audits with organisational priorities. The Committee discussed the need for a process to prioritise audits which will be discussed in more detail by the Executive Team, with suggestions for involving Committee Chairs and considering health equity audits. The Committee approved the clinical audit plan while expressing interest in being more involved in the decision-making process. **MH**

Decision: The Committee approved the Clinical Audit Programme 2025/26.

QSEC 25 (76) **Waiting List Management**

Ms Marilize Preez joined the meeting and provided an interim update on the review of waiting list management, revealing significant variability and inefficiencies in how waiting lists are managed across the Health Board. Key findings included the use of multiple waiting lists for the same specialties, reliance on non-standardised procedures, inconsistent discharge criteria, and poor communication with patients. The review highlighted the impact on patient experience and the need for improved governance and audit processes. Mrs O'Connor emphasised the importance of addressing poor communication, with plans for a workshop in January 2026 to improve patient experience. Ms Sarah Harraway and Ms Marks stressed the importance of considering the impact on patient outcomes and organisational efficiency, advocating for a customer service approach to improve overall patient experience.

Mrs Marks emphasised the strategic importance of improving this area for both the organisation and the patients it serves. Mrs Marks expressed optimism about the efforts to investigate the inefficiencies and complexities undertaken thus far and welcomed the development of a plan to implement improvements in the coming month.

Dr Gjini then highlighted the benefits of conducting a health equity audit, noting that those from socio-economically deprived backgrounds often experience the longest waits. Dr Gjini referenced the inclusion of beneficial elements in the digital plan for prevention and indicated that a senior leadership team member, Ms Glenna Jones, would be working on steering the initiative towards a "waiting well" service. Dr Gjini recognised the complexity of the challenge and welcomed the oversight being provided.

Mr Henwood added context by discussing the significant impact of delayed appointments and potential misdiagnoses, which can lead to severe outcomes such as loss of life from advanced cancer. He stressed the inefficiency of the current system and the importance of improved communication with patients to reduce Did Not Attend (DNA) rates. Mr Henwood noted the compassionate work of clinicians in overcoming communication challenges, however the systems in place are not consistent or reliable.

Mrs Daniel briefly touched on the impact, outcome, and value of the initiatives being discussed. She referred to the importance of linking early findings into upcoming Board papers on customer services and digital elements, ensuring that ongoing work is integrated and progressed effectively.

Mrs Wilson suggested that the various strands of work should be collated and presented to the Executive Team before returning to the Committee with a clear plan. Mrs Lewis supported this approach, acknowledging the urgency and importance of the work while emphasising the need for clear communication and respect towards patients. **SD/AC**

Prof Kloer concluded the discussion by recognising the scale of the challenges and the need for a fundamental overhaul of how the organisation connects with patients. He stressed the importance of balancing immediate improvements with long-term solutions. Mrs Lewis echoed this sentiment, suggesting that quick change ideas could be tested in isolated services to inform broader work.

Decision: The Committee **received assurance** that a full review and report relating to Waiting List Management will be completed for consideration to inform a Health Board action plan.

QSEC 25 (77) **Quality Assurance Report**

The Quality Assurance report discussion began with Ms Steele linking the report to earlier discussions on the Targeted Intervention update and routine areas discussed earlier in the meeting.

Thanking Ms Steele, Mrs Lewis reflected on the report's evolution since 2018, noting significant improvements in data presentation. She suggested further refinements to enhance readability and ensure focus on key priorities and proposed a review of how effectively the report meets the Committee's needs.

Mrs Daniel expressed optimism that the development of Clinical Care Group (CCG) reports would allow for less detail in the overarching assurance report, improving its clarity and effectiveness.

Ms Steele considered reverting to a paper format to provide more narrative and learning behind the data, suggesting that the report could serve as a supporting document rather than a primary narrative. The Committee

decided to review the format of the quality assurance report to enhance readability and focus on key areas. **CS**

Mrs O'Connor provided an update on complaints management, correcting figures in the targeted intervention report and detailing progress in reducing the backlog of complaints. She highlighted progress to improve the timeliness of complaint resolutions and the upcoming implementation of new regulations.

Ms Harraway raised a broader concern about demonstrating the impact of closed actions on reducing risk and improving patient experience. Ms Steele acknowledged the need to shift the report's focus towards impact and learning.

Ms Rebecca Richards discussed challenges in infection prevention and control (IPC), particularly around C difficile rates. She highlighted operational pressures, such as ambulance handovers and surge capacity boarding, which impact IPC compliance. Ms Richards outlined ongoing projects aimed at reducing infections and improving antimicrobial stewardship.

Dr Gjini added context on the predisposition of the local population to infections due to factors like aging and comorbidities. She noted that while the number of cases is small, fluctuations are high due to extensive testing.

Mr Henwood expressed optimism that upcoming initiatives, such as electronic prescribing, would enhance oversight and help reduce infection rates. He emphasised the importance of linking services and projects to achieve meaningful improvements.

Mrs Daniel suggested including primary care prescribing data in future reports to identify any outliers and provide a comprehensive view of infection prevention work.

Ms Richards provided an update on flu prevalence and the Health Board's approach to universal masking, explaining the rationale behind monitoring prevalence and reviewing risk assessments.

Mrs Lewis concluded the discussion by acknowledging the comprehensive nature of the report and the assurance it provided, while noting that this assurance is subject to the issues raised during the discussion.

Decision: The Committee **received assurance** that processes are in place to review, monitor and improve the quality of services through various mechanisms contained within the report.

QSEC 25 (79) **Deep Dive: Orthopaedics**

Mrs Lianne Gregory provided an in-depth analysis of orthopaedics service delivery, highlighting three key areas: service delivery, quality and safety, and patient experience. She emphasised the challenges posed by WG performance management, particularly for complex patients requiring extensive pre-operative and surgical planning. Mrs Gregory noted significant progress in reducing pathway waits from four years to two and detailed current progress to further reduce the wait for the first outpatient appointment to 26 weeks through an in-sourcing contract.

From a quality and safety perspective, Mrs Gregory described the establishment of a Health Board-wide departmental meeting for sharing learning, presenting complex cases, and delivering training. This initiative involves all grades of medical staff, ward staff, physiotherapists, Allied Health Professions aiming to engage all involved in the patient pathway. She also reported a reduction in the volume and length of open waiting incidents, with only eight open Datix incidents in trauma orthopaedics as of the previous day.

Regarding patient experience, Mrs Gregory highlighted enhancements in patient communication and support through the introduction of the waiting list support service, a single point of contact, and an orthopaedic prehabilitation service. She shared positive feedback, with 60% of patients appropriately supported by the waiting list service and 40% by the orthopaedic prehabilitation service.

Looking ahead, Ms Gregory outlined proposed plans to increase efficiency and productivity to meet Getting Things Right First Time (GIRFT) standards for joint replacement surgery. These plans include aligning job plans for consultants and anaesthetists, ensuring consistent theatre teams, and maximising the use of main theatre environments. She stressed the need for general anaesthetic sessions at the Prince Philip Day Surgery unit to shift activity from main theatres, thereby increasing arthroplasty volumes.

Quality monitoring plans involve strengthening assurance through compliance with best practice standards and monthly reviews of elective activity, including auditing Key Performance Indicators (KPIs) around surgical site infections, complications, and revision rates. Mrs Gregory also mentioned the need to address data entry backlogs for the National Joint Registry and the National Hip Fracture Database.

From a patient experience perspective, Mrs Gregory proposed reducing multiple patient attendances through multidisciplinary clinics and implementing a virtual joint school alongside the waiting list support service and orthopaedic prehabilitation service.

Mrs Lewis thanked Mrs Gregory for her comprehensive presentation and opened for questions. Mrs Harraway raised concerns about the separation of trauma and elective services, questioning whether improvements in elective orthopaedics could impact trauma services. Mrs Gregory acknowledged the interdependencies between trauma and elective services and emphasised the importance of addressing both elements in a coordinated manner.

Mr Imperato inquired about productivity challenges related to theatre capacity. In response, Mrs Gregory explained the importance of delivering elective inpatient activity at sites meeting British Orthopaedics Association (BOA) standards and highlighted the potential to increase joint replacements per list through regular theatre staff and consultant anaesthetist alignment.

Mrs Patel enquired about the impact of lower medical activity on surgeons' skills. Mrs Gregory provided reassurance that consultants are delivering an appropriate volume of joint replacements annually, although achieving GIRFT standards would require further efficiency improvements. Mr Henwood provided additional assurance, noting the availability of detailed surgeon data through the National Joint Registry, which evidences no current issues with surgeon performance.

Ms Goode referenced the establishment of a theatre steering group to drive efficiency and productivity, with feedback from recent theatre walkarounds indicating areas for improvement.

Mrs Lewis concluded the discussion, expressing satisfaction with the thoroughness of the discussions and the helpfulness of the prepared slides. She encouraged Committee members to refer back to these resources in preparation for the Clinical Services Plan discussion at the Board.

Decision: The Committee **received assurance** from the Deep Dive: Orthopaedics report, recognising the strong case for change and the effectiveness of current mitigations.

QSEC 25 (80) **Deep Dive: Ophthalmology**

Ms Victoria Coppack, Service Delivery Manager for Ophthalmology and Neurology presented a detailed overview of the ophthalmology service, focusing on workforce challenges, service delivery risks, and efforts to improve patient care. She outlined the challenges experienced by delivering services across eight separate sites, which impacts recruitment, retention, training, and development of staff. Ms Coppack highlighted the fragility of the service, particularly in terms of out-of-hours on-call coverage and the reliance on a limited number of consultants.

Ms Coppack detailed the risks associated with intravitreal waiting times and delivery, noting the high-risk cohort of patients at risk of permanent sight loss. She emphasised the significant investment received to improve services, including recruiting additional staff and running additional weekend clinics. Plans to increase clinic capacity at various sites, including Cardigan and Withybush Hospital (WGH) were discussed, along with the outsourcing of intravitreal injections.

The challenges of clinic delivery and theatre capacity were addressed, with Ms Coppack noting the need to move intravitreal injections out of Amman Valley Day Hospital to outpatient departments to increase cataract delivery. She also highlighted the importance of regional consultant recruitment to support the service and improve on-call rota coverage.

Ms Coppack provided assurance on progress to manage feedback and incidents, particularly around waiting times, by regularly validating waiting lists and prioritising high-risk patients. She discussed the need for advanced roles within ophthalmology, similar to those implemented in Swansea Bay University Health Board, to maximise efficiency and capacity.

Mrs Marks raised questions about population health and the impact of an ageing population on service demand. Mrs Coppack acknowledged the growth in the ageing population and the importance of primary care input, particularly through the Welsh General Ophthalmic Services (WGOS) framework. She emphasised the need to increase service capacity and efficiency to manage the growing demand.

Dr Gjini added that regular testing and early management could reduce the clinical need for eyesight services, aligning with broader population health strategies.

Mrs Lewis thanked Mrs Coppack for her comprehensive presentation, noting the importance of the fragility scoring matrix in understanding service challenges. Committee

members agreed to take assurance from the discussion and recognised the detailed case for change presented.

Decision: The Committee **received assurance** from the Deep Dive: Ophthalmology report and recognised the detailed case for change presented.

QSEC 25 (81) **Deep Dive: Radiology**

Ms Angela Bell provided an overview of the Radiology Service, focusing on the recent escalation from level 2 to level 3 in the fragile services domain. She highlighted the challenges experienced by the senior leadership team and the impact on timely care delivery.

Ms Bell discussed the investment received in Radiology and the positive impact on service quality, particularly in terms of timely care. She also addressed key challenges in the sonography service, noting the need for additional resources and support.

The discussion provided assurance on the progress in managing service fragility and improve patient care, recognising the importance of ongoing investment and leadership support.

Members expressed satisfaction with the detailed overview and agreed to take assurance from the discussion, acknowledging the challenges and mitigations in place.

Decision: Members **received assurance** from the Deep Dive: Radiology report, acknowledging the challenges and mitigations in place.

QSEC 25 (82) **Operational Allied Health Services Clinical Care Group Update**

Ms Bell addressed the Committee regarding the challenges and progress within the sonography service. She highlighted the prolonged absence of a key team member and the increased fragility in the sonography service, particularly after the retirement of two workforce members in WGH area. This has resulted in a heightened risk score from 20 to 25. Despite these challenges, Ms Bell reported positive developments such as the annual plan funding which has enhanced radiography and radiology capacity, although demand still exceeds capacity. Plans are in place for further investment in future annual planning, and the creation of the care group operating model is seen as a beneficial step for early discussions about service impacts on diagnostics.

Ms Bell also referenced cross CCG collaboration and support from the Director of Delivery, aiming to establish

an integrated midwifery sonography service over the next one to three years. Interim plans include extending insourcing for the current workforce, addressing the national shortage of sonographers. Efforts are underway to enhance leadership within the radiography team, including appointing a quality manager and a specific leadership role to facilitate cross care group discussions and identify effective ways of working.

Mrs Lewis acknowledged the earlier discussion on ultrasound risks and enquired whether there has been a significant increase in MRI requests over the past five years. Ms Bell agreed to share this information following the meeting. Members expressed concerns regarding the increasing number of risks identified. Ms Bell explained that introducing fresh perspectives within the CCG had enabled a more thorough review of the risk register, resulting in a 30% increase in identified risks. This was seen positively as it provided clarity on risks, mitigations, and areas requiring escalation. **AB**

Mrs Daniel suggested focusing on fragile services and workforce planning, particularly in transitioning from historically medical procedures towards enhanced advanced and consultant level practice. Ms Bell welcomed this support, which would align with the intention of clinicians working to top of their licence.

Mrs Lewis summarised the importance of understanding the drivers behind quality, safety, and experience proposals, recognising Radiology's central role in patient care pathways. She encouraged colleagues to use this information for Board discussions and thanked Ms Bell for her presentation.

Decision: The Committee took assurance on the quality governance arrangements in place within the Clinical Care Group in relation to quality safety and patient experience.

QSEC 25 (83) **Community and Integrated Medicine Clinical Care Group Update**

Mrs Anna Chiffi discussed the alignment of systems across the CCG to ensure equitable access to services. She provided an example from respiratory services where lung cancer services are centralised in Prince Philip Hospital, however efforts are made to ensure equitable access for all residents within the Health Board. Mrs Chiffi emphasised the importance of clear pathways of care, regardless of geographic location.

Ms Harraway expressed concern regarding monitoring equitable access and service provision. In response, Mrs

Chiffi explained the thematic approach being taken to address audit recommendations and the establishment of a whole system learning panel chaired by Dr Karen Brown, Associate Medical Director. This Panel reviews audits, incidents, complaints, concerns, and mortality cases, generating actions to embed learning and improve services. Mrs Chiffi highlighted the ambition to create a psychological safety environment and shared accountability for learning.

Mrs Marks questioned the implementation of audit recommendations and their impact. Mrs Chiffi detailed the focus on thematic processes and the monthly learning panel, aimed at embedding learning and foster improvements. Mrs Marks expressed reassurance in the process and management of audits.

Dr Gjini introduced the health equity impact assessment tool, designed to ensure equitable service provision. Dr Gjini stressed the difference between equal access and equitable services, aiming for everyone to benefit equally from services rather than just equal distribution.

Mrs Daniel enquired about the processes in place to reduce the escalation status. Mrs Chiffi described ongoing work to reduce open incidents, which include holding focused meetings, protecting time for ward managers, and implementing scrutiny panels. While acknowledging the challenges, she reported progress in achieving timely closure of incidents and embedding thematic learning.

Decision: The Committee took assurance on the quality governance arrangements in place within the CIMCCG in relation to quality safety and patient experience.

QSEC 25 (84) **Planned Care and Specialist Services Clinical Care Group**

Ms Morgan discussed the complexity of the CCG and the maturity of governance arrangements. She highlighted the backlog of outstanding mortality proportionate investigations and the steps undertaken to address these, including targeted meetings and the involvement of the Clinical director for Planned Care. Ms Morgan emphasised the importance of sharing learning across the CCG's.

Mrs Lewis expressed concern regarding a recent clinical health knowledge report which has identified that Glangwili Hospital (GGH) has almost twice as many mortality rates as Bronglais Hospital (BGH) and Withybush Hospital (WGH) for post operative trauma patients. Ms Morgan explained that the absence of orthogeriatric services at GGH is adversely affecting

patient outcomes. Work is currently underway to address this issue through collaboration with other care groups to enhance orthogeriatric provision and reduce patient outliers. Mr Henwood acknowledged that the mortality rates are unacceptable and emphasised the need for a scientific review to understand the underlying causes. He has commissioned a colleague to undertake this review, which will provide a comprehensive analysis and potential solutions. The Committee will receive an update ahead of the next meeting. **MH**

Mrs Wilson provided additional context, referencing the clinical health knowledge systems report indicating almost double mortality rates for hip fractures. This underscored the urgency of addressing orthogeriatric service gaps and improving patient outcomes.

The discussion concluded with a recognition of the need for continued focus on governance, learning, and collaboration across care groups to address complex challenges and improve patient care.

Decision: The Committee **received assurance** on the quality governance arrangements in place within the Planned Care & Specialist Clinical Care Group in relation to quality, safety and patient experience.

QSEC 25(86) **Use of Production Survey Guideline 568**

Mrs O'Connor presented the updated guidelines for staff who wish to produce a patient-related survey. The guidelines have been updated in line with the new People's Experience Framework and the new national survey. The consultation process confirmed that the updated guidelines present no impact from an equality perspective.

Decision: The Committee ratified the updated Production and Use of Surveys Guidelines Policy number 568.

QSEC 25 (87) **QSEC Work Plan 2025-26**

QSEC 25 (88) **Date of Next Meeting: 12 February 2026**

QSEC 25 (89) **Any Other Business**

Mrs Daniel and other members acknowledged Mrs Lewis's contributions and impact on the Committee and the organisation since taking on the role of Chair of the Committee. Mrs Lewis thanked everyone for their kind words and emphasised the importance of teamwork in achieving success.

GIG CYMRU NHS WALES
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University Health Board

TABLE OF ACTIONS FROM
QUALITY, SAFETY & EXPERIENCE COMMITTEE (QSEC) MEETING
HELD ON 4 DECEMBER 2025

Reference	Item	Responsible	Timescale	Update
QSEC 25 (55)	• **Table of Actions:** To confirm timelines to report back findings from engagement events to try to ascertain why the patient experience feedback from ethnic groups varies from other groups within the demographic data.	**LOC**	~~**4 Dec 2025**~~ **9 April 2026**	**Complete:** The findings will be reported via the Quality Assurance Report in April 2026.
QSEC 25 (72)	• **Assurance and Risk Report:** To share with the Chair of QSEC a more detailed brief on how risk 797 relating to Ultrasound and Sonography services is being managed, the impact on patient safety and mitigating actions.	**AC**	**11 Dec 2025**	**Complete**
QSEC 25 (72)	• **Assurance and Risk Report:** To consider articulating a risk relating to Corridor Care within the risk management system.	**AC**	**29 Jan 2026**	**Complete:** The Executive Team discussed this as corridor care is currently incorporated within Risk 1027. It was agreed that Risk 1027 would be reviewed and provide clarity on how corridor care is managed and risks mitigated.
QSEC 25 (72)	• **Assurance and Risk Report:** To escalate Risk 1032 autism spectrum disorder (ASD) diagnostic waiting times to the Executive Team for a comprehensive review and future Board consideration.	**AC**	**21 Jan 2026**	**Complete**

QSEC 25 (73)	• **Listening and Learning Sub Committee Report:** To strengthen the Listening and Learning Sub Committees terms of reference and membership to improve assurance outcomes, with plans to bring revised ToR to the Committee for consideration in February 2026.	**MH/ SD/ LOC**	**29 Jan 2026**	**Agenda item 5.2 on the agenda**
QSEC 25 (75)	• **Clinical Audit Programme:** To discuss developing a process to prioritise audits at Executive Team, with suggestions to involve Committee Chairs and to also considering health equity audits.	**MH**	**21 Jan 2026**	**Complete:** Clinical Audit will ask clinical executives and Committee Chairs during February 2026 for priority audits which will be reported during 2026/27
QSEC 25 (76)	• **Waiting List Management:** To bring together the various strands of work relating to the waiting list management issues to the Executive Team to develop a clear plan before returning to the Committee in February 2026.	**MP/ SD/ AC**	**29 Jan 2026**	**Complete:** Agenda item 3.2
QSEC 25 (77)	• **Quality Assurance Report:** To consider a review the format of the quality assurance report to enhance readability and focus on key areas.	**CS/ SD**	**29 Jan 2026**	**Complete:** Review of quality assurance report undertaken taking into account discussion at the December meeting. Agenda item 3.3
QSEC 25 (82)	• **Operational Allied Health Services Clinical Care Group Update:** To clarify why there has been such a significant increase in Magnetic Resonance Imaging (MRI) scans	**AB**	**29 Jan 2026**	**Complete:** The increase in demand for MRI aligns with the national trend, with both inpatient and outpatient requests rising. For inpatients, the increase corresponds with the development of national pathways, such as those for stroke. In the context of cancer staging, MRI usage has escalated in line with treatment pathways, now requiring multiple MRI scans instead of a single Computerised Tomography (CT) scan. Furthermore, direct access to MRI for patients with

				Musculoskeletal diagnoses represents another area of growth.
QSEC 25 (84)	• **Planned and Specialist Care:** To undertake a review to provide a comprehensive understanding of recent clinical health knowledge (CHKs) report which has identified that Glangwili Hospital (GGH) has almost twice as many mortality rates as Bronglais Hospital (BGH) and Withybush Hospital (WGH) for post operative trauma patients	**MH/ SG**	**29 Jan 2026**	**Complete:** A report is being presented to the Integrated Quality, Finance and Performance Delivery Group on 11 March and QSEC will receive an update on 9 April 2026.

LOC: Louise O'Connor	AC: Andrew Carruthers	MH: Mark Henwood	CS: Cathie Steele	OM: Olwen Morgan
SD: Sharon Daniel	SG: Subhamay Ghosh	AB: Angela Bell	MP: Marilize Preez	

1.3

1.3 - Committee Self Assessment Report

Eleanor Marks (Hywel Dda UHB - HDUHB Vice Chair)

For approval

Attachments

1.3 QSEC Committee Self Assessment.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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:	Quality Safety and Experience Committee (QSEC) Self-Assessment Report 2025/2026
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Joanne Wilson, Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	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 purpose of the report is to present the outcome of the Quality and Safety Committee Self-Assessment 2025/2026 process to the Committee.

Cefndir / Background

In line with Section 10.2.1 of Standing Orders, the Board is required to introduce a process of regular and rigorous self-assessment and evaluation of its own operations and performance and that of its Committees and Advisory Groups. Section 10.2.2 also states that each Committee must also submit an annual report to the Board 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 sub-Committees it has established.

In addition to the annual Committee self-assessment process, after each meeting Independent Member (IM) Reflective Sessions take place to gather feedback and insights from Members on the meeting, in terms of what has gone well, what could have gone better, how quality has informed discussions, and issues that need to be raised at the Committee Chair's meeting. This feedback helps with the evaluation process and continuous improvement.

During previous years, Committee self-assessments have been based on a comprehensive review of feedback provided by the Committee Membership from the completion of a long questionnaire assessment. While these approaches provided valuable insights, they also led to survey fatigue and limited engagement. Feedback from a recent Corporate Governance Conference has highlighted the need for a proportionate process for assessment that avoids unnecessary complexity. This year's approach will streamline the assessment, focusing on critical governance behaviours and outcomes rather than exhaustive questionnaires.

This year's Committee self-assessment form focuses on five core areas of governance and assurance:

Oversight and Impact on Quality & Safety
The Committee effectively oversees and influences improvements in the organisation's quality and safety outcomes.

Data, Indicators, and Assurance
The Committee receives good quality papers and uses accurate, timely, and relevant data to provide assurance on quality and safety experience, impact and outcomes for patients.

Culture and Accountability
The Committee promotes a culture of safety, transparency, and learning across the organisation.

Risk Recognition and Response
The Committee effectively identifies and responds to emerging quality and safety risks.

Continuous Improvement and Committee Effectiveness
The Committee regularly evaluates its own performance and takes steps to improve its effectiveness and strategic influence.

Asesiad / Assessment

To improve response rates, taking into account that there is a process of continuous improvement through the IM Post Committee Reflective Sessions, a short questionnaire was circulated to members to gather feedback on 5 key areas for the Committee.

Respondents were asked to rate their level of agreement to 5 statements relating to key areas of focus for the Committee on a scale of 1–5. (1 - strongly disagree up to 5 – strongly agree) and to provide more information to support their rating.

Below are the statements relating to 5 key areas of focus for the Committee and the average ratings based on the responses received 5 (out of 9) responses were received (56% response rate).

Area and Statement	Average Rating
Oversight of quality & safety outcomes *The Committee effectively oversees and influences improvements in the organisation's quality and safety outcomes.*	4.4
Data, Indicators, and Assurance *The Committee receives good quality papers and uses accurate, timely, and relevant data to provide assurance on quality and safety experience, impact and outcomes for patients.*	3.4
Culture and Accountability *The Committee promotes a culture of safety, transparency, and learning across the organisation.*	4.4
Risk Recognition and Response *The Committee effectively identifies and responds to emerging quality and safety risks.*	4.2
Continuous Improvement and Committee Effectiveness *The Committee regularly evaluates its own performance and takes steps to improve its effectiveness and strategic influence.*	4.2

The following themes were provided:

What has gone well:

- Effective chairing and strong Independent Member engagement.
- Effective scrutiny through high support and high challenge to those delivering the services.
- A positive culture of professionalism, openness and transparency.
- Continued oversight of areas requiring improvement.
- The revised approach to writing papers using the Domains of Quality (STEEEP) and enablers as outlined in the Duty of Quality support continuous quality improvement.

What we want to strengthen going forward:

- Strengthen operational reporting by focussing on outcomes and impacts to quality, supported by data, with less focus on performance, to avoid risks being reported after they have materialised.
- Strengthen operational governance to minimise 'surprises' and being proactive in considering urgent service issues/changes.
- Continue to improve quality of data reported to Committee

Suggestions from Respondents

- Consider Cross-Committee triangulation
- A more proactive approach in terms of risk management and control.

Overall Conclusion

The Committee is performing strongly, with high ratings across all domains. It demonstrates maturity and continuous improvement, supported by effective leadership and robust processes.

Area for improvement	By Whom	By When
Ensure report authors receive feedback on the quality of their papers being brought to Committee in order to improve and develop. More focus on the key themes such as risk, outcomes, impacts relating to patients etc.	Executive Leads	March 2026
To strengthen operational governance arrangements to reduce reporting of urgent service issues/changes and facilitate more proactive reporting of risks before they materialise	Chief Operating Officer	July 2026

Argymhelliad / Recommendation

The Committee is asked to **CONSIDER** the outputs from the Committee Self-Assessment process and **AGREE** to the actions to be taken to improve its effectiveness.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committees 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 Audit Committee Handbook.1
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)	Not Applicable
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:	QSEC Terms of Reference QSEC Self-Assessment digital form results
Rhestr Termau: Glossary of Terms:	Included within the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg Parties / Committees consulted prior to Audit and Risk Assurance Committee:	Director of Corporate Governance

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:	No direct impacts
Risg: Risk:	No direct impacts

Cyfreithiol: **Legal:**	No direct impacts
Enw Da: **Reputational:**	No direct impacts
Gyfrinachedd: **Privacy:**	No direct impacts
Cydraddoldeb: **Equality:**	No direct impacts

1.4

1.4 - Targeted Intervention Progress Report

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

Attachments

1.4 Targeted Intervention Update.pdf

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Quality, Safety and Experience Committee
Escalation De-escalation Criteria Progress Update

12 February 2026

Introduction

This pack provides the Quality, Safety and Experience Committee (QSEC) with an evidence-based update against the Targeted Intervention (TI) de-escalation criteria within the Quality, Safety and Experience remit. It triangulates the latest position across Urgent and Emergency Care (UEC) services within Community and Integrated Medicine (CIM), Planned Care and Cancer within Planned and Specialist CCG (PSC), hospital-acquired infections (HCAI), and our response to HIW inspections and wider regulatory requirements.

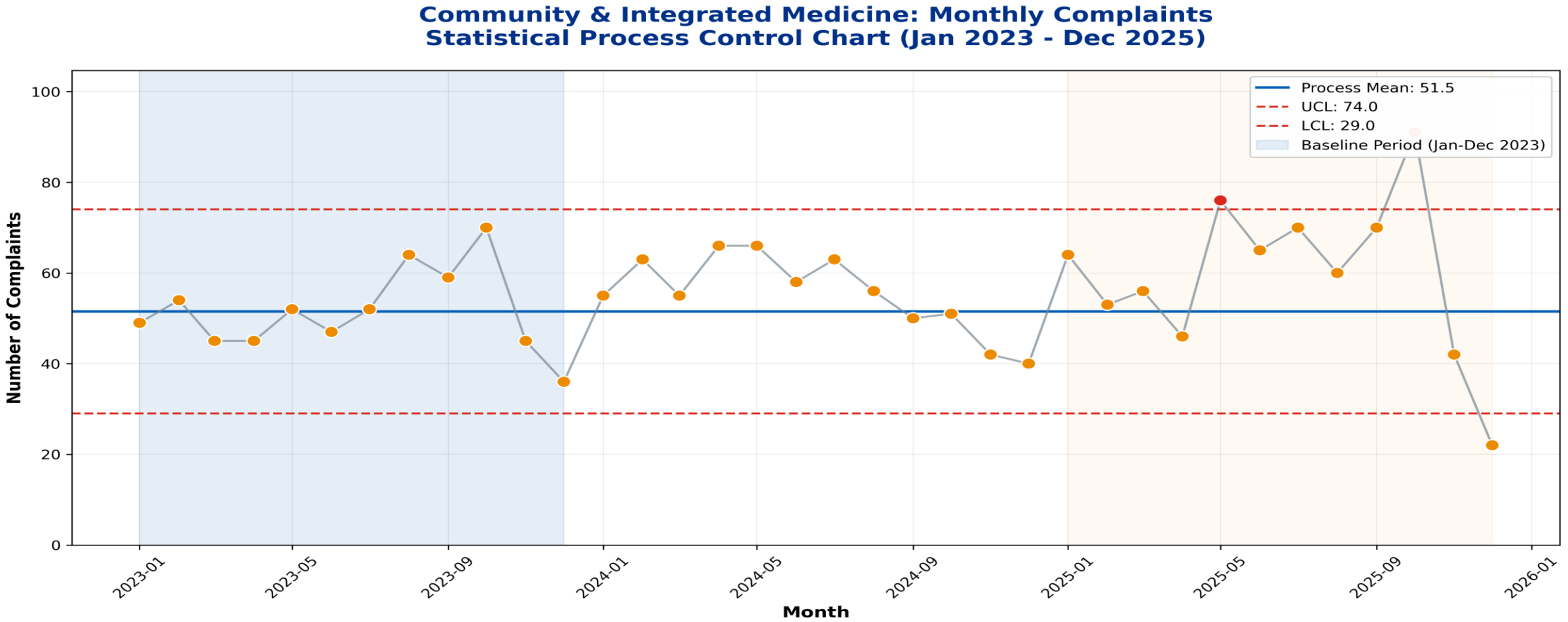
The update draws on the 'Our Performance' dashboard (as at December 2025), aligned Datix/complaints extracts for the relevant service cuts, the Health Inspectorate Wales (HIW) inspections action dashboard (as at 29 January 2026), and the Beacon dashboard summary slides included within this pack. The purpose is to provide QSEC with clear line of sight on: (i) current position against the de-escalation thresholds; (ii) the scale and ageing of incidents, complaints and regulatory actions; (iii) the credibility of improvement trajectories and evidence of sustainability; and (iv) where assurance remains constrained and further executive intervention is required.

Introduction

TI Reference	Criterion Summary	Committee Relevance	Current Rating
MD1	Ability to identify early signs of service fragility through triangulation of workforce, incidents, complaints, mortality and regulatory intelligence	Fragile Services Framework oversight, escalation to QSEC	**Advise**
MD2	Leadership, accountability and improvement planning in fragile services, including clinical leadership appointments and Project Management support	Improvement plan integrity and leadership assurance	**Advise**
MD3	Tracking and closing external recommendations (HIW, Royal Colleges, regulators) through a central, reliable system	Quality governance, external recommendation assurance	**Advise**
MD4	Board visibility and oversight of fragile services, including routine reporting of trajectories and improvement milestones	QSEC scrutiny of fragile services reporting before Board	**Advise**
MD5	Handling of concerns, complaints and incidents within UEC, including responsiveness, investigation timeliness and learning	Incident/complaints governance, UEC safety and learning	**Advise**
MD6	Reduction in Clostridioides difficile infections (hospital-onset ≤6 cases for 3 consecutive months)	Infection Prevention Control (IPC) performance oversight; organism-specific reduction	**Advise**
MD7	Reduction in Staphylococcus aureus bacteraemia (hospital-onset ≤2 cases for 3 consecutive months)	IPC oversight; bacteraemia performance	**Alert**
MD8	Reduction in Escherichia coli bacteraemia (hospital-onset ≤5 cases for 3 consecutive months)	IPC oversight; urinary/biliary infection improvement	**Alert**
MD9	Addressing root causes of hospital-acquired infections (learning, environmental audits, HPV, training compliance, pathways)	System-wide IPC assurance	**Alert**
MD10	Planned care incident, complaint and feedback management, and patient experience during long waits	Incident governance, complaints performance, PX	**Alert**
MD11	Prompt and effective responses to HIW inspections, regulatory notices, never events and coroners' reports	Regulatory assurance oversight	**Advise**
MD12	Improving patient and family feedback; timely complaint resolution; embedding learning	Patient experience governance	**Alert**

TI-2025/547/MD5/3 – Community and Integrated Medicine (CIM) Complaints

ADVISE



SPC Analysis Key Points

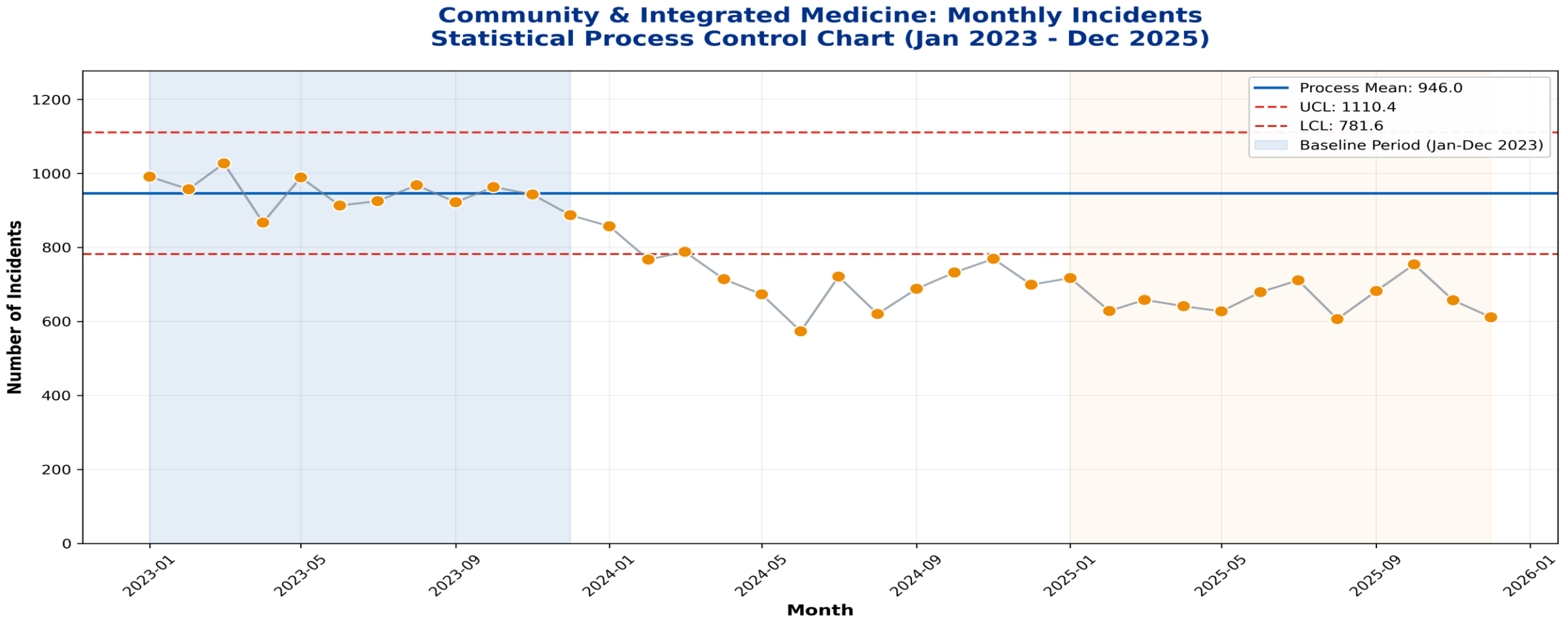
- Process mean: 51.5 complaints/month (baseline Jan-Dec 2023)
- UCL: 74.0 | LCL: 29.0
- 2025 mean: 59.6 (16% above baseline)
- October spike (91) exceeds UCL – special cause
- December drop (22) below LCL – requires investigation

Rationale – Advise

The SPC chart shows common cause variation with isolated special cause signals. The October spike (91 complaints) exceeded the upper control limit, whilst December showed an unusually low count (22). The process mean has shifted upward in 2025 compared to baseline. Whilst not demonstrating sustained [illegible]on, the volatility and upward drift warrant continued monitoring to ensure the underlying process remains stable.

TI-2025/547/MD5/3 – CIM Incidents

ADVISE



SPC Analysis Key Points

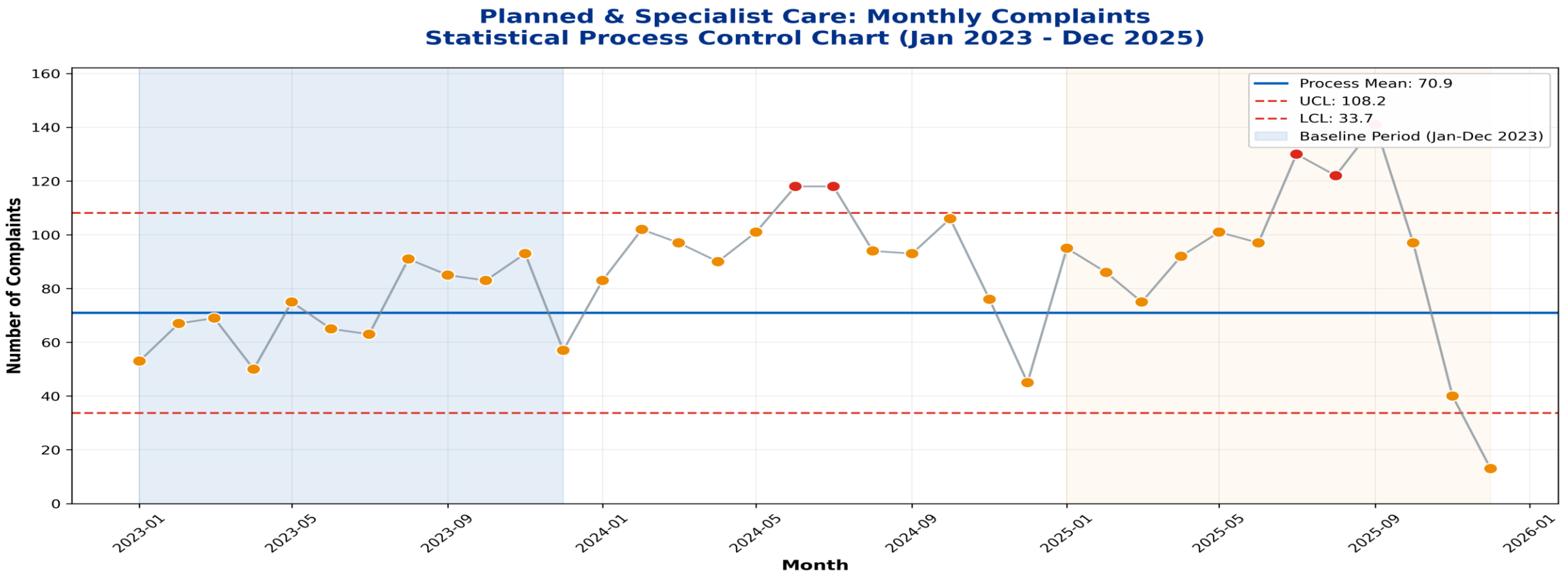
- Process mean: 946 incidents/month (baseline)
- UCL: 1,110 | LCL: 782
- 2025 mean: 664 (30% reduction from baseline)
- 22 points below LCL – sustained special cause (positive)
- 19 consecutive runs below mean confirms process shift

Rationale – Advise

The SPC chart demonstrates positive special cause variation, with a sustained and significant reduction in incident volumes from the 2023 baseline. The 30% reduction represents meaningful improvement in incident occurrence (New not Backlog). However, the narrative context reveals that 1,663 incidents remain over 3 months old with some cases exceeding 1,400 days. Whilst new incident volumes have reduced, the backlog clearance [illegible]on timeliness remain significant concerns, preventing an Assure rating.

TI-2025/547/MD10/1 – Planned and Specialist Care (SCP) Complaints

ALERT



SPC Analysis Key Points

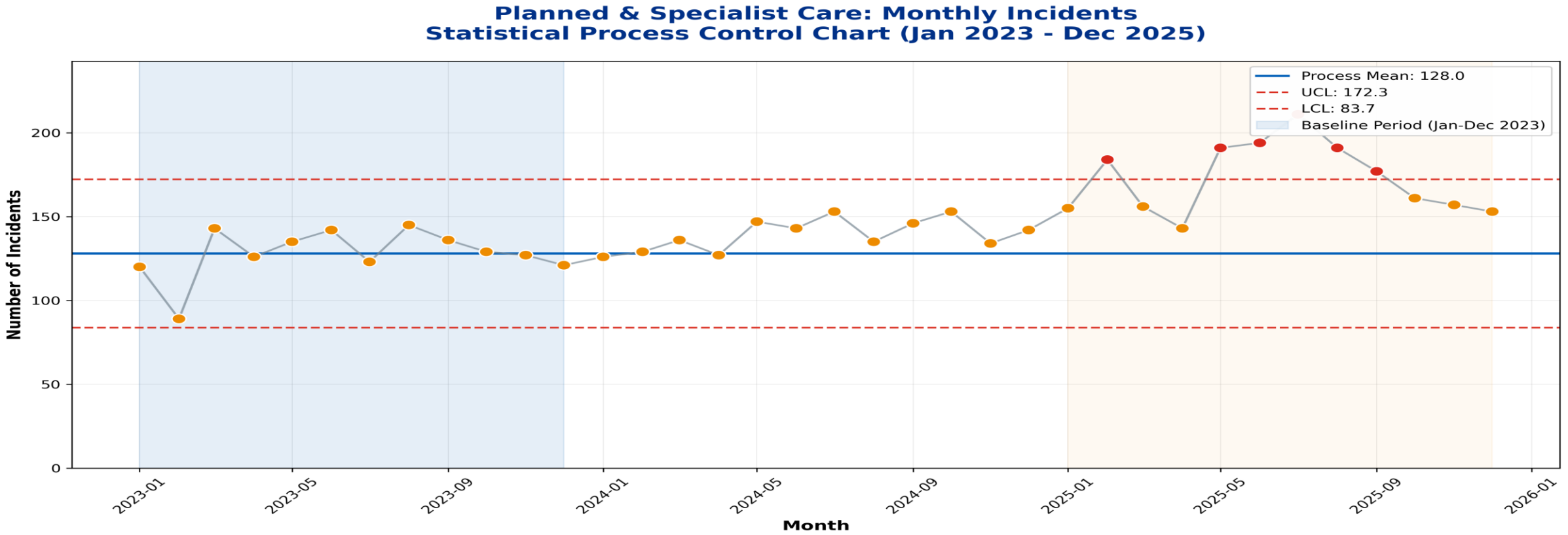
- Process mean: 70.9 complaints/month (baseline)
- UCL: 108.2 | LCL: 33.7
- 2025 mean: 90.8 (28% above baseline)
- 5 points above UCL (Jul-Sep) – sustained special cause
- September peak (141) significantly exceeds UCL

Rationale – Alert

The SPC chart demonstrates negative special cause variation with a sustained upward shift in complaint volumes and timeliness. Five consecutive months (Jul-Sep 2025) exceeded the upper control limit, with September reaching 141 complaints. This pattern, combined with complaint timeliness data showing cases outstanding for up to 495 days in Obstetrics, indicates systemic pressures within PSC. The Alert rating reflects both the statistical evidence of process deterioration and the operational context of elective pathway fragility.

TI-2025/547/MD10/1 – PSC Incidents

ALERT



SPC Analysis Key Points

- Process mean: 128 incidents/month (baseline)
- UCL: 172 | LCL: 84
- 2025 mean: 173 (35% above baseline)
- 6 points above UCL – sustained special cause (negative)
- July peak (211) significantly exceeds UCL

Rationale – Alert

The SPC chart demonstrates negative special cause variation with a sustained upward shift in incident volumes. The 2025 mean (173) now exceeds the upper control limit established from the 2023 baseline. Six months exceeded the UCL, with July reaching 211 incidents. Combined with the narrative evidence of 432 incidents aged over 3 months and cases outstanding for up to 908 days, this indicates systemic pressures requiring urgent intervention. The sustained deterioration and backlog accumulation warrant an Alert rating.

Healthcare Acquired Infections (HCAI) De-escalation Criteria and 2025 Status

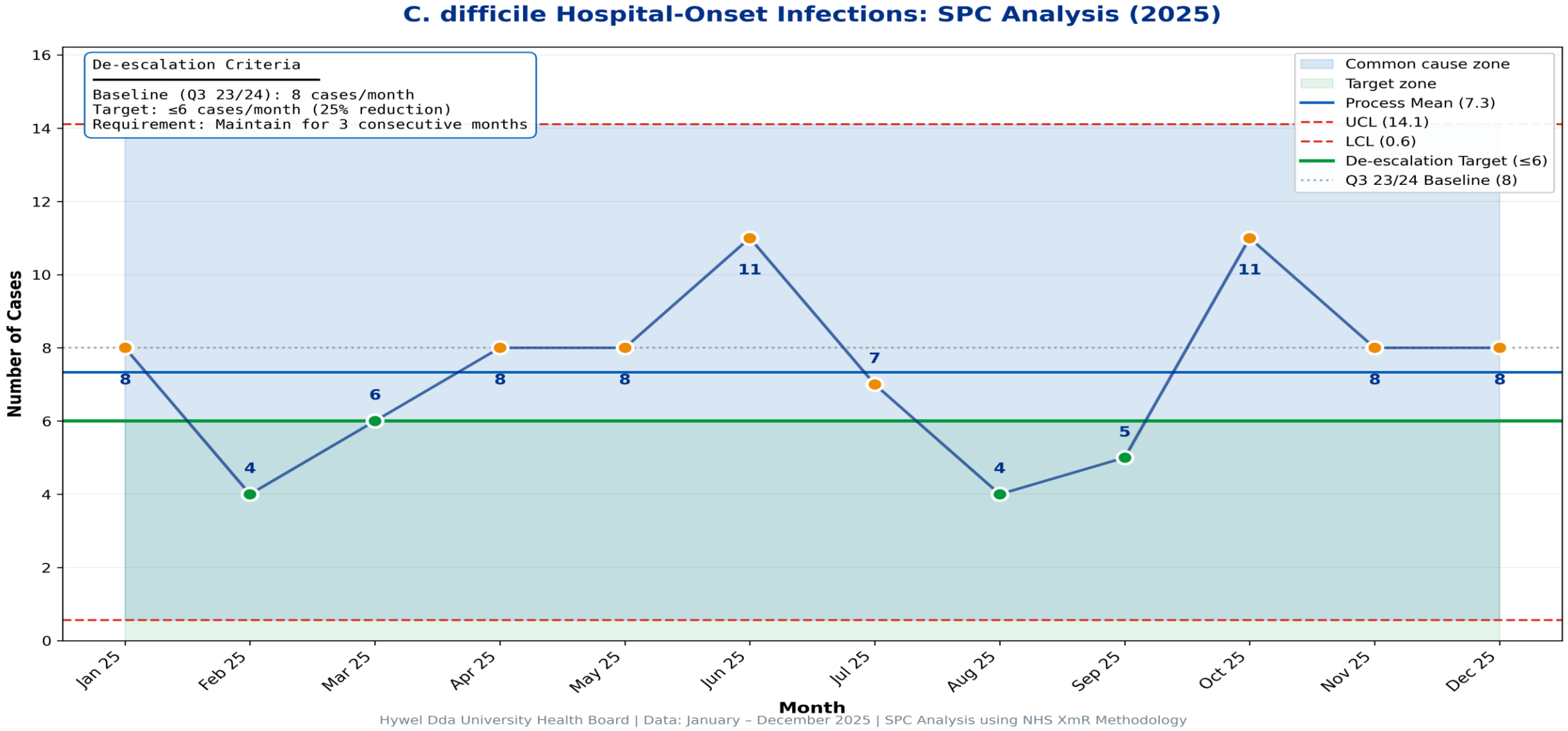
Requirement: Achieve target reduction and maintain for 3 consecutive months

Infection	Baseline (Q3 23/24)	Target	Reduction Required	2025 Months at Target	Max Consecutive Months	De-escalation Status
C. difficile	8 cases/month	≤6 cases/month	25%	4/12	2	**Alert**
S. aureus	3 cases/month	≤2 cases/month	33%	0/12	0	**Alert**
E. coli	7 cases/month	≤5 cases/month	25%	3/12	2	**Alert**

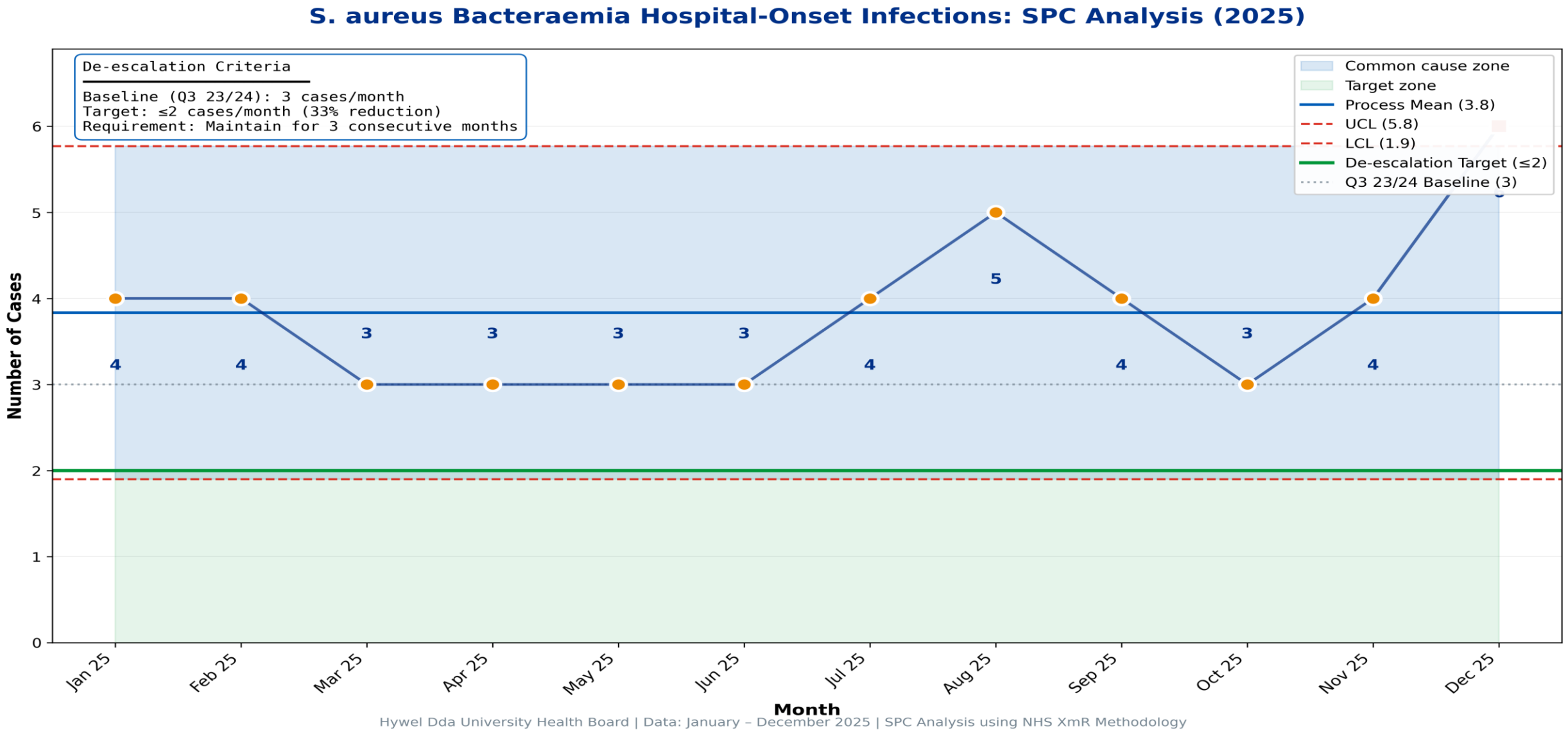
Key Finding: None of the three HCAI metrics meet de-escalation criteria in 2025

- **S. aureus:** Most challenging – zero months at target throughout 2025; December spike to 6 cases
- **C. difficile:** Mid-year improvement (Aug-Sep) not sustained; recurring spikes to 11 cases (Jun, Oct)
- **E. coli:** Strong start (Jan: 0, Feb: 5) but deteriorated significantly in H2 2025

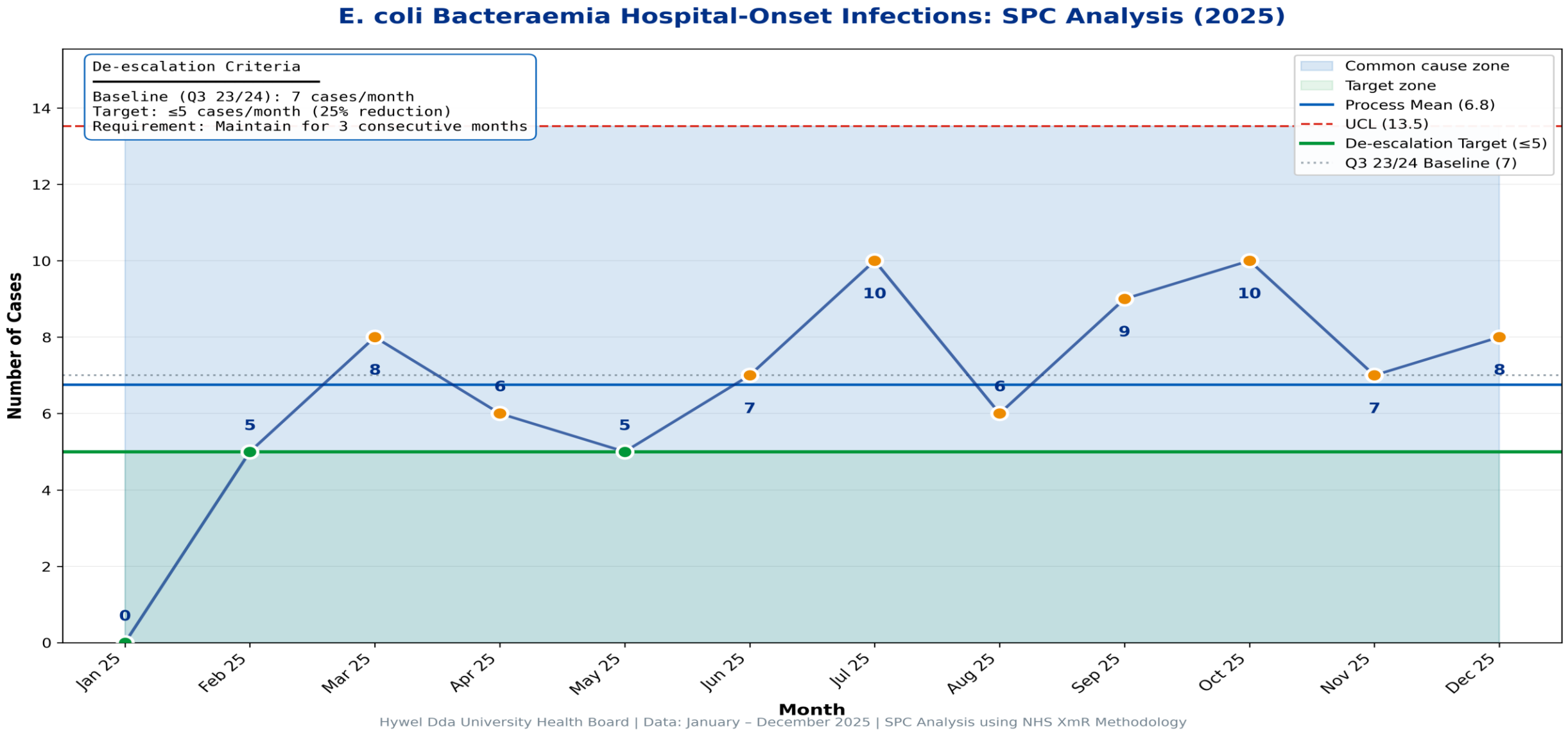
C. difficile: Statistical Process Control Chart



S. aureus Bacteraemia: Statistical Process Control Chart



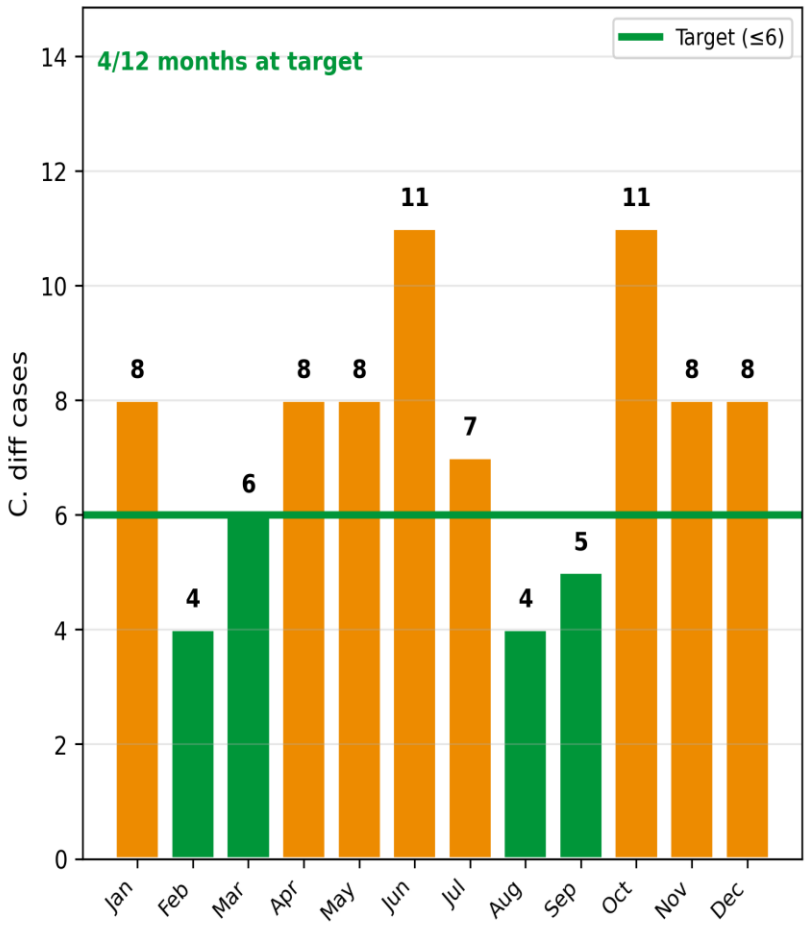
E. coli Bacteraemia: Statistical Process Control Chart



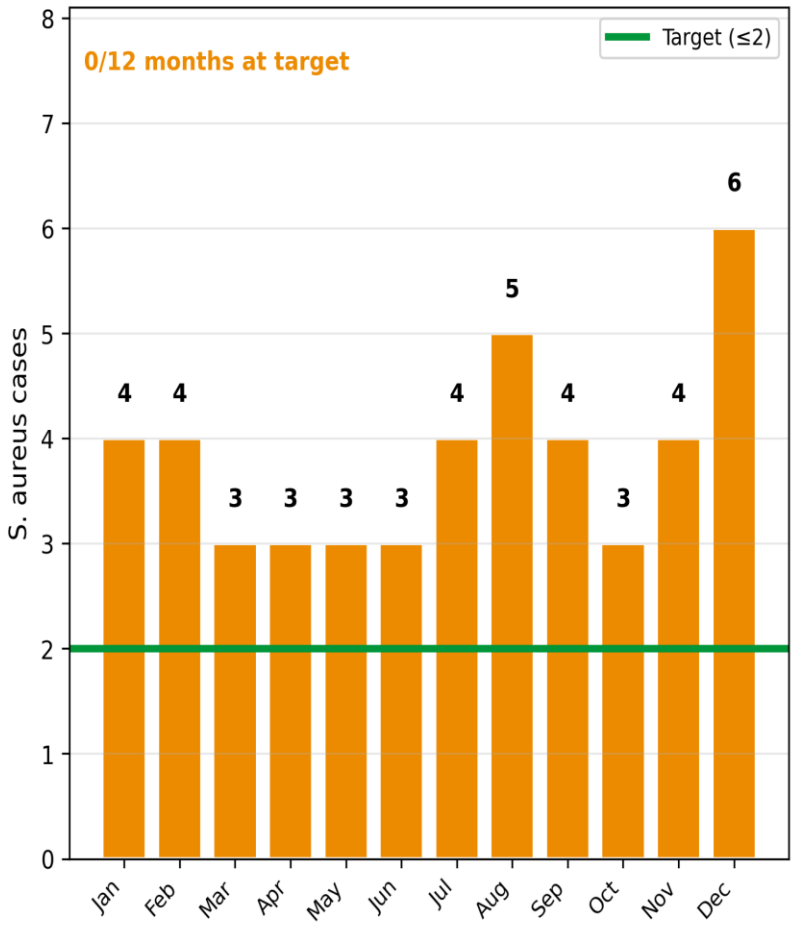
2025 Performance Summary

Hospital-Acquired Infections: 2025 Performance Summary

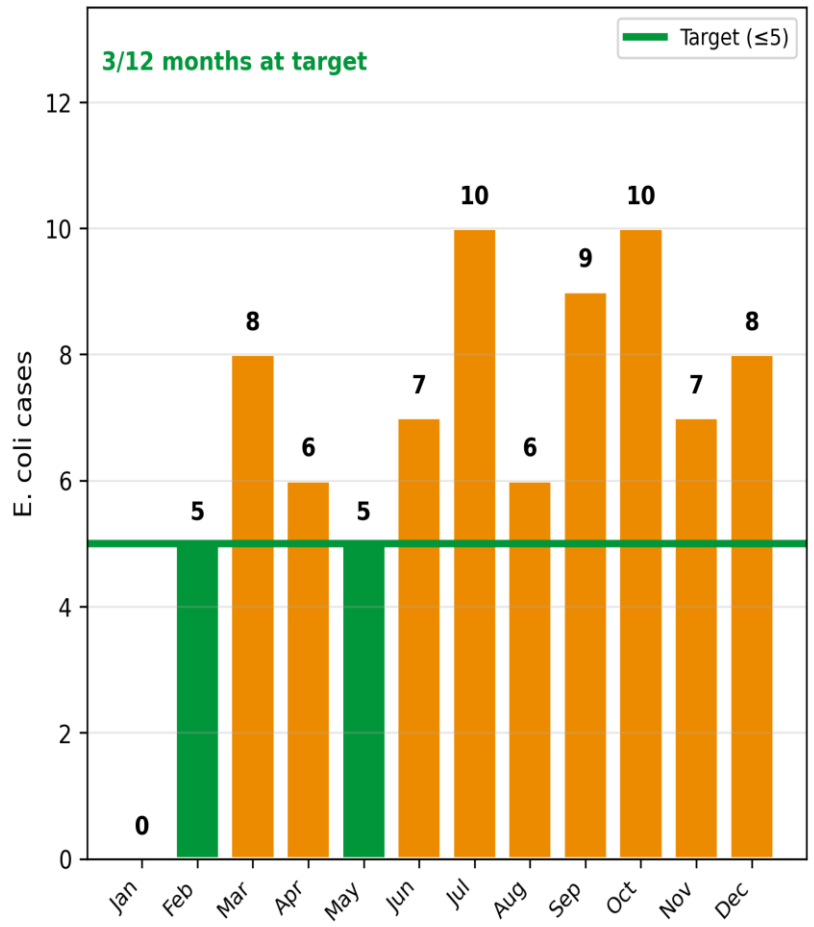
C. difficile



S. aureus bacteraemia



E. coli bacteraemia



2025 Monthly Data

Infection	Target	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
C. diff	≤6	8	4	6	8	8	11	7	4	5	11	8	8
S. aureus	≤2	4	4	3	3	3	3	4	5	4	3	4	6
E. coli	≤5	0	5	8	6	5	7	10	6	9	10	7	8

Colour key: Green = at or below target | Orange/Red = above target

SPC Analysis Summary

C. difficile: Process mean 7.3 cases/month (UCL 14.1, LCL 0.6). Recurring pattern of spikes to 11 cases in June and October suggests potential systemic or seasonal factors. Best performance in Feb (4), Aug (4), Sep (5).

S. aureus: Process mean 3.8 cases/month (UCL 5.8, LCL 1.9). December spike to 6 cases approaches UCL – requires investigation. Stable at 3 cases Apr-Jun but target of ≤2 requires 47% further reduction.

E. coli: Process mean 6.8 cases/month (UCL 13.5). January anomaly (0) cases. Clear H2 deterioration with Jul-Oct averaging 9 cases. Only 3 months at target, none consecutive from March onwards.

Key Findings

1. De-escalation criteria NOT MET for any HCAI metric in 2025
2. S. aureus: Zero months at target – requires step-change intervention
3. C. difficile: Recurring spikes (11 cases June -October 2025) indicate systemic issues
4. E. coli: H2 deterioration with 6 consecutive months above target (July-December 2025)
5. All three process means exceed their respective targets
6. Current processes display common cause variation (high non-compliant mean/average) – fundamental change needed

Data source: HDUHB Escalation Framework | Analysis period: January – December 2025

TI-2025/547/MD9/1 – Addressing root causes of HCAIs

Lead executive - Mrs Sharon Daniel, Director of Nursing, Quality and Patient Experience

Issue

Beyond meeting organism-specific numerical targets, the Health Board must demonstrate comprehensive understanding of the underlying drivers of HCAIs and provide evidence that actions taken are leading to sustained reductions in infection burden.

Current status

The Infection Prevention Strategic Steering Group (IPSSG) oversees a broad Quality-Planning, Quality-Control and Quality-Improvement programme. Key actions include:

- Delivery of the annual IP&C work plan and compliance with Wales-wide HCAI improvement circulars.
- Strengthened surveillance structures via standardised scrutiny meetings for hospital-onset HCAIs.
- Environmental audit and observational audit programmes, with improvement plans monitored.
- HPV enhanced cleaning implemented across three acute sites.
- HCID/ID pathway training completed for GGH and BGH, with PPH and WGH scheduled later in 2025.
- Participation in the Wales C. difficile Focus Forum and National Learning Collaborative.

Dashboard data to December 2025 shows:

- **Mixed trends across all three organisms,** with improvements in August for C. diff (4) and November for E. coli (5), but subsequent relative deterioration in December (C. diff 8; E. coli 8).
- **S. aureus fluctuating** between 3–6 cases throughout the period, without achieving the TI threshold.

TI-2025/547/MD9/1 – Addressing root causes of HCAIs

Rationale - Alert

The improvement infrastructure is robust and multi-layered, and there are clear examples of month-on-month improvement (e.g. August). However, no de-escalation threshold relating to said organisms is achieving sustained performance below TI thresholds, and December data show relative deterioration in both C. diff and E. coli. The mixed infection profile and the absence of sustained impact from interventions justify an Alert rating

TI-2025/547/MD11/1 – Prompt responses to inspections, incidents and regulatory notices

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Lead executive - Mrs Sharon Daniel, Director of Nursing, Quality and Patient Experience

Issue

The Health Board is required to demonstrate that it responds promptly, consistently and effectively to HIW inspections and wider regulatory notices. The reliability of these processes is an important component of assurance under Targeted Intervention, particularly given the breadth of inspections across acute, community and mental health services over the past 18 months.

Current status

The latest inspection dashboards provide a detailed and, in some areas, challenging picture. Fourteen HIW inspections are currently active, generating a combined 451 actions. While nearly 300 of these have now been completed, the remainder show a mixed pattern of timely progress, partial completion and overdue work.

A review of the inspection summary indicates that:

- 295 actions have been fully completed.
- 156 actions are still in progress, with a relatively small proportion recorded as partially complete. With 4 completed and currently waiting approval.
- However, 68 actions are now overdue, and a further 12 have been marked as unable to complete.

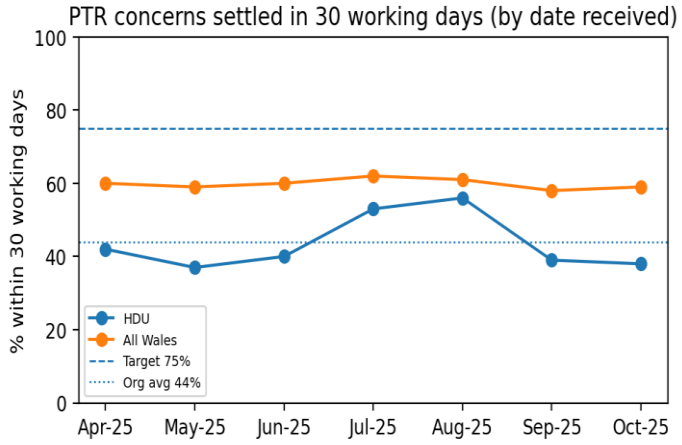
This means that although the Health Board is closing the majority of inspection actions, there is a persistent number of delayed actions.

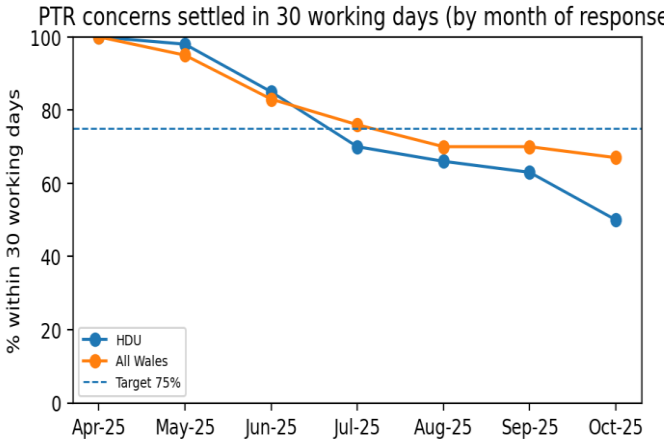
Beacon Dashboard – patient concerns (Putting Things Right (PTR)): what the Graphs are telling us

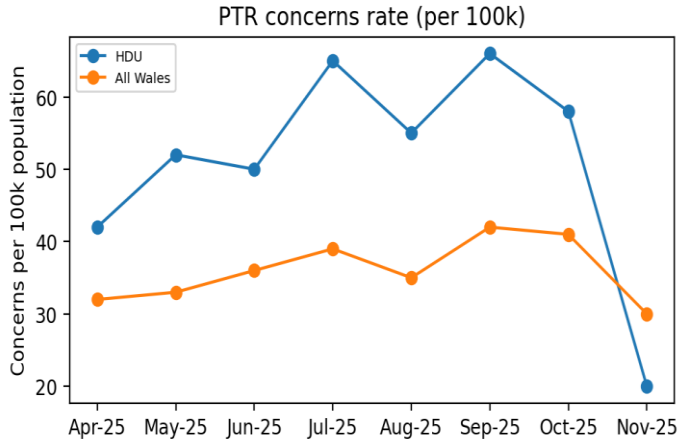
Apr–Nov 2025

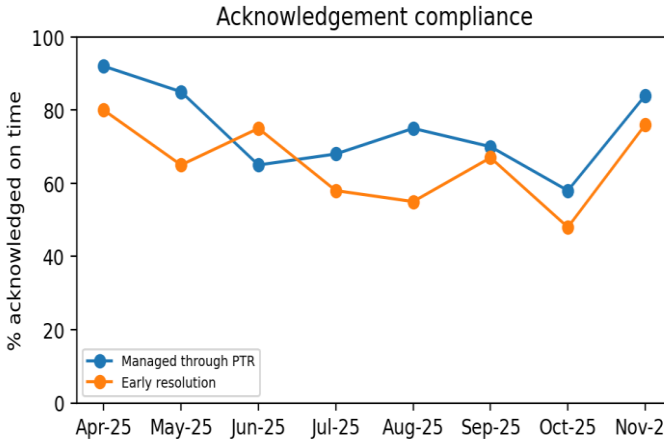
Headline messages

1. Timeliness by date received is consistently below the 75% 30-working-day expectation (Oct 38% vs target 75%: -37pp; All Wales 59%: -21pp).
2. Timeliness by month of response deteriorates across the year (Apr 100% → Oct 50%), consistent with increasing backlog / throughput pressure (and possibly change to legislation/reporting).
3. Demand signal - PTR concerns per 100k is above All Wales for most months Apr–Oct (peak 66 per 100k in Sep), before a marked drop in Nov.
4. Process reliability - acknowledgement compliance is variable (approx 48–92%), with a notable dip in Oct and recovery in Nov.









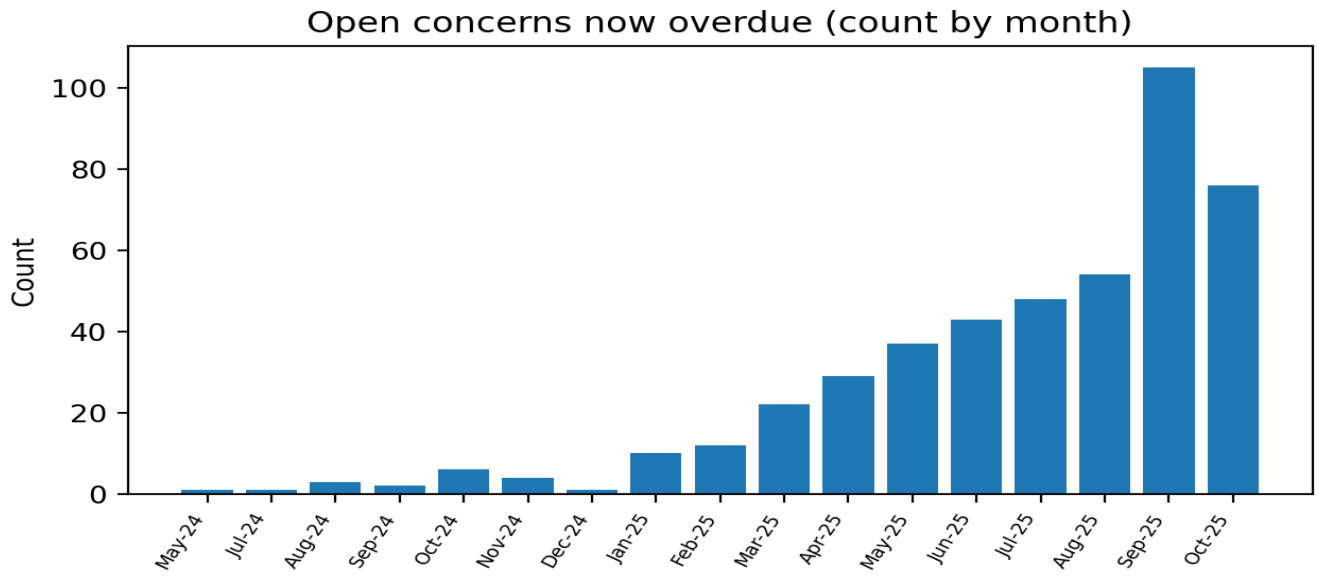
Source: Beacon dashboard ..

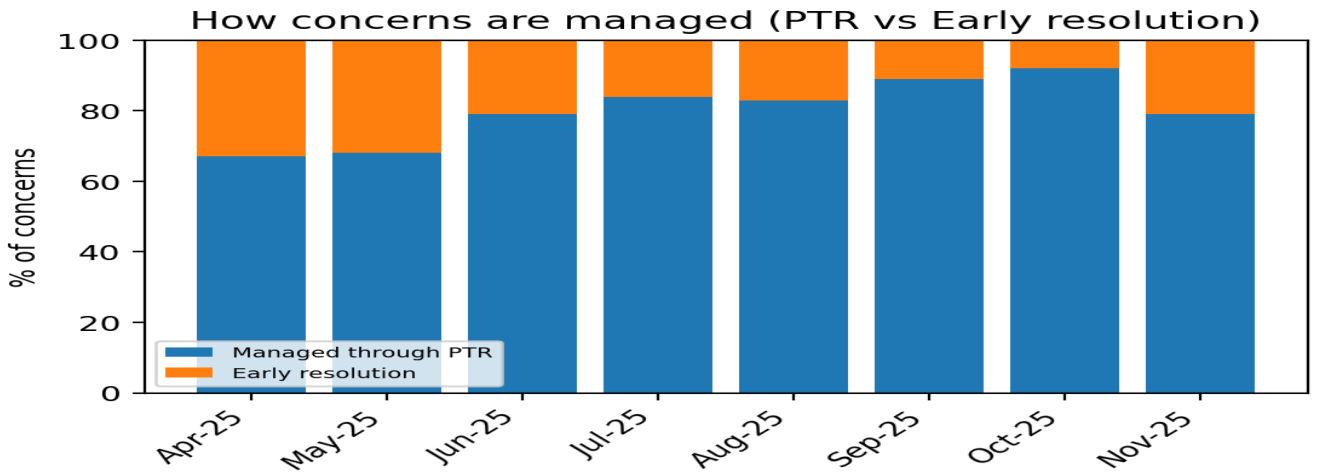
Backlog and flow – where the constraint is showing up

Overdue open concerns (Dec 2025 snapshot) and route mix (Apr–Nov 2025)

What the backlog distribution implies

1. Open overdue concerns: 454 in total (sum of all bars shown).
2. Backlog is concentrated in recent months: Aug–Oct 2025 = 235 (52%); Sep–Oct alone = 181 (40%).
3. Route mix shifted heavily towards formal PTR handling (up to 92% PTR / 8% early resolution in Oct), which is likely increasing workload and lengthening cycle time.
4. If the aim is to recover timeliness, the first order priority is reducing overdue count while stabilising inflow (triage + early resolution).
5. Learning loop - use a simple monthly 'themes → actions → impact' log so that concerns translate into demonstrable improvement.





Source: Beacon dashboard screenshots. Overdue counts are read directly from the labelled bar chart. Route mix estimated from the screenshot.

Conclusion

- Across the TI criteria covered in this update, the position remains mixed. Unscheduled and Emergency Care (CIM integrated systems) and Planned Care and Cancer (Cancer & Scheduled Care) continue to carry sizeable backlogs of aged incidents and open complaints, and the dominant constraint remains timeliness of service responses and closure. This limits the level of assurance that can be provided at this point in time, notwithstanding improvements in parts of the reporting period.
- HCAI performance has not met de-escalation criteria for any of the organism metrics during 2025 and the broader root-cause criterion remains at Alert, reflecting the absence of sustained impact from interventions and recent deterioration in the profile. The HIW inspections portfolio shows strong overall completion, but overdue exposure has increased materially following the Emergency Department inspection cohort, requiring disciplined, time-bound closure trajectories and explicit resourcing.
- The Beacon dashboard content within this pack provides additional triangulation on performance stability, areas of volatility and the extent to which improvement is sustained over time. Taken together, the evidence indicates that on-going efforts are required to reduce the oldest and most overdue cohorts and to demonstrate sustained compliance with de-escalation thresholds.

Recommendations

The Committee is asked to note:

- The current position against the TI de-escalation criteria within the QSEC remit, triangulated through the 'Our Performance' dashboard for Datix/complaints extracts (PSM; CIM integrated systems), the HIW inspections dashboard, and Beacon dashboard evidence contained within this pack.
- The scale and ageing profile of open complaints and incidents, and that the principal constraint to closure remains timely "awaiting service comments" / response completion.
- The HIW inspections action position and the concentration of overdue actions within a small number of inspections, particularly the ED inspection cohort.

The Committee is asked to recognise:

- That improvement is not yet consistently evidenced as sustained across the criteria set, and that "direction of travel" alone is insufficient for de-escalation where ageing/backlog and timeliness remain outside threshold.
- That the Beacon dashboard evidence strengthens triangulation on stability/volatility and should be read as part of the overall evidence base for assurance within this pack.

DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG

SAFE | SUSTAINABLE | ACCESSIBLE | KIND

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

1.5

1.5 - QSEC Terms of Reference for Review

Eleanor Marks (Hywel Dda UHB - HDUHB Vice Chair)

For approval

Attachments

QSEC ToRs SBAR Feb 26.pdf

QSEC Terms of Reference.v19 updated Feb 26.pdf

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:**	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 26 March 2026.

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 2025, with approval subsequently granted by the Board on 31 July 2025. Following this, at the QSEC meeting on 14 August 2025, the new Quality & Safety Governance Arrangements were agreed, which included the decision to dis-establish the Quality and Safety Experience Committee. The Terms of Reference were updated to reflect this change and incorporate any relevant amendments agreed on 14 August 2025.

Asesiad / Assessment

The Quality, Safety and Experience Committee Terms of Reference and operating arrangements (**Appendix 1**) have been reviewed due to changes in its membership. These are clearly marked on Appendix 1 and relate to the following:

Section	What has changed?	Why?
4.1	Membership - section amended	Membership section amended following the changes to Committee membership effective from 1 January 2026, the requirement for the ***Health and Safety Committee (HSC) Vice-Chair*** *and the* ***People, Organisational Development & Culture Committee (PODCC) Chair*** to be members of QSEC has been removed. The revised requirement now states that ***"A Member of HSC and PODCC"*** *will also serve as* ***Members of QSEC***.
4.3	In-attendance - section amended	Removal of the "***Director of Primary Care, Community & Long Term Care***" as an In Attendance member, following changes to Executive Team and senior management team portfolios.

Argymhelliad / Recommendation

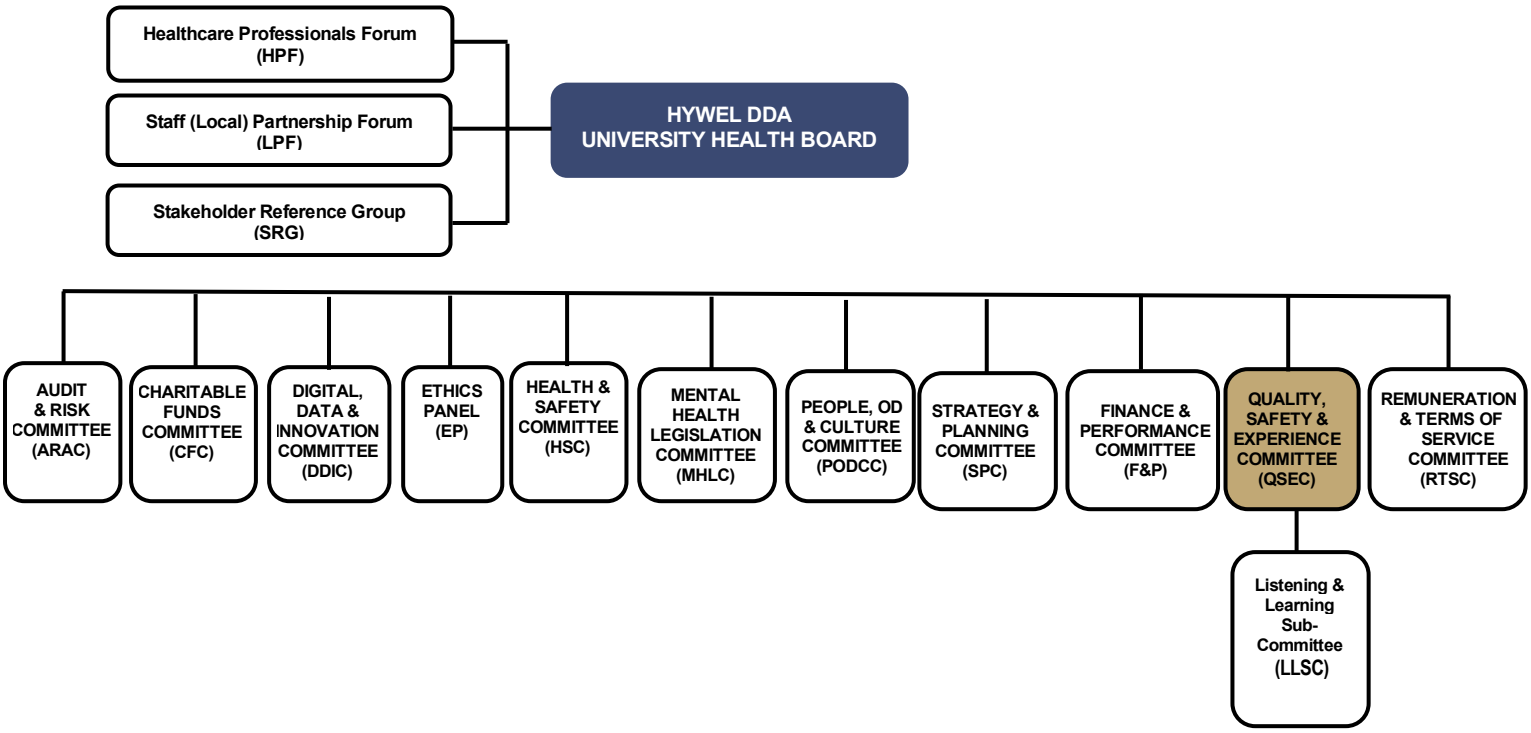
The Committee are asked to approve the Quality, Safety and Experience Committee's Terms of Reference (version 19) for onward ratification by the Board on 26 March 2026.

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 Phrofiod: 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	Approved
V17	Hywel Dda University Health Board	31.07.2025	Approved
V18	Quality, Safety and Experience Committee	14.08.2025	Alongside the new Quality & Safety Governance Arrangements
V19	Quality, Safety and Experience Committee	12.02.2026	For approval

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):

3. Key Responsibilities

The Quality, Safety & Experience Committee shall:

3.1 Provide advice to the Board on the adoption of a set of key indicators of quality of care against which the University Health Board's performance will be regularly assessed and reported on.

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

3.3 Receive assurance through Sub-Committee Update Reports and other management/task & finish group reports that risks relating to their areas are being effectively managed across the whole of the Health Board's activities (including for hosted services and through partnerships and Joint Committees as appropriate).

3.4 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 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 and monitor the impact on patients of the Health Board's services and their quality.

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

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.

4. Membership

4.1 The membership of the Committee shall comprise:

Member
Independent Member (Chair)
Independent Member (Vice-Chair)
3 x Independent Members (which will include a Member of the Health and Safety Committee ~~Vice-Chair~~ and the 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
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
Assistant Director of Nursing, Quality and Assurance
Llais Cymru/ Citizens Voice Body Representative (not counted for quoracy purposes)

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.

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10. Reporting

10.1 The Committee, through its Chair and Members, shall work closely with the Board's other Committees, including joint and Sub-Committees and groups to provide advice and assurance to the Board through the:
10.1.1 Joint planning and co-ordination of Board and Committee business.
10.1.2 Sharing of information.

10.2 In doing so, the Committee shall contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

10.3 The Committee, may, subject to the approval of the Board, establish Sub-Committees or task and finish groups to carry out on its behalf specific aspects of Committee business. The Committee will receive an update following each meeting providing an assurance on business undertaken on its behalf. The Sub-Committees reporting to this Committee are:

10.3.1 Listening & Learning Sub-Committee

10.4 The Committee Chair, supported by the Committee Secretary, shall:

10.4.1 Report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes the submission of a Committee update report, as well as the presentation of an Annual Report within **six** weeks of the financial year.
10.4.2 Bring to the Board's specific attention any significant matter under consideration by the Committee.
10.4.3 Ensure appropriate escalation arrangements are in place to alert the Health Board Chair, Chief Executive or Chairs of other relevant Committees of any

urgent/critical matters that may compromise patient care and affect the operation and/or reputation of the Health Board.

10.5 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self assessment and evaluation of the Committee's performance and operation including that of any Sub-Committees established. In doing so, account will be taken of the requirements set out in the NHS Wales Quality & Safety Committee Handbook.

11. Secretarial Support

11.1 The Committee Secretary shall be determined by the Director of Corporate Governance/Board Secretary.

12. Review Date

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

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 HCAIs 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

20 Mins

2 - Unscheduled Emergency Care Accelerated Work Programme Update and Patient Story

Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Anna Chiffi (Hywel Dda UHB - Assistant Director of Nursing, Patient Safety, Quality)

Attachments

Unscheduled Emergency Care Accelerated Work Programme Update QSEC.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

BWYLLGOR ANSAWDD, DIOGELWCH A PHROFIAD
QUALITY, SAFETY AND EXPERIENCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	12 February 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Unscheduled Emergency Care Accelerated Work Programme Update
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Andrew Carruthers, Chief Operating Officer
SWYDDOG ADRODD: REPORTING OFFICER:	Anna Chiffi, Assistant Director of Nursing and Patient Experience

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

Ambulance handover delays and Emergency Department (ED) overcrowding continue to represent significant organisational risks, with material impact across patient safety, flow, and community response times.

Despite improvements observed during late 2025—where median waits reduced to approximately 15 minutes and >75% of handovers completed within 45 minutes —substantial site specific variation persists, alongside increasing community harm arising from reduced ambulance availability.

The accelerated implementation of the Emergency & Urgent Care (EUC) Programme and the 45minute Ambulance Release Protocol (All Wales) introduces both opportunity and risk for Hywel Dda University Health Board, necessitating strengthened governance, closely monitored mitigations, and assurance mechanisms. -minute Ambulance Release Protocol (All-Wales).

Cefndir / Background

Strategic and policy context

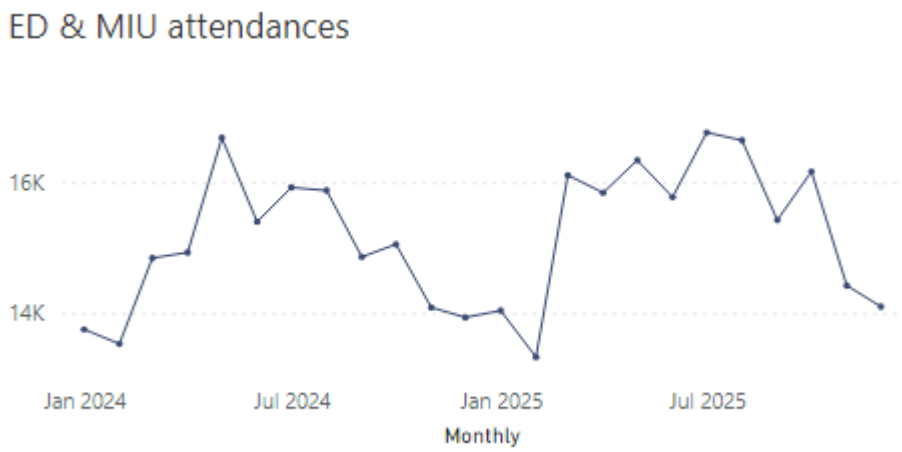
- Aligned to the Six Goals for Urgent and Emergency Care Programme including Goals 2–6 (rapid response, optimal hospital care, flow, discharge, and community resilience).
- Welsh Health Circular (WHC) guidance, Emergency Pressures Escalation Policy (Policy 489), Ambulance Hand over Policy (Policy 445), (Draft) Boarding in non-designated Clinical Areas During Periods of Operational Escalation Procedure, and the All -Wales 45-minute Release Protocol underpin required compliance.

Current performance context

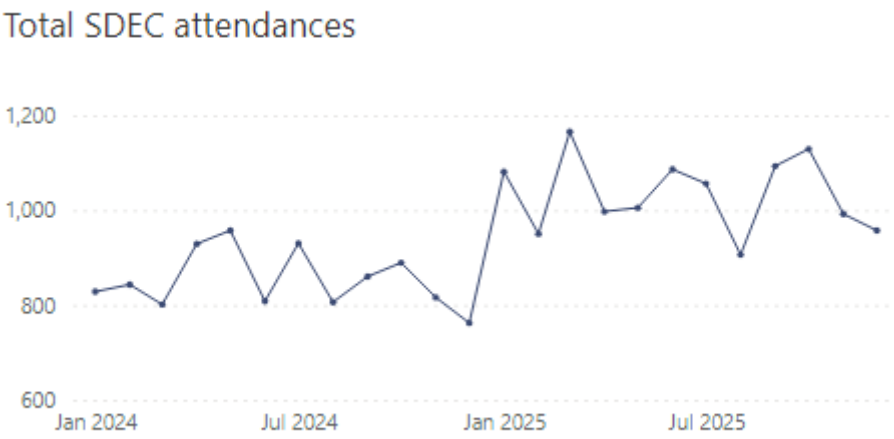
Evidence across the organisation shows:

- **Site variation:** Bronglais Hospital (BGH) and Withybush Hospital (WGH) frequently record >1–4-hour delays despite improvements; Glangwili Hospital (GGH) (as historically busiest Emergency Department (ED) remains most challenged; Prince Philip Hospital (PPH) exhibits fewer breaches but is highly surge -sensitive.
- **Operational pressures:** Boarding, surge areas, extended waits for triage, constrained staffing, and frequent demand–capacity mismatch.

This graph demonstrates attendance fluctuations across the two year period, rising through early 2024, dipping at the end of that year, rebounding sharply in early 2025, and then gradually declining again toward late 2025.



The graph shows attendances fluctuating through 2024 with no clear upward pattern, followed by a noticeable rise at the start of 2025 after which activity remains higher and more variable for the rest of the period, indicating a clear shift to a consistently busier level than the previous year.



The expansion of Same Day Emergency Care (SDEC) appears to have helped moderate demand on EDs by offering a viable alternative pathway for patients requiring urgent

assessment and treatment. As SDEC activity has increased—particularly after its step change in early 2025—ED attendances showed signs of stabilising, with the most pronounced dip occurring at the point SDEC capacity expanded. While natural seasonal variation in ED activity continues, the overall pattern suggests that SDEC has absorbed a proportion of lower acuity or rapidly treatable cases that might previously have presented to ED, helping to smooth peaks in demand and reduce pressure on front door services.

Asesiad / Assessment

1. Risks and Impacts of Compliance with NHS Wales 45-Minute Requirement

a. Site level Risk overview

Site	Current Risk Picture	Key Contributory Factors	Impact
BGH	Recurrent >60–180 min delays despite improvement work.	Flow constraints, limited major injury capacity, staffing fragility, rising acuity.	High boarding and surge utilisation, increased patient safety risk, Welsh Ambulance Service Trust (WAST) lost hours.
WGH	Persistent long delays >180 min; variation from peaks in community conveyance.	Workforce shortages, queue surges, limited early discharge capacity.	Community risk escalation for Red/Amber responses; increased Infection Prevention & Control (IPC) risks in overcrowded ED.
GGH	Most challenged ED across the Health Board; significant crowding and delayed hand overhand over.	High front door demand, bed allocation delays, complex discharge backlog, door demand, bed allocation delays, complex discharge backlog.	Overcrowding, repeated corridor activation, senior decision-maker gaps.
PPH	Lower long-wait volumes but vulnerable to sudden surges.	Limited surge space, weekend discharge variation, dependency on flow from GGH/region.	Rapid deterioration in risk profile with minor changes in conveyances.

b. Impact of reducing handover delays on community risk

- Reduction in handover times **improves ambulance availability**, enabling **faster response** to Red/Amber calls.
- Accelerated compliance with the 45-minute standard is anticipated to **reduce cumulative lost hours**, however structural fragility at site-level risks **re-shifting harm from community to hospital** unless managed holistically (flow, discharge, escalation, divert). The chart below shows that monthly hours lost due to handovers taking longer than 15 minutes have generally trended downward from early 2024 through late 2025. After peaking at around 5,000 hours in the first quarter of 2024, lost hours declined through mid-2024, briefly rose again toward early 2025, and then fluctuated at a lower but variable level throughout the year. By late 2025, the figures stabilised noticeably

below the early-2024 peak, indicating an overall improvement in reducing prolonged handover delays.

2. Quality, Safety and Patient Experience Implications (EUC Programme Acceleration)

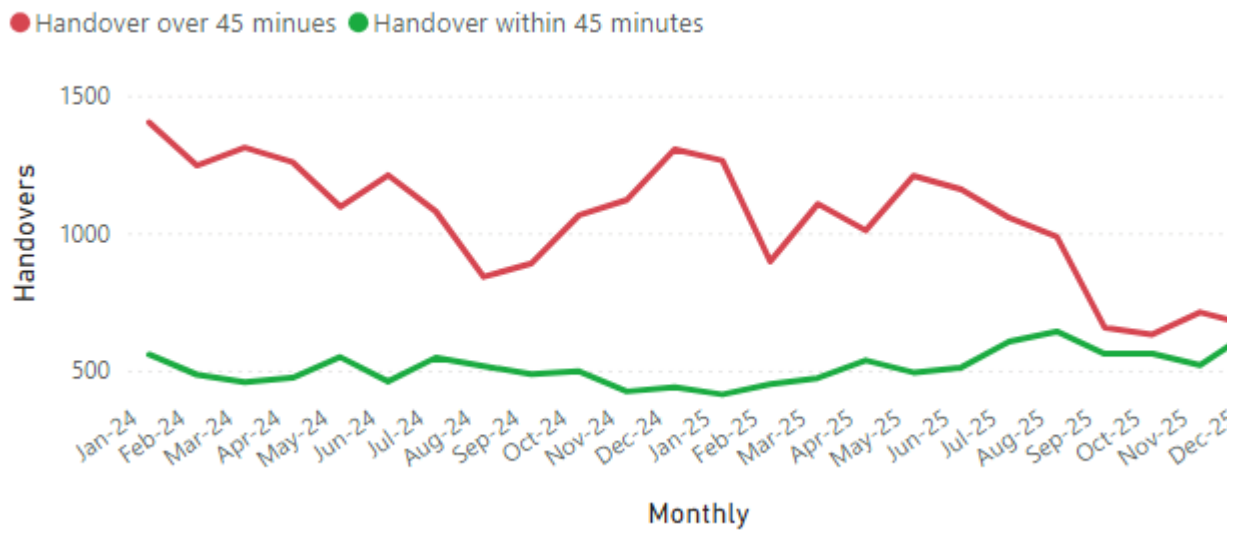
Safe

- Reduced handover delay decreases exposure to clinical deterioration in ambulances and improves ED situational safety.
- Corridor care and overcrowding continue to heighten risks: delayed observations, missed deterioration, privacy/dignity breaches, and infection IPC compromise.

Timely

- Streaming hubs and advanced clinical triage reduce unnecessary ED attendances and enable scheduled urgent care pathways.
- However, rapid change introduces variation in workforce readiness and potential delay in appropriate signposting if not consistently staffed.

The graph below provides information in relation to our 45-minute performance. Across January 2024 to December 2025, ambulance handovers taking **over 45 minutes** (red) dominate volumes showing a **broad improvement** by the end of the period. They begin very high in early 2024, ease through mid-2024 to a low around late summer, then rebound over winter to a peak near **February 2025** before gradually falling again, ending **notably lower** in late 2025. In contrast, handovers **within 45 minutes** (green) remain **stable and much lower** throughout. The **gap narrows in the final quarter of 2025**, driven by reduced prolonged handovers rather than a marked rise in timely handovers, indicating **some progress in mitigating delays** and sustained headroom to increase the proportion completed within the 45minute standard.

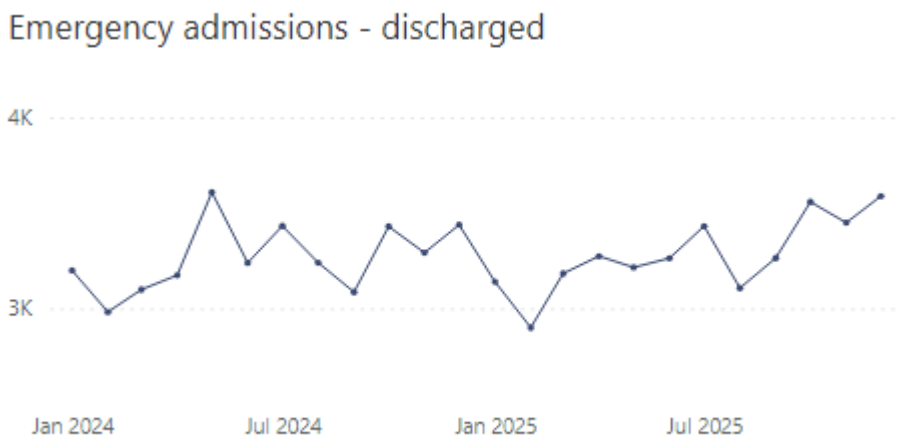


Effective

- Enhanced community pathways (SDEC, Same Day Urgent Care (SDUC), rapid response within 1 hour) increase opportunity for avoidance of hospital admission.
- Impact depends on community capacity and interdependencies with social care and Continuing Health Care (CHC) related delays.

Emergency Admissions Discharged:

Emergency admissions discharged have fluctuated over the past two years, however the overall trend is clearly improving. After notable dips in early 2025, activity rises steadily through mid to late 2025, with discharge numbers consistently climbing above earlier levels. This upward trajectory shown in the graph below suggests strengthening patient flow and increasing capacity to safely discharge patients from emergency care.



Efficient

- Improved handover efficiency increases ambulance availability and improves whole system flow.
- Risks include potential inefficiency if additional ED capacity (e.g., surge or expansion spaces) does not have matched staffing and governance oversight.

Equitable

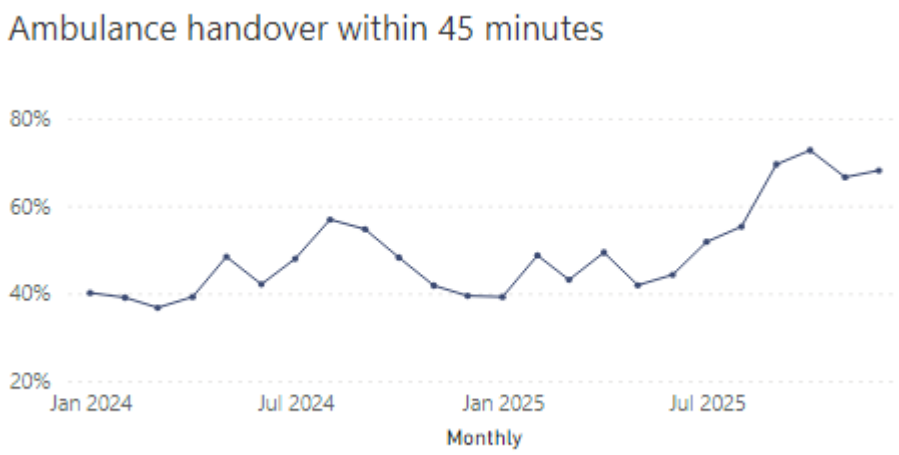
- Variability between sites risks inequity in waiting experience, risk exposure, and access to alternatives such as clinical streaming hubs.

Person Centred-Centred

- Corridor care, delays, and overcrowding negatively impact privacy, communication, hydration, and dignity. The *UEC Accelerated Transformation Position Statement (January 2026)* outlines the Health Board's progress in transforming urgent and emergency care through improved access, enhanced emergency department environments, and systemwide patient flow initiatives. Key actions include developing a 24/7 "contact first" access model, piloting and approving a seven-day Clinical Streaming Hub and SDEC model, establishing integrated community teams, and implementing a dedicated single point of access (SPoA) transport and mentorship programme. The statement also highlights improvements to ED cleanliness, communication, and front of house experience, while emphasising the launch of the Patient Flow Unit, deployment of MIYA Flow, strengthened discharge processes, and workforce development aligned with the Six Goals Programme. Overall, it reflects significant progress with clear plans for further implementation, evaluation, and systemwide operational alignment.
- Streaming hubs and scheduled urgent care increase clarity and predictability for service users.
- Patient feedback continues to provide a critical lens on the quality, safety and experience of care across our system, clearly signposting both what matters most to patients and where improvement efforts must focus. The feedback consistently highlights that strengthening communication during waits is one of the most impactful actions can be progressed, with patients reporting significantly better experiences when they are kept informed, even when delays are unavoidable. Alongside this, patients are drawing attention to the need for sustained efforts to reduce waiting times and improve the timeliness of diagnostics, supported by more efficient pathways such as those emerging through SDEC. They also emphasise the importance of addressing environmental factors—comfort, seating, temperature, and access to basic needs—which continue to affect the experience of care, particularly during prolonged waits. Crucially, feedback reaffirms that staff kindness, professionalism and reassurance remain core strengths that must be protected and nurtured. While local improvements in flow and communication are visible in some sites, system-wide pressures such as crowding, staffing constraints and limited community capacity continue to shape patient experience and must be addressed collectively. Taken together, this feedback provides a clear and compelling mandate for where improvement actions need to be targeted.

3. Mitigations: Corridor Care & Flow Management

- **Streaming Hubs (7/7 operation):** Reduces front door pressure by triaging and signposting to SDEC, Primary Care, Hot Clinics, Community teams by triaging and signposting.
- **SDEC Expansion:** Facilitates same day treatment, reducing admissions and protecting beds.
- **45m-Minute Release Plans:** Ensures timely hand over using designated additional assessment spaces while prioritising safety. The graph below demonstrates the progress made since January 2024.



- **Escalation Framework (Policy 489):** Standardised triggers, checklists, and executive notifications at 30/60/120-minute breach points.
- **Red and Amber 1 Release Protocols:** Ensures immediate release for life threatening calls.

- **Daily Flow Huddles & Command Structure:** Provides real time operational oversight.**Strengthened Discharge Pathways:** Home First Standard Operating Procedure (SOP), winter sprint discharge focus, 2 and 4 week reviews of delayed transfers.
- **Work Undertaken to Support the Boarding Policy:** Over the past year, considerable and structured work has been undertaken across the Health Board to ensure that the **Boarding Policy (Guideline 1256)** is safe, governance aligned, risk assessed and operationally usable at site level. This work has been clinically led and aligned to the **Emergency Pressures and Escalation Policy (Policy 489)** and national UEC escalation frameworks. It integrates NHS Wales escalation levels, national UEC frameworks, and local operational plans for all four acute sites.
- Standardised definitions for **surge, boarding, double boarding, boarding at risk, and boarding at extreme risk**.
- Mandatory environmental and individual **risk assessments** before boarding decisions. Clear **red lines** relating to staffing, acuity, IPC standards, and safe environments. Explicit authority structures and clarity around when wards may safely **decline boarding**.

Cross-reference matrices linking escalation level → boarding type → risks → controls → review frequency.

4. Assurance: Detecting Emerging or Heightened ED and Inpatient Risks

- **Daily Sitreps, Executive Dashboards, and Flow Monitoring** (deterioration triggers, occupancy >95%, ambulance queues >3, triage delays).
- **Breach Audits and Retrospective Harm Reviews** for >60, >120, >180-minute delays.
- **Clinical Risk Escalation to On-Call Bronze–Silver–Gold** using structured protocols.
- **Rapid Quality Reviews** (as recently led by Executive Medical Director in UEC pathways) provide targeted assurance and immediate action setting.
- **Environmental audits and IPC checks** in corridor and surge zones.
- **Weekly EUC governance oversight** aligned to Six Goals Programme workstreams.

Argymhelliad / Recommendation

The Quality, Safety and Experience Committee is asked to take an assurance on the quality governance arrangements in place within the Community and Integrated Medicine Clinical Care Group in relation to quality, safety and patient experience specific to the Unscheduled Emergency Care Accelerated Work Programme.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	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.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
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 Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: **Further Information:**

Ar sail tystiolaeth: Evidence Base:	Contained within the body of the report
Rhestr Termau: Glossary of Terms:	Contained within the body of the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	Community and Integrated Medicine Clinical Care Group meetings

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

3

90 Mins

3 - Assurance

3.1

3.1 - Equity Impact Assessment Tool

Ardiana Gjini (Hywel Dda UHB - Executive Director of Public Health), Jo McCarthy (Hywel Dda UHB - Consultant in Public Health)

Attachments

3.1 QSEC Health equity tool QSEC Feb 26.pdf

HEALTH EQUITY CHECKLIST.pdf

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:	Introducing the Equity focussed Health Impact Assessment Tool
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Dr Ardiana Gjini, Executive Director of Public Health
SWYDDOG ADRODD: REPORTING OFFICER:	Dr Jo McCarthy, Consultant in Public Health

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

Health inequalities are unfair, preventable differences in health across the population and between different groups in society. While health inequalities ultimately lead to differences in people's health status and life expectancy, it is important to note that there are also inequalities in the access that people have to healthcare services, and in their opportunities to lead healthy lifestyles.

Action to reduce health inequalities is arguably more important than ever. The COVID-19 pandemic and cost of living crisis has led to families coming under significant, and increasing, financial pressure as household gas and electricity bills, vehicle fuel costs, and the price of food all continue to rise.

The Public Health (Wales) Act, passed in 2017, sets an expectation for public bodies to undertake Health Impact Assessments when it proposes to take an action or make a decision of a strategic nature. A consideration of the impact on equity is essential in all strategic decisions the Health Board makes, including in some operational and service spaces.

The Public Health Directorate in the Health Board have developed an Equity Focussed Health Impact Assessment tool which can be used by services to consider whether current or new programmes or projects could impact on health inequalities as a key part of the impact assessment work. The tool can be used to prompt thinking around how plans could be adapted or altered to reduce inequities in terms of accessibility and acceptability of services and programmes. Equity-Impact-Assessment-Toolkit--V-6.0-.xlsx (link accessible for internal staff only).

The purpose of this paper is to describe the tool and the initial roll out of its use and to support the journey to expand use through the Health Board to support services to align with expectations set out in the Public Health Wales Act (2017). Consideration must, as part of this work, be given to how inequities (when recognised) can be mitigated.

Cefndir / Background

The Health Board has committed to implementing a social model for health and placing prevention at the centre of all its work. To support a shift in this direction from a service perspective, the 20four7 model has been developed. This model encourages consideration of:

- **The "20" element**, representing the 20% of families in the population who are the least economically affluent.
- **The "4" element**, which focuses on preventable causes of ill health and opportunities to improve health, including weight management, exercise and movement, smoking cessation, and reducing drug and alcohol use.
- **The "7" element**, which highlights the key areas where there is the greatest opportunity to reduce avoidable demand on services. These areas are:
  • Children and young people
  • Older people and frailty
  • Cancer, including prevention and support for people living with cancer
  • Respiratory illness, including prevention, support, and rehabilitation
  • Cardiovascular illness, with an emphasis on prevention, support, and rehabilitation
  • Diabetes and metabolic illness, including prevention and support
  • Mental health, focusing on improving mental health across the population and supporting those with a mental health–related diagnosis.

The '20%' element of the model includes:

- a population focus, working with partners to decrease health inequalities at a regional level.
- a pathway focus, working with the clinical leads for key areas where there is potential to reduce health inequalities.
- A focus on 'equity in all we do', challenging us to consider equity in all our programmes and projects, this is where the health equity impact assessment can be a valuable tool.

The health equity assessment prompts service, programme and project leads to consider the impact of health inequalities that any change or new initiative may have. The ambition is that the tool becomes an essential element of service and programme planning throughout the Health Board.

Undertaking Equity focussed Health Impact Assessments for strategic decisions, going forward, is not optional. It is an expectation outlined at a national level. However, how this is implemented and how far beyond key strategic decisions it is utilised is at the health boards discretion. As an equity focussed Health Board, with a model which supports the drive towards reducing health inequalities, the hope would be that the tool is easy to use and intuitive, encouraging its wide adoption.

Asesiad / Assessment

The equity focussed health impact assessment tool addresses five key questions:

1) Does this approach consider access?
2) Will this approach address need?
3) Does this approach optimise interventions and assess effectiveness?
4) Does this approach consider partnerships and social acceptability?
5) Could this approach widen inequalities?

Each of these areas includes more detailed questions which can be considered as appropriate to the service, programme or project.

Figure 1: Introduction to the Equity Focussed Health Impact Assessment

INTRODUCTION:

Population health and wellbeing can be influenced by wider socio-economic and environmental factors and their impact vary considerably across different population groups as defined by age, sex, geography and deprivation.

Health equity is a fundamental principle that recognises that everyone deserves the opportunity to achieve their full health potential. However, inequalities in health outcomes continue to persist, disproportionally affecting marginalised and underserved individuals and communities.

WHY DOES HEALTH EQUITY MATTER?

Everyone has the right to live a healthy life, but systemic barriers and injustices such as where you were born, level of education, adverse childhood experiences, community cohesion and access to quality education and housing often prevent certain individuals and population groups from accessing the resources and opportunities they need to achieve optimal health.

Promoting health equity can also lead to better health outcomes for all, as improving overall access to quality healthcare and services can improve population health.

Equity is the absence of avoidable, unfair or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically or by other means of stratification.

World Health Organisation

The route to achieving equity will not be accomplished through treating everyone equally. It will be achieved by treating everyone justly according to their circumstances.

Race Matters Institute

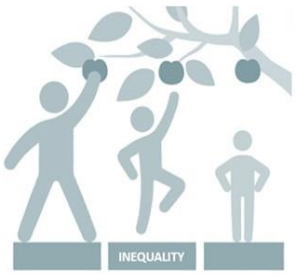
HEALTH INEQUALITIES MAY BE DRIVEN BY:

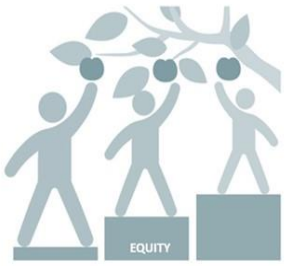
- Different experiences and distribution of the wider determinants of health or structural factors. For example, the environment, community life, income or housing. In other words, the social economic and environmental conditions in which people live, work and play.
- Different exposure to social, economic and environmental stressors and adversities. These affect states of mind from an early age and throughout life. Stress and psychological wellbeing directly affect resilience, health conditions and health behaviours.
- Differences in health behaviours or other risk factors between groups, for example smoking, diet, and physical activity levels have different social distributions. Health behaviours may be influenced by wider determinants of health, like income.
- Unequal access to or experience of health and other services between social groups.

Figure 2: Definitions of Inequalities and Equity

DEFINITIONS

INEQUALITY refers to differences in outcomes between different groups of people, often due to factors such as income, education, race, gender or geographic location. These differences can lead to unequal access to healthcare, education, employment and other essential services leading to a cycle of poverty and social exclusion. Inequality can perpetuate social divisions and create barriers to social mobility. Addressing inequality requires a focus on the social determinants of health and implementing policies and interventions that aim to reduce disparities and promote equity and inclusivity.





EQUITY is the concept of fairness and justice in the distribution of resources and opportunities, with a focus on addressing the needs and circumstances of individuals to ensure everyone has an equal chance to succeed. It involves recognising and acknowledging the systematic barriers that contribute to inequality and highlights the principle of ensuring that all individuals have equal access to services and opportunities to achieve their full potential regardless of their social or economic status. It is about addressing the root causes of inequalities and working towards eliminating barriers to and improving access and quality for all populations.

Figure 3: The cost of inequalities

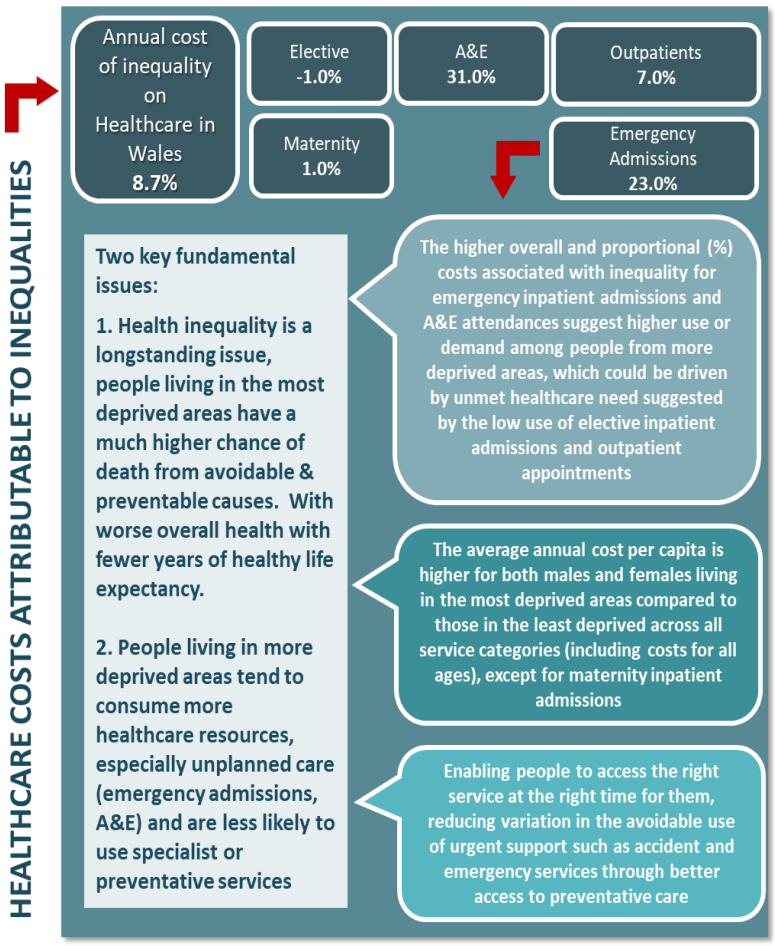
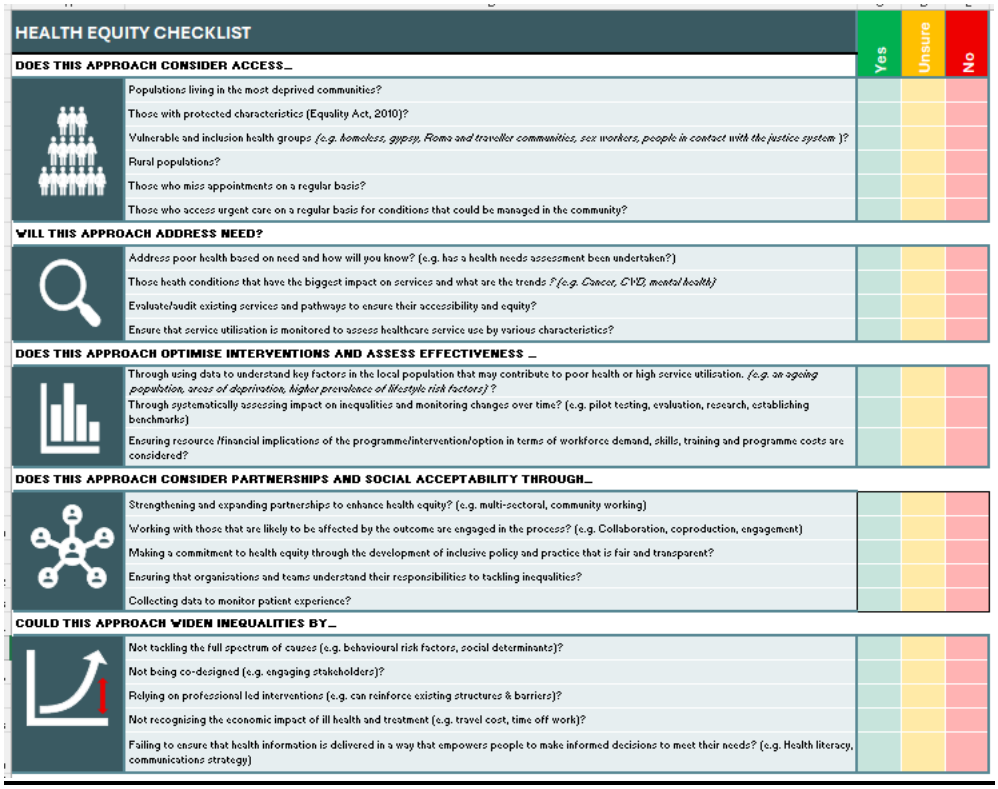


Figure 4: The equity checklist



HEALTH EQUITY CHECKLIST	Yes	Unsure	No
DOES THIS APPROACH CONSIDER ACCESS…			
Populations living in the most deprived communities?			
Those with protected characteristics (Equality Act, 2010)?			
Vulnerable and inclusion health groups *(e.g. homeless, gypsy, Roma and traveller communities, sex workers, people in contact with the justice system)*?			
Rural populations?			
Those who miss appointments on a regular basis?			
Those who access urgent care on a regular basis for conditions that could be managed in the community?			
WILL THIS APPROACH ADDRESS NEED?			
Address poor health based on need and how will you know? (e.g. has a health needs assessment been undertaken?)			
Those heath conditions that have the biggest impact on services and what are the trends ? *(e.g. Cancer, CVD, mental health)*			
Evaluate/audit existing services and pathways to ensure their accessibility and equity?			
Ensure that service utilisation is monitored to assess healthcare service use by various characteristics?			
DOES THIS APPROACH OPTIMISE INTERVENTIONS AND ASSESS EFFECTIVENESS …			
Through using data to understand key factors in the local population that may contribute to poor health or high service utilisation. *(e.g. an ageing population, areas of deprivation, higher prevalence of lifestyle risk factors)* ?			
Through systematically assessing impact on inequalities and monitoring changes over time? (e.g. pilot testing, evaluation, research, establishing benchmarks)			
Ensuring resource /financial implications of the programme/intervention/option in terms of workforce demand, skills, training and programme costs are considered?			
DOES THIS APPROACH CONSIDER PARTNERSHIPS AND SOCIAL ACCEPTABILITY THROUGH…			
Strengthening and expanding partnerships to enhance health equity? (e.g. multi-sectoral, community working)			
Working with those that are likely to be affected by the outcome are engaged in the process? (e.g. Collaboration, coproduction, engagement)			
Making a commitment to health equity through the development of inclusive policy and practice that is fair and transparent?			
Ensuring that organisations and teams understand their responsibilities to tackling inequalities?			
Collecting data to monitor patient experience?			
COULD THIS APPROACH WIDEN INEQUALITIES BY…			
Not tackling the full spectrum of causes (e.g. behavioural risk factors, social determinants)?			
Not being co-designed (e.g. engaging stakeholders)?			
Relying on professional led interventions (e.g. can reinforce existing structures & barriers)?			
Not recognising the economic impact of ill health and treatment (e.g. travel cost, time off work)?			
Failing to ensure that health information is delivered in a way that empowers people to make informed decisions to meet their needs? (e.g. Health literacy, communications strategy)			

Additional elements of the tool, including advice on collating information, information on the Welsh Index of Multiple Deprivation (WIMD) assessment, data sources, mitigation, barriers and facilitators are outlined within the main document, which can be accessed here:

Copy of Equity-Focused HIA Version 3.0.xlsx

Feedback to date

The tool has been used and refined over the past few months. Feedback indicates that the tool strikes a good balance, being straightforward to use, while broad in its questioning, yet still providing enough detail to be genuinely informative and support decision-making.

The tool has proved useful as part of the Hywel Dda Arts Referral Programme as it provided a systematic approach to checking the team had considered equity as well as reassurance in terms of mitigating against any challenges and ensuring access to the programme is equitable. The summary of mitigation strategies, barriers and facilitators included in the tool has been highly praised.

The tool has also proven useful in partnership working and has been part of work planning with the food partnerships across Hywel Dda. The data sources and Welsh Index of Multiple Deprivation (WIMD) section have proved invaluable in ensuring the partnership is working with key communities in the least affluent areas and those who are at risk or experiencing food insecurity, even being able to drill down to postcode/street level.

However, feedback included that there are clear overlaps in terms of the Health Equity Impact Assessment, Quality Impact Assessments and Equality Impact Assessments which already have to be undertaken. Feedback has included that, once the Integrated Impact Assessment or the planned toolkit is introduced, this will mitigate the overlap because the information will all be in one place.

It is important that the tool is recognised as independent of Equality Impact Assessments. While Equality Impact Assessments (EqIA) cover socio-economic impacts of all strategic decisions, as required by the Socio-Economic Duty which was enacted as a part of the Equality Act in 2021, the Equity tool prompts for further detail. EqIA consider impact on the 9 protected characteristic groups, the socio-economic impacts and the impact on the armed forces community as required by the Armed Forces Covenant Duty. However, the EqIA process would not specifically address the broader vulnerable groups, such as sex workers and those in the criminal justice system.

Further changes will be made to the Equity focussed Health Impact Assessment tool based on feedback from Equality, Diversity and Inclusion colleagues. These edits will include referring to parts of an EqIA where these have been completed and streamlining the engagement elements so that engagement with affected individuals happens once for multiple assessments. The tool will continue to evolve as more services utilise it and feedback on its use and will be reviewed as part of a wider toolkit of assessment documents, which are currently in development.

Formal use of the tool in strategic decision making, 2025-26

The Clinical Services Plan Programme team has utilised the tool extensively in their options appraisals around strategic direction and delivery of services in a number of clinical areas. These include critical care, dermatology, emergency general surgery, endoscopy, ophthalmology, orthopaedics, radiology, urology and stroke services. Ensuring proposed

changes to do not negatively impact on equity of access to high quality care has been at the heart of planning discussions, and the equity focussed health impact assessment tool has been key to this.

Use of the tool going forward

It is expected that the Equity focussed Health Impact Assessment (HIA) will be utilised for strategic decision making, and also for key operational decisions, and become a standard part of practice throughout the Health Board in 2026. Discussions are ongoing around the governance, policy and use of equity focussed health impact assessments.

As highlighted, the equity focused HIA forms an important and integral part of the 20four7 prevention model. Currently, the EF-HIA has been incorporated within the 20four7 planning checklist, this is an MS Form being used by CCGs and Directorates to ensure the Prevention Model is being considered during the 2026/27 planning cycle: 20four7 Model Planning Cycle Self-Assessment Checklist – Fill in form

Discussions with colleagues are in progress with the intention to embed the 20four7 prevention model with existing quality improvement processes, therefore ensuring prevention is seen as a key element of quality and patient safety i.e. prevention prevents avoidable patient harm.

Argymhelliad / Recommendation

The Committee is asked to **receive assurance** that an effective monitoring process in in development for potential health inequalities across the Health Board and that use of the health equity tool, and any related quality improvement activity will be audited and reported through internal governance structures as appropriate.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	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
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 Domains of Quality
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	4. The best health and wellbeing for our individuals, families and communities

Amcanion Cynllunio Planning Objectives	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:	Public Health Wales Act (2017) Welsh Index of Multiple Deprivation (WIMD) Socio-Economic Duty Armed Forces Covenant Duty
Rhestr Termau: Glossary of Terms:	Contained within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	Business Executive Team

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	There are no capital requirements. Financial impact will be difficult to measure, but in reducing inequalities will be positive.
Ansawdd / Gofal Claf: Quality / Patient Care:	There are no perceived adverse outcomes
Gweithlu: Workforce:	No perceived risk
Risg: Risk:	No perceived risk
Cyfreithiol: Legal:	It is highly unlikely there is any scope for legal challenge
Enw Da: Reputational:	Not Applicable
Gyfrinachedd: Privacy:	Not Applicable

Cydraddoldeb: Equality:	The purpose of the tool is to reduce inequalities

EQUITY CHECKLIST

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

RECOMMENDATIONS:

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

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

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

3.2

3.2 - Management of Waiting Lists/DNAS/ Appointments:

Marilize Preez (Hywel Dda UHB - Improvement and Transformation Lead), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)

Attachments

3.2 Waiting List Management Feb 2026.pdf

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:	Waiting List Management
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Andrew Carruthers: Chief Operating Officer
SWYDDOG ADRODD: REPORTING OFFICER:	Marilize Preez: (Improvement & Transformation 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 report on the Management of Waiting Lists/ DNA's/ Appointments presented at Public Board on the 25th September was unable to provide assurance to the Board on the current processes around waiting list management, appointment bookings and communication with patients. The Board requested that a much broader review of the processes be undertaken and the outputs of the review used to inform an action plan to improve communication and pathway management.

An interim update on the review was presented at QSEC on the 4th December 2025 with agreement to provide a final report to the committee in February 2026 to review the findings and recommendations in the first instance, with a final report to be presented at Public Board in March 2026.

Cefndir / Background

Definitions:

- **Did not attend (DNA):** Patient misses a scheduled appointment without prior cancellation.

- **Could not attend (CNA):** Patient contacts the service in advance of the appointment time to cancel or reschedule the appointment.

Following media publications and freedom of information requests earlier this year regarding Hywel Dda University Health Board (HDUHB) patients being removed from waiting lists without warning, and reports of patients being removed following missed appointments which were never communicated to them, or where the appointment letter arrived after the appointment date, the executive team requested an initial review of current communication processes with patients on waiting lists, including access points, to identify any potential factors which might lead to late receipt of appointment letters and/or outcomes of DNA/CNA in August 2025. The findings of the initial review, and an overview of the waiting list management process set out by Welsh Government within the "Referral to Treatment" (RTT) Guidance was presented at Public Board. Discussions at Public Board identified several cases of poor patient experience as a

result of current waiting list management and communication processes highlighting the impact on patients and the need to improve.

Operational teams recognise that communication with patients is not as it should be, and that improvements are possible, even within the current infrastructure constraints. There is also an ask from the board to identify if the current situation is reflective or symptomatic of the current pressures being experienced by staff and the organisation in general to meet targets leading to people losing sight of the person/patient at the other end of the communication.

National Guidelines for the Management of Referral to Treatment waiting times (RTT) in Wales were introduced in 2009, and the refreshed RTT guidance (April 2025) provides clear guidance on appointment booking, reasonable offer, and communication for RTT reportable services. However, a large proportion of services and waiting lists sit outside the RTT remit.

For RTT reportable services the following guidance applies:

Booking Processes

- Booking is mutually agreed between the service provider and patients, fostering shared decision-making and clear communication of appointment details, modes (face-to-face, telephone, video), timing, and location.

- Health Boards must encourage shared decision-making and involve patients fully in administrative and treatment arrangements.

- If a patient is to be seen within six weeks, a direct booking system should be used. If the appointment is going to be more than six weeks in the future, confirmation of the acceptance of the referral is needed either by letter, text, or phone.

- Each attempt to contact the patient under the booking processes must be recorded and available for subsequent audit.

- Direct booking for clinics with less than 10 working days' notice should be done directly with the patient, either **face-to-face or via telephone**. If the patient does not accept the offer of a short notice appointment, this cannot be managed as a reasonable offer, and the clock remains unaffected.

Appointment Communication

- Communication with patients is a key pillar for managing RTT within target times (26-week and 36-week pathways for complex cases).

- Patients and carers with additional communication needs must receive information in formats they can access (e.g., large print, braille, easy read, or via interpreters).

- A partial booking process occurs whereby appointments are agreed with the patient, following a written request for the patient to telephone if they require an alternative appointment.

- Under the partial booking process, an acknowledgement must be sent to the patient when the referral is received and accepted. This should explain the booking process that will be used for their appointment, including a choice of digital or non-digital methods. A letter should then be sent to the patient four weeks before it is anticipated they will be seen,

asking them to phone and make an appointment, or book their appointment via the patient-facing platform within the next 10 days.

- Direct booking occurs by either being booked in a face-to-face or telephone interaction with the patient, or through a direct dialogue with the patient via letter/email and or text. In this case, any correspondence will be sent at least 10 working days prior to the appointment date. 10 working days is recognised as a *reasonable notice period* (as per access policy).

- A reasonable offer is considered as an offer of two possible dates and/or times, which must be more than two weeks in the future.

- All appointments within an RTT period must be arranged under "reasonable offer" principles, mutually agreed by patient and provider.

- Appointment planning should consider:
    - Patient preferences (including appointment modality: face-to-face, telephone, video consultations).
    - Appointment confirmation and reminders to reduce DNAs.
    - Accessibility and mobility considerations for vulnerable groups.

- Health Board's must consider postage times when sending letters offering a direct booking appointment to patients to avoid the patient receiving the letter on, or following, the day of the appointment. If a patient does not attend an appointment (and DNA recorded) and subsequently contacts the HB to state that they did not receive the appointment letter in time, the Health Board should amend the patient record, and the clock should continue with no adjustment. An alternative timely offer should be made to the patient at the earliest opportunity. To avoid this, health Boards must ensure that letters offering a direct booking should be sent a minimum of 10 working days before the appointment date.

- If a patient is removed from the waiting list for reasons other than treatment, the patient and their referrer must be informed of the removal and the reasons for it.

As previously stated, the guidance does not apply to all waiting lists and pathways which adds an additional layer of complexity.

The interim update in December 2025 included findings from an initial review in August 2025 of 14 waiting lists, in addition to the review of 38 subspecialties between October – November 2025, which is outlined below.

- In August 2025 the Health Board's "Patient Access- Elective Care policy" was out of date. The policy was updated to reflect the refreshed RTT guidance published April 2025 but was still awaiting formal approval at that point.

- A limited amount of RTT patients' services in the Health Board report that they follow a partial booking process whereby appointments are agreed with the patient, following a written request for the patient to telephone if they require an alternative appointment. Under the partial booking process, an acknowledgement letter must be sent to the patient when the referral is received and accepted to explain the booking process. Currently the Health Board does not send acknowledgement letters to patients once referrals have been accepted. This functionality has been turned off since January 2025.

- The majority of services (wider than planned care) are utilising direct bookings either via letters, phone or face-to-face. The review identified variation in the recording of direct bookings offered via phone or face-to-face on the patient administration system for audit and pathway management purposes in terms of DNA/CNA, especially for appointments offered within less than 10 working days.

- A review by the digital team identified that 19% (n= 59,322) of appointment letters were sent within 10 days or less of the appointment date over a 6-month period. Of these appointments 6.5% (n=3,856) of patients could not attend (CNA) and 3.7% (n=2,195) did not attend (DNA). These appointments would not be considered a “reasonable offer” under RTT guidance if patients were not additionally informed either by phone or face-to-face and agreed to the appointment. The variation in recording of information relating to direct bookings limits the ability to audit if these patients where correctly recorded as a DNA/ CNA.

- The majority of waiting list are on WPAS but some services report utilising Excel spreadsheets (n=10), or paper-based lists in addition to WPAS to manage waiting lists.

- Most services report not utilising or not having a standard operating procedure (SOP) for staff to follow in terms of waiting list management/ appointment bookings/ documenting on systems- even in RTT reportable services.

- Variation in practice regarding discharging patients following a DNA, some will discharge after 1 DNA, others discharge after 2 or 3 DNA’s.

- Multiple letter formats - some utilising standardised templates on WPAS and others use letters written within services with limited or no guidance.

- Letters printed and sent from multiple locations (centrally and from individual offices/ services).

- Letters being sent for appointments within less than 10 days without evidence on WPAS of a phone or face-to-face contact.

- Limited audit and governance processes in place across some services (not specifically RTT services).

- Clinical staff booking appointments/ managing waiting lists/ sending letters due to lack of administrative staff to support waiting lists management within some services.

- Multiple access points and contact numbers for service users on patient letters, the letter templates reviewed contained as a minimum two phone numbers, one in the letter header and a different number in the letter content, with some letters containing more.

- No single access point linked to all services that service users can contact to cancel or change appointments, multiple services had their own telephone number which included numbers to medical secretaries, and unmanned answer phones.

- Different services offer various methods of communicating if patients are unable to attend or the need to reschedule appointment with some services offering the option to leave a voicemail whilst others do not. Additionally, some appointment letters include an email contact address, but this is not provided by all services.

- The Hybrid Print and Post/ Patient hub roll out will address some issues identified as part of the review and allow patients access to text reminders, digital appointment letters and accessible communication formats.

- The Waiting List Support Service (WLSS) provides a single point of contact, within the Health Board's Communication Hub, offering self-management advice, promoting healthy lifestyle, and personalised support for patients who are awaiting treatment or surgery to prevent deconditioning and deterioration in their condition, and support them to prepare for treatment. The WLSS helps patients manage their health and wellbeing whilst waiting, signposts to community and clinical services and identify potential harm from waiting and escalates as/where necessary. The service is not responsible for RTT pathway management in terms of appointments/ cancellations/ DNA / CNA/ validation but have agreed communication routes to relevant services to address these if they are raised by patients.

Following the interim report presented at QSEC, the Quality Improvement and Service Transformation (QIST) continued team to work with the clinical care groups and services to map the remaining waiting lists identified and associated processes in terms of communication, booking, cancellations and discharge/ removal from the list.

Asesiad / Assessment

The QIST team has concluded an extensive review of 198 identified waiting lists in 109 subspecialities/ services across all clinical care groups in the Health Board, as well as linking into both national and local programmes of work that relates to waiting list management. As the request from the Executive Team involved all waiting list, there has been an additional focus on identifying "hidden" waiting lists not currently reported on. The review highlighted the complexity of waiting list management and number of different individuals involved in the process.

In addition to the findings outlined in the interim report (summarise above) the review identified:

- The Health Board's "Patient Access – Elective Care Policy" has been ratified and updated to reflect national changes to RTT guidance. However, the policy only covers elective planned care RRT reportable services. There is no overarching "Patient Access Policy" for non- RTT services.

- Not all staff are aware of the elements in the policy/ RTT guidance and the implications on pathway management. From a national perspective WG Planned Care Policy is supporting the national roll-out of a learning programme based on best practice by Swansea Bay UHB Planned Care Academy. This programme which supports front-line staff in the day-to-day application of the RTT guidelines will focus upon developing the knowledge and skills to consistently, accurately, safely and equitably apply the RTT rules, and communicate effectively with patients in the delivery of person-centred care, working in partnership with patients and shared decision making.

- Guidance is in place to support waiting list management of vulnerable people (children, young people and adults) who were not brought in for appointments or clinics via the "Monitoring Vulnerable People Who Are Not Brought In or Did Not Attend Appointments and No Access Visits Procedure". The understanding and application of the guidance is variable across different services.

- National WPAS system improvements are needed to support the identification of vulnerable individuals and preferred communication needs, including sensory needs.

- Understanding and utilisation of the “Purple Dot” flag on WPAS (indicating neurodiversity and learning disability) locally and nationally is poor and there is no agreed process to support the appropriate allocation of a “purple dot” to an individual on the system. Correct knowledge and application of the flag will support improved patient communication, pathway management and patient experience. This had been identified and raised nationally via the health board’s informatics team.

- Although the referral acknowledgment letter functionality has been turned off on WPAS for RTT services, the review identified 18 services that do currently send referral acknowledgement letters from their individual services.

- 6-monthly “Keeping in Touch” letters, assuring patients that they are still on the waiting list, are not routinely sent. The review only identified 4 services contacting patients 6-monthly if they are still waiting.

- All patients on RTT pathways that have been listed for a procedure are sent listing acknowledgement letters which also provides the contact number for the Waiting List Support Service (WLSS), and an email address.

- DNA letters are not routinely sent by all services, some patients are only informed that they have DNA’d if they are subsequently discharged and receive their discharge letter. Most discharge letters normally state that patients can contact the service.

- Not all services inform patients when they have been discharged or removed from the list. Some services inform the referring GP but not the patient.

- More services are utilising the communication hub/ WLSS as a single point of contact to improve patient communication and support but additional capacity within these services will be required based on the number of services identified during review.

- There has been significant progress in the roll-out of the Hybrid Print and Post (HPP) project with most planned care services’ out-patient consultant clinics now on the system (18 out of 23 services in December 2025). This allows patients to have access to their letters on the digital platform, receive appointment reminders 7 and 2 days before their clinic appointment, and the ability to send clinic cancellation messages to patients if needed. The digital team is working with other services including allied health professional services to roll out to Health Care Professional (HCP) clinics on WPAS,

- Progress on the NHS Wales App will support improved communication for people on waiting lists moving forward. Referral acknowledgment letters, once a referral is accepted, are starting to be sent via the App.

- A paper has been summited to Board on the 29th January 2026 for a decision relating to the Outline Business Case (OBC) for a Patient Service Centre (PSC) and Patient Relationship Management Tool.

The review did not find clear evidence that the current pressure on the organisation and staff to meet targets deliberately influenced waiting list management processes. Most of the findings relate to lack of awareness or inconsistent interpretation of relevant published guidance (if

available) such as what constitutes a reasonable offer, absence of standardised guidance, processes and/or training to support staff in waiting list management, and WPAS system limitations to record narrative around patient communications and pathway management decisions to support audit processes.

Changes within the refreshed RTT guidance published in April 2025 includes an optimisation pathway for high-risk patients requiring prehabilitation to enable them to get fit for surgical treatment. Patients on optimisation pathways RTT clocks are “stopped” and once the optimisation period is finished the clock is restarted as the point it was stopped. However, the WPAS system has no automated function to indicate to staff that a patient is on an optimisation pathway and is dependant on staff keeping a keep a record of these patients and to restart the clock on the system. There is a risk that patients could be “missed” and the clock not restarted as the WPAS system functionality is unable help staff to identify patients or track patients – especially considering the volume of patients on waiting lists and the number of staff involved in waiting list management.

Recommendations based on the review:

Immediate (within 1 month):

- A cross-CCG Task and Finish Group to be established to develop an overarching Access Policy and relevant SOPs to provide all services with clear guidance on waiting list management, including the management of vulnerable people not brought in.
- Review current validation process and governance structures within CCGs in relation the waiting list management and reporting.

Medium term (within 3 months):

- Education and training for all staff involved in waiting list management, including the learning programme based on best practice by Swansea Bay UHB Planned Care Academy.
- An audit programme to be established to monitor compliance with the guidance, including patient communication across all services and CCGs.
- Review and standardisation of letter templates to ensure accessibility criteria and digital accessibility standards are adhered to.
- Support services still utilising Excel spreadsheets to migrate to a patient administration system.
- Explore interim solutions to identify vulnerable people and communication/ sensory needs on WPAS whilst a national system solution is being developed.
- Develop a process to provide more narrative around pathway management on WPAS, including patients on optimisation pathways.

Long term (> 6 months):

- Explore the impact of expanding capacity within the Communication hub/ WLSS to support more patients and services via a SPOC, acknowledging the OBC for a wider Patient Service Centre (PSC) and Patient Relationship Management Tool.
- Optimise digital solutions to support Waiting list management (HPP/ NHS app)

The next Enabling Quality Improvement in Practice (EQIiP) cohort will be centred on “Customer focus” which will provide support to services and CCG to progress these recommendations.

Argymhelliad / Recommendation

The Quality, Safety & Experience Committee is asked to note the findings from the review of Management of Waiting Lists/ DNA's/ Appointments and the recommendations to support improved waiting list management.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.6 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.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
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	4 Planned care, diagnostics and cancer Recovery 6 Clinical services plan 9 Digital plan Choose an item.
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 8. Transform our communities through collaboration with people, communities and partners Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	

Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiod: 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:**	Contained within the body of the report
Risg: **Risk:**	Contained within the body of the report
Cyfreithiol: **Legal:**	Not applicable
Enw Da: **Reputational:**	Contained within the body of the report.
Gyfrinachedd: **Privacy:**	Not applicable
Cydraddoldeb: **Equality:**	Contained within the body of the report

3.3

3.3 - Quality Assurance Report

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

Attachments

3.3 QS Assurance Report Feb2026 v0.1.pdf

Quality and Safety Assurance Report

Quality, Safety and Experience Committee

12 February 2026

Situation

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
- Complaints management
- Public Services Ombudsman for Wales
- Infection prevention and control
- Inspections and peer reviews including activity of Healthcare Inspectorate Wales (HIW)

Patient Safety Incidents and Nationally Reported Incidents

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

There were 15,204 incidents reported on Datix Cymru in Hywel Dda UHB between 01/01/2025 and 31/12/2025. Of these, 12,139 were Patient Safety Incidents.

Of the 12,139 patient safety incidents reported, 9,462 have been closed. 68 (0.7%) were closed as moderate, severe or catastrophic harm.

The top 3 incident classifications (patient safety incidents reported between 01/11/2024 and 31/10/2025 and closed as moderate, severe or catastrophic harm) were pressure damage (20); accident or injury (14); and treatment and procedure (9). This can be broken down further into the categories.

Pressure ulcer developed or worsened during care in this clinical care area/caseload	16
Slip, trip or fall	13
Treatment or procedure issues	8

A review, using the support of AI, identified the main themes, within the lessons learned of patient safety incidents reported between 01/01/2025 and 31/12/2025 and closed, were:

1) Clinical Assessment & Decision-Making

Many incidents involve incomplete assessment, failure to recognise deterioration, missed injuries, and delayed escalation to senior clinicians.

Actions to be taken:

Strengthen use of structured assessment tools (ABCDE, trauma pathways, Advanced Trauma Life Support (ATLS) principles).
Ensure timely senior or specialist review when presentation is complex.
Reinforce need for comprehensive documentation of clinical findings and rationale.
Mandate re-assessment if symptoms persist, worsen, or do not align with initial diagnosis.

2) Escalation & Communication

Escalation often happened late, was incomplete, or relied on assumptions. Communication between teams, patients and families is critical.

Actions to be taken:

Escalate immediately when deterioration is identified or when safeguarding factors arise.
Improve communication handover processes (nursing ↔ medical, ward ↔ community).
Ensure Next of Kin is informed promptly following incidents.
Apply Duty of Candour processes consistently, including documentation and letters.

3) Risk Assessment & Documentation

Many incidents highlight missing or incomplete risk tools, care plans, body maps, or inconsistent records.

Actions to be taken:

Complete Purpose-T, Waterlow, and Falls assessments at admission AND after changes.
Keep documentation aligned: risk tools must match care plans and repositioning schedules.
Ensure body maps are completed before discharge and co-signed.
Improve accuracy and frequency of updates to WNCR and wound charts.

These themes have been shared with:

- Clinical Care Groups for discussion, consideration and improvement action
- The learning library and Viva Engage

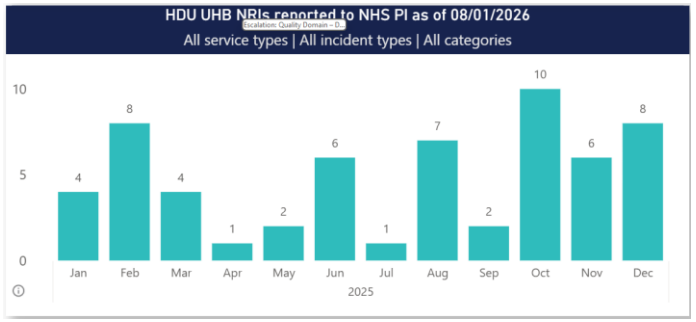
Nationally Reportable Incidents

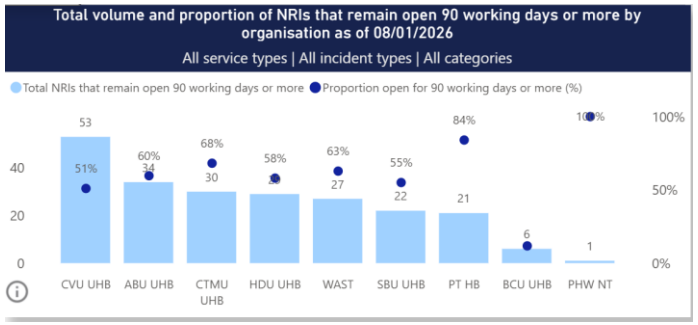
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

59 Patient Safety Incidents were reported to the NHS Wales Performance and Improvement (previously known as NHS Wales Executive between 01/01/2025 and 31/12/2025.

As of 08/01/2026, 47 incidents were open with NHS Performance and Improvement on the Health Board's Datix Cymru system (excluding those reported and awaiting confirmation of reference number).

23 incidents are been open with NHS Performance and Improvement for 90 days or more.

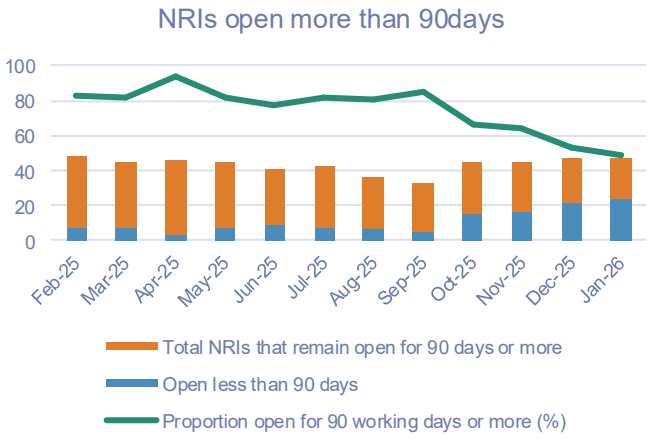


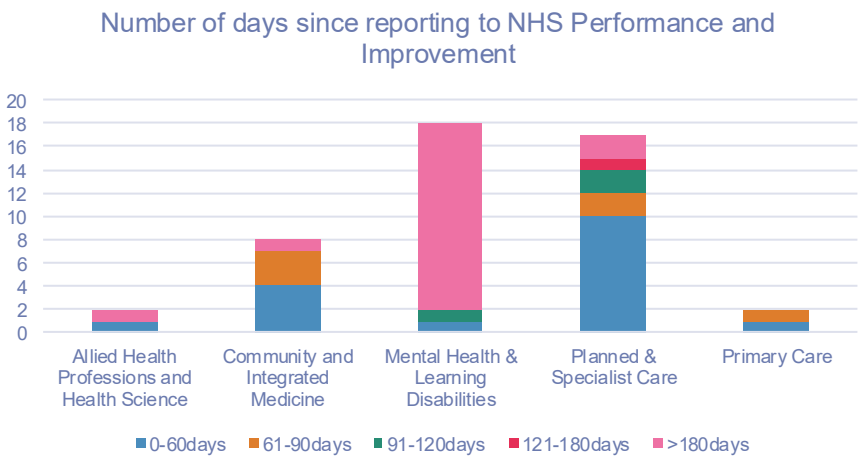


Source: Beacon Dashboard 08/01/2026

HDU UHB top 10 NRI categories occurring by volume (incident dates between Jan-25 and Dec-25) as of 08/01/2026

NRI category	Total
Neonate	15
Clinical assessment, clinical diagnosis	6
Unexpected death	4
Communication issues	2
Maternal	2
Treatment or procedure issues	2
Administration errors	1
Compliance with bundle/ guidance	1
Diagnostic testing - Pathology	1
Healthcare record	1
Medical devices	1
Medication documentation errors	1
Medication prescribing error	1
Mental Health Act Administration	1
Self-harm / self-injurious behaviour	1
Sterilisation / decontamination of equipment (including vehicles)	1





NRI category	Total
Neonate	
Stillbirth	7
Unexpected admission to neonatal unit (gestation 37 weeks+)	3
Other neonatal adverse occurrence	2
Baby unexpected admission to neonatal unit (gestation up to 36 weeks)	1
Cord PH <7.05 arterial or <7.1 venous	1
Other maternity adverse occurrence	1

Source: Beacon Dashboard 08/01/2026

Clinical assessment, clinical diagnosis	
Diagnosis delayed	2
Inadequate clinical assessment	2
Delay in clinical assessment	1
Other	1

Source: Datix Cymru 08/01/2026

Health Board Overview – Duty of Candour

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

		Harm post investigation					
		None	Low	Moderate	Severe	Catastrophic / Death	Total
Manager's interim harm assessment	Moderate	14	53	158	3	1	229
	Severe	1	9	4	13	3	30
	Catastrophic / Death	3	5	1	1	5	15
	Total	18	67	163	17	9	274

Top 3 incident classifications

Incidents occurring after 01/04/2023 where duty of candour has triggered

Pressure Damage, Moisture Damage	**71**
Pressure ulcer developed or worsened during care in this clinical care area/caseload	61
Pressure ulcer present before admission to this clinical care area/caseload	6
Pressure from medical device present before admission to this clinical care area/caseload	2
Pressure from medical device developed or worsened in this clinical care area/caseload	2
Accident, Injury	**71**
Burns or scalds	1
Contact with object or animal	1
Slip, trip or fall	66
Patient injury	3
Treatment, procedure	**54**
Blood / plasma products transfusion	3
Treatment or procedure issues	51

Learning identified:

Theme	Description
Documentation & Communication	Accurate records, clear handovers, and effective team/patient communication
Escalation & Timely Response	Prompt action on deterioration, abnormal findings, and adherence to escalation protocols
Risk Assessment & Prevention	Regular assessments, use of preventative measures, and following safety protocols

Source: Datix Cymru 08/01/2026

People's Experience Feedback

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Since the introduction of the revised Welsh Patient Experience Survey in April 2025, the following tables represent the volume of surveys issued via Friends and Family Testing (FFT) and those who access the Survey together with responses.

Friends and Family Test

	Surveys			Responses				Targeted Contacts	
Month	Number of Surveys with New Responses	Surveys with New Targeted Responses	Surveys with New Passive Responses	Total New Responses	# of New Targeted Responses	# of New Passive Responses	# of Responses in Welsh	# of Contacts by SMS	# of Contacts by IVR
Dec-25	1	1	0	2249	2249	0	0	13160	2405
Nov-25	1	1	0	2552	2552	0	0	14141	2529
Oct-25	1	1	0	2592	2592	0	0	14613	2765
Sep-25	1	1	0	2527	2527	0	0	14316	2639
Aug-25	1	1	0	2093	2093	0	0	11451	2358
Jul-25	1	1	0	2592	2592	0	0	14297	2997
Jun-25	1	1	0	2455	2455	0	0	13456	2765
May-25	1	1	0	2304	2304	0	0	13149	2713
Apr-25	1	1	1	1764	1762	2	0	9995	2653

NHS Wales People's Experience Survey

Question:	Survey	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Benchmark
2. How would you rate your overall experience?	NHS Wales People's Experience Survey (PES)	79.1	79.7	78.4	80.5	80.9	78.8	80.0	78.1	80.6	85
6. Were you able to communicate in your preferred language?	NHS Wales People's Experience Survey (PES)	94.7	95.6	96.5	96.8	95.4	95.3	96.1	94.0	94.8	85
7. Was the time you waited:	NHS Wales People's Experience Survey (PES)	70.2	67.7	68.0	70.3	67.4	67.8	67.5	65.1	72.1	85
8. Did you feel well cared for?	NHS Wales People's Experience Survey (PES)	83.7	83.9	82.0	84.7	83.8	81.7	83.4	81.6	84.7	85
9. Were you treated with dignity and respect?	NHS Wales People's Experience Survey (PES)	91.1	91.6	90.2	92.0	91.6	90.7	91.0	89.2	90.8	85
10. Did you feel that you were listened to?	NHS Wales People's Experience Survey (PES)	87.4	87.4	85.5	88.2	87.9	86.0	86.6	85.0	87.3	85
11. Were you involved as much as you wanted to be in decisions about your care?	NHS Wales People's Experience Survey (PES)	87.1	86.5	85.1	87.9	87.7	85.8	86.6	85.1	86.1	85
12. Were things explained to you in a way you could understand?	NHS Wales People's Experience Survey (PES)	91.2	90.0	89.5	90.9	91.0	89.2	90.5	88.0	89.4	85
Overall:		85.5	85.3	84.4	86.4	85.7	84.4	85.2	83.3	85.7	
Respondents:				50	972	1011	879	794	685	698	

Health Board Overview – Complaints Management

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Number of complaints received by month since Apr 25 (PTR)

April 2025	165
May 2025	204
June 2025	194
July 2025	249
August 2025	211
September 2025	249
October 2025	219
November 2025	95
December 2025	38

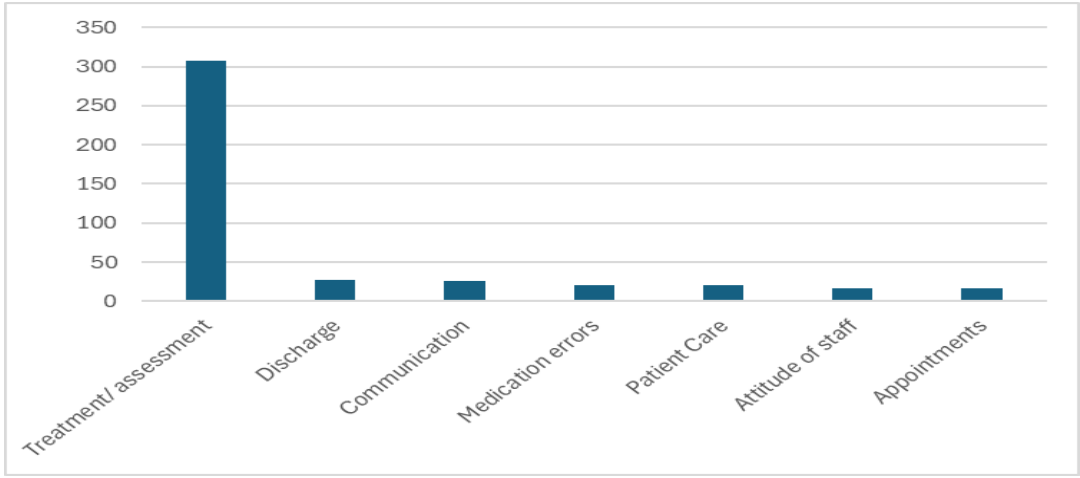
Proportion of complaints within 30 working days

For the period April to November 2025, the Health Board's performance against the 30-working day target is 54%, including early resolution cases.

There are 7 complaints > 12 months (excluding those at final stage), which is a reduction from previously reported 24 cases. It remains a priority to ensure that no concerns are open over 12 months and to continue bringing this closer to under 10 months by end of March 26. The business continuity status of hospitals and recent pressures have made reviews by senior clinical staff more difficult to obtain, given the prioritisation of urgent clinical care. This has slowed progress towards all cases under 12 months. Whilst progress has been slower than expected, bottlenecks in obtaining senior clinical opinions and resolving complex clinical issues with MDT decisions have added delays. The 7 cases may acknowledge a qualityfing liability and have needed input from Legal & Redress Team. Whilst we recognise that such complaints should not reach this stage, we nevertheless remain committed to giving a full, open and clinically robust response that offers appropriate redress:

There are still a high proportion of enquiries which should not be part of the complaints process and should be managed at first point of contact by other teams across the organisation. The noticeable reduction in new Putting Things Right (PTR) complaints in November/ December 2025 reflects attempts to categorise enquiries more appropriately.

Top themes for open complaints at end January 2026



Main themes giving rise to complaints remain consistent, with the highest volume relating to clinical treatment/ assessment. Communication, attitude and appointments remain the next most frequent themes. Services receiving the highest volume of complaints are the EDs, Orthopaedic services, General Medicine, Gynaecology and Ophthalmology. This correlates to the areas with the highest volumes of patient activity and appointments.

Public Services Ombudsman for Wales

- Following a Public Interest Report regarding the provision of specialist learning disability Epilepsy Services received in November 2025, the Health Board has since complied with the recommendations of the Ombudsman, and an ongoing action plan has been formulated with a further report being presented to Board for its oversight.
- In Q3 2025/26, there were eleven interventions from PSOW, which included two new investigations. There have been two final reports issued in Q3, neither of which were upheld. There have been 20 decisions not to investigate in the same quarter of the year.
- The Public Services Ombudsman for Wales (PSOW) annual report Turning the page - Annual Report and Accounts 2024/25 can be found on the PSOW website.

Infection Prevention and Control (IP&C)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Quality Planning

- Organisation Annual Plan
- Annual IP&C work plan
- Infection Prevention Strategic Steering Group Work Plan
- Welsh Health Circulars (WHC) relating to IP&C and Public Health
- WHC Antimicrobial Resistance (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 Control

- Standardisation of assurance/ scrutiny groups in progress
- Reports to and from Clinical Care Groups (CCG) / subgroups of Infection Prevention Strategic Steering Group (IPSSG)
- Review of Health Board (HB) 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 Antimicrobial Group (AMG) and antibiotic pharmacists of compliance to Start Smart The Focus (SSTF) for each acute site
- All CCGs to review data within the Health Board Safety Dashboard and ensure that cases are reviewed (see Quality Improvement)
- Review of monthly data from HARP with internal HB analysis and scrutiny and use of infographics in CCGs
- Outbreak management meetings held as required.

Quality Improvement

- Assurance/ scrutiny meetings held. All hospital onset/ HCAI are discussed and learning obtained / action plans implemented, themes derived with a move to learning panels
- Working with managed practices - presenting infographics for infections/ sources/ learning
- Environmental audit programme and observational audits programme in place with improvement action plans produced
- Review of Synbiotix scores in relation to IP&C audit programme
- HPV in use in 3 acute sites
- HCID/infectious disease pathway training dates have been completed for GGH and BGH, dates in September and October for PPH and WGH
- Engagement in the National C.diff Learning Collaborative

Quality Assurance

Performance de-escalation summary

Latest position key

Goal achieved | Minimal progress made or decline from previous month | Making good progress towards goal | Same as baseline or worse

	Measure	De-escalation criteria	Baseline	Baseline	Goal	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Infections	Number of laboratory confirmed C.difficile cases with hospital onset	25% reduction, maintained for 3 months	8	Baseline (average Q3 23/24)	6	7	4	5	11	8	8
	Number of laboratory confirmed S.aureus bacteramia cases with hospital onset	33% reduction, maintained for 3 months	3	Baseline (average Q3 23/24)	2	4	5	4	3	4	6
	Number of laboratory confirmed E.coli bacteramia cases with hospital onset	25% reduction, maintained for 3 months	7	Baseline (average Q3 23/24)	5	10	6	9	10	7	8

All CCGs to review progress against the HB Safety Dashboard

Review of monthly data from HARP with internal HB analysis and scrutiny

ANTT 83.35% compliance

Level 2 mandatory training at 75.36%.

HPV enhanced cleaning now available at 4 acute sites

Universal masking introduced into the HB on 11/12/25

IP&C continued

Table 1. Current FY rate per 1,000 hospital admissions of specimens by HB, Apr - Dec 25

Additional filters for Table 1.
Select month or FY: Current FY
Select organism group: All organisms

< than same period last FY
= same period last FY
> than same period last FY

	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Aneurin Bevan UHB	2.3	0.06	1.27	3.38	1.07	0.32
Betsi Cadwaladr UHB	3.31	0.08	1.78	4.94	1.33	0.39
Cardiff and Vale UHB	2.96	0.28	1.94	4.24	1.84	0.48
Cwm Taf Morgannwg UHB	2.66	0.11	1.8	6.26	2.25	0.19
Hywel Dda UHB	2.96	0.27	1.92	6.53	2.24	0.39
Powys THB	18.77	0	0.89	0.89	0	0
Swansea Bay UHB	3.43	0.14	1.83	4.34	1.85	0.39
Velindre NHST	1.21	0	1.61	4.84	0	0.81
Wales	2.94	0.14	1.71	4.74	1.63	0.36

There is a mixed trend for the Health Board, with some infections improving and others being more challenging.

- E. coli bacteraemia rates remain high suggesting a need for targeted interventions for population base.
- *E. coli* and *C. difficile* show higher average monthly increases in October to November vs April–September.

Table 1. Current FY rate per 1,000 hospital admissions of specimens by acute hospital in Hywel Dda UHB, Apr - Dec 25

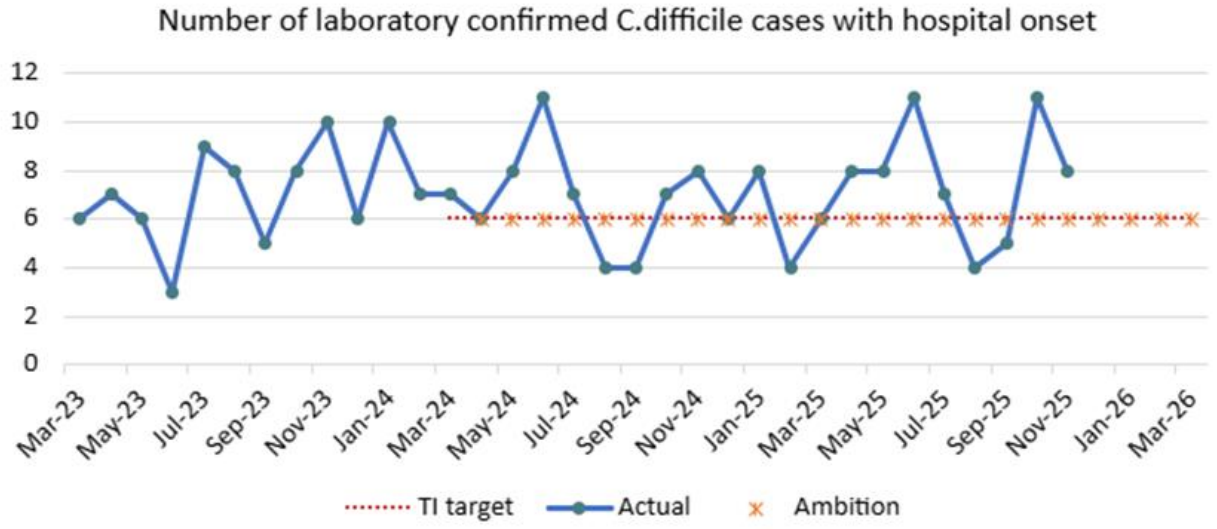
Additional filters for Table 1.
Select month or FY: Current FY
Select organism group: All organisms

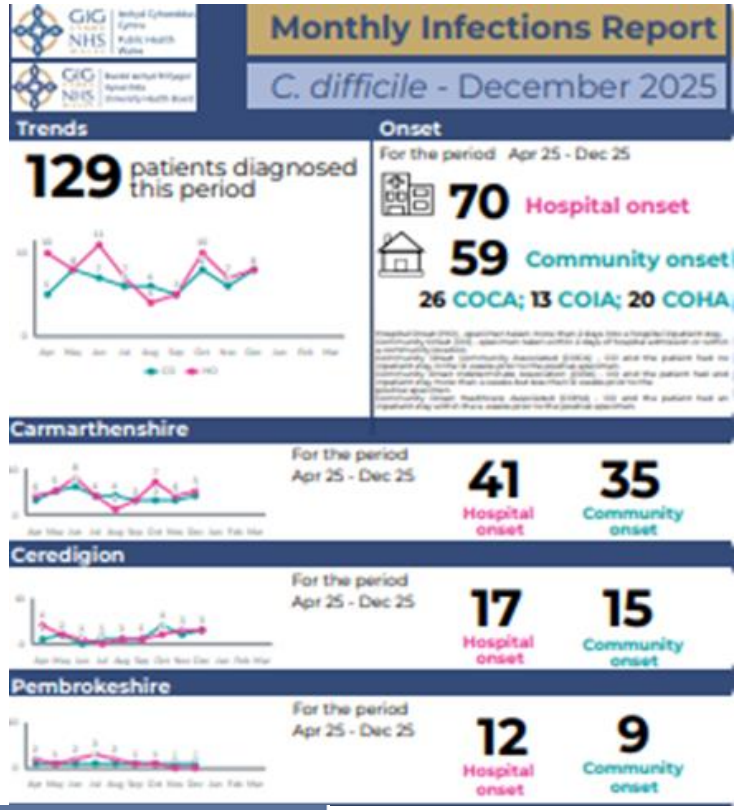
< than same period last FY
> than same period last FY

	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Bronglais General Hospital	4.02	0.18	2.56	7.48	2.74	0.55
Glangwili General Hospital	1.79	0.41	1.68	5.61	2.14	0.41
Prince Philip Hospital	2.54	0.12	1.61	4.84	1.84	0.23
Withybush General Hospital	1.65	0.22	2.53	9.56	2.53	0.44

IP&C C.difficile

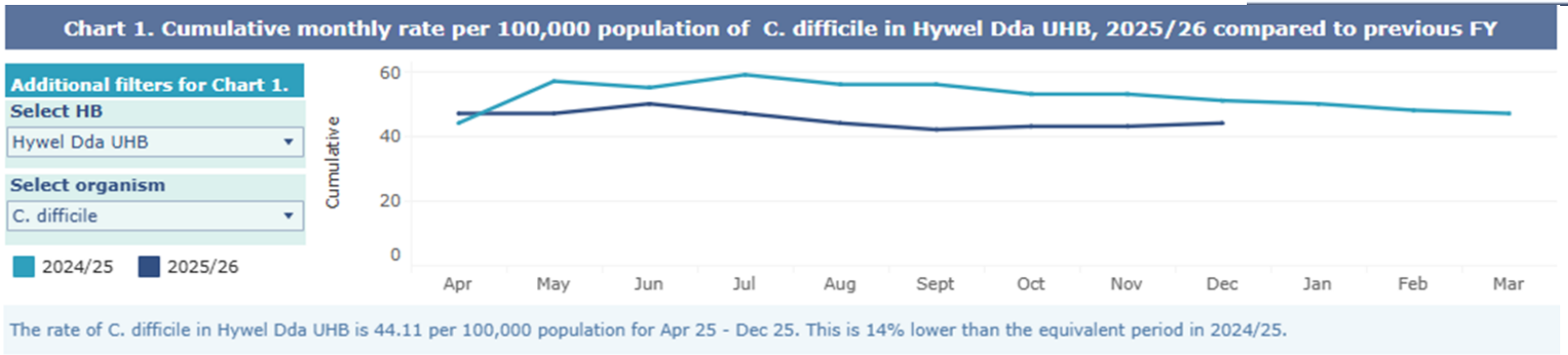
Improvement Goal: To reduce the overall burden of C. diff infection by at least 25% against the 2024-25 counts





4 patients

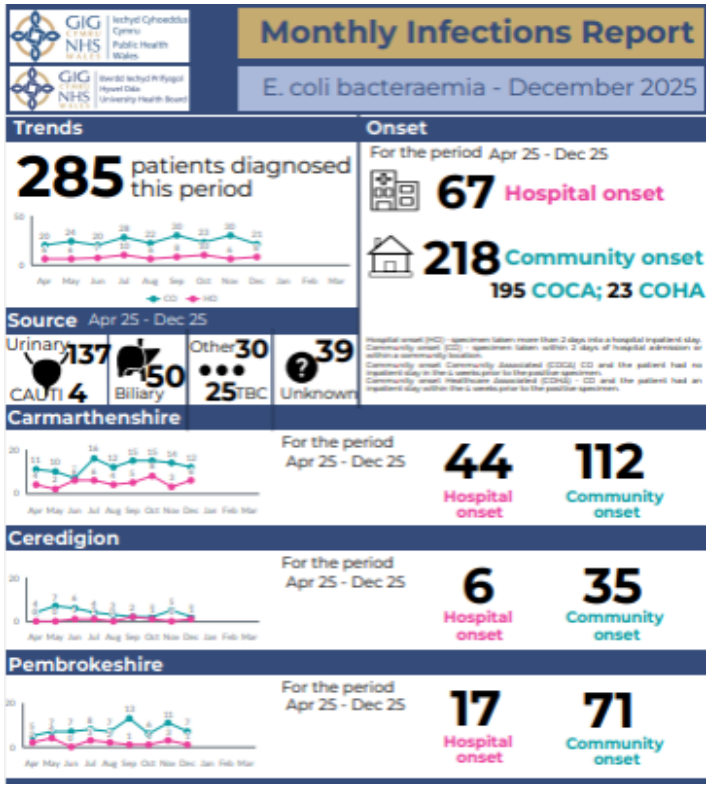
have had 2 positive samples 28 days apart 1/04/25 to 30/11/25

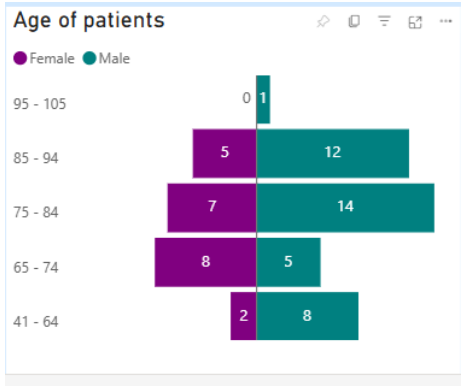


IP&C E.coli bacteraemia

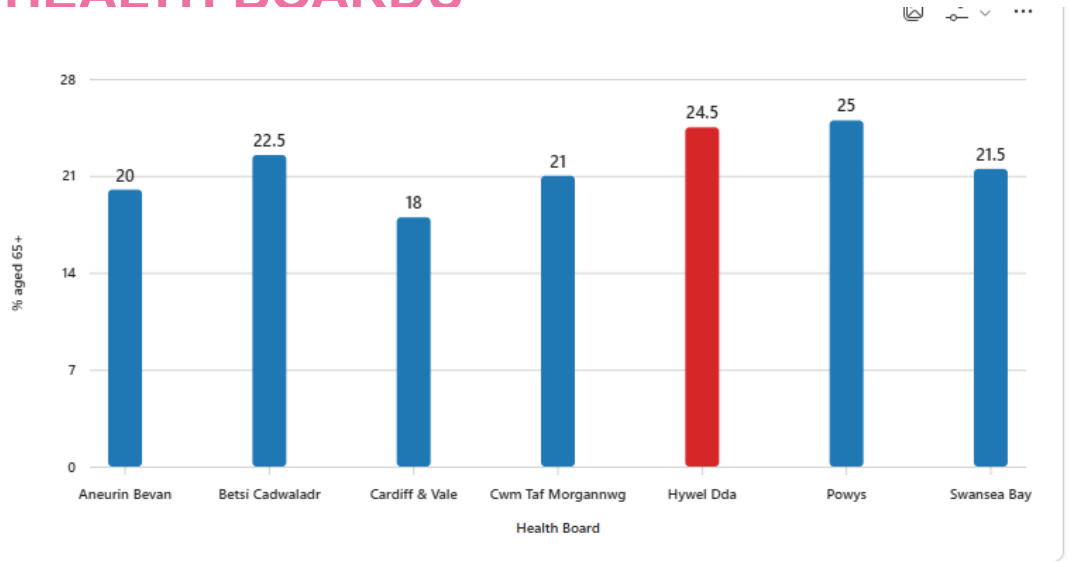
Improvement Goal: A reduction of at least 10% in cases of hospital onset E. coli blood stream infections (BSI) is expected vs the cases in 2024-2025.

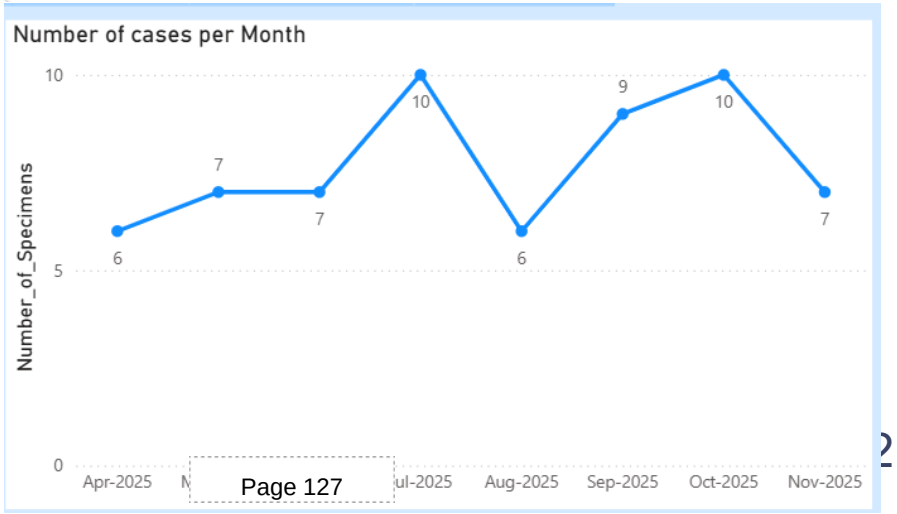
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board





AGE PROFILE COMPARISON ACROSS WELSH HEALTH BOARDS



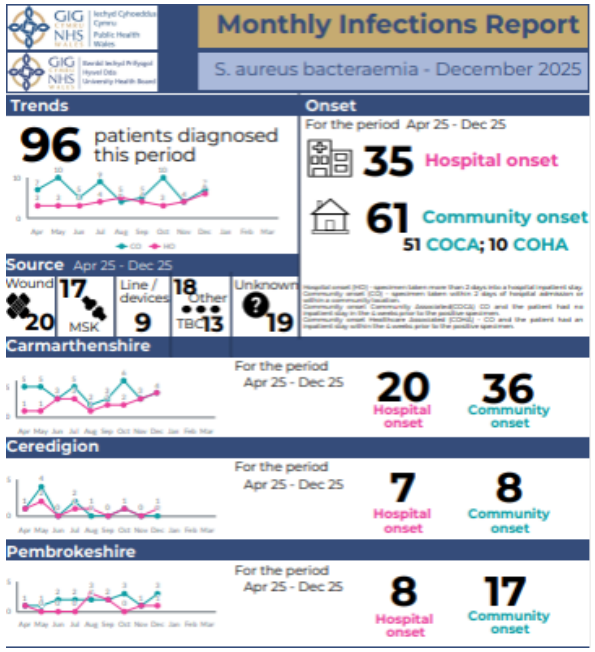


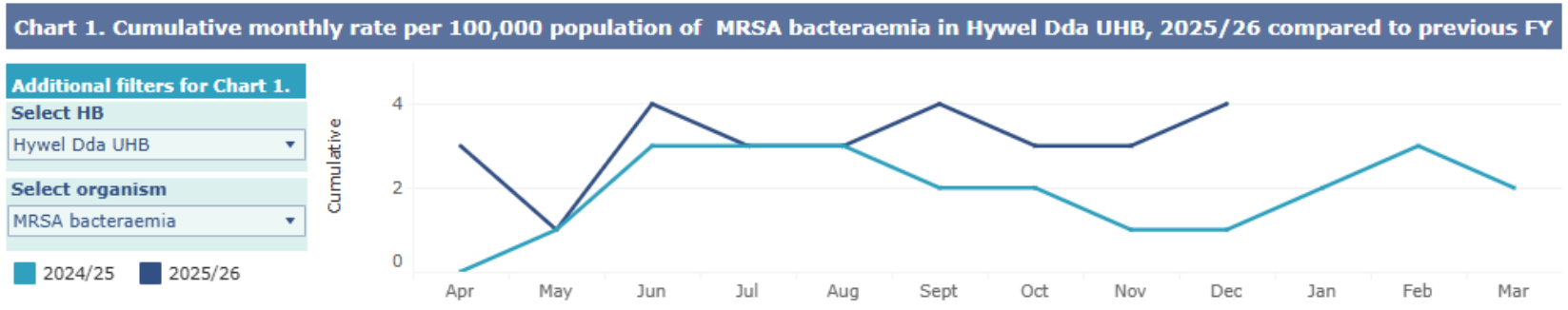
Implications: Older population → higher vulnerability to HAIs, *C. difficile*, increased antibiotic exposure, longer stays.

IP&C S. aureus bacteraemia

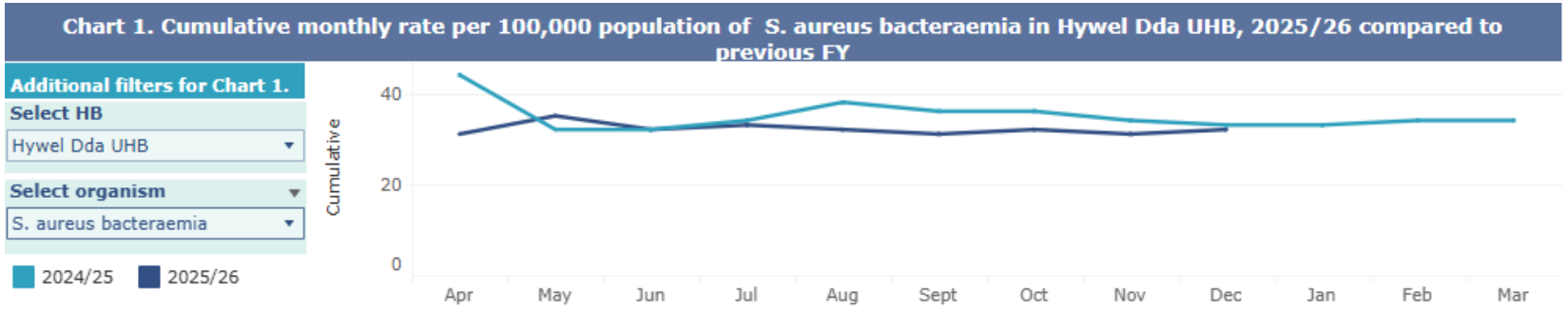
MSSA Improvement Goal: A decrease of at least 20% compared to the 2024/25 baseline counts for all Health Boards.

MRSA Improvement Goal: All Health Boards should have fewer MRSA BSI cases in 2025/26 than in 2024/25.





The rate of MRSA bacteraemia in Hywel Dda UHB is 4.10 per 100,000 population for Apr 25 - Dec 25. This is 139% higher than the equivalent period in 2024/25.



The rate of S. aureus bacteraemia in Hywel Dda UHB is 32.83 per 100,000 population for Apr 25 - Dec 25. This is 2% lower than the equivalent period in 2024/25.

S.aureus 7 less equivalent period
MSSA 11 less same period
MRSA 4 more than same period

Key actions-
-Review of Aseptic non touch technique compliance and ensuring invasive device bundles are in place

Health Inspectorate Wales (HIW) / Care Inspectorate Wales (CIW) / Human Tissue Authority (HTA) inspection activity:

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Inspections

Cwm Seren, November 2025 – publication of report expected 12/02/2026
Learning Disability Inspection, November 2025 - publication of report expected 22/01/2026

The Health Board have has received the following letters from HIW requesting assurance during 2025 (those in grey type have been previously reported to QSEC

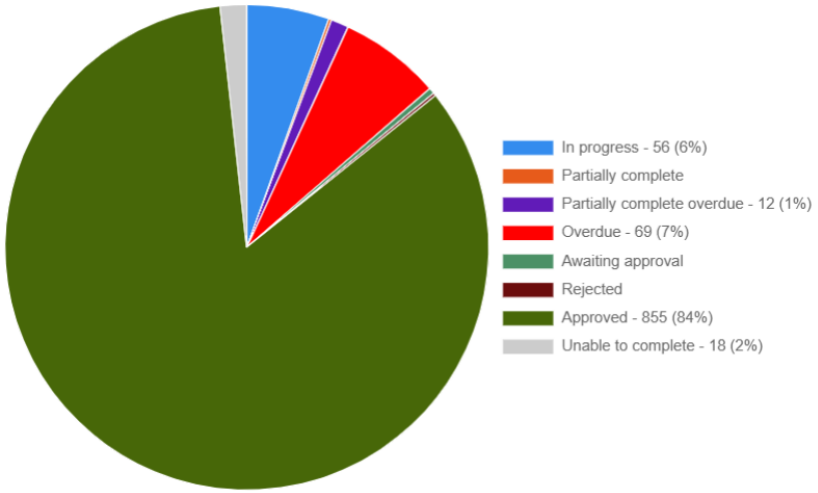
Date of letter	HIW ref	Matter
24/11/2025	15323	Theatres: • Staff training and experience • Staffing levels, burnout and turnover • Patient safety risks and incident reports • Staff wellbeing and morale • Senior management and culture concerns
18/11/2025	15315	Play park adjacent to Cwm Seren
23/10/2025	15014	A&E Glangwili General Hospital: • Hygiene ad infection control • Incident reporting and follow up • Staff safety and support • Escalation and response to concerns
08/10/2025	13391	Update on CSP consultation for Critical Care
18/08/2025	14435	Bro Cerwyn
13/08/2025	13272	MH&LD CTP compliance including update on actions to improve compliance
13/08/2025	14414	Withybush Hospital - procedures in place for informing patients about the re-enablement team, as well the information provided to them
24/07/2025	13747	WGH / Mental Health family concern – outcome date requested. Responded to 29/07/25 to advise plan to share on 8th Aug 25.

Date of letterv	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
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 13272 13274	Paediatric Medical Workforce – request for update regarding recruitment progress Mental health services provision in north Ceredigion – request for further information St Non's Ward – request for update
06/06/2025	13747	Withybush General Hospital – care of patient
11/06/2025	13391	Critical care provision in Carmarthenshire - status and timescales CSP consultation
11/06/2025	13274	St Non's Ward – request for update
08/07/2025	13747	WGH / Mental Health family concern – update requested
08/07/2025	14043	GGH Radiology anonymous staffing concerns
18/07/2025	14165	WGH Ward 10 assurance – assurance re provision for food and water and support for patients on ward

HIW Quality Checks/Inspections: Reviews and inspections

Improvement Actions relating to HIW reviews

Source: AMaT 21/01/2026



	Overdue	Partially complete (overdue)
Community and Integrated Medicine	38	5
Estates and Facilities	0	0
Mental Health and Learning Disabilities	4	0
Nursing, Quality and Patient Experience	0	0
Operational Allied Health and Health Science	13	3
Planned and Specialist Care	0	0

	Position as at 25/11/2025	Position as at 21/01/2026
Overdue	68	69
Partially complete (overdue)	16	12
Partially complete	3	2
In progress	87	56
Rejected (to be resubmitted)	5	2

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
14	134/247 (54%)	1/1 (100%)	0	0	56	2	12	69	12	4	2	294

Note for each open inspection, an action is created for the QAS Team to confirm with HIW closure of the inspection actions (this is not included within the HIW inspection report). Therefore. if actions are overdue, the action for QAST will also be overdue.

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
29	297/297 (100%)	18/18 (100%)	0	0	0	0	0	0	6	0	0	561

HIW Quality Checks/Inspections: Open reviews and inspections

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Code	Title	MD	SD	WN	PIR	Actions								View
						In progress	Partially complete	Partially complete (Overdue)	Overdue	Unable to complete	Completed (awaiting approval)	Rejected	Completed	
Healthcare Inspectorate Wales (HIW)/2024/396	HIW Children and Young People Mental Health Review	4/9 (44%)	0	0	0	8	1	2	1	1	0	0	10	
Healthcare Inspectorate Wales (HIW)/2025/716	HIW Cwm Seren LSU & PICU	0/15 (0%)	0	0	0	20	0	0	0	0	0	0	0	
Healthcare Inspectorate Wales (HIW)/2025/628	HIW Derwen Ward 04054	3/9 (33%)	0	0	0	0	0	1	13	0	1	2	38	
Healthcare Inspectorate Wales (HIW)/2022/19	HIW GGH IRMER Inspection (Nov 2022)	19/21 (90%)	0	0	0	0	0	0	2	0	0	0	34	
Healthcare Inspectorate Wales (HIW)/2025/565	HIW GGH Maternity Services 03924	11/13 (85%)	0	0	0	2	0	0	0	0	0	0	21	
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)	18/40 (45%)	0	0	0	0	0	0	3	4	0	0	26	
Healthcare Inspectorate Wales (HIW)/2025/668	HIW Inspection BGH Emergency Department	14/29 (48%)	0	0	0	5	0	3	22	3	0	0	40	
Healthcare Inspectorate Wales (HIW)/2024/86	HIW IRMER Diagnostic Imaging x-ray department Withybush Hospital January 2024	6/9 (67%)	0	0	0	0	0	2	1	1	0	0	10	
Healthcare Inspectorate Wales (HIW)/2023/69	HIW St Non, St Caradog, Canolfan Bro Cerwyn WGH	12/18 (67%)	1/1 (100%)	0	0	0	0	0	2	0	0	0	23	

HIW Quality Checks/Inspections:
Open reviews and inspections continued:

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Code	Title	MD	SD	WN	PIR	Actions								View
						In progress	Partially complete	Partially complete (Overdue)	Overdue	Unable to complete	Completed (awaiting approval)	Rejected	Completed	
Healthcare Inspectorate Wales (HIW)/2024/498	IRMER Regulations	7/9 (78%)	0	0	0	0	0	0	0	3	0	0	0	7
Healthcare Inspectorate Wales (HIW)/2025/587	Joint Inspection of Child Protection Arrangements (Pembrokeshire)	11/21 (52%)	0	0	0	3	1	1	9	0	3	0	0	17
Healthcare Inspectorate Wales (HIW)/2025/595	Mynydd Mawr Ward, Prince Philip HospitaL 03921	19/24 (79%)	0	0	0	2	0	1	4	3	0	0	0	48
Healthcare Inspectorate Wales (HIW)/2025/596	Nuclear Medicine IRMER WGH 03909	10/26 (38%)	0	0	0	11	0	2	9	0	0	0	0	20
Healthcare Inspectorate Wales (HIW)/2025/706	Significant Accidental or Unintended Exposures Notifications (IRMER Dec 2025)	0/4 (0%)	0	0	0	5	0	0	0	0	0	0	0	0

Recommendations

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
- Complaints management
- Public Services Ombudsman for Wales
- Infection prevention and control
- Inspections and peer reviews including activity of Healthcare Inspectorate Wales (HIW)

Authors

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 – Louise O'Connor, Assistant Director for Legal Services and Patient Experience
5. Complaints Management – 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 – Caroline Burgin, Patient Safety and Assurance

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

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

3.4

3.4 - Safeguarding Update Report

Cathie Steele (Hywel Dda UHB - Interim Assistant Director of Nursing Assurance and Safeguarding), Sharon Daniel (Hywel Dda UHB - Executive Director of Nursing, Quality & Patient Experience)

Including 1097 Corporate Safeguarding Policy for approval

For approval

Attachments

3.5 Safeguarding Report to QSEC Feb 2026.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

IS-BWYLLGOR ANSAWDD, DIOGELWCH A PHROFIAD
QUALITY, SAFETY AND EXPERIENCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	12 February 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Safeguarding Update: arrangements with the Health Board to meet the Safeguarding duties
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Sharon Daniel, Executive Director of Nursing, Quality and Patient Experience
SWYDDOG ADRODD: REPORTING OFFICER:	Charlotte Westacott, Head of 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

This report provides an update to the Quality, Safety and Experience Committee on the Health Board's safeguarding arrangements, outlining current activity, key developments, and actions underway to strengthen compliance with statutory safeguarding requirements.

Cefndir / Background

Safeguarding duties for health boards in Wales are principally set out in the Social Services and Well-being (Wales) Act 2014, supported by associated statutory guidance. While local authorities hold the primary statutory responsibility for safeguarding the welfare of children, the Health Board—alongside police, NHS Trusts, probation services, and youth offending teams—has a legal duty under Section 28 of the Children Act 2004 to ensure its functions are discharged with due regard to safeguarding and promoting the welfare of children.

Under Part 7 of the Social Services and Well-being (Wales) Act 2014, local authorities must establish Safeguarding Children Boards, with representation from statutory partners including the Health Board. In this context, Local Health Boards and NHS Trusts are recognised as statutory relevant safeguarding partners.

The Wales Safeguarding Procedures set out the all Wales framework for safeguarding children and adults at risk of abuse or neglect. They apply to all practitioners—across statutory, private, and voluntary sectors—ensuring consistency in safeguarding practice regardless of organisational structure or professional background.

The Health Board is an active member of the Mid and West Wales Statutory Safeguarding Board, established under the Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015. To support internal governance, the Health Board has established a Strategic Safeguarding Steering Group (SSSG), which provides assurance to the Quality & Safety Intelligence Group on the organisation's statutory responsibilities relating to safeguarding children, adults, and broader public protection.

The Health Board's Safeguarding Team supports compliance with the Social Services and Well-being (Wales) Act, the national guidance Working Together to Safeguard People and the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015. The team provides expert advice and operational support across a range of safeguarding functions, including children's safeguarding, adult safeguarding, Children Looked After, and violence against women, domestic abuse and sexual violence (VAWDASV).

Asesiad / Assessment

Quality Assurance

The Strategic Safeguarding Steering Group (SSSG) meets bi-monthly (six meetings per year). The terms of reference have been reviewed and approved by the Quality and Safety Intelligence Group (QSIG) in September 2025. The Executive Director of Nursing, Quality and Patient Experience is the Chair of SSSG. SSSG seeks to provide assurance:

- To the Board via QSIG, that an appropriate system for safeguarding of children and adults accessing health care or health care premises is in place across the University Health Board.
- That appropriate systems are in place for the UHB to discharge its duties in relation to children and adult at risk of abuse and neglect and Children Looked After.
- That appropriate systems are in place for the UHB to discharge its duties in relation to violence against women, domestic abuse and sexual violence.
- That the relevant guidance and standards are achieved or being worked towards in order to reduce risk and ensure the safety and delivery of high standards in safeguarding and public protection work.

With the introduction of the new Clinical Care Groups and the integrated governance arrangements established, work is underway to establish CCG Safeguarding Delivery Groups. Prior to the organisational restructure and introduction of CCGs, delivery groups were in place in each directorate. The directorates were required to report on safeguarding matters to the SSSG. This reporting requirement has now moved to the CCGs.

Partnership and Multi agency working.

The Health Board continues to be an active contributor to the Regional Safeguarding Boards and the National Safeguarding Service, with notable input this period into work streams focusing on Strengthening Safeguarding in Wales subgroups, Section 5 Persons in a Position of Trust (PIPOT) review of guidance and transitional safeguarding. Collaborative working with police and local authority partners also continues to strengthen, particularly in Pembrokeshire, where discussions are underway regarding a local authority–funded Health Safeguarding and Mental Health post within the Front Door service. Cross agency learning from -high-risk- cases and the delivery of multi-agency training remain key priorities.

Quality Planning (and Quality Improvement)

Child Death Review (CDR)

Hywel Dda has recently participated in a review of the child death review system in Wales, prompted by concerns that current arrangements are complex, involve multiple processes, and are affected by legislative gaps and inconsistent incident reporting factors that create risks and limit opportunities to reduce childhood mortality. Welsh Government commissioned the Child Health Network and Public Health Wales to scope these arrangements and develop recommendations to strengthen the national process. A broad stakeholder steering group including representation from Hywel Dda was established, with work streams examining mortality review processes, the Child Death Review Programme, and legislative considerations. A facilitated session on 4 November 2025 identified the need for an All-Wales Child Death Review Framework to provide a strategic, standardised approach and highlighted the importance of securing additional funding to address existing gaps that impact the consistency and quality of reviews. This work remains ongoing.

Strengthening safeguarding in Wales review

Welsh Government is undertaking a review of its child Safeguarding protocols and governance and accountability mechanisms for safeguarding children and adults in Wales. The review aims

to ensure that systems remain effective, responsive and focused on achieving the best outcomes for the people of Wales. The final report will be released in Spring 2026.

In parallel, the National Safeguarding Service is developing a Safeguarding Quality Statement, associated quality standards, quality metrics, and an Assurance and Accountability Framework. Once published, these will be considered by the Health Board to inform the development of an internal safeguarding delivery framework, including strengthened performance measures designed to further improve safeguarding practice.

Quality Control (and Quality Improvement)

Joint Investigation of Child Protection Arrangements (JICPA)
The UHB were involved in a Joint Inspection Child Protection Arrangements in March 2025 in Pembrokeshire, publication of the final report was in June 2025. The UHB did not have any immediate actions but have identified areas for improvement which are being addressed. The main themes being improving training compliance, strengthening multi agency working, the multi-agency and single agency recommendations continue to be monitored via Strategic Safeguarding Steering Group. The actions are recorded on AMaT and included in the HIW section of the regular Quality Assurance report update that QSEC received.

Our Bravery Brought Justice
In November 2025, the Health Board was notified by Welsh Government of the *"Our Bravery Brought Justice"* Extended Child Practice Review Gwynedd 2024 relating to child sexual abuse, which set out 27 recommendations across five themes, with only one split recommendation relating to Health. The Head of Safeguarding has reviewed the requirements and is working closely with regional partners and CAMHS to ensure they are appropriately incorporated into existing safeguarding processes. A focused gap analysis with CAMHS is underway. Early findings indicate that the main challenge relates to current system and IT limitations in aggregating the required data, this is being actively reviewed. Progress will be monitored via SSSG. A corporate response to Welsh Government is required by 3 March 2026.

S5 Persons in a Position of Trust (PIPOT)
The Corporate Safeguarding Team continue to support the services with the management of allegations concerning PIPOT in line with statutory safeguarding duties set out in the Social Services and Well-being (Wales) Act 2014, which requires organisations to have clear arrangements for responding to concerns about staff or volunteers who may pose a risk to children or adults at risk. These procedures ensure that allegations are managed promptly, proportionately, and in line with multiagency safeguarding frameworks, including appropriate information- sharing- with employers and regulatory bodies such as the Disclosure and Barring Service. All activity within this area is captured within Datix Cymru (Once for Wales Concerns Management System) ensuring the Health Board carries out their required actions and maintaining organisational memory.

Safeguarding LINC
The Mid and West Wales Safeguarding Board (MAWWSB) is leading an innovative and pioneering programme, unique within Wales and the wider UK. This collaborative initiative will integrate safeguarding related data from partner organisations into a central data warehouse, strengthening information sharing and enabling earlier identification and intervention for children at risk. The programme has significant potential to enhance child safeguarding arrangements across the region and will further support Hywel Dda staff to manage safeguarding cases proactively and reactively in a safe, timely- and effective manner. Hywel Dda is actively engaged in this work, and the Data Sharing Agreements required to underpin the project have now been finalised.

Safeguarding Referrals

The Health Board are compliant with statutory duties. Safeguarding Childrens and Adults at risk referrals continue to be completed by practitioners in a timely way. This is captured effectively by Datix Cymru which allows us to evidence timely identification, reporting, and management of abuse, neglect, or exploitation in accordance with the Social Services and Well-being (Wales) Act 2014 Duty to Report, and Wales Safeguarding Procedures. The system enables the Health Board to monitor safeguarding activity, ensure compliance with statutory duties, quality assure and provide assurance on identification and protection of individuals at risk. Outcomes, themes, and any identified learning are fed back through the Service Delivery Groups to support continuous improvement.

The pilot Independent Domestic Abuse Advocate (IDVA) service at Bronglais Hospital concluded in May 2025 due to the absence of ongoing funding, leaving a gap in dedicated support for victims of domestic abuse presenting to Emergency Departments. This risk extends across all Emergency Departments within the Health Board, where the absence of on-site safeguarding practitioners or IDVA support limits opportunities for timely intervention and sustained outcomes. Establishing consistent safeguarding or IDVA provision within EDs would significantly mitigate this risk and enhance support for individuals experiencing domestic abuse.

Safeguarding training compliance

Safeguarding training compliance remains below the 85% target for Level 3 Child and Adult Safeguarding and Group 2 Ask and Act training. Service Safeguarding Delivery Groups (SDGs) continue to provide detailed compliance reporting by professional group, including clear identification of completed risk assessments and associated mitigating actions. This remains an outstanding action on the JICPA action log and continues to be monitored via the SSSG. To support improvement, work is underway to develop a joint adult and child Level 3 training package aligned to the Intercollegiate Document to improve accessibility, consistency, and compliance trajectory.

Children Looked After

Numbers of Children Looked After (CLA) children on 27 January 2026 are 924 compared to 936 on 27 December 2025, the slight decrease is due to many children turning 18 years of age and some returning to their placing Health Boards.

The CLA Team continue to promote the national CIVICA process to ensure the voices of children, young people and carers are captured and used to shape, influence, and strengthen practice.

Corporate Safeguarding Policy (1097)

The Health Board's Corporate Safeguarding Policy is currently under review. The policy was previously approved by the People, Organisational Development and Culture Committee and it has been agreed that this responsibility will change to QSEC.

The date for review was 15 December 2025. The Head of Safeguarding post has been vacant, and this vacancy delayed the full review of the policy. With the post now filled, review and consultation are progressing with an aim of taking the policy to the Strategic Safeguarding Steering Group for support and then bringing the final policy to QSEC for approval in June 2026. Therefore, QSEC are asked to agree to the policy being extended for six months .

Quality Improvement

Restorative Supervision

The newly introduced restorative supervision sessions have been introduced for the Safeguarding Service which provides a supportive, reflective space for staff managing complex safeguarding cases, helping to reduce stress and burnout, strengthen professional decision making-, and improve wellbeing and resilience. By promoting a learning culture and supporting staff to manage the emotional demands of safeguarding work, restorative supervision enhances practice quality and contributes to safer outcomes for children and adults.

Safeguarding supervision has undergone significant transformational development, now reaching a broader range of service areas across the Health Board. Compliance is monitored through the Service Delivery Groups, with clear accountability for delivery and oversight maintained by individual service leads.

Learning From Reviews

The Health Board is currently involved in one single unified safeguarding review (SUSR) with 2 MAPF's in line to commence shortly. Key emerging themes include information sharing, the need for improved professional curiosity in the community.

Multi-agency learning action plans are ongoing from previous reviews, and the Safeguarding Team is monitoring implementation with service leads. Learning will be disseminated once finalised via SDG's, training and supervision sessions.

Argymhelliad / Recommendation

The Quality, Safety and Experience Committee is asked to:

- **Receive assurance** on the Health Board's safeguarding arrangements and the current activity, key developments, and actions underway to strengthen compliance with statutory safeguarding requirements.
- **Agree** to a six-month extension for the Corporate Safeguarding Policy

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.21 Provide assurance in relation to the organisation's arrangements for safeguarding vulnerable people, children and young people.
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)	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	4. Improve Population Health through prevention and early intervention, supporting people to live happy and healthy lives 8. Transform our communities through collaboration with people, communities and partners

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Social Services and Well-being (Wales) Act 2014, Children Act 2004 Wales Safeguarding Procedures Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015. Working Together to Safeguard People Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015
Rhestr Termau: Glossary of Terms:	Included within the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	Strategic Safeguarding Steering Group (SSSG) Quality & Safety Intelligence Group

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	The partnership working through the Mid and West Wales Statutory Safeguarding Board does has financial implications for the Health Board. For example, the Health Board contributes 25% of the cost for Domestic Homicide Reviews that relate to cases within Hywel Dda UHB. Requests for other contributions are also made in year through sub-groups to the Mid and West Wales Statutory Safeguarding Board which means that it is difficult to forecast the budget required for the safeguarding work.

Ansawdd / Gofal Claf: **Quality / Patient Care:**	Safeguarding activity has a direct impact on the quality and safety of patient care. Delays in identifying abuse, neglect or exploitation, missed opportunities for early intervention, and inconsistent multi-agency working can all increase the likelihood of harm to vulnerable children and adults. Service gaps—such as the absence of onsite safeguarding or IDVA support in Emergency Departments—reduce timely responses, affect continuity of care, and limit support for those at highest risk. Additionally, low safeguarding training compliance leads to inconsistent practice, reduced professional confidence, and an increased risk of missed safeguarding indicators, all of which can compromise patient safety.
Gweithlu: **Workforce:**	Safeguarding activity places significant demands on the workforce, with staff managing complex and emotionally challenging cases that can contribute to stress, burnout, and reduced wellbeing. Service gaps—such as limited onsite safeguarding or IDVA support—can increase pressure on frontline teams and impact their ability to respond effectively. Variability in safeguarding training compliance can also lead to inconsistent practice and reduced professional confidence. The introduction of restorative supervision and strengthened safeguarding oversight structures helps to support staff resilience, promote reflective practice, and ensure the workforce is equipped to deliver safe and effective safeguarding responses.
Risg: **Risk:**	Safeguarding activity presents a number of risks, including delays in identifying abuse or neglect, missed opportunities for early intervention, and service gaps such as limited onsite safeguarding or IDVA support, all of which may increase the likelihood of harm to vulnerable individuals. Variability in safeguarding training compliance also risks inconsistent practice. These risks are mitigated through strengthened governance via the Strategic Safeguarding Steering Group, ongoing multi-agency working, enhanced monitoring through Datix Cymru, development of improved training packages, and the introduction of restorative supervision to support staff in managing complex cases. Where required, risks are further assessed and managed through the Integrated Impact Assessment process

Cyfreithiol: **Legal:**	Safeguarding activity carries potential legal implications where delays, gaps in practice, or failures to meet statutory safeguarding duties could expose the Health Board to legal challenge. Compliance with the Social Services and Well-being (Wales) Act 2014, Children Act 2004, Wales Safeguarding Procedures, and associated regulations is essential to demonstrate that the organisation is discharging its legal responsibilities appropriately.
Enw Da: **Reputational:**	Safeguarding activity carries inherent reputational risk, particularly where delays, gaps in practice, or service deficiencies—such as lack of onsite safeguarding or IDVA support—may lead to harm or missed opportunities for intervention. Such incidents can attract political, media, or public scrutiny, potentially undermining confidence in the Health Board's safeguarding arrangements. Ensuring robust governance, consistent practice, timely reporting, and clear evidence of compliance with statutory duties helps mitigate reputational exposure and demonstrates organisational accountability.
Gyfrinachedd: **Privacy:**	Safeguarding activity involves the collection, use, and sharing of sensitive personal information, which carries potential risks to individuals' privacy rights and confidentiality if data is not handled appropriately. Inadequate information-sharing practices, system limitations, or breaches in security controls could lead to unauthorised access, inappropriate disclosure, or misuse of safeguarding information. To mitigate these risks, all information-sharing must follow relevant legislation, organisational policies, and secure systems.
Cydraddoldeb: **Equality:**	Not required for this report.

4

20 Mins

4 - Risk

4.1

4.1 - Assurance and Risk Report- Executive Leads

Attachments

QSEC PRR ORR AI Report - Jan 2026 FINAL.pptx

Appendix 1- Overdue Audit Inspection recommendations.pdf

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Assurance and Risk Report

Quality, Safety & Experience Committee – 12 February 2026

Situation

This report provides the Quality, Safety & Experience Committee (QSEC) with the status of the principal risks, operational risks, and audit and inspections recommendations within its remit.

The Committee is asked to seek assurance from the Lead Executive Directors that risks are being managed effectively, and that recommendations from audits and inspections are being implemented by the Health Board.

Corporate risks, Welsh Health Circulars and Ministerial Directions are reported at alternate meetings, and will be presented to QSEC at its next meeting in April 2026.

Principal Risks:
4
Under Review

Operational Risks
467

Audit and Inspection Reports
31

Risk Management - Overview

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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.

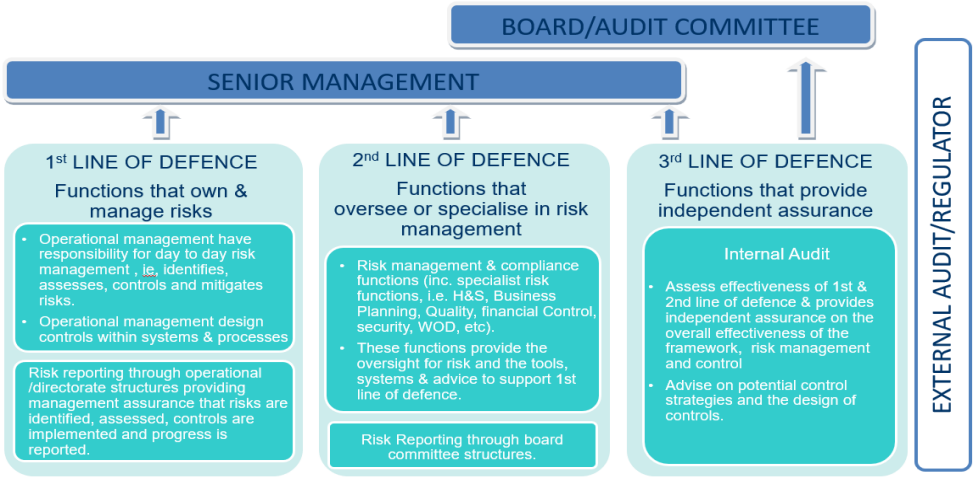
The Health Board's risk management process is recorded via the Datix Risk Register module, and enables risks to be recorded at either Principal, Corporate or Operational level. An escalation process is in place to ensure that risks which require escalation or de-escalation are done via appropriate approval processes and governance arrangements.

The Health Board operates within the widely accepted "Three Lines of Defence" model to ensure the appropriate responsibility is allocated for the management, reporting and escalation of risk.

Risks are aligned to an appropriate Clinical Care Group or Executive Function (hereto referred to as "Functions"), and each has a designated risk lead responsible for reviewing in a timely and comprehensive manner.

The Board's Committees are responsible for the monitoring and scrutiny of corporate and operational risks within their remit and providing assurance to the Board that risks are being managed effectively and report areas of significant concern (e.g where the risk appetite is exceeded, or there is a lack of action).

Committees are also responsible for reviewing risks over tolerance and where appropriate, recommend the 'acceptance' of risks that cannot be brought within risk appetite.



Principal Risks

As a result of the Strategy Refresh, presented to Board in January 2026, the plan is to present a refreshed Board Assurance Framework (BAF) to Board in July 2026. A review of principal risks will be undertaken as part of the BAF refresh, in addition to the supporting planning goals and outcome measures per the timeline below.

Refreshed principal risks will be discussed at Board seminar in June 2026 ahead of presentation to the Board in July 2026.

Each principal risk will be aligned to a Board committee, and will be reported on via the Assurance and Risk Report to ensure that they are being managed appropriately, taking in to account gaps in control, planned actions and agreed tolerances, and to provide assurance to the Board through their update report the management of these risks.

Operational Risks assigned to QSEC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Of the 467 operational risks aligned to QSEC, 412 have been identified as reportable based on the following criteria:

- QSEC has been selected by the risk lead as the 'Assuring Committee' on Datix;
- Risks have been identified at operational level on Datix risk module;
- The current risk score is 'extreme' or 'high'; and
- The current risk score is either equal to or exceeds its target risk score.

Following identification and assessment of risks, each risk is aligned to a specific Health Board committee or sub-committee. Effective risk management requires a 'monitoring and review' structure, ensuring that risks are effectively identified and assessed, and that appropriate controls and responses are in place. Operational risks are managed within Clinical Care Groups (CCG) and Executive Functions (collectively referred to as "Functions") under the ownership and leadership of individual Executive Directors. Each CCG must establish local arrangements for the review of their Risk Registers, which includes the validation of the information and risk scores, and the prioritisation and identification of solutions to their risks. Each CCG Integrated Goverance Group (CCG IGG) is provided with an Assurance and Risk Report, with any issues escalated to the Integrated Quality, Finance and Performance Delivery Group via the 3As Report following each CCG IGG meeting.

The Health Board has formal monitoring and scrutiny mechanisms in place to provide assurance to the Board regarding the effective management of risks. Monthly assessments are made for each Function on their risk management, informing their overall level within the 'Governance' domain as part of the Health Board's internal escalation framework. A key metric in the Health Board's internal escalation process under the Governance domain is how Functions are managing risks in terms of the scale, significance, timeliness and quality, with measures extended from April 2025 to inform levels to be awarded (detailed on the next slide).

The Assurance and Risk Team provide focussed support for those Functions at levels 3 and 4 to aid their de-escalation / recovery and prevent those awarded level 2 status being further escalated. Detail is provided within each report provided and presented at Function governance meetings explaining the reasons behind their escalation status, and suggested actions required to de-escalate (where appropriate). Whilst the four levels within the escalation framework have been agreed, the Executive Team are currently determining processes to support those Functions who may be assessed as being in Level 4. Functions are currently assessed as being either level 1, 2 or 3 pending formalisation of these processes.

Operational Risks assigned to QSEC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Measures to assess against the Governance Domain (risks)

Level	Criteria
Level 4 – no assurance and insufficient actions / engagement	No plan in place and no engagement, (eg no risk action plans, no expected date to achieve Target Risk Score). No evidence that risks are escalated via CCG management structures where necessary, no engagement and the ability for leadership to make informed decisions on prioritisation of resources
Level 3 – no assurance	Lack of evidence that risks are being managed and mitigated within expected timescales. Evidence where known risks are not articulated on the function's risk register. **Less than 80% compliance** of risks and risk actions being updated within required timescales Limited evidence that risks are escalated via CCG management structures where necessary, therefore not demonstrating good engagement and the ability for leadership to make informed decisions on prioritisation of resources
Level 2 – Limited assurance	Relevant risks articulated on risk registers with action plans in place, but lack of evidence that risks are being managed and mitigated within expected timescales. *(eg risk action plans not being implemented within original action dates, limited evidence of reduction in current risk score).* **Between 80% - 89% compliance** of risks and risk actions being updated within required timescales Some evidence that risks are escalated via CCG management structures where necessary, demonstrating engagement and the ability for leadership to make informed decisions on prioritisation of resources
Level 1 – Reasonable assurance	Relevant risks articulated on risk registers with action plans in place, and evidence that the function is delivering against these (eg specific and measurable risk action plans, current risk score and target risk score clearly articulated, achieving expected target risk dates) **Over 90% compliance** of risks and risk actions being updated within required timescales Evidence that risks are escalated via CCG management structures where necessary, demonstrating good engagement and the ability for leadership to make informed decisions on prioritisation of resources

Operational Risks assigned to QSEC

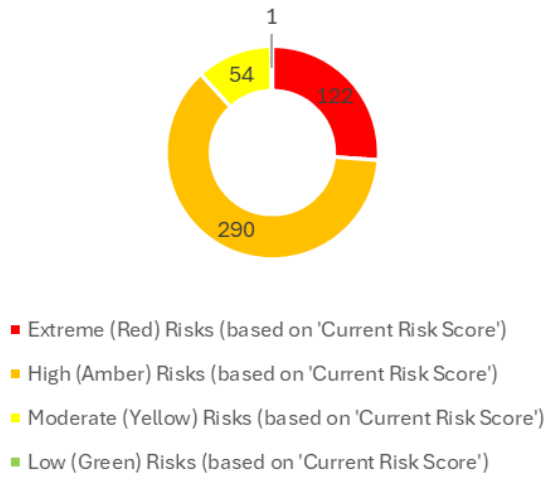
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Of the 467 operational risks aligned to QSEC (an increase from the 389 previously reported to the Committee in October 2025), a summary of the 39 operational risks with a current risk score of >20 is provided over the next slides.

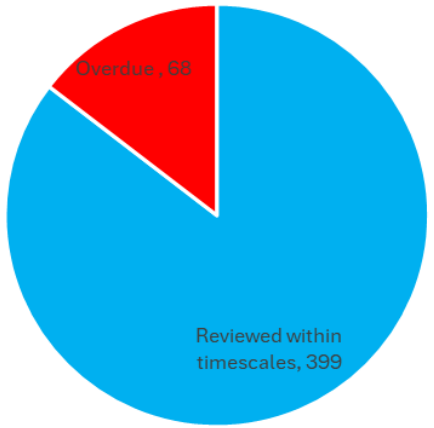
Details related to target risk scores (TRS) became mandatory fields on Datix as of 1 July 2025, and therefore for the 10 risks which do not currently have this detail (noted as 'Unable to Assign TRS date'), risk leads will be asked to provide this detail by the next report to QSEC.

Where expected dates to achieve the TRS have lapsed (denoted in red on the following slides), the Assurance and Risk Team continue to remind risk leads to ensure the appropriate actions and updates are taken on Datix (e.g., has this risk now been fully managed and mitigated? If the TRS has not been met what further actions are required? What is the revised TRS date and an updated rationale?).

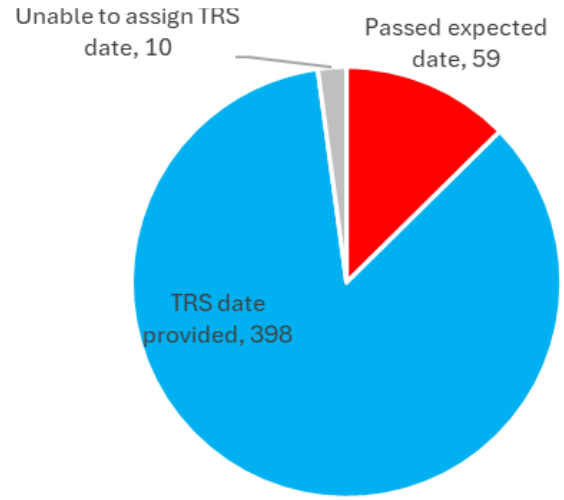
Current Level of Risks Aligned to QSEC



Operational Risks Aligned to QSEC



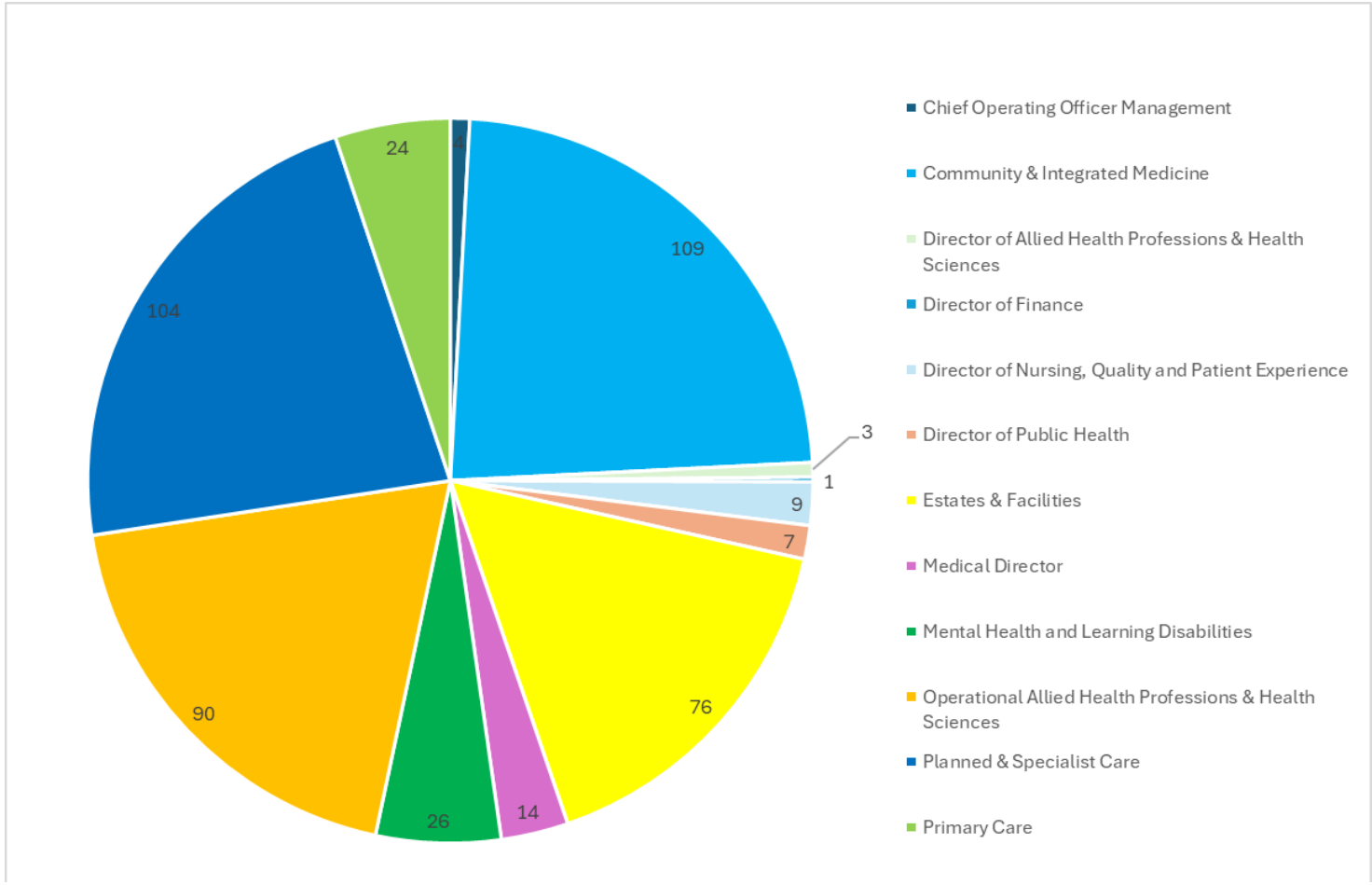
Target Risk Score Status



Operational Risks assigned to QSEC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risks Split Out By Clinical Care Group/Executive Function



Extreme Level Operational Risks
(Page 1 of 5)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Overseeing Clinical Care Group / Executive Function	Lead Director	Current Risk Score	Target Risk Score	Expected Date to Achieve Target Risk Score	Date of last risk review
1603 - Risk of delayed response and breach of waiting time targets due to increased referrals for children with selective eating	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	25	10	30/04/2027	29/12/2025
2228 - Risk of patient safety affected due to discontinuation of the electronic prescribing system Vision for Outpatient Department (OPD) clinics and services	Medicines Management	Medical Director	25	4	01/05/2026	27/11/2025
1349 - Risk of being unable to deliver ultrasound services at Withybush General Hospital (WGH) due to a lack of appropriately trained obstetric staff	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	25	4	31/03/2028	17/12/2025
1256 - Risk to safety and management of hip fracture patients due to lack of Orthogeriatric service at Glangwili General Hospital (GGH)	Planned & Specialist Care	Chief Operating Officer	25	4	30/06/2026	05/01/2026
2264 - Inconsistent delivery of urgent and emergency care	Community & Integrated Medicine	Chief Operating Officer	20	5	31/12/2026	07/01/2026
2141 - Risk of harm to patients, staff and public due to insufficient physical security measures in place at Bronglais General Hospital (BGH)	Community & Integrated Medicine	Chief Operating Officer	20	5	03/08/2025	17/12/2025
2136 - Risk of being unable to provide a haematology and blood transfusion service due to insufficient staffing	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	5	31/08/2025	15/12/2026
2113- Risk of patient harm in Emergency department WGH due to demand exceeding capacity	Community & Integrated Medicine	Chief Operating Officer	20	12	30/04/2026	15/12/2025
2102- The risk of radiology service delivery due to leadership fragility	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	10	01/12/2026	17/12/2025

Extreme Level Operational Risks
(Page 2 of 5)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Overseeing Clinical Care Group / Executive Function	Lead Director	Current Risk Score*	Target Risk Score	Expected Date to Achieve Target Risk Score	Date of last risk review
1547 - There is a risk to timely and safe radiology provision as capacity does not match demand	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	8	30/03/2029	17/12/2025
1309 - Risk to meeting demands for diagnostic reporting due to shortfall in Consultant Cellular Pathologist workforce	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	10	31/08/2028	29/12/2025
1115 - Risk of increased time in Accident and Emergency due to lack of inpatient beds, GGH.	Community & Integrated Medicine	Chief Operating Officer	20	12	31/10/2025	12/02/2026
750 - Risk of delays at Emergency Department due to lack of substantive middle grade doctors	Community & Integrated Medicine	Chief Operating Officer	20	12	15/01/2026	15/12/2025
2265 - Risk of failure of ceiling mounted operating ophthalmic microscope	Planned & Specialist Care	Chief Operating Officer	20	2	31/03/2026	08/01/2026
2258 - Risk of timely access to the ENT procedure room on Merlin due to boarding policy when GGH is in surge escalation.	Planned & Specialist Care	Chief Operating Officer	20	4	31/03/2027	22/12/2025
2219 - Backlog in triaging dermatology referrals	Planned & Specialist Care	Chief Operating Officer	20	2	31/03/2027	30/12/2025
2170 - Risk of harm to patients due to insufficient capacity to meet demand for occupational therapy in acute hospitals	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	8	30/09/2027	29/12/2025
2156 - Risk of patient harm within the bone health service due to lack of clinical capacity across HDdUHB	Community & Integrated Medicine	Chief Operating Officer	20	4	31/03/2026	15/12/2025

Extreme Level Operational Risks
(Page 3 of 5)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Overseeing Clinical Care Group / Executive Function	Lead Director	Current Risk Score*	Target Risk Score	Expected Date to Achieve Target Risk Score	Date of last risk review
2151- Risk of poorer outcomes due to delayed prescribing for those with complex co-morbid Obesity	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	9	31/08/2026	29/12/2025
2133- Risk of unsustainable Cellular Pathology Service Delivery and Service Collapse due to extremely poor estate condition and size	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	2	31/12/2026	02/01/2026
2118 - Risk of harm to physiotherapy patients due to inadequate medical service capacity at GGH	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	12	31/03/2026	29/12/2025
2114 - Risk of patient harm from a delay in surgical management due to inadequate capacity for Mastoid surgery	Planned & Specialist Care	Chief Operating Officer	20	5	31/12/2025	30/12/2025
2090 - Risk to patient care in the Ceredigion area due to workforce capacity	Mental Health and Learning Disabilities	Chief Operating Officer	20	6	03/08/2026	29/12/2025
2028 - Harm to patients/staff due to extreme theatre workforce shortages at GGH affecting ability to provide safe/essential care	Planned & Specialist Care	Chief Operating Officer	20	6	30/06/2026	24/12/2025
1996 - Risk of reduced workforce recruitments and developments due to lack of funding	Planned & Specialist Care	Chief Operating Officer	20	8	31/07/2026	24/12/2025
1968- Risk of closure of wards and departments due to failure of roof structure of PPH	Estates & Facilities	Chief Operating Officer	20	5	31/03/2030	18/12/2025

Extreme Level Operational Risks
(Page 4 of 5)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Overseeing Clinical Care Group / Executive Function	Lead Director	Current Risk Score*	Target Risk Score	Expected Date to Achieve Target Risk Score	Date of last risk review
1930 - Risk of harm to mortuary staff and porters when manual handling due to failure of hoist (Whisper 200)	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	6	31/03/2026	02/01/2026
1894 - Risk of stroke patients not receiving the therapy rehabilitation they need due to lack of staffing	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	8	31/03/2026	05/01/2026
1820 - Risk of patient harm due to the withdrawal of funding for the Diabetes Remission Service	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	8	31/03/2026	29/12/2025
1717 - Risk of harm to children and young people living with obesity due to no weight management service provision	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	6	31/03/2027	29/12/2025
1706 - Risk of loss of Nuclear Medicine Service due to decline in condition of equipment and failure to comply with Natural Resources Wales compliance.	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	2	30/07/2027	17/12/2025
1661 - Risk to delivery of Quality, effective weight management service due to demand outstripping capacity	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	6	14/04/2027	29/12/2025
1517 - Risk of poor outcome and poor experience due to breaches of routine physiotherapy waiting times	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	12	31/12/2026	29/12/2025
1488 - Risk of major endoscopy service disruption if decontamination equipment fails at BGH due to age	Planned & Specialist Care	Chief Operating Officer	20	8	31/03/2027	24/12/2025
1308 - Risk of Urgent Treatment Delays for Stone Patients in Urology due to backlog outweighing capacity	Planned & Specialist Care	Chief Operating Officer	20	6	31/03/2026	22/11/2025

Extreme Level Operational Risks
(Page 5 of 5)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Overseeing Clinical Care Group / Executive Function	Lead Director	Current Risk Score*	Target Risk Score	Expected Date to Achieve Target Risk Score	Date of last risk review
1290 - Risk of increased Adult Attention Deficit Hyperactivity Disorder (ADHD) waiting list due to referrals exceeding service capacity.	Mental Health and Learning Disabilities	Chief Operating Officer	20	16	26/04/2030	09/12/2025
1287 - Risk of clients not being provided with timely interventions due to waiting lists for assessment & diagnosis of Autism Spectrum Disorder (ASD).	Mental Health and Learning Disabilities	Chief Operating Officer	20	16	30/04/2026	09/12/2025
834 - Risk of clinical deterioration due to reduced service resilience within the Clinical Haematology sub-specialty	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	8	30/09/2026	29/12/2025
1992 - Risk to patient safety due to insufficient medical staffing to volume of medical patients severe & inpatient acuity	Community & Integrated Medicine	Chief Operating Officer	20	4	31/10/2025	14/01/2026

Risk Themes (1 of 2)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk owners can assign 'themes' to risks on Datix, allowing risk information to be shared on specific areas with relevant subject matter experts within the Health Board. They in turn can offer specific support and guidance to risk owners in the management of risk and identify trends and areas of concern. Each risk theme is aligned to a specific and relevant committee or sub-committee to provide assurance that processes are in place to deliver a holistic approach to risk management. Theme owners are provided with a thematic risk register on a bi-monthly basis to identify trends, or risk clusters, and to consider whether there are gaps in controls in the Health Board's control framework, and to determine whether further action is required to prevent risks from materialising.

The following themes are currently aligned to QSEC as of January 2026:

Risk Theme	Definition	Number of risks
Business continuity /service disruption	A risk that threatens to disrupt the functioning of the organisation, typically caused by an untoward incident or disaster that has a negative impact on operations.	110
Consent and Mental Capacity	Risks relating to consent to examination or treatment e.g. missing, illegible, incorrect consent form; failure to obtain consent; mismatch between consent form and list etc. Risks relating to people who may lack mental capacity e.g. failure or concerns relating to assessment of decision-making capacity; acting in the person's best interests; consulting with those close to the person etc.	0
Deprivation of Liberty Safeguards (DoLS)	Risks relating to a failure to submit DoLS referral when needed, a person being deprived of their liberty when they have capacity to consent to be in hospital, a lack of awareness of what actions can and cannot be taken when a DoLS authorisation is in place (e.g. you can stop someone from absconding), DoLS doesn't give authority for care and treatment decisions, a patient with a DoLS authorisation can be discharged).	1
Fragile Services	A fragile service is one where there is a risk of a diminished service being delivered, or a service being unable to be delivered	178
Infection Control	An incident that may compromise the effectiveness of infection prevention and control measures, leading to staff and/ or patients being exposed to a confirmed or suspected pathogen increasing the likelihood of a transmission event and a healthcare acquired infection (HAI) or outbreak	27

Risk Themes (2 of 2)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Theme	Definition	Number of risks
Medical Devices	A risk related to a medical device or devices, including any instrument (other than a medicine) that is used to diagnose, monitor, treat or manage a medical condition. The definition covers a wide range of products including syringes, dressings, surgical tools, scanners, software, apparatus, machines and some medical apps.	30
Medication	A risk that involves the prescribing, dispensing or supply, administration or monitoring of medicines.	20
NICE / National Guidance	Risks related to the Health Board's ability to comply with evidence-based guidance for health and care.	43
Safeguarding	Safeguarding in its wider context is everyone's responsibility and we have duty of care to support children and adults. It is expected that services and professionals "own" their concerns and take responsibility for the work that needs to be done to keep individuals safe. This includes taking action before, during and after a safeguarding referral has been made. Should risks arise whereby children and adults may be put at risk due to gaps in service provision, or training compliance for example, then a safeguarding theme may be assigned to the risk.	22

The Assurance and Risk Team are working with the Interim Assistant Director of Nursing, Assurance and Safeguarding to review existing risk themes to re-align them to the revised quality and safety operational governance structure which underpins the newly established Quality and Safety Intelligence Group (QSIG).

It will be the responsibility going forward of the relevant QSIG sub-group to review those operational risks thematically aligned to them to oversee and monitor (second line of defence) to help ensure that operational leads (first line of defence) are effectively managing risks.

Audits and Inspections - Overview

The Health Board remains in Level 4 status with Welsh Government (WG) as a result of challenges relating to financial sustainability, strategy and planning, service delivery and organisational performance. Whilst the Health Board has been de-escalated for 'Leadership and Governance' from Level 3 to Level 1, the Health Board must meet the revised criteria:

- Evidence that all recommendations from the Royal Colleges / Health Inspectorate Wales (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;
- Support the implementation and realisation of GIRFT and the national programme reviews opportunities;
- Support the implementation and realisation of the three Ps policy, GIRFT, theatre optimisation, CIN optimisation programmes and related national improvement recommendations; and
- Develop a prompt response to any HIW unannounced inspections, Audit Wales and Royal College recommendation, developing and completing action plans that demonstrate sustainable evidence.

All reports from audits, inspections and reviews undertaken across the Health Board are logged and tracked on AMaT (Audit Management and Tracking), with progress updated by relevant service leads against each recommendation, with evidence required to be uploaded to demonstrating progress and implementation, and any barriers to completion clearly noted.

AMaT enables services to directly update progress against all recommendations via one central system, promoting a consistent approach with regards to processes and reporting, improvement in transparency and accountability, supporting services with their governance arrangements, and improvement in information flow. Progress is monitored via the utilisation of a traffic light system based on performance against original completion dates.

Status Category	Definition
Overdue	The recommendation is behind schedule to the timescale provided by the lead officer.
Unable to Complete (NEW)	The recommendation cannot be implemented due to existing barriers and/or it is no longer relevant/appropriate for the Health Board. Formal sign-off by the CCG/Function Lead is required prior to escalation to the Executive Team for formal approval via operational governance structures.
Pending Decision (NEW)	The recommendation is pending a decision in order to implement e.g. outcomes of annual planning process, approval of funding requests, outcome of a QIA panel. Committee updates will detail whether the recommendation is overdue or not whilst decision pending.
In Progress	The recommendation is currently in progress, and within the agreed original timeframe for implementation.
Reliant on External Factors	The recommendation is considered to be outside the gift of the Health Board to currently implement, e.g. reliant on an external organisation to implement.
Complete Pending Formal Approval (NEW)	The Service / Function have completed the recommendation and currently awaiting formal approval to close.
Complete	The recommendation has been confirmed as completed by the CCG / Function Lead and formal approval to close has been received.

Audits and Inspection reports assigned to QSEC
(Page 1 of 5)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

There are currently 31 reports assigned to QSEC to enable them to undertake the following responsibility set out in their Terms of Reference:

- *3.17 Seek assurances on the requirements arising from the Health Board's regulators, Welsh Government and professional bodies*

HIW inspection activity is monitored by the Quality & Safety Team (QAST) with further detail presented to QSEC via item 4.1 on the agenda (Quality Assurance Report).

For those recommendations that are overdue by more than 6 months, meetings have been scheduled during Q4 of 2025/26 with relevant Executive Leads and CCG/Function leads to review and to identify whether the recommendations have been fully implemented or if additional support or escalation is required to further progress.

Date of report	Report Issued By	Report Title	Clinical Care Group/ Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommend-ations in original report	Overdue	In progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Barriers to Completion
Oct-19	Delivery Unit	Review of Dermatology Services in Wales Hywel Dda University Health Board	Planned and Specialist Care	Chief Operating Officer	Sep-25	~~Sep-25~~ Apr-28	5	3	0	2	0	0	0	0	Recruitment challenges and lack of available suitable clinical space to provide service.
Oct-24	Internal Audit	Falls Management Final Internal Audit Report October 2024	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	May-25	~~May-25~~ ~~Dec-25~~ N/K	6	2	0	4	0	0	0	0	No barriers noted
Jun-25	Internal Audit	Discharge Management (Follow Up) Final Internal Audit Report 2024/25	Community & Integrated Medicine	Chief Operating Officer	Mar-25	N/K	1	1	0	0	0	0	0	0	No barriers noted
Jan-25	Internal Audit	Mortuary Services Final Internal Audit Report 2024/25 Swansea Bay University Health Board Hywel Dda University Health Board	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	Mar-25	Mar-26	9	1	0	4	3	1	0	0	No barriers noted
Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 November (Publication date 16 February 2023)	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	Sep-23	~~Sep-23~~ ~~Aug-25~~ Dec-26	19	1	0	18	0	0	0	0	Recurrent and non-recurrent finance required

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Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Date of report	Report Issued By	Report Title	Clinical Care Group/ Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommend-ations in original report	Overdue	In progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Barriers to Completion
Feb-24	HIW	Children and Young People Mental Health Review	Mental Health and Learning Disabilities	Chief Operating Officer	Feb-26	Feb-26	9	2	2	4	0	0	0	1	Insufficient staffing resource to facilitate this forum at present.
Jan-24	HIW IRMER	HIW IRMER Diagnostic Imaging x-ray department Withybush Hospital January 2024	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	Apr-26	Apr-26	9	1	1	7	0	0	0	0	No barriers noted
May-23	HIW	Mental Health Discharge Review	Mental Health and Learning Disabilities	Director of Nursing, Quality and Patient Experience	Mar-24	~~Apr-24~~ ~~Dec-24~~ ~~Mar-25~~ ~~Oct-25~~ Mar-26	40	2	0	35	0	3	0	0	Awaiting publication of national standards
Sep-23	NHS Wales Executive	Children and Young Person's Neurodevelopmental Services All Wales Review	Planned and Specialist Care	Chief Operating Officer	Nov-24	~~Nov-24~~ ~~Oct-25~~ Mar-26	9	1	0	8	0	0	0	0	No barriers noted
Sep-23	NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	Planned and Specialist Care	Chief Operating Officer	Dec-24	~~Dec-24~~ ~~Aug-25~~ Jun-26	9	2	0	7	0	0	0	0	Financial barriers to provide training and workforce challenges
Apr-23	Peer Review	Out of Hours Peer Review, issued April 2023	Primary Care, Community Strategy & Long Term Care	Chief Operating Officer	Dec-23	~~Mar-24~~ ~~Mar-25~~ ~~Dec-25~~ Jun-26	17	3	0	0	13	0	0	1	Lack of Urgent Primary Care Centre in HB.
Jun-23	Peer Review	Follow Up: Congenital Heart Defect Provider, Assessment Return, issued June 2023	Planned and Specialist Care	Chief Operating Officer	Nov-22	~~Nov-24~~ N/K	10	0	0	9	1	**0**	0	**0**	No barriers noted

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Oct-23	HIW	St Non, St Caradog, Canolfan Bro Cerwyn WGH	Mental Health and Learning Disabilities	Director of Nursing, Quality and Patient Experience	Oct-24	~~Oct-24~~ ~~Oct-25~~ Jan-26	19	1	0	18	0	0	0	0	Fragility of current medical workforce capacity.
Jun-24	Welsh Risk Pool	Welsh Risk Pool Concerns Assessment (December 2024)	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	Mar-25	~~Mar-25~~ ~~Jul-25~~ Mar-27	11	1	0	8	2	0	0	0	Organisational pressures and re-organisations, in addition to pending restructure of investigation framework and learning arrangements have impacted the delivery of this recommendation.
Oct-24	HIW IRMER	IRMER Regulations	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	Jul-25	~~Jul-25~~ Jan-26	9	2	0	7	0	0	0	0	No barriers noted
May-25	Internal Audit	Standards of Cleanliness Final Internal Audit Report 2024/25	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Oct-25	~~Oct-25~~ N/K	6	1	0	5	0	0	0	0	No barriers noted

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Jan-25	Internal Audit	Reinforced Autoclaved Aerated Concrete – Withybush General Hospital Final Internal Audit Report 2024/25	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Mar-26	Mar-26	6	0	1	5	0	0	0	0	No barriers noted
May-25	HIW	HIW GGH Maternity Services	Planned and Specialist Care	Chief Operating Officer	Sep-26	Sep-26	13	0	1	12	0	0	0	0	No barriers noted
Jul-25	Internal Audit	Nursing Management Final Internal Audit Report 2025/26	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	Sep-25	~~Sep-25~~ ~~Dec-25~~ N/K	3	2	0	1	0	0	0	0	No barriers noted
Mar-25	HIW	Joint Inspection of Child Protection Arrangements (Pembrokeshire)	Director of Nursing, Quality and Patient Experience	Chief Operating Officer	Mar-26	Mar-26	21	5	4	10	2	0	0	0	Access to Level 3 training. Paediatric Consultant workforce. The policy will need to include multi-agency partners.
Jun-25	HIW IRMER	Nuclear Medicine IRMER WGH	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	Apr-27	Apr-27	26	1	14	10	1	0	0	0	Fragility of management
Aug-25	HIW	Mynydd Mawr Ward, Prince Philip Hospital	Community & Integrated Medicine	Chief Operating Officer	Jul-26	Jul-26	24	6	1	15	2	0	0	0	No barriers noted
Sep-25	HIW	Derwen Ward, Glangwili General Hospital	Community & Integrated Medicine	Chief Operating Officer	Nov-25	~~Nov-25~~ N/K	9	6	0	3	0	0	0	0	No barriers noted

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Oct-25	Internal Audit	Human Tissue Authority Final Internal Audit Report 2025/26	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	Dec-25	Dec-25	6	0	0	0	6	0	0	0	No barriers noted
Aug-25	Audit Wales	Discharge Planning Progress Update – Hywel Dda University Health Board August 2025	Community & Integrated Medicine	Chief Operating Officer	Mar-26	Mar-26	1	1	0	0	0	0	0	0	No barriers noted
Oct-25	Royal College of Physicians	Joint Advisory Group on GI Endoscopy	Planned and Specialist Care	Chief Operating Officer	Mar-26	Mar-26	2	0	2	0	0	0	0	0	No barriers noted
Oct-25	HIW	HIW Inspection BGH Emergency Department October 2025	Community & Integrated Medicine	Chief Operating Officer	Mar-27	Mar-27	29	13	3	12	1	0	0	0	No barriers noted
Nov-25	NHS Wales Performance and Improvement	Adult Eating Disorders Mapping & Progress Update National Report	Mental Health and Learning Disabilities	Chief Operating Officer	May-26	May-26	3	0	3	0	0	0	0	0	No barriers noted
Nov-25	HIW IRMER	Significant Accidental or Unintended Exposures Notifications (IRMER Dec 2025)	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	Feb-26	Feb-26	4	0	4	0	0	0	0	0	No barriers noted
Dec-25	Internal Audit	Patient Experience Final Internal Audit Report 2025/26	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	Jun-26	Jun-26	5	0	5	0	0	0	0	0	No barriers noted
Dec-25	HIW	Cwm Seren LSU and PICU	Mental Health and Learning Disabilities	Chief Operating Officer	Sep-26	Sep-26	15	0	15	0	0	0	0	0	No barriers noted

Recommendations

The Committee is requested in relation to the areas presented in this paper to:

Risk Management

- **RECEIVE ASSURANCE** that identified controls are in place and working effectively; and
- **RECEIVE ASSURANCE** that all planned actions are credible and deliverable, and in line with agreed plans, and will be implemented within stated timescales and will reduce risks further and/or mitigate the impact should risks materialise.

Audits, Inspections and Regulatory Reports

- **RECEIVE 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 with any barriers to delivery noted.

DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG

SAFE | SUSTAINABLE | ACCESSIBLE | KIND

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Hywel Dda
University Health Board

Inspection Title	Recommendation	Action	Clinical Care Group/Executive Function	Lead Director	Original Due Date	Current Due Date	Comments/Updates
Audit Wales - Discharge Planning Progress Update – Hywel Dda University Health Board August 2025	R1 To make more effective use of its discharge lounges, the Health Board should: 1.1. actively promote the use of discharge lounges in its discharge planning process and associated training; 1.2. undertake work to understand why patients appropriate for discharge lounges are not being moved to the discharge lounge; and 1.3. monitor the use of discharge lounges, including the length of time patients remain in discharge lounges.	On the week commencing 8 September 2025, we are undertaking a 'reset week' with a focus on patient flow, processes and discharge. An element of this exercise is to concentrate on increasing the number of patients being discharged before midday, supported using our discharge lounges. The targeted approach will enable us to capture and develop criteria for patients suitable for transfer to the discharge lounge alongside some of the perceived constraints in relation to this.	Community & Integrated Medicine	Chief Operating Officer	31/10/2025	31/10/2025	
Audit Wales - Discharge Planning Progress Update – Hywel Dda University Health Board August 2025	R1 To make more effective use of its discharge lounges, the Health Board should: 1.1. actively promote the use of discharge lounges in its discharge planning process and associated training; 1.2. undertake work to understand why patients appropriate for discharge lounges are not being moved to the discharge lounge; and 1.3. monitor the use of discharge lounges, including the length of time patients remain in discharge lounges.	The Health Board has recognised that there is a requirement for a competency profile review for nursing staff working in our discharge lounges to enable patients that require final clinical interventions to have these completed in the discharge lounge. Examples of these competencies include dressings and IV administration.	Community & Integrated Medicine	Chief Operating Officer	31/12/2025	31/12/2025	
Audit Wales - Discharge Planning Progress Update – Hywel Dda University Health Board August 2025	R1 To make more effective use of its discharge lounges, the Health Board should: 1.1. actively promote the use of discharge lounges in its discharge planning process and associated training; 1.2. undertake work to understand why patients appropriate for discharge lounges are not being moved to the discharge lounge; and 1.3. monitor the use of discharge lounges, including the length of time patients remain in discharge lounges.	Our SharePoint page now holds a toolkit specifically appropriate to hospital discharge. This includes an individual page holding a suite of information concerning discharge lounges. Relevant documentation is accessible from this area and includes forms such as an SBAR transfer document that aims to facilitate and expedite the transfer in a safe and efficient manner. A Welsh PAS transfer to discharge guide also simplifies the process for updating the patient location in a timely approach. Using this data will be conducive to our ongoing monitoring of discharge lounges and the amount of time that patients remain there. This is already embedded as a requirement for the transferring ward however closer monitoring and review will ensure compliance.	Community & Integrated Medicine	Chief Operating Officer	31/10/2025	31/10/2025	
HIW Children and Young People Mental Health Review	Health boards must reflect on the feedback from CAMHS referrers, parents, and carers to enhance transparency regarding the criteria and thresholds for accessing CAMHS assessments and interventions. This process should involve revising the outcome letter templates used to communicate decisions following the Single Point of Access (SPOA) and CAMHS assessments, ensuring that they clearly convey the rationale behind decisions and improve overall understanding and communication.	1. T&F group will review and establish standard letters for SPOA & Secondary S-CAMHS: Initial contact letters & follow up letters to include a clear rationale for clinical decision.	Mental Health & Learning Disabilities	Chief Operating Officer	03/11/2025	03/11/2025	05/11/25 UPDATE - SPoC letters have been signed off and are now in use. - Secondary CAMHS letters have been drafted and are out for feedback with team leads and team secretaries. These will be completed and implemented by the end of November. Previous update: We believe our capacity to provide clarity in relation to criteria and thresholds is hampered by the lack of sufficient clarity nationally in relation to this. Further clarity at a national level would support enhanced transparency by allowing us to provide additional detail and to define terms such as mild, moderate and severe. 25/11/2025: Work underway. Revised completion date of 31st December 2025.
HIW Children and Young People Mental Health Review	Health boards must reflect on the feedback from CAMHS referrers, parents, and carers to enhance transparency regarding the criteria and thresholds for accessing CAMHS assessments and interventions. This process should involve revising the outcome letter templates used to communicate decisions following the Single Point of Access (SPOA) and CAMHS assessments, ensuring that they clearly convey the rationale behind decisions and improve overall understanding and communication.	T&F group will review and establish standard letters for SPOA & Secondary S-CAMHS: Service user information leaflet outlining criteria of NHS S-CAMHS and CAPA model	Mental Health & Learning Disabilities	Chief Operating Officer	03/11/2025	03/11/2025	UPDATE 5/11/2025: A leaflet has been drafted and updated based on initial feedback. It has gone out for further feedback and will be completed and sent out for use by the end of November. Previous update: We believe our capacity to provide clarity in relation to criteria and thresholds is hampered by the lack of sufficient clarity nationally in relation to this. Further clarity at a national level would support enhanced transparency by allowing us to provide additional detail and to define terms such as mild, moderate and severe. 25/11/2025: Work underway. Revised completion date of 31st December 2025.
HIW Children and Young People Mental Health Review	Health boards must reflect on the feedback from CAMHS referrers, parents, and carers to enhance transparency regarding the criteria and thresholds for accessing CAMHS assessments and interventions. This process should involve revising the outcome letter templates used to communicate decisions following the Single Point of Access (SPOA) and CAMHS assessments, ensuring that they clearly convey the rationale behind decisions and improve overall understanding and communication.	Service User Forum will be involved in reviewing and co -production of leaflets	Mental Health & Learning Disabilities	Chief Operating Officer	03/11/2025	03/11/2025	05/11/2025 Leaflet drafted and provided to three team leads to gather feedback from CYP and parents/carers. 25/11/2025: Work underway. Revised completion date of 31st December 2025.
HIW Children and Young People Mental Health Review	Health boards must explore the options available within their local CAMHS teams to facilitate a strengthened approach for communication and partnership working with GP clusters and/ or directly with GP practices.	S-CAMHS will discuss with GP Clusters to discuss an agreed approach to partnership working and improving communication, including the suggestion of a regular (bi-monthly) forum	Mental Health & Learning Disabilities	Chief Operating Officer	04/08/2025	04/08/2025	28/10/2025: Awaiting confirmation of cluster meeting dates from Cath Burrell (Clinical Director, Primary Care Services). Further information re GP leads is being sought to move this forward. Revised completion date 31/12/2025.
HIW Derwen Ward 04054	The health board must ensure that checks of the drug refrigerator in the clinical room are monitored and recorded daily.	• To further sharing and dissemination of learning within wider Health Board forum: 2. Senior Nurse Management Team (SNMT),	Community & Integrated Medicine	Chief Operating Officer	17/11/2025	17/11/2025	

HIW Derwen Ward 04054	The health board must ensure that sufficient domestic staff are available to clean the ward to maintain appropriate infection prevention and control (IPC)	To undertake spot checks of domestic staff compliance with hand hygiene and PPE when in clinical areas. Findings and remedial actions to be reported to the Infection Prevention Strategic Steering Group.	Community & Integrated Medicine	Chief Operating Officer	31/10/2025	31/10/2025	To note: the Facilities Team will be implementing a new model of cleaning provision across all acute hospital sites. This will include the recruitment of additional staff to improve cleanliness standards and the introduction of revised rotas and shift patterns tailored to each site's operational needs. A Task & Finish (T&F) Group will be established to support the Facilities and Nursing Teams during the implementation phase of the new cleaning and catering model. The group will meet monthly to review progress, identify challenges, and coordinate solutions. Membership will include representatives from both teams, with meeting outcomes documented and shared. The group will remain active until full implementation is achieved. Interviews for a Facilities Manager (Band 8a) to support the Facilities Team during the implementation phase of the new cleaning and catering model will start week commencing 22nd September 2025. The recruitment process to fill the 8.63 WTE vacancies in the domestic team has commenced. The Hotel Services Manager will provide fortnightly updates on recruitment progress, including shortlisting, interview dates, and onboarding timelines. Full staffing levels are expected to be achieved by 30 November 2025, with impact on service delivery reviewed monthly thereafter.
HIW Derwen Ward 04054	The health board must ensure that multi patient use items such as BP cuffs, are appropriately decontaminated between use and that clean equipment is correctly labelled.	To review training attendance and requirements of staff for IPC e-learning module. Training compliance will be monitored via Carmarthenshire System Infection Prevention and Control Locality Meeting.	Community & Integrated Medicine	Chief Operating Officer	29/10/2025	29/10/2025	
HIW Derwen Ward 04054	The health board must ensure that multi patient use items such as BP cuffs, are appropriately decontaminated between use and that clean equipment is correctly labelled.	To undertake spot checks of the results to ensure sustained compliance.	Community & Integrated Medicine	Chief Operating Officer	31/10/2025	31/10/2025	
HIW Derwen Ward 04054	The health board must ensure that patient records are stored securely at all times.	To review the training attendance and requirements of staff for Information Governance e-learning and report the findings to the Carmarthenshire Integrated Performance and Business Management Care Group, with a clear plan for improvement if required.	Community & Integrated Medicine	Chief Operating Officer	31/10/2025	31/10/2025	
HIW Derwen Ward 04054	The health board must ensure that all staff have received training and complete patient risk assessments appropriately and take the relevant action in line with local or national guidance, and document this in patient records. This includes: •Taking appropriate action when NEWS scores are 3 or above •Completing and documenting Sepsis Screening for those at risk of sepsis, such as a NEWS score of 5 or above •Completing and documenting VTE risk assessments on admission and thereafter in line with local and national guidance.	To review the current training compliance of staff for NEWS 2 e-learning module and develop a plan to ensure timely completion of the e-learning module. Training compliance will be monitored via RADAR scrutiny meeting.	Community & Integrated Medicine	Chief Operating Officer	13/11/2025	13/11/2025	
HIW Derwen Ward 04054	The health board must ensure that all staff have received training and complete patient risk assessments appropriately and take the relevant action in line with local or national guidance, and document this in patient records. This includes: •Taking appropriate action when NEWS scores are 3 or above •Completing and documenting Sepsis Screening for those at risk of sepsis, such as a NEWS score of 5 or above •Completing and documenting VTE risk assessments on admission and thereafter in line with local and national guidance.	To review the current training compliance of staff for classroom ILS/BLS and develop a plan to ensure timely completion of the learning. Training compliance will be monitored via RADAR scrutiny meeting.	Community & Integrated Medicine	Chief Operating Officer	13/11/2025	13/11/2025	

HIW Derwen Ward 04054	The health board must ensure that all staff have received training and complete patient risk assessments appropriately and take the relevant action in line with local or national guidance, and document this in patient records. This includes: •Taking appropriate action when NEWS scores are 3 or above •Completing and documenting Sepsis Screening for those at risk of sepsis, such as a NEWS score of 5 or above •Completing and documenting VTE risk assessments on admission and thereafter in line with local and national guidance.	To arrange additional training to support the early recognition of a deteriorating patient.	Community & Integrated Medicine	Chief Operating Officer	15/09/2025	15/09/2025	Completed prior to AMAT upload- The dates for the additional training are 25th, 27th and 29th September 2025) Staff have been reminded of the requirement to document all risk assessments and associated actions in the patient record, as per Monitoring, Recording of Adult Physiological Observations and Response to Physical Deterioration Policy. This includes initial assessments, reassessments, and any interventions taken. This will be reinforced through staff meetings and training. Review training attendance and requirements of staff for NEWS 2 e-learning module. Review training attendance and requirements of staff for classroom ILS/BLS Additional training arranged to support the early recognition of a deteriorating patient. Weekly spot checks will be conducted by the senior ward manager or designated team member to ensure compliance with accurate NEWS scoring and escalation of sepsis as per guidance. Implementation of E-Observations (Electronic NEWS recording) throughout the hospital site. Pharmacy/Nursing to reinforce the need for Medical Colleagues to complete and document the VTE Risk Assessment. VTE Site Improvement plan in place. Preventing Thrombosis and VTE showcase event. Hospital Acquired Thrombosis SharePoint page available with current resources and information. Monthly spot checks of VTE risk assessments on Surgical, Medical and Trauma & Orthopaedic ward areas. Review of VTE risk assessment compliance findings to be discussed within the Carmarthenshire System Quality and Safety Governance meeting
HIW Derwen Ward 04054	The health board must ensure that all staff have received training and complete patient risk assessments appropriately and take the relevant action in line with local or national guidance, and document this in patient records. This includes: •Taking appropriate action when NEWS scores are 3 or above •Completing and documenting Sepsis Screening for those at risk of sepsis, such as a NEWS score of 5 or above •Completing and documenting VTE risk assessments on admission and thereafter in line with local and national guidance.	To reinforce to medical staff the requirement to complete and document the VTE Risk Assessment.	Community & Integrated Medicine	Chief Operating Officer	30/09/2025	30/09/2025	
HIW Derwen Ward 04054	The health board must ensure that all staff have received training and complete patient risk assessments appropriately and take the relevant action in line with local or national guidance, and document this in patient records. This includes: •Taking appropriate action when NEWS scores are 3 or above •Completing and documenting Sepsis Screening for those at risk of sepsis, such as a NEWS score of 5 or above •Completing and documenting VTE risk assessments on admission and thereafter in line with local and national guidance.	To promote the Hospital Acquired Thrombosis SharePoint page which is available with current resources and information.	Community & Integrated Medicine	Chief Operating Officer	30/09/2025	30/09/2025	
HIW Derwen Ward 04054	The health board must ensure that all staff have received training and complete patient risk assessments appropriately and take the relevant action in line with local or national guidance, and document this in patient records. This includes: •Taking appropriate action when NEWS scores are 3 or above •Completing and documenting Sepsis Screening for those at risk of sepsis, such as a NEWS score of 5 or above •Completing and documenting VTE risk assessments on admission and thereafter in line with local and national guidance.	To review the VTE Site Improvement plan currently in place to ensure it covers the findings of HIW.	Community & Integrated Medicine	Chief Operating Officer	15/09/2025	15/09/2025	Completed prior to AMAT upload- Monthly spot checks of VTE (Venous Thromboembolism) risk assessments are carried out on the Surgical, Medical, and Trauma & Orthopaedic ward areas by the Quality Improvement VTE Lead or designated clinical lead. Findings are reported to the governance team and any gaps in compliance will be addressed through targeted staff feedback and re-education. The VTE site improvement plan has been uploaded. Quality improvement work continues to improve VTE risk assessment compliance in accordance with the action plan
HIW Derwen Ward 04054	The health board must ensure that all staff have received training and complete patient risk assessments appropriately and take the relevant action in line with local or national guidance, and document this in patient records. This includes: •Taking appropriate action when NEWS scores are 3 or above •Completing and documenting Sepsis Screening for those at risk of sepsis, such as a NEWS score of 5 or above •Completing and documenting VTE risk assessments on admission and thereafter in line with local and national guidance.	To review of VTE risk assessment compliance findings to be discussed within the Carmarthenshire System Quality and Safety Governance meeting (feeding into our Clinical Care Group)	Community & Integrated Medicine	Chief Operating Officer	30/09/2025	30/09/2025	

HIW Derwen Ward 04054	The health board must ensure that all the findings in this immediate improvement plan are not systemic across all other wards within the hospital and the wider health board.	To share the immediate actions through the Community and Integrated Medicine Professional Nurse Forum.	Community & Integrated Medicine	Chief Operating Officer	31/10/2025	31/10/2025	
HIW Derwen Ward 04054	The health board must ensure that all the findings in this immediate improvement plan are not systemic across all other wards within the hospital and the wider health board.	To support with individual ward review to monitor and ensure compliance with actions. Where compliance is found to not be in place, immediate remedial activity to commence.	Community & Integrated Medicine	Chief Operating Officer	01/10/2025	01/10/2025	
HIW Derwen Ward 04054	The health board must ensure that all the findings in this immediate improvement plan are not systemic across all other wards within the hospital and the wider health board.	To present the Quality Improvement audit results for all wards (inclusive of actions at the Care Group Quality and Safety Group for assurance.	Community & Integrated Medicine	Chief Operating Officer	16/10/2025	16/10/2025	All ward areas audit added as evidence.
HIW Derwen Ward 04054	The health board must ensure that all the findings in this immediate improvement plan are not systemic across all other wards within the hospital and the wider health board.	CB to ensure all actions complete prior to closure	Community & Integrated Medicine	Chief Operating Officer	31/10/2025	31/10/2025	
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	To source a document control system.	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	30/09/2023	30/09/2023	Update 23/11/23 added to risk register Requirement escalated in exception report to OQSEC 09/01/2024 6/9/24- Update: This action cannot be completed at this time as it requires additional investment. I will be escalating this in my next QSEG report. 13/12/24- Update- presented to QSEG- on annual plan to employ quality radiographer. Have considered document from other services. Remains ongoing. On risk register Feb 2025- Update need for document control system and quality lead Radiographer included in Radiology annual plan March 2025 update- HB annual plan approved by the Board on 28/03/2025 which has included the Quality Lead Radiographer and document control system. Steps will be put in place shortly to recruit to the post and procure a document control system. April 2025- Currently wiring the JD for this post which will be advertised May 2025. Recruitment expected August 2025 September 2025 - OCP starting - expected to be advertised in December 25 - post filled May 26 - unable to complete action until Dec 26 (post needs to be filled before document control system can be purchased)
HIW GGH IRMER Inspection (Nov 2022)	The employer is required to provide an update on the action taken to ensure the employer's written procedure is adhered to by entitled referrers making a referral prior to exposures performed during surgical theatre cases.	CB to ensure all actions closed and evidence uploaded prior to closure of report	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	03/02/2025	03/02/2025	
HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within	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.	CB to ensure all actions closed and evidence uploaded prior to closure of report	Mental Health & Learning Disabilities	Chief Operating Officer	05/05/2025	05/05/2025	
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.	p)Pilot application of the SAFECARE tool across an individual mental health inpatient ward to inform an approach to full implementation.	Mental Health & Learning Disabilities	Director of Nursing, Quality and Patient Experience	30/11/2023	30/11/2023	Update 24/05/24 Delay in updates to this action due to delay in publication of Welsh levels of care guidance for inpatient mental health and pause of All Wales Mental Health Workstream for Nurse Staffing. Extraordinary MH Workstream Group meeting scheduled for 4th June 2024 where practical application of Welsh Levels of Care within SAFECARE will be reconsidered. Local capacity being scoped within the Hywel Dda Nurse Staffing Team in anticipation of being able to work towards implementing a local pilot of SAFECARE across one mental health inpatient ward. Timescale for completion therefore revised to 31/12/2024. Update -07/01/2025 - Executive meeting did not go ahead on 18/12/2025 therefore meeting has been rescheduled - revised completion date 31/01/2025 Update 23/05/25 - Inpatient Workforce Stabilisation Paper, including recommendation for roll out of SafeCare across mental health wards presented to Executive Team on 07/05/25 - paper uploaded as evidence. Confirmation now received of commitment and support to this. SafeCare Pilot to be undertaken in Older Adult Mental Health Services ahead of full roll out scheduled by the Nurse Staffing Team to take place in October 2025. Action remains in progress with revised timescale of 31/10/2025. 25/11/2025: Senior Nurse for Older Adult Inpatient Wards has advised that whilst there had been an issue with Bryngolau staff accessing Safecare (since the day it was made live) this was resolved on 24/11/2025. The staff have been completing paper records in the meantime however they are now in a better position to continue inputting the data accurately on the Safecare system. Update requested from Nurse Staffing Programme Team. Revised completion date 31/03/2026. 30.12.25 Update: Safecare is in pilot stage usage on Bryngolau Ward. Technical glitches remain with staffs log-ins (manual collection in place). Anticipating to be operational for March deadline prior to full roll-out.

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.	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 & Learning Disabilities	Director of Nursing, Quality and Patient Experience	30/11/2023	30/11/2023	Update 22/11/23 Training Needs Analysis tool developed by Learning and Development Team to be piloted across MHLD services. Update 24/05/24 Update. Progress with action delayed due to directorate capacity to facilitate pilot of TNA tool. Directorate to re engage with Learning and Development to agree a plan to progress. Completion date therefore revised to 30/09/24. Update 30/06/2025: Capacity has remained a challenge and the CCG to re-engage with Learning and Development to agree a plan to progress. To also progress appointment of Head of Nursing, and an additional post. Revised completion date 31st October 2025. 25/11/2025: Recent bid for HEIW Funding has been approved which incorporates funding to support completion of this piece of work. Next steps to be agreed with Assistant Director of People Planning. Revised completion date 31/03/2026. Update 30/12/25 Meeting planned to take place on 05/01/26 with Clinical Education Manager to plan delivery of TNA. Revised completion date remains as 31/03/26.
HIW Inspection BGH Emergency Department	HIW requires details on how the health board will ensure that measures are in place to ensure that medication storage fridge temperatures are checked and recorded on a daily basis.	To complete checks of medication storage fridge temperature alongside the daily checks of the resuscitation trolley	Community & Integrated Medicine	Chief Operating Officer	02/10/2025	02/10/2025	As of 02/08/25, this is now part of the daily resus checklist and is being actively completed. In addition, senior nurse management team will undertake regular spot checks to ensure ongoing compliant
HIW Inspection BGH Emergency Department	HIW requires details on how the health board will ensure that measures are in place to ensure that medication storage fridge temperatures are checked and recorded on a daily basis.	To notify all staff of change.	Community & Integrated Medicine	Chief Operating Officer	02/08/2025	02/08/2025	Notified by A&E Ward sisters across usual communication channels. Paper copy record kept in dept. Evidence to be uploaded
HIW Inspection BGH Emergency Department	HIW requires details on how the health board will ensure that measures are in place to ensure that medication storage fridge temperatures are checked and recorded on a daily basis.	Weekly spot checks to be undertaken by senior nurse management team to ensure ongoing compliance and submit assurance to System General Manager. This will be monitored through the update report to the Clinical Care Group Governance meeting until action plan is fully implemented.	Community & Integrated Medicine	Chief Operating Officer	30/09/2025	30/09/2025	
HIW Inspection BGH Emergency Department	HIW requires details on how the health board will ensure that the paediatric emergency trolley is checked regularly and an accurate record of checks maintained.	To discuss with EUCC team and ensure that they are aware that the paediatric emergency trolley is to be included in the daily checks of the resuscitation trolley. To issue reminder also to be given regarding record keeping of checks.	Community & Integrated Medicine	Chief Operating Officer	05/08/2025	05/08/2025	This was already part of the daily resus checklist and is actively completed. It is recognised that the paeds checklist originally issued is for a ward and different equipment is utilised in a resus area. Discussions held and confirmed to continue with daily resus checklist but to ensure everything is recorded. All staff notified and aware. In addition, senior nurse management team will undertake regular weekly spot checks to ensure ongoing compliance and submit assurance to System GM
HIW Inspection BGH Emergency Department	HIW requires details on how the health board will ensure that the paediatric emergency trolley is checked regularly and an accurate record of checks maintained.	Weekly spot checks to be undertaken by senior nurse management team to ensure ongoing compliance and submit assurance to System General Manager. This will be monitored through the update report to the Clinical Care Group Governance meeting until action plan is fully implemented.	Community & Integrated Medicine	Chief Operating Officer	30/09/2025	30/09/2025	
HIW Inspection BGH Emergency Department	HIW requires details on how the health board will ensure that the 'difficult airway' trolley is checked regularly and an accurate record of checks maintained.	To utilise whiteboard in main theatres with checklist so that any gaps easily identifiable.	Community & Integrated Medicine	Chief Operating Officer	04/08/2025	04/08/2025	
HIW Inspection BGH Emergency Department	HIW requires details on how the health board will ensure that the 'difficult airway' trolley is checked regularly and an accurate record of checks maintained.	To issue reminder also to be given regarding record keeping of checks.	Community & Integrated Medicine	Chief Operating Officer	04/08/2025	04/08/2025	
HIW Inspection BGH Emergency Department	HIW requires details on how the health board will ensure that the 'difficult airway' trolley is checked regularly and an accurate record of checks maintained.	Weekly spot checks to be undertaken by senior nurse management team to ensure ongoing compliance and submit assurance to System General Manager. This will be monitored through the update report to the Clinical Care Group Governance meeting until action plan is fully implemented.	Community & Integrated Medicine	Chief Operating Officer	30/09/2025	30/09/2025	
HIW Inspection BGH Emergency Department	The health board must evaluate and enhance security measures to ensure the safety of both staff and patients.	To progress implementation of the recovery plan which is in place and supports ongoing compliance and reinforces key competencies. To establish a programme of regular monitoring and refresher training to maintain standards and ensure continued readiness across the team.	Community & Integrated Medicine	Chief Operating Officer	31/12/2025	31/12/2025	From Rachel Wood: I had confirmation that my name had been allocated to this in error. That was from Louise Cullum. The recovery plans need to be authored by operational leads. I have explained this to them, I can support them to do this but I can't be responsible for this.
HIW Inspection BGH Emergency Department	The health board must review the mental health assessment room and ensure that it is fit for purpose and safe to use.	To review the risk assessment for the room in question.	Community & Integrated Medicine	Chief Operating Officer	31/12/2025	31/12/2025	
HIW Inspection BGH Emergency Department	The health board must review the mental health assessment room and ensure that it is fit for purpose and safe to use.	To arrange site visit to advise on the call alarm system.	Community & Integrated Medicine	Chief Operating Officer	31/12/2025	31/12/2025	Charles will take a look at the call alarm system when on site in w/c 10/11/2025.
HIW Inspection BGH Emergency Department	The health board must review the mental health assessment room and ensure that it is fit for purpose and safe to use.	To seek advice from Mental Health teams in relation to the alarm system.	Community & Integrated Medicine	Chief Operating Officer	30/09/2025	30/09/2025	Work is in progress to do necessary works on this room. Review 31st March 2026

HIW Inspection BGH Emergency Department	The health board must ensure that the paediatric emergency trolley and difficult airway trolley are appropriately sealed when not in use.	To address the risk of essential equipment being removed from the paediatric emergency and difficult airway trolleys, tamper-evident security tabs have now been sourced and implemented. These tabs seal the trolleys between checks, providing assurance that equipment remains intact and ready for use in the event of an emergency. Compliance with sealing and checking procedures will be monitored through regular audits and reviewed at local assurance meetings to ensure sustained safety and readiness.	Community & Integrated Medicine	Chief Operating Officer	30/09/2025	30/09/2025	Complete however ongoing checks remain in place. 31st March 2026
HIW Inspection BGH Emergency Department	The health board must ensure that staff are reminded of the need to maintain good hand hygiene in order to reduce the risk of cross infection.	To remind staff of the importance of complying with good hand hygiene practices to reduce the risk of infection and support safe patient care and to reinforce this message through safety huddles and visual prompts in clinical areas.	Community & Integrated Medicine	Chief Operating Officer	31/10/2025	31/10/2025	
HIW Inspection BGH Emergency Department	The health board must ensure that staff are reminded of the need to maintain good hand hygiene in order to reduce the risk of cross infection.	To ensure any concerns are escalated to the Care Group's Quality, Health and Safety Meeting to ensure sustained oversight and improvement.	Community & Integrated Medicine	Chief Operating Officer	30/09/2025	30/09/2025	
HIW Inspection BGH Emergency Department	The health board must ensure that immunocompromised cancer patients presenting at ED are appropriately accommodated, to reduce the risk of harm.	To establish an oncology assessment pathway, enabling patients who contact the triage line to be signposted directly to a designated assessment space on Meurig Ward. This pathway will enhance timely access to specialist care.	Community & Integrated Medicine	Chief Operating Officer	30/09/2025	30/09/2025	
HIW Inspection BGH Emergency Department	The health board must ensure that the paediatric area is kept secure and that adult patients are not accommodated within this area when children are accommodated.	To undertake a site visit with the security team to discuss and address additional security measures for the paediatric area.	Community & Integrated Medicine	Chief Operating Officer	31/12/2025	31/12/2025	Paediatric area is part of the minor injuries unit and it is a open communal aera. it would be very difficult to implement additional security measures in the department. The Security Adviser will visit site in w/c 10/11/2025.
HIW Inspection BGH Emergency Department	The health board must ensure that pressure area risk assessments are undertaken routinely for patients whose presenting condition warrant such a risk assessment.	To remind staff of the importance of completing timely and accurate pressure area risk assessments to prevent avoidable harm.	Community & Integrated Medicine	Chief Operating Officer	31/12/2025	31/12/2025	
HIW Inspection BGH Emergency Department	The health board must ensure that pressure area risk assessments are undertaken routinely for patients whose presenting condition warrant such a risk assessment.	To support this, to introduce regular spot checks and documentation audits, with results reviewed through existing local assurance meetings. To continue to monitor trends in incident reporting related to pressure damage through the meetings and escalate to the Care Group's Quality, Health and Safety Meeting for oversight, ensuring ongoing vigilance, learning, and improvement.	Community & Integrated Medicine	Chief Operating Officer	30/09/2025	30/09/2025	
HIW Inspection BGH Emergency Department	The health board must ensure that pressure area risk assessments are undertaken routinely for patients whose presenting condition warrant such a risk assessment.	To ensure that any concerns are escalated to the Care Group's Quality, Health and Safety Meeting providing sustained oversight and improvement.	Community & Integrated Medicine	Chief Operating Officer	30/09/2025	30/09/2025	
HIW Inspection BGH Emergency Department	The health board must ensure that falls risk assessments are undertaken routinely and in a timely way for patients whose presenting condition warrant such a risk assessment.	To remind staff of the importance of completing timely and accurate falls risk assessments to prevent avoidable harm.	Community & Integrated Medicine	Chief Operating Officer	31/12/2025	31/12/2025	
HIW Inspection BGH Emergency Department	The health board must ensure that falls risk assessments are undertaken routinely and in a timely way for patients whose presenting condition warrant such a risk assessment.	To support this, to introduce regular spot checks and documentation audits, with results reviewed through existing local assurance meetings. Trends in falls related incidents will be monitored through these meetings and escalated to the Care Group's Quality, Health and Safety Meeting for oversight if required, ensuring ongoing vigilance, learning, and improvement.	Community & Integrated Medicine	Chief Operating Officer	30/09/2025	30/09/2025	
HIW Inspection BGH Emergency Department	The health board must ensure that falls risk assessments are undertaken routinely and in a timely way for patients whose presenting condition warrant such a risk assessment.	To ensure that any concerns are escalated to the Care Group's Quality, Health and Safety Meeting to ensure sustained oversight and improvement.	Community & Integrated Medicine	Chief Operating Officer	29/09/2025	29/09/2025	
HIW Inspection BGH Emergency Department	The health board must ensure that patient assessments are fully completed and documented.	To remind staff of the importance of accurate and complete assessments	Community & Integrated Medicine	Chief Operating Officer	31/12/2025	31/12/2025	
HIW Inspection BGH Emergency Department	The health board must ensure that patient assessments are fully completed and documented.	To support this, to introduce regular spot checks and documentation audit, with results reviewed through existing local assurance meetings. Trends will be monitored through these meetings and escalated to the Care Group's Quality, Health and Safety Meeting for oversight, ensuring ongoing vigilance, learning, and improvement.	Community & Integrated Medicine	Chief Operating Officer	30/09/2025	30/09/2025	
HIW Inspection BGH Emergency Department	The health board must ensure that patient assessments are fully completed and documented.	To ensure that any concerns are escalated to the Care Group's Quality, Health and Safety Meeting to ensure sustained oversight and improvement.	Community & Integrated Medicine	Chief Operating Officer	30/09/2025	30/09/2025	
HIW Inspection BGH Emergency Department	The health board must ensure that fluid intake and output balance charts are being completed consistently.	To remind staff of the importance of accurate and complete assessments	Community & Integrated Medicine	Chief Operating Officer	31/12/2025	31/12/2025	
HIW Inspection BGH Emergency Department	The health board must ensure that fluid intake and output balance charts are being completed consistently.	To support this, to introduce regular spot checks and documentation audit, with results reviewed through existing local assurance meetings. Trends will be monitored through these meetings and escalated to the Care Group's Quality, Health and Safety Meeting for oversight, ensuring ongoing vigilance, learning, and improvement.	Community & Integrated Medicine	Chief Operating Officer	30/09/2025	30/09/2025	
HIW Inspection BGH Emergency Department	The health board must ensure that fluid intake and output balance charts are being completed consistently.	To ensure that any concerns are escalated to the Care Group's Quality, Health and Safety Meeting to ensure sustained oversight and improvement.	Community & Integrated Medicine	Chief Operating Officer	30/09/2025	30/09/2025	
HIW Inspection BGH Emergency Department	The health board must ensure that staff documentation in patient records provide sufficient clinical/ care details, and records are completed consistently and are legible.	To remind staff of the importance of accurate and complete assessments.	Community & Integrated Medicine	Chief Operating Officer	31/12/2025	31/12/2025	

HIW Inspection BGH Emergency Department	The health board must ensure that staff documentation in patient records provide sufficient clinical/ care details, and records are completed consistently and are legible.	To support this, to introduce regular spot checks and documentation audit, with results reviewed through existing local assurance meetings. Trends will be monitored through these meetings and escalated to the Care Group's Quality, Health and Safety Meeting for oversight, ensuring ongoing vigilance, learning, and improvement.	Community & Integrated Medicine	Chief Operating Officer	30/09/2025	30/09/2025	
HIW Inspection BGH Emergency Department	The health board must ensure that staff documentation in patient records provide sufficient clinical/ care details, and records are completed consistently and are legible.	To ensure that any concerns are escalated to the Care Group's Quality, Health and Safety Meeting to ensure sustained oversight and improvement.	Community & Integrated Medicine	Chief Operating Officer	30/09/2025	30/09/2025	
HIW Inspection BGH Emergency Department	The health board must ensure that the GP Out of Hours Service provides consistent and effective support to the ED when this is required.	We acknowledge and appreciate the ongoing efforts of the GP Out of Hours service in helping to reduce demand at the EUCC front door. During periods of operational pressure, the Silver On-Call Manager has the ability to liaise directly with the Out of Hours team to explore capacity for additional support. However, this is dependent on the level of demand within their own service at the time. This collaborative approach is part of our wider system response to managing flow and ensuring patients receive timely and appropriate care.	Community & Integrated Medicine	Chief Operating Officer	30/09/2025	30/09/2025	
HIW IRMER Diagnostic Imaging x-ray department Withybush Hospital January 2024	The Employer is required to provide HIW with details of the action taken to revise and update the employer's written procedure and flow chart for pregnancy enquiries for staff must be updated to ensure it includes reference to the circumstances when a pregnancy test should be considered and how the result will be effectively communicated	CB to ensure all actions closed and evidence uploaded prior to closure of report	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	05/05/2025	05/05/2025	
HIW IRMER Diagnostic Imaging x-ray department Withybush 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.	1. A document control system needs to be sourced	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	31/12/2024	31/12/2024	13/12/24- presented to QSEG- ongoing review and remains on risk register. Feb 2025- Update need for document control system and quality lead Radiographer included in Radiology annual plan March 2025 update- HB annual plan approved by the Board on 28/03/2025 which has included the Quality Lead Radiographer and document control system. Steps will be put in place shortly to recruit to the post and procure a document control system. April 2025- Quality Manager recruitment should be complete by Aug 2025 and an immediate must do within the workplan will be sourcing the quality control system. September 25 - OCP starting in Oct 25 - three month process. Expected to advertise post in Dec/Jan 26 - in post May 26. Post needs to be filled before action can be closed - expected Dec 2026
HIW IRMER Diagnostic Imaging x-ray department Withybush Hospital January 2024	Employer must provide HIW with details of action taken to manage entitlement of all duty holders (medical, non-medical and third party across the site). They must provide an action plan detailing when this process will be completed and the mitigation in place in the meantime to promote patient safety.	2.All Medical/third party referrers to be identified by implementation of the new PACS and RIS system which will move entirely to electronic referrals.	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	31/12/2025	31/12/2025	13/12/24- System go live Sept 25
HIW St Non, St Caradog, Canolfan Bro Cerwyn WGH	The health board must ensure that staff have alarms and engage with staff to come up with solutions to make staff feel safer whilst working in a remote area.	CB to ensure all actions closed and evidence uploaded prior to closure of report	Mental Health and Learning Disabilities	Director of Nursing, Quality and Patient Experience	05/05/2025	05/05/2025	
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	To undertake a Directorate wide audit of Rapid Tranquilisation against standards for physical health monitoring within the Health Boards Rapid Tranquilisation Policy.	Mental Health and Learning Disabilities	Director of Nursing, Quality and Patient Experience	31/03/2024	31/03/2024	Update 23/05/24 Progress with this action has been delayed due to limited medical capacity. Plans to develop a rapid tranquilisation audit will be discussed at the newly formed Clinical Audit and Effectiveness Group meeting taking place in June 2024. Timescale for completion revised to 30th September 2024. Update 04/09/25 Rapid Tranquilisation Audit identified as a priority audit within MHLD Clinical Audit and Effectiveness Forward Audit Plan presented to MHLD CCG Integrated Governance Group 19/08/25. Timescale for completion revised to 31/12/25. Update 30/12/25 Clinical audit underway and is currently in the data review stage; reviewers have a deadline of 8th of January to ensure all cases are reviewed. Final audit report expected to be completed by 31/01/26. Evidence uploaded.
Internal Audit - Falls Management Final Internal Audit Report October 2024 (Reasonable)	R2. Previous internal audit recommendation reiterated: A delivery plan for the Falls Strategy should be completed identifying key milestones and timescales for completion. This should form the basis of progress monitoring to QSEC.	Chair of Inpatient Falls Group to clarify strategic direction and responsibility for development of a HDUHB Falls Strategy direction through submission of a SBAR to the executive team for guidance on the direction of a Falls Strategy and agreement on whether we are aiming for a preventative focus sitting with Public Health, or a management focus aligned to 6 Goals workstreams, deconditioning, frailty and dementia.	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	31/03/2025	31/03/2025	16/12/24 - Initial meeting held with Exec Director of Nursing, Exec Director of Public Health, Exec Director of Allied Health Professionals to agree outline of strategy and next steps. Aim to provide an overarching strategy including prevention through to inpatient fall management encompassing a preventive strategy aligned to health ageing / social model for health- change of narrative 'promoting independence' . Paper being developed on proposed strategy for discussion with exec team. 04/02/2025 - Working group established to review development of a Promoting Independence and Falls Strategy. 1st meeting held on 4/2/25 and actions agreed. 17/03/2025 - Further meetings planned for 14/04/2025 - responsible person amended to Mandy Davies as Ceri Griffiths leaving healthboard. 25/04/2025: Meetings held between Executive Directors (JS and AG) and Anna Llewellin to discuss strategic direction of the Falls Strategy Group. Executive Group is currently looking at promoting an independence framework which will include a falls strategy and work remains ongoing. . Anna will take this forward in the coming weeks/months, now that she is in post. Revised completion date of 31st December 2025.

Internal Audit - Falls Management Final Internal Audit Report October 2024 (Reasonable)	R6. More detailed and frequent (e.g. annual) falls reporting to QSEC, including MFRA compliance, a summary of falls incident themes and trends and action taken to prevent recurrence.	The Inpatient Falls Group will provide an annual report to QSEC (commencing May 2025) which will include oversight of falls improvement work including EQLIP programmes and QI initiatives; compliance with NAIF audits and actions plans, compliance with MFRA reporting, trends and themes of falls incidents including closure timeliness and learning from events / themes identified.	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	31/05/2025	31/05/2025	18/06/2025: Revised completion date of December 2025.
Internal Audit - Mortuary Services Final Internal Audit Report 2024/25 Swansea Bay University Health Board Hywel Dda University Health Board (Limited)	R1. Memorandum of Understanding Roles and responsibilities have been clearly documented within the Transitional MoU and Mortuary Service MoU. While the Transitional MoU has been approved by both health boards in May 2024, no signed version of the document could be located during our review. The Mortuary Service MoU was originally instigated in 2022 to address staffing issues in HDUHB. The document has been reviewed and approved by the Chief Executives of both health boards in March 2024. However, the contact point for SBUHB is not recorded within the document; and we have been unable to confirm the reporting of the MoU within the health boards and its communication to mortuary staff.	We will ensure the Transitional MoU is signed and the document is easily accessible. The Mortuary MoU will be reviewed and updated to ensure key contact information is included, and we will ensure the final version is circulated appropriately within both health boards and communicated to mortuary staff.	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	31/03/2025	31/03/2025	11/04/25 - Following discussion with both Health Board legal and governance teams, the MOU approved in May 2024 Boards (and minuted as such) cannot be signed retrospectively. However, the transitional MOU is not yet ready to move to 'final' stage as originally planned from April 2025. Therefore, a paper is going to both Boards in March 2025 to seek approval to the continue the Transitional MOU. If this is approved, then signatures can be added (and the evidence provided) 14/07/25 - awaiting signed transitional MOU
Internal Audit - Mortuary Services Final Internal Audit Report 2024/25 Swansea Bay University Health Board Hywel Dda University Health Board (Limited)	R3. (External) Financial Responsibilities The Transitional MoU details in respect of the ODN that the "Health Boards agree to share the costs and expenses arising in respect of the Project between them in accordance with the Contributions Schedule set out in Annex D," and that the Schedule will be approved within three months of the date of the Transitional MoU (May 2024). We note that the development of the ODN has been impacted by capital funding and the delivery plan is behind schedule, however, the ODN Service Specification and commissioning arrangements have not been finalised. This would assist in determining how the ODN, including leadership roles, will be financed. In relation to the regional mortuary service provision, there is a spreadsheet that details the basis for the sharing of staffing costs between the health boards. However, current arrangements need to be more explicit to confirm the basis of the recharge	(External) We will formally document the agreement between the health boards of shared costs for the provision of the regional mortuary service and ODN.	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	31/03/2025	31/03/2025	Dec 2024 – Meeting organised between both operational and financial teams within both SBU and HD to discuss financial arrangements with regards to Di and regional APT's. Dec 2024 – Initial draft SLA constructed and circulated for review and comment. Final draft SLA to be attached to Mortuary MOU. This is still ongoing and being finalised and further meetings are scheduled for March and April 2025. Awaiting further decisions to be made by SBU and HD board meetings. 15/05/25 - Paper submitted to Public board meeting 27th March where a 12 month extension was requested. Awaiting meeting minutes 02/06/25 - further meeting set up for 08/07/25 to discuss draft SLA with the intention to finalise it. Awaiting signed SLA. Draft uploaded
Internal Audit - Nursing Management Final Internal Audit Report 2025/26 (Limited)	R2. Escalation / Approval of Agency Requests Escalation to agency requires approval by the Head of Service/Nursing. Sample testing of 25 shifts escalated to agency since implementation of the new SOP in April 2025 identified that only 16% of agency shifts reviewed had been escalated to agency on Allocate (i.e., 'approved') by the Head of Nursing. The SOP permits approval by a 'nominated deputy,' although there is ambiguity about which role(s) this could or should be, and it contradicts the intention of the SOP which is to ensure tight grip and control over agency use through senior management approval. In keeping with this it would be prudent to escalate rather than delegate approval, in the absence of the Head of Nursing.	The SOP will be updated to require, in the absence of the Head of Nursing, delegated approval by the Deputy Head of Nursing or escalation to the Assistant Director of Nursing, Quality & Patient Experience, emphasising that this should be the exception rather than the norm.	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	30/09/2025	31/12/2025	Discussions with the Assistant Directors of Nursing who are in agreement with the revised wording. SOP to be updated to reflect the wording change. Revised completion date 30/11/2025 23/10/2025: Gareth Heaven has requested that the due date be changed to 31st December 2025. Copy of email (as evidence of this request) uploaded to file.
Internal Audit - Nursing Management Final Internal Audit Report 2025/26 (Limited)	R3. Absence Management Sample testing identified widespread non-compliance with the key requirements of the NHS Wales Managing Attendance at Work Policy, including: • Absence of any documentation in support of some episodes • Failure to undertake Return to Work interviews, or significant delays in completion • Absence of sufficient self-certificates and/or fit notes covering the whole of the absence • Failure to identify and act on review prompts	The good practice identified at PPH Ward 9 will be process mapped into a guidance document and shared with all Heads of Service/Nursing for implementation within their respective areas.	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	30/09/2025	30/09/2025	Revised completion date 31/12/2025
Internal Audit- Discharge Management (Follow Up) Final Internal Audit Report 2024/25 (Assurance Rating: N/A)	R1. Documentation of Discharge Planning Of the 100 patient records reviewed within WNCR, eight had partially completed discharge elements whilst 19 had not been completed. A sample of 20 patient manual medical notes were tested. A total of four files had been identified where there was limited discharge planning documentation evident of patient clinical file and the WNCR discharge section had been partially or not completed.	No evidence was received by Internal Audit to support the implementation of the agreed management actions including (i) staff education and required compliance with the WNCR system following the development of the SharePoint site, and (2) a review of WNCR records for to ensure compliance with requirements. Testing was undertaken on a sample of 50 patients discharged from acute hospital sites during April 2025 to ensure the discharge element within the WNCR system has been fully completed. Concluding testing, we identified 34 out of the 50 sampled patients had a completed discharge element on their WNCR record, with high levels of compliance displayed for Withybush General Hospital patients	Community & Integrated Medicine	Chief Operating Officer	31/03/2025	31/03/2025	10/06/2025- This report is a follow up from the previous report - HDU-2425-13 Discharge Management Internal Audit Report 2024/25 (Recommendation 4 in the previous report was not implemented)
IRMER Regulations	Identify areas where more than one employer may be involved with and exposure and consider if the co-operation regulation needs actions. e.g. referrer (GP referrals), operator (third party imaging providers) or practitioner (out of hours practitioner service) has a different employer; to other duty holders	Co-operation between employers: consider where relevant	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	31/07/2025	31/07/2025	Update 3.9.25- All Wales approach – FO taking to AWIQF for update and progress. revised target date 31.1.26

IRMER Regulations	Schedule 3 is re-organised with changes to core and specific training. Training in the amendment changes is required plus discipline specific review with additions to the "all modalities" elements probably most significant. A plan to cover any additions will be required.	Review training needs of practitioners and operators	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	30/06/2025	30/06/2025	update 3.9.25- Query sent to SE on 21/7 re All Wales progress made to date revised target date 31.1.26, update 12.11.25 need action from JA/MH to ensure EIRMER is added as mandatory.
IRMER Regulations	Schedule 3 is re-organised with changes to core and specific training. Training in the amendment changes is required plus discipline specific review with additions to the "all modalities" elements probably most significant. A plan to cover any additions will be required.	CB to ensure all actions complete to allow for closure	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	30/06/2025	30/06/2025	unable to complete until earlier actions have been completed
Joint Inspection of Child Protection Arrangements (Pembrokeshire)	The quality of leadership varies significantly by service. In some areas, such as health visiting and school nursing, there is strong professional ownership and proactive approaches to safeguarding. However, the absence of supervision, professional challenge, and reflection is notable. Records frequently show repeated concerns without escalation, suggesting missed opportunities to lead safeguarding practice with vision and purpose.	Clinical Care Groups to identify resource to implement safeguarding specialist roles to support professional ownership and proactive approaches to safeguarding, e.g. Emergency Departments as priority area.	Director of Nursing, Quality and Patient Experience	Chief Operating Officer	31/12/2025	31/12/2025	This improvement plan is agreed with Clinical Care Groups, but an update on progress is to be reported to the November 2025 Strategic Safeguarding Steering Group.
Joint Inspection of Child Protection Arrangements (Pembrokeshire)	Training compliance is a concern, particularly for Level 3 safeguarding children training. Only 37% of medical and dental staff were compliant in December 2024. The provision of training is regularly available, but attendance levels are often low.	All services to put in place improvement plans to achieve 85% compliance across all professional groups with Level 3 training by 31st March 2026	Director of Nursing, Quality and Patient Experience	Chief Operating Officer	30/09/2025	30/09/2025	CCGs to identify targeted improvement plans and report to Strategic Safeguarding Steering Group November 2025.
Joint Inspection of Child Protection Arrangements (Pembrokeshire)	Training compliance is a concern, particularly for Level 3 safeguarding children training. Only 37% of medical and dental staff were compliant in December 2024. The provision of training is regularly available, but attendance levels are often low.	All services to put in place improvement plans to achieve 85% compliance across all professional groups with Level 3 training by 31st March 2026	Director of Nursing, Quality and Patient Experience	Chief Operating Officer	30/09/2025	30/09/2025	As this action 'sits' within Nursing, Medical Quality, Safety & patient Experience the ADoN Olwen Morgan will be the overall action lead, assisted by Mr. Ihab Abassi, AMD. CCGs to identify targeted improvement plans and report to Strategic Safeguarding Steering Group November 2025.
Joint Inspection of Child Protection Arrangements (Pembrokeshire)	Training compliance is a concern, particularly for Level 3 safeguarding children training. Only 37% of medical and dental staff were compliant in December 2024. The provision of training is regularly available, but attendance levels are often low.	All services to put in place improvement plans to achieve 85% compliance across all professional groups with Level 3 training by 31st March 2026	Director of Nursing, Quality and Patient Experience	Chief Operating Officer	30/09/2025	30/09/2025	CCGs to identify targeted improvement plans and report to Strategic Safeguarding Steering Group November 2025.
Joint Inspection of Child Protection Arrangements (Pembrokeshire)	Training compliance is a concern, particularly for Level 3 safeguarding children training. Only 37% of medical and dental staff were compliant in December 2024. The provision of training is regularly available, but attendance levels are often low.	All services to put in place improvement plans to achieve 85% compliance across all professional groups with Level 3 training by 31st March 2026- Above plans (JICPA / 09) to be reported to Strategic Safeguarding Steering Group	Director of Nursing, Quality and Patient Experience	Chief Operating Officer	30/11/2025	30/11/2025	
Joint Inspection of Child Protection Arrangements (Pembrokeshire)	Training compliance is a concern, particularly for Level 3 safeguarding children training. Only 37% of medical and dental staff were compliant in December 2024. The provision of training is regularly available, but attendance levels are often low.	All services to put in place improvement plans to achieve 85% compliance across all professional groups with Level 3 training by 31st March 2026- Above plans (JICPA / 09) to be reported to Strategic Safeguarding Steering Group	Director of Nursing, Quality and Patient Experience	Chief Operating Officer	30/11/2025	30/11/2025	
Joint Inspection of Child Protection Arrangements (Pembrokeshire)	Training compliance is a concern, particularly for Level 3 safeguarding children training. Only 37% of medical and dental staff were compliant in December 2024. The provision of training is regularly available, but attendance levels are often low.	All services to put in place improvement plans to achieve 85% compliance across all professional groups with Level 3 training by 31st March 2026- Above plans (JICPA / 09) to be reported to Strategic Safeguarding Steering Group	Director of Nursing, Quality and Patient Experience	Chief Operating Officer	30/11/2025	30/11/2025	As this 'sits in Nursing, Medical, Quality & patient Experience the Assistant Director of Nursing, Quality, Safety & patient Experience should be the overall action lead, assisted by the Care Group Associate Medical Director, Mr. Ihab Abassi.
Joint Inspection of Child Protection Arrangements (Pembrokeshire)	The reliance on CP medicals being completed by acute paediatricians in an out-of-county hospital, due to the lack of a service in Pembrokeshire, presents a long-standing and unresolved challenge to all agencies involved. The Health Board should consider how best to resolve theses issues to ensure a more timely and seamless service, both for agencies and for the children and families involved.	Work with Local Authority partners to agree an escalation process when health assessments are delayed.	Director of Nursing, Quality and Patient Experience	Chief Operating Officer	30/09/2025	30/09/2025	There is no agreement from consultants on a unified way forward at present. Further meeting due Nov 12th. This will require funding to implement a new rota. 12/11/2025 - meeting held. The community paediatric service would not be able to support this without considerable investment. Options for delivering a 5 day service are being scoped.
Joint Inspection of Child Protection Arrangements (Pembrokeshire)	The reliance on CP medicals being completed by acute paediatricians in an out-of-county hospital, due to the lack of a service in Pembrokeshire, presents a long-standing and unresolved challenge to all agencies involved. The Health Board should consider how best to resolve theses issues to ensure a more timely and seamless service, both for agencies and for the children and families involved.	CP Medical Pathway: Convene review planning group and scoping meeting. Map current job plans, rota commitments and workload (community vs acute). Draft Options Appraisal (e.g. community-led, acute-led, hybrid model). Final recommendations and implementation plan.	Director of Nursing, Quality and Patient Experience	Chief Operating Officer	31/12/2025	31/12/2025	A review planning group has been established.
Joint Inspection of Child Protection Arrangements (Pembrokeshire)	Partners should ensure timely information sharing about emerging safeguarding themes and work together to disrupt and reduce such risks within the population and for individual children.	Prevention & emerging risks: HV and Midwifery to draft a Free Birth policy for consultation with regional multi-agency partners.	Director of Nursing, Quality and Patient Experience	Chief Operating Officer	30/09/2025	30/09/2025	A draft policy has been developed for health visiting and internal health board consultation with Midwifery has taken place. In addition to this discussions have been had with the policy lead for the Health Board as well as bench marking with another Health Board. Children's Commissioner has also been consulted. When all is complete policy to be shared with multi -agency partners for further consultation before finalising, also taking into account the National perspective and progress on the management of Free birthing. This process near finalisation waiting for SBAR to be completed and policy taken to SNMT for sign off. 11th Dec 2025 update: It has been decided that this policy will be a stand alone policy for Health Visiting, the literature review is complete, EQIA is being completed along with SBAR and then will be progressed. Evidence of SBAR and EQIA to be uploaded once completed.

Joint Inspection of Child Protection Arrangements (Pembrokeshire)	Partners should ensure timely information sharing about emerging safeguarding themes and work together to disrupt and reduce such risks within the population and for individual children.	Prevention & emerging risks: Review strategies across the multi-agency partnership to reduce substance ingestion by young children	Director of Nursing, Quality and Patient Experience	Chief Operating Officer	31/12/2025	31/12/2025	To be discussed at the Safeguarding Leads regional meeting.
Mynydd Mawr Ward, Prince Philip HospitaL 03921	Implement robust measures to maintain clinic room temperatures within recommended guidelines for safe medication storage.	The monitoring chart link requires to be embedded within the medicine policy for ease of access. This action has been requested and is underway.	Community & Integrated Medicine	Chief Operating Officer	30/09/2025	30/09/2025	Link embedded but awaiting ratification- update 1.10.25 (expected completion Dec 2025) Copy of the daily temperature log has been cascaded to all Heads of Nursing. Medicines policy is under review with no clear time scale on completion. A request has been made to extend the review for a further 6 months. (updated on the 7/10/25) Medicines Policy is being review. The Daily temperature log templates are being imbedded into the policy as links. I have no definitive date of when this will be approved. (updated 29:12:25)
Mynydd Mawr Ward, Prince Philip HospitaL 03921	Implement robust measures to maintain clinic room temperatures within recommended guidelines for safe medication storage.	The requirement of the daily treatment room temperature check process and compliance will be reviewed and amended within a Quality Improvement Health Board Wide Task and Finish group. ToR being devised. Dates being arranged.	Community & Integrated Medicine	Chief Operating Officer	31/10/2025	31/10/2025	Temperature Controlled Medicines Task and finish group September 2025
Mynydd Mawr Ward, Prince Philip HospitaL 03921	Provide clear guidance and additional training to staff to ensure their understanding of the risks associated with temperature deviations, and the appropriate action to take in such circumstances.	Review Medicines Administration, Recording, Review, Storage & Disposal e-learning module content.	Community & Integrated Medicine	Chief Operating Officer	30/09/2025	30/09/2025	All Wales Group are updating this work underway, working with HIW for editing to ensure capability with ESR This is an All Wales piece of work that is underway. No clear time scale on completion. Group to meet in the next month. Updated 7/10/25 No new update to give .Work remains to be done on this. Working with HEIW on this piece of work. (updated 29:12:25)
Mynydd Mawr Ward, Prince Philip HospitaL 03921	Provide clear guidance and additional training to staff to ensure their understanding of the risks associated with temperature deviations, and the appropriate action to take in such circumstances.	Medicines Policy currently being reviewed and updated to capture the requirements in relation to the treatment room and fridge temperature monitoring. Policy is out of date but has been agreed an extension pending completion of review.	Community & Integrated Medicine	Chief Operating Officer	10/10/2025	10/10/2025	Currently remains under review - Aim is January 2026 Policy is being updated. No definitive date of completion(updated 29:12:25)
Mynydd Mawr Ward, Prince Philip HospitaL 03921	The health board must urgently review the physiotherapy provision on the ward, to ensure patients receive timely and appropriate assessments, along with suitable therapeutic support during the interim period.	To embed a robust and structured approach to patient rehabilitation on the ward.	Community & Integrated Medicine	Chief Operating Officer	30/11/2025	30/11/2025	To note: the recruitment process to fill the 3.5 vacancies commenced in June 2024. Initial attempts at recruitment in July 2024 were unsuccessful and, alongside the increased site pressures to support patient flow, this impacted on the ability to deliver consistent rehabilitation. In December 2024, three band 6 physiotherapists were appointed, however start dates were delayed due to notice periods, completion of band 5 rotations and maternity leave. Recruitment in March 2025 and June 2025 has been successful. Further recruitment is to commence in October and November 2025.
Mynydd Mawr Ward, Prince Philip HospitaL 03921	The health board must ensure that all staff are compliant with Duty of Candour training and are appropriately supported to understand and apply its principles in their roles.	To undertake a weekly (for a period of four weeks) validation of manager's interim harm assessment for patient safety incidents reported on Mynydd Mawr This will be in addition to the established monthly validation of all patient safety incidents closed in the month.	Community & Integrated Medicine	Chief Operating Officer	30/11/2025	30/11/2025	
NHS Delivery Unit - Review of Dermatology Services in Wales Hywel Dda University Health Board	R1. Health board to invest and support in an additional consultant whole time equivalent, considering increasing the number by a minimum 1 WTE with opportunities of other medical specialities such as plastic surgery to support locally and other dermatology units to support remotely	Awaiting management response	Planned and Specialist Care	Chief Operating Officer	30/09/2025	30/09/2025	The Dermatology Consultant Capacity currently remains at 2.0 WTE this is due to the available core budget. There is currently an advert out to recruit for one WTE Dermatology Consultant. Completion date set to 30/06/2026 to allow ample time for recruitment for a Dermatology Consultant.
NHS Delivery Unit - Review of Dermatology Services in Wales Hywel Dda University Health Board	R4. Re- establish the organisations patch testing service	Awaiting management response	Planned and Specialist Care	Chief Operating Officer	30/09/2025	30/09/2025	To date the Health Board has experienced difficulty in recruiting a suitably trained doctor to carry out patch testing. There are currently two job advertisements for a Consultant Dermatologist and a Locum Consultant Dermatologist. The Health Board are also experiencing a shortage of clinical space for the patch testing to be carried out. 3 rooms have been identified at DSU PPH for the Dermatology Service, however practicalities around air handling, reception cover and medical records support need to be agreed before these rooms can be utilised for the Dermatology Service. Further space is also required and this is being supported via the CSP. At present, patients are being referred to SBUHB for patch testing.
NHS Delivery Unit - Review of Dermatology Services in Wales Hywel Dda University Health Board	R5. Allow access to the identified clinic space in outpatients to expand.	Awaiting management response	Planned and Specialist Care	Chief Operating Officer	30/09/2025	30/09/2025	The recommendation relates to the initial clinical space within the outpatients department at Glangwili General Hospital (GGH) that was earmarked for Dermatology back in 2019. However due to the COVID-19 Pandemic that clinical space was utilised by the Minor Injuries Unit (MIU) at GGH. MIU have since returned to their original location and another service has used that space as the Dermatology Service moved to Prince Phillip Hospital (PPH) during the COVID-19 pandemic. 3 rooms have been identified at DSU PPH, however practicalities around air handling, reception cover and medical records support need to be agreed before the space can be utilised by the Dermatology service. Further space is required in order to carry out the service to patients and this is currently being supported via the CSP. The service continues not to have a dedicated department as mentioned in the report. Revised date April 2028
NHS Wales Executive Children and Young Person's Neurodevelopmental Services All Wales Review	Arrangements for transition of CYP between children's and adult ASD and ADHD assessment should be clarified and strengthened to ensure that CYP are not disadvantaged in relation to waiting time or access to age-appropriate expertise.	Review current transition arrangements for older YP people waiting diagnostic assessments of ASD and ADHD	Planned and Specialist Care	Chief Operating Officer	30/11/2024	30/11/2024	02/12/2025: Meetings held between ASD and ADHD teams, awaiting final confirmation of agreement from Adult ADHD team to agree transition arrangements. Revised Date: February 2026

NHS Wales Executive Children and Young Person's Neurodevelopmental Services All Wales Review	Arrangements for transition of CYP between children's and adult ASD and ADHD assessment should be clarified and strengthened to ensure that CYP are not disadvantaged in relation to waiting time or access to age-appropriate expertise.	Develop an all age Transition policy/pathway for Neurodivergent Children & Young People.	Planned and Specialist Care	Chief Operating Officer	30/11/2024	30/11/2024	11th April. Series of meetings held to date and on-going Assigned lead on Action Plan is Angharad Davies, therefore re-assigned on AMat for updating purposes 4th Dec 2024 Initial document approval form and EQIA screening complete. HB Transition policy now under development in collaboration with Policies team, to be taken to Women and Childrens Written Clinical Documentation Group on the 31.01.25. All age transition pathway for Neuro-divergent Children and Young people to be included within HB policy. 31/10/2025: Work is ongoing surrounding this policy/pathway. Revised completion date 31.12.2025 02/12/2025: Transition policy pathway is still being developed and will likely to be agreed in the new year. Policy has been drafted and sent to MH&LD CCG leads for approval, awaiting outcome. Revised Completion date: March 2026.
NHS Wales Executive Review of Psychology and Psychological Interventions for Children and Young People	The HB should explore opportunities for improved psychological interventions and patient outcomes by sharing resources and professional expertise, to enhance joint clinical work between SCAMHS and Paediatric Psychology.	Identify and implement opportunities for improved psychological interventions & patient outcomes across Paediatrics and S-CAMHS	Planned and Specialist Care	Chief Operating Officer	31/07/2024	31/07/2024	Identified opportunities, however, implementation is a challenge. SDM's from both directorates are working on these challenges. Planned meeting with relevant colleague to support referral/s advice/ signposting liaison meeting to discuss relevant cases is in hand. Evidence to be added 04/12/2024 - Update requested via Email from TH. Awaited. 02/12/2025: Lead Nurse for Children Community and Lead for Psychology and SCAHMS are working together to explore opportunities to share expertise. Ongoing meetings are in place for further discussions. There is a B8a Child Health Psychology post due to go to FCSG for approval and this post has already received CCG approval. Due to the small size of the Paediatric psychology team we are unable to progress this matter further until this post is in place. Revised Date: December 2026 (this takes into account approval from FCSG, recruitment and embedding into the post)
NHS Wales Executive Review of Psychology and Psychological Interventions for Children and Young People	The HB should ensure equity of training availability and budgets, supervision, and professional leadership between directorates to ensure all staff have equal opportunities for development and support.	Identifying gaps in funding and provision for development in paediatric psychology	Planned and Specialist Care	Chief Operating Officer	31/07/2024	31/07/2024	Benchmarking document has been produced as a hard copy and will be scanned and uploaded.
Nuclear Medicine IRMER WGH 03909	The employer should consolidate the two procedures on the referral process into one.	Review relevant Employers Procedures to amalgamate EP5 and EP25.	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	01/01/2026	01/01/2026	
Nuclear Medicine IRMER WGH 03909	The employer must ensure that: •All IR(ME)R entitlement and training competency documentation is completed in full, with the appropriate signatures, in a timely manner and before entitlement is granted •The employer's procedure contains reference to the correct titles of staff.	Develop new entitlement document which reflects all duty holders under IR(ME)R.	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	01/01/2026	01/01/2026	
Nuclear Medicine IRMER WGH 03909	The employer must ensure that: •All IR(ME)R entitlement and training competency documentation is completed in full, with the appropriate signatures, in a timely manner and before entitlement is granted •The employer's procedure contains reference to the correct titles of staff.	Review all job titles within Employers Procedures	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	01/01/2026	01/01/2026	
Nuclear Medicine IRMER WGH 03909	The employer must ensure that the employer's procedure includes the correct duty holder to justify nuclear medicine procedures, for pregnant or breastfeeding individuals.	Review Employers Procedure 8 to amend the duty holder required to justify Nuclear Medicine procedures.	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	01/01/2026	01/01/2026	
Nuclear Medicine IRMER WGH 03909	The employer must ensure that the relevant employer's procedure includes: •Details on the formal process and responsibilities of identifying and conducting both clinical and IR(ME)R audits •Reference to the audit report templates that should be used •Specific terminology to ensure clarity between clinical and IR(ME)R audits.	Employers Procedure 21 to be reviewed and amended to include: •Details on the formal process and responsibilities of identifying and conducting both clinical and IR(ME)R audits •Reference to the audit report templates that should be used and included as an appendix. •Specific terminology to ensure clarity between clinical and IR(ME)R audits.	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	01/01/2026	01/01/2026	

Nuclear Medicine IRMER WGH 03909	The employer must ensure that the relevant employer's procedure is updated to include: •Clarity on the circumstances of informing or not informing patient •Making it clear that the relevant practitioner, referrer and operator should always be informed of any CSAUEs •The process in place for recording and analysing accidental or unintended exposures including near misses •References to nuclear medicine equipment.	Employers Procedure 19 to be reviewed and updated to include: •Clarity on the circumstances of informing or not informing patient	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	01/01/2026	01/01/2026	
Nuclear Medicine IRMER WGH 03909	The employer must ensure that the relevant employer's procedure is updated to include: •Clarity on the circumstances of informing or not informing patient •Making it clear that the relevant practitioner, referrer and operator should always be informed of any CSAUEs •The process in place for recording and analysing accidental or unintended exposures including near misses •References to nuclear medicine equipment.	Employers Procedure 19 to be reviewed and updated to include: Making it clear that the relevant practitioner, referrer and operator should always be informed of any CSAUEs	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	01/01/2026	01/01/2026	
Nuclear Medicine IRMER WGH 03909	The employer must ensure that the relevant employer's procedure is updated to include: •Clarity on the circumstances of informing or not informing patient •Making it clear that the relevant practitioner, referrer and operator should always be informed of any CSAUEs •The process in place for recording and analysing accidental or unintended exposures including near misses •References to nuclear medicine equipment.	Employers Procedure 19 to be reviewed and updated to include: The process in place for recording and analysing accidental or unintended exposures including near misses	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	01/01/2026	01/01/2026	
Nuclear Medicine IRMER WGH 03909	The employer must ensure that the authorisation guidelines and the employer's procedure is updated to correctly reflect the process and ensure there is clarity on who is authorising the exposure to carers and comforters.	The Employer's Procedure will be amended to offer specific guidance to staff, and including recording of authorisation following advice from MPE.	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	28/10/2025	28/10/2025	Meeting with RPE delayed due to DHoS unexpected leave and service pressures. - updated date 31.12.25
Nuclear Medicine IRMER WGH 03909	The employer must ensure that: •The adjuvant drugs used in nuclear medicine are part of the formulary •The nuclear medicine protocols are ratified and approved to ensure compliance with regulation 240 of the Human Medicines Regulations 2012.	Nuclear Medicine protocols to be reviewed, amended and ratified appropriately by Head of Radiology Services Manager, in consultation with the ARSAC licence holders and MPE to ensure compliance with regulation 240 of the Human Medicines Regulations 2012.	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	01/01/2026	01/01/2026	Draft documents have been developed by NM team and MPE. Meeting to discuss with all stakeholders to be scheduled.
Nuclear Medicine IRMER WGH 03909	The employer must ensure that: •A document list of relevant IR(ME)R theoretical training is introduced and completed by staff •The relevant employer's procedure states the process for the review of training records and how the review of training records is recorded.	Process added to Employers Procedure around review of training records.	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	01/01/2026	01/01/2026	

Peer Review Out of Hours Peer Review, issued April 2023	R6. The Advanced Paramedic Practitioner role within OOH has not been formalised but is working well. The APPS would like to do more shifts.	Review the formalisation of the APP role within the OOH MDT and possibly joint roles with Urgent Primary Care.	Primary Care	Chief Operating Officer	30/06/2023	30/06/2023	26/04/2023- WAST APP pilot has been in place since October 2018 and has made a positive difference to shift fill outcomes and access to care particularly through home visits. The audit already undertaken was received positively and highly supportive of the model and is being built on through discussion with the Clinical Lead (OOHs) and the recently appointed Professional Development Lead for Advanced Practice at WAST. 26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019. 27/06/2023 - Meeting to be held with locality managers for APP on 12/07/2023 to discuss shift fill and current model. Working with SDEC and Intermediate Care to understand the feasibility of a joint rotational model, further from previous discussions with TUEC and Primary Care. Discussion ongoing with WAST in terms of supporting the mentorship of trainee APPs and the growth of new cohorts. Shift fill is less than 50% per week as at June 2023 due to current qualified APPs leaving, and unable to backfill positions. Contract re-negotiation with WAST is highly likely, and likely to cause additional delays to the implementation of this recommendation. 16/08/2023 - due to management structure changes at WAST, and several APPs leaving, this has delayed the full implementation of the recommendation, however improvements beginning to be noticed and a new cohort of APPs are currently embedding. Ongoing financial constraints are also impacting on the ability to fully implement this recommendation as at August 2023 04/12/2023 - There has been a prolonged period of reduced APP shift fill that is being addressed by WAST with the assurance that shift fill is set to improve imminently. 08/05/2024 - Shift fill did improve however not sustained. This may be linked to the same APPs being used in other areas of the HB despite OOHs funding two WTE. Assessment of the sustainability and resilience of the APP relationship with WAST is being considered and a decision will be reached in Q1 24/25. This again may be influenced by the move to Primary Care and any opportunities this may present for 24/7 offering of Primary Care. The revised date has been amended to reflect realistic progress within this financial year. 26/07/2024 - There is performance variation with this role, and there needs to be a further collaborative review with WAST and input post OCP (see links to consolidation and rural model actions). 24/09/2024 - Action to be reviewed post-OCP to determine long-term opportunities 16/12/2024 - a new leadership structure in WAST looking after APPs, we have now held an introductory meeting and intend to formalise these on an ongoing basis to look at how we formalise utilisation of APPs on an ongoing basis, given that demand for them in other areas is prevalent. 18/03/2025 - review of the APP programme to be considered in line with the development of the Primary Care & Community Services strategic plan 01/10/2025 - APP Arrangements are currently in review. Changes in WAST need to be understood and clarity is required to determine an whether SLA or MoU will be renewed. A review of our MDT model is going to be carried out once the salaried GPs recruitment is completed. Revised date = June 2026 (to allow time for recruitment and review of plan).
Peer Review Out of Hours Peer Review, issued April 2023	R12. There was some success in developing the health care support worker roles and the National 111 programme supported the Health Board to train drivers and reception staff. However these staff are not being utilised on shift in OOHs.	Review how utilisation of HCSW in bases in the West could support a rural model of care.	Primary Care	Chief Operating Officer	30/06/2023	30/06/2023	26/04/2023- Explore with CTUHB. Ties in with TUEC programme work. Skill set to be scoped and compared with opportunities and needs. 26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019. 27/06/2023 - Work is ongoing with the OOH Service to understand the current Airedale model. Working with SDEC and Intermediate Care to understand the feasibility of a joint rotational model, further from previous discussions with TUEC and Primary Care. Due to changes in senior leadership arrangements, this work is ongoing as at June 2023. Interaction with Salus may cause further delay, therefore proposed revised timescale of December 2023. 16/08/2023 - current financial constraints are limiting the ability to progress this recommendation at pace, as OOH structure may change, therefore recommendation to be re-visited once more clarity in place. 04/12/2023 - There is no further progress to date. 08/05/2024 - Those trained as HCSW are being encouraged to utilise their skills. Clinicians are being encouraged to support such colleagues and feedback has been positive. As the number of face to face consultations continues to increase these opportunities should also be more frequent. Evaluation of the role will be ongoing. All new recruits to the OOH operational team will be trained as HCSW through the Skills to Care programme. 26/07/2024 - This is faltering due to lack of engagement with the predominant locum GP workforce. 30/09/2024 - Re-evaluation of action following OCP 16/12/2024 - Dashboard reports will be developed to enable a better understand of service needs, which will support collaboration with the Six Goals programme. 18/03/2025 links to other peer review recommendations around HCSWs and the link with the Primary and Community Services Academy and the development of the Primary Care and Community Services Strategic Plan development 01/10/2025 - The rural model of care will be considered following service changes such as recruitment of salaried GPs (see R1 and R6) which will inform MDT possibilities. A significant amount of work in the UEC space where other services are involved has largely superseded this recommendation (e.g. Six Goals programme). To be escalated via CCG for steer on closure of recommendation on the basis that newer initiatives and workstreams have superseded this work (evidence to be collated for approval to close action). A revised date of June 2026 has been given to allow time to collate information/evidence etc and enact any further actions required following report to CCG.

Peer Review Out of Hours Peer Review, issued April 2023	R16. Clinicians raised concerns about the appropriateness of calls sent across from 111, which could have been closed by 111.	Consider a table top review of calls sent across by 111 deemed inappropriate	Primary Care	Chief Operating Officer	30/09/2023	30/09/2023	26/04/2023- Data gathering has continued with the recent restoration of Adastra and its concentrator. Analysis of call profiles to be undertaken and interpretations to be compared. 26/04/2023 - This reports supersedes the previous report Out of Hours Peer Review, issued November 2019. 04/12/2023 - Continues to be challenged nationally by all HBs. Professor Mark Lawrence has undertaken a survey to be published in the new year. Upwards of 60% of calls are passed as priority 1 (Emergency in general practice) however les than 1% of these maintain that level of priority following medical triage. 05/03/2024 - Regular feedback to 111 about the appropriateness of calls and disproportionately large numbers of Priority 1 calls. This is also a factor in the above action. The report by Professor Mark Lawrence has recently been shared and is being reviewed nationally. WAST are due to have a replacement for their front end Clinical Assessment programme and this will allow some changes including a change to some triage categories which may see the sensitivity reduced and less calls being categorised at Priority 1. 08/05/2024 - New system has been in place for 1 week and has seen a change in process. The data from this new system will be monitored and assessed over the next 6 months in order to determine whether it has improved the processes in place. 26/07/2024 - The new front end system is undergoing a national review and this action will be captured within the scope of this. This includes a Delphi study and we will likely close this action post publication of the study. 20/09/2024 - awaiting publication of the results of the Delphi study. However, we are still hearing anecdotally that inappropriate calls are being passed through i.e. patient is too unwell to attend or self care could be applied. We will continue to review calls and monitor progress. 16/12/2024 - we are still awaiting the Delphi publication. We also know that we have under reporting in OOH, we are encouraging more Datix reporting, so we can better understand the extent of the problem and ensure appropriate review. Revised Due Date: 31/12/2025 01/10/2025 - Feedback from clinicians around any local issues in our Health Board to be undertaken and to be fed back to CCG to approve closure of this recommendation. A form is being developed to sent out.
Welsh Risk Pool Concerns Assessment (December 2024)	R06 HDUHB to ensure all action plans and evidence of actions undertaken are uploaded to the Datix Cymru System.	Establish a process to ensure all actions associated with moderate or above concerns should be uploaded to the AMAT system and to ensure action plan is linked to the datix record.	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	31/03/2025	31/03/2025	Incorporated into process and e mail request to Assistant Directors of Nursing to ensure all action plans associated with complaints are entered into AMAT rather than separate documents for monitoring. Evidence to be linked to datix.
Welsh Risk Pool Concerns Assessment (December 2024)	R10 HDUHB to consider issuing an Inquest Policy and SOP which can provide clarity on the process to the wider organisation	To provide a supplementary SOP on inquest management to the Inquest guidance document. To be approved by Listening and Learning Sub-Committee in March 2025 and updated on policy database.	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	31/03/2025	31/03/2025	
Welsh Risk Pool Concerns Assessment (December 2024)	R11 HDUHB to utilise Datix Cymru for the management of inquests ensuring all documents are uploaded.	Review permissions, with the Hywel Dda Datix Cymru system lead, to ensure there is security in how records are accessed within the health board to maintain confidentiality and protection of witness statements and other documentation.	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	31/03/2025	31/03/2025	Quality Assurance Information System Senior Officer to provide Head of Legal Services with confirmation of staff who access the claims modules and the types of records in this module e.g. Inquests. At present the Claims team only plus the Datix Administration team have full access to the module with the exception of Court of Protection which is restricted further.

4.2

4.2 - Epilepsy in Learning Disabilities Update on Public Interest Report

Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Dana Scott (Hywel Dda UHB - Director of Midwifery & Professional Governance for Women & Children)

Attachments

4.2 PSOW Epilepsy in Learning Disabilities.pdf

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:**	Update on Progress Against PSOW Public Services of Wales (PSOW) Public Interest Report Recommendations – Learning Disabilities Epilepsy Service
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Andrew Carruthers, Chief Operating Officer
SWYDDOG ADRODD: **REPORTING OFFICER:**	Dana Scott, Director of Midwifery

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 paper provides an update to the Quality, Safety & Experience Committee (QSEC) on progress made against Recommendations issued by the Public Services Ombudsman for Wales (PSOW) in the *Public Interest Report* concerning the Learning Disabilities (LD) Epilepsy Service.

Significant work has been undertaken by the LD Epilepsy Task & Finish Group to strengthen pathway clarity, governance, external clinical assurance, and oversight of the LD epilepsy patient cohort.

Cefndir / Background

PSOW Public Interest Report

The Ombudsman's Public Interest Report (2025) identified concerns regarding pathway clarity, access to specialist support, the need for external clinical assurance, and the requirement for strengthened governance for adults with Learning Disabilities and epilepsy.

Summary of Ombudsman Recommendations

Recommendation A

Implement a clear and accessible LD Epilepsy Care Pathway, aligned to external clinical review findings, and update the Ombudsman within four months of the report.

Recommendation B

Ensure action plans include timescales and are subject to formal Board oversight.

Recommendation C

For each of the 7 complainants, provide a written apology for the lack of communication and lack of alternative provision put in place for the care of their relatives following the end of the LD Epilepsy Service

Recommendation D

Provide a comprehensive breakdown to each of the 7 complainants about the current care that is being offered to their relatives, the status of and responsibility for any ongoing monitoring/ care reviews/ risk plans, and who to contact for advice or concerns.

Recommendation E

Undertake a thorough audit of LD epilepsy patient lists to confirm:

- All have up-to-date care plans, risk assessments, and emergency medication plans.
- No patients have been missed or are awaiting neurology review without oversight.
- Board oversight is in place to ensure completion of the audit.

Asesiad / Assessment

Recommendation A – LD Epilepsy Care Pathway

- The Adults with Learning Disability and Epilepsy Pathway was **formally approved on 31 July 2025**.
- A Learning Disabilities Epilepsy Services **Task & Finish Group** was established to review and refine the Pathway following the Ombudsman's findings.
- Membership includes multidisciplinary stakeholders and, more recently **external professional representation** from a Swansea Bay University Health Board Neurology Consultant.
- A **pathway mapping workshop** took place (against the revised pathway) on **24 November 2025**, identifying ambiguous processes across Technology, Staff, Patients, Communication, Education, and Safety.
- A **driver diagram** was produced to inform improvement options.

Position: The Pathway is approved and undergoing further redesign to address learning emerging from the Public Interest Report and audit findings.

Recommendation B – Timescales and Board Oversight

- Quality Improvement and Transformation teams shared pathway review outputs with stakeholders in **December 2025** and at the Task & Finish Group on **9 January 2026**.
- An additional meeting on **12 January 2026** generated an **initial action plan with defined timelines**, overseen by the T&F Group.
- Ongoing oversight is provided through the Integrated Quality, Finance, Planning and Delivery Group (IQFPD) and through QSEC and ultimately the Board.

Position: Governance oversight and timescales are in place; further actions will mature as pathway development proceeds.

Recommendation C: Recommendation c – written apology letters

- Letters were issued on 24 November 2025, fulfilling PSOW compliance. However, feedback during the meeting in December with the Nursing & Medical Directors and Chair of the Task and Finish Group carers identified inaccuracies in some of the letter content and a requirement to strengthen review criteria and feedback mechanisms. Thus, while the recommendation is technically complete, the work is not closed, and feedback is being addressed via the Task and Finish Group.

Recommendation D – care summaries

- Care summaries were issued to all seven complainants. Work is ongoing to further refine the responsibility for ongoing monitoring/ care reviews/ risk plans aligned to pathway review work progressing via the Task and Finish Group.

Recommendation E – LD Epilepsy Patient Audit

A tri-county audit has been completed across Neurology, Community Team Learning Disabilities (CTLD) and LD Epilepsy Nursing, reconnecting with families and assessing safety and visibility of support.

Audit Findings**:**

- **154 LD epilepsy patients identified** across the three counties.
- **94%** have in-date reviews.
- All **8 overdue reviews** have planned appointments.
- **No patients lost to follow-up**.
- All patients have oversight from **Neurology, CTLD or GP**.
- Risk and emergency medication plans are either **in place or booked**.
- Oversight is provided through **IQFPD → QSEC → Board**.

The audit identified variation in waiting times across counties, with longer neurology waits evident in Carmarthenshire due to population size and historical complexity. Families reported heightened anxiety associated with delays and uncertainty.
Position: The audit requirement has been met; further analysis will be presented to QSEC in future report for assurance on equity, access, and variation.

Task & Finish Group – Ongoing Workstreams

The T&F Group continues to progress:

- Finalisation of the pathway redesign and external clinical assurance.
- Review and refinement of audit findings.
- Development of improvement actions from pathway mapping.
- Strengthened communication processes for families.
- Continued governance oversight through IQFPD, QSEC and the Board.

The Ombudsman process has supported reflective learning and reinforced a commitment to dignity, compassion, transparency and partnership.

The LD Epilepsy Task & Finish Group will continue to progress work to strengthen the current pathway and ensure that compliance with the organisations response to the recommendations set out in the Public Interest Report is continuously strengthened. The T&F Group will utilise the Risks, Assumptions, Issues, Dependencies (RAID) tool to give structured oversight of the

workstreams. Work has also progressed aligned to a thematic analysis of complaints received on cessation of the service in 2021 to identify cross cutting themes and address feedback received from service users i.e. access delays, Specialist Nurse Capacity, Workforce constrains, loss of Specialist LD- Epilepsy Clinic, communication and pathway confusions, risk and safety concerns.

A clinical Accountability Map has been developed to define the balance of responsibility between **Neurology**, **CTLD clinicians**, **LD Epilepsy Nurse Specialist**, **General Practitioner (GP)**, and **carers**, to ensure clear escalation routes for seizure deterioration or Sudden Unexpected Death in Epilepsy (SUDEP) risk, set out "who does what" when families are unsure whom to contact and to provide assurance that ambiguity has been removed.

Clinical Accountability Map (LD) Epilepsy Care

Clinical function	Responsible Service	Further Detail / Clarification
Annual epilepsy care review	CTLD Nursing	Planned annually; may be joint with LD Epilepsy Nurse Specialist for complex needs.
Early review triggered by change in seizure pattern	CTLD Nursing / LD Epilepsy Nurse Specialist	Triggered by family, GP, Emergency Department (ED), community teams or neurology; triaged same week.
Neurology review (consultant-led)	Neurology	Outpatient or PIFU model; only undertaken when specialist input is required.
SUDEP risk assessment	CTLD Nursing / LD Epilepsy Nurse Specialist with Neurology oversight	Completed annually and at any change in presentation.
Rescue medication governance (prescribing, training, review)	CTLD Nursing (competency), Pharmacy (accuracy), GP/Neurology (prescribing)	Annual competency check required; rescue pathways must be family friendly.
Best Interest MDT participation	CTLD MDT + LD Epilepsy Nurse Specialist	LDENS input essential for epilepsy-related decisions; CTLD nurses attend when broader LD care involved.
Crisis or urgent deterioration pathway	LD Epilepsy Nurse Specialist, Neurology/ ED	Clear escalation route required in pathway redesign

Work is also progressing in relation to the workforce requirement to stabilise the LD Epilepsy Service linked to capacity and demand modelling, also the development of a 'Carer Feedback Loop & Communication Protocol' is progressing to ensure families receive clear information and can raise questions safely.

It is recognised that the LD epilepsy service faces continued systemic risks, but the issues are known, documented, and now consolidated into a single improvement programme. This improvement programme is not simply a response to regulatory recommendations; it is a commitment to providing equitable, safe and compassionate care for some of our most vulnerable patients. By strengthening our pathway, clarifying clinical responsibilities, improving

communication and stabilising our workforce, we will rebuild trust and create a sustainable epilepsy service that meets the needs of people with learning disabilities and their families.

The LD Epilepsy Task & Finish Group will continue to report into Formal Executive Team.

Argymhelliad / Recommendation

The Quality Safety and Experience Committee is asked to:

- **Take assurance** on the progress made against Recommendations thus far.
- **Acknowledge the continued work** of the LD Epilepsy Task & Finish Group.
- **Receive a further update** at a future meeting for full assurance on equity, access and variation.

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:	
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	Not Applicable
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	3. Great 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:	
Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	LD Epilepsy Task & Finish (T&F) Group

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

5

20 Mins

5 - Sub Committee and Group Updates

5.1

5.1 - Estates and Facilities Clinical Care Group

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

Attachments

5.1 EF CCG report QSEC 12.02.26 Final.pdf

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

5.2

5.2 - Listening and Learning Sub Committee and Terms of Reference for Review

Mark Henwood (Hywel Dda UHB - Executive Medical Director), Louise O'Connor (Hywel Dda Health Board - Assistant Director)

Attachments

LLSC 3As report January 2026.pdf

LLSC TORs for approval.pdf

ADRODDIAD DIWEDDARU'R PWYLLGOR/

SUB-COMMITTEE UPDATE REPORT

LISTENING AND LEARNING SUB-COMMITTEE

Date of last meeting/ Dyddiad y cyfarfod diwethaf: **30 January 2026**

Quoracy/ Cworwm: The meeting was quorate

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:

The Sub-Committee convened to discuss the regulatory changes that apply to peoples experience and the management of concerns, complaints and incidents, as well as the new all Wales Accessible Communication and Information Standards.
Alert[1] (may require discussion)/ **Rhybuddio** (efallai y bydd angen trafodaeth)

- The Listening and Learning Sub-Committee had no matters of which to alert the Committee..

Advise[2] (to monitor)/ **Cynghori** (i fonitro)
The Listening and Learning Sub-Committee wishes to **advise** members of the Committee that:

- The Health Board is supporting the national oversight and implementation of the regulations led by NHS Performance and Improvement as part of the forthcoming requirements of the **Listening to People Regulations and the National Patient Safety Plan**. The revised regulations set out a new operating model for how the Health Board listens, responds to concerns and learns to prevent future harm and improve experiences. This included a mandatory offer of a listening discussion; improved redress and resolution (financial limit change from £25,000 to £50,000) requiring more complexity in investigations and decisions around qualifying liability.

  Two stages would be introduced, early resolution and proportionate investigation. Welsh Government had set a target of 40% that all complaints should be able to be resolved in the early resolution stage.

  Priorities for the organisation were: ensuring concerns could be addressed in real time and addressing queries without recourse to the complaints procedure and improving the quality of the investigation process and increasing investigation resource and capacity. Improved quality measures would need to be introduced to evidence the impact on harm reduction.
  A revised investigative approach was proposed, introducing a central patient safety hub to coordinate and risk assess across all patient safety concerns

[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*.

ensuring proportionality of approach and quality assurance. Early resolution and learning conversations would be used for low-level concerns, with facilitated reviews and after action and learning. Formal investigations reserved for significant harm, unsafe systems or where required by external scrutiny.

Assure[3] (to note)/ Sicrhau (i nodi)
Listening and Learning Committee/Sub-Committee/Group wishes to **assure** members of the Committee that:

- **The Accessible Communication and Information Standards** came into effect in 2013 and have recently been expanded by Welsh Government to include other communication needs. These revised standards need to be considered in all service provision and communication with patients, carers and the public. As part of the presentation the Sub-Committee heard a story from Rachel, who is deaf and shared her experience of receiving services from another Health Board, who failed to provide an interpreter. She described the impact that this had on her particularly when trying to give informed consent for treatment for her daughter to have surgery. The recording of a patient's communication needs is required to be entered onto systems so that these can be identified early by staff and appropriate arrangements / adjustments made.

  A number of workstreams were noted as already progressing within the higher-priority areas, including improvements to accessing concerns procedures, interpreter facilities, staff awareness and training, appointment letters, site facilities, and the establishment of a service checklist. Ongoing monitoring will also be undertaken through peoples experience feedback, particularly in relation to language and communication needs.

- The Sub-Committee received a 7-minute briefing prepared following an unexpected death in the emergency department which addressed learning in response to the department's trauma response in this case. The family in this case would be supporting the organisation with training staff.
  Several **complaints** were received around communication and equality issues and the learning identified was supported. The importance of staff training and support was emphasised.

- Two **Public Services Ombudsman reports** were received which had not been upheld however had identified some points of learning around clinical documentation and clinical thinking. This learning would be included in the Medical Director's newsletter and shared across teams.

- Two **public interest reports** relating to other health boards had been received regarding orthopaedic waiting list management. The findings would be considered in the context of Hywel Dda's orthopaedic services.

- **The Sub-Committee reviewed its terms of reference**, which are attached for consideration and approval. The Terms of Reference have been strengthened to ensure that the work of the Sub-Committee evolves from

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

identification of themes to actively ensuring that change happens and has a positive impact. The aim of the Sub-Committee was reinforced - to ensure that listening leads to learning and learning leads to safety of care and better experiences. It was recognised that every story and piece of feedback becomes an opportunity for improvement.

Review of Risks/ Adolygiad o Risgiau

- No new risks were identified at this meeting; however, a change impact assessment for the introduction of the new Listening to People Regulations would be considered at the next meeting given the significance of the change.

Recommendation/ Argymhelliad

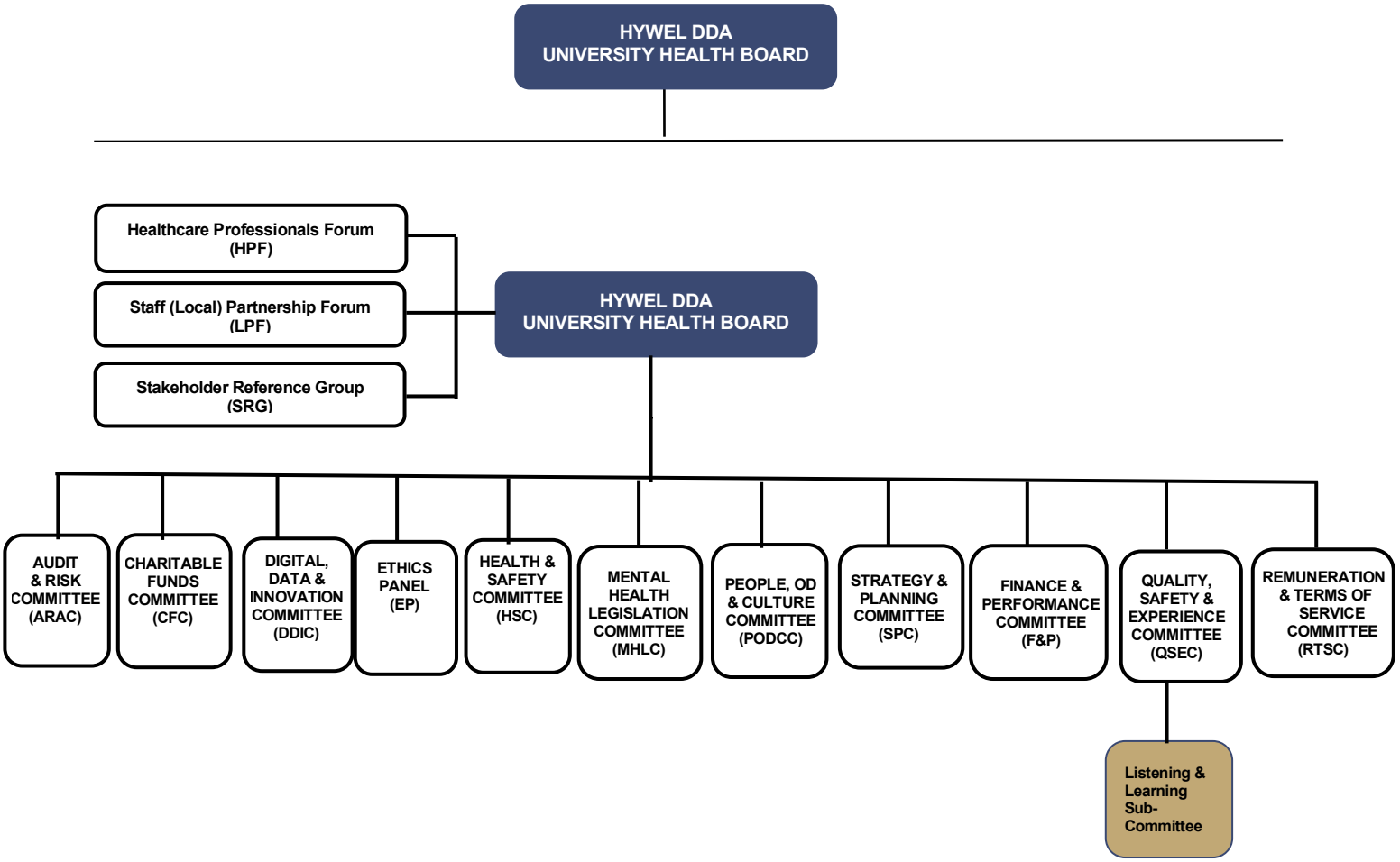
The Committee is asked to:

- Note the items the Committee is advising it of
- Take assurance from the items that the Sub Committee is providing assurance on
- Approve the LLSC terms of reference.

Date of next meeting/ Dyddiad y cyfarfod nesaf: 10 March 2026

IS-BWYLLGOR GWRANDO A DYSGU
LISTENING & LEARNING SUB-COMMITTEE

TERMS OF REFERENCE



Version	Issued to:	Date	Comments
V0.1	Listening and Learning Sub-Committee	3/6/2020	Approved
V0.1	Quality, Safety and Experience Assurance Committee	9/6/2020	Approved
V0.2	Listening and Learning Sub-Committee	7/7/2021	Approved in Principle
V0.2	Listening and Learning Sub-Committee	1/12/2021	Approved
V0.3	Quality, Safety and Experience Committee	8/2/2022	Approved
V.04	Listening and Learning Sub-Committee	4/11/2024	Approved
v.04	Quality, Safety and Experience Sub-Committee	5/12/2024	Approved
V.05	Executive Team	7/1/2026	Approved
V0.5	Listening and Learning Sub-Committee	30/1/2026	Approved
V.05	Quality, Safety and Experience Committee	12/02/2026	For Approval

1. Constitution

The Listening and Learning Sub-Committee has been established as a Sub-Committee of the Quality, Safety and Experience Committee (QSEC) and constituted from June 2020.

2. Purpose

2.1 The Sub-Committee will provide a multi-professional, cross organisational forum to identify, share and scrutinise learning from concerns and good practice. The Sub-Committee will identify opportunities to learn from, as a minimum:

- Complaints;
- Incidents and near misses;
- Inquests;
- Claims;
- Clinical Audit findings;
- People experience stories and feedback;
- Appreciative Inquiry
- Staff feedback
- Medical Examiner Review/Mortality review
- People's Experience Surveys (including staff surveys);
- Audit Wales and Internal Audit Reports;
  External reports such as Llais, Health Inspectorate Wales; Public Services Ombudsman
- Learning from national agencies or other health bodies

2.2 The Sub-Committee will also provide a forum to promote systemic change and drive innovation to ensure that best practice and areas of concern are highlighted and communicated to the responsible Executive level officer or Board Committee/Working Group.

2.3 The Sub-Committee will identify learning points and changes to practice evolving from investigation and review of concerns, identifying themes and trends arising out of this work. This will help provide the Health Board with assurance that current and emerging clinical risks are identified and robust management plans are in place.

2.4 The Sub Committee will provide leadership in the use of Appreciative Inquiry to strengthen organisational culture, to ensure learning from experience is strengths based, relationship centred and aligned to continuous improvement and system learning.-Committee -based, relationship-centred and aligned to continuous improvement and system learning.

2.5 Each member will act as a Learning Ambassador, ensuring insights from the Sub-Committee are cascaded to their teams and local feedback is brought into discussions. The Sub-Committee will move beyond identifying themes to actively tracking the journey from feedback to improvement, ensuring accountability for change. The Sub-Committee will ensure appropriate mechanisms for measuring improvement impact.

2.6 A structured follow-up cycle will monitor the impact and evidence of changes over time, reinforcing the Sub-Committee's role in embedding a culture of listening, learning, and continuous improvement across the Health Board.

2.7 The Sub-Committee will work closely with the lead officers for quality improvement, ensuring feedback on themes and areas of good practice/ areas for improvement formally align with the Health Board's quality improvement programme. Consideration will also be given to co-production or involving patients in improvement planning and shaping solutions.

2.8 The Sub-Committee will have responsibility for the oversight and effective implementation of the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations; implementation of the Listening to People Guidance; the People's Experience Framework; and the Learning from Events Framework. This will include monitoring of key performance indicators and quality metrics.

3. Key Responsibilities

3.1 Ensure that the learning from the investigation of concerns (incidents, complaints and claims, health and safety incidents) is shared with and communicated with clinical teams across the Health Board.

3.2 Ensure that people's experience informs the evaluation of known or emerging concerns or challenges with clinical services, and solutions to ensure patient safety and continuous improvement.

3.3 Embed Appreciative Inquiry as the core approach to listening, reflection and improvement, ensuring that learning is rooted in strengths, relationships and what matters most to people. Through curiosity, compassion and collaboration, the Sub-Committee promotes a culture that seeks to understand what works well, amplifies positive practice, and uses shared learning from patient and staff experiences to inform meaningful and sustainable improvement, while fostering psychological safety and collective ownership of change.

3.4 To provide a safe and open forum for peer review and support for the investigation processes and recommendations or learning arising from this work.

3.5 Identify themes and trends from feedback, external reviews and through other patient experience mechanisms such as surveys and patient stories. These will be represented by speciality, ward, clinical area, directorate and hospital.

3.5.1 The sub-committee will require data analytical support with appropriate data analysis tools to leverage data insights to inform decisions.

3.6 Request 'deep dive' reviews into any areas of concern highlighted by the review of emerging themes/trends. Escalate any immediate areas of concern to the relevant group/committee or senior staff, as appropriate.

3.7 Consider actions that have been or are proposed to be implemented following investigations into concerns and consider where actions can be shared with other services to ensure that best practice and improvements to the quality and safety of patients and learning is disseminated across the Health Board.

3.8 As part of the Health Board's Learning Framework, the sub-committee will request evidence to provide assurance to the board (and to the public and other stakeholders) of feedback to improvement. This will include evidence of sharing across the Health Board of lessons learnt and consideration of organisational wide approaches to improvement.

A structured follow-up cycle addressing the impact and evidence of changes, will enable the Sub-Committee to track the impact of changes over time, strengthening its role in embedding a culture of listening, learning, and continuous improvement across the Health Board. The feedback will also inform communications throughout the organisation about what has changed as a result and to our communities.

3.9 Receive assurance on development of lessons learnt actions plans following external review, such as PSOW; HIW; Audit, Llais, and a compliance check review process, to ensure ongoing monitoring and implementation.

3.10 Seek assurance reports from relevant partnerships, and consider the actions required in relation to any issues identified.

3.11 Any area of concern regarding lack of evidence of improvement, repeated concerns in relation to specific areas, or overdue actions will be escalated to the Quality, Safety and Experience Committee via the Sub-Committee report.

3.12 Establish and maintain a Feedback-to-Improvement Tracker, documenting actions, timelines, and evidence of impact. This will enable the Sub-Committee to demonstrate progress and provide assurance to the Board and stakeholders.

3.13 Agree issues to be escalated to Clinical Care Group and other Health Board Governance and Assurance Committees with suggestions for action.

4. Membership

4.1 The membership of the Sub-Committee shall comprise:

Title
Executive Medical Director (Chair)
Deputy Medical Director (Vice Chair)
Independent Member
Associate Medical Director Community & Integrated Medicine Care Group
Assistant Director of Nursing, Quality and Patient Experience, Community & Integrated Medicine
Associate Medical Director (Primary Care & Community)
Associate Medical Director Planned and Specialist Care
Assistant Director of Nursing Quality and Patient Experience, Planned and Specialist Care
Associate Medical Director, Mental Health and Learning Disabilities

Assistant Director of Nursing, Quality and Patient Experience, Mental Health and Learning Disabilities
Associate Medical Director (Quality and Safety)
Assistant Director (Legal Services/Patient Experience) (Lead Officer)
Assistant Director of Nursing Assurance & Safeguarding
Assistant Director of Nursing and Quality Improvement
Deputy Director, Allied Health Professions
Deputy Director, Health Science
Assistant Director of Quality, Safety and Experience, Allied Health Professions
Assistant Director of Public Health, Strategic Business and Operations
Clinical Director (Clinical Effectiveness)
Assistant Director of Business, Partnerships and Inclusion
Head of Business Partnerships and Inclusion
Head of Quality and Governance
Patient Safety and Assurance Manager
Head of Complaints and Resolution Management
Head of Legal Services/Solicitor (or Deputy)
Head of Patient Experience
Head of Health, Safety & Security
Head of Value Based Health Care
Head of Culture and Workforce Experience
Head of Clinical Effectiveness
Workforce & OD – Relationship Management Team
Clinical Leads (appropriate agenda items)
Head of Engagement and Transformation

4.2 Officers, and external stakeholders will be invited on an ad hoc basis according to the agenda.

4.3 Members are expected to:

- Actively share learning within their teams and care groups.
- Bring local feedback and insights to Sub-Committee discussions.
- Support the structured follow-up cycle by providing evidence of implemented changes.
- Take responsibility for ensuring organisational wide sharing.

4.4 Membership of the Sub-Committee will be reviewed on an annual basis.

5. Quorum and Attendance

5.1 A quorum shall consist of a minimum of 10 members, one of whom must be the Chair or Vice Chair.

5.2 An Independent Member shall attend the meeting in a scrutiny capacity.

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 Should any officer member be unavailable to attend, a nominated deputy will attend in their place subject to the agreement of the Chair, to ensure consistency in representation and feedback.

5.5 The Sub-Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of matters.

6. Agenda and Papers

6.1 The Sub-Committee Secretary is to hold an agenda setting meeting with the Chair and/or the Vice Chair, at least 6 weeks before the meeting date.

6.2 The agenda will be based around the work plan and action log from previous meetings, issues emerging throughout the year and requests from Sub-Committee members or other Health Board Committees or Groups. Following approval, the agenda and timetable for papers will be circulated to all members.

6.3 All papers should have relevant sign off before being submitted to the Sub-Committee Secretary.

6.4 The agenda will be divided into two sections; the first will be the Listening Section based upon a theme. This part of the agenda will focus less on receiving written reports and will listen to patient stories and feedback, themes and issues identified, followed by discussion amongst members about learning to be taken back into directorates; opportunities for systemic learning, and service improvement with specific actions to address the learning identified. The second section will have a business focus and will receive reports from external regulators such as the Ombudsman; monitor progress and implementation of Listening to People arrangements; the Learning Framework and the People's Experience Framework.

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

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

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

7. Frequency of Meetings

7.1 The Sub-Committee will meet bi-monthly and shall agree an annual schedule of meetings. Additional meetings will be arranged as determined by the Chair of the Sub-Committee in discussion with the Sub-Committee Lead.

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

8. Accountability, Responsibility and Authority

8.1 The Sub-Committee will be accountable to the Quality, Safety and Experience Committee for its performance in exercising the functions set out in these terms of reference.

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

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

9. Reporting

9.1 The Sub-Committee through its Chair and members, shall work closely with the Clinical Care Groups Integrated Governance Committees and other sub-committees/working groups, to provide evidence of learning, assurance and emerging clinical risks to the Board through the:

9.1.1 Timely reporting of emerging trends, themes and hotspots
9.1.2 Sharing of learning from concerns and best practice

9.2 Reports should include impact metrics and evidence of improvement actions taken, not just themes identified. This will ensure transparency and demonstrate the effectiveness of learning processes.

9.3 In doing so the work of the Sub-Committee shall contribute to the integration of quality governance across the organisation, ensuring that all sources of assurance are incorporated.

9.4 The Sub-Committee may establish groups or task and finish groups to carry out focused time sensitive pieces of work based on the assessment of data and risk assessment.

9.5 The Sub-Committee Chair, supported by the Sub-Committee Secretary, shall:

9.5.1 Report formally to Quality, Safety and Experience Committee on the Sub-Committee's activities.
9.5.2 Bring any actual or emerging problems or clinical risks to the attention of the Executive Officer or operational group.

10. Secretarial Support

10.1 The Secretary shall be determined by the Lead Officer of the Sub-Committee.

11. Review Date

11.1 These terms of reference shall be reviewed on an annual basis by the Sub-Committee for approval by the Quality, Safety & Experience Committee.

6

5 Mins

6 - Policies for Approval

6.1

6.1 - Safety Alerts Policy

Caroline Burgin (Hywel Dda UHB - Patient Safety and Assurance Manager)

Attachments

6.1 Management of Safety Alert Notices SBAR.pdf

429-ManagementandDistributionofSafetyAlertsandNotices-for approval.pdf

EqIA Screening 429 - Safety Alerts Policy 14 11 25.pdf

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:	Management and Distribution of Safety Alerts and Notices Policy – review
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Sharon Daniel, Executive Director of Nursing, Quality and Patient Experience
SWYDDOG ADRODD: REPORTING OFFICER:	Caroline Burgin, Patient Safety and Assurance Manager

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 Management and Distribution of Safety Alerts and Notices Policy (the Policy) is due for review within the next 12 months and as there have been some changes in the way the Quality Assurance and Safety team are managing all Health Board Safety Alerts and Notices, a review has been undertaken in advance of the required review date. This is an update to the existing policy (429) within the Health Board and has been updated to align with current processes.

Cefndir / Background

The Policy sets out how the Health Board will fully discharge its accountabilities and obligations in respect of safety alerts by effectively managing the dissemination process and having in place suitable monitoring arrangements for ensuring that actions arising are executed in a timely manner and that in the event of deviation from the recommendations escalation measures are employed.

Asesiad / Assessment

The Health Board is committed to ensuring the health and safety of patients, staff and others and acting on safety alerts helps to achieve this. Those most vulnerable are likely to have at least one and probably multiple protected characteristics and this is likely to have relevance for the very young, old and people with disabilities. This protocol will assist in protecting the safety and welfare of patients and will have positive impact on the Human Rights of Patients.
A trawl of similar written control documents in NHS Wales and Trusts in NHS England did not identify any potential negative impacts against any protected characteristic. No complaints have been received in relation to equality, diversity or human rights in relation to predecessor policies within the Health Board.

The policy has been derived from several “best practice” examples and advice received from the Delivery Unit of the Welsh Government.

The policy is informed by the Medicines and Healthcare Products Regulatory Agency (MHRA), National Patient Safety Agency (NPSA) and NHS Estates.
Argymhelliad / Recommendation The Committee is asked to approve Policy 429 Management and Distribution of Safety Alerts and Notices.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.6 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.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	1. Safe 2. Timely 3. Effective
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply Not Applicable Not Applicable
Amcanion Strategol y BIP: UHB Strategic Objectives:	3. Great care
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	Contained in the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	Executive Director of Nursing, Quality and Patient Experience

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: **Financial / Service:**	No
Ansawdd / Gofal Claf: **Quality / Patient Care:**	No
Gweithlu: **Workforce:**	No
Risg: **Risk:**	No
Cyfreithiol: **Legal:**	No
Enw Da: **Reputational:**	No
Gyfrinachedd: **Privacy:**	No
Cydraddoldeb: **Equality:**	Equality Impact Assessment included

Management and Distribution of Safety Alerts and Notices Policy

Policy information

Policy number: *429*
Classification: Corporate
Supersedes: Previous versions
Version number: 5
Date of Equality Impact Assessment: 14.11.2025

Approval information

Approved by: Quality Safety and Experience Committee (QSEC)
Date of approval:
Date made active:
Review date:

Summary of document:
This Policy sets out how the Health Board will fully discharge its accountabilities and obligations in respect of safety alerts by effectively managing the dissemination process and having in place suitable monitoring arrangements for ensuring that actions arising are executed in a timely manner and that in the event of deviation from the recommendations escalation measures are employed

Scope:
This policy applies to all staff within the Health Board and relates to documents received by the organisation referred to as safety alerts.

For the purpose of this policy the term ‘safety alert’ will be used as a representative term for all the type of alerts as identified in section ‘types of safety alerts’ of this policy.

The policy does not replace the duty and professional accountability of staff to report any adverse incident involving a medical device, hazardous product or unsafe procedure, in line with Health Board policies and other written control documents

To be read in conjunction with:
156 - Risk Management Strategy – opens in a new tab
674 - Risk Assessment Management Procedure – opens in a new tab
010 - Health & Safety Policy – opens in a new tab
894 – Putting Things Right Policy – opens in a new tab
982 – Incident Near Miss and Hazard Reporting Policy – opens in a new tab
467 – Medical Devices Management Policy – opens in a new tab

Owning group: Quality Assurance and Safety team

Executive Director job title: Director of Nursing, Quality and Patient Experience

Reviews and updates:
1 – new policy 1.6.2015
2 - minor changes 2.12.2015
3 - full review 13.8.2020
4 - full review 13.6.2023
5 - full review

Keywords: Alert, notice, safety notice, patient safety solution

Glossary of terms

The Health Board	Hywel Dda University Health Board
Safety Alert	Generic terms which covers a number of different types of alerts and notices.
MHRA	Medicines and Healthcare Products Regulatory Agency
NRLS	National Reporting and Learning System
NWSSP	NHS Wales Shared Services Partnership Facilities Services
DH	Department of Health
AMAT	Audit Management and Tracking (software package)
LSN	Local Safety Notice

Contents

Introduction

Safety alerts are issued when there is a specific safety issue that without immediate action being taken could result in a serious or fatal injury. Safety alerts can relate to equipment, processes, procedures or substances. When a safety alert is issued action should be taken although it may not be immediate.

Policy Statement

Hywel Dda University Health Board (the Health Board) will fully discharge its accountabilities and obligations in respect of safety alerts by effectively managing the dissemination process and having in place suitable monitoring arrangements for ensuring that actions arising are executed in a timely manner and that in the event of deviation from the recommendations, escalation measures are employed.

Scope

This policy applies to all staff within the Health Board and relates to documents received by the organisation referred to as safety alerts.

For the purpose of this policy the term ‘safety alert’ will be used as a representative term for all the type of alerts as identified in section ‘types of safety alerts’ of this policy.

The policy does not replace the duty and professional accountability of staff to report any adverse incident involving a medical device, hazardous product or unsafe procedure, in line with Health Board policies and other written control documents

Aim

The aim of this policy is to ensure that the organisation responds in a timely and robust manner to any safety alert received, supported by a management system, which enables Board assurance.

Objectives

The aim will be achieved by:

- ensuring safety alerts are promptly and consistently disseminated to relevant directorates / departments / services
- ensuring appropriate corrective actions are taken to address the recommendations made within the alert within the set timeframe
- ensuring that the required governance arrangements are in place to provide the Board with the assurance.

Types of Safety Alerts Included in this Policy

A “safety alert” is a generic term which covers a number of different types of alerts and notices. The main types of safety alerts received by the Health Board are listed below:

Patient Safety Solutions issued by Welsh Government

Through analysis of reports of patient safety incidents submitted to Patient Safety Incident Management System (PSIMS) (in England), and safety information from other sources, advice has been issued to the NHS as and when issues arise. This advice is to help ensure the safety of patients and is issued directly to NHS organisations in Wales. Solutions cover a wide range of topics, from vaccines to patient identification.

Safety alerts: These require prompt action within a specified implementation date in order to address high risks/significant safety problems.

Safety notices: These are issued to ensure that organisations and all relevant healthcare staff are made aware of potential patient safety issues at the earliest opportunity. A Notice allows organisations to assess the potential for similar patient safety risks in their own areas and take immediate action. This stage ”warns‟ organisations of emerging risk. It can be issued in a timely manner, once a new risk has been identified to allow rapid dissemination of information for action.

Notices may be re-issued as an Alert if increased risk or further action is identified / required.

Safety Alerts issued by the Medicines and Healthcare Products Regulatory Agency (MHRA)

The MHRA is responsible for the regulation of medicines and medical devices and equipment used in healthcare and the investigation of harmful incidents. The MHRA also regulates blood and blood products, working with UK blood services, healthcare providers, and other relevant organisations to improve blood quality and safety.

The MHRA presently use the following forms for the distribution of safety information, these are:

Medical Device Alerts usually requires timely action in respect to the safe use and management of medical equipment and can include user information, engineering information of training information.

Medical Device Bulletins offers guidance on improved management standards in the field of medical devices. Although presented as guidance, in most cases these bulletins contain information that supports a safe system of work, of the type the HSE (in England would expect to see if enquiries were made following a serious incident.

Drug Alerts require timely action in respect to medicines products and correspond to medical device alerts.

Safety Warnings for Medicines safety information which is usually of lesser significance to that contained in Drug Alerts

The MHRA have developed the following protocols in support of their alerts dissemination to NHS staff:

- **Immediate Action:** Used in cases where there is a risk of death or serious injury and where the health Board is expected to take immediate action on the advice.
- **Action:** Used where the Health Board is expected to take action on the advice, where it is necessary to repeat warnings on long standing problems, or support or follow-up manufacturers' field modifications.
- **Update:** Used to update the Health Board about previously reported incidents or series of incidents, possibly on a topical or device group basis and where further follow-up safety information is judged to be beneficial
- **Information request:** Used to alert the Health Board about a specific issue that may become a problem and where the MHRA are requesting feedback. These alerts will be sent out with additional questions to be completed.

Safety Alerts issued by the Department of Health (DH) Estates and Facilities

These are aimed at providing a safe environment and reducing risks to patients, staff and visitors in the NHS, by managing the risk relating to non-medical equipment, engineering plant installed services and building fabric in the NHS. There are four categories:

- **Immediate Action:** Used in cases where there is a risk of death or serious injury and where the recipient is expected to take immediate action on the advice.
- **Action:** Used where the recipient is expected to take action on the advice, where it is necessary to repeat warnings on long standing problems, or to support or follow-up manufacturers' field modifications.
- **Update:** Used to update the recipient about previously reported incidents or series of incidents, possibly on a topical or device group basis, and where further follow-up safety information is judged to be beneficial.
- **Information request/notice:** Used to alert users about a specific issue that may become a problem and where NHS Estates are requesting feedback. These alerts will be sent out with additional questions to be completed.

Safety Alerts issued by the NHS Wales Shared Services Partnership (Facilities Services) (previously Welsh Health Estates)

NHS Wales Shared Services Partnership (NWSSP) is committed to promoting and facilitating the delivery of high standards in patient care in Wales through the built environment.

Other types of safety alerts include the following;

- Pharmaceutical Alerts
- Product recalls
- Field Safety Notices

Pharmaceutical Alerts allow practitioners to keep up to date with changes affecting their practice, including drug news, safety updates, drug alerts, legislative changes and new guidance or standards.

6.5.2 **Field Safety Notices** are the principal means by which manufacturers of medical devices communicate safety information to consumers of their products. These notices provide an early warning to consumers that a product may not be fit for purpose and hence sound distribution of these notices by the health board is imperative.

The list is not exhaustive and from time-to-time other safety alerts may be received which require an equivalent response by the Health Board.

Safety Alerts Principles: external information

This refers to safety information coming into the organisation, for example from Welsh Government.

Safety Alerts Process

The Health Board has a duty to disseminate safety alerts throughout the organisation and to ensure that appropriate action is taken in order to minimise risk to staff and patients. This is shown in the flowchart of process in Appendix 1.

Receipt of Alerts

All safety alerts will be received via the Quality Assurance and Safety Team, using by e-mail HDD.Alerts@wales.nhs.uk and will be recorded on a central database.

As an additional safeguard the Quality Assurance and Safety Team will periodically check the Public Health Alerts/Contacts web site for all safety alerts issued within NHS Wales to ensure that none have been missed.

Safety alerts are occasionally received independently by individual members of staff e.g. the Medical Director. Any member of staff receiving a safety alert **must** inform the Quality Assurance and Safety Team, through the email address HDD.Alerts@wales.nhs.uk address, to ensure that the team are aware of the safety alert and that appropriate action can be taken.

Initial Distribution

The Quality Assurance and Safety Team will monitor the alerts email box for newly issued safety alerts. The Quality Assurance and Safety Team will email the safety alert to an agreed Nominated Health Board Safety Alerts Lead for action.

The safety alert will also shared on the SharePoint Safety Alerts and Notices page – opens in a new tab - (unless advised otherwise by the Nominated Health Board Safety Alerts Lead).

Nominated Health Board Safety Alerts Leads

The Nominated Health Board Safety Leads (Safety Alert Leads) will support the procedure by providing guidance and instruction. The Safety Alerts Leads are detailed below:

Issuing Authority	Safety Alert	Nominated Health Board Safety Alerts Leads
Welsh Government	Patient Safety Alert	Head of Quality and Governance
	Patient Safety Notice	Head of Quality and Governance
MHRA	Medical Device Alerts	Head of Clinical Engineering
	Medical Device Bulletins	Head of Clinical Engineering
	Drug Alerts	Clinical Director of Pharmacy and Medicines Management
	Safety Warnings for Medicines	Clinical Director of Pharmacy and Medicines Management
Department of Health	Estates and Facilities	Director of Estates, Facilities and Capital Management
NWSSP Facilities Services	Estates and Facilities	Director of Estates, Facilities and Capital Management
Royal Pharmaceutical Society or drug companies	Pharmaceutical Alerts	Clinical Director of Pharmacy and Medicines Management
Medical Device companies	Product recalls / Manufacturer Field Safety Notices	Head of Clinical Engineering,

Safety Alerts Principles: internal information

This refers to information which has become known within the organisation as a result of local incidents and near misses.

Reporting of incidents and near misses

All staff must follow the Health Board 982 Incident, Near Miss and Hazard Reporting Policy (opens in a new tab) involving:

- Medical equipment and supplies. This includes medical devices, laboratory equipment and medical supplies

- Estates equipment, including engineering plant, installed services, piped medical gas and gas scavenging system, buildings, building fabrics and vehicles.

The member of staff reporting an incident or near miss relating to a medical device must ensure that the equipment is secured. The equipment should not be returned to the manufacturer without consent to do so from the Head of Clinical Engineering. Refer to the relevant section of Policy 467 – Medical Devices Management Policy. (opens in a new tab).

The Health Board has a duty to review incidents or near misses as described above.

Sharing of Learning (external)

Where appropriate, such incidents or near misses will be reported to the relevant agency e.g. Welsh Government, MHRA etc. The relevant technical and/or specialist managers will be responsible for making the appropriate report to the relevant agency, and will make a record of the report on the relevant Datix record.

Sharing of Learning (internal)

Local Safety Notices (LSNs) are created and distributed within the Health Board for the purpose of disseminating important safety information to users without delay. These may be followed up by formal issue of a safety alert to an external government authority or agency such as the MHRA. The principal distribution mechanism for LSNs is the Health Board's intranet site although this is usually supported by the use of targeted email distribution of the notice to staff known to have an interest. LSNs should be given the same priority as externally issued notices as they might contain the earliest safety information to be available on a particular issue.

Roles and Responsibilities

Chief Executive

The Chief Executive has overall responsibility for the management of safety alerts and for ensuring that information relating to patient and staff safety is acted upon. For the practical operation of the system, and due to the wide range of alerts received by the Health Board, the Chief Executive has allocated oversight of this process to the Director of Nursing, Quality and Patient Experience.

Director of Nursing, Quality and Patient Experience

Executive responsibility for risk matters, including robustly distributing and monitoring safety alerts, is delegated by the Chief Executive to the Director of Nursing, Quality and Patient Experience.

Quality Assurance and Safety Team

The Quality Assurance and Safety Team will, upon receipt of a safety alert:

1. Log the Safety Alert on the central management system (Database and AMaT system)

2. Email all the relevant Nominated Health Board Safety Alerts Lead(s)
3. The email will advise Nominated Health Board Safety Alerts Lead of the deadline date for return, and will carry a reminder flag on the deadline date. The email will also have attached a link to the safety alert record on the central management system (AMaT) where the required action will be recorded.
4. Email the Health Board Communication Team / load to the Sharepoint page for the safety alert to be included in the internal communication, *Hywel Dda Heddiw/Today/ Viva Engage* and on the intranet page under *Report Somethingf/Safety Alerts and Notices* (unless advised otherwise by the Nominated Health Board Safety Alerts Lead).
5. Monitor the management system (AMaT) for updates provided by the Nominated Health Board Safety Alerts Lead. Where details of actions undertaken have not been captured on the central management system (AMaT) a reminder will be sent by the Quality Assurance and Safety Team to the Nominated Health Board Safety Alerts Lead. Escalation for continued non-action will be to the relevant Director.

Thereafter, the Quality Assurance and Safety Team will ensure the following actions will be undertaken:

6. Attach any email or other evidence to the appropriate safety alerts record within the central management system (AMaT) if required.
7. Compile a final compliance report which will be posted on the alerts intranet page.
8. Prepare a compliance report for presentation to the Operational Quality Safety and Experience Sub Committee.
9. Work with Safety Alerts Leads and subject experts to develop LSNs

Nominated Health Board Safety Alerts Leads

The Nominated Health Board Safety Alerts Lead(s) will receive all relevant safety alerts (see Safety alerts and notices) and will have a responsibility to:

1. Provide appropriate guidance or instruction, such as reports or position statements in relation to the content of each individual safety alert received within seven working days
2. Assess if action is required in accordance with the alert
3. Distribute, where appropriate, relevant safety alerts to the relevant General Manager(s) for action within their area of responsibility, requesting that confirmation is received that there is compliance with the safety alert.
4. Where a safety alert requires a written control document review or development of a new written control document, ensure that the relevant organisational lead is aware of this requirement and takes appropriate action. The Chair of the Clinical Written Control Document Group should be copied into the correspondence.
5. Ensure that the required actions are completed by the due date and that a record of actions is recorded on the central management system (AMaT), along with any evidence of compliance
6. If the Health Board is unable to comply with the safety alert by the required date, ensure that a non-compliance form is completed and returned to the Quality Assurance and Safety Team. The non-compliance form must indicate:
    a. The reason(s) why the Health Board is unable to comply with the alert
    b. The actions being taken to achieve compliance
    c. The date that non-compliance was entered onto the Health Board risk register
    d. The estimated date that the Health Board will be compliant with the alert.

7. Report areas of non-compliance to safety alerts to the appropriate sub-committee or group
8. Support the Quality Assurance and Safety Team with preparation of the report on compliance to Operational Quality Safety and Experience Sub Committee
9. Ensure that relevant incidents are reported to the relevant agency e.g. Welsh Government, MHRA etc. and that a record of the report is captured on the relevant AMaT record
10. Work with the Quality Assurance and Safety Team to develop LSNs.

Depending on the nature and content of the safety alert, a co-ordinated approach may be required to provide advice and appropriate documentation, such as risk assessments, throughout the Health Board. In this situation, the safety alerts lead will inform the responsible General Managers and will arrange a meeting of the parties, in order to provide a co-ordinated and integrated response to the safety alert.

General Managers

General Managers (directorate and site) will receive, from the Safety Alerts Lead, a copy of relevant safety alerts. The General Manager will play a key role in ensuring appropriate dissemination of the safety alert and the action to be taken. Dissemination will include to Heads of Department and Ward Managers

The General Manager may identify, from within their area of responsibility, a nominated person to action the safety alert; however, the General Manager will retain the responsibility for action within their area of responsibility. Where the General Manager is unable, or believes it would be inappropriate, to implement certain actions, this should be recorded in the safety alerts return. These returns will be captured on the central database (AMaT) for reporting to Quality, Safety and Experience Committee. Non-compliance with an alerts should also be discussed and recorded at the Directorate Quality and Safety Group

Heads of Department and Ward Managers

Heads of Department and Ward Managers will:

- Read carefully each safety alert they receive
- Respond to safety alert emails without delay, particularly when responses are required within a specific timescale.
- Note that response times notified will vary according to the urgency of the action required and read receipts will be requested when emails are sent
- Ensure that safety alerts relating to their area are easily accessible to all staff and that staff are made aware of the safety alert.
- Where bank staff, agency staff or staff from other areas are working in a particular location, safety alerts directly relating to patient safety and/or relevant equipment, must be highlighted.

All Staff

All staff have a duty to read the safety alerts they receive and implement measures introduced in response to safety alert.

Any member of staff independently receiving any type of 'safety alert', such as a manufacturer's safety sheet issued directly to the member of staff, should forward the safety alert to the Quality Assurance and Safety Team, through the email address HDD.Alerts@wales.nhs.uk address, and seek appropriate advice before the formal distribution procedure is initiated.

Governance Framework: Scrutiny and Assurance on behalf of the Board

The Health Board must ensure that areas of non-compliance with safety alerts are monitored and reported to the appropriate Committee of the Board and / or Sub-Committee including any mitigation to manage the risk. The Health Board must have a robust system in place to assure themselves that progress is being achieved against compliance with solutions.

Quality, Safety and Experience Committee

The Quality, Safety and Experience Committee will receive regular reports detailing compliance against safety alerts and exception reports where necessary. The Committee will be accountable for advising the Quality, Safety and Experience Assurance Committee of any clinical, financial or other risk to the organisation related to safety alerts.

The Quality, Safety and Experience Committee will be supported by formally groups who carry out on its behalf specific aspects of Committee business, for example the Medical Devices Group.

Clinical Care Group Quality, Safety and Experience Groups

Directorates and departments must ensure compliance against safety alerts. Relevant safety alerts should be received at the Clinical Care Group's quality, safety and experience group.

When a directorate or department is unable to attain compliance with a safety alert, the safety alert should be formally discussed at the directorate quality, safety and experience group and any areas of concern discussed. A risk assessment must be undertaken and entered onto the Directorate risk register by the General Manager or the departmental risk register by the Departmental Manager.

The Directorate must report non-compliance and mitigations to the Quality, Safety and Experience Committee.

Directorate Written Control Documentation Groups

Directorate written control documentation groups will be responsible for ensuring written control documents consider relevant safety alerts in the development of new written control documents and also ensure that existing written control documents are reviewed when a new safety alert is published.

Clinical Written Control Documentation Group

The clinical written control documentation group will assure itself that relevant safety alerts have been considered when new written control documents are developed or when existing written control documents are reviewed.

Storage and Retention of Safety Alerts

All safety alerts and supporting technical guidance and instruction will be available on the intranet Safety alerts and notices (opens in a new tab)

A list of all Patient Safety Solutions can be found at http://www.patientsafety.wales.nhs.uk/safety-solutions (opens in a new tab)

All MHRA safety alerts can be found at https://www.gov.uk/drug-device-alerts (opens in a new tab)

All Royal Pharmaceutical Society alerts can be found https://www.rpharms.com/publications/pharmacy-alerts/ (opens in a new tab)

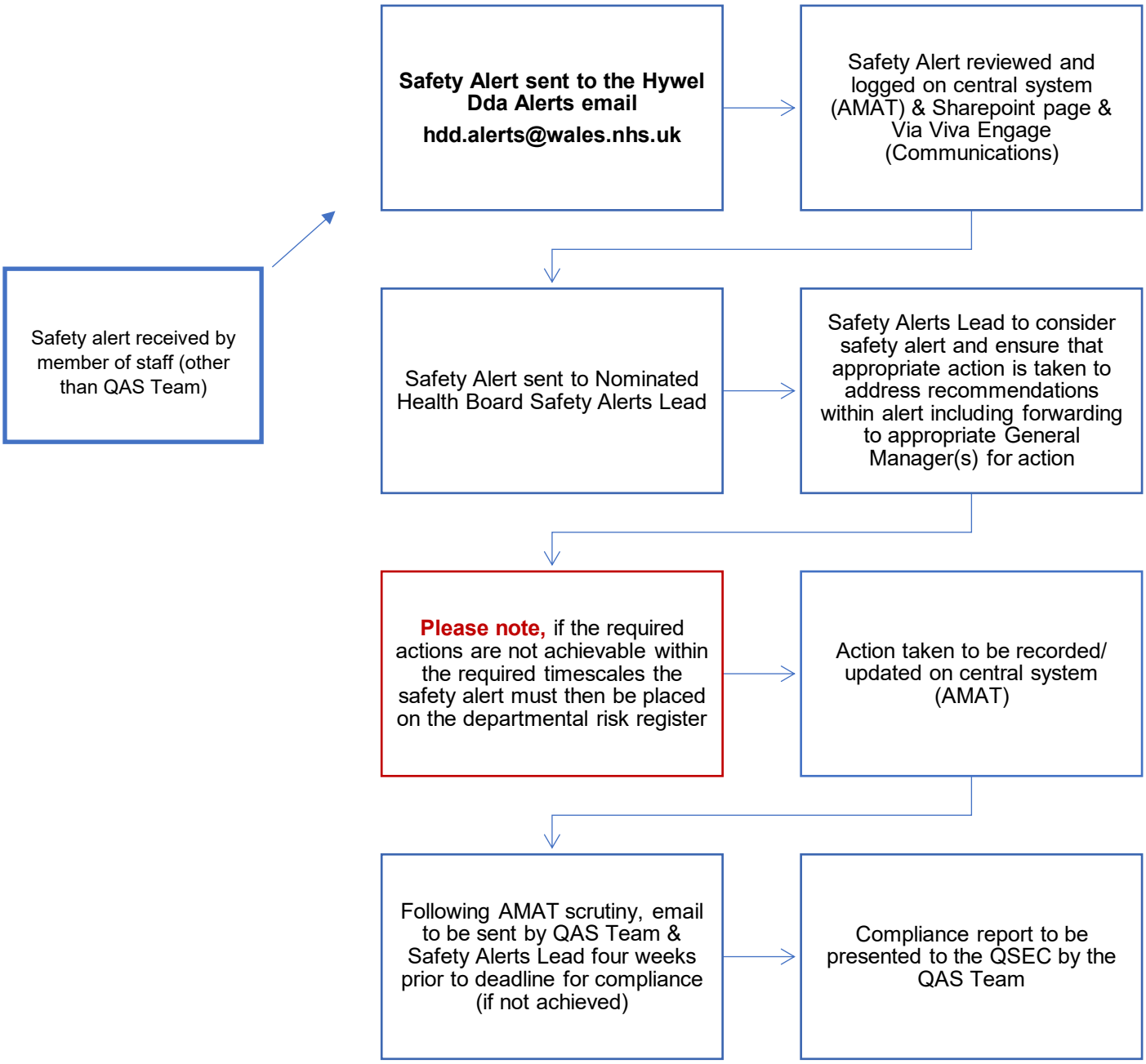
The Quality Assurance and Safety Team will store the original safety alert and all responses received from the Nominated Health Board Safety Alerts Leads

References

NHS Executive (2023) NHS Executive Policy on Patient Safety Incident Reporting and Management (issued via WHC/2023/017)

Welsh Government (2014) Guidance on NHS Wales Patient Safety Solutions

Appendix 1: Safety Alerts Flowchart



Equality Impact Assessment (EqIA) Screening Template

When to complete an EqIA Screening

An EqIA Screening Template must be completed when reviewing, changing and developing procedures/ proposals/ projects/ policies. This is a first step and is used to consider whether there are any negative impacts that may arise.

Purpose of an EqIA Screening Template

The purpose of this short exercise is to ensure that you have shown appropriate due regard when considering the impact for people with protected characteristics in your decision making. The screening process is designed to help you consider the circumstances and to inform evidence-based decisions.

If the proposal is of a significant nature and it is apparent from the outset that a full EqIA will be required, then it is not necessary to complete this Screening Template, you can proceed to complete the full EqIA.

If no negative impacts are identified following completion of the EqIA screening then it is not necessary to undertake a full EqIA however, the decision and justification must be clearly recorded in this document.

On completion of the Screening Template:

- Ensure that all the white boxes within the screening are completed.
- Ensure that the Procedure/ Project/ Proposal/ Policy owner has signed and dated the Screening Template.
- Send a copy of the completed template along with the related policy or project proposal to Inclusion.hdd@wales.nhs.uk for the Diversity & Inclusion Team to review.
- Each Screening Template will be reviewed by the Diversity & Inclusion Team and feedback will be provided to the Procedure/ Project/ Proposal/ Policy owner. This may include recommendations for further action to inform robust decision-making.

Support

For further support please visit the EqIA Sharepoint or contact:
Email: Inclusion.hdd@wales.nhs.uk
Tel: 01554 899055

Director and Directorate	Sharon Daniel Executive Director of Nursing, Quality and Experience / Nursing Directorate
Service Area	Quality Assurance and Safety team

Title of Procedure, Project, Proposal, Policy being screened:	429 - Management and Distribution of Safety Alerts and Notices

Description of the Procedure/ Project/ Proposal/ Policy being screened (including key aims and objectives)

This is an update to the existing policy within the Health Board (429) and this and has been amended to bring it up to date and align to current process.

The aim of this policy is to ensure that the organisation responds in a timely and robust manner to any safety alert received, supported by a management system, which enables Board assurance.

Objectives

The aim will be achieved by:

- ensuring safety alerts are promptly and consistently disseminated to relevant directorates / departments / services
- ensuring appropriate corrective actions are taken to address the recommendations made within the alert within the set timeframe
- ensuring that the required governance arrangements are in place to provide the Board with the assurance.

Evidence considered (including staff and population data, relevant research, expert and community knowledge etc.)

Hywel Dda Health Board is committed to ensuring the health and safety of patients, staff and others; action on safety alerts helps to achieve this. Those most vulnerable are likely to have at least one and probably multiple protected characteristics and this is likely to have particular relevance for the very young, old and people with disabilities. This protocol will assist in protecting the safety and welfare of patients and so has a positive impact on the Human Rights of Patients.

A trawl of similar written control documents in NHS Wales and Trusts in NHS England did not identify any potential negative impacts against any protected characteristic. No complaints have been received in relation to equality, diversity or human rights in relation to predecessor policies within the HB.

The policy has been derived from a number of “best practice” examples and advice received from the Delivery Unit of the Welsh Government.

This procedure is informed by the Medicines and Healthcare Products Regulatory Agency (MHRA), National Patient Safety Agency (NPSA) and NHS Estates

References
NHS Executive (2023) NHS Executive Policy on Patient Safety Incident Reporting and Management (issued via WHC/2023/017)
Welsh Government (2014) Guidance on NHS Wales Patient Safety Solutions

This is an existing Health Board policy (429) and amendments have been made to bring it up to date and align it to current process. There is no negative impact identified relating to any of the protected characteristics.

Assess which protected characteristics will potentially be affected by the proposal in the table below (please ✓ the relevant box to confirm positive, negative or no impact)**.**

If at any point a negative impact has been identified (actual or potential), you do not need to proceed with the completion of this form, as a full EqIA must be undertaken: Equality Impact Assessments (EqIAs) (sharepoint.com)

Age Is it likely to affect older and younger people in different ways or affect one age group and not another?					
Positive Impact		Negative Impact		No Impact	✓
Justification of impact identified: This is an existing Health Board policy, and has been amended to bring it up to date and align with process. There haven't been any complaints in respect of any protected group since it's creation.					
Disability Is it likely to affect those with a physical disability, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes?					
Positive Impact		Negative Impact		No Impact	✓
Justification of impact identified: This is an existing Health Board policy, and has been amended to bring it up to date and align with process. There haven't been any complaints in respect of any protected group since it's creation.					
Gender Reassignment Is it likely to affect those who either: • Have undergone, intend to undergo or are currently undergoing gender reassignment. • Do not intend to undergo medical treatment but wish to live in a different gender from their gender at birth					
Positive Impact		Negative Impact		No Impact	✓
Justification of impact identified: This is an existing Health Board policy, and has been amended to bring it up to date and align with process. There haven't been any complaints in respect of any protected group since it's creation.					
Marriage / Civil Partnership Under the Equality Act, the characteristic of Marriage and Civil Partnerships is only protected in the workplace/ employment. Is it likely to affect those who are married or in a Civil Partnership? This means someone who is legally married or in a civil partnership.					
Positive Impact		Negative Impact		No Impact	✓

Justification of impact identified: This is an existing Health Board policy, and has been amended to bring it up to date and align with process. There haven't been any complaints in respect of any protected group since it's creation.

Pregnancy and Maternity
Is it likely to affect those who are pregnant or have recently had a baby? Maternity covers the period of 26 weeks after having a baby, whether or not they are on Maternity Leave.

Positive Impact		Negative Impact		No Impact	✓

Justification of impact identified: This is an existing Health Board policy, and has been amended to bring it up to date and align with process. There haven't been any complaints in respect of any protected group since it's creation.

Race / Ethnicity
Is it likely to affect people of a different race, nationality, colour, culture or ethnic origin including non-English / Welsh speakers, Gypsies/Travellers, asylum seekers and migrant workers?

Positive Impact		Negative Impact		No Impact	✓

Justification of impact identified: This is an existing Health Board policy, and has been amended to bring it up to date and align with process. There haven't been any complaints in respect of any protected group since it's creation.

Religion or Belief
Is it likely to affect people who have a religion or belief? The term 'religion' includes a religious or philosophical belief.

Positive Impact		Negative Impact		No Impact	✓

Justification of impact identified: This is an existing Health Board policy, and has been amended to bring it up to date and align with process. There haven't been any complaints in respect of any protected group since it's creation.

Sex
Is it likely to affect people who are mostly male or female. Where it applies to both equally does it affect one differently to the other?

Positive Impact		Negative Impact		No Impact	✓

Justification of impact identified: This is an existing Health Board policy, and has been amended to bring it up to date and align with process. There haven't been any complaints in respect of any protected group since it's creation.

Sexual Orientation
Whether a person's sexual attraction is towards their own sex, the opposite sex or either.

Positive Impact		Negative Impact		No Impact	✓

Justification of impact identified: This is an existing Health Board policy, and has been amended to bring it up to date and align with process. There haven't been any complaints in respect of any protected group since it's creation.

Armed Forces Community
Consider whether this impacts on members of the Armed Forces and their families, whose health needs may be impacted long after they have left the Armed Forces and returned to civilian life. Also consider their unique experiences when accessing and using day-to-day public and private services compared to the general population. It could be through 'unfamiliarity with civilian life, or frequent moves around the country and the subsequent difficulties in maintaining support networks, for example, members of the Armed Forces can find accessing such goods and services challenging.'

For a comprehensive guide to the Armed Forces Covenant Duty and supporting resource please see: **Armed-Forces-Covenant-duty-statutory-guidance**					
Positive Impact		Negative Impact		No Impact	✓
Justification of impact identified: This is an existing Health Board policy, and has been amended to bring it up to date and align with process. There haven't been any complaints in respect of any protected group since it's creation.					
Socio Economic Duty Consider those on low income, economically inactive, unemployed or unable to work due to ill-health. Also consider people living in areas known to exhibit poor economic and/or health indicators and individuals who are unable to access services and facilities. Food / fuel poverty and personal or household debt should also be considered. For a comprehensive guide to the Socio-Economic Duty in Wales and supporting resources please see: more-equal-wales-socio-economic-duty					
Positive Impact		Negative Impact		No Impact	✓
Justification of impact identified: This is an existing Health Board policy, and has been amended to bring it up to date and align with process. There haven't been any complaints in respect of any protected group since it's creation.					
Welsh Language Is it likely to impact on opportunities for people to use the Welsh language? The Welsh language should be treated no less favourably than the English language.					
Positive Impact		Negative Impact		No Impact	✓
Justification of impact identified: This is an existing Health Board policy, and has been amended to bring it up to date and align with process. There haven't been any complaints in respect of any protected group since it's creation.					

If a negative impact has been identified, you are not required to complete this form as a full EqIA must be undertaken. A full EqIA template and guidance can be found on the following link: Equality Impact Assessments (EqIAs) (sharepoint.com)

Screening Completed by:	Name	Caroline Burgin
	Title	Patient Safety & Assurance Manager
	Contact details	Caroline.Burgin@wales.nhs.uk
	Date	13/11/2025
Screening Authorised by: (Directorate level owner of the procedures/ proposals/ projects/ policy)	Name	Caroline Burgin
	Title	Patient Safety & Assurance Manager
	Contact details	Caroline.Burgin@wales.nhs.uk
	Date	13/11/2025
Guidance has been provided by Diversity & Inclusion Team:	Name	Alan Winter
	Title	Senior Diversity & Inclusion Officer
	Contact details	Alan.winter@wales.nhs.uk
	Date	14/11/2025
Diversity and Inclusion Team additional Comments:		

Please note: The D&I team will save a copy of the completed form for reference. If any changes are made after the date of review, it is the directorate's responsibility to update the EqIA and inform the D&I team.

7

7 - For Information

7.1

7.1 - QSEC Work Plan 2026-27

Attachments

Draft QSEC Work Programme 2026 27.pdf

QUALITY SAFETY & EXPERIENCE COMMITTEE WORK SCHEDULE APRIL 2026– MARCH 2027

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 2026 – March 2027.

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2026	11 June 2026	11 August 2026	9 October 2026	3 December 2026	9 February 2027
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**						✓
Assurance and Risk Report • Corporate Risks • Operational Risks • Internal and External Audit Reports • Monitoring of Ministerial Directions • Monitoring of Welsh Health Circulars (WHCs)	**Executive Leads**	**RW**	✓	✓	✓	✓	✓	✓

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2026	11 June 2026	11 August 2026	9 October 2026	3 December 2026	9 February 2027
Self-Assessment - Six month review of actions August 2026	**Chair**	**JW**			✓ update on actions			✓outcome report
Patient/Staff Story	**SD**	**LOC/ Service Leads**	✓	✓	✓	✓	✓	✓
Policies for Approval (as required)	**All**	**All**		✓	✓	✓	✓	✓
Targeted Intervention Progress Report	**SA**	**Executive Leads**	✓	✓	✓	✓	✓	✓
Assurance								
Annual Report on Committee's Activity	**AL/SD**	**All**	✓					
Annual Report from Sub-Committees	**SD**	**LOC**		✓				
A report on the impact of revised governance arrangements	**SD/ AC/ JS/ MH**		✓					
Clinical Audit Programme for Approval	**MH**	**IB**		✓ outcome from reviews				

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2026	11 June 2026	11 August 2026	9 October 2026	3 December 2026	9 February 2027
Duty of Quality Assurance Report incorporating: • 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) • WHC's overview *(every other meeting) (TI 52)*	**SD**	**CS**	✓	✓	✓	✓	✓	✓
Safeguarding Assurance Report	**SD**	**CW**		✓		✓		✓
Infection Prevention Control Report	**SD**	**RR**	✓		✓		✓	

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2026	11 June 2026	11 August 2026	9 October 2026	3 December 2026	9 February 2027
Duty of Candour Annual Report 2025/26	**SD**	**CS**		✓				
Duty of Quality Annual Report 2025/26	**SD**	**CS**			✓			
Nurse Staffing Levels (Wales) Act: Assurance Reports (as required) –Annual Report and Spring Calculation Cycle	**SD**	**HH**		✓				
Cleanliness Standards Audit report and Action Plan	**JS**	**SC/ EB**			✓			
Fuller Inquiry assurance of progress of recommendations	**JS**	**CB**	✓					
First Contact Physiotherapist Report	**JS**	**JB**	✓					
Clinical Care Group Updates								
Mental Health and Learning Disabilities	**AC**	**RTP**		✓		✓		✓
Community and Integrated Medicine	**AC**	**ACh**	✓		✓		✓	
Allied Health Services	**AC**	**SQ**	✓		✓		✓	
Planned and Specialist Care	**AC**	**PG**	✓		✓		✓	
Estates and Facilities	**JS**	**EB/ SC**		✓		✓		✓
Public Health	**AG**	**BL**		✓		✓		✓

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2026	11 June 2026	11 August 2026	9 October 2026	3 December 2026	9 February 2027
POLICIES			**EXPIRY DATE**					
1133 Service User Access Policy - Psychological Therapies	**AC**	**Andrew Homfray**	5-Mar-26 Extended whilst full review is finalised					
429 Management and Distribution of Safety Alerts and Notices Policy	**SD**	**Cathie Steele**	13-Jun-26					
004 Claims Management Policy	**SD**	**Louise O'Connor**	5-Oct-26					
894 Putting Things Right Management and Resolution of Concerns Policy (Incidents, Complaints and Claims)	**SD**	**Louise O'Connor**	5-Oct-26					
63 Use of Patient and Carers Stories Guideline	**SD**	**Louise O'Connor**	13-Feb-27					
307 Production of Patient and Carer Information Policy	**SD**	**Louise O'Connor**	21-Mar-27					
892 Incidents Near Miss and Hazard Reporting procedure	**SD**	**Cathie Steele**	31-Jul-27					
18 Inquest guidance	**SD**	**Louise O'Connor**	15-Aug-27					
309 - Continuing NHS Healthcare Operational Policy to Support Framework for Implementation	**AC**	**Tracy Devantier**	15-Aug-27					
568 Production and Use of Surveys Guideline	**SD**	**Louise O'Connor**	4-Dec-28					
Sub Committee Update Reports								
Listening and Learning:	✓	✓	✓	✓	✓	✓	✓	✓ TOR for review
For Information								

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2026	11 June 2026	11 August 2026	9 October 2026	3 December 2026	9 February 2027
HIW Annual Report	**N/A**	**N/A**					✓	
JCC Quality Safety Outcomes Sub Committee	**N/A**	**N/A**	✓	✓	✓	✓	✓	✓
Work plan 2026/27	**N/A**	**N/A**	✓	✓	✓	✓	✓	✓
Patient Experience Report	**N/A**	**N/A**	✓	✓	✓	✓	✓	✓
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 days of the meeting	**CSO**	**CSO**	✓	✓	✓	✓	✓	✓
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	**CSO**	**CSO**	✓	✓	✓	✓	✓	✓

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2026	11 June 2026	11 August 2026	9 October 2026	3 December 2026	9 February 2027
the decision tracker								
Produce written update report for Board	**CSO**	**CSO**	✓	✓	✓	✓	✓	✓
Prepare schedule of meetings	**CSO**	**CSO**					✓	
QSEC Annual Work Programme	**CSO**	**CSO**	✓	✓	✓	✓	✓	✓

Initials

SD- Sharon Daniel	CSO-Katie Lewis	MP: Marilize Preez	LOC- Louise O'Connor	MH- Mark Henwood
AC- Andrew Carruthers	BL- Bethan Lewis	CS- Cathie Steele	AG- Ardiana Gjini	JS- James Severs
HH- Helen Humphreys	SA- Shaun Ayres	MD- Mandy Davies	RW- Rachel Williams	IB: Ian Bebb
RTP- Rebecca Temple Purcell	ACh- Anna Chiffi	SC: Simon Chiffi		

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8 - Date of Next Meeting : 9 April 2026