



Operational Governance Plan Update

- Andrew Carruthers: Chief Operating Officer
- Sharon Daniel: Interim Executive Director of Nursing, Quality & Patient Experience

Quality, Safety and Experience Committee

February 2025

The purpose of this report is to provide the Quality, Safety and Experience Committee (QSEC) with an update on the Operational Governance Plan that will be effective following the introduction of the revised Operational Structure.

In congruence with the overarching aim of the Health Board's Quality Management System (QMS) strategic framework, the revised operational governance arrangements will provide a system-wide approach to achieving quality of care in a way that secures continuous improvement.

This report provides information on:

1. Progress with the operational structure Organisational Change Policy
2. Operational Governance and Performance Management Arrangements
3. Proposed Leadership Development and Organisational Development (OD) Programme
4. QMS Update
5. Self-assessment process
6. Monitoring arrangements

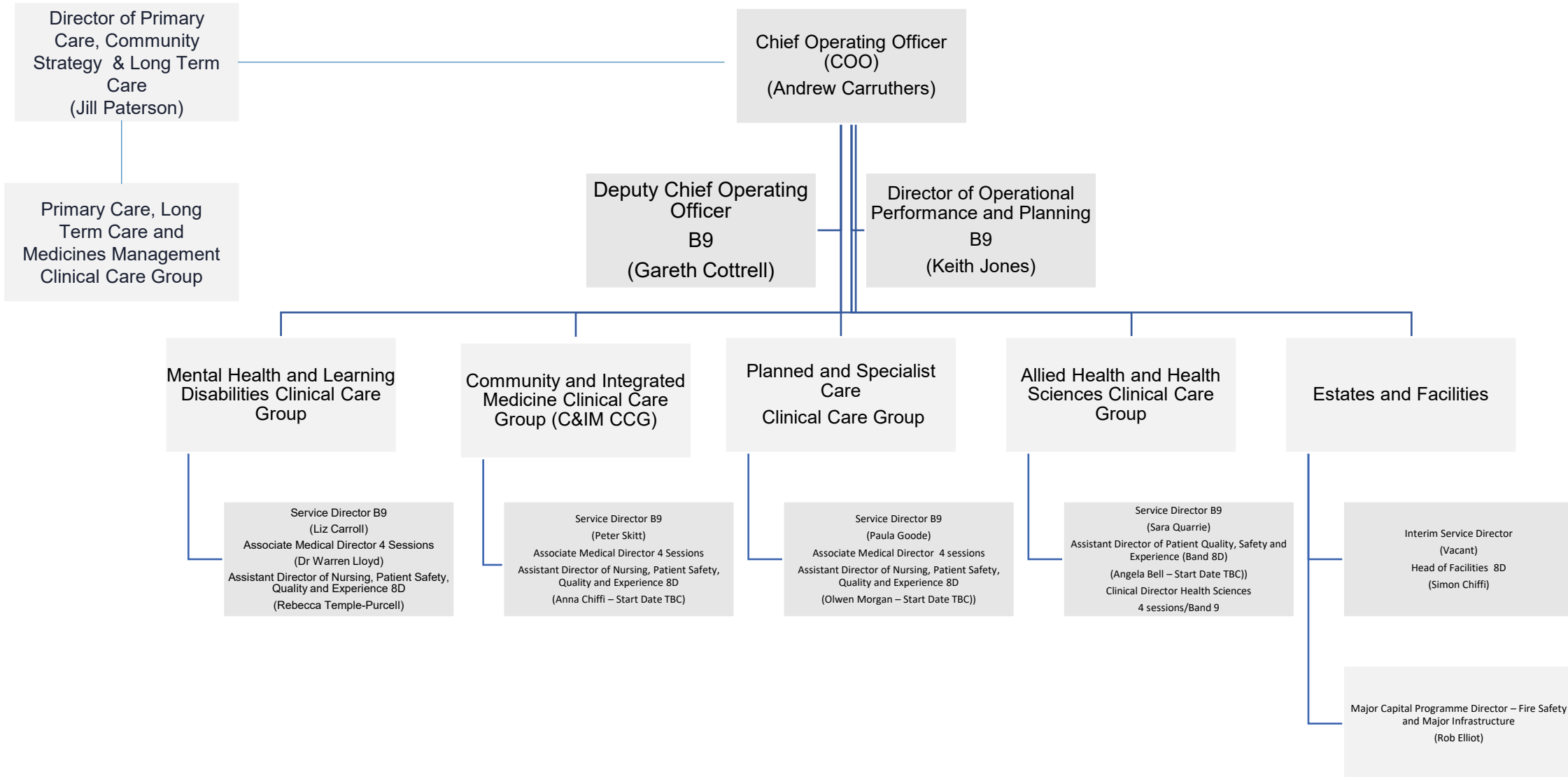


1. Operational Structure



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1. Operational Structure – Appointments Update



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- Deputy COO started 2nd December 2024
- Director of Operational Planning and Performance – proposed start end of February 2025
- C&IM CCG Service Director started December 2024
- Allied Health Profession (AHP) & Health Science (HS) and Planned & Specialist Care Clinical Care Groups (CCG) Service Directors appointed and all in post from 2nd February 2025
- Community & Intermediate Care and Specialist Care CCG Assistant Directors of Nursing, Patient Quality, Safety and Experience – appointed and agreeing start dates hoped to be in February
- AHP & HS CCG Assistant Director of Patient Quality, Safety and Experience appointed – Start date 31st March 2025
- Service Group General Manager Planned Care and Cancer appointed
- System Service Group General Manager Carmarthenshire appointed and started

11 Appointments so far through the revised Band 8C and above process!

1. Operational Structure – Next Steps

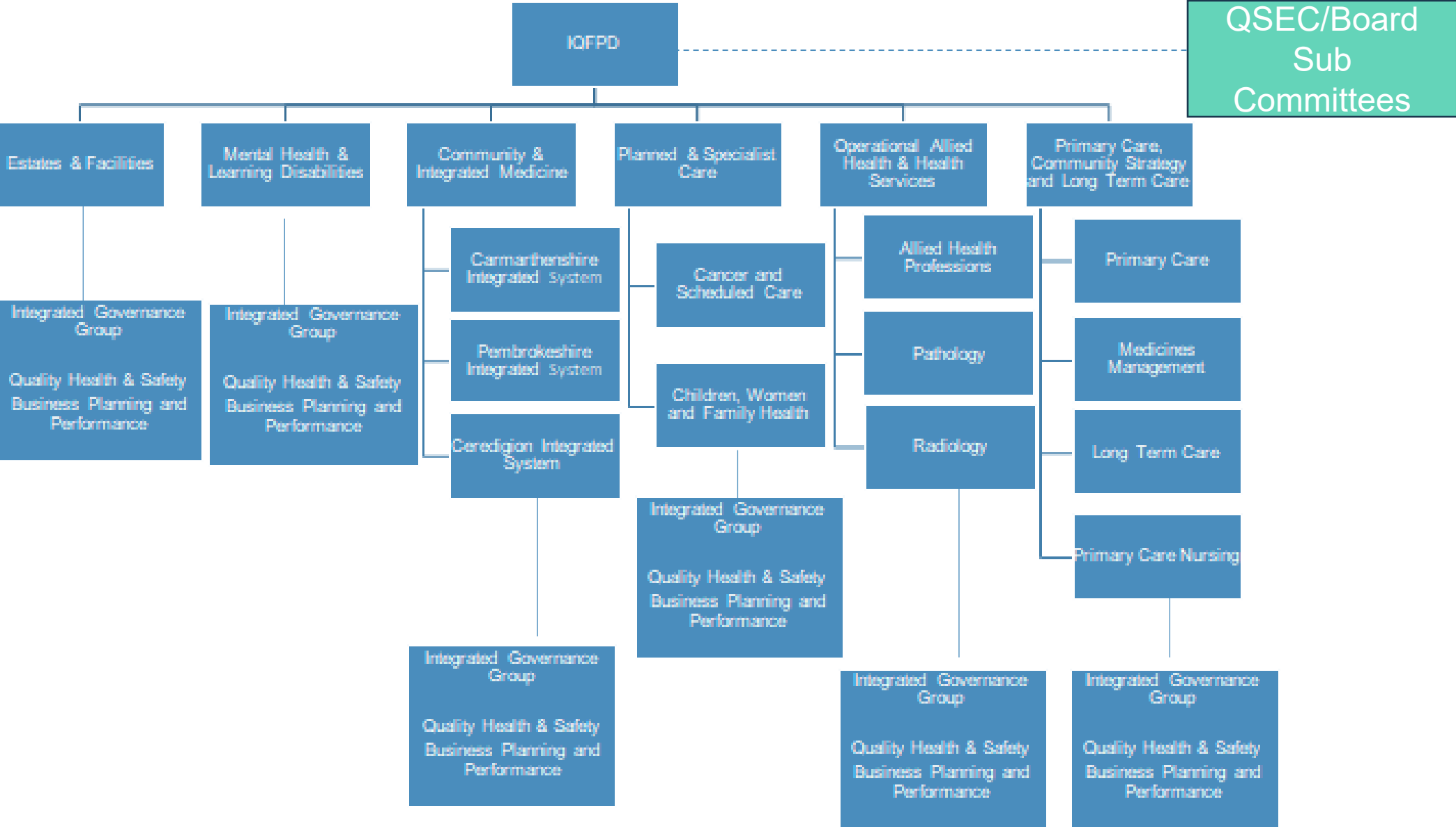


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- Remaining Service Group General Manager posts advertised externally 17th January – Closing date 29th January 2025. Interviews in February to include
 - System General Manager Pembrokeshire
 - System General Manager Ceredigion
 - Service Group General Manager – Children, Women and Family Health
- Head of Nursing (HON) restricted competition process to be run through February, led by Deputy COO.
- CCG Associate Medical Directors – to follow Medical Director Recruitment process. Timeline TBC
- Service Group Clinical Directors – to follow Associate Medical Director (AMD) process. Timeline TBC

2. Operational Governance Arrangements



3. Leadership Development and OD Programme

Design Principles



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- 1) Ensure there is a mechanism to promote pan-health board system working and prevent silo thinking at CCG level.
 - 2) Create a regular, safe space, for operational teams to debate and discuss plans to address issues and to help the COO shape the strategic direction of service delivery.
 - 3) Establish a senior leadership community that brings together operational and corporate functions to establish the delivery of the strategic service changes.
 - 4) Facilitate the creation of a space for the new senior operational leadership team to operate, learn together and lead cohesively
 - 5) Provide a protected space for collective leadership development across the system to enhance organisational performance and service delivery outcomes
- **Operational Leadership Group Activity February to June**
 - Initial Meeting in February to set out intent and get to know you
 - Proposing weekly/fortnightly masterclasses for colleagues to lead with group to set the expectation e.g. quality governance, planning etc

3. Leadership and OD Masterclasses QMS



- Quality Planning:

- Health & Care Quality Standards & Enablers
 - Leadership
 - Workforce
 - Culture
 - Information
 - Learning Improvement and Research
 - Whole System Perceptive



- Quality Control

- [Quality Control](#)
- [Our Safety Dashboard - Power BI](#)
- [Performance](#)
- [QIA-v4.0--with-new-panel-record-.xlsx](#)



- Quality Improvement

- [Quality Improvement](#)
- [Setting Improvement measures](#)
- [Concerns investigation and management](#)

4. Quality Management System



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- The Hywel Dda Quality Management System (QMS) Strategic Framework

“to provide a system-wide approach to achieving quality of care in a way that secures continuous improvement”

our “approach, structure and tools provided to empower staff to lead and deliver services that meet quality and safety expectations and standards”

- The Health and Social Care (Quality and Engagement) (Wales) Act 2020 introduces a Duty of Quality which came into force in April 2023. As a Health Board, we are required to:

“think and act differently by applying the concept of “quality” across all functions within the context of the health service and health needs of their populations.”¹

“ [have] quality-driven decision-making and planning, to ultimately deliver better outcomes for all people who require health services” ¹

- A number of diagrams have been produced to demonstrate the QMS



March 2023 – QMS draft to Board

April 2023 – WG statutory guidance¹

Improvement Cymru 2023

2023

NHS Executive Dec 2024

1. Welsh Government (2023) The [Duty of Quality Statutory Guidance](#) 2023 and Quality Standards 2023

2. NHS Wales Executive (2024) *Developing a Quality Management System*

4. Quality Management System in healthcare (Wales)



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Quality Planning

A process for leadership to annually plan and prioritise the design and redesign of processes, services and products, allocate resources and identify capacity and capability to meet population needs.

It includes:

- A relentless focus on customer need, staff wellbeing and culture informed by internal and external feedback.
- Purpose aligned to need and integrated into daily work and improvements

Quality Improvement

Standardised training and coaching approach incorporating established methodologies for continuous improvement for our populations.

It includes:

- Development of improvement skills throughout the organisation, from Board to frontline, with a small cadre of experts to support.
- Improvement designed and delivered as close to the frontline as possible by those involved with its delivery – staff, service users, family and carers.



Quality Assurance

A process to ensure that the system is operating effectively and providing quality care in line with standards, guidelines and policy.

It includes:

- Provides a clear line of sight across the organisation and identifies gaps against the purpose and customer need.
- Reviewing data retrospectively.
- Can be both internal and external.

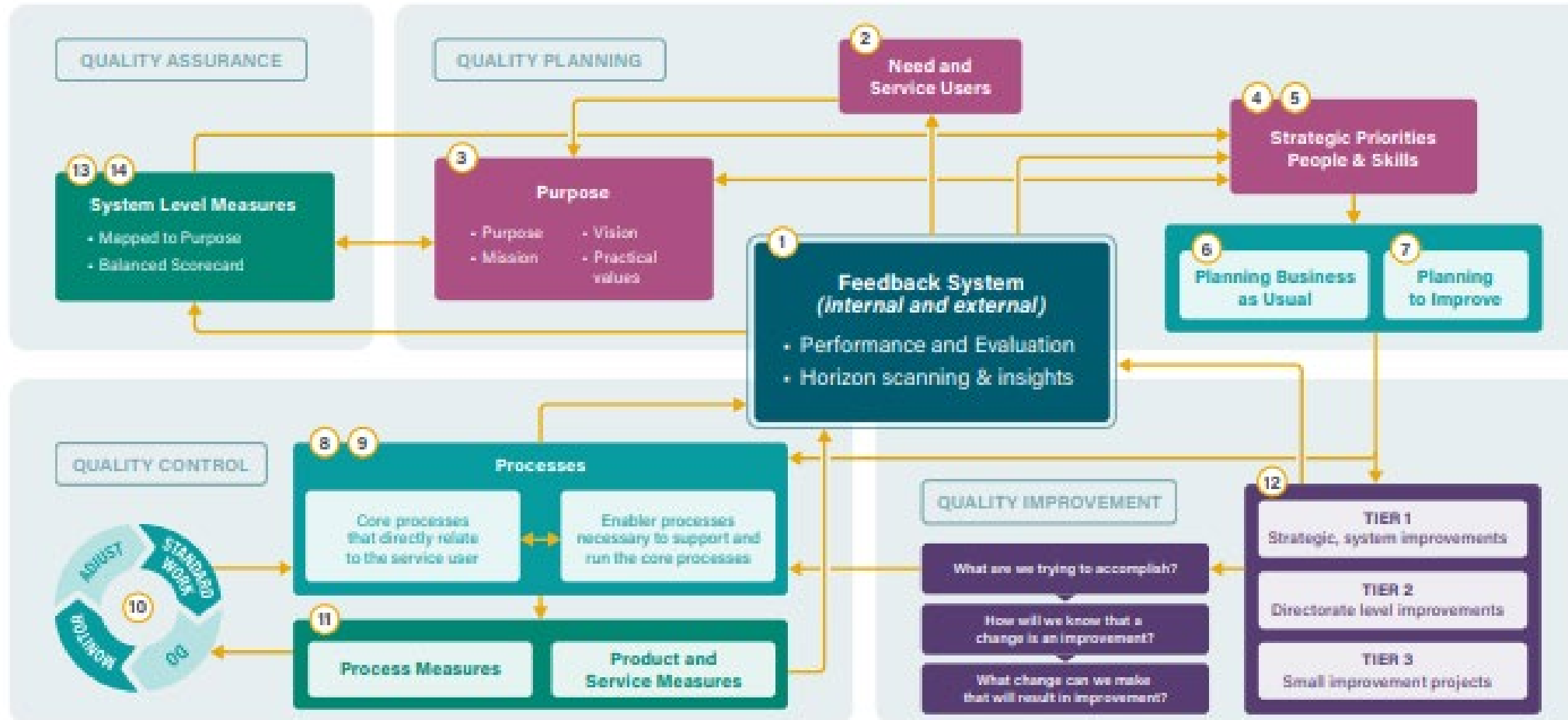
Quality Control

Connected daily operational management to monitor and maintain quality, including the use of real-time measures over time.

It includes:

- Those closest to the work develop standardised processes to ensure reliability and reduce variation.
- Making real-time corrections to processes if required and clear escalation routes if necessitated.
- Visual management to focus efforts and identify issues early.

4. Operating a quality management system



Ref: NHS Wales Executive (2024) *Developing a Quality Management System*

Figure 3 The method for operating a quality management system (adapted from Associates in Process Improvement. Quality as a Business Strategy: Building a System of Improvement. Austin, Texas: Associates in Process Improvement; 1999)

4. Quality Management System: Our Approach

1st April 2025



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IQFPD: Level of autonomy informed by escalation level

Quality Control

- 8. Do we have a standardised process in place to manage daily work?
- 9. Are our processes operating as we need and delivering the products and services we need?
- 10. What isn't working as it should be and can be improved by those closest to the work?
- 11. What is our data telling us isn't working as it should be and needs to be escalated for improvement support?

Quality Improvement

- 12. Has the improvement resulted in the products and services achieving the intended outcome and meeting the need?

QSESC



QSEC:

Quality Planning

1. Has something in our internal processes or external environment signalled a change?
2. Does the signal indicate a change in the need or in our customers?
3. Does the signal indicate our purpose needs to change?
4. What does the leadership need to do to get the system ready to meet the need?
5. Do we need to change our plans to achieve the outcomes we need?
6. Planning to operate:
 - Which processes are meeting expectations and where they need to be?
 - What people do we need and what skills capacity and capabilities do they need to have?
7. Planning to Improve:
 - Which new processes, products or services need to be designed and why?
 - Which existing processes, products or services need to be redesigned and why?

Quality Assurance

- 13. Are we assured of our performance over time?
- 14. Are we assured that we have the necessary culture, people, infrastructure and improvement programmes to deliver on the outcomes?

5. Self-Assessment Maturity Matrix: CCG quality and clinical governance



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Maturity matrix to support the development and improvement of quality and clinical governance in CCG/CSG

TO USE THE MATRIX: IDENTIFY WITH A CIRCLE THE LEVEL YOU BELIEVE YOUR ORGANISATION HAS REACHED AND THEN DRAW AN ARROW TO THE RIGHT TO THE LEVEL YOU INTEND TO REACH IN THE NEXT 12 MONTHS. 0 – 6

PROGRESS LEVELS	0 No	1 BASIC LEVEL Principle accepted and commitment to action	2 EARLY PROGRESS Early progress in development	3 FIRM PROGRESS Progress becomes mainstreamed	4 RESULTS Initial achievements evident	5 MATURITY Results systematically achieved over time	6 EXEMPLAR Others learning from our consistent achievements
KEY ELEMENTS							
Safety and Experience (Cathie and Louise)	No						
Quality and Effective Clinical Practice (Donna, Cathie and Rachel)	No						
Risk, Impact and Fragility Assessment (Charlotte, Rachel and Sharon (for fragility))	No	Staff are aware of the UHB's risk management framework and understand key elements of this e.g. risk assessment, risk escalation, etc. This is included within the local induction process. Risk management training needs assessed and actioned. New risks are being entered into the risk register, but this is reactive, and the CCG/service have started to review these. Awareness that integrated impact assessments need to be completed for key programmes of work/proposals for change	There exists evidence that risks are being reviewed and calibrated, and action plans agreed. Risk registers are systematically reviewed at CCG and service level, and risk informs quality improvement activity. There are examples of appropriate escalation of risks. The risk management system is externally tested and recognised, through internal audit. Evidence that integrated impact assessments are being undertaken.	Risk identification is proactive and a key part of annual business planning and quality assurance cycles. SMART action plans are in place for all risks, with realistic target risk scores set. CCG and service leadership are fluent in the UHB's risk management approach and understand the UHB's risk appetite and tolerance approach. There are examples of different CCGs and services collaborating to mitigate risks. Evidence that integrated impact assessments are commenced at start of key programmes of work/proposals for change, impacts are addressed as far as reasonably possible and help to inform decision making.	Robust arrangements in place to ensure all risks are reviewed in line with UHB guidance. Risks are triangulated between CCGs to identify corporate issues. Multiple examples of risk escalation with concomitant actions taken, and of risk score reductions, supported by performance and quality metrics. CCG and service leadership are confident that the risk system is picking up issues they consider important, such as potential fragilities, and relevant to improve patient experience. Staff are aware of the top risks within the CCG/service, and what is being done to mitigate these risks. Evidence that there are robust arrangements to monitor integrated impact assessments post project.	Internal audit provides positive assurance that risk management is robust and adding value. Staff are involved in peer learning exercises within the UHB and externally. There is evidence of consistent risk reduction through the timely completion of action plans and the lowering of risk scores over the last 24 months. Risk profiling of Cost Improvement Plans (CIPs) shown to be accurate over time. There is evidence of consistent monitoring of integrated impact assessments	Improvements derived from risk management are shared with other CCGs. Contribution by CCG to organisational patient safety learning efforts Evidence that integrated impact assessment has led to successful programme implementation. Evidence that improvements derived from integrated impact assessments are shared with other CCGs.
External Audit and Regulatory Reports (Charlotte, Rachel Cathie)	No	Staff are aware of the importance of responding to recommendations from audits/inspectors/regulators. Roles and responsibilities are clear.	Governance process in place to sign off management responses. Reviewing outstanding recommendations is a standing agenda at CCG and	Review findings inform annual planning process and quality assurance cycles. SMART actions where any additional resource requirements have been agreed before submission to	Robust arrangements in place to ensure all recommendations are reviewed and implemented. CCG and service leadership are confident that they have processes in place to	Internal audit provides positive assurance that arrangements are robust and add value. Consistently implementing recommendations within	Less scrutiny of CCG and service. Evidence of positive reviews. Other organisations learn from CCG or service.

What does 'Good Quality Governance' Look like?

The Maturity Matrix is a flexible developmental tool to help the Board ensure that they understand the quality governance competencies at CCG level.

- The maturity matrix describes clinical governance maturity at CCG levels
- Can be used to guide development towards best practice
- Facilitate Board accountability for quality and patient safety. Build the right levels of grip at each CCG.

5. Self-Assessment: What Good Looks Like



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• Key Elements:

- Safety & Experience
- Effective Clinical Practice
- Risk, Impact and Fragility Assessment
- External Audit and Regulatory Reporting
- Health & Safety

Good Looks Like This



Plus:

- Accountability
- Transparency
- Continuous Improvement

5. Self-Assessment: Using our tools / feedback systems



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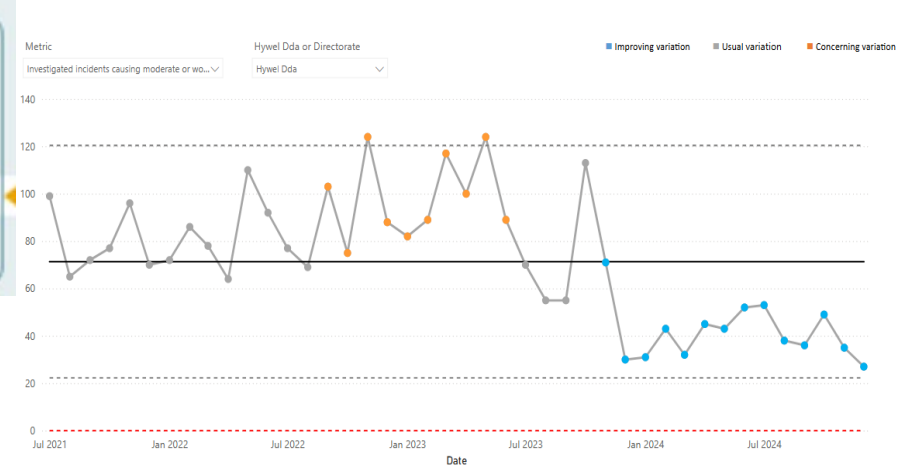
Assurance achieved
66%
Dec 24
Total score: 92
Maximum score: 140

Topic	Measure	Oct 24	Nov 24	Dec 24	Trend (Apr 22 - Dec 24)
Incidents	Incidents open >60 days	453	417	400	
	Incidents open >120 days	392	359	348	
	Patient safety incidents closed with moderate or above harm	2	0	0	
Patient experience	Longest open complaint	450	480	511	
	% complaints responded to within 30 days	12.5%	40.0%	75.0%	
Healthcare Acquired Infection	C diff hospital onset	2	1	0	
	S aureus hospital onset	0	0	0	
	E coli hospital onset	0	2	0	
Patient safety measures	Falls (more than minimal harm - on reporting)	2	3	3	
	Pressure damage (developed or worsened during clinical care)	5	7	8	
	Medication errors - low harm or above on reporting	5	7	6	
	Avoidable VTE (all levels, hospital acquired)	0	0	0	
Deteriorating patient	Unplanned admissions from wards to ITU	n/a	n/a	0	
	ITU admissions from A&E/MIU where the patient waited over 4 hours	n/a	n/a	0	

1

Feedback System (Internal and external)

- Performance and Evaluation
- Horizon scanning & insights

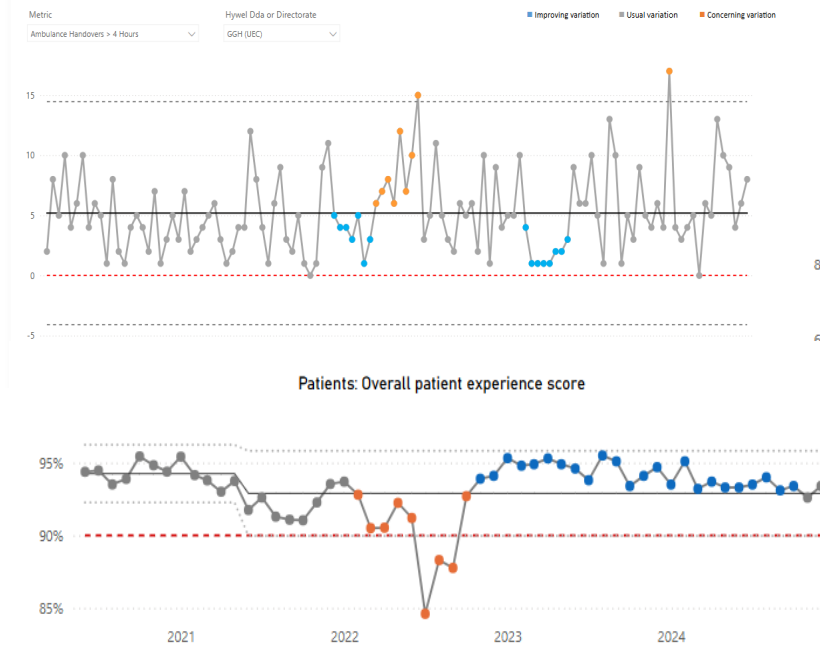


Risk overview

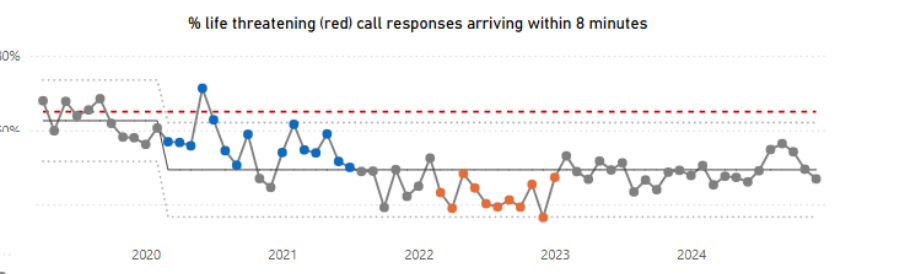
Open risks	Risks overdue	% overdue	Open actions	Actions overdue	% overdue
553	108	20%	909	176	19%

Risk heatmap

Impact	Likelihood				
	Rare 1	Unlikely 2	Possible 3	Likely 4	Almost Certain 5
Catastrophic 5	1516 1520 1858 1491 1382 1848	1596 1970 1947 1991 1873 1862 1619 1539 ...	1263 2007 1953 1308 1398 1640 1955 1982 ...	1680 1284 1082 118 1526 1531 2005 1115 9 ...	
Major 4	1846 1900 1941 1606 1647 1704 222	1966 1967 1684 2001 488 212 1040 1490 15 ...	1553 1614 1399 1549 1679 1959 1974 1984 ...	1764 1815 1960 1661 1786 1882 1903 1976 ...	1867 1517 1309 1932 1933 1930 1904 1927 ...
Moderate 3	1005 1147 1148 1796	1387 474 476 1149 1155 1157 1913 1874 ...	1764 1815 1960 767 1775 1632 430 1975 1965...	1832 1995 1770 1931 1989 1910 1871 838 4 ...	1832 1995 1770 784 1948 1758 1754 1512 3 ...
Minor 2	1236 1942 1476 473 936 828 1133 800 1095	1853 1998 1671 473 936 828 1478 1922 462 447 1756 19 ...	1616 1254 481 1853 1998 1671 1478 1922 462 947 837 1353 ...	1616 1254 481 1456 1375 991 1645 1338	
Negligible 1			1403		



July 2022 low data point cause: change to the system causing a delay in surveys being sent out and functionality issues



5. Self –Assessment: Our Safety Dashboard



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The Performance, Informatics and Quality Assurance and Safety Teams have been working with colleagues to further develop the **Our Safety Dashboard** [Our Safety Dashboard - Power BI](#). A heat map and an assurance score has been introduced along with additional measures.

Our Safety Dashboard - escalation overview

Refresh Date: 19/01/2025



New measures on the dashboard:

- Healthcare Acquired Infections (HCAI)
- avoidable VTE
- deteriorating patient

Measure planned for addition in this quarter

- Nationally reportable incidents investigated within agreed timescales
- % of complaints managed through early resolution
- % complaints referred to the Ombudsman
- Duty of Candour
- Health Inspectorate Wales (HIW) improvement plans

Report home page Escalation overview Escalation assurance scores Escalation trends HB & Directorate overview Services & teams overview HB & Directorate SPC charts Services & teams SPC charts



Assurance achieved

40%
Dec 24

Total score: 56
Maximum score: 140

An example

Topic	Measure	Oct 24	Nov 24	Dec 24	Trend (Apr 22 - Dec 24)
Incidents	Incidents open >60 days	204	252	232	
	Incidents open >120 days	217	175	147	
	Patient safety incidents closed with moderate or above harm	6	2	1	
Patient experience	Longest open complaint	1185	438	489	
	% complaints responded to within 30 days	47.1%	27.3%	57.1%	
Healthcare Acquired Infection	C diff hospital onset	0	1	1	
	S aureus hospital onset	1	0	1	
	E coli hospital onset	5	2	3	
Patient safety measures	Falls (more than minimal harm - on reporting)	2	6	10	
	Pressure damage (developed or worsened during clinical care)	9	10	7	
	Medication errors - low harm or above on reporting	8	6	14	
	Avoidable VTE (all levels, hospital acquired)	0	0	0	
Deteriorating patient	Unplanned admissions from wards to ITU	n/a	n/a	12	
	ITU admissions from A&E/MIU where the patient waited over 4 hours	n/a	n/a	1	

5. Self-Assessment: Escalation Criteria Incidents & Complaints



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Proportion of complaints settled within 30 days

Improved performance remains on an improvement trajectory with performance above the All-Wales average.

Hywel Dda UHB proportion of complaints settled within 30 days (financial year 2023-24)

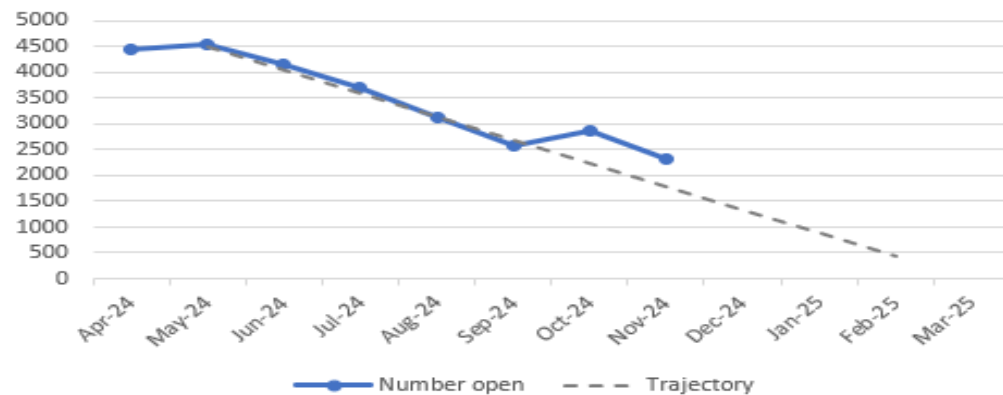
63.22%

Hywel Dda UHB proportion of complaints settled within 30 days (financial year 2024-25)

76.98%

Data extract from Beacon Dashboard

Incidents open more than 120 days



Proportion of complaints settled through Early Resolution

From 1 November 2024, the Board approved an increase in the time allowed to respond to an early resolution case of 5 working days.

New triage arrangements are having a positive impact and improved patient / complainant experience.

The Putting Things Right (PTR) cases have reduced further in December, as highlighted below and now number are less than half of what they were in Q1 of this year.

Concerns Management/Investigation workshop for senior leaders held on 31 October, in preparation for new **PTR implementation 2025** (involving NHS Executive and Welsh Risk Pool (WRP)).

Received	Managed through PTR
April	200
May	207
June	218
July	226
August	179
September	168
October	205
November	144
December	100
Total	1647

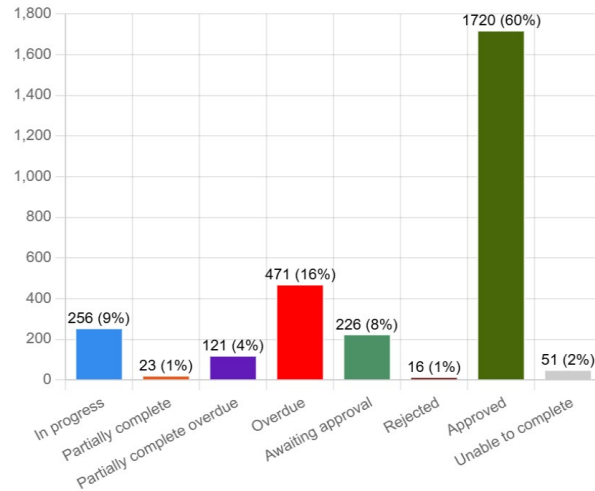
5. Self- Assessment: Escalation Criteria: External Reviews and inspections



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Improvement Actions relating to HIW reviews



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

	Position Feb 2024	Position as at 21 Jan 2025
Overdue	51	14
Partially complete (overdue)	17	9
Partially complete	1	5
In progress	119	8

See appendix for list of overdue actions

Source: AMAT 21/01/2025

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
12	138/234 (59%)	7/11 (64%)	0	0	8	5	9	14	6	5	1	220

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
22	193/193 (100%)	10/10 (100%)	0	0	0	0	0	0	5	0	0	392

5. Self-Assessment: Patient Experience Feedback



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Patient Experience Data Integration:

- Recent rollout incorporating CIVICA, Datix, and FFT feedback into escalation and improvement meetings.
- FFT Scores: Consistently above 90%, with a high volume of feedback.
- Positive Assurance: Favourable Ombudsman feedback and 'significant assurance' rating from the Welsh Risk Pool audit.
- Complaints response: 76% of complaints were closed within the 30-working day target timescale advised in the Putting Things Right Regulations.

Mitigating actions

- Quality Improvement (QI) Integration
- Adding patient experience metrics into directorate packs and the patient safety dashboard.
- Linking Datix/CIVICA insights directly to QI cycles.
- Maintaining high engagement
- Sustaining productive collaboration with the Ombudsman and WRP

Forward look

- Full utilisation of feedback:
As data becomes fully integrated, directorates can better use real-time insights for service improvements.
- Embedding feedback data within daily decision-making and maintaining strong external assurance positions to improve the quality of services in line with patient needs and expectations.
- **Patient Experience Framework**

5. Self-Assessment: Quality Impact Assessment



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Hywel Dda Quality, Assurance and Safety

Home Incident reporting Concerns investigation and management Nationally reportable patient safety incidents Safety alerts and notices ...

☆ Not following English ▾

Immersive reader

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Quality Impact Assessment



Patient Safety (Hywel Dda UHB - Assurance, Safety & Improvement)
Generic Account

Ensuring quality in all our strategic decisions

A quality impact assessment (QIA) is a process through which we can consider and record the quality impact of business cases, services changes and other major consultations.

The purpose of a QIA is:

- To inform strategic quality-driven decision-making;
- To identify and assess the effect or influence of a proposal on the quality and safety of the healthcare system, in line with the Health and Care Quality Standards;
- To ensure that we identify any actions needed to reduce risks where quality or safety could be negatively affected, and to ensure these risks and mitigations feed into existing corporate monitoring processes;
- To provide assurance of quality-driven decision-making, together with audit trail.

Quality Impact Assessment

5. Self-Assessment: Fragile Services



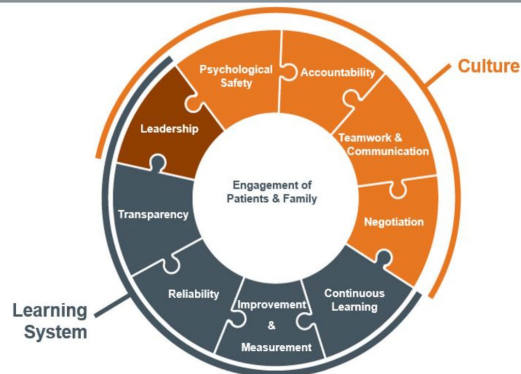
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The **Fragile Services Register** (FSR) will provide an accessible reporting process for services at risk, where and how the services was identified, how the service is being supported and by who, progress and outcome of the support.

The dedicated support will facilitate a review of the service risk, weighted criteria score agreed and a self-assessment against the Framework for Safe, Reliable and Effective Care, with the clinical and managerial leads for the service, an improvement /management action plan will be put in place with a delivery timeframe of 6 months.

Framework for Safe, Reliable, and Effective Care



Safe Care Collaborative Diagnostic Tool: A Framework for Safe, Reliable and Effective Care

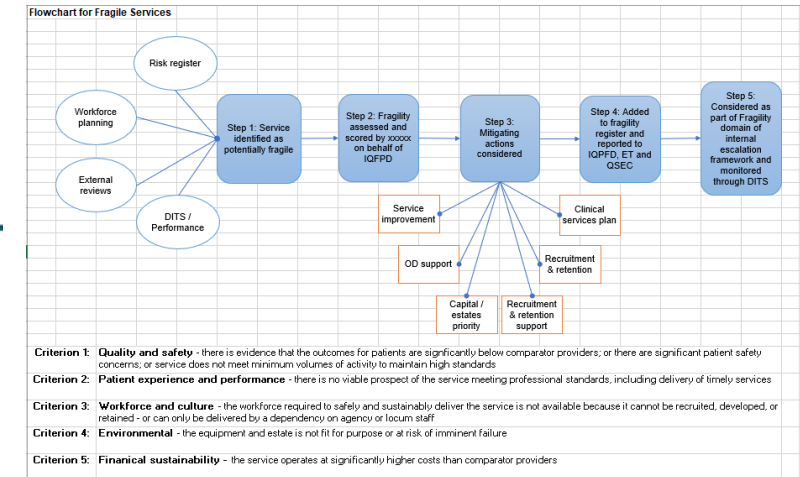
Radar chart of strategic, clinical, and operational concepts that are critical to achieving safe, reliable, and effective care.



Landing Page
Data Collection

GWELLIANT CYMRU IMPROVEMENT CYMRU

	Selected assessment:	Numerical value
Psychological Safety	Exemplary	4
Accountability	Significant impact	3
Teamwork and communication	Making progress	2
Negotiation	Making progress	2
Continuous Learning	Significant impact	3
Improvement	Just beginning	1
Measurement	Making progress	2
Reliability	Exemplary	4
Transparency	Making progress	2
Leadership	Significant impact	3



6. Monitoring Arrangements: Indicators of Success



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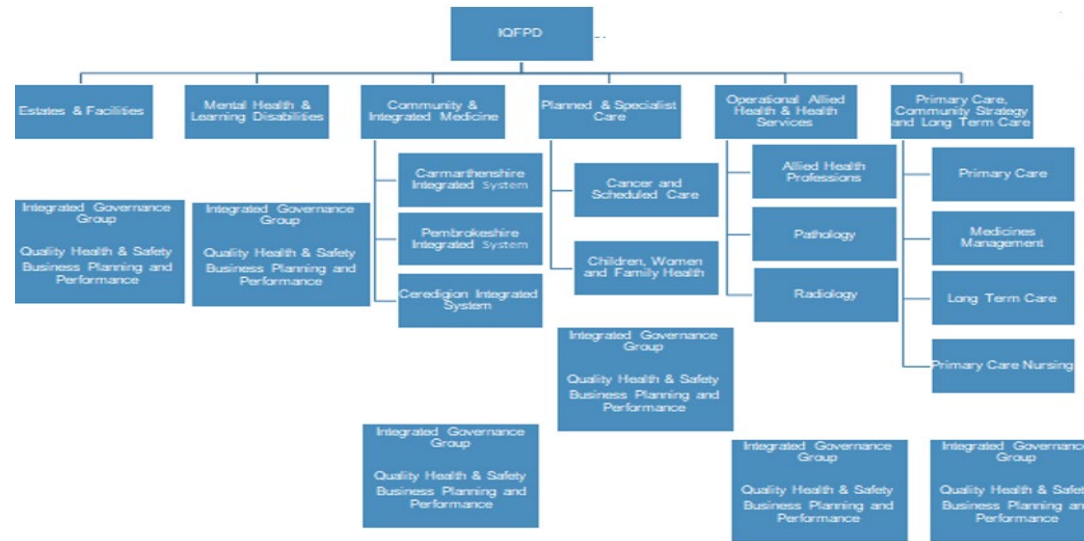
Indicators:

- High patient satisfaction
- Strong Safety metrics (low rates of adverse events)
- Compliance with Regulatory Inspection
- Positive staff engagement, recruitment and retention rates
- Evidence of improved population health & outcomes

Good Governance in Practice:

- Regular Governance Meetings: clear agendas, evidence-based discussions, actionable decisions
- Integration of Technology: Use of digital tools to monitor quality and performance in real time
- Crisis Preparedness: Robust plans to handle emergencies or sudden change in demand

Directorate
Improving Together
(DITS) Escalation



QSEC/Board
Sub
Committees



Interface with new structure:

- 1) Consider the professional groups and advisory groups alignment with the new CCG and service group structure.
- 2) Consider quality governance escalation levels that reflect an assessment of leadership and delivery maturity in the new structure?

Recommendations



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

The Quality, Safety and Experience Committee is asked to take assurance that progress is being made to the revision of Operational Governance arrangements with a plan to implement from the 1st April 2025.



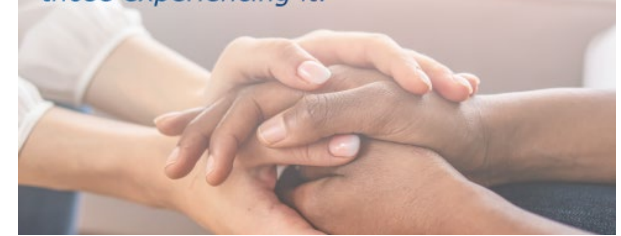
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The Duty of Candour

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



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