Date	**13/02/2025**
Time	**09:30 - 12:30**
Location	**Microsoft Teams Meeting/ Ystwyth Boardroom**

Quality, Safety and Experience Committee Meeting

HDD_Quality, Safety & Experience Committee

NHS Wales

Agenda - 13 February 2025

1 Governance

1.1 Declarations of Interest

Anna Lewis (Hywel Dda UHB - Independent Board Member)

1.2 Minutes from the Previous Meeting and Table of Actions

10 min
Anna Lewis (Hywel Dda UHB - Independent Board Member)

1.3 Targeted Intervention Progress Report- Executive Leads

10 min

1.4 Operational Governance Plan Update

10 min
Sharon Daniel (Hywel Dda UHB - Interim Executive Director of Nursing, Quality & Patient Experience), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)

1.5 Review of Patient Experience Reporting - Verbal

10 min
Anna Lewis (Hywel Dda UHB - Independent Board Member), Sharon Daniel (Hywel Dda UHB - Interim Executive Director of Nursing, Quality & Patient Experience)

1.6 Paediatric Services: Neonatal Ventilators: Patient and Staff Experience Feedback

10 min
Nick Davies (Hywel Dda UHB - Service Delivery Manager - Acute Paediatric and Neonatal Services), Leah Andrew (Hywel Dda UHB - Senior Nurse Quality Assurance Manager for Neonates)

1.7 Quality, Safety and Experience Committee (QSEC) Self-Assessment Outcome Report 2024/25

5 min
Anna Lewis (Hywel Dda UHB - Independent Board Member)

2 Risk

2.1 **Nurse Staffing Levels Impact of Reduction of Agency and Bank Staff on Quality, Safety and Patient Experience Interim Report**

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

2.2 **Update on the service changes in the Minor Injuries Unit in Prince Philip Hospital, Tregaron Hospital and Paediatrics in Bronglais Hospital**

10 min
Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Ceri Griffiths (Hywel Dda UHB - Interim Assistant Director of Nursing)

3 **Break**

4 **Assurance**

4.1 **Quality Assurance Report**

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

4.2 **Quality, Safety and Experience Sub Committee**

10 min
Mark Henwood (Hywel Dda UHB - Interim Medical Director)

4.3 **Listening and Learning Sub Committee Update Report**

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

4.4 **Urgent and Emergency Care Discharge Management Internal Audit**

10 min
Ceri Griffiths (Hywel Dda UHB - Interim Assistant Director of Nursing), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)

4.5 **Allergy Testing Service**

10 min
Mark Henwood (Hywel Dda UHB - Interim Medical Director)

5 **Risks and Matters for Escalation to Board**

Anna Lewis (Hywel Dda UHB - Independent Board Member)

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6 **For Information**

6.1 **Withyhedge Update**

5 min

6.2 **QSEC Work Plan 2024-25**

5 min

6.3 **Welsh Government Integrated Quality, Planning and Delivery minutes**

5 min

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7 **Date of Next Meeting - 8 April 2025**

0 min

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09:30,

1 - Governance

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1.1 - Declarations of Interest

Anna Lewis (Hywel Dda UHB - Independent Board Member)

1.2

10 Mins

1.2 - Minutes from the Previous Meeting and Table of Actions

Anna Lewis (Hywel Dda UHB - Independent Board Member)

Attachments

2024-12-05 - QSEC - Minutes.pdf

Table of Actions QSEC 5 December 2024 V1.pdf

MINUTES OF THE HDD QUALITY, SAFETY & EXPERIENCE COMMITTEE MEETING

Date of Meeting: **09:30, Thursday 05 December 2024**
Venue: **Microsoft Teams Meeting/ Ystwyth Boardroom**

Present:
Anna Lewis, Independent Member and Chair of the Committee
Delyth Raynsford, Independent Member and Vice Chair of the Committee
Chantal Patel, Independent Member
Ann Murphy, Independent Member
Cllr Rhodri Evans, Independent member

In Attendance
Andrew Carruthers, Chief Operating Officer
Gareth Cottrell, Deputy Chief Operating Officer
Jill Paterson, Director of Primary Care, Community and Long-Term Care
Dr Ardiana Gjini, Executive Director of Public Health
Cathie Steele, Interim Assistant Director of Quality and Assurance (deputising for Sharon Daniel, Interim Executive Director of Nursing, Quality and Patient Experience)
Dr Eiry Edmunds, Deputy Medical Director (deputising for Mr Mark Henwood, Interim Executive Medical Director)
James Severs, Executive Director of Allied Health Professions and Health Science
Louise O'Connor, Assistant Director of Legal and Patient Experience
Sam Dentten, Llais Cymru Representative
Dan Jones, Patient Experience Officer (Part)
Simon Chiffi, Head of Operations (Part)
Lance Reed, Clinical Director of Therapies (Part)
Luke Jones, Therapies and Health Sciences (Part)
Marilize Preez, Improvement and Transformation Lead (Part)
Neil Griffiths, Service Delivery Manager of Urology (Part)
Chris Sayer, Mental Capacity Act Senior Practitioner (Part)
Debora Harry, Senior Nurse Manager (Part)

Minutes Ref.	Item	Action
QSEC (24) 93	**Introductions and Apologies** The Chair, Ms Anna Lewis, welcomed members to the Quality, Safety & Experience Committee (QSEC) meeting. The following apologies for absence were noted: • Sharon Daniel, Interim Executive Director of Nursing, Quality and Patient Experience • Mark Henwood, Interim Medical Director	

- Subhamay Ghosh, Associate Medical Director for Quality and Safety
- Iwan Thomas, Independent Member

QSEC (24) 94 **Declarations of Interest**

No Declarations of Interest were noted.

QSEC (24) 95 **Minutes from the Previous Meeting and Table of Actions**

The minutes of the QSEC meeting held on 8 October 2024 were approved as an accurate record of proceedings.

In response to Ms Lewis's request for an update on the Upper Gastrointestinal (UGI) position, Mr Andrew Carruthers indicated that four locums had been taken on to fill the gaps in capacity, and the Health Board was currently advertising for an NHS locum. Mr Carruthers was hopeful that at least one NHS locum could be recruited from the 17 applications. He confirmed that the issue would be considered within the Clinical Services Plan (CSP).

QSEC (24) 96 **Patient Story**

Ms Louise O'Connor introduced a presentation relating to the contrasting experience of the married fathers of two young children in attending the Accident and Emergency Department (A&E) and Paediatric Ambulatory Care Unit (PACU). The parents had been directed to Glangwili Hospital (GGH) A&E by the GP. Due to the father and younger child having differing surnames, the parent was repeatedly asked to explain the absence of the child's birth mother. He explained on several occasions that he and his husband had adopted the child's older brother and were now responsible for the younger child, pending completion of the adoption process. The parent expressed concern that either this was not noted in the child's records or staff were not reading the notes.

He also expressed concern at the way the child was examined by the attending doctor, considering that the child had been waiting a number of hours, was tired, unwell and had become agitated.

The parent compared his experience with his partner's experience the following day when he had also attended A&E with the child's older sibbing who was unwell. He indicated that because the elder child had completed the adoption process and had the same surname as his father, no questions were asked regarding the birth mother.

Ms Lewis expressed the Committee's thanks to the family for sharing their story.

Ms O'Connor confirmed that the patient story had been shared with Ms Paula Evans, Lead Paediatric Nurse; the A&E team; and the Equality and Diversity team for inclusion in the training programme. The Committee agreed that an update should be presented at Listening and Learning Sub Committee (LLSC) for

consideration of broader learning to be shared across the organisation. This should be included in the LLSC's update to QSEC in April 2025. **LOC**

Ms Chantal Patel indicated that there was a recurring theme of poor communication within the Health Board and that Ms Amanda Glanville, who oversees training and education, should also be sighted on the matter. **LOC**

Mrs Delyth Raynsford expressed concern regarding the understanding and equality of anyone going through the adoption process and suggested that Ms Janet Edmonds, Looked After Children (LAC) nurse should be involved in system wide training for Hywel Dda University Health Board (HDdUHB) staff, prioritising A&E receptionists. **LOC**

Dr Ardiana Gjini and Mr James Severs expressed concern at the unconscious bias explaining their rationale for this. In response, Dr Eiry Edmunds believed that there may be mitigating factors with the intention behind the communication regarding family history from a safeguarding perspective; however, it was not well executed.

Members recognised the complexity of the challenges outlined within the patient story and that QSEC was not in a position to resolve operational issues. However, received assurance by the actions already agreed recognising this would be discussed at LLFE Sub Committee.

Decision: QSEC NOTED the patient story.

QSEC (24) 97 **Corporate Risk Report**

The Committee noted that no new risks had been added to the Corporate Risk Register since the previous report.

Risk 1812 *Risk of non-compliance with Medical Examiners (Wales) Regulations due to the failure to fully resource internal processes.* Following a decrease in score since the previous meeting, Mrs Joanne Wilson advised that once confirmation is received in terms of status of medical records scanning, the risk, subject to approval from Formal Executive Team, this may be de-escalated to directorate level.

The following risks were discussed

Risk 797: *Risk to the ability to deliver ultrasound services due to workforce pressures:* Mrs Raynsford commented that due to limited progress on this risk, whether regional support is being considered. In response, Mr Carruthers indicated that there was a reliance on external providers and agreed to establish Swansea Bay University Health Board's (SBUHB) position. He also indicated that the diagnostic conversation in the region had not been to this level of detail. It had primarily focused on what the community diagnostic model might look like. However, based on **AC**

recent conversations particularly in the context of certain pathways, there is likely scope to consider an alternative model.

In response to Ms Lewis' enquiry regarding the consequences for patients who do not receive their ultrasound scans in a timely manner, Mr Carruthers indicated that alongside delayed diagnoses, is the critical and high-risk area of obstetric ultrasound, which poses a significant risk to both the Health Board and to individuals if not performed within the set timings. This area was monitored most closely, whilst the remainder of capacity challenges were managed as part of the broader radiology demand, capacity, and waiting times. When a patient was on an urgent cancer pathway, they were prioritised, and HDdUHB escalated and managed the diagnostic capacity accordingly.

Ms Lewis enquired if there were mitigations in place and how often a delay in obstetric ultrasound appeared in incident reviews or data.

Ms Cathie Steele indicated that sonography incidents had been observed in maternity but were not due to delays in obstetric ultrasounds. Instead, issues related to the interpretation of the scan had been reported. In terms of delays, no issues had been recorded, however, the Health Board does not meet the standards for scanning at certain points in the maternity journey.

Mr Severs indicated that work was underway to manage the risk differently and that HDdUHB was not making progress regarding the quality of patient experience. He drew attention to the functioning of the Ultrasound Control Group (UCG) advising that if not addressed, there was a risk that community requirements would not be met. Mr Severs indicated that, following several cancelled UCGs, the meeting scheduled for the week commencing 9 December 2024 would provide an update, which would facilitate a more detailed report through the radiology report at the next Committee meeting. He also indicated that a more focused review of the radiology risk was necessary.

Ms Lewis expressed concern that the issue appeared to have been stagnant for some time, and that QSEC was not fully aware of the consequences. In view of the uncertainty QSEC could not be assured of the situation. She indicated that this matter required urgent attention and a thorough triangulation with incident data to ensure that any delays experienced by individuals, did not have consequential impacts on their maternity care or any non-obstetric work.

Ms Patel concurred with the Chair's comments regarding the consequences of the issues related to the inability to deliver the ultrasound service. She indicated that this situation necessitated a decision on whether agency cover was required to address it; and requested clarity regarding an apparent ban on agency staff and whether it had impacted the quality of patient care. Ms Lewis also

enquired how, if the consequences of the shortfall in quality were now understood. In response, Ms Steele indicated that there were two distinct services to consider: sonography pertaining to maternity, and ultrasound sonography pertaining to radiography. Quality Impact Assessments (QIAs), which could be shared with QSEC, indicated the need for locum or agency cover; and the impact of not having agency or locum cover has been considered from a quality perspective.

QSEC agreed to advise the Board that the risk is being closely monitored; and that enquiries will be made regarding regional working recognising this needs to be brought back to a future Committee. **AC**

Cllr Rhodri Evans shared his concerns regarding numerous extreme risks and that while actions had been taken, there were no specific dates associated with some risks. He indicated that **Risk 1959**: *Risk of poor patient outcomes and experience due to inability to effectively recognise and manage acute deterioration* identified in 2019, remains unresolved. As of July 2024, compliance rates for Level 2 and Level 3 Resuscitation training are referenced. Although there may not be set compliance targets, it was essential to identify the most appropriate training level. He emphasised the importance of these matters as they pertain to quality, safety, and experience.

Cllr Evans requested a clear timeline for addressing these issues.

Ms Lewis indicated that the meeting will systematically review each risk, applying the Triple-A (Alert, Advise, Assure) approach to each risk within this report, rather than addressing the report in its entirety.

Mrs Lewis commented that a number of risks have continued for several years and although the Health Board considers them beyond tolerance, they are being tolerated.

Ms Lewis suggested that the Board should be encouraged to engage in a more serious discussion about this matter. Committees have become accustomed to reviewing reports in this manner. Mrs Wilson welcomed the observation and provided assurance that the Executive Team are in the process of reviewing risk tolerance as part of the planning process for next year.

Risk 1027: *Risk to delivery of timely urgent and emergency care due to demand exceeding current capacity:* An improving trend regarding lengths of stay in Urgent and Emergency Care was noted. Mr Carruthers advised that Mr Peter Skitt was monitoring longer stay patients over 100 days and would intervene as appropriate.

Mrs Lewis suggested that a review of 21 day stays and under should also be undertaken. In response, Mr Carruthers recognised that patients admitted for 72 hours and over in the main remain in hospital for up to 21 days. Therefore, confirmed that a key focus of improvements is on admission avoidance and consequently reducing longer lengths of stay.

The Committee was assured on this occasion; further improvements are required particularly at Glangwili General Hospital.

Risk1032: *Risk of timely diagnosis and treatment of MH&LD clients due to demand and capacity:* Ms Lewis enquired whether QSEC should focus solely on meeting the Welsh Government (WG) target if it was deemed unattainable: or on broader concerns. She also enquired whether *a* business case should be made to address this issue. Mr Carruthers indicated that the issue was currently addressed at Integrated Quality, Financial Performance and Delivery (IQFPD) Group and escalation meetings with a focus on understanding and addressing the capacity issue. He also indicated that the current measures used may not be the most helpful in terms of having a meaningful impact on outcomes. Whilst the Directorate had been asked to develop a plan to achieve the required level of capacity, it is recognised that discussions will be required with stakeholders and partners on their role on the pathway.

Mr Carruthers also indicated that the risk had arisen during the COVID-19 pandemic and that the current risk context may need to be re-evaluated to ensure the current situation was accurately reflected.

The Committee noted that the Service had been asked to outline measures that have the greatest impact in terms of patient outcomes, and the recent workshops had addressed this. This will result in a full review of the risk to clarify the mitigation measures required to manage the risk from a patient outcomes perspective.

The Committee agreed to advise the Board that whilst it was assured on this occasion due to the work being undertaken by the service, this risk may be escalated at the next meeting.

Risk 1664: *Risk to Ophthalmology service delivery due to a national shortage Consultant Ophthalmologists and the inability to recruit:* The Committee reviewed the current patient waiting times and the associated risks, noting that there was a significant number of people on the waiting list, and references to irreversible vision loss as a consequence of these delays. However, beyond this general statement, there was a lack of specific data on how many individuals had been affected by vision loss due to delayed access to care. Ms Lewis requested precise data to outline the full impact of the delays on patient outcomes. Mr Carruthers advised that while there had been instances of vision loss among patients on the waiting list, the number of such cases was not as high as **AC**

might be expected given the number of delayed patients. This was noted as an important consideration in assessing the overall risk. QSEC discussed the broader impact of delays on patients' eyesight, emphasising the importance of addressing this issue to prevent further deterioration of vision among those waiting for care. Ms Steele indicated that confusion over appointments had been partly responsible for some reported cases; and that when identified, patients go through a redress process to address any acts or omissions that led to harm.

For clarity, Mr Carruthers advised that the risk was originally assessed from the perspective of Welsh Government targets, the primary concern was the unreported waiting list, which is not nationally reported and does not fall under performance metrics for Intravitreal Injection Therapy (IVT) services. This was recently highlighted in Executive Team discussions because the unreported waiting list for degenerated IVT services carries significant service risk due to the substantial capacity challenge.

Mr Carruthers indicated that he had requested the team to develop a clear plan to prioritise a demand and capacity solution for IVT services due to concerns regarding this pathway. This may make routine waiting positions more challenging, however alternative routes would be explored to address the capacity demand challenge, including regional working. Ms Paterson indicated that a fixed transition plan for the move from Secondary to Primary Care, with clear timelines, subject to operational structures would be developed for consideration. Similar to prioritising urgent surgical pathways for cancer, it was essential to focus on addressing the IVT service issue.

Ms Lewis raised the recurring theme of lack of quality data, despite having an abundance of performance data. She noted that it is challenging to definitively determine the outcomes for patients based on the available data.

Mr Carruthers proposed presenting a deep dive on this risk to QSEC on 10 April 2025, when clinical risk data should be available. **AC**

Ms Lewis commented that there is a common theme on a number of risks that suggests that quality is improving, however due to the absence of data metrics it is difficult to corroborate this.

Risk 1859: *Risk of poor patient outcomes and experience due to inability to effectively recognise and manage acute deterioration.* Members noted the lack of compliance for resuscitation training was previously escalated to PODCC.

Mrs Mandy Davies confirmed that significant work is taking place in terms of the most appropriate training level and method to deliver training to meet mandatory requirements. **MD**

Mrs Lewis proposed that an update be presented to QSEC on 10 April 2025, which will include a quality dashboard.

Risk 1531: *Risk of being unable to safely support the Consultant on-call rota at Withybush Hospital (WGH) and Glangwili Hospital (GGH) due to workforce pressures:* Mr Carruthers advised that applicants had been shortlisted for interviews scheduled on 12 December 2024. Referencing the general surgery on-call rota and the associated challenges, Mr Carruthers noted that the facility had been narrowing in recent years, and an urgent temporary change had been implemented last year. GGH has become a higher risk due to expected timings and the age profile of the workforce. It is common for General Surgeons to transition from the on-call rota to focus on elective work as they progress in their careers. This transition was expected to become an increasing challenge in the coming years and should be reflected in the Clinical Services Plan (CSP). Should the rota not be covered, Mr Carruthers indicated that to manage site capacity and emergency pressures, patients may be diverted out of hours if necessary. This was categorised by specialty or specific pathway rather than a total diversion; and that during the winter period, it was not uncommon to for patients to be diverted between GGH and other sites, depending on capacity. He indicated that similar practices were applied to general surgery and medicine, with patient diversions occurring as needed. While the default practice was to avoid diversions due to the challenges they pose, it was sometimes necessary to manage emergency flow. He also acknowledged the importance of collaboration with the Wales Ambulance Service Trust (WAST) in managing these diversions.

The Committee agreed that the Board could receive assurance from candidate interviews scheduled for 12 December 2024; and the contingency plan currently in place.

Risk 1708: *Risk of increasing fragility in primary care contractor services due to recruitment challenges:* Referencing Cllr Evans earlier remarks regarding issues on the risk register that were tolerated or accepted, Ms Paterson indicated that many of these issues are not due to a lack of understanding or management but are often unexpected, particularly in relation to dental contracts, which may be due to recruitment challenges or providers' dissatisfaction with the metrics set under the new contract, leading them to revert to private practice rather than NHS provision. There were management processes in place for both General Medical Service (GMS) dental and other contractors to address these issues. She advised that occasionally, contracts were handed back unexpectedly across various services. This could be due to relationship breakdowns within practices. Ms Paterson advised that there were systems in place to manage service fragility and explore different ways of working. Strategic thinking was required to provide services differently and address these challenges.

The Committee noted that changes in services occur when contracts are returned by independent contractors, and the

impact on patients in the short term. It was important to manage these changes to ensure continuity of care.

Mrs Lewis recognised that the risk relates to independent contractors and therefore the Health Board is limited on mitigating the risk, however it is prudent for QSEC to scrutinise on a regular basis.

Risk 684: *Risk to the timely investment and replacement of Radiology equipment and supporting infrastructure:* In response to Ms Lewis's enquiry regarding capital investment, and the lack of sufficient capital affecting the ability to provide quality and safe environments for staff and patients, Mr Carruthers confirmed that is included as part of the capital programme discussions. Further commenting that insufficient capital to manage high risks effectively is a challenge across all Health Boards in Wales. He also indicated that there may be opportunities for regional solutions to address capital challenges in the form of regional diagnostic hubs, which WG may be more supportive of funding, compared to individual equipment replacements.

Mrs Raynsford indicated that, as Chair of the Charitable Funds Committee, there had been a significant increase in requests for replacement equipment. This trend was also common across other Health Boards, but the solution was not within the control of the organisations.

QSEC agreed to advise the Board that due to insufficient capital funding, management of this risk is outside the Health Board's control.

Risk 1810: *Risk to delivering effective and timely cancer service due to Aseptic Unit facilities being non-compliant with Quality Assurance of Aseptic Preparation Services (QAAPS):* Ms Paterson advised that the Aseptic Unit Business Justification Case was delayed due to a lack of response from contractors to the initial tender. Following support from WG, a more specialist procurement process is being undertaken, with assurance received that continual monitoring of the unit is taking place.

In order for QSEC and Board to fulfil their responsibilities, Mrs Lewis requested that Mr Severs, in collaboration with clinical colleagues, agreed to develop metrics for articulating the quality, safety, and experience impacts of different risks. **JS**

The Committee noted that while operational details were important, its primary concern was to understand the impact of risks and issues on patients and communities to facilitate informed recommendations to the Board.

Decision: The Committee REVIEWED each risk in the Corporate Risk Report and where assurances were inadequate will advise Board of the intent to continue to monitor the risks discussed.

QSEC (24) 98 **Allergy Testing Service - deferred**

QSEC (24) 99 **Fragile Service Update Report**

Ms Mandy Davies joined the meeting.

Ms Mandy Davies presented the Fragile Services – Framework for Identification, Monitoring and Sustainability Support update report, highlighting the following:

- A Fragile Services Oversight Group (FSOG) Terms of Reference (ToR) had been created
- The FSOG will report to the Quality & Safety Intelligence Group (QSIG) and onwards to the Integrated Quality, Finance and Performance Delivery (IQFPD) Group
- A register was being developed on SharePoint to log all identified fragile services through various mechanisms, whereas previously only the risk register was used
- The ToR and Framework now include the various mechanisms for identifying fragile services
- For most fragile services, a quality impact assessment of workforce considerations is conducted as part of the equality impact assessment

In response to Ms Anne Murphy's enquiry regarding the inclusion of workforce within the ToR, Ms Davies agreed to ensure they were included. **MD**

In response to Ms Patel's enquiry regarding the need for clear criteria to determine what is required to prevent a service from becoming fragile, and whether services could be rectified without additional financial support, Dr Eiry Edmunds indicated that it was necessary to consider how services were delivered rather than relying on additional funding. The emphasis should be on aiming for high-quality services and understanding what they look like; and making changes to avoid fragility in services, and whilst additional funding may be required, it is also about being more efficient with the funding provided.

Ms Lewis enquired whether an early warning signs approach is being used to identify fragile services. Ms Davies highlighted the importance of identifying services through the DITS and escalation processes and indicated that the next meeting on 24 December 2024 would focus on identifying and supporting fragile services.

The Committee welcomed the development and implementation of the framework and governance for providing an effective process to recognise and respond to clinical services that are at risk of becoming Fragile Services.

Ms Mandy Davies left the meeting.

Decision: The Committee:

- DISCUSSED the work that has progressed in relation to fragile services.
- CONSIDERED whether the revised methodology represented an effective process to recognise and respond to services deemed at risk of being or becoming fragile.
- CONSIDERED whether the process had the ability to influence organisational culture and learning systems and improve risk mitigation.

QSEC (24) 100 **Quality Assurance Report**

Mr Simon Chiffi joined the meeting.

Ms Steele presented the Quality Assurance Report with an apology that the Healthcare Inspectorate Wales (HIW) Overdue Action Appendix was not included within the papers and would therefore be shared on the screen. She indicated that the Quality Management System, which was approved over a year ago by the Board, was not static; changes and adaptations had been made since its approval. She highlighted the following:

- Incident reporting showed a dip during April 2023, which was being investigated as a dashboard issue.
- Further work was ongoing to shift the focus from individual medication errors to a system-wide approach.
- Quality Impact Assessments (QIAs) were included in the ongoing work.

In terms of the Bryngolau Ward, Prince Philip Hospital HIW Report:

- The Action Plan has now been published and on the HIW website and is available on Audit Management and Tracking (AMaT).
- Positive progress has been made, with only 19 actions outstanding from the original 30.
- A number of actions are related to Mental Health & Learning Disabilities (MH&LD) and Ophthalmology, which are being managed via the risk register.
- Four estates actions are complete or in progress with a work plan in place for the replacement of curtains and installation of appropriate anti-ligature blinds. Mr Simon Chiffi confirmed that the Bryngolau specific action would be fully completed in the week commencing 9 December 2024.

Ms Steele provided an update on other outstanding HIW recommendations as follows:

- The oldest radiology action relating to document control is being investigated, with enquires being made into the document control system used by pathology.
- There are 19 actions for MH&LD which was overrepresented compared to the rest of the organisation. Meetings were ongoing and revised dates had been agreed for completion.

In response a query from Mrs Lewis relating to the number of outstanding actions for MH&LD, Ms Steele indicated that the recent Cwm Taf Morgannwg UHB discharge report included several recommendations similar to those in the Bryngolau HIW report, which all of NHS Wales was tasked with evaluating within their respective areas. Ms Lewis and Mrs Raynsford raised concerns about the high number of open actions, with Mrs Raynsford requesting urgent mitigations.

In terms of the review of the bedroom environments, Ms Steele confirmed that the curtains were promptly removed in July 2022 and replaced with mirrored one-way glass. Mr Carruthers indicated that the delay on closing this action could be due to a number of issues such as capacity.

Ms Lewis agreed to meet with Ms Sharon Daniel and other colleagues to explore an appropriate course of action for QSEC to scrutinise the series of concerns currently emerging regarding any delays in completing outstanding actions, in particular those assigned to the MH&LD service. **SD**

Ms Lewis also agreed to meet with Ms Daniel and Mr Severs to consider the relationship between QSEC and Quality, Safety and Experience Sub Committee (QSESC), to ensure that the Committee receives assurance; and that QSESC can effectively manage quality within operations to provide that assurance. **SD**

Ms Murphy commended the reduction in infection, prevention and control levels indicating that although progress was slow, it was welcome.

QSEC agreed to assure the Board regarding the reduction of outstanding HIW recommendations, that the process and escalation was working and would continue to be monitored by the Committee.

In response to Ms Lewis' enquiry regarding the three service changes agreed at Board in September 2024, Mrs Wilson apologised this action was not taken forward and agreed to liaise with Ms Daniel to provide a Chair's Briefing prior to the Christmas break regarding the following:

- Temporary night closure of the Minor Injuries Unit at Prince Philip Hospital (PPH)
- Bronglais paediatrics
- Tregaron

Regarding the nurse staffing levels referenced within the paper on page 121 at the second bullet point, Ms Lewis queried a text error which Ms Steele clarified. Ms Lewis then referenced updates received by the Board which indicate an almost full establishment of the qualified nursing workforce, which does not appear to triangulate with the nurse staffing levels indicated in the report.

Ms Steele indicated that specific areas such as GGH are close to being fully staffed with the arrival of the last tranche of international nurses, however despite the positive staffing establishment, 44% of night shifts are still running short. She also indicated that data from October and November 2024 was required for a comprehensive analysis, as current data only covered the period to the end of September 2024. Further consultation with nursing staff and colleagues was necessary to verify the data.

Ms Steele confirmed that clinical incident data was compared with staffing shortfalls on those shifts. She agreed to triangulate the different sources of information to provide clarity in future reports. **CS**

Regarding the Welsh Health Circular relating to children's incontinence products, Ms Lewis sought clarification on whether the issue was due to lack of funding or if the products were not provided because they were not funded; and the consequences for children and their families if these products were not provided.

Mr Severs indicated that the Community Paediatric Nurse had caried out a scoping exercise to clarify the issue and to understand the current guidance, including the impact of not providing incontinence products. The report will be presented to QSESC in January 2025. There is currently no budget or establishment for paediatric incontinence with it noted this is part of a wider service review of Hywel Dda Children's disability services. Furthermore, it was noted there is currently no children's disability provision in Pembrokeshire.

Ms Raynsford expressed her concern that the issue had been delayed by two to three years and noted the inequity for children and young people in comparison to adult services.

Due to the concerns raised, Mr Severs agreed to provide an update on the present situation outside the meeting. **JS**

The Committee agreed that the Board could be assured that the situation was being monitored by the Committee to ensure appropriate actions were taken.

Decision: The Committee RECEIVED ASSURANCE that processes were in place to review, monitor and improve the quality of the service through:

- The Quality Management System
- Patient safety incidents including nationally reported patient safety incidents
- Duty of Candour
- Infection, prevention and control
- Nurse Staffing Levels (Wales) Act 2016
- Inspections and peer reviews including activity of Healthcare Inspectorate Wales (HIW)
- Quality Impact Assessments
- Welsh Health Circulars

QSEC (24) 101 **Listening and Learning (From Events) Framework**

Ms Steele presented the Listening and Learning (From Events) Framework indicating that this was a starting point and highlighting the following:

- That there is ongoing consultation with taking place at various groups to gather feedback.
- Recognition of the long-standing discussions on learning from events over the past 20 years.
- An emphasis on listening as a key method of learning.
- The need to include tips and skills for effective listening in the framework.
- The importance of listening to staff, incidents, and speaker processes to gather data.
- Discussions on how to analyse and interpret data to identify learning opportunities.
- Identification of specific areas of events that provide valuable learning insights.
- Acknowledgment of the existing investigation process
- An emphasis on the importance of learning and taking action based on investigations.
- The need for actions to be implemented across the Health Board.
- A framework to ensure a nurturing environment where everyone can learn, flourish, and provide psychologically safe care.
- The empowerment of individuals to speak up and contribute to the learning process.
- An emphasis on encouraging staff to think about how they are using routes of learning and exploring additional opportunities.
- The importance of seeking learning opportunities and reflecting on individual experiences rather than just listening to patient stories in meetings.

Ms Steele indicated that the final document would outline responsibilities for learning, highlighting that learning is not only about being provided with information, but actively seeking and reflecting on learning opportunities. A learning library and portal would be created to share collected learning points which services would be able to contribute to using Viva Engage, making it word searchable.

In response to Ms Patel's query regarding the process of sharing learning with other directorates, and whether there was a mechanism to ensure shared information is being reviewed and reflected upon to implement changes, Ms Steele indicated that directorate and service management teams needed to be proactive in considering shared learning which would be facilitated by action plans and ensuring that discussions in the Listening and Learning Sub-Committee were reported to their respective areas. Ms Steele also emphasised the need to gather evidence and ensure it was incorporated into the quality improvement space. Action planning and learning actions would then evolve into thematic organisational identity approaches.

Ms O'Connor emphasised the importance of improving sharing and ownership from a thematic multidisciplinary team (MDT) perspective to develop broader learning.

Mr Severs commended the Framework and welcomed the MDT perspective. He highlighted the need for evidence of the implementation of learning to ensure that the Committee can be assured that the Health Board was effectively applying the learning.

In response to Ms Lewis' enquiry about gaps in data, Ms Steele advised that qualitative and outcome data was missing. Ms Lewis also queried how the learning could be made less transactional and Ms Steele indicated that sharing personal stories in the Whole Hospital Audit, may make the audit more meaningful for attendees as personal stories provide a relatable and impactful way to convey learning and improvements.

Ms Murphy sought confirmation on the use of internet, SharePoint, and Viva Engage for information sharing as when she had accessed Viva Engage, only 486 from 13,000 staff had viewed it. She emphasised the need for alternative methods to ensure all staff, including housekeeping and facility staff, can access important information; and the importance of not making information sharing too internet-heavy.

Ms Raynsford raised a concern regarding staff in community settings or lone workers. Ms Steele indicated that notice boards throughout HDdUHB could be regularly updated and full engagement from all directorates would be required.

Ms Lewis indicated that engagement with each of the service director leads was crucial, as the availability of time for learning needed to be integrated into the directorate's ethos and culture of learning and working. Additionally, for the Board and corporately, utilisation of this information is vital in informing priorities and improvements. Ms Lewis suggested including a responsibility for the Board under the responsibility section, particularly in setting the cultural tone within the organisation. **CS**

Decision: The Committee RECEIVED ASSURANCE from the update on the development of the Health Board's Listening and Learning (from events) Framework.

QSEC (24) 102 **Listening and Learning Sub Committee Update Report and Terms of Reference for Approval**

Ms O'Connor presented the Listening and Learning Sub Committee Update Report and Terms of Reference (ToR) for approval, indicating that as discussions on the learning framework evolved and the debate around Committee links continued, the ToR will be updated further in 2025. She indicated that the previously approved extension to Policy 568: Production and Use of Surveys Guideline until 15 November 2024 was in anticipation

of the revised People's Experience Framework for Wales and a new national Experience Survey being issued. It was anticipated that the new framework would be issued as a Welsh Health Circular in December, when the Health Board would need to consider the new requirements and undertake an assessment of current process. A revised governance process would need to be agreed and implemented for survey management. In order to complete this task and undertake sufficient consultation with stakeholders, it was requested that a further 6-month extension be granted until 5 June 2025.

Decision: The Committee

- RECEIVED ASSURANCE from the Listening and Learning Sub Committee Update Report.
- APPROVED the updated terms of reference (Appendix 1).
- APPROVED the extension of 6 month's for '568 Production and Use of Survey Guideline', (Appendix 2) pending receipt of the Welsh Health Circular and revised People's Experience Framework.

QSEC (24) 103 **Quality, Safety and Experience Sub Committee Update Report**

Mr Severs highlighted the need to establish a connection between QSESC and LLSC and confirmed that as previously discussed, work was in progress to address connection and reporting differences, with an expected completion in December 2024.

Referencing the difference in reports on falls, for clarity, Ms O'Connor advised that the assurance received at LLSC related to the process in place to reduce incidents, not on performance.

Decision: The Committee:

• NOTED the items that the Committee was advising them of
• RECEIVED ASSURANCE on the items that the Committee was providing assurance on.

QSEC (24) 103 **National Nosocomial COVID-19 Programme Learning Action Plan**

Ms Steele presented the Learning from the National Nosocomial COVID Review Programme report indicating that the recommendations outlined in the national report had been aligned with the actions already in process., as well as with ongoing reviews and current projects.

In response to Ms Lewis' enquiry regarding the significant compliance risks, Ms Steele advised that HDdUHB's ageing estate posed the greatest risks referencing a recommendation regarding isolation of patients with the correct air flow; and the Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) directives, which had attracted significant attention, particularly with the release of the recent HIW report. The Health Board is currently undertaking a quality improvement initiative aimed at enhancing communication and engagement with families regarding DNACPR considerations.

Ms Lewis indicated that at a recent All Wales Quality and Safety meeting Ms Sue Tranka, Chief Nursing Officer (CNO), had emphasised the importance of clearly articulating the quality and safety consequences associated with ageing estate, which was identified as a recurring theme in discussions, described as a "golden thread." There was a suggestion to compile an overview of areas where the organisation is falling short, with ageing estate being a significant contributory factor. This overview would include examples such as wider infection control issues, privacy, and dignity concerns.

Mr Severs confirmed that the issue was monitored by the Health and Safety Sub-Committee and liaison between Clinical Executives and the Chief Operating Officer (COO).

Whilst QSEC received assurance that the issue is being monitored by HSSC, agreed to advise the Board regarding the impact of the Health Board's aging estate on completing recommendations related to the National Nosocomial COVID-19 Programme Learning Action Plan.

Ms Anna Bird joined the meeting.

Decision: The Committee RECEIVED ASSURANCE that the recommendations made within the End of Programme Learning Report for the National Nosocomial COVID-19 Programme were CONSIDERED and are being taken forward within the Health Board.

QSEC (24) 105 **Cleanliness Standards Audit report and Action Plan**

Mr Chiffi presented the Cleanliness Standards Audit report and Action Plan: Progress Update report indicating that the report provided an update on the progress with the recommendations made within the final internal limited audit report on the Standards of Cleanliness published on 26 April 2024.

Mr Chiffi indicated that there were 10 clear matters arising from the main internal report, which were discussed in the weekly Standard of Cleanliness Internal Action Meeting. He reported positive progress with six out of the ten clear actions completed. Two further actions were scheduled for completion, with the remaining actions falling within the training domain, including refresher training and rolling out of the pilot study conducted in GGH across the wider Health Board. Capacity challenges were well documented, however there was a significant focus on addressing these.

Mr Chiffi advised efforts were being made to address the challenging financial position in order to secure the necessary funding to increase capacity. This should enable the Symbiotics auditing process to meet the full recommendations within the internal audit. The action plan, which has been scheduled for completion by October 2025, is being rolled out as planned.

Mr Chiffi confirmed that that the Environmental Cleaning Policy would be considered at the Policy Group on 5 December 2024.

Ms O'Connor enquired whether the patient experience feedback received through Civica in relation to cleanliness was considered in directing planning priorities. In response, Mr Chiffi indicated that he did not have access to the Civica data and would welcome it, as most feedback was provided through monthly team site walkthroughs, which are actioned as part of the auditing process, and participation in partnership forums when possible. Ms O'Connor agreed to share the Civica feedback with Mr Chiffi on a regular basis. Ms O'Connor also agreed to share Civica feedback with the Environmental Hygiene Group. **LOC**

In response to Ms Lewis' enquiry regarding whether the measures implemented were sufficient to prevent these issues from recurring in the future, Mr Chiffi indicated that his focus was on preparing for the internal audit well ahead of their re-inspection in April 2025. He was in regular contact with the internal audit team to review and discuss the evidence on hand, ensuring that all concerns were addressed from a governance perspective.
In terms of cleanliness on the ground, Mr Chiffi indicated that the team was working through a resource package and raised concerns that WG had indicated an update to the Welsh Cleaning Standards expected early in the New Year. This would impact frequency of audits and, consequently, cleanliness across the Health Board.

Ms Lewis acknowledged the potential risk and noted that processes were now in place to identify and manage this risk more effectively than six months ago. She thanked Mr Chiffi and his colleagues for their efforts in addressing the issues, noting the significant progress made from a challenging situation a few months ago.

QSEC agreed that the Board could receive assurance from this report.

Mr Simon Chiffi left the meeting.

Decision: The Committee:
• ACKNOWLEDGED the background to this report and its findings as published in April 2024.
• RECEIVED ASSURANCE that significant collaboration and work had since taken place to address a very large percentage of these recommendations with some final work remaining.
• NOTED that facilities will re-engage with Internal Audit to discuss positive progress in advance of audit return April 2025.

QSEC (24) 106 **Veteran Health**

Ms Anna Bird presented the Health of Veterans and the Armed Forces Community report, advising that a comprehensive paper was presented to People, Organisational Development & Culture Committee (PODCC) earlier in the year to provide assurance on

the work being done to meet the requirements of the Armed Forces Covenant Duty. The report focused on three key areas:

- Understanding the needs of veterans.
- Raising awareness and encouraging self-identification of veteran status.
- Increasing the number of veterans registering with GP practices:
  - according to the 2021 census, approximately 15,000 individuals within HDdUHB identified as having previously served in the armed forces.
  - Increasing awareness and encourage self-identification had resulted in an increase in the number of veterans registering with their GP practices.

Ms Bird indicated that efforts had been made to understand the health needs of the veteran population. A health needs assessment document was developed by the Public Health Team several years ago, and there were plans to refresh it in due course. She also indicated that it was recognised that there were various physical and mental health issues arising from an individual's time in service; and that understanding patient experience had been a key focus.

In response to Ms Murphy's enquiry regarding how the report could be accessed by ex-armed forces staff, Ms Bird indicated that the report was available in the public papers and could be accessed on the HDdUHB website. It could also be made available on SharePoint, printed, and posted on notice boards. Ms Bird agreed to liaise with the Communications Team to ensure the report was accessible to all staff.

The existence of an armed forces staff network was highlighted, which staff were encouraged to join. Information was shared with members of the networks and steering groups, who are involved in co-creating the reports.

In response to a query regarding the emphasis placed on the veteran cohort due to their typically poorer outcomes after military life compared to the general population, Ms Bird indicated that the project had focused on the data available to show the impact of the work being done to improve these outcomes to provide a baseline from which further work could continue.

Ms Bird acknowledged that further improvements were needed to measure the impact of the work being undertaken. She indicated that positive comments had been received from the Veterans Commissioner for Wales regarding the ongoing work, although these were informal and not focused on patient experience or outcome measurements. She also noted that there was still progress to be made in measuring outcomes effectively. The ability to segment data by veteran status was currently limited, although work was being undertaken to improve this. One of the challenges faced is that existing data systems, such as the Welsh Patient Administration System (WPAS), do not adequately support

the recording of veteran status or entitlement to priority treatment. Identifying veterans requires the use of key notes and text, which complicates data collection and analysis.

The Committee noted that efforts were ongoing to work with digital colleagues to address these challenges and improve data recording and analysis.

The Committee also recognised the need to improve the collection and reporting of outcomes for the veteran population; and that efforts would be made to enhance data systems and undertake Health Equity Audits to better understand and address the needs of veterans.

Mrs Raynsford indicated that the work of Veterans NHS Wales focussed on the impact of service delivery in the mental health arena. The "walk and talk" initiative was noted for its role in preventing further involvement with more acute mental health services.

Ms Lewis suggested that a link to the Veteran Health report be included within the QSEC 3As Board Update Report.

Miss Anna Bird left the meeting.

Decision: The Committee:

- NOTED the update report
- RECEIVED ASSURANCE that the work being undertaken demonstrates that the Health Board is proactively implementing the Armed Forces Covenant.

QSEC (24) 107 **Rheumatology Deep Dive**

Mr Neil Griffiths joined the meeting.

Mr Neil Griffiths presented the Rheumatology Service HDdUHB update report, indicating that the report provided an update on the Rheumatology service development and the challenges since 2020, during its transition phase. The highlights were provided by Mr Griffiths including:

- Key challenges, for example meeting referral to treatment (RTT) targets and adhering to National Institute for Clinical Excellence (NICE) and British Society for Rheumatology (BSR) guidelines in treating early inflammatory arthritis (EIA) and giant cell arteritis (GCA).
- The Clinical Nurse Specialist (CNS) and Consultant teams stepped up to cover the prescribing role previously undertaken by the pharmacist.
- In terms of achievements in the last six months, recruitment for an additional consultant to backfill.
- There is a need for a substantive second pharmacist.
- The Rheumatology Day Unit at Prince Philip Hospital (PPH) was managed by the CNS and nursing staff, with an increase

in gastroenterology patients (around 40% of all patients). This impacted the budget, with reliance on bank staff to backfill vacancies.

- The next steps include settling the team, filling positions, and focusing on efficiency gains to regain capacity.
- Plans to bring RTT targets in line and achieve increased patient safety by meeting NICE and BSR guidelines for GCA and EIA patients within their short time scales of three days and three weeks.

In response to Ms O'Connor's enquiry regarding the patient experience perspective and the significant amount of contact from patients, Mr Griffiths indicated that the team had worked closely with the Patient Advice and Liaison Service (PALS) team to address patient feedback. The longer-term challenge was meeting the demands and themes outlined in the report, particularly the delay in the first appointment. The focus on EIA and GCA patients had extended the time taken to see routine and urgent patients. He also indicated that standard responses were being developed in collaboration with the PALS team. Although the volume of complaints was not high, there were recurring themes related to delays in treatment.

Mr Griffiths confirmed that a locum consultant had been funded through recovery funding, and progress was being made. The aim was to reduce the first outpatient appointment wait time to below 52 weeks by March 2025. The patient experience team are aware of the work being undertaken to address the delays.

Ms Raynsford enquired how patients were managed in the community whilst they were awaiting their referrals. Mr Griffiths indicated that collaboration with Llais colleagues had been ongoing to address patient concerns. A specific group of patients with lupus, who were well represented, were being communicated with to ensure they understood the delays in treatment. Mr Griffiths acknowledged that there had not been direct contact with primary care colleagues regarding these delays, although agreed that the team would endeavour to contact them.

Ms Lewis noted that even in a fully established service, the workforce was small and therefore vulnerable to the absence of a single person, as evidenced in the challenges experienced by the service. She enquired whether regional collaboration would be beneficial for this specialty, given the workforce challenges.

Mr Carruthers acknowledged the potential benefits of regional collaboration with SBUHB and agreed to explore further conversations to address workforce gaps and reduce waiting times. Public concerns around travel times and distances would be considered in these discussions. **AC**

The Committee agreed that the Board could be assured by the update report.

Decision: The Committee:
• NOTED the challenges facing the Rheumatology service since 2020
• RECEIVED ASSURANCE from the work being undertaken by all members of the team to meet those challenges
• NOTED the next steps proposed in reducing the fragility and increasing the efficiency of the service.

QSEC (24) 108 **Planned Care Recovery**

Ms Marileze Preez and Ms Debora Harry joined the meeting.

Ms Marileze Preez presented the Planned Care Recovery update, highlighting that a new approach had been introduced where Patient Reported Outcome Measures (PROMs) were conducted with patients as soon as they were listed for treatment. This facilitated identification of their baseline condition and stratification of the support they needed based on that assessment. Based on the assessment, patients would either go straight to optimisation and prehabilitation (prehab) or be managed through the non-clinical call handler for Making Every Contact Count (MECC) conversation. A system was also in place to repeat the PROM again in six months to identify any deterioration or improvement in the patient's condition and to improve patient outcomes by providing tailored support; and monitoring changes in their condition over time.

Ms Debora Harry advised that the Health Board had recently begun collecting patient experience data for those on the See on Symptoms (SOS)/ Patient Initiated Follow-Up (PIFU) pathway. Although to date only six responses had been received, they had been positive. She indicated that the team would continue to strive for more comprehensive patient experience feedback for the pathway

Ms Lewis acknowledged the significant positivity in the current approach, despite the long waiting times for help. She recognised that the improvement in waiting times was attributable to a change in practice which appeared to be having a significant impact on managing patient needs. However, Ms Lewis queried the potential harm to patients waiting on a list and whether there was a proactive way to monitor their ongoing health and needs, acknowledging that patients could self-present should they feel their condition deteriorating.

Ms Preez indicated that there was a proactive approach to informing patients to contact the waiting support service if their condition deteriorated. The waiting support service had established red flags, developed in collaboration with services, to identify deterioration that needed to be escalated back into services. Clinical reviews within the waiting support service could then be conducted by nurses or therapists to identify deterioration. The Committee noted that clear escalation routes were in place to refer patients back into specialties if they had clinically

deteriorated, although there was no easy method for capturing how many people were using this process and for what purpose.

Ms Preez indicated that the waiting list support service currently managed over 50,000 patients, supporting approximately 1,200 patients a month. Approximately 2% of these patients needed escalation back into clinical services for a clinical review, which is reported to WG.

Mrs Raynsford's enquired how patients were informed in what circumstance should they contact the waiting list support service, following receipt of a letter indicating they were on a waiting list. Ms Preez advised that various methods were used to inform patients about the waiting list support service, including leaflets, engagement campaigns, updated letters, text messages, and non-digital communication. Efforts would continue to ensure that patients were aware of the support available to them.

The Committee agreed that the Board could receive assurance that various Planned Care initiatives currently in place would support patients on an elective care waiting list.

Ms Preez and Ms Harry left the meeting.

Decision: QSEC:
• RECEIVED ASSURANCE from the various Planned Care initiatives in place to support patients waiting on an elective care waiting list.

QSEC (24) 109 **Therapies Services Paediatric Occupational Therapy Referral to Treatment Improvement Plan**

Mr Lance Reed joined the meeting.

Mr Lance Reed presented the Occupational Therapy (OT) (Paediatrics) Improvement Plan, highlighting the following:

- There has been a continued improvement from the August 2024 report, showing a reduction in the overall number of breaches in paediatrics and paediatric OT, as well as a reduction in long waits.
- All patients on the waiting list had been approached, canvassed, and validated by the waiting list support service.
- Patients had been given explicit information on how to contact the service if their child's condition deteriorated while on the waiting list.
- Regular validation was undertaken, including keeping in touch with phone calls to ensure patients still required the service and could request additional support if needed.

Mr Reed indicated that the process of appointing a third clinician to join the team was underway, in addition to the two clinicians already recruited to address longer waiters and waiting times. The team was exploring a split post with the post-viral chronic fatigue and Myalgic Encephalomyelitis (ME) service, focusing on the paediatric element and children presenting with chronic fatigue

and ME. This exploration includes looking at the post-viral service and the paediatric OT service.

Mr Reed also indicated that discussions were underway on how to work more collectively across the Neurodevelopmental (ND) service. He acknowledged the potential for running joint group sessions with parents to avoid separate referrals, as referrals to paediatric OT were often generated from the ND service intervention.

Mr Reed confirmed that the focus remained on the integrated improvement plan, which included data reporting, risk profiling, and mitigation; and he acknowledged that the development of a holistic PROM for children was a key challenge, though efforts would continue to address this.

The Committee commended Mr Reed and the team on the significant improvement outlined and wished him well in his retirement.

Mr Reed left the meeting.

Decision: The Committee:

- RECEIVED ASSURANCE that the Occupational Therapy (Paediatrics) improvement plan has progressed.
- AGREED the next update against the Occupational Therapy (Paediatrics) improvement plan for QSEC in April 2025.

QSEC (24) 110 **Compliance with Additional Learning Needs Act**

Mr Severs indicated that due to a recent change in the position, the Compliance with Additional Learning Needs Act report would be presented at the Strategy Group before being considered at QSESC, for inclusion in the next QSESC Update report.

QSEC (24) 111 **Withybush Creche Statement of Purpose**

The Quality, Safety and Experience Committee APPROVED the Creche Operational Document subject to updates to the staffing arrangements contained within the appendices.

QSEC (24) 112 **Improving Patient Experience Report**

The Quality, Safety and Experience Committee NOTED the Improving Patient Experience Report.

QSEC (24) 113 **QSEC Work Plan 2024-25**

The Quality, Safety and Experience Committee NOTED the QSEC Work Programme 2024-25.

QSEC (24) 114 **Ombudsman Investigation Report**

The Quality, Safety and Experience Committee NOTED the Ombudsman Investigation Report.

QSEC (24) 115 **Joint Commissioning Quality and Safety Committee Chair's Report**

The Quality, Safety and Experience Committee NOTED the Joint Commissioning Quality and Safety Committee Chair's Report.

TABLE OF ACTIONS FROM
QUALITY, SAFETY & EXPERIENCE COMMITTEE (QSEC) MEETING
HELD ON 5 DECEMBER 2024

QSEC (24) 96	**Patient Story:** • To share the patient story with Listening and Learning Sub Committee and Amanda Glanville who oversees Health Board education and training.	**LOC**	**February 2025**	**Complete.** The story has been shared and the Listening and Learning Sub-Committee received the story at the meeting held on 3 February 2025
QSEC (24) 96	**Patient Story:** • To liaise with Looked After Children (LAC) nurse to provide system wide training for Hywel Dda University Health Board (HDdUHB) staff, prioritising A&E receptionists.	**LOC**	**February 2025**	**Complete:** The Story has been shared with Lead Nurse for Looked After Children.
QSEC (24) 97	**Corporate Risk Report:**Risk 797: *Risk to the ability to deliver ultrasound services due to workforce pressures:* • To investigate Swansea Bay University Health Board's (SBUHB)position regarding ultrasound capacity, to facilitate an update report with the next Corporate Risk report.	**AC**	**April 2025**	**In progress:** Scheduled for April 2025
QSEC (24) 97	**Risk 797:** *Risk to the ability to deliver ultrasound services due to workforce pressures:* • QSEC agreed to advise the Board that the risk is being closely monitored; and that enquiries will be made regarding	**CSO**	**December 2025**	**Complete**

	regional working recognising this needs to be brought back to a future committee.			
QSEC (24) 97	**Risk 1664:** *Risk to Ophthalmology service delivery due to a national shortage of Consultant Ophthalmologists and the inability to recruit:* • To consider whether the data regarding the impact of the delays on patient outcomes requires a report to be scheduled for February 2025.	**AC**	**February 2025**	**Complete:** The data was considered at Integrated Quality, Finance and Performance Delivery Group and the levels of harm were not considered to be concerning.
QSEC (24) 97	**Corporate Risk Report:** • In collaboration with clinical colleagues, to develop metrics for articulating the quality, safety, and experience impacts of different risks	**SD/MH/JS**	**February 2025**	**In Progress:** The safety dashboard has been further developed to include additional metrics and further development is planned. Work is underway to develop the template for Care Group reporting to ensure there is articulation of issues and risks through the quality lens.
QSEC (24) 99	**Fragile Service Update Report:** • To ensure that Workforce is represented in the A Fragile Services Oversight Group (FSOG) Terms of Reference.	**MD**	**February 2025**	**Complete**
QSEC (24) 100	**Quality Assurance Report:** • To meet with the Chair and other colleagues to explore an appropriate course of action for QSEC to scrutinise the series of concerns currently emerging regarding the Mental Health & Learning Disability (MH&LD) service.	**SD**	**February 2025**	**Complete:**Noted and will be considered for future reports.
QSEC (24) 100	**Quality Assurance Report:**			

	• To meet with the Chair and Mr James Severs to consider the relationship between QSEC and Quality, Safety and Experience Sub Committee (QSESC), to ensure that the Committee receives assurance; and that QSESC can effectively manage quality within operations to provide that assurance.	**SD**	**February 2025**	**Complete**

QSEC (24) 100	**Quality Assurance Report:**
	
	• To liaise with Ms Daniel to provide a Chair's Briefing prior to the Christmas break regarding the following:
	  • Temporary night closure of the Minor Injuries Unit at Prince Philip Hospital (PPH)
	  • Bronglais paediatrics
	  • Tregaron
		JW	**December 2024**	**Complete:** Appended to QSEC Board Update Report.

QSEC (24) 100	**Quality Assurance Report:** • To provide an update outside the meeting regarding the Welsh Health Circular relating to children's incontinence products; and the inequity for children and young people in comparison to adult services.	**JS**	**February 2025**	**Complete:** To be reported via Integrated Quality, Financial Performance and Delivery Group
QSEC (24) 101	**Listening and Learning (From Events) Framework:** • To include a responsibility for the Board under the responsibility section of the Listening and Learning (From Events) Framework**,** particularly in setting the cultural tone within the organisation.	**CS**	**February 2025**	**Complete:** Noted and will be considered in final framework.

QSEC (24) 105	**Cleanliness Standards Audit report and Action Plan:** • To share Civica feedback with the Environmental Hygiene Group.	**LOC**	**February 2025**	**Complete:** Regular reports will be submitted to the department on any cleanliness or hygiene matters.
QSEC (24) 107	**Veteran Health:** • To request the Comms Team that The Health of Veterans and the Armed Forces Community report and Appendix are placed in a prominent position on the HDdUHB Website.	**AB**	**February 2025**	**Complete:** The report has been saved in SharePoint Page in 2 locations: - Armed Forces under the Armed Forces Covenant Duty - Business, Partnerships and Inclusion - Home – As part of our news feed.
QSEC (24) 107	**Rheumatology Deep Dive:** • To liaise with Swansea Bay University Health Board (SBUHB) to explore regional collaboration to address workforce gaps and reduce waiting times.	**AC**	**February 2025**	**In Progress:** Regional collaboration discussions have taken place with SBUHB. The Directorate have successfully appointed to a consultant post and have requested a pause on making another formal approach until the impact of that appointment on some of the challenges previously shared is understood.
QSEC (24) 111	**Withybush Creche Statement of Purpose (Approved):** • To update the appendices attached to the Withybush Creche Statement of Purpose prior to republishing.	**CJ**	**February 2025**	**Complete:** The Withybush Hospital Creche Statement of Purpose and Prospectus Appendices were updated and uploaded on to the corporate policy page.

SD - Sharon Daniel	AC - Andrew Carruthers	LOC – Louise O'Connor	JW – Joanne Wilson	JS - James Severs	CS – Cathie Steele
MD – Mandy Davies					

1.3 **10 Mins**

1.3 - Targeted Intervention Progress Report- Executive Leads

Attachments

TI Progress Report 13th Feb 2025 - QSEC.pdf

1.3 TI Tracker QSEC.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

1. Finance, strategy and planning
2. Performance and outcomes
3. Fragile services
4. Governance
5. Leadership, capability and culture
6. Quality of care

Escalation Domains

Quality, Safety and Experience Committee (QSEC)

13th February 2025

Targeted Intervention Progress Report

Introduction

Introduction

- The following slides highlight five material Targeted Intervention (TI) de-escalation criteria for QSEC's consideration. These criteria have been selected due to their strategic importance, potential to escalate if not carefully managed, and relevance to ongoing quality and safety improvements. While some indicators appear relatively stable or in an 'Assure' status at present, they could quickly move into an alert status if performance or key mitigations begin to deteriorate. Consequently, it is critical that the Committee maintains clear oversight of these areas, ensuring that timely interventions and sustainable improvements are delivered.

Healthcare Associated Infections (HCAIs) & Infection Prevention

(TI Criterion #50)

Executive Lead: Sharon Daniel, Interim Executive Director of Nursing, Quality & Patient Experience

Current Status: Advise

Key Points

- Trajectory & Performance - Focus on Clostridium difficile, Staph aureus, and E. coli.
- Data shows stabilisation/improvement in C. diff and E. coli rates; Staph aureus remains variable.

Quality Improvement Plan

- Root Cause Analysis (RCA) reviews, Aseptic Non Touch Technique (ANTT) training (target ≥85%), enhanced cleaning.
- Most recent plan reviewed on 30th October; feedback provided to ensure sustainability.

Risks & Actions

- Risk of reversion to higher infection rates if device management or hand hygiene lapses.
- Ongoing monthly performance monitoring at executive level to maintain scrutiny.

Complaints & Patient Concerns

(TI Criterion #51)

Executive Lead: Sharon Daniel, Interim Executive Director of Nursing, Quality & Patient Experience

Current Status: Assure

Key Points

- Performance - Closure rate of complaints within 30 working days is 78.4%, exceeding the 70% TI threshold.
- 5-day early resolution window significantly reduced Putting Things Right (PTR) caseload.

Quality & Engagement

- Workshops with clinical leads to enhance the quality of responses.
- Aligning complaint processes with new PTR regulations (Q1 2025–26).

Risks & Actions

- Sustaining quality alongside the pace of closures.
- Ensuring robust escalation pathways if volumes spike or if clinical complexities arise.

Outstanding External Recommendations

(TI Criterion #34 AND #52)

Executive Lead: Sharon Daniel, Interim Executive Director of Nursing, Quality & Patient Experience

Current Status: Alert

Key Points - Scope & Oversight:

- Recommendations from Health Inspectorate Wales (HIW), Ombudsman, Royal Colleges.
- Some delays persist due to capacity constraints and unrealistic initial deadlines.

Progress & Gaps

- A planned ‘deep dive’ into older/unresolved actions aims to accelerate completion.
- Ombudsman engagement remains generally positive, though three new investigations opened recently.

Risks & Actions

- Delays could create reputational/regulatory risks if not resolved.
- Recalibrate action plans with realistic deadlines; track progress through QSEC.

Patient Experience & Feedback Loop

(TI Criterion #23)

Executive Lead: Sharon Daniel, Interim Executive Director of Nursing, Quality & Patient Experience

Current Status: Advise

Key Points

- Data Integration - CIVICA, Datix, and FFT feedback are routinely reviewed for quality and service improvements.
- FFT consistently >90% satisfaction; high volume of feedback compared with other Health Boards.

Assurance & Improvements

- Positive external assurance from the Welsh Risk Pool audit and Ombudsman feedback.
- Further embedding patient feedback loops into directorate reporting from Q3 2024–25.

Risks & Actions

- Ensuring uniform adoption of feedback-to-improvement cycles across all services.
- Maintaining response rates and continuing to improve user engagement.

5. Fragile Services & Board Assurance

(TI Criteria #32, #33 & #35)

Executive Lead: Lee Davies, Executive Director of Strategy and Planning (with operational input from Sharon Daniel, Interim Executive Director of Nursing, Quality & Patient Experience)

Current Status: Advise

Key Points

- Identification & Tracking - Existing safety dashboard (staff sickness, agency use, IPC data) provides partial view.
- Need to integrate additional metrics (mortality reviews, patient experience, complaints) for a comprehensive fragility assessment.

Board Oversight

- Clinical Service Plan (CSP) has highlighted system fragilities (e.g., site configuration, workforce pressures).
- A methodology for assessing broader service fragility was presented to QSEC; a formal register of fragile services is still in development.

Risks & Actions

- Without a fully established framework, potential blind spots may emerge.
- Plan to present an updated approach to the Public Board (March 2025), ensuring a cohesive response across all fragile services.

Summary & Next Steps for QSEC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

1. **HCAIs & Infection Prevention** – Ensure the Infection, Prevention and Control (IPC) plan is clear and on track; ensure long-term sustainability of improvements.
2. **Complaints & Patient Concerns** - Maintain above-target closure rates while improving the quality of responses; align with PTR changes.
3. **Outstanding External Recommendations** - Address capacity constraints, recalibrate deadlines, and use a ‘deep dive’ to clear any backlog.
4. **Patient Experience & Feedback** - Fully embed CIVICA and FFT data at directorate level; sustain ≥90% satisfaction.
5. **Fragile Services & Board Assurance** - Finalise and operationalise the fragility assessment framework; present updates to QSEC and the Board.

DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG

SAFE | SUSTAINABLE | ACCESSIBLE | KIND

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Criteria	Action	Reporting Group	Committee	Status	Status Change	Status Change Date	Executive Lead	Summary of Current Status	Lead Executive Response (if applicable)	Documented Plan and Dates for Delivery (Evidence)	Actions Outstanding	Evidence and Assurance	Risk
23	Improving ratings from service user feedback experience responses and evidence of use of Datix and CIVICA data to inform quality improvement processes and the experience of patients and their families.	IQFPD	QSEC	Advise			Sharon Daniel	•Better Data Integration - CIVICA, Datix, and FFT are now standard inputs in routine meetings, offering a broader view of patient feedback. •High FFT Scores - Patient satisfaction consistently exceeds 90%. •External Feedback - Generally positive Ombudsman engagement (12 decisions not to investigate, 2 partly upheld), plus significant assurance from the Welsh Risk Pool audit.	If the status for alert relates to ongoing monitoring thenm this is fair. Feedback from service users via the FFT is consistently above 90%. The amouont of feedback received in Hywel Dda is significantly higher than other HB (although there is no national standard/benchmar for this). The HB receives pt Experience report at each meeting , this is not the case across Wales. We have had favourable feedback from the Ombudsman this year and have achieved sigificat assurance from the WRP audit. “We have improved how patient experience data is used, and we will keep expanding these feedback loops to strengthen quality improvement across all services.”	•Embed patient experience data into all directorate reports (in place from Quarter 3 of 2024–25). •Provide regular updates to QSEC/Board.	•Fully incorporate Datix/CIVICA feedback into formal quality improvement projects (target: Quarter 4 of 2024–25). •Maintain FFT satisfaction above 90% and keep improving complaints response times	•FFT Scores; Ombudsman feedback; WRP audit reports. •Directorate packs and escalation meeting minutes.	1184 (P)
32	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 AW HMC RC Llais etc) mortality reviews duty of quality/candour infection protection control performance clinical and medical leadership.	IQFPD	QSEC	Advise			Sharon Daniel	The health board’s safety dashboard currently includes essential data points such as staff sickness, agency use, infection prevention and control, falls, medication errors, and pressure damage. These elements provide a foundational view to assess the factors affecting service resilience. The next critical step is to incorporate additional metrics, such as mortality reviews, patient experience, and complaints data, to build a more comprehensive understanding. By triangulating these expanded data points, we can enhance our ability to identify and address the underlying drivers of fragility within services, supporting more informed decision-making and targeted improvements.	Framework approved at QSEC in December. Sharepoint platform developed and Fraile Services Oversight Group established. eporting via IQPFD through to Executive Team				210 risks aligned to fragile risk theme.
33	Fragile services (including but not limited to stroke primary care orthopaedics and ophthalmology) are supported by strong clinical leadership have an effective integrated improvement plan project management structure and effective transformation support. Where appropriate key performance metrics will be agreed.	IQFPD	QSEC	Advise			Sharon Daniel	Within the Clinical Services Plan (CSP), there is robust information on specific programmes, particularly for services within its scope, such as stroke, orthopaedics, ophthalmology, and primary care. Additionally, the risk register serves as a mechanism to highlight fragile services, providing an inherent process for identifying risks due to the nature of each service. However, while these tools contribute to understanding service fragility, a structured framework specifically focused on fragile services beyond the CSP scope has yet to be fully established. For instance, the fragile services register within the TI framework remains incomplete, indicating that while there is awareness of fragility, a more defined and comprehensive framework would enhance clarity on fragile services across the board. This development remains a work in progress.	Does this sit better with mark Henwood				210 risks aligned to fragile risk theme. CSP Project Risk Register?
34	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.	IQFPD	QSEC	Alert			Sharon Daniel	As part of directorate escalation meetings, we regularly review outstanding recommendations, including those linked to Health Inspectorate Wales (HIW) reports, to ensure these are effectively discharged. However, not all areas currently have the requisite improvement plans in place, highlighting a need for enhanced capacity and coordination. This gap is largely due to the demands on teams managing multiple priorities. Strengthening our approach to improvement planning will be critical to meeting all outstanding recommendations in a timely manner moving forward.	Do we have a baseline and what is a de-escalation threshold? Currently no Royal College Visits received or pending. HIW sits under the Governance Domain & contributes to the escalation scoring. We report complaince to all DITS, Escalation Meetings - we have AMaT System and we monitor it at DITS, IQPD nd QSEC. **Action:** Undertake a Deep Dive on remaining historical actions that cannot be progressed.				No identified risk however non-implementation may result in risks on directorate and service risk resgisters
35	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.	IQFPD	QSEC	Advise			Lee Davies	The Board is regularly updated on the CSP, which has provided valuable insights into the overall fragility across services, driven in part by site configuration issues. The CSP has highlighted the degree of system-wide fragility and identified specific services under strain. While there is clinical data supporting fragility within the CSP’s scope, including complaints, claims, and cost implications, services outside this scope lack the same comprehensive oversight. A more cohesive model - integrating workforce pressures, financial assessments, service resilience, and patient accessibility - would help frame the Board’s understanding and response to fragile services more effectively. A methodology to assess fragilty in this way has been developed and presented to QSEC. However, a robust response across all fragile service areas is still evolving and work is progressing through the Quality intelligence group to introduce this methodology and develop a register of fragile services.	The work on fragile services will be overseen through QSEC and the intention is to present it to Public Board in March 25				N/A
48	A culture of listening learning and improving is embedded throughout the organisation based on early and rapid triangulation and resolution of issues from a variety of sources including quality mortality staffing levels patient outcomes user and staff feedback.	TI coordination grou	QSEC	Advise			Mark Henwood/Sharon Daniel	The Quality Surveillance Group, led by Clinical Executives, aims to embed a culture of listening, learning, and improvement across the organisation. The safety dashboard currently supports this work through data on staff sickness, agency use, infection prevention and control, and safety metrics like falls, medication errors, and pressure damage. Moving forward, integrating additional information such as mortality reviews, patient experience, and complaints data will further strengthen the group’s capacity to address gaps and drive evidence-based improvements. This expanded approach will ensure that insights from these areas are fully utilised in embedding a responsive and learning-oriented culture across the organisation. -Quality Surveillance Group: Oversees data on IPC, safety metrics, and staff sickness across the organisation -Expanded Feedback: CIVICA, Datix, and FFT data are routinely reviewed, helping identify potential concerns more quickly. -Complaints Culture: The new 5-day early resolution process reduced PTR cases from over 200 earlier in 2024 to around 100 in December, suggesting a more proactive approach		-Continue rolling out staff and patient feedback in monthly improvement huddles (by Quarter 3 of 2024–25) -Update Quality Surveillance Group metrics from January 2025 to include new feedback sources.			1184 (P) 1189 (P) 1195 (P)

50	Stabilisation of the increased trajectory of cases of HCAI and evidence of continuous improvement accompanied by a strong QI approach and plan that has oversight and monitoring by board Quality Safety Committee and Board. The health board to have a clear improvement plan based on a root cause analysis to address the issue of hospital onset HCAIs.	IQFPD	QSEC	Advise			Sharon Daniel	Our focus remains on three primary HCAI types: C. diff, Staph aureus, and E. coli. Current HCAI Trends: -C. diff: Performing below the threshold (4 cases in August/September), suggesting effective cleaning and antimicrobial stewardship. -Staph aureus: Continues to fluctuate around baseline, requiring tighter device management and hand hygiene compliance. -E. coli: Near target (5 cases); improvements need to be sustained to avoid spikes. **Quality Improvement Measures**: ANTT training (target 85% compliance), regular RCA reviews, and site-specific interventions (e.g., advanced cleaning methods). A clear and well set out improvement plan, received and reviewed on 30th October, has been provided with feedback to ensure changes are sustainable. While improvements are being achieved, our focus remains on securing long-term stability rather than short-term performance gains.					1490 (S) 1640 (S)
51	70% of complaints that had final reply (Reg 24) / interim reply (Reg 26) to be closed less than 30 working days of concern received.	IQFPD	QSEC	Assure			Sharon Daniel	Current performance in responding to complaints stands at 78.43%, exceeding both the TI target of 70% and the national target of 75%, which is a positive outcome. A workshop with clinical leaders and external partners has taken place to strengthen the focus on quality in complaints handling and align with upcoming regulatory changes. Need on-going plans however such as a SoP Summary of Current Status -Performance: Current closure rate stands at 76.98%, exceeding both the TI target of 70% and the national target of 75%. -Early Resolution: Introducing a 5-day early resolution window from 1 November 2024 has helped reduce PTR caseloads (down to around 100 in December), suggesting a more efficient and patient-focused approach.		-Continue staff training and refinement of complaint triage processes (rolling basis, next review Q4 2024–25). -Align with upcoming PTR regulatory changes by Q1 2025–26.		-Complaints data (Beacon Dashboard) showing closure rates. -Workshop outcomes with clinical leads and external partners, focusing on quality in complaint handling.	No risk identified
52	Effective response from the health board to external reports and reviews including those from Audit Wales the Ombudsman Royal Colleges and HIW resulting in sustainable improvements.	IQFPD	QSEC	Alert			Sharon Daniel	The health board has established oversight mechanisms for responding to external reports and reviews, with QSEC providing structured oversight and escalation processes in place at the directorate level. -Ombudsman Engagement: Three new investigations opened (Oct–Nov 2024), 12 not investigated, and 2 partly upheld, indicating generally fair external scrutiny. -Timelines & Capacity: Many historic recommendations faced delays due to unrealistic initial deadlines or resource constraints. -Resetting Improvement Plans: Directorates are recalibrating their action plans to ensure deadlines are both achievable and closely monitored.	This links to row 35 Action: Deep Dive	-Recalibrated improvement plans for all open HIW/Royal College recommendations by Q4 2024–25. -QSEC 'deep dive' on older actions (12 months+) by Q2 2025–26.	-Complete the update of all directorate action plans with new, realistic dates -Continue close monitoring of Royal College/HIW outcomes to prevent backlog recurrence.		No identified risk however non-implementation may result in risks on directorate and service risk resgisters
53	Demonstrate how service user and staff experience/involvement is being used to improve quality processes and inform service development across the organisation.	IQFPD	QSEC	Advise			Sharon Daniel	While performance has been strong, we've yet to receive a permanent, comprehensive plan addressing some of the ongoing challenges raised, particularly around consistency across services. This isn't a request for new work but rather a call for clear evidence of sustainable improvement, as we would expect from any directorate, to ensure these achievements are maintained over the longer term. -Integrated Feedback: CIVICA and FFT data are now used in local 'improvement huddles,' aligning patient experience insights with staff input. -PTR and Complaints Trends: Significant drop in PTR cases suggests that user feedback loops are having a practical impact. -Staff Engagement: Pilot schemes (e.g., monthly 'temperature checks') aim to gather staff perspectives on key issues, ensuring alignment with patient-centric improvements.					1184 (P) 1189 (P) 1195 (P)
54	Demonstrate the progress made against implementing the requirements of the Duty of Candour and Duty of Quality including the embedding of the Care and Quality Standards through the organisation from Board to service area delivery.	IQFPD	QSEC	Assure			Sharon Daniel	Based on the documentation, the Health Board demonstrates a structured approach to meeting Duty of Candour requirements. The bi-monthly Quality and Safety Assurance Report to the Quality, Safety, and Experience Committee (QSEC) includes regular updates on Duty of Candour incidents, ensuring that issues are escalated and reviewed within a consistent governance framework. Additionally, the Health and Social Care Quality and Engagement Act Annual Report outlines the Health Board's adherence to statutory obligations, detailing incidents that triggered the Duty of Candour and the actions taken in response. These processes suggest that the Health Board is actively embedding Duty of Candour principles into its quality and safety culture. Regular updates to QSEC and an annual overview of compliance support a transparent and accountable approach, providing a foundation for continuous improvement and alignment with legal standards. While these mechanisms indicate a commitment to Duty of Candour, ongoing reviews and updates will be essential to ensure that these standards are consistently met and embedded across all services.		-Roll out standardised 'improvement huddles' in all major directorates by Q3 2024–25 -Finalise a comprehensive approach for capturing and acting on staff feedback by Q4 2024–25.			No risk identified

55	Oversight of safeguarding arrangements to ensure the board have sufficient meaningful assurance that organisation is delivering against its safeguarding statutory responsibilities.	IQFPD	QSEC	Assure			Sharon Daniel	The Health Board demonstrates comprehensive safeguarding oversight, structured to ensure delivery against statutory safeguarding responsibilities. The Strategic Safeguarding Working Group (SSWG) regularly reviews safeguarding practices across a wide array of areas—including adult and child safeguarding, mental health, estates, and facilities—and provides updates through the Quality, Safety, and Experience Committee (QSEC). The SSWG's remit covers critical aspects such as incidents and trends in adult and child safeguarding reports, challenges in mental health and domestic abuse cases, support for looked-after children, and violence against women, domestic abuse, and sexual violence (VAWDASV) initiatives. The regular updates from SSWG to QSEC, along with detailed safeguarding reports, provide the Board with visibility into safeguarding risks, mitigation actions, and service-specific challenges, such as training compliance and staffing gaps within certain sectors. The Health Board has also committed to ongoing capacity and demand assessments to ensure appropriate resourcing for safeguarding roles and responsibilities, including workforce compliance with safeguarding training. These mechanisms collectively ensure that the Health Board has a structured approach to monitor and improve safeguarding practices. This layered oversight provides meaningful assurance to the Board that safeguarding responsibilities are not only being met but also continually assessed to identify areas for improvement, addressing complex cases, and mitigating risks where needed.					No risk identified
56	Use of National Clinical Audit and Outcome Review Programme and Value in Health dashboards to support quality improvement and address unwarranted variation in care. (including the use of patient and staff feedback to influence service design).	IQFPD	QSEC	Advise			Sharon Daniel						No risk identified

1.4 **10 Mins**

1.4 - Operational Governance Plan Update

Sharon Daniel (Hywel Dda UHB - Interim Executive Director of Nursing, Quality & Patient Experience), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)

Attachments

1.4 Quality Governance Arrangements.pdf

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

Situation

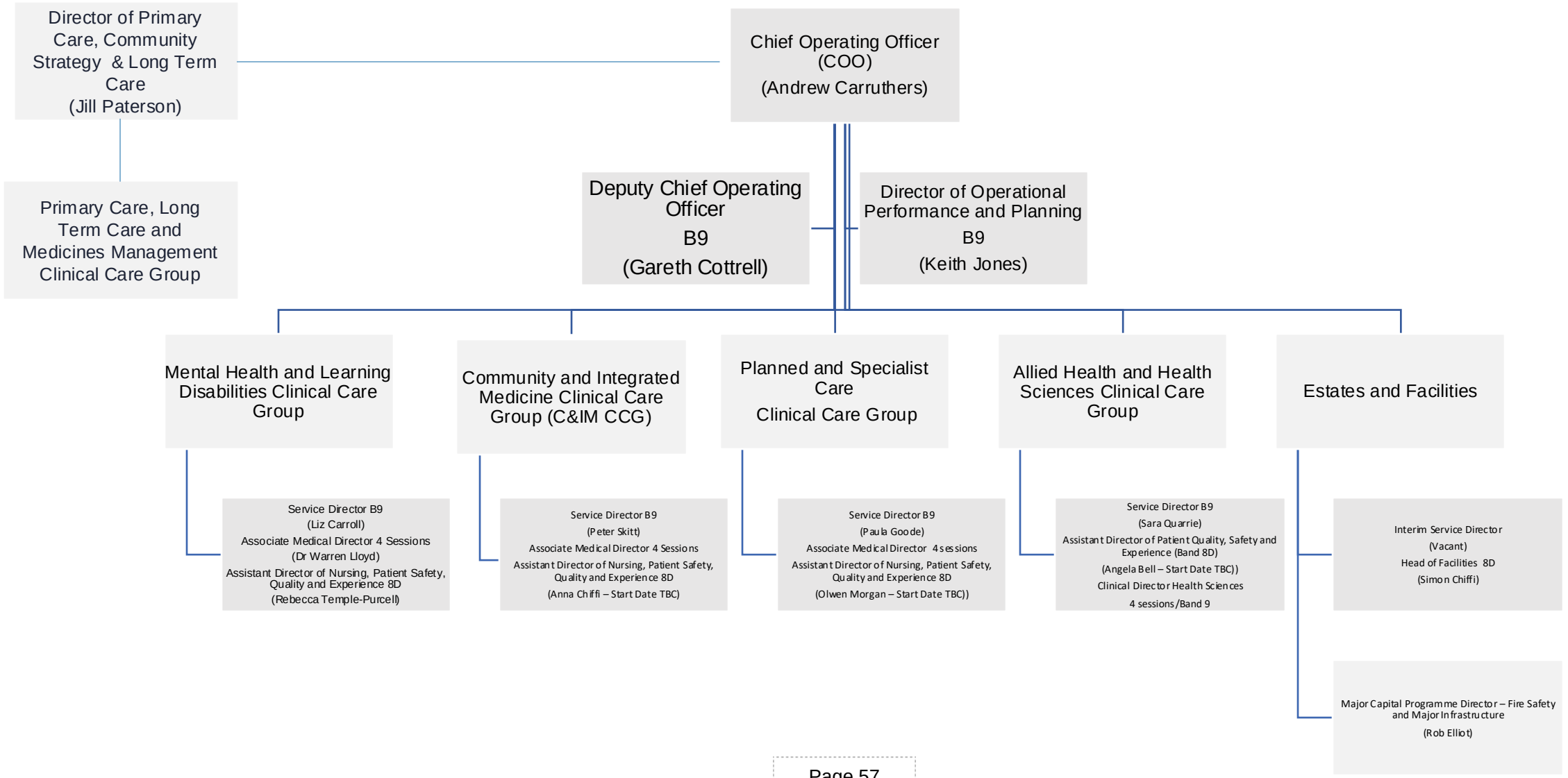
The purpose of this report is to provide the Quality, Safety and Experience Committee (QSEC) with an update on the Operational Governance Plan that will be effective following the introduction of the revised Operational Structure.

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



1. Operational Structure – Appointments Update

- 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

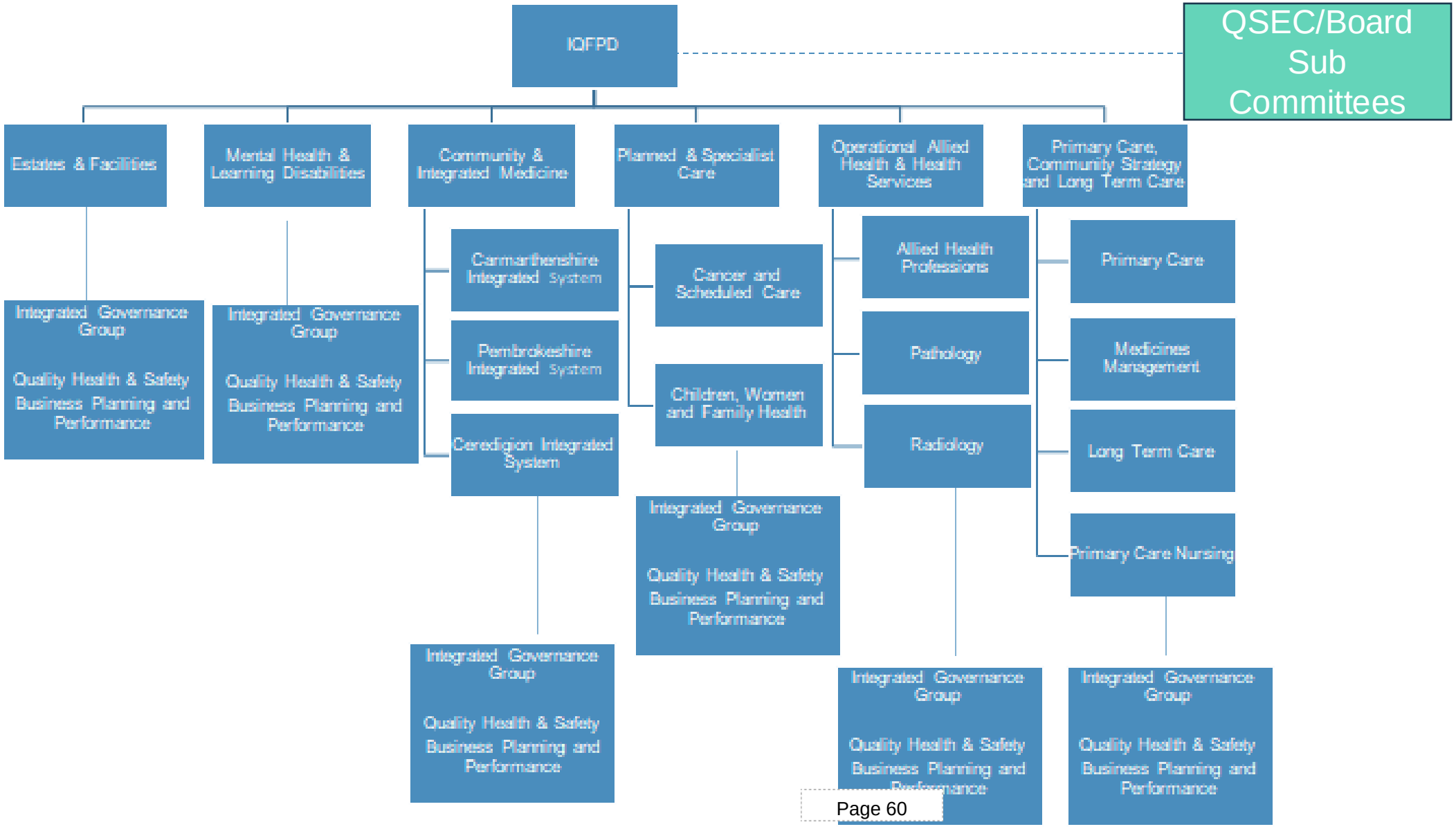
- Remaining Service Group General Manager posts advertised externally 17th January – Closing date 29th January 2025. Interviews in February to include

  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

- 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 guidance[1]	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

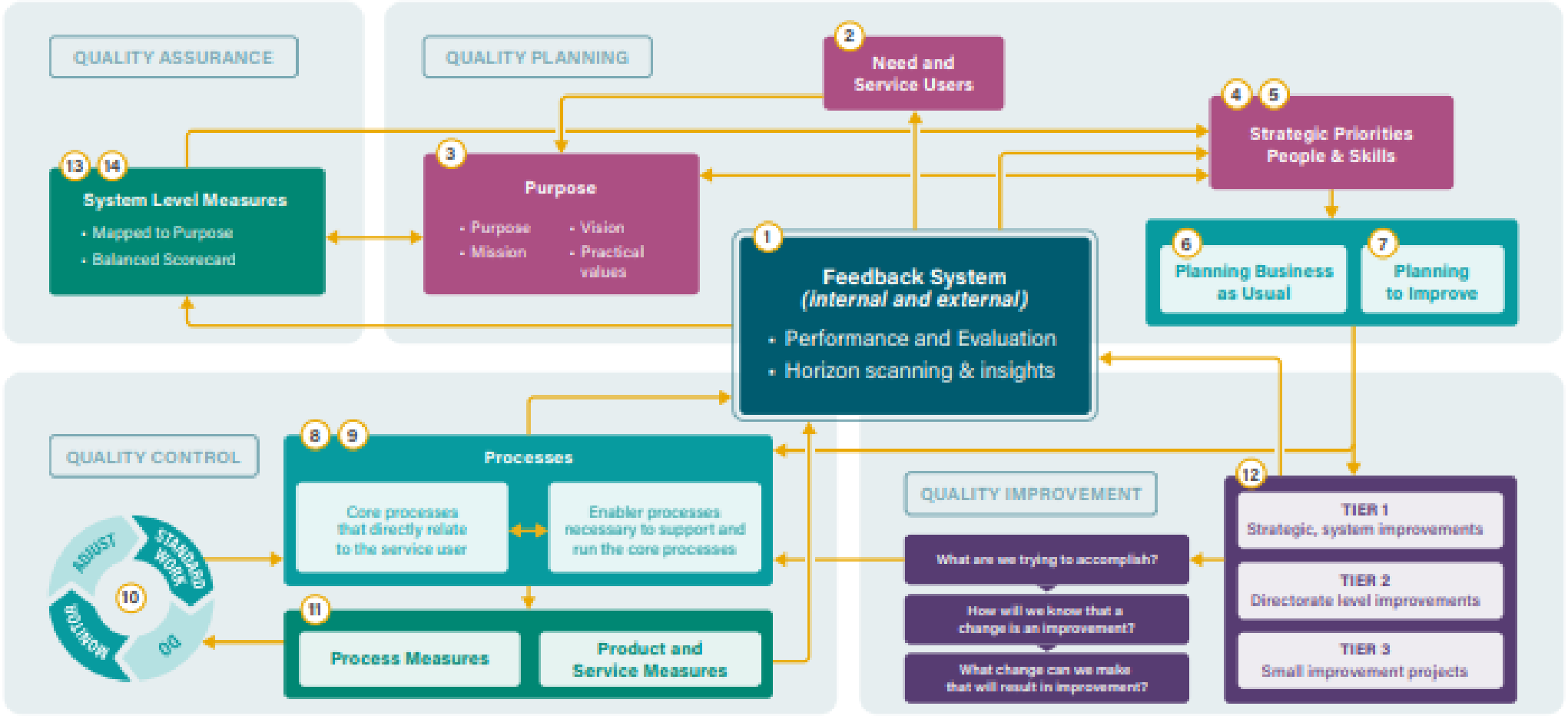
Connected daily operational management to monitor and maintain quality, including the use of real-time measures over time.

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.

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

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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Integrated Governance Group CCG (CSGs) ⟷ Integrated Quality, Financial Performance and Delivery Group (IQFPD)/Exec & Senior Ops Leadership ⟷ Quality, Safety and Experience Sub Committee (QSESC) ⟷ QSEC

IOFPD: 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. O – 6

PROGRESS LEVELS / KEY ELEMENTS	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
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 impacts identified in 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/inspectorates/ 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

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

- **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

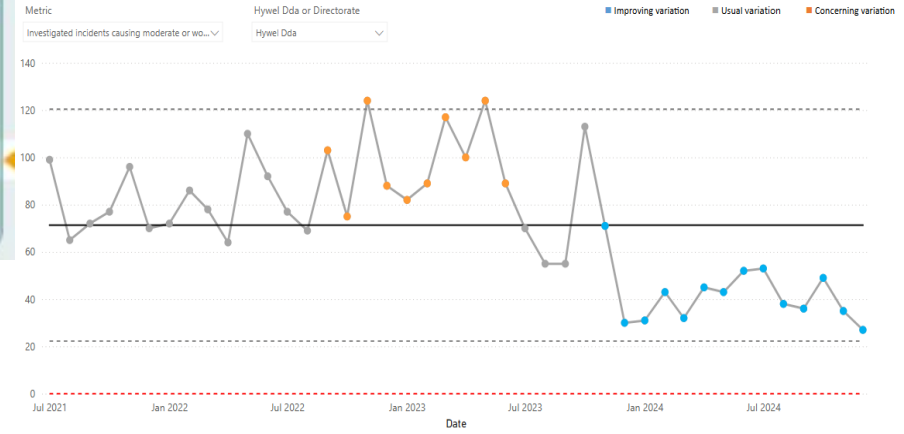
Topic	Measure	Oct 24	Nov 24	Dec 24	Trend (Apr 22 - Dec 24)
Incidents	Incidents open >60 days	453	417	400	
	Incidents open >120 days	392	359	348	
	Patient safety incidents closed with moderate or above harm	2	0	0	
Patient experience	Longest open complaint	450	480	511	
	% complaints responded to within 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			

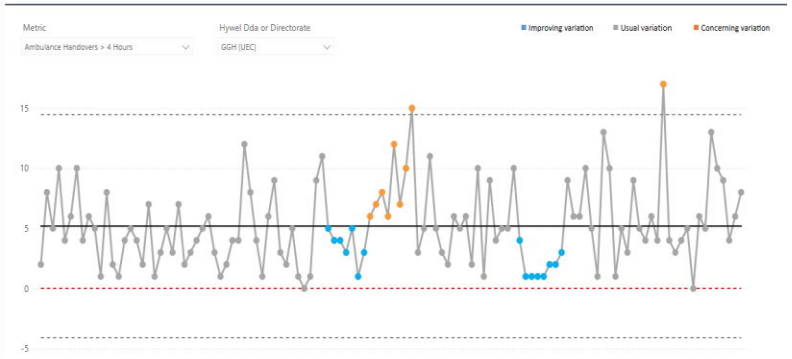
Refresh Date: 28/01/2025

1

Feedback System
(internal and external)

- Performance and Evaluation
- Horizon scanning & insights



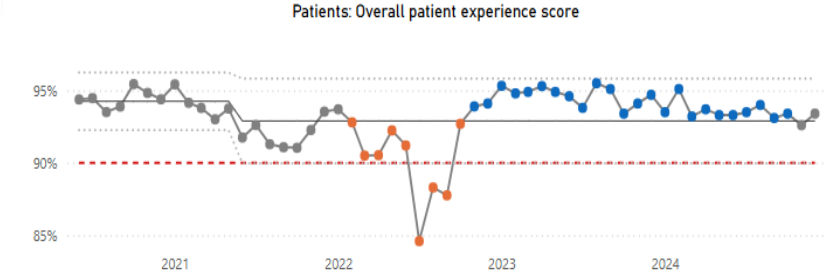


Risk overview

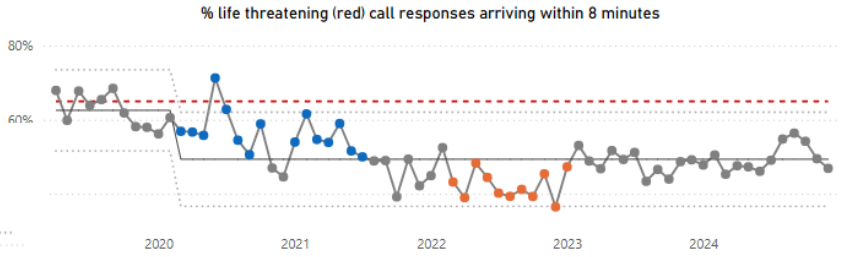
Open risks	Risks overdue	% overdue	Open actions	Actions overdue	% overdue
553	108	20%	909	176	19%

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	1606 1647 1704 222	1846 1900 1941 2001 488 212 1040 1490 15 ...	1966 1967 1684 1549 1679 1959 1974 1984 ...	1553 1614 1399 1661 1786 1882 1903 1976 ...	1867 1517 1309 1932 1933 1930 1904 1927 ...
Moderate 3	1796	1005 1147 1148 1149 1155 1157 1913 1874 ...	1387 474 476 767 1775 1632 430 1975 1965..	1764 1815 1960 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 1478 1922 482 447 1756 19 ...	1616 1254 481 1456 1375 991 947 837 1353 ...	1645 1338
Negligible 1				1403	



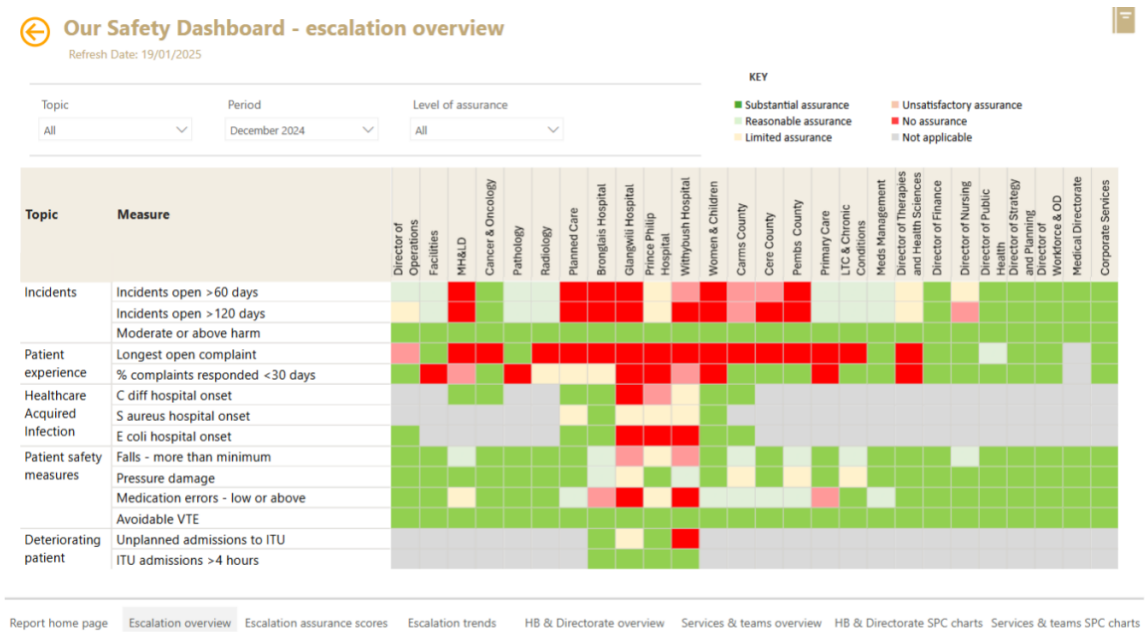
July 2022 low data point cause: change to the system causing a delay in surveys being sent out and functionality issues



5. Self –Assessment: Our Safety Dashboard

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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.



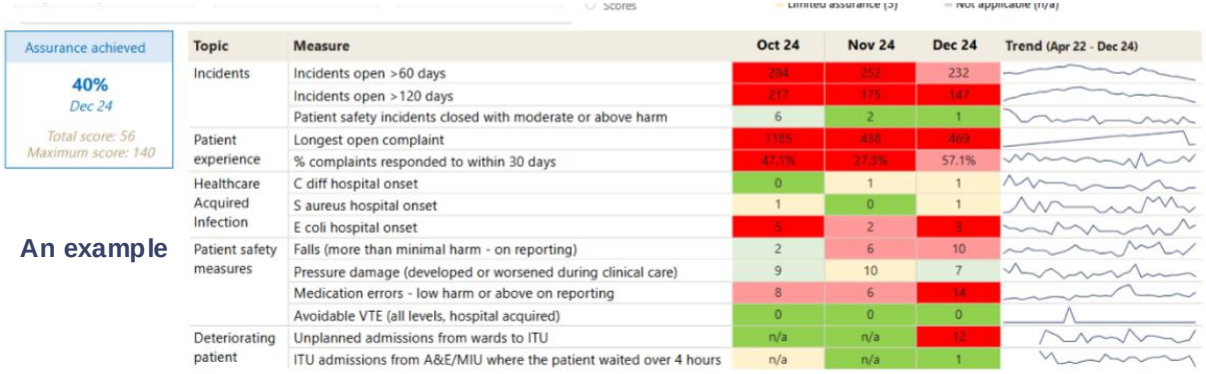
New measures on the dashboard:

- 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

An example



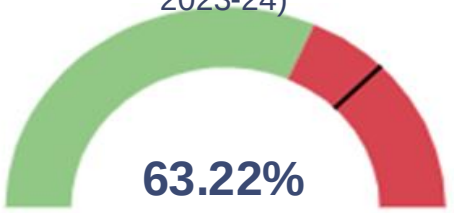
5. Self- Assessment: Escalation Criteria Incidents & Complaints

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

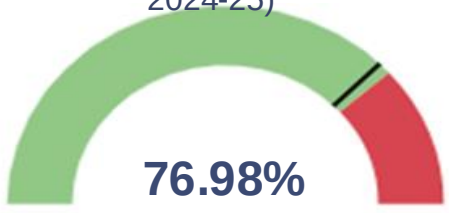
Proportion of complaints settled within 30 days

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

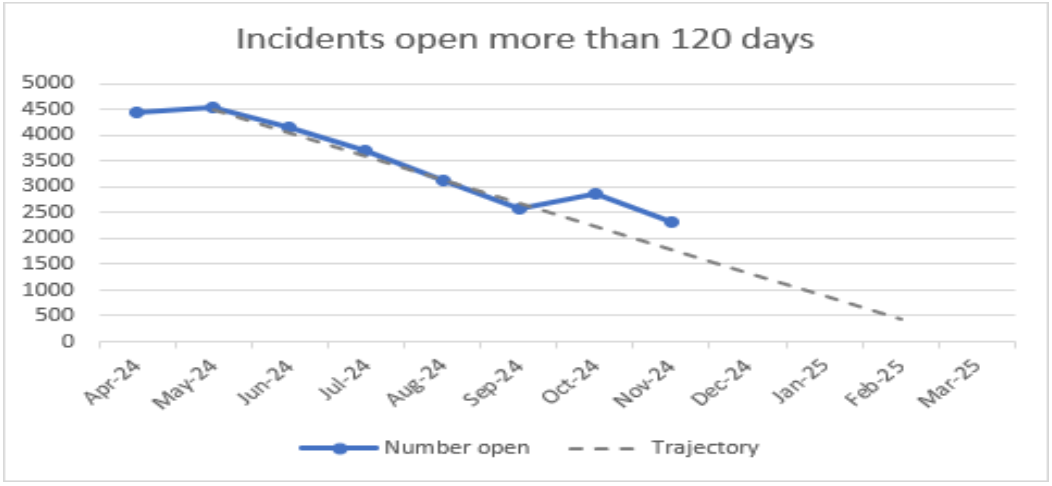
Hywel Dda UHB proportion of complaints settled within 30 days (financial year 2023-24)



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



Data extract from Beacon Dashboard



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.

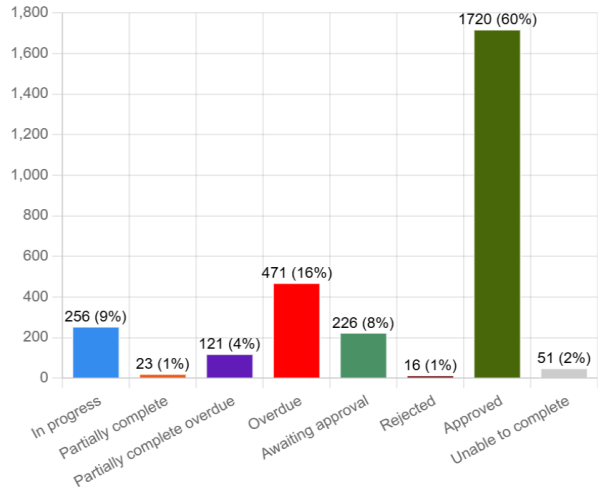
Concerns Management/Investigation workshop for senior leaders held on 31 October, in preparation for new PTR implementation 2025 (involving NHS Executive and Welsh Risk Pool (WRP).

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

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

5. Self- Assessment: Patient Experience Feedback

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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.

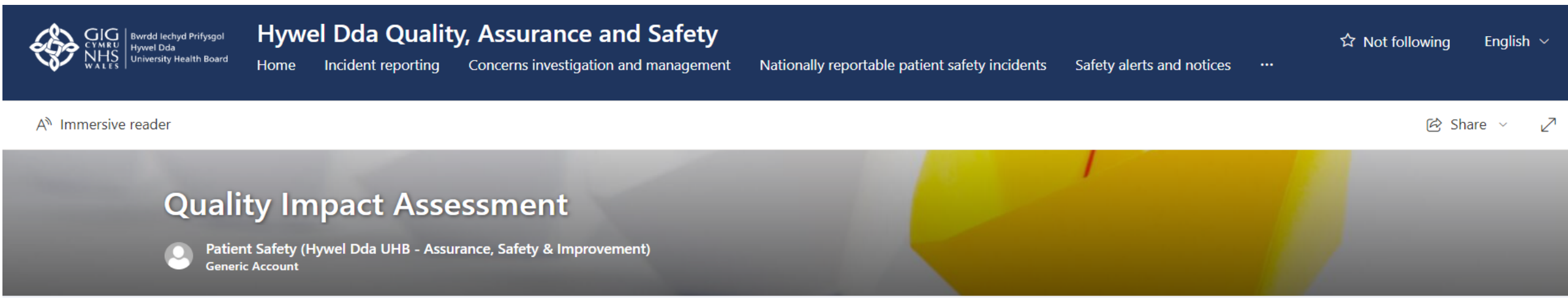
Mitigating actions

- 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

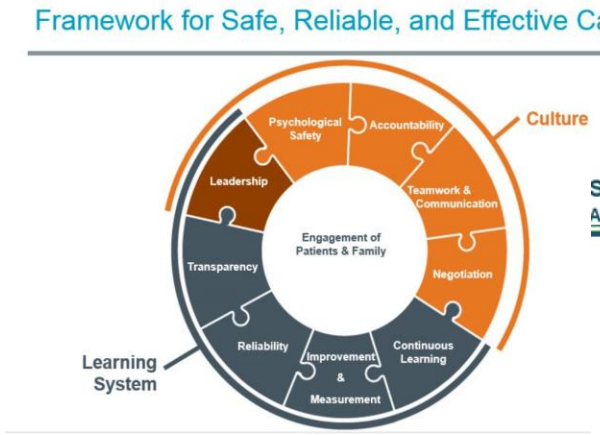


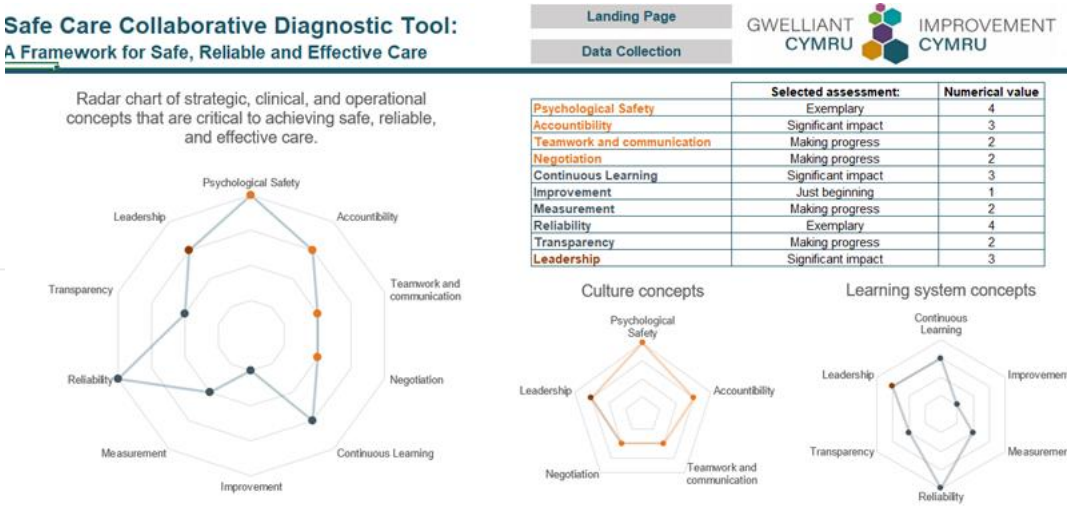
Quality Impact Assessment

5. Self-Assessment: Fragile Services

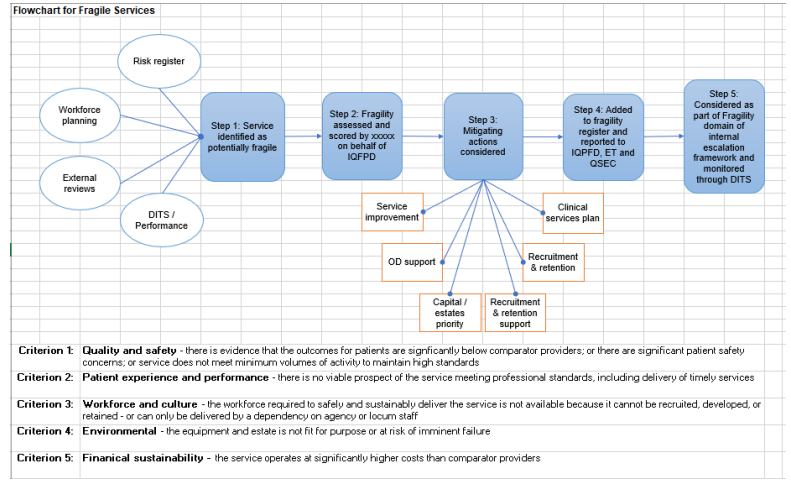
The **Fragile Services Register** (FSR) will provide an accessible reporting process for services at risk, where and how the services was identified, how the service is being supported and by who, progress and outcome of the support.

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.





	Selected assessment:	Numerical value
Psychological Safety	Exemplary	4
Accountibility	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



Criterion 1:	**Quality and safety** - there is evidence that the outcomes for patients are significantly below comparator providers; or there are significant patient safety concerns; or service does not meet minimum volumes of activity to maintain high standards
Criterion 2:	**Patient experience and performance** - there is no viable prospect of the service meeting professional standards, including delivery of timely services
Criterion 3:	**Workforce and culture** - the workforce required to safely and sustainably deliver the service is not available because it cannot be recruited, developed, or retained - or can only be delivered by a dependency on agency or locum staff
Criterion 4:	**Environmental** - the equipment and estate is not fit for purpose or at risk of imminent failure
Criterion 5:	**Finanical sustainability** - the service operates at significantly higher costs than comparator providers

6. Monitoring Arrangements: Indicators of Success

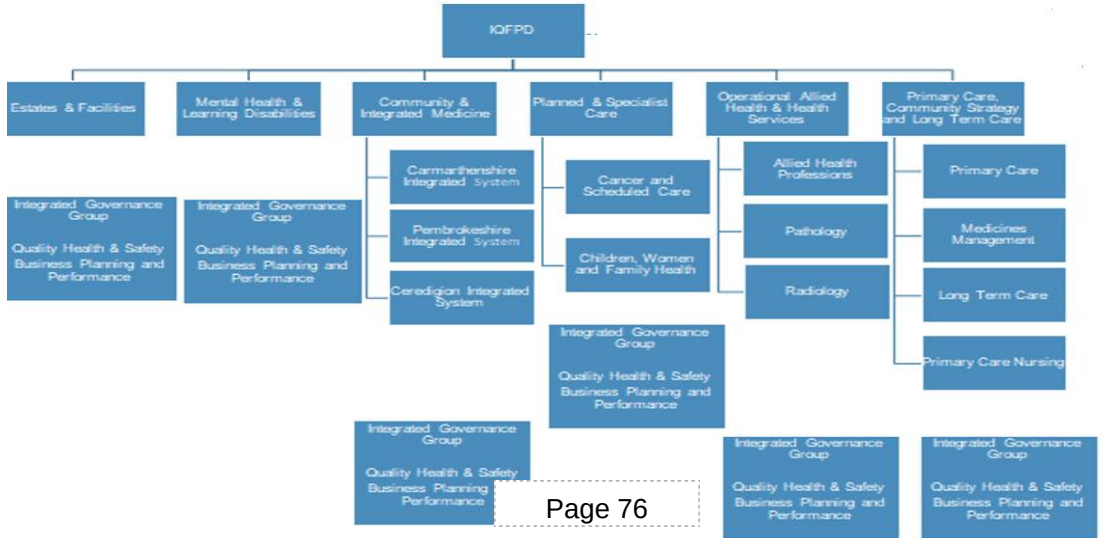
Indicators:

- 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

Discussion Points

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

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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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

1.5 **10 Mins**

1.5 - Review of Patient Experience Reporting - Verbal

Anna Lewis (Hywel Dda UHB - Independent Board Member), Sharon Daniel (Hywel Dda UHB - Interim Executive Director of Nursing, Quality & Patient Experience)

1.6

10 Mins

1.6 - Paediatric Services: Neonatal Ventilators: Patient and Staff Experience Feedback

Nick Davies (Hywel Dda UHB - Service Delivery Manager - Acute Paediatric and Neonatal Services), Leah Andrew (Hywel Dda UHB - Senior Nurse Quality Assurance Manager for Neonates)

Attachments

1.6 Neonatal Ventilators- QSEC update Jan 25.pdf

Impact and outcomes of care following Charitable Funds investment in Neonatal Ventilators.

Leah Andrew, Senior Nurse Quality Assurance Manager Neonates
Nick Williams-Davies, Service Delivery Manager
January 2025

Background

- Late in 2023, it was acknowledged that the Health Board was unable to adhere to national British Association of Perinatal Medicine (BAPM) Standards. Furthermore, the service was unable to meet some of the outcome measures of the national improvement projects such as Perinatal Excellence to Reduce Injury in Premature Birth (Wales) (PERIPrem Cymru).

- The ventilators in place at that time (SLE 5000) could not deliver the respiratory support required. Additionally, they were out of support/ maintenance contracts with no means to repair, replace or service them. This meant that the provision of the most up to date care was unavailable and quality was comp

Risk to neonates pre investment

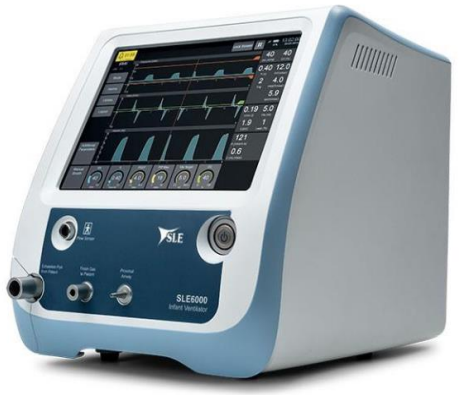
- The ventilators were not capable of providing Volume Guarantee (VG) ventilation. Also known as volume targeted ventilation, VG is the ability to deliver specific and accurate ventilatory pressures when supporting the neonate.
- VG is known to be protective to the lungs of premature infants and lead to reduced rates of chronic lung disease, including the use of home oxygen.
- The use of volume targeted ventilation is an integral part of the PERIPrem project - ensuring good perinatal optimisation of preterm infants, leading to improvements in survival and neurodisability.

Risks cont.

- The risk to babies was also subject to feedback from the Cymru inter-Hospital Acute Neonatal Transfer Team (CHANTS). Prior to the arrival of the transfer team, the most up to date advice was issued to include VG – which the Health Board (HB)was unable to initiate as VG was unavailable. Upon arrival, this risk was mitigated due to utilisation of CHANTS equipment.
- Anecdotal feedback at that time indicates conditions improved prior to arrival in tertiary care due to this level of intervention.
- Specialist Care Baby Unit (SCBU) historically utilised three different machines, to provide three different modes of ventilation, a more complex series of interventions in comparison.

Charitable Funds Investment

- Investment of the new “SLE6000” ventilator has resulted in the provision of safer, higher quality care across the health board.
- The Charitable Funds Committee approved a £121k investment in November 2023. The new machines were in place and staff fully trained from April 2024.
- CHANTS feedback is entirely positive – optimal care is delivered earlier and transfers are less complicated in this regard.
- The ventilator is capable of providing all 3 ventilatory requirements- making care at the cot side much less complex- and has resulted in a reduction in consumables purchased – improving cost efficiencies.
- The neonatal team is now able to provide Nasal continuous positive airway pressure (NCPAP) via the new machines. This has resulted in reduced clinical risk by providing a consistent pressure that self-regulates the flow to maintaining the pressure needed. This has been seen to reduce the need for invasive ventilation, clearly beneficial to neonatal outcomes.



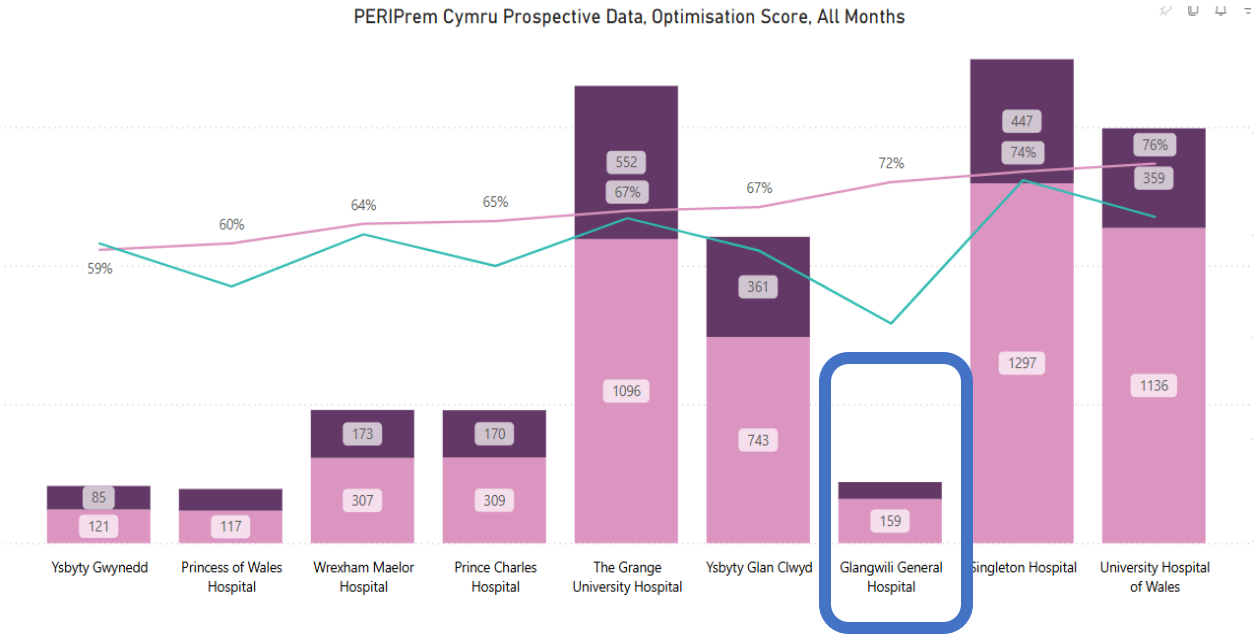
PROMS and PREMS

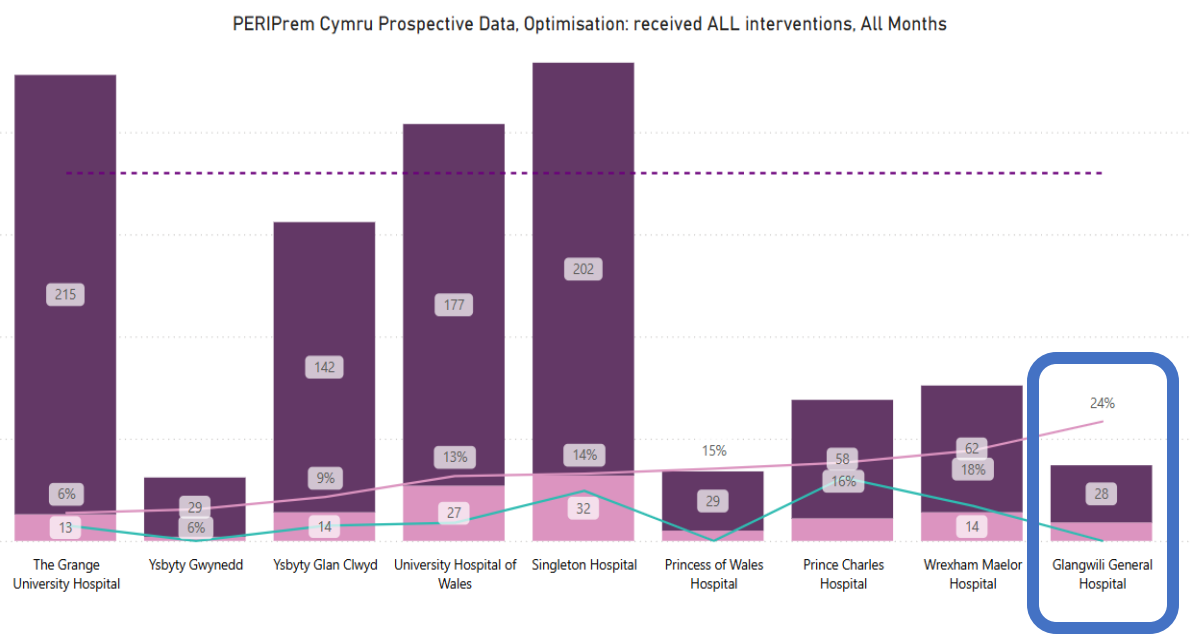
- Risk to neurodisability/ long term respiratory conditions has reduced.
- PERIPrem Cymru and BAPM standards are now being met.
- This in turn has a profoundly positive impact on the mental wellbeing of parents, carers and families. This is particularly pertinent for families that can now be kept closer to home, minimising separation from support networks and siblings/children.
- Efficiencies seen in relation to training, as only one machine staff need to be trained and deemed competent to use rather than 3.
- Risk of user error reduced, and ease of use / user confidence is promoted.
- Clear long term health economy benefits realised for those babies requiring such critical care interventions.

PERIPrem Cymru

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

- Since the investment, Hywel Dda is ranked 3rd in Wales for optimisation of preterm infants.
- Also number one in Wales for the most babies fully optimized each month (of which ventilatory considerations are an essential criteria)





Patient story/ feedback

It has proved exceptionally difficult to obtain a patient story or feedback from parents in relation to the impact this new equipment has had.

This is believed to be due to their experience when navigating a significant trauma in their lives where their premature baby is so critically ill- and often where the mother is also receiving treatments, sometimes separated from her child.

To address this, Neonatal Services will link in with the Patient Experience Midwife to improve feedback

Feedback has been obtained from the clinical team that have used the new machine:

Staff Feedback

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Easier to use and set up. Alarms are clear and easy to read and fix
Neonatal Staff Nurse

The pressures are maintained easier than on the older cpap machines
Neonatal Staff Nurse

The graphs are amazing, interchangeable ventilation strategies are great, CO2 option is ideal and volume control is precise
Paediatric Consultant

I'm so pleased that our Hywel Dda babies are now receiving gold-standard respiratory care and being given the best chance in the short term and long-term. This is in keeping with the aims of PERIPREM Cymru - giving all premature babies the best chance at the start of life.
Paediatric Consultant

Sle6000 ventilators give us the ability to provide more accurate delivery of volume targeted ventilation compared to our old ventilators making a safer delivery of ventilation to our babies especially premature reducing risk of lung injury meeting the periprem requirement supporting better outcomes in life for our babies and families .
Neonatal

The ventilators have recently been utilised for ncpap and high flow, Ncpap is particularly effective in my opinion as the flow rate is adjusted automatically to achieve a set PEEP, resulting in more consistent pressures which our older equipment was incapable of. In regard to high flow, the SLE6000 circuits are considerably cheaper than the optiflow circuits resulting in cost savings. Additionally, having one circuit that does ventilation, nCpap and high flow makes it easier to train staff on one piece of equipment as opposed to three separate machines and again contributes to cost saving.
Neonatal Charge Nurse

Conclusion

- The investment of £121k to support the procurement of the 4 ventilators has significantly improved neonatal care delivery.
- Quality and safety (Q&S) is of paramount importance in the Neonatal environment, and the Q&S improvement in terms of BAPM compliance and PERIPrem progression along with Patient Reported Outcome Measures (PROMS) and Patient Reported Experience Measures (PREMS) is reassuring.
- The outcomes and experience for the babies (and families) right at the very start of their life has improved immeasurably as a result of the investment.

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SAFE | SUSTAINABLE | ACCESSIBLE | KIND

GIG CYMRU NHS WALES

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Hywel Dda
University Health Board

1.7 **5 Mins**

1.7 - Quality, Safety and Experience Committee (QSEC) Self-Assessment Outcome Report 2024/25

Anna Lewis (Hywel Dda UHB - Independent Board Member)

Attachments

1.7 QSEC SA Outcome SBAR 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:**	13 February 2025
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Quality, Safety and Experience Committee (QSEC) Self-Assessment Outcome Report 2024/25
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Anna Lewis, QSEC Chair Sharon Daniel, Interim 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)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to present the outcome of the Quality, Safety and Experience Committee (QSEC) Self-Assessment 2024/25 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.

A short digital form was issued to members and in-attendance members which requested feedback on the following areas:

- Governance and administration
- Committee's inputs
- Conduct of Committee meetings
- Interface with other Committees, including the Board
- Committee's impact
- Individual role on Committee

With only 4 responses received, the response rate was low, making it difficult to assess the committee's effectiveness during this period. It is acknowledged that further improvements may be necessary.

The feedback from this form was considered alongside other information, such as:

- Matters escalated to the Board
- IM Reflective sessions

- Auditor/Regulator feedback

The QSEC Chair and Lead Executive met to consider the Committee's effectiveness to date based on responses from the above digital form and feedback from auditors/regulators and other intelligence on how the Committee currently operates, where it has made an impact and what it has shone a light on, and the areas where it could have done better.

Asesiad / Assessment

The QSEC Chair and Lead Director met to consider the responses from the digital form, completed by Committee members, along with feedback from auditors/regulators and other intelligence on how the Committee currently operates.

The below analysis was based on responses from the digital form and feedback from auditors/regulators and other intelligence on how the Committee currently operates:

What we want to continue to do next year

- Committee's governance and administration (however needs more strategic focus)
- Good clinical and multi-disciplinary representation
- Time spent on right items
- Compassionate challenging evident
- Cross-referral/collaborative working strengthened between Committees
- Committee Chair provides clear and concise information to the Board on the activities of the Committee and the implication of all identified gaps in assurance and/or control.
- Effective chairing, conducive to open and productive debate, general agreement that IMs effectively manage boundary between scrutiny and operational involvement
- Most respondents felt the Committee had driven improvements in quality on specific matters during the year, e.g. Same Day Emergency Care (SDEC), Clinical Services Plan (CSP)
- All respondents felt equipped to undertake their role on the Committee
- Committee Chairs meetings have improved better cross sharing of issues/matters and identification of common themes

What we want to change going forward

- Not all members agreed that the Committee was paying attention to both short-term priorities and longer-term needs, aligned to HDdUHB's strategic objectives
- Concerns that operational arrangements are not sufficiently robust to ensure full sightedness on all QSE matters
- Papers and their presentation are still too operational and focussed on service delivery and process, and are less likely to contain information about impacts, outcomes, risks and mitigations, outcome measurements or improvement over time, not clear on STEEP objectives
- About half of respondents felt that the voice of the patient could be stronger in papers
- Only a quarter of respondents indicated that Independent Members manage their boundary between scrutiny and operational involvement/detail effectively
- Only a quarter of respondents reported that the Board does not provide sufficient scrutiny and challenge to the Committee and provide feedback where appropriate on areas that raised to its attention
- A quarter of respondents raised concerns relating to the quality of TI reporting as headline data is provided rather than root causes or complex systemic challenges which underpin performance - more focus on TI areas that have deteriorated

- How the Committee can demonstrate that it has driven improvements in quality on specific matters during the year
- Completing outstanding actions from last year's Committee self-assessment process
- Presenters reading through the full report and not just highlighting the key points
- Challenge from Executive Directors could be stronger

QSEC priorities for 2025/26

On governance:

1. Strengthen an intelligence-led approach to committee business, using defined QSE metrics to understand the outcomes and impact of the organisation's improvement efforts.
2. Clarify whether matters are being presented to the committee for oversight/scrutiny or escalation and in turn do the same when presenting QSEC papers to the Board.
3. Maintain the improved focus on relevant risks as captured in the risk register and guard against the normalisation of longstanding issues which, by definition, cannot be satisfactorily assured within agreed tolerance.

On service developments including access:

4. Provide oversight of all Board-approved service developments from a QSE perspective, testing the QSE impact using a variety of metrics.
5. Provide regular scrutiny of the implementation of the Improvement Strategic Framework (2023-26).
6. Increase the focus on the experience of people who are waiting to access services and any associated harm, both for planned and unscheduled care.

On strategic outcomes:

7. Be purposeful in shifting the committee's focus to include wider concerns around population health & long term impact, aligned to the organisation's ambition for a social model of health.

Actions to be taken forward:

The following actions will be taken forward by the Director of Corporate Governance/Board Secretary:

Action	By whom	By when
To ensure there is better alignment on QSEC agendas to the strategic objectives of the Health Board in terms of improving quality and long term impacts for the population (*Priority 7*)	Director of Nursing, Quality, and Patient Experience	Apr 25
To review the QSEC sub-committee structure following the review of operational governance arrangements to ensure there is full sightedness on all QSE matters ('no surprises') (*Priority 2 & 3*)	Director of Quality, Safety and Patient Experience	Feb-25
To strengthen both the mindset for good governance and the technical skills of operational leaders as part of the implementation of the Operational Governance Structure and new training programme for new managers in the Health Board, to ensure that the patient voice/STEEEP is reflected in all dialogue (incl. reports) at QSEC. A series of masterclass workshops on a variety of topics will be put in place to support leaders to operate in accordance with the requirement o the Committee (*Priority 1, 2, 3 & 6*)	Chief Operating Officer/Director of Quality, Safety and Patient Experience/ Director of Corporate Governance	Apr 25

To identify, through all of the UHB's QSE intelligence infrastructure, TI areas that have deteriorated for deep dive reports to provide assurance that root causes or systemic challenges of issues are being addressed (*Priority 1*)	Director of Nursing, Quality, and Patient Experience	Ongoing
To embed the new learning framework to contribute to an intelligence-led approach to committee business *(Priority 3)*	Director of Nursing, Quality, and Patient Experience	Mar 26
To ensure, through the use of metrics, oversight of all Board-approved service developments from a quality, safety and experience perspective through *(Priority 4 & 6)*	Chief Operating Officer	Throughout 2025/26
To receive regular reports on the implementation of the Improvement Strategic Framework (2023-26) *(Priority 5)*	Director of Nursing, Quality, and Patient Experience	Throughout 2025/26
Further focus through Board Development for the below areas: -Independent Members effectively managing the boundary between scrutiny and operational involvement/detail effectively during Committee discussions. -the Board providing sufficient scrutiny and challenge to the Committee and provide feedback where appropriate on areas that raised to its attention -Increasing challenge from Executive Directors at Committees *(Priority 1, 2 & 3)*	Director of Corporate Governance/Director of Workforce & OD	Jun 25
To ensure the priorities for 2025/26 are considered when setting agenda and requesting papers	Director of Nursing, Quality, and Patient Experience	Apr 25
Pilot the use of a short end-of-meeting Menti to gather real time feedback for immediate and ongoing improvement in committee effectiveness.	Director of Corporate Governance	Apr 25
Explore the inclusion of a 'critical friend' in one or more of the committee meetings to offer a fresh perspective on strengths and 'blind spots'.	QSEC Chair/ Director of Corporate Governance	Jun 25

Argymhelliad / Recommendation

The Quality and Safety Committee is asked to consider the outputs from the Committee Self-Assessment process, and to agree the actions to be taken to improve its effectiveness.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	10.5 The Director of Corporate Governance/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)	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 Auditor and Regulator feedback through Structured Assessment and Internal Audit reports
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:	QSEC Chair Director of Corporate Governance/Board Secretary

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

2

2 - Risk

2.1 **10 Mins**

2.1 - Nurse Staffing Levels Impact of Reduction of Agency and Bank Staff on Quality, Safety and Patient Experience Interim Report

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

Attachments

2.1 Nurse Staffing Levels Quality Safety Experience Committee SBAR Februa~.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:	13 February 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Nurse Staffing Levels: Impact of Reduction of Agency and Bank Staff on Quality, Safety and Patient Experience Interim Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Sharon Daniel, Interim Executive Director of Nursing, Quality & Patient Experience
SWYDDOG ADRODD: REPORTING OFFICER:	Janice Cole-Williams, Assistant Director of Nursing Catrin Jones, Nurse staffing programme lead.

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This paper provides the Quality, Safety and Experience Committee with an overview of the recent implementation of the agency and bank reduction plan in nursing and considers whether there has been any impact on the quality, safety and experience of patients as a result.

Cefndir / Background

This SBAR builds on the report provided to the People, Organisational Development & Culture Committee (PODCC) on the 9th April 2024. It was an update on the stabilisation work programme, the recruitment of internationally educated nurses and included discussion on whether there had been any impact of these changes on clinical outcomes. A subsequent action from the meeting was to *"examine the triangulation between clinical outcomes and reduction of agency and bank staff, and report back to Committee."* This update was provided to People, Organisational Development & Culture Committee (PODCC) on the 29th of October 2024 and highlighted the need for further review of any impact these changes may be having on the quality, safety and experience of patients.

Work currently being undertaken is in line with requirements set out in the Nurse Staffing Levels (Wales) Act 2016 (the 'Act') and includes:

- The health board's responsibilities to provide "sufficient nurses to allow the nurses time to care for patients sensitively" in all settings (Section 25a).
- The responsibilities of the designated person for calculating and maintaining the nurse staffing levels for those areas were S25b (3) applies (Section 25b and Section 25c).
- The Welsh Government's responsibilities to develop statutory guidance (Section 25d); and
- The health board's reporting responsibilities (Section 25e).

The statutory guidance (2021) published to support the application of the 'Act' defines nurse

staffing levels as the number of Registered Nurses (RN) and others who undertake nursing duties under the supervision of RN which is “appropriate to provide care to patients that meets all reasonable requirements” (Welsh Government, 2016; p. 3).

Asesiad / Assessment

The RN nursing stabilisation programme, which includes the recruitment of internationally educated nurses, has focused on the recruitment of substantive staff to fill nurse staffing deficits, with the outcome of getting to a ‘no planned agency position’ across the HB by the 1st November 2024 (apart from in Bronglais General Hospital (BGH) where there will be no planned agency as of the 1st March 2025). This workforce stabilisation has reinforced the requirement for ongoing professional development pathways, supporting safer quality care delivery and improved retention of a ‘new’ workforce.

The data for Unscheduled Care, BGH, Glangwili General Hospital (GGH), Prince Philip Hospital (PPH), Withybush General Hospital (WGH); Planned Care; Mental Health & Learning Disabilities; Women and Children, Carmarthenshire, Ceredigion and Pembrokeshire communities show that for the nursing and midwifery workforce:

- The monthly Whole Time Equivalent (WTE) usage of temporary nursing workforce reported through Allocate shows that Registered Nurse (RN) agency usage has continued to reduce month on month to 101.36 WTE as of 31st December 2024 (compared to 341.25 WTE in January 2023 - on and off contract agency usage); a reduction of 70%.
- Agency usage is expected to reduce further due to the placement of newly registered nurses (NRNs) and internationally educated nurses (IENs), as well as the finalisation of the stabilisation programme for nursing at BGH by March 2025.

As of December 2024, the Band 5 RN vacancy position is 121.7 WTE. This is an improvement from September 2024, when the vacancy position was 166 WTE, compared with 277 WTE in May 2023, a reduction of 56.32%. The vacancy position is expected to reduce further once all NRNs commence their employment, and the internationally educated nurses obtain NMC registration.

The data set out below relates to 1st April 2023 - 31st December 2024. Whilst the use of RN agency workers reduced during this period, there were still agency workers being utilised. Sickness and annual leave historically increase in January, February, and March, which risks increasing agency usage in the short term. Although mitigations are ongoing to address these challenges, their full impact won't be seen until a new leave year starts.

The full impact of the reduction in agency usage won’t be fully understood until all areas including BGH have reached the point of no planned agency, following which ongoing analysis will be required.

Ongoing analysis is required to better understand any correlation between the reduction of agency workers and changes in clinical outcomes. This paper provides an initial update to the Quality, Safety and Experience Committee.

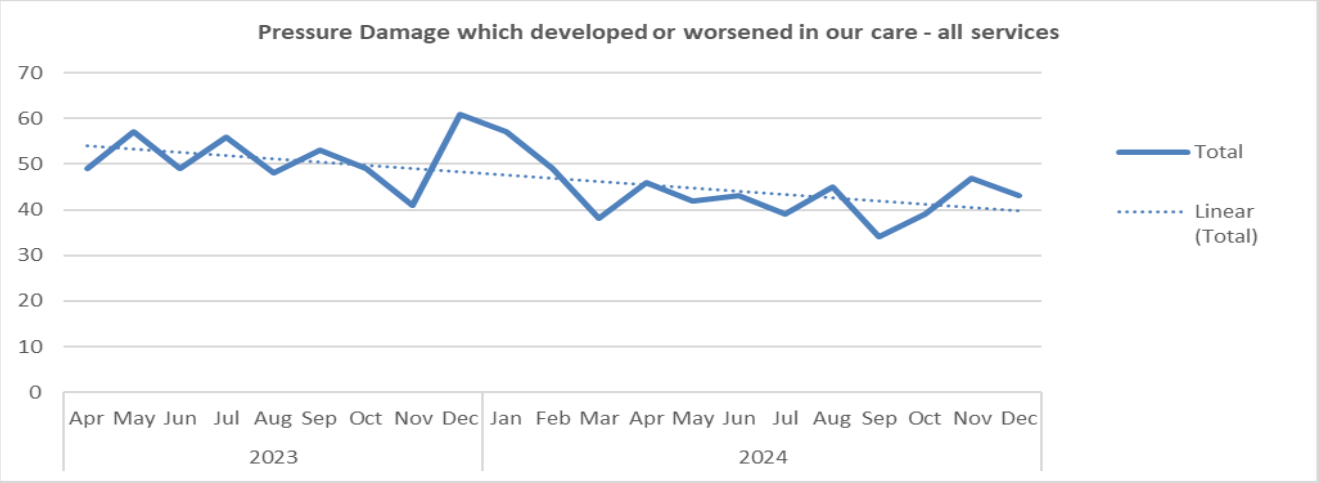
The Quality metrics reviewed for the purpose of this report are as follows:

Patient safety incidents:
There was a total of 24,362 Patient Safety Incidents reported across all services within Hywel Dda UHB between 1st April 2023– 31st December 2024 (data from Datix Cymru).

Pressure Damage which developed or worsened in our care

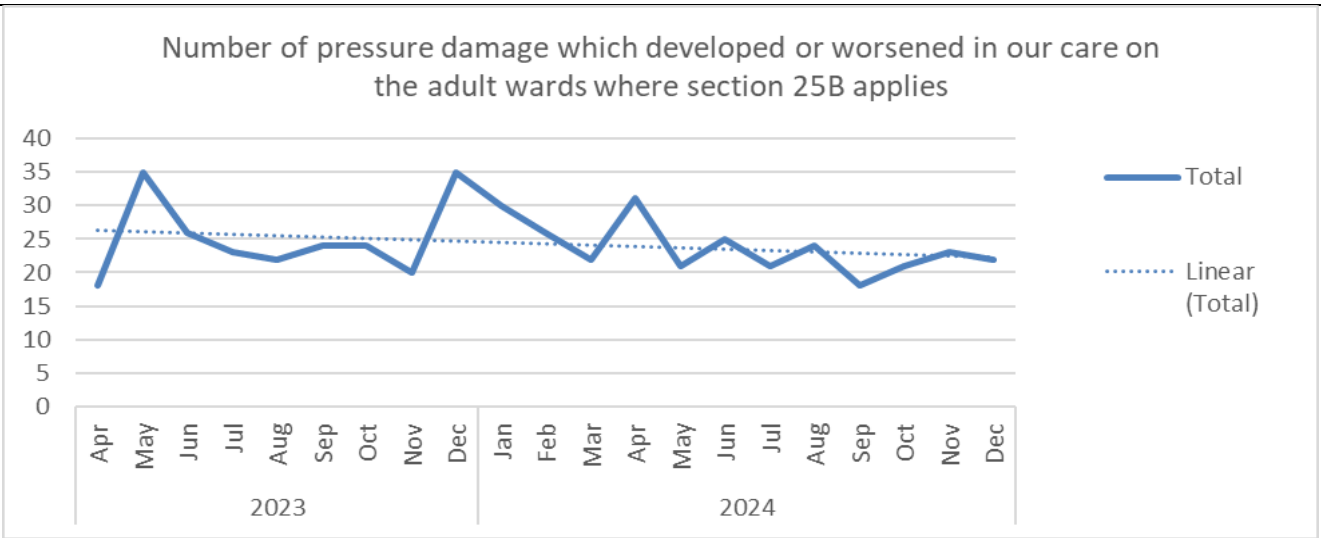
- All our services

•There is a downward trend in the number of pressure damage cases which developed or worsened in our care since 1st April 2023 across the services referenced in this paper with the data showing that an average of 51.4 incidents were reported every month during 2023, which reduced to an average of 43.5 incidents during 2024 (range a high of 62 in December 2023 to a low of 34 in September 2024).

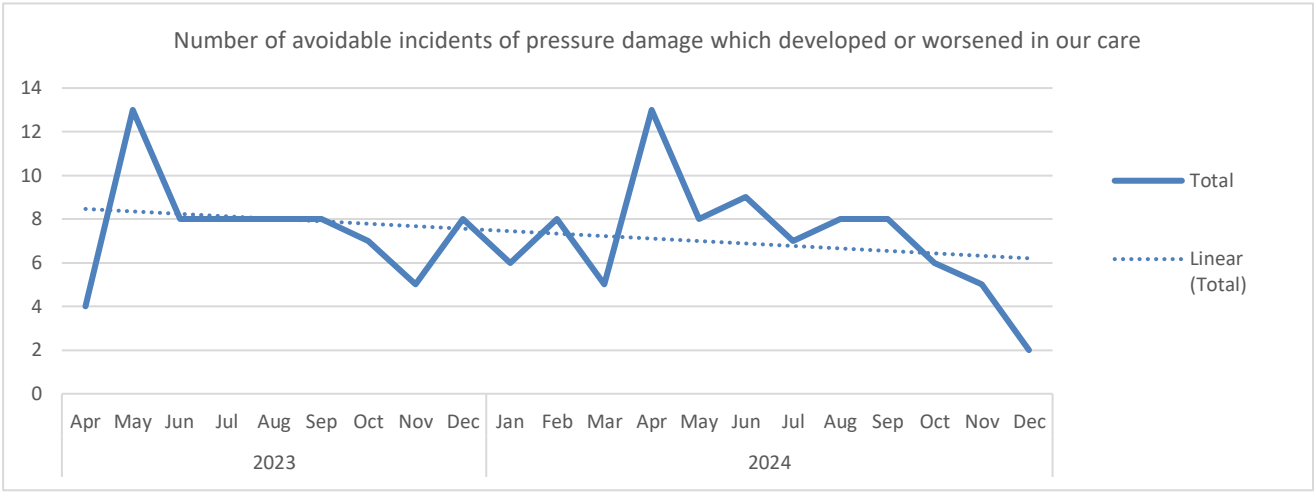


- The number of incidents of avoidable harm across all our services has also decreased from an average of 18 incidents a month during 2023 to an average of 14.75 incidents a month in 2024 (range a high of 23 in May 2023 to low of 3 in December 2024).
- The number of pressure damage incidents where a temporary worker was involved (across all our services) has also seen a decrease from an average of 3.7 incidents per month during 2023 to an average of 1.66 per month for the 2024 period, with no incidents involving a temporary worker since October 2024.

- Adult Wards where S25B applies**:**
  The number of pressure damage cases which developed or worsened in our care on the adult wards where section 25B of the Nurse Staffing Levels (Wales) Act (the 'Act') applies i.e. adult acute medical and surgical inpatient wards, where most of the nursing stabilisation work has focused has reduced marginally from an average of 25.22 per month in 2023 to an average of 23.66 per month in 2024.



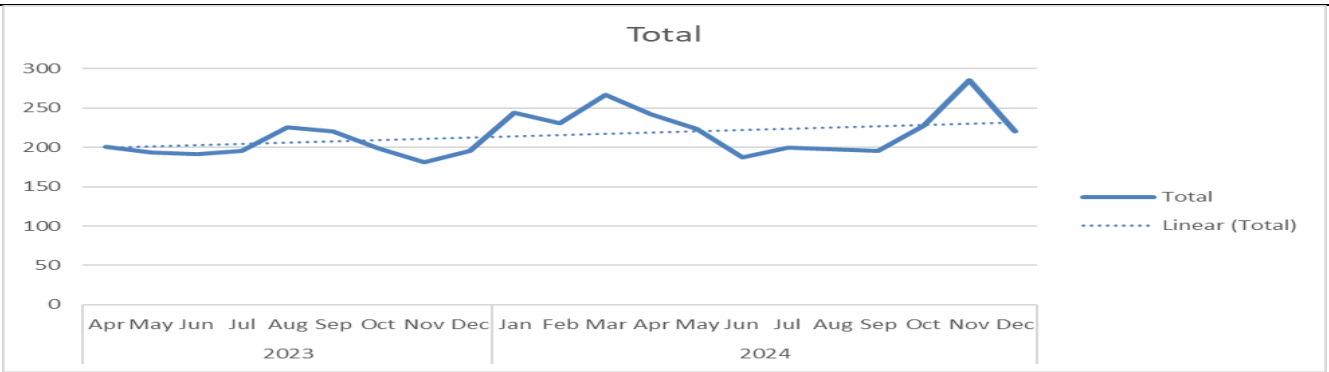
- The number of incidents resulting in avoidable harm has also seen a small reduction (an average of 7.66 per month in 2023 and an average of 7.08 per month in 2024) although only two incidents of avoidable damage were reported in December 2024.



- The number of pressure damage incidents where a temporary worker was involved has also seen a decrease from an average of 1.77 incidents per month during 2023 to an average of 0.75 incidents per month for 2024 period, with no incidents in involving a temporary worker reported since September 2024

Falls

- **Across all our services**
  There has been an increase in the number of falls being reported across our services from an average of 220 falls per month in 2023 to an average of 226.75 incidents of falls in 2024 with November 2024 seeing 285 incidents of falls reported.

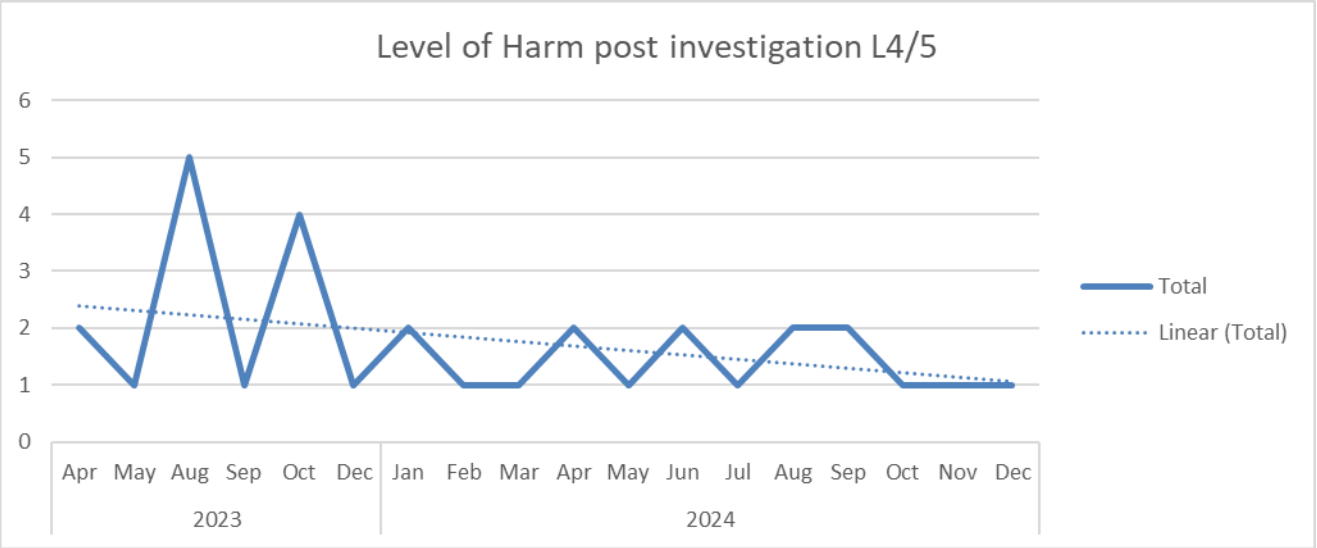


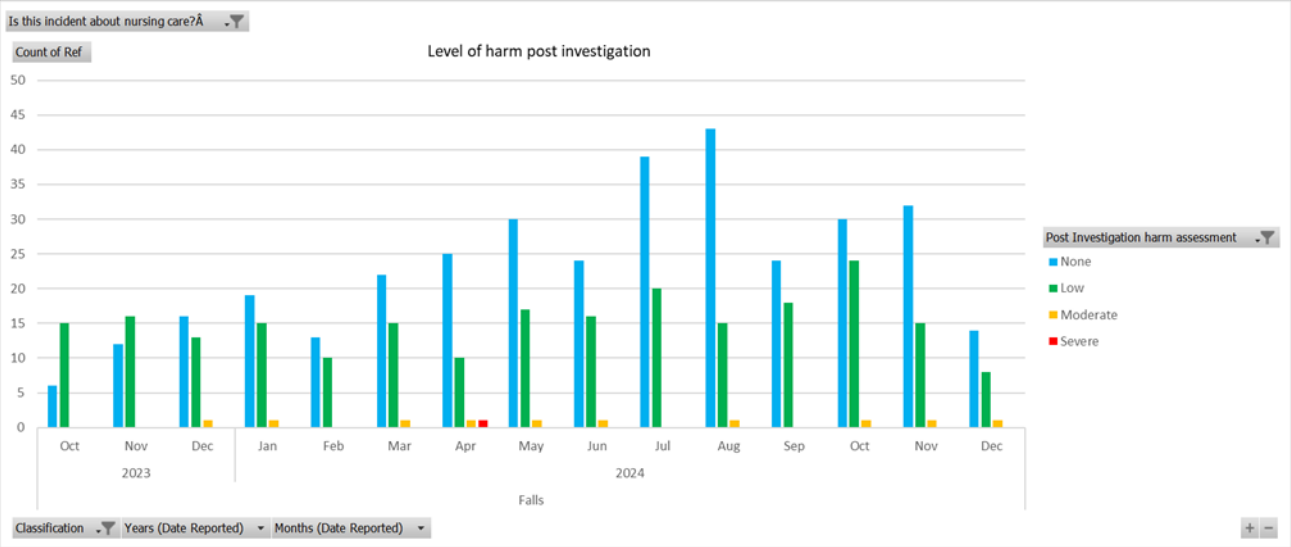
- **Adult Wards where S25B applies:**
  The number of falls reported across the wards where S25B applies have also seen an increase from an average of 112.66 per month in 2023 to 116.08 per month in 2024. A review of factors such as, the number of uncovered Enhanced Patient Support (EPS) shifts, unfilled shifts and operational pressures including increases in surged beds were included to evaluate whether there was a correlation with the increase in falls and changes to the agency and bank staffing, however, no notable correlation was identified.

  The inpatient Falls Group and ongoing Falls quality improvement work continues in all sites and monthly scrutiny and assurance meetings are held across acute and community services, where learning from events and opportunities for new initiatives are shared.

  One potential reason for an increase in reporting may be related to better awareness and a better reporting culture. The recent work promoting deconditioning awareness is also helping educate patients to maintain their independence and mobility, however, this may contribute to an increase in falls. There has been an Initial spike in November in relation to falls but this is now on a downwards trend and will be monitored.

Level of harm Post investigation



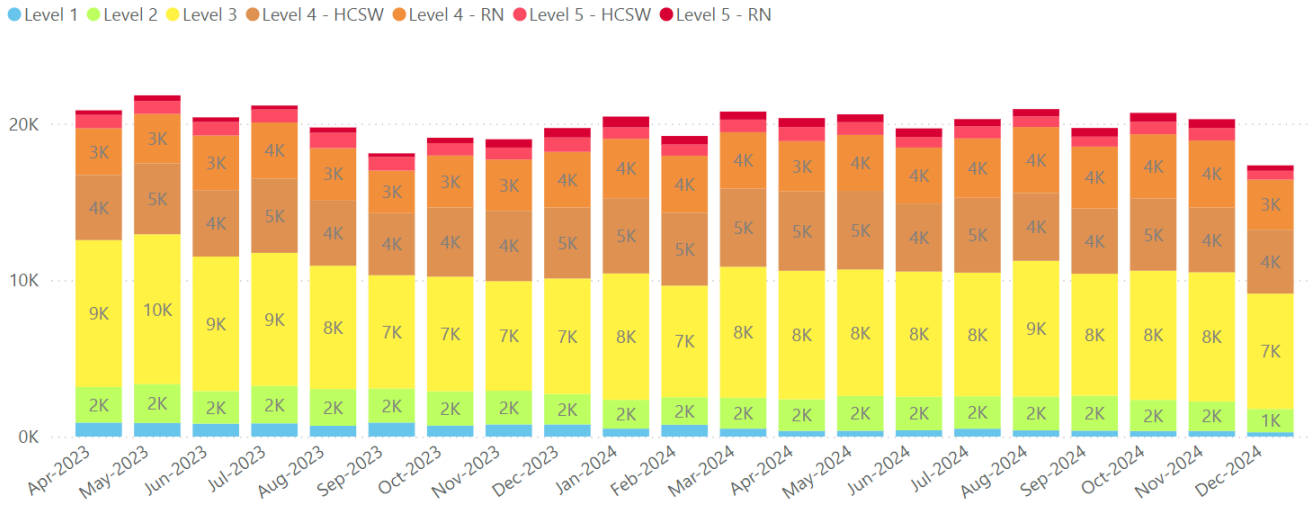


- The number of falls resulting in Level 4/5 harm has seen a small reduction (an average of 1.55 per month in 2023 and an average of 1.41 per month in 2024)

Acuity

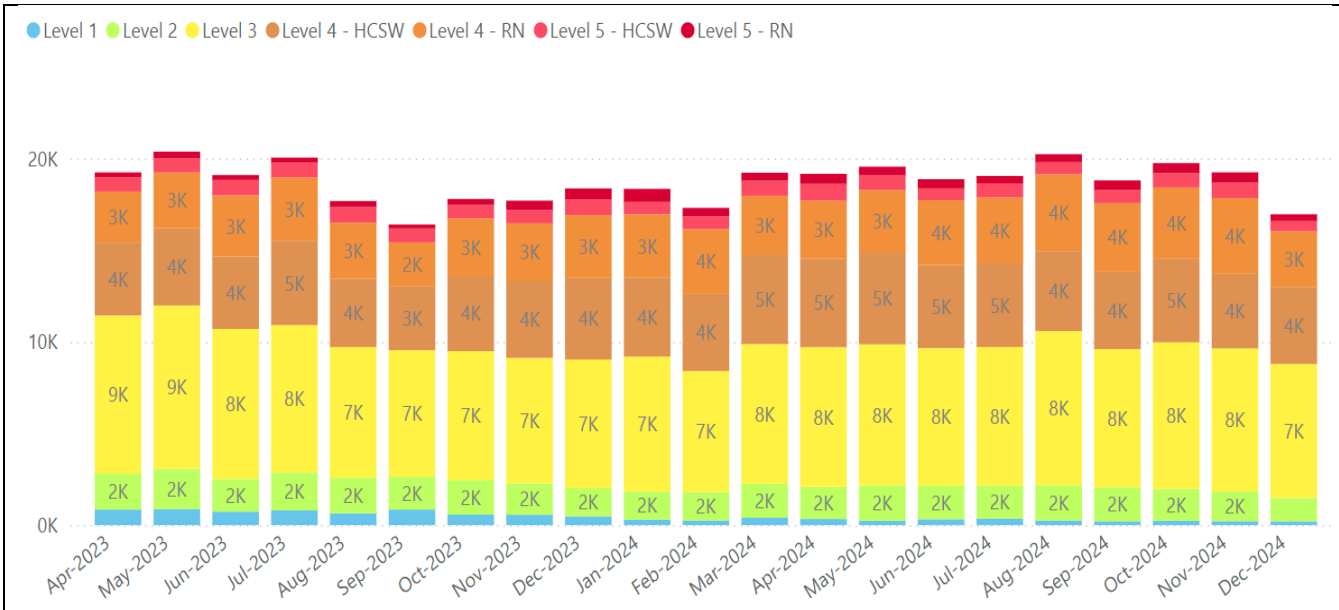
- Acuity can be defined as the measurement of the intensity of nursing care required by a patient. We capture acuity in wards where S25B applies.

Acuity Day

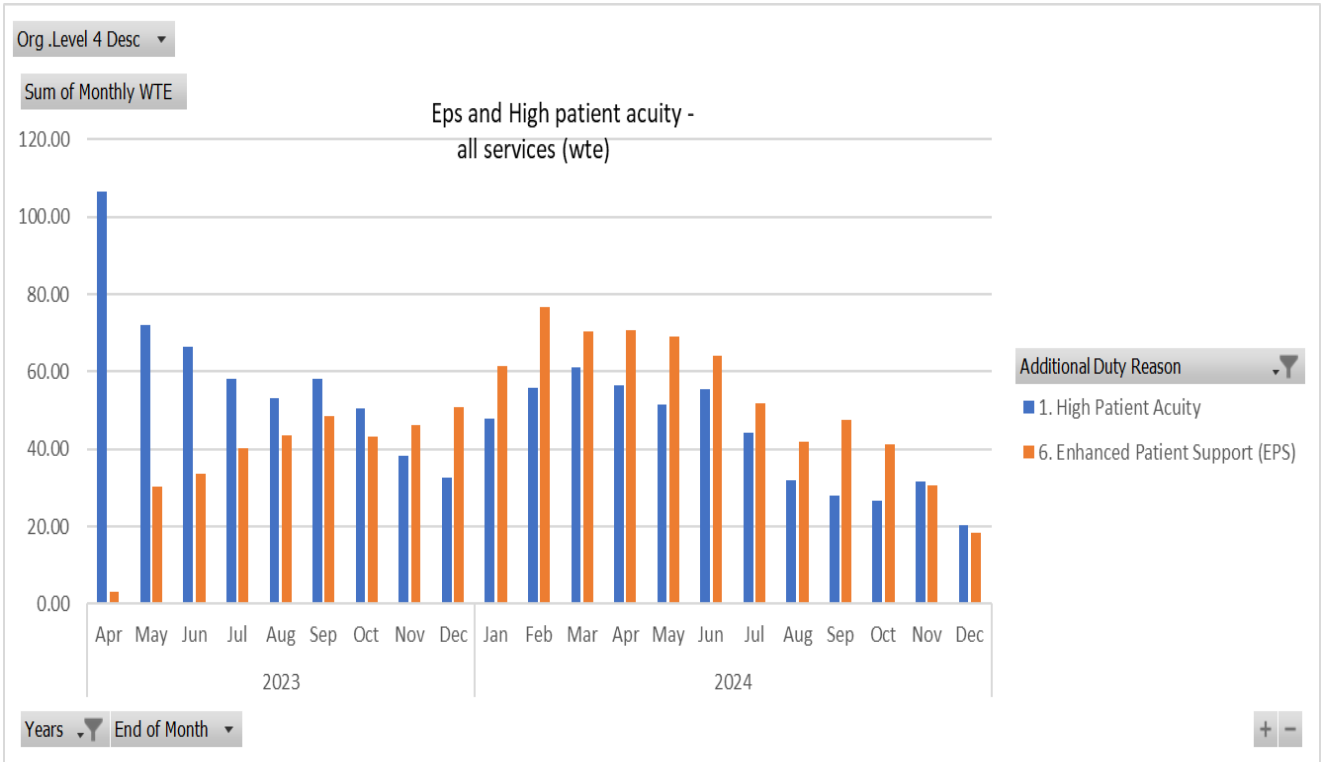


There have been no changes to acuity that would explain the slight increase in falls being reported.

Acuity Night



The acuity has remained consistent during this reporting period, with no significant variation between night and day.



- There has been a decrease in the overall Bank HCSW requests across all reasons and a significant decrease in the requests being sent through for EPS/high patient acuity across all areas (from a total of 83.46wte in December 2023 to 38.55wte for December 2024).
- Feedback from services show a reduction of EPS usage has been due to Baywatch, Cohorting patients, use of chair alarms where indicated, alongside ongoing quality improvement work.

Action: Further work to understand whether the reduction in the use of EPS is seeing an impact on increased falls.

Medication Administration Errors

Across all our services

- The number of medication administration errors affecting patients (closed and open incidents) is reported as seeing a small decrease from an average of 41 incidents per month during 2023 to an average of 39.91 incidents per month for 2024. The number involving temporary staffing has seen an increase from an average of 12.77 incidents per month in 2023 to an average of 13.41incidents per month in 2024.
- There is now a robust monitoring process being undertaken to support orientating temporary staff. We will continue to monitor across all services.

Adult Wards where S25B applies

- The number of medication administration errors affecting patients has seen a decrease with an average of 15 incidents per month reported in 2023 compared to 14 incidents in 2024. The number involving a temporary worker has seen a decrease from 5.88 incidents per month in 2023 to an average of 4.41 incidents per month in 2024.

Complaints/Concerns

Of the 3179 complaints received between 1st April 2023 and 31st December 2024, 190 were deemed, following investigation, to be wholly or partly relating to nursing care. There has been no noticeable increase in complaints.

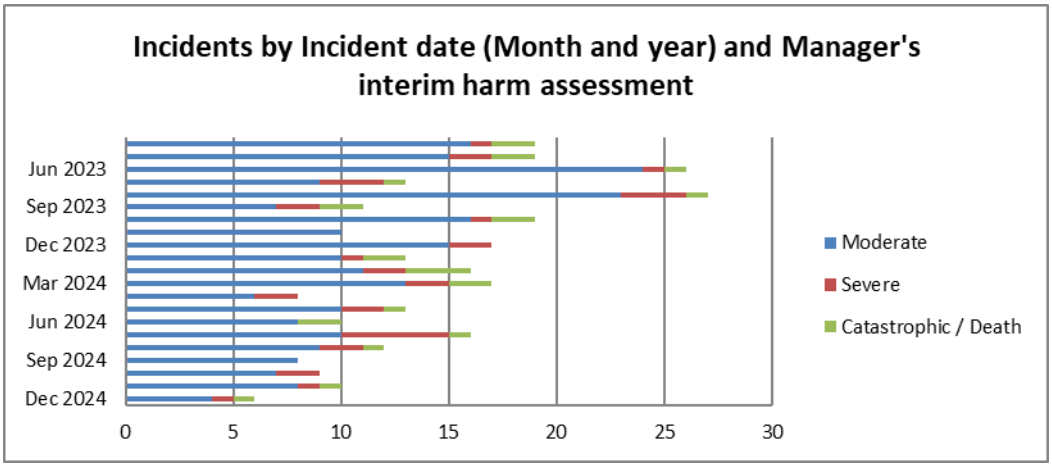
Triangulating the data:

There are other mechanisms and data that we can use to triangulate the impact of reduction in temporary staffing on clinical outcomes. These include:

•**'Walk Rounds'-** staffing levels and availability has been a theme raised during the 'Walk Rounds' up to June 2024; raised during 15 of the 29 'Walk Rounds'. We will monitor the feedback from Walk Rounds undertaken from July 2024 onwards to see whether this theme continues to feature.

•**Duty of Candour***:*

As of 14th January 2024, 173 incident records have been closed where duty of candour had been triggered during the manager's initial assessment of the patient safety incident.



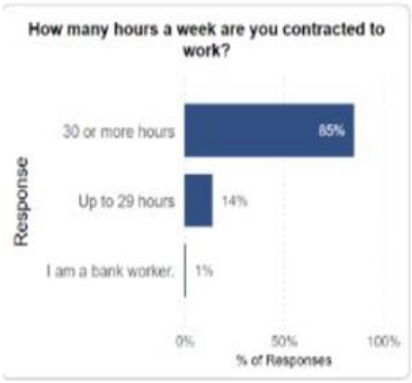
- **Staff well being** There is evidence that having the right nurse staffing levels has a positive impact on staff, with some studies showing that staff with the most demanding workloads were more likely to report job dissatisfaction exacerbated by missed breaks; poor compliance with mandatory training; emotional exhaustion and their intention to leave their job, Having the right number of staff, however, leads to an increase in people wanting to join the profession and improved retention figures (Aiken et al., 2012; Butler et al., 2019; Halm, 2019; Hill, 2017; MacPhee et al., 2017; Tellez, 2012, Van den Heede et al., 2013; Wynendale et al., 2019). Data we do have is shown below.

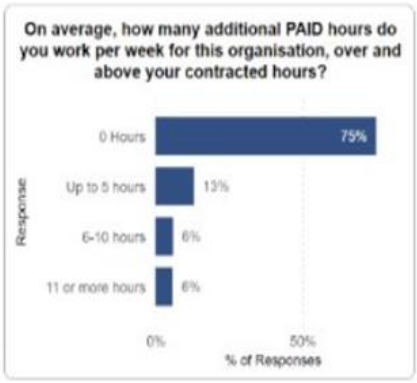
- **NHS Staff Survey** – Whilst recognising that the survey was for all staff groups, the 2023 NHS staff survey findings showed that when asked about work pressure, the respondents noted the following.

Morale

Work pressure

Question	Never	Rarely	Sometimes	Often	Always
I am able to meet all the conflicting demands on my time at work.	3%	11%	35%	41%	10%
I have adequate supplies, materials and equipment to do my work.	2%	11%	24%	39%	24%
There are enough staff at this organisation for me to do my job properly.	11%	21%	34%	26%	9%





The results from the NHS Staff Survey 2024 will be available in February 2025 and this will be a useful comparator which will help to inform the impact of reducing the reliance on a temporary workforce on our staff.

Monitoring of Key Quality indicators:

The number and level of harm of falls, pressure damage and medication errors are considered as part of any nurse staffing level review. Reviews are undertaken as a minimum of six monthly for those wards where Section 25B of the Nurse Staffing Levels (Wales) Act applies i.e. adult acute medical and surgical inpatient wards, paediatric inpatient wards. and for any Section 25A areas when a nurse staffing review is undertaken.

- Operational teams have scrutiny processes in place that enable incidents and complaints to be reviewed and consideration given to what actions need to be taken and what learning can be shared. Scrutiny & Assurance Meetings are held for each acute site (with representation from community teams) to monitor and scrutinise inpatient falls, identifying causal factors and sharing learning to prevent recurrence. Outcomes from the Scrutiny & Assurance Meetings feed into the Directorate QSE Groups, which report to the Quality, Safety & Experience Sub-Committee (QSESC). The Adult Inpatient Falls Reduction Improvement Group (AIFRIG) was established as a group of the Operational QSES in May 2023. The role of the Group is to “review and analyse claims, learning from events

and performance reports which will help inform operational direction and contribute to the reduction and improvement of inpatient falls".

- There are health board and advisory groups which focus on key aspects of care and monitor practice related issues. e.g. the nutrition and hydration and falls groups.

Argymhelliad / Recommendation

The Quality, Safety & Experience Committee is requested to take assurance that a review of the reduction of agency and bank staff initiative has not identified an impact on the quality, safety or experience outcomes of patients, however, this will continue to be closely monitored.

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:	Not applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	Domains of Quality 1. Safe 6. Person-Centred
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	3. Data to knowledge 4. Learning, improvement and research
Amcanion Strategol y BIP: UHB Strategic Objectives:	3. Striving to deliver and develop excellent services 5. Safe sustainable, accessible and kind care
Amcanion Cynllunio Planning Objectives	1 Workforce Stabilisation
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

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	Data extracted from Datix, Our Performance dashboard and papers presented to People Organisational Development Culture Committee
Rhestr Termau: Glossary of Terms:	RN – Registered Nurse HCSW – Health Care Support Worker

Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	Not applicable

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not applicable
Ansawdd / Gofal Claf: Quality / Patient Care:	The report sets out Impact of Reduction of Agency and Bank Staff on Quality, Safety and Patient Experience
Gweithlu: Workforce:	The report sets out the number of incidents between 1st of April 2023 – 31st of December 2024
Risg: Risk:	Not applicable
Cyfreithiol: Legal:	Not applicable
Enw Da: Reputational:	Not applicable
Gyfrinachedd: Privacy:	all data is anonymous
Cydraddoldeb: Equality:	Not applicable

2.2 **10 Mins**

2.2 - Update on the service changes in the Minor Injuries Unit in Prince Philip Hospital, Tregaron Hospital and Paediatrics in Bronglais Hospital

Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Ceri Griffiths (Hywel Dda UHB - Interim Assistant Director of Nursing)

Attachments

2.2 QSEC update on strategic changes v1.0.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:**	13 February 2025
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Update on the service changes in the Major Injuries Unit in Prince Phillip Hospital, Tregaron Hospital and paediatrics in Bronglais General Hospital
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Andrew Carruthers, Chief Operating Officer
SWYDDOG ADRODD: **REPORTING OFFICER:**	Collation of paper: Cathie Steele, Interim Assistant Director of Nursing Assurance and Safeguarding Author for Minor Injuries Prince Phillip Hospital: Iona Evans, Interim Head of Nursing, Unscheduled Care Author for Tregaron Hospital: Tracey Evans, Head of Community Nursing, Ceredigion Author for Paediatrics Bronglais Hospital: Paula Evans

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 this report is to provide the Quality, Safety and Experience Committee (QSEC), with an update on the service changes made to the Minor Injuries Unit in Prince Phillip Hospital, Tregaron Hospital and paediatrics in Bronglais General Hospital

Cefndir / Background

In September 2024, the Board approved a number of urgent service changes:

Minor Injuries Unit, Prince Phillip Hospital

As a result of quality and safety risks, in part relating to a lack of General Practice (GP) cover, the Board, in September 2024, approved an urgent temporary change in the opening hours of the Minor Injuries Unit (MIU) in Prince Phillip Hospital (PPH) for a six-month period at the Public Board meeting in September 2024.

Healthcare Inspectorate Wales (HIW) made an unannounced inspection visit to the Minor Injuries Unit (MIU) in Prince Philip Hospital (PPH) in June 2023. An action plan in response to the HIW recommendations following this visit was developed.

Since this review, work continued to review the current 24/7 model for the MIU in PPH, reflecting a number of key factors, including increasing challenges to maintaining the medical staffing within the MIU, along with recent recommendations from the HIW inspection which required an urgent review of the service to address patient and clinical safety recommendations.

In March 2024, HIW received a letter from staff, which had previously been sent to the Nursing and Midwifery Council (NMC) in June 2023, expressing concerns regarding the clinical safety of the unit. HIW wrote to the Health Board requesting assurance on the matters raised.

The full paper presented to Board can be found here.

Following this decision, the urgent temporary change has been enacted from the 1st November 2024 and the MIU is now open from 8am-8pm for a period of six-months. An update report was provided to Board in November 2024.

Tregaron Hospital

The Ceredigion 2024/25 Annual Plan submission focused upon accelerating the Cylch Caron model of care by decommissioning the remaining in-patient beds in Tregaron Community Hospital. The decommissioning of the beds enabled staff to be released into the community, supporting the Healthier Mid and West Wales priorities of effectively supporting patients to remain closer to home.

Several challenges associated with the safe function of Tregaron Community Hospital were identified:

The beds in Tregaron Hospital had reduced from 15 to 9 from November 2023, to mitigate the nurse staffing risk and to meet the safe staffing requirements. There were a considerable number of vacancies which have been ongoing for some time and may, in part, be related to the uncertainty of the Cylch Caron development. Added to this there were also occupational health requirements for a number of staff which need to be considered.

There was also a need to monitor the acuity of patients admitted into the hospital due to staffing levels.

The challenges associated with staffing were noted through the Risk Register, risk 1897 – Maintaining safe staffing in Tregaron Community Hospital. Only having one Registered Nurse on site was a quality and safety risk, as there was no cover should that one individual be unable to work due to sickness at short notice.

There was no designated therapy input into Tregaron Community Hospital with therapies covering acute and community sites with one team, if there is pressure in the acute sites their needs will take priority. Therefore, patients with rehabilitation needs could not be met.

The clinical oversight for the patients stepped up from the community was delivered through the Clinical Assistant model, this was a fragile model due to a number of reasons. Those patients who were transferred from the acute setting remained under the care of their Secondary Care Consultant; over the years it had become more difficult to ensure that these patients received regular reviews due to the competing demands on the Consultants' time. However, there was a significant issue with the fragility of the Clinical Assistant cover within Tregaron Community Hospital.

The temporary body store in Tregaron Community Hospital required significant investment to ensure compliance with the present-day standards.

There continued to be significant issues associated with the maintenance of the building, which were ongoing for some time. Whilst there were a number of mitigating actions in place, outstanding issues were noted through the risk register.

The full paper presented to Board can be found here.

Paediatric Inpatient Provision in Bronglais General Hospital (BGH)

During the first eight-and-a-half months of 2024, service sustainability risks at Angharad Ward, Bronglais General Hospital (BGH) increased significantly due to shortfalls in the availability of paediatric nurses. The service was operating at risk, with a significant reliance on variable pay staff to enable service delivery to be maintained.

As the service prepared for the winter period, the staffing challenges and associated service sustainability risks were predicted to increase due to additional staffing pressures from October 2024. Availability of paediatric nurses was predicted to deteriorate further from October, when two full time junior sisters commenced maternity leave. Junior sisters are experienced and skilled members of the team; therefore, the absence of the expertise provided by these key roles was predicted to compromise the clinical leadership and quality of care, in a team where existing shortfalls in junior staff remain.

This is recorded in the Risk Register entry 996 - “Fragile service provision in acute paediatrics BGH due to paediatric registered nursing deficit” and the score of this risk had been increased to 20, an extreme risk given the forecast position from October 2024. It was also been escalated as a Directorate Level Risk, from service level, due to the concerns regarding patient quality and safety directly related to the availability of nursing staff.

The full paper presented to Board can be found here.

Asesiad / Assessment

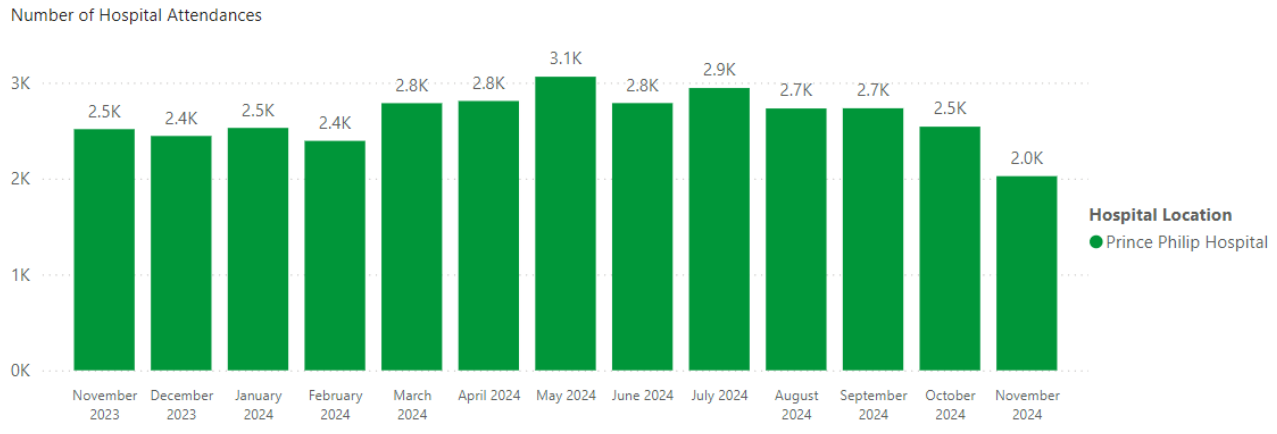
Minor Injuries Unit, Prince Phillip Hospital
Following the delivery of the Operational Group and agreed actions, development of the standard operating procedure, engagement sessions with staff and the public, extensive communications, the temporary overnight closure continued as planned for the 1st of November 2024.

From the above actions, there has been minimal service impact and no significant patient safety, quality, and experience concerns to date.

MIU Attendance:

There is a reduction noted in October MIU attendance with further drop in November. Re-direction protocols are in place and being re-enforced for patients attending outside of the criteria and scope of MIU. As a result of this, as well as the key communication etc., a reduction in the ‘major’ activity is also noted for November.

Overall attendance:



The 4- and 12-hour performance within MIU has also improved with a clear monitoring process in place to sustain this.

December 2024

4 and 12 Hour Performance Summary

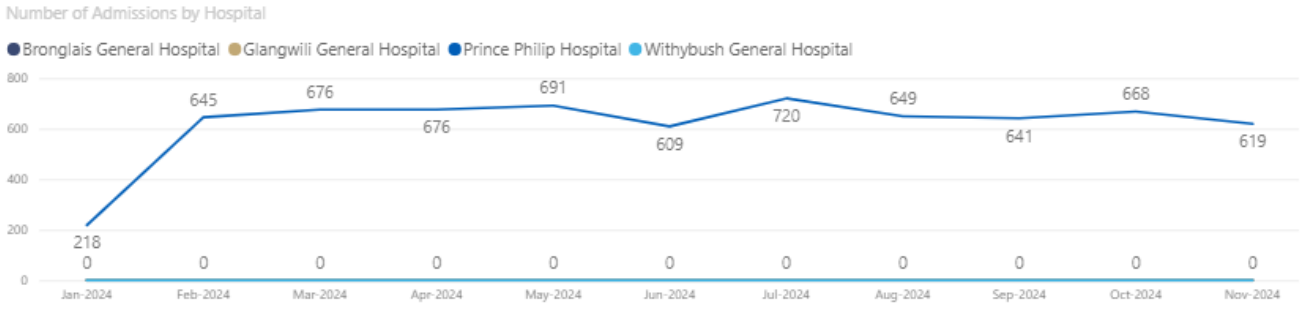
Hospital	Total Attendances	New Attendances	4-Hour Breaches	4-Hour Performance	12-Hour Breaches	12-Hour Performance
Glangwili General Hospital	642	642	335	47.82%	81	87.38%
Withybush General Hospital	473	464	224	51.72%	79	82.97%
Bronglais General Hospital	352	350	154	56.00%	50	85.71%
Prince Philip Hospital	275	255	6	97.65%	0	100.00%
Total	**1,742**	**1,711**	**719**	**57.98%**	**210**	**87.73%**

Previous Eighteen-Month 4-Hour Performance Summary

Hospital	Jun-2023	Jul-2023	Aug-2023	Sep-2023	Oct-2023	Nov-2023	Dec-2023	Jan-2024	Feb-2024	Mar-2024	Apr-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Sep-2024	Oct-2024	Nov-2024
Bronglais General Hospital	66.74%	60.54%	61.40%	58.68%	62.09%	64.55%	58.46%	62.61%	67.22%	65.08%	64.86%	65.65%	64.12%	64.30%	66.24%	66.36%	64.41%	65.06%
Glangwili General Hospital	59.20%	55.71%	53.18%	57.09%	57.64%	59.44%	58.73%	52.90%	51.28%	52.91%	53.29%	51.11%	49.08%	47.03%	46.56%	46.59%	46.50%	44.93%
Prince Philip Hospital	84.27%	83.84%	78.94%	78.37%	80.30%	86.39%	84.76%	85.20%	82.53%	79.64%	80.49%	78.33%	84.96%	86.81%	88.50%	81.75%	88.80%	97.16%
Withybush General Hospital	60.65%	58.28%	53.63%	56.13%	53.97%	52.61%	52.77%	53.74%	57.74%	55.65%	57.39%	54.58%	56.66%	59.71%	58.23%	57.89%	59.42%	52.33%

As part of the planned overnight closure, strengthening the medical take via Same Day Emergency Care (SDEC)/Acute Medical Assessment Unit (AMAU) (including Out of Hours (OOH) with the support of public communications, primary care, 111/GP OOH, Welsh Ambulance Service Trust (WAST) was undertaken (as per Standard Operating Procedure (SOP). There have been no obvious additional requirements for patients to be transferred/re-directed from MIU PPH to Emergency Department (ED) GGH/Swansea Bay University Health Board, though this data is being collated. There has been 1 transfer delay (12 hours) from MIU to Swansea Bay (trauma patient) in November.

AMAU admission activity remains consistent. This is risk assessed daily.



<u>Risk Register:</u>

There have been significant risks being held within MIU (especially prior to the overnight closure). These risks are being reviewed with consideration of temporarily reducing/closing as a result of the promotion and communication around the scope of the MIU purpose as well as the standard operating procedures of managing ‘major’ attendance and strengthening the medical take.

The risks for review/closure or reduction are:

1919	USC: PPH	01/04/2024	Risk of patient deterioration in MIU due to lack of GP cover	Extreme	15	High
1293	USC: PPH	25/11/2021	Risk of avoidable harm to patients at MIU due to inappropriate patients presenting (PPH).	High	12	Moderate

The risks that remain are:

1904	USC: PPH	18/06/2024	Risk of transfer delays to tertiary centres for urgent treatment due to lack of ambulance transport	Extreme	20	Moderate
1903	USC: PPH	18/06/2024	Risk of patient harm due to the need to surge additional beds on various wards (PPH)	Extreme	16	Moderate

New risks to be added:

Title of risk: **Maximum characters: 128**	Risk that patients will attempt to access MIU out of core hours (8pm and 8am)	due to temporary overnight closure of MIU.

This will lead to an impact/effect on patient safety and quality of care by delaying timely and appropriate care within the correct hospital/ medical setting (right care, right time, right place, first time).
Risk of patients (adult & paediatrics) self-presenting within the AMAU. Risk of security breach to the main hospital.

Title of risk: **Maximum characters: 128**	Risk that the public will self-present to AMAU out of hours with an unwell child	due to temporary overnight closure of MIU.

List all potential consequences of the risk

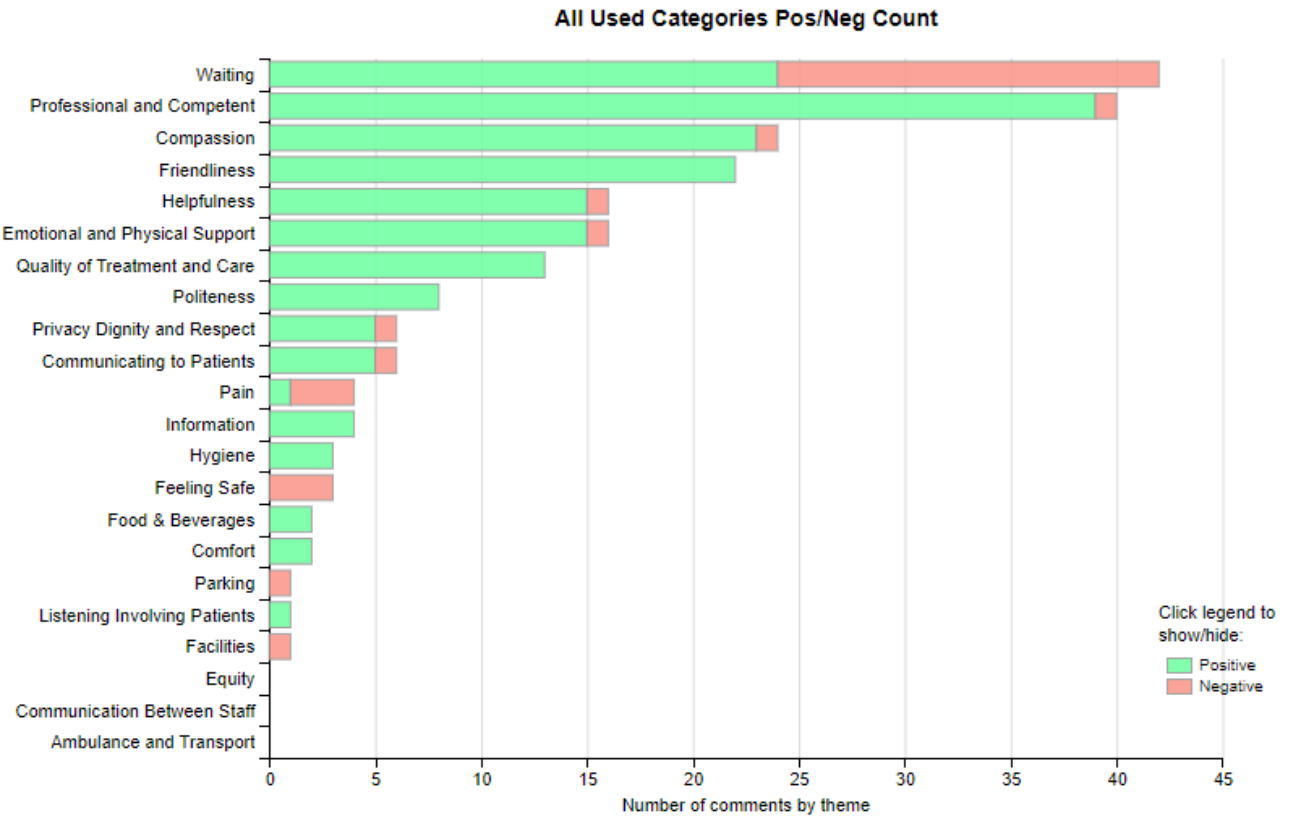
This will lead to an impact/effect on patient safety and quality of care by delaying timely and efficient treatment and could compromise their outcome as a result of no paediatric services/support on site nor paediatric trained medical/nursing workforce.

Incidents reported:

In November 2024, 8 incidents were reported. 4 of these incidents related to patients self presenting or being brough via WAST conveyance outside of the scope for the MIU. 1 incident related to a delay in transfer of a patient (post trauma) to Swansea Bay UHB. The remaining incidents were unrelated to the service change.

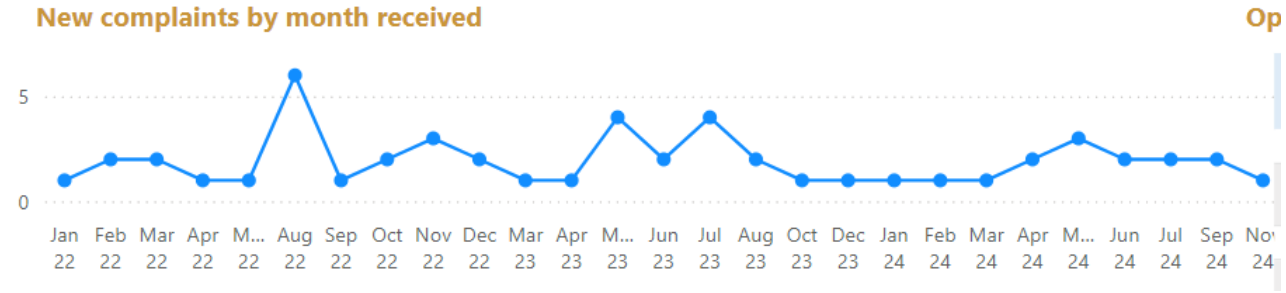
Complaints/Patient Feedback:

In November 2024, **254** patient's provided feedback via CIVICA. As a comparative, in November 2023 this figure was 277.



There have been less than 5 complaints raised through Patient Advice and Liaison Service (PALS)/Complaints process regarding MIU in November. These are related to the changes

made to the open hours of the MIU. This is a reduction in trend of complaints in comparison to previous months.



Workforce

November sickness 11.4% for November with anxiety/stress disorder as main reason followed by cold/flu symptoms. (This data is from 28th Oct to the 24th Nov 2024). This will be monitored going forward.

	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24
100 UNSCHEDULED CARE PRINCE PHILIP DMDA	8.05%	9.01%	8.44%	8.27%	8.92%	8.74%	7.39%	7.37%	8.88%	8.96%	8.72%	9.22%
100 CAR PPH Medical Secretaries 0103	4.48%	8.20%	12.90%	12.32%	9.29%	3.71%	2.30%	3.89%	2.83%	3.46%	6.60%	6.41%
100 CAR PPH Minor Injuries Unit (MIU) 0062	2.56%	4.97%	9.42%	12.64%	19.86%	17.00%	9.16%	8.08%	8.82%	4.65%	7.05%	12.60 %
100 CAR PPH MIU Medical Staff 0061	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Tregaron Hospital

The decommissioning of the remaining beds in Tregaron Community Hospital was undertaken through the multidisciplinary process in conjunction with the patient and their family with long term plans for discharge based on the needs and ensuring safe discharge. It is also essential to ensure that the future workforce is developed in a safe, sustainable, and appropriate way, and to this end the approach taken has been -

Consultation with the staff started on 3rd October 2024 and ended on 2nd November 2024. Consideration was given to the comments and responses received and then feedback and any adjustments were relayed to staff on 10th November 2024. During this consultation period a stakeholder meeting was also held for public feedback.

The implementation process commenced following decommissioning of the beds.

To date there have been no incidents reported or complaints received relating to the closure of the inpatient beds in Tregaron Hospital.

Staffing

- All nursing staff received 1-1 meetings with workforce representation, staff side representation and a senior nurse to discuss the community plan and what their preferred option would be.
- There have been regular meetings held with staff to ensure good communication is maintained with opportunities for any concerns to be raised and addressed.
- Staff have been allocated to community teams and Out-patient teams as their preferred preference. Opportunities for staff development have been put in place to ensure that Tregaron staff have the skills they require to support the Community Nursing Teams
- Individual training plans have been discussed with staff on a one-to-one basis; this will remain ongoing and bespoke training programmes developed in conjunction with 1 to 1 meetings.

- Competency Workbooks have been developed and provided to all staff to support in obtaining and maintaining competencies in the community setting.
- The training programme is flexible and is tailored to ensure Tregaron staff are trained and competent through individual learning needs.
- The next meeting with staff and mentors to be held in January with a plan to bring staff back into Tregaron to work with the community nursing services in this area to provide care closer to home.
- Scoping work is underway with Infection Prevention and Control colleagues and estates in Tregaron hospital to explore opening Outpatient clinics within the building. Some clinics are already up and running with more planned in the new year.

Although this has been a really difficult time for staff going through such huge changes to their working environment, it has also provided some opportunities for most, enabling development, The Health Board has been fully committed to supporting all affected staff to explore all opportunities offered.

Repurposing the community nursing staffing from Tregaron Community Hospital provides the opportunity to strengthen the existing community services by

- Enabling the nursing workforce to wrap around the GP cluster population as part of neighbourhood nursing community teams.
- Reducing the travelling times between patients thus increasing capacity
- Provide a skilled integrated community workforce that will be able to play an integral part in preventing hospital admissions and facilitate early discharge.
- Continue to Provide 24-hour community nursing team in Ceredigion.
- Strengthen the existing core community nursing service including the Outpatient and leg clinic model and palliative care provision. Support the Same Day Urgent Care model by providing wrap around support.
- Provide opportunities for staff development, not only with holistic and generic skills, but also enhanced skills which delivers care focused on the greatest needs of their patients.
- Extend Same Day Urgent Care Outreach Service enabling equitable service provision across the County.
- Provide increased opportunities for people in Ceredigion to stay well and increase their resilience with the support of enhanced practice.
- Accelerate implementation of the Community Nursing Specifications to provide a more consistent, resilient, and sustainable 24/7 neighbourhood district nursing model for Ceredigion.
- Accelerate development of the enhanced community care model providing an alternative pathway to admission via the clinical streaming hub.
- Interim beds continue to be commissioned in the independent sector for those patients who do require 24-hour nursing care.

Paediatrics, Bronglais General Hospital (BGH)
The current model operates on a Paediatric Assessment Care Unit plus (PACU+) model with a reduction in patient beds from 11 beds to 4 beds including a stabilisation space. This refreshed model removes inpatient care and has a refreshed PACU referral criterion. This new model is aligned with the Royal College of Paediatric and Child Health standards for Short Stay Paediatric Assessment Unit (SSPAU) PACU is a form of SSPAU.

<u>Incidents</u>
There have been no incidents concerned with patient harm relating to the PACU + model

Complaints
There have been no complaints relating to the PACU + model

Patient feedback
To date there has been no patient feedback regarding the change in service model to the PACU+. A plan is in place to gather staff stories and a patient story which will be used in a follow up press story.

Activity
Between 18th November and 16th December 2024, the average Length of Stay has been 0.93 beds decreasing to 0.5 days. There have been 24 ward attenders in November and there have been 8 ward attenders in December (to 16th December). There have been 85 inpatients in November and to date there have been 113 inpatients.

Emergency activity has increased with 85 episodes in November and 109 episodes in December (to 16th December). There have been no day cases admissions during this period of time. During this time there have been less than 5 occasions where children have been transferred to Glangwili General Hospital (GGH).

There have been 10 occasions whereby children have stayed over 36 hours (the range is from 38 hours to 118 hours (4.9days)). There have been ongoing discussions between the medical and nursing staff as to the need to transfer to GGH with all children reviewed and discussed as to the benefit of being transferred.

Staffing
From 17th October 2024, there has been continued recruitment with new starters commencing in October, November and December taking the Band 5 establishment to 4.6 whole time equivalent (WTE). The Band 6 establishment is currently 8.3WTE with 2WTE Band 6 members of staff on fixed term contracts.

There is currently one fixed term contact covering the maternity leave of one member of staff and one full time contact out to advert covering the maternity leave of a second member of staff.

This leaves the Register Nurse band 5 coverage as 4.6 WTE with a deficit of 1WTE. There is currently 1WTE band waiting for their Nursing and Midwife Council (NMC) registration pin number to come through. Once this has been achieved they will be moved into a Band 5 post taking the deficit to 0.01WTE.

Since 18th November 2024 there have been 3 occasions where staff have had to be moved to Angharad ward from GGH due to gaps in staffing. This has been due to last minute sickness.

Risks
All risk have been managed appropriately and no issues have been highlighted in the three times per week touch point which has been established to support the staff.

Argymhelliad / Recommendation

The Quality, Safety and Experience Committee, is asked to receive assurance from this update that there is no evidence of a negative impact on patient experience and safety relating to the service changes made to the Minor Injuries Unit in Prince Phillip Hospital, Tregaron Hospital and paediatrics in Bronglais General Hospital.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	2.1 Scrutinise, assess and seek assurance in relation to the patient impact, quality and health outcomes of the services provided by the Board.
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)	1. Leadership 2. Culture and valuing people 5. Whole systems persepctive
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	Not Applicable 6a Clinical services plan
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 yr ymgynghorwyd â nhw cyn Cyfarfod y Pwyllgor: Parties / Committees consulted prior to In Committee Meeting:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	The impact on finance was considered prior to the service change.

Ansawdd / Gofal Claf: **Quality / Patient Care:**	Quality impact assessments (QIA) were received for each of the service changes. These were considered by the QIA panel.
Gweithlu: **Workforce:**	The impact on workforce was considered prior to the service change. Monitoring is continuing.
Risg: **Risk:**	The risk impact was considered prior to the service change and is continuing to be monitored.
Cyfreithiol: **Legal:**	The legal impact was considered prior to the service change
Enw Da: **Reputational:**	The service changes and impact was discussed at the Board meeting.
Gyfrinachedd: **Privacy:**	No impact identified
Cydraddoldeb: **Equality:**	An EQIA was undertaken for each service change.

3

3 - Break

4

4 - Assurance

4.1

10 Mins

4.1 - Quality Assurance Report

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

Attachments

3.1 QS Assurance Report Feb2025.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Quality and Safety Assurance Report

Quality, Safety and Experience Committee

February 2025

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:

- Making a difference for patients
- Patient safety incidents including nationally reported patient safety incidents
- Duty of Candour
- Infection, prevention and control
- Inspections and peer reviews including activity of Healthcare Inspectorate Wales (HIW)
- Improvements to the Our Safety Dashboard
- Quality Improvement Strategic Framework – an update
- Royal College of Nursing (RCN) Report: On the Frontline of the UK's Corridor Care Crisis

Making a difference for patients

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Diogel Safe

Amserol Timely

Effeithlon Efficient

Effeithiol Effective

Teg Equitable

Person ganolog Person centred

Paediatric diabetes team has best outcome measure performance in Wales

17 January 2025

Hywel Dda University Health Board's (UHB) paediatric diabetes team is the best performing in Wales and third in England and Wales according to latest figures from the National Paediatric Diabetes Audit.

The National Diabetes Audit, conducted by the Royal College of Paediatrics and Child Health, collects data from NHS organisations across Wales and England to support clinicians in their work, to help patients get the best care and to use data to improve treatment and management.

One measure of success is a patient's HbA1C number – a test which measures the amount of blood glucose attached to a patient's haemoglobin, found in red blood cells.

Hywel Dda's paediatric diabetes team is led by Dr Simon Fountain-Polley and Dr Swe Lynn.

Dr Swe Lynn, consultant paediatrician, explained: "HbA1C is an important blood test that gives a good indication of how well diabetes is being managed and is a very strong predictor of future health. It's our predictor for the risk of long-term complications from diabetes. So, the lower the number the better.

"Within the national paediatric diabetes audit data for 2022 to 2023, our average HbA1C is the lowest in Wales and it's the third lowest in England and Wales. There are more than 170 units – health boards, and NHS trusts in England, for example - that provide data to the National Paediatric Diabetes Audit (NPDA).

"This is a good achievement for us bearing in mind we're a small unit in terms of the units across England and Wales."

The paediatric diabetes unit was set up some 15 years ago when Hywel Dda UHB was formed and was one of the smallest teams in Wales. But specialist staff were recruited and now the team includes two consultants, dietitians, paediatric specialist nurses, admin support and a psychologist.

Case study:

Seren and Katie enjoying a coffee

When Seren Morgan, 10, from Carmarthen was rushed into hospital seriously ill in April of 2024, her and her family's lives changed forever.

Seren was diagnosed with Type 1 diabetes and now, thanks to the support of her family and the paediatric diabetes team based at Glangwili, Seren is able to manage her condition and do many of the things she enjoys.

Ask Seren what she likes to do in her spare time and she reels out a full schedule – drama club, cricket in the summer, piano on a Wednesday afternoon, getting together with friends. And she has just spent time on a school trip at an outdoor pursuits centre in the Brecon Beacons.

But none of this has been simple. In the past, Seren's mum Katie would drop her off at drama club but now she will stay there to keep an eye on her blood sugar levels. Seren could not stay overnight in Brecon with her friends – her parents took her to Brecon every day and brought her home each night.

"Seren got poorly at Christmas time with various viruses and then we were back and forth to the hospital in Cardiff. She was having really severe symptoms, which we just didn't realise was diabetes Type 1," said Katie.

"It was only when we went to our family GP, who looked at Seren and thought there was something really wrong, that we were whisked into Glangwili Hospital. And it was on the 16th of April that Seren was diagnosed with Type 1 diabetes. It was very shocking."

"It was difficult, especially for Seren, because she went immediately into emergency treatment, which was really painful and really traumatic.

"We're still having support now for Seren to get over what was a traumatic event in her life."

Katie has praised the support she has had from Dr Simon Fountain-Polley and the paediatric team at Glangwili.

The full story can be found at https://hduhb.nhs.wales/news/press-releases/paediatric-diabetes-team-has-best-outcome-measure-performance-in-wales/

Patient Safety Incident Reporting

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

There were 12,942 Patient Safety Incidents reported on Datix Cymru in Hywel Dda UHB between 1st January 2024 – 31st December 2024.

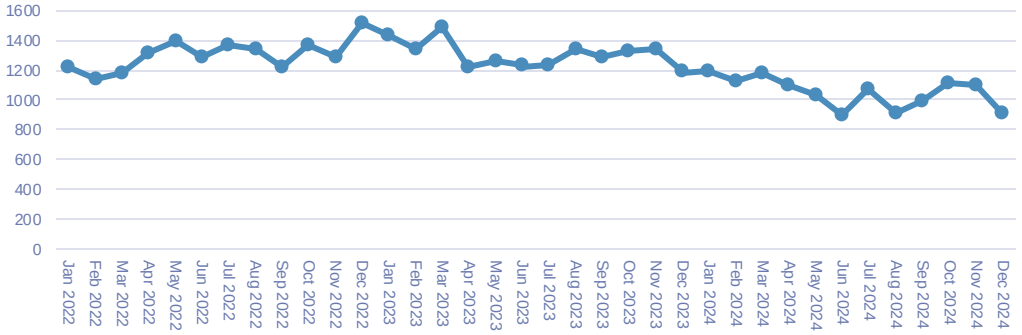
Of the 12,942 patient safety incidents reported, 9,879 have been closed. 1% were closed as moderate, severe or catastrophic harm. The top 3 incident categories (incidents reported between 01/11/2023 and 31/10/2024 and closed as moderate, severe or catastrophic harm) were:

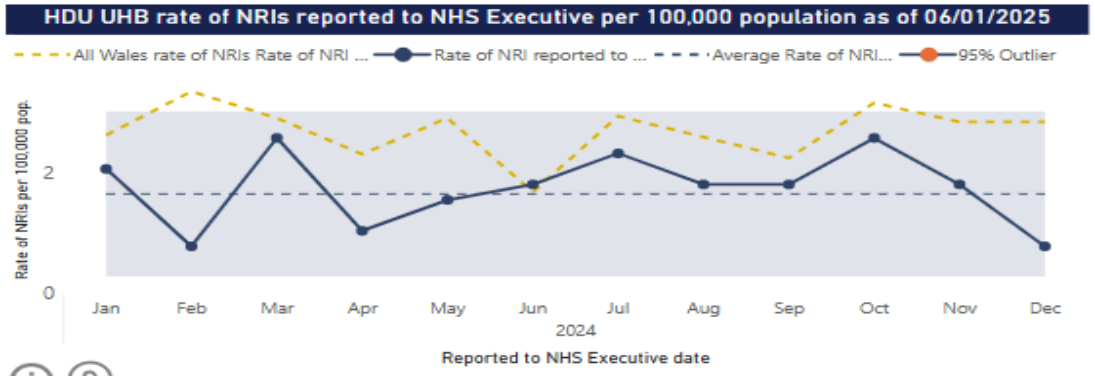
Pressure ulcer developed or worsened during care in this clinical care area/caseload	29
Slip, trip or fall	21
Treatment or procedure issues	11

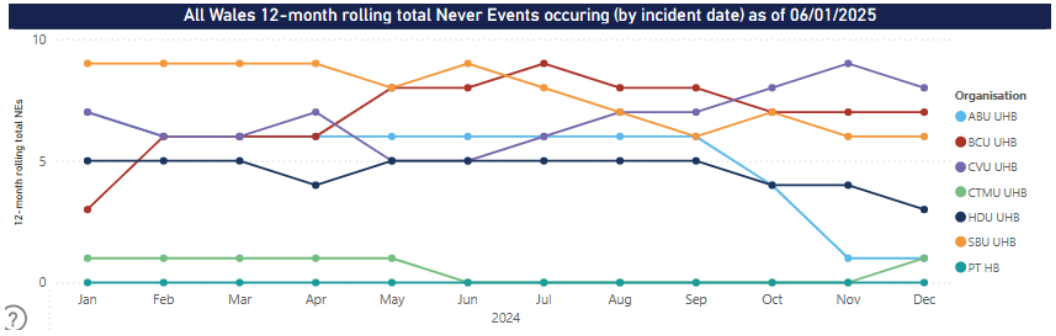
Diogel Safe

Patient Safety Incidents by month of occurrence

As at 31/12/2024







HDU UHB Never Events occuring (by incident date, Jan-24 to Dec-24) as of 06/01/2025

Year	2024											
Never Event	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Administration of medication by the wrong route	0	0	0	0	1	0	0	0	0	0	0	0
Retained foreign object post procedure	1	0	0	0	0	0	1	0	0	0	0	0
Total Never Events	**1**	**0**	**0**	**0**	**1**	**0**	**1**	**0**	**0**	**0**	**0**	**0**

Nationally Reporting and Serious Incident learning

Themes & Learning Poster: Sharing Learning Points Health Board wide

World Patient Safety Day 17 September 2024

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

"Get it right, make it safe!"

This year the theme of World Patient Safety Day on 17th September 2024 is "Improving diagnosis for patient safety" with the slogan "Get it right, make it safe!" highlighting the critical importance of correct and timely diagnosis in ensuring patient safety and improving health outcomes. A diagnosis identifies a patient's health problem and is key to accessing the care and treatment they need. A diagnostic error is the failure to establish a correct and timely explanation of a patient's health problem, which can include delayed, incorrect, or missed diagnoses, or a failure to communicate that explanation to the patient.

What was the issue?

- The patient attended the Emergency Department, following a fall at work. It was reported that the patient had collapsed and had an altered level of consciousness. The patient was seen by a SHO under the medical team on the day of admission. It was documented that the patient reported that they had severe pain in their neck and could not feel their legs. It was also documented that the patient was weak in the upper and lower limbs and could move them slightly but could not lift them. The doctor documented the diagnosis as cervical spinal trauma secondary to a fall. No spinal precautions were put in place and no referral to the T&O team was made.
- A CT scan of the cervical spine was carried out later that day which concluded that there was no evidence of any acute fracture or bony injury shown within the cervical spine. But also said that "a MRI of the cervical spine should be performed for further assessment".
- A spinal MRI was undertaken 3 days later which and reported left sided ischaemic changes with severe canal stenosis at C4 / C6.
- An MDT decided that the patient was not suitable for surgical decompression. The opinion of an External Spinal Surgeon said that the window for surgery, in their opinion, is the first 24 to 36 hours after injury. The patient was tetraplegic.

Contributory Factors

- On the day of admission, the doctor gave a diagnosis of spinal trauma but did not put spinal precautions into place or make a referral to the T&O team.
- A CT scan was undertaken which said that a ligamentous injury cannot be excluded on the grounds of a CT examination and if there were clinical concerns for a ligamentous injury, "a MRI of the cervical spine should be performed for further assessment", however the MRI was not undertaken until 3 days later.

What could we improve on?

- During the course of the investigation it was noted by clinical reviewers, independent to whether the incident occurred and an external reviewer that the neurological examinations were below the standard expected for the patient's presentation.
- The External Spinal Surgeon said that in their opinion, there was a missed opportunity to decompress the spinal cord as soon as neurological deterioration occurred.

What have we learnt?

- There is a need for higher index of suspicion for "silver trauma", particularly cord injury in patients presenting with abnormal neurology following a fall with evidence of existing spinal degeneration/stenosis.
- Neurological findings must be formally objectively assessed and clearly documented.
- When a spinal injury is suspected spinal precautions must be put in place immediately until all assessments to determine whether a spinal injury is present or not have been completed.

If you have any comments about this issue, please send them to: patient.safety@wales.nhs.uk
Do you have a concern about patient safety? Please report using our Incident reporting (sharepoint.com)or Speak Up Safely https://nhswales365.sharepoint.com/sites/HDD_Intranet/SitePages/Speak-up-safely.aspx

7 Minute Patient Safety Briefing
Care after death

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

1 **Background**

A deceased patient remained in the Emergency Department (ED) viewing room at GGH for 2 days (approximately 43 hours) after the date and time of death. There was a failure to transfer the patient to the mortuary in a timely manner and the 'procedure for care after death of patients' was not followed.

2 **Care & Service Delivery Problems**

- Failure to orientate agency staff with procedure for care after death of patients in the ED.
- Failure to complete environmental checks by nurse in charge of shift.
- Failure to follow process to request timely portering to transfer patient to the mortuary via correct process. The 'Synbiotix' portering system was not activated, resulting in the breakdown in communication and delay in transfer from ED to the mortuary.

3 **Contributory Factors: Team function, leadership, roles and responsibility as well as verbal communication.**

- Poor communication among staff.
- New Porter requesting system (Synbiotix) recently implemented and unfamiliar to staff.
- WelshPAS system not accurately maintained, patient discharged from system without confirming the patient had physically left.
- Failure to complete environment checks.
- Busy department with high patient acuity.

4 **What could we improve?**

- Care after Death checklist to ensure consistency with standards and the Care After Death Policy.
- Improved systems and team communication: Implementation of 'yellow rose' and inclusion in daily Patient Flow and Huddle information. At the start of each shift, Quality checklists to be completed.
- Reinforce roles and responsibilities of the nurse in charge, ensuring environmental and patient safety checks are completed.
- Appropriate use of Synbiotix system when requesting transfer of patients to mortuary from the ED. All temporary staff/agency to be aware of the system, and have log in access, to ensure correct procedures followed to transfer patients to the mortuary.

5 **What have we learnt:**

- The importance of clear communication to ensure standards are maintained after death.
- Because of this incident the staff in ED have devised a prompt – a Yellow Rose sign to be placed on the door of the viewing room when occupied. The Rose sign to be returned to the ED navigator (Nurse in Charge) once patient has been transferred to the mortuary - implementation has been communicated to all staff with the support of the practice educator and through departmental meetings.
- The importance of maintaining up to date information on systems, e.g. WelshPAS and the implications on patient safety.
- The importance of completing checklists accurately to evidence best practice and ensure safe working environments.
- The negative psychological impact resulting from an incident of this nature for both the family of the deceased and the staff within the ED and the Mortuary.

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

Themes & Learning Poster: Sharing Learning Points Health Board wide

World Patient Safety Day 17 September 2024

"Get it right, make it safe!"

This year the theme of World Patient Safety Day on 17th September 2024 is "Improving diagnosis for patient safety" with the slogan "Get it right, make it safe!" highlighting the critical importance of correct and timely diagnosis in ensuring patient safety and improving health outcomes. A diagnosis identifies a patient's health problem and is key to accessing the care and treatment they need. A diagnostic error is the failure to establish a correct and timely explanation of a patient's health problem, which can include delayed, incorrect, or missed diagnoses, or a failure to communicate that explanation to the patient.

What was the issue?

- The patient presented to the Emergency Department (ED) with a 3 week history of back pain and reported recent incontinence. The ED reviewed the patient and at this time the patient was not aware that they were pregnant. The ED clinician documented that they performed a full examination and arranged for a pregnancy test. The ED clinician documented that the urine analyser machine recorded 'error' on 3 attempts for a pregnancy test, returning an inconclusive result. With hindsight, this error message likely occurred because the urine sample was actually amniotic fluid.
- The patient was prescribed treatment for a Urinary Tract Infection and discharged. Within 24 hours, the patient re-presented to the ED with continued back pain. A CT scan of the patient's urinary tract showed a near term gestation pregnancy and the patient was referred to Obstetrics. A foetal heartbeat could not be detected and the patient sadly had a stillbirth.

Contributory Factors

- Cognitive bias is a systematic error in thinking which affects how information is processed and decisions are made. In this instance, diagnostic momentum took hold which reduced the ability to consider other alternatives.
- The working diagnosis was Cauda Equina Syndrome, Kidney stones, or Urinary Tract Infection. The investigation concluded that as the patient was of reproductive age, had presented with pain, and the pregnancy tests were inconclusive, pregnancy should have been considered as a differential diagnosis.

What could we improve?

There were missed opportunities to detect the pregnancy during the patient's first admission. The inconclusive urine analysis result and the staff not persisting in getting a definitive result caused the delay in diagnosis. Consideration could have been given to performing a blood pregnancy test (Serum HCG). An earlier pregnancy test would on the balance of probability would have been positive and this would have provided a different schedule of care. There may have been an opportunity to intervene and this may have resulted in a different outcome for the baby.

What have we learnt?

• Healthcare professionals should consider the possibility of a pregnancy, even in women who state they are not, as the woman may be unaware of an undetected pregnancy, If the machine does not produce a conclusive result, then consideration should be given to getting the test in another way (e.g. blood serum test, if urine dip test was inconclusive). Thinking critically, carefully considering other diagnosis, and consulting peers for a second opinion can help to improve diagnostic accuracy.

If you have any comments about this issue, please send them to: patient.safety@wales.nhs.uk
Do you have a concern about patient safety? Please report using our Incident reporting (sharepoint.com)or Speak Up Safely https://nhswales365.sharepoint.com/sites/HDD_Intranet/SitePages/Speak-up-safely.aspx

Nationally Reporting and Serious Incident learning

Quality Assurance & Safety Team
7 Minute Patient Safety Briefing - Professional Documentation: Safe, Effective, and Legal.
"If it wasn't documented, it wasn't done."

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

1 **Background: Professional and legal standards:**
Documentation demonstrates how healthcare professionals applied their knowledge, skills, and judgment according to their regulatory standards of practice. Professional standards set out clear principals on documentation and these underpin the Health Board's Clinical Record Keeping Policy which require healthcare professionals to attain. Documentation is generally accepted as evidence in legal proceedings. In a legal sense, documentation and record keeping is there for the protection of the healthcare professional. A well-kept record can protect the practitioner in instances where the legal defence of their actions is required.

2 **Nursing Midwifery Council (NMC) and Allied Healthcare professional regulatory bodies guidance.**
There are standards throughout the relevant Codes of Conduct that are indirectly related to record keeping practice. The purpose of recording care is to evidence decision making and clinical judgements while supporting delivery and continuity of care, subsequently improving communication between healthcare professionals and the identification of risks to the person accessing the service. Nurses are required from a regulatory and employer perspective to provide evidence of their contribution, professional judgement and interventions in care delivered.

3 **General Medical Council (GMC) guidance.**
Key points – Good medical records summarise the key details of every patient contact. Clinical records should include:
- Relevant clinical findings
- The decisions made and the actions agreed, and who is making the decisions and agreeing the actions
- The information given to patients/families
- Any drugs prescribed or other investigation or treatment and the rationale for doing so
- Who is making the record and when.

4 **Common contributing factors in investigations:**
- Writing illegible or incomplete records
- Entries not dated and time-stamped by the staff member who created the entry
- Clinical rationale not being clearly justified in the patient notes

5 **Lessons Learnt:** The most important role of documentation is to assure high quality patient care. One of the key principles of legally defensible documentation is strict adherence to organisational policies and procedures and regulatory frameworks which mandate that care must be documented as evidence that care was provided. Judges, juries, and other interested parties take the position, **"If it wasn't documented, it wasn't done."**

6 Make Documentation Your Ally.
FACT improve your documentation.
F = Factual
A = Accurate
C = Complete
T = Timely

7 **Outcome:**
Documentation is a matter of professionalism and proof of care given. The principles of good documentation are not new. Lapses in applying these principles create problems when documentation is presented as evidence to defend against failure to meet standards of care. When concentrating on the principles of documentation healthcare professionals will document the quality care they provide and fulfil their professional responsibilities.

Quality Assurance & Safety Team: 7 Minute Briefing

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)
Healthcare Inspectorate Wales

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

1 **Background**
Healthcare Inspectorate Wales undertook a Review of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions for adults in Wales. Their report was published in May 2024.

2 **Summary**
The review explored whether patients are actively involved in decision making about DNACPR and whether those decisions are clearly recorded and communicated between healthcare professionals.

When people are affected by life-limiting and palliative illnesses, an open discussion about the reasons not to resuscitate them if their heart and lungs cease to function, can be an important part of advance care planning, and can help minimise distress at a later stage. To facilitate and support the DNACPR decision process, clinicians in Wales who make decisions not to resuscitate a person, must legibly and fully complete a DNACPR Form. This will ensure that the patient's wishes are respected and that decisions reflect the best interests of an individual.

Further reading
Summary: Review of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Decisions for Adults in Wales | Healthcare Inspectorate Wales (hiw.org.uk)

Do Not Attempt CardioPulmonary Resuscitation (DNACPR) HDUHB SharePoint

3 **Opportunities to Improve**
During the review, HIW identified a number of areas where improvement could be made.
A Health Board wide action plan has been developed to consider the other recommendations in the report.
A very small snapshot of the recommendations are included in the points below.

7 **Some areas for individual reflection**
1. How are you supporting patients to make timely and informed decisions?
2. Could you find patient information leaflets and supporting guidance about DNACPR ? Where would you look? Who would you ask?
3. What standard is your documentation? Does it meet professional and organisational standards?

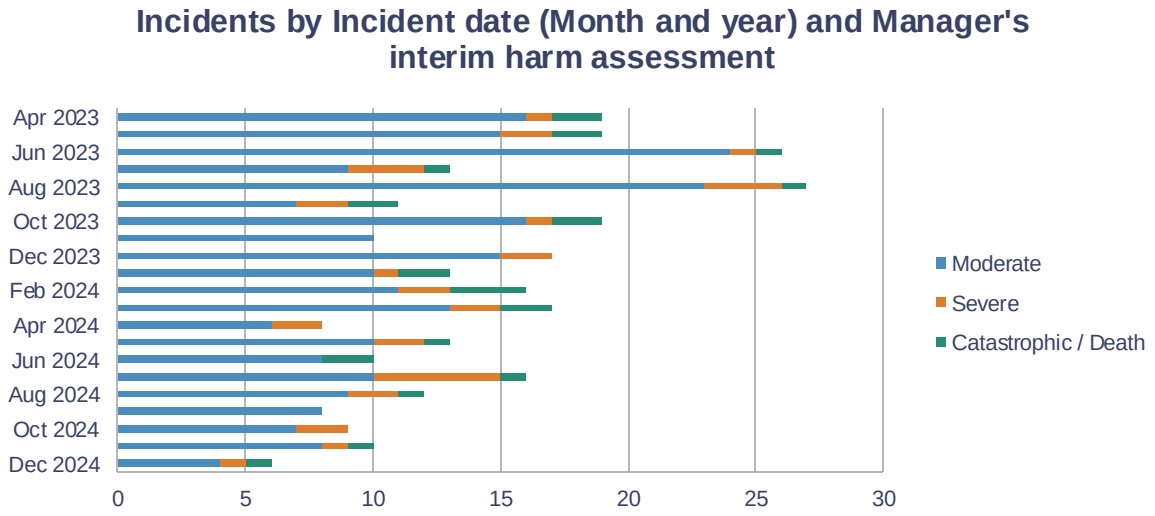
4 **Improvement: DNACPR discussions and supporting information**
DNACPR discussions should be held as early as appropriate with patients and those close to them, to allow them time to understand the decision, reflect on discussions and to generate follow-up discussions if appropriate.

Patients and those close to them should be provided with, or signposted to, information resources, in an appropriate format, to help them understand and consider the CPR process, and what DNACPR means.

6 **Improvement: Review by the Senior Responsible Clinician**
Section 6 of the DNACPR form must completed in a timely manner by the Senior Responsible Clinicians in line with the all-Wales Policy.

5 **Improvement: Clear Documentation**
Clinicians completing the date section 'for review' within a DNACPR form, must clearly document all the required information including the date and their professional registration numbers, to ensure that clinicians are identifiable if required.

Duty of Candour



173 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	9	33	103	0	1	146
	Severe	1	4	3	6	2	16
	Catastrophic / Death	2	4	1	2	2	11
	Total	12	41	107	8	5	173

Top 3 incident classifications

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

Pressure Damage, Moisture Damage	**41**
Pressure ulcer developed or worsened during care in this clinical care area/caseload	38
Pressure ulcer present before admission to this clinical care area/caseload	2
Pressure from medical device present before admission to this clinical care area/caseload	1
Accident, Injury	**34**
Slip, trip or fall	32
Patient injury	2
Maternity adverse occurrence	**21**
Maternity adverse occurrence - Neonate	13
Maternity adverse occurrence -Maternal	[illegible]

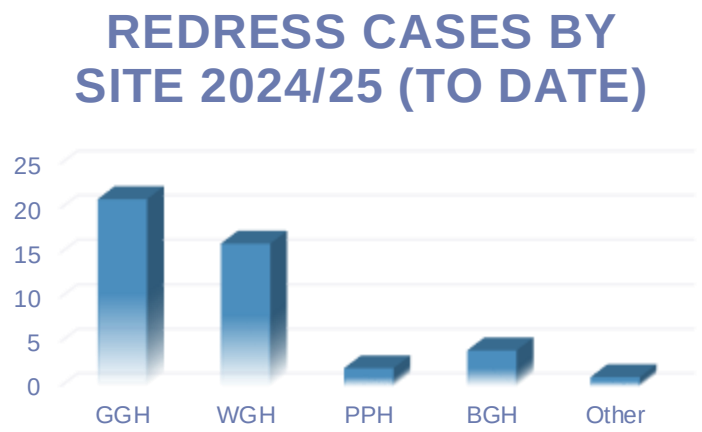
Learning identified:

- Importance of assessing overall clinical picture
- Consideration of clinical impression when reviewing radiological imaging
- Notification of senior clinician when trauma call made
- Cognitive bias and clinical assessment and diagnosis

Health Board Overview – Outcomes from complaints

So far in financial year 2024/25, 76% of complaints were closed within the 30-working day target timescale advised in the 'Putting Things Right Regulations. The national target is 75%. The average closure rate per quarter is 516 complaints.

186 complaints in Q3 were either closed and not upheld, or upheld but not found to have caused harm. Since April this year, 44 cases have been escalated to redress because failings have, or may have caused harm to patients. These have mostly occurred at our general hospital sites (below).



The failings in care identified through the PTR investigation process have centred mostly on A&E, Women's and Children's Services and Trauma & Orthopaedic specialities.

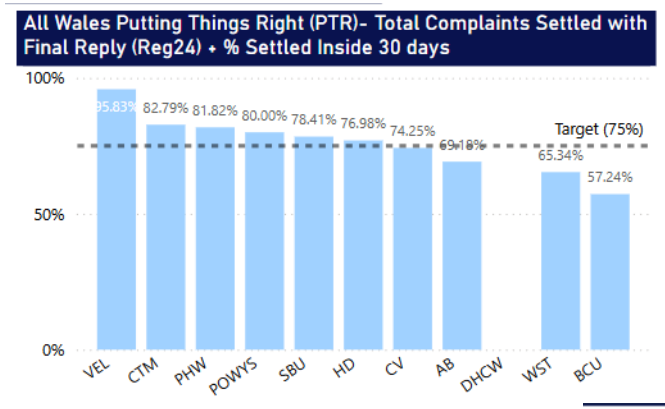
The number of cases escalated to redress remains lower in Q3 than preceding quarters this year:

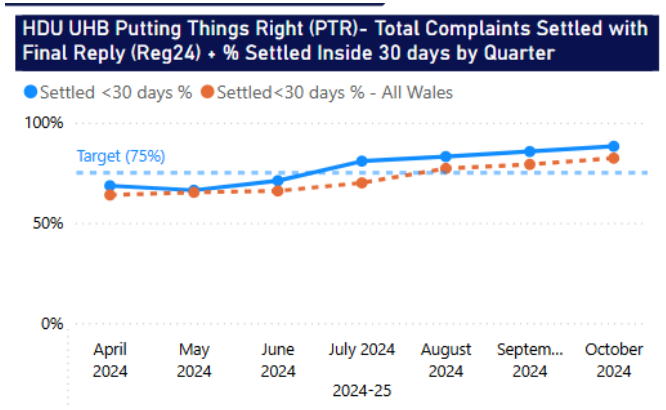
Cases escalated to Redress 2024/ 25	
April	4
May	7
June	3
July	5
August	7
September	8
October	1
November	4
December	5
Total	44

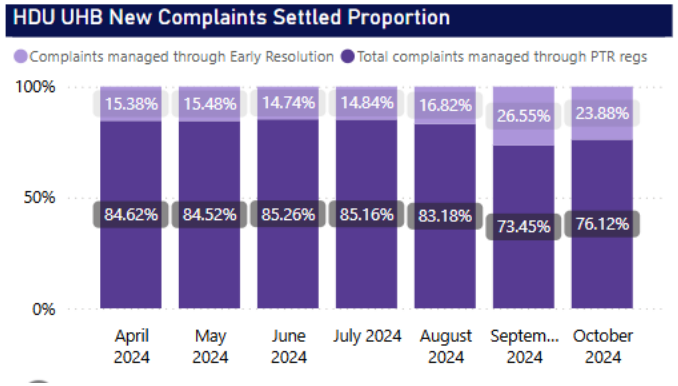
Learning from the Ombudsman

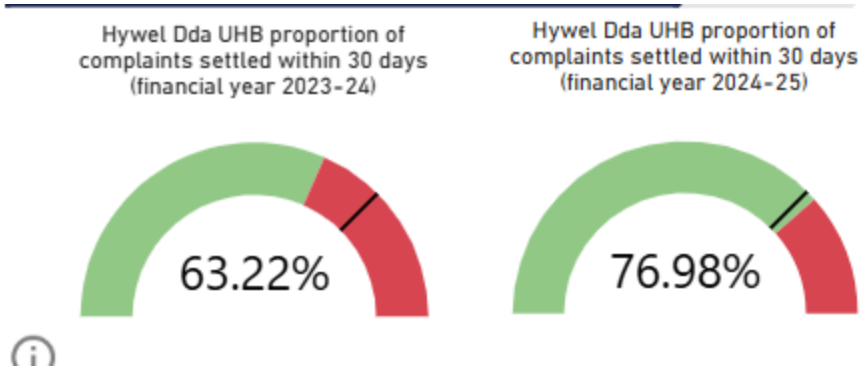
Three new investigations have been commenced by the Ombudsman in the period October-November 2024. There have been 12 decisions not to investigate. Two final reports were received which were both partly upheld. The Health Board agreed to five early resolutions agreements proposed by the Ombudsman in the period.

Health Board Overview – Complaints Management









This information has been taken from the Beacon Dashboard, which has been produced following submission of validated complaints data by each health body.

The chart shows an improvement in performance since 2023-24 and has remained on an improvement trajectory during the current year, with performance remaining above the all Wales average.

The chart below depicts a reduction in PTR complaints during the previous two months, which we believe has coincided with the pilot triage process in place, resulting in a higher percentage of concerns being addressed as local resolution.

Health Board Overview – Complaints performance

- From 1st November 2024, the Board approved an increase in the time allowed to respond to an early resolution case of 5 working days, the spirit of the revised Putting Things Right (PTR) arrangements. 5 working days was chosen as this is the timeframe allowed for acknowledgments under formal PTR (new stage 2). This together with the new triage arrangements is having a positive impact and improved patient / complainant experience. The PTR cases have reduced further in December, as highlighted in the table below and now number less than half of what they were in Q1 of this year.

Received	Managed through PTR
Apr	200
May	207
Jun	218
Jul	226
Aug	179
Sep	168
Oct	205
Nov	144
Dec	100
Grand Total	**1647**

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

Friends & Family Test (FFT) Patient Feedback by patient type

An attendance at an outpatient appointment or a discharge from ward or A&E, triggers an invite to patients to share their feedback. The FFT text message is sent out to a patient within 24hrs from being discharged. Survey fatigue is a persistent challenge, to overcome this the system is configured to only send an invite to a patient once over a 3 month period. This can however compromise both response rates and data quality. The CIVICA system ensures we have concise, well timed surveys that use skip logic and mobile-friendly designs.

The tables show the amount of responses we received during this period for each patient type for our acute sites. Our outpatient and our Emergency departments have the highest number of responses due them seeing the highest volume of patients . Our inpatient responses are proportionate to activity in this area. We consistently achieve over 15% response rate, which is nationally recognised as an excellent rate.

Day cases have the highest positive feedback with over 96.1% at Bronglais and 100% at Prince Philip Hospitals. Prince Philip has overall positive feedback of 95.2% with all acute sites receiving over 90% positive feedback.

The following are voice messages of feedback received via the FFT system (click to play):

https://youtu.be/oAbKuN7zUfM CICC MIU
https://youtu.be/9WT7MYPqexE PPH OPD
https://youtu.be/Ywo1elNNGsI BGH A&E
https://youtu.be/0txni1cLlEI WGH A&E

Bronglais	% Positive	% Negative	Total Responses	Percentage of total responses
Total	95.0%	5.0%	820	100%
Outpatient	97.5%	2.5%	387	47%
Emergency Patient	90.2%	9.8%	276	34%
Inpatient	96.9%	3.1%	68	8%
Day Case	100.0%	0.0%	64	8%
Paediatric Inpatient	100.0%	0.0%	14	2%
Maternity Inpatient	85.7%	14.3%	7	1%
Maternity Outpatient	33.3%	66.7%	3	0%
Paediatric Outpatient	100.0%	0.0%	1	0%

Glangwili	% Positive	% Negative	Total Responses	Percentage of total responses
Total	90.3%	9.7%	2034	100%
Outpatient	93.7%	6.3%	1173	58%
Emergency Patient	80.8%	19.2%	452	22%
Inpatient	88.3%	11.7%	280	14%
Day Case	98.6%	1.4%	72	4%
Maternity Inpatient	83.3%	16.7%	18	1%
Paediatric Inpatient	100.0%	0.0%	15	1%
Maternity Outpatient	100.0%	0.0%	10	0%
Paediatric Outpatient	85.7%	14.3%	7	0%
Mental Health Outpatient	50.0%	50.0%	5	0%
Community & Primary Care Patient	100.0%	0.0%	1	0%
Mental Health Inpatient	0.0%	100.0%	1	0%

Withybush	% Positive	% Negative	Total Responses	Percentage of total responses
Total	92.0%	8.0%	1270	100%
Outpatient	95.8%	4.2%	618	49%
Emergency Patient	85.1%	14.9%	395	31%
Day Case	96.1%	3.9%	104	8%
Inpatient	91.5%	8.5%	91	7%
Maternity Outpatient	92.5%	7.5%	53	4%
Mental Health Outpatient	80.0%	20.0%	6	0%
Paediatric Outpatient	100.0%	0.0%	3	0%

Prince Philip	% Positive	% Negative	Total Responses	Percentage of total responses
Total	95.2%	4.8%	1668	100%
Outpatient	99.1%	3.4%	1124	67%
Emergency Patient	89.8%	10.2%	316	19%
Inpatient	92.8%	7.2%	113	7%
Day Case	100.0%	0.9%	111	7%
Mental Health Inpatient	96.6%	0.0%	4	0%

Friends and Family Test (FFT) Patient Feedback by location

Bronglais	% Positive	% Negative	Total Responses	Percentage of total responses
Total	94.9%	5.1%	818	100%
Outpatient Department	97.6%	2.4%	302	37%
Accident and Emergency Department	90.2%	9.8%	276	34%
Cardio-Respiratory Department	97.4%	2.6%	40	5%
Day Surgery Unit	100.0%	0.0%	33	4%
Integrated Sexual Health Clinic	95.5%	4.5%	24	3%
Ceredig Ward	100.0%	0.0%	22	3%
Endoscopy Department	100.0%	0.0%	21	3%
Rhiannon Ward	86.7%	13.3%	15	2%
Clinical Decisions Unit (Green)	100.0%	0.0%	9	1%
Rheumatology Department	100.0%	0.0%	8	1%

Glangwili	% Positive	% Negative	Total Responses	Percentage of total responses
Total	90.4%	9.6%	2031	100%
Outpatient Department (Blue)	93.4%	6.6%	817	40%
Accident and Emergency Department	79.0%	21.0%	406	20%
Cardio-Respiratory Unit	94.1%	5.9%	124	6%
Madog Suite	92.6%	7.4%	72	4%
Tysul Ward	92.3%	7.7%	69	3%
Aberglasney Suite	98.3%	1.7%	59	3%
Same Day Emergency Care Unit	97.5%	2.5%	43	2%
Picton Ward	81.6%	18.4%	38	2%
Endoscopy Department	100.0%	0.0%	34	2%
EEG/EMG Department	100.0%	0.0%	30	1%

Withybush	% Positive	% Negative	Total Responses	Percentage of total responses
Total	92.0%	8.0%	1268	100%
Outpatient Department (A)	95.3%	4.7%	366	29%
Accident and Emergency Department	83.5%	16.5%	335	26%
Cardio-Respiratory Department	98.5%	1.5%	141	11%
Same Day Emergency Care Unit	93.0%	7.0%	58	5%
Physiotherapy Department	94.2%	5.8%	57	4%
Gynaecology Care Suite	91.8%	8.2%	49	4%
Medical Day Unit	100.0%	0.0%	34	3%
Ward 4	96.3%	3.7%	30	2%
Day Surgery Unit	85.2%	14.8%	27	2%
Endoscopy Department	100.0%	0.0%	22	2%

Prince Philip	% Positive	% Negative	Total Responses	Percentage of total responses
Total	95.2%	4.8%	1667	100%
Outpatient Department	96.9%	3.1%	893	54%
Minor Injuries Unit	88.5%	11.5%	272	16%
Cardio-Respiratory Department	100.0%	0.0%	77	5%
Rheumatology Department	87.9%	12.1%	70	4%
Day Surgery Unit	98.2%	1.8%	58	3%
Same Day Emergency Care Unit	97.5%	2.5%	44	3%
Physiotherapy Department	100.0%	0.0%	39	2%
Acute Medical Assessment Unit	85.7%	14.3%	37	2%
Pre Op Assessment Clinic	100.0%	0.0%	36	2%
Endoscopy Department	100.0%	0.0%	27	2%

Community	% Positive	% Negative	Total Responses	Percentage of Total Responses
Total	93.6%	6.4%	1064	100%
Unmapped	95.7%	4.3%	523	49%
Cardigan Integrated Care Centre	96.7%	3.3%	253	24%
Tenby Cottage Hospital	98.7%	1.3%	80	8%
Hafan Derwen	91.7%	8.3%	56	5%
Aberaeron Integrated Care Centre	88.9%	11.1%	36	3%
South Pembrokeshire Hospital	97.0%	3.0%	33	3%
Amman Valley Hospital	96.8%	3.2%	32	3%
Carmarthenshire	50.0%	50.0%	19	2%
Pembrokeshire	42.9%	57.1%	7	1%
Ceredigion	50.0%	50.0%	5	0%

Community	% Positive	% Negative	Total Responses	Percentage of Total Responses
Total	93.6%	6.4%	1064	100%
Unmapped	95.7%	4.3%	523	49%
Outpatient	93.9%	6.1%	242	23%
Emergency Patient	97.4%	2.6%	239	22%
Community & Primary Care Patient	45.8%	54.2%	26	2%
Mental Health Outpatient	57.1%	42.9%	15	1%
Inpatient	100.0%	0.0%	12	1%
Other	0.0%	100.0%	4	0%
Maternity Outpatient	100.0%	0.0%	3	0%

Cardio- respiratory have the third highest number of responses with all sites receiving over 94% positive feedback. All Endoscopy departments have received 100% positive feedback for this period. Please note that within the community section is an area called 'unmapped' these are new location codes which are currently being mapped into the system, these are across the Health Board and not just within community. These are being mapped on an ongoing basis

Performance de-escalation summary

Latest position key

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

	Measure	De-escalation criteria	Baseline	Goal	Latest position				
					Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Infections	Number of hospital onset C.difficile infections	25% reduction, maintained for 3 months	8	6	4	4	7	8	6
	Number of hospital onset Staph aureus infections	33% reduction, maintained for 3 months	3	2	5	3	0	2	3
	Number of hospital onset E.coli infections	25% reduction, maintained for 3 months	7	5	4	5	4	9	5

Table 1. Latest month count of hospital onset (HO)* specimens by acute hospital in Hywel Dda UHB, Dec 24

Additional filters for Table 1.

Select month or FY

Latest month

Select organism group

All organisms

- < than last month
- = last month
- > than last month

	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Bronglais General Hospital	0	0	0	0	0	0
Glangwili General Hospital	3	0	1	0	3	0
Prince Philip Hospital	2	0	0	3	0	0
Withybush General Hospital	1	0	1	2	1	0

*HO specimens - specimens taken > than 2 days (where day 1 is day of admission) into a hospital inpatient stay.

Table 1. Latest month count of specimens by HB, Dec 24

Additional filters for Table 1.

Select month or FY

Latest month

Select organism group

All organisms

< than last month
= last month
> than last month

	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Aneurin Bevan UHB	18	2	9	27	7	2
Betsi Cadwaladr UHB	33	0	11	45	9	4
Cardiff and Vale UHB	11	1	12	22	9	2
Cwm Taf Morgannwg UHB	17	2	9	25	18	0
Hywel Dda UHB	12	0	8	22	11	1
Powys THB	2	0	0	0	0	0
Swansea Bay UHB	23	1	11	16	12	5
Velindre NHST	1	1	0	0	0	0
Wales	117	7	60	157	66	14

Table 1. Current FY rate per 1,000 hospital admissions of specimens by HB, Apr - Dec 24

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	2.83	0.16	1.63	3.61	1.19	0.41
Betsi Cadwaladr UHB	3.63	0.15	1.63	5.31	1.38	0.25
Cardiff and Vale UHB	3.17	0.1	2.57	4.14	1.84	0.6
Cwm Taf Morgannwg UHB	2.58	0.12	1.85	5.25	1.7	0.22
Hywel Dda UHB	3.47	0.12	2.15	6.29	1.85	0.46
Powys THB	20.2	0	1.01	1.01	0	0
Swansea Bay UHB	4.34	0.08	1.97	3.6	1.91	0.28
Velindre NHST	1.61	0.4	0.4	4.04	3.23	0
Wales	3.34	0.13	1.9	4.62	1.59	0.36

- 150 cases of C.diff within the health board this financial year to date. 130 reported at this point for 23/24
- From July 2024 the data set displays less variance
- Progress is being made towards a reduction in comparison to 2023/24 data

Actions

- C.diff infection (CDI) Improvement Group established with Deputy medical director chairing. Meeting arranged for 21/01/2025
- Continued use of DiffX and HPV disinfection, working collaboratively with Estates and Hotel Facilities.

Targeted work

- Review of November data and scrutiny of cases demonstrated a period of increased incidence for 2 wards in PPH and 1 ward in Bronglais General Hospital (BGH)
- Cases were not linked in time or person to suggest a transmission event
- Genome sequencing has been completed, strains are those already circulating within the HDUHB
- Existing actions are being revisited, this include but are not limited to-
    - Reviewing practices
    - Hand hygiene audits
    - Environmental audits
    - Environmental decontamination- collaborating with hotel facilities and estates and use of HPV.
    - Providing teaching around C.diff and transmission

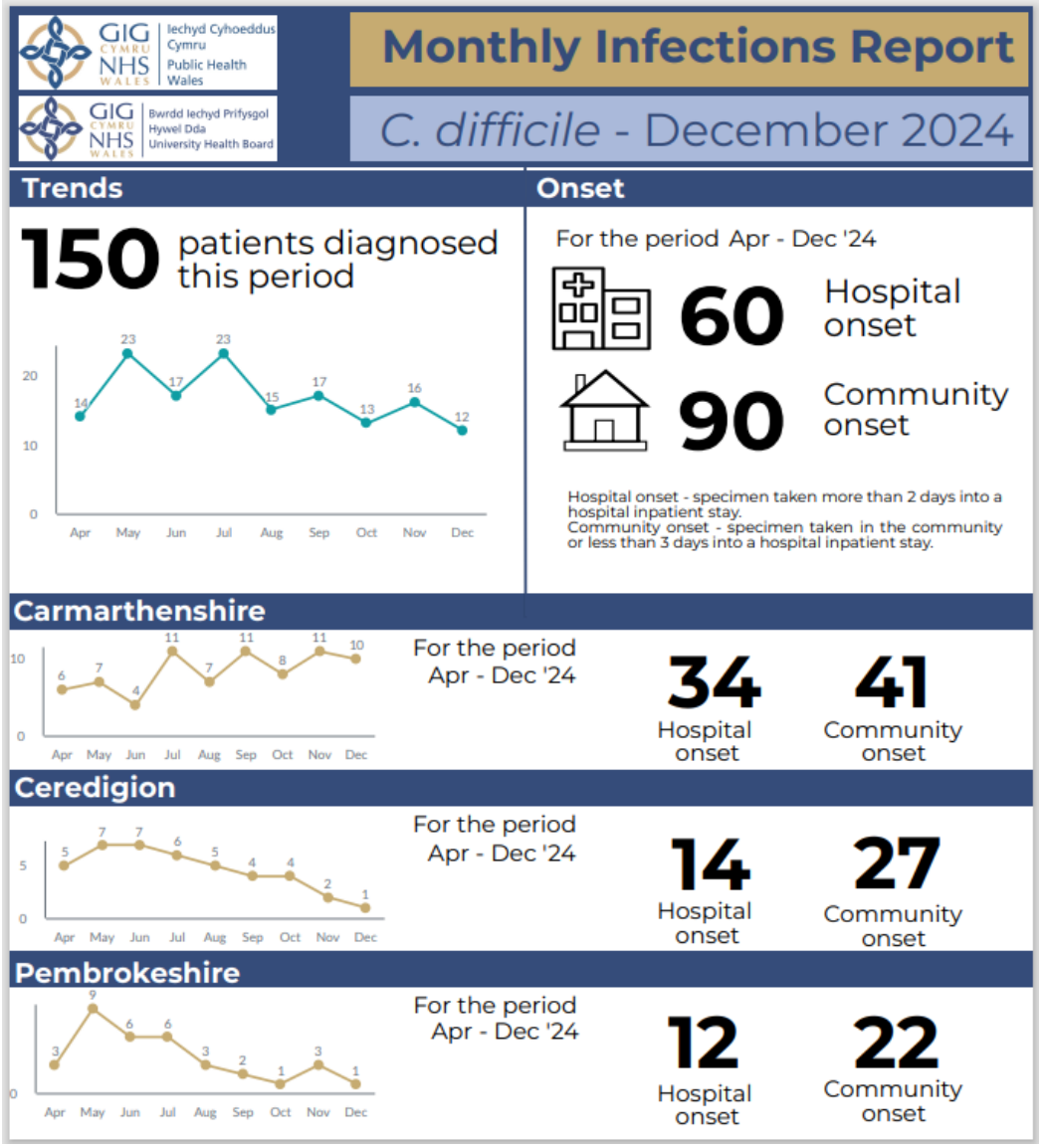
C.diff relapses and FMT

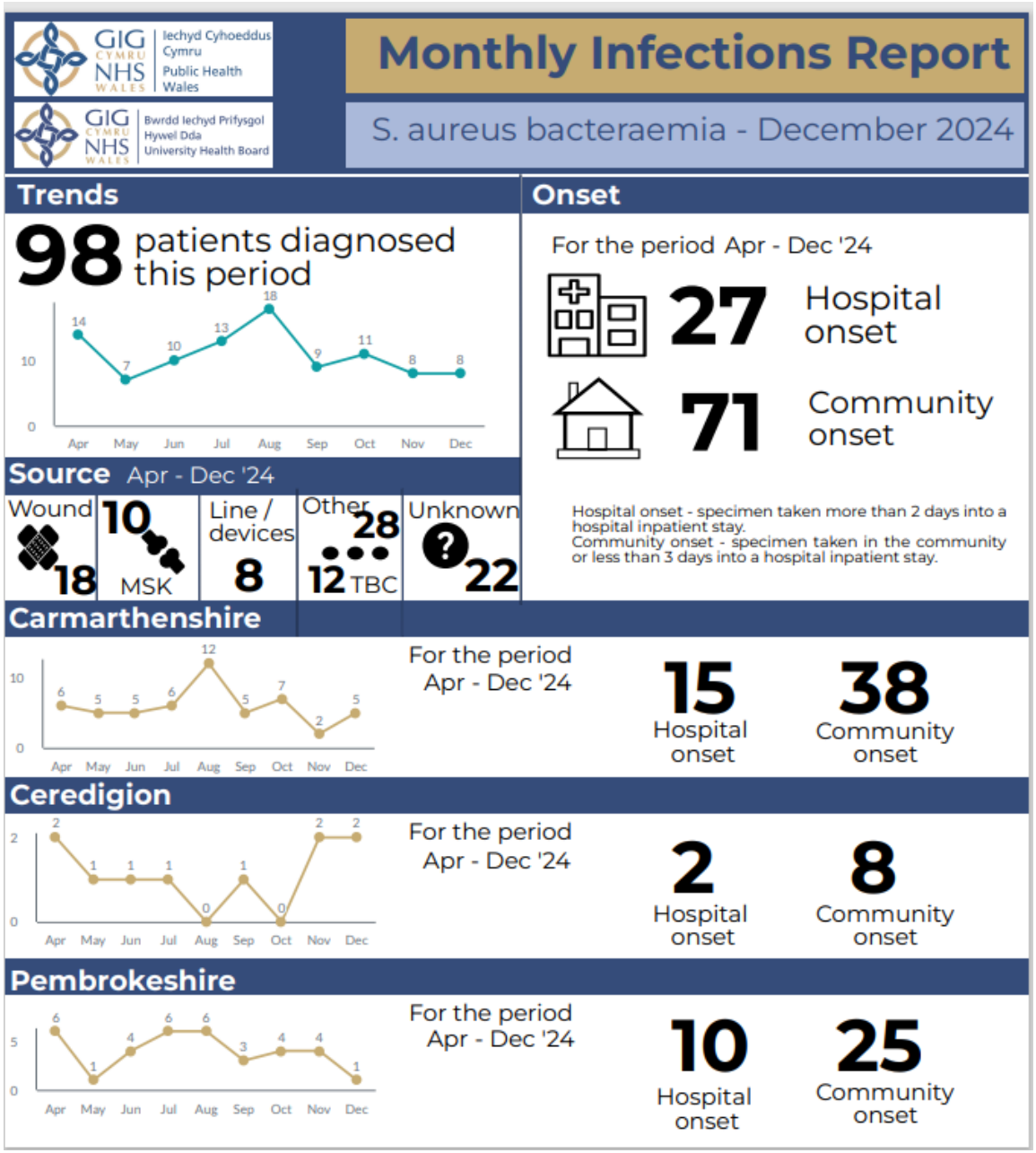
From 1st April 2024 to November 2024 there have been a total of 11 patients with a relapse and 3 patients with 2 relapses of C.diff infection

For 1st April 2023 to 31st March 2024 there was a single patient suffering 5 episodes, 8 patients with 2 relapses and 19 patients with a single relapse of C.diff infection.

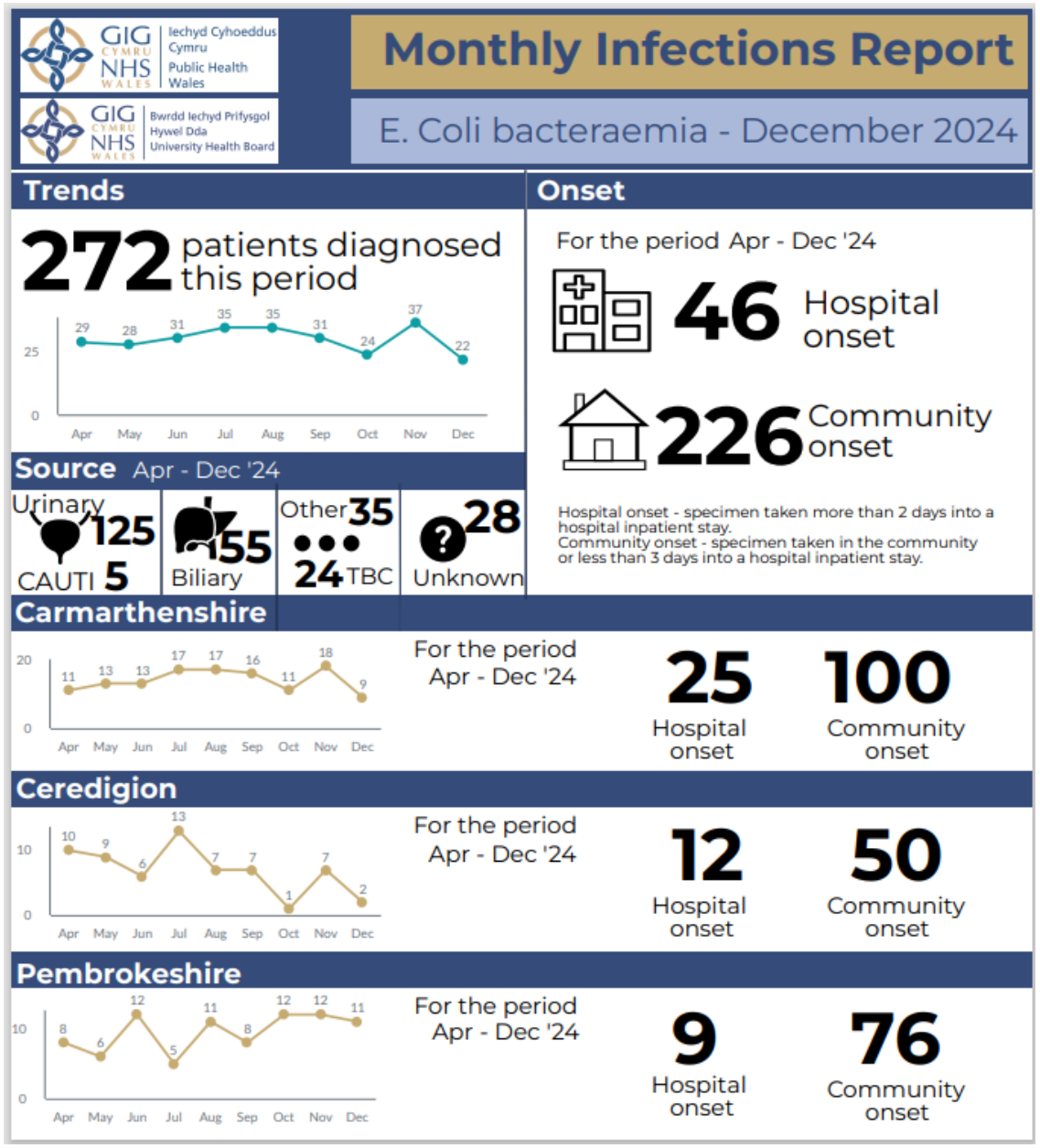
This suggests the work with FMT is having a positive impact-

- 10 FMT procedures have been carried out in the HB since 1st April 2024 with a 70% success rate
- Clinician and microbiologist engagement in the process





- Some improvement in Aseptic Non-Touch Technique (ANTT) compliance 79.3%, this is an increase from 77.6% in October
- 1 case relating to dialysis unit- device related
- Peripheral Venous Catheter (PVC) bundle compliance monitored, with an emphasis on devices being removed at the earliest opportunity
- 25% cases in December were hospital onset and 38% cases for December were hospital onset



- Spike in E.coli cases for November 2024
- Less variance noted thought data set
- Lower cumulative rate in comparison to previous year and below trajectory
- 3 cases with a hepatobiliary source and 4 with a urinary source

<u>Actions</u>

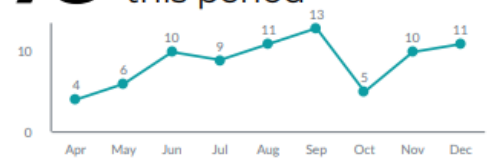
- Continued education of staff around catheter and device care
- To continue to profile Aseptic Non-Touch Technique (ANTT)

Monthly Infections Report

Klebsiella sp bacteraemia - December 2024

Trends

79 patients diagnosed this period



Onset

For the period Apr - Dec '24

15 Hospital onset

64 Community onset

Hospital onset - specimen taken more than 2 days into a hospital inpatient stay.
Community onset - specimen taken in the community or less than 3 days into a hospital inpatient stay.

Source Apr - Dec '24

Urinary	Biliary	Other	Unknown
CAUTI 0 / 32	15	14 / 10 TBC	8

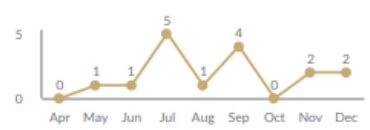
Carmarthenshire

For the period Apr - Dec '24

12 Hospital onset

31 Community onset

Ceredigion

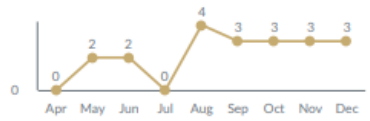


For the period Apr - Dec '24

1 Hospital onset

15 Community onset

Pembrokeshire



For the period Apr - Dec '24

2 Hospital onset

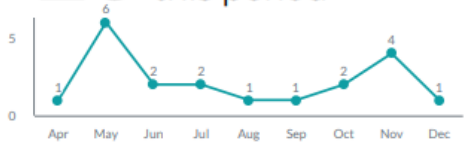
18 Community onset

Monthly Infections Report

P. aeruginosa bacteraemia - December 2024

Trends

20 patients diagnosed this period



Onset

For the period Apr - Dec '24

6 Hospital onset

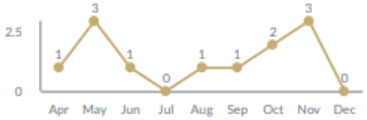
14 Community onset

Hospital onset - specimen taken more than 2 days into a hospital inpatient stay.
Community onset - specimen taken in the community or less than 3 days into a hospital inpatient stay.

Source Apr - Dec '24

Urinary	Biliary	Other	Unknown
CAUTI 3 / 2	4	1 TBC / 5	5

Carmarthenshire

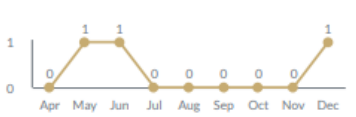


For the period Apr - Dec '24

4 Hospital onset

8 Community onset

Ceredigion

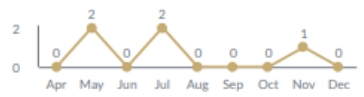


For the period Apr - Dec '24

0 Hospital onset

3 Community onset

Pembrokeshire



For the period Apr - Dec '24

2 Hospital onset

3 Community onset

Outbreaks Jan 2025 / Areas of Concern

Hospital Site	Number of outbreaks	Organism	Bed days lost
BGH	0	N/A	0
GGH	1	Norovirus/ C.diff	5
PPH	1	Influenza A/ Norovirus	61
WGH	0	N/A	0

A number of infection control concerns have arisen since the last report to QSEC

- Prince Philip Hospital (PPH) cluster / period of increased incidence (PII) of C.diff
- Glangwili General Hospital cluster of Verona Integron-encoded Metallo-β-lactamase (VIM) Pseudomonas

Actions

VIM Pseudomonas

- Water testing has been completed and actions taken to mitigate future risk
- Refurbishment work on ward with a trial of Hypochlorous acid to treat sinks/ drains

C.Diff and other infections

- Healthcare Acquired Infection assurance / scrutiny meetings held. Cases discussed and antimicrobial stewardship highlighted.
- Feedback to C.Diff Infection (CDI) Improvement group
- Plan for deep cleaning / HPV of wards in PPH

HIW / CIW / HTA inspection activity:
01/08/24 – 30/10/24

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

There has been 1 new inspection report published by Health Inspectorate Wales (HIW) for Bryngolau ward (see below), but no further reports were published by Health Inspectorate Wales (HIW) or the Human Tissue Authority (HTA) relating to the Health Board in the period 1st November 2024 to 31st January 2025.

https://www.hiw.org.uk/system/files/2024-12/20241205PrincePhilipHospitalEN.pdf

HIW undertook an unannounced inspection of Bryngolau Ward, Prince Philip Hospital on 2nd – 4th September 2024. There were a number of areas of immediate concern identified relating to health, safety and security and during the inspection and the immediate improvement plan was submitted on 9th September to address those concerns. The report has since been published and actions are underway as shown on the following slides.

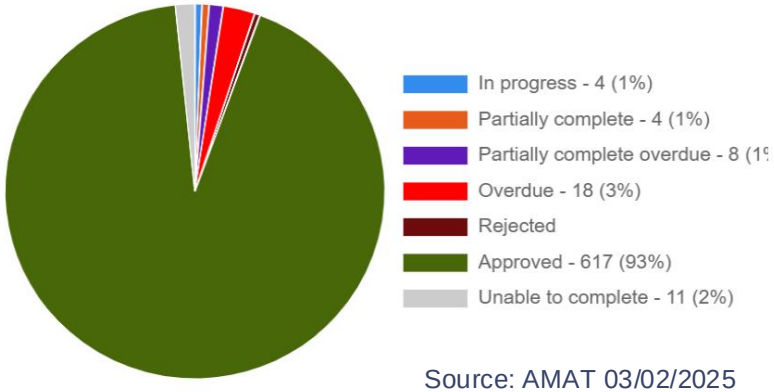
We have received a number of assurance queries from HIW during the reporting period.

All open HIW / other body inspection actions plans are chased on a bi-monthly basis and escalated if no progress is seen within 14 days. Directorates are able to log into the live AMaT system and update their own actions and upload evidence of completion.

Directorates are actively supported and engaged to develop a SMART action plans within a realistic timeframe. HIW expect an update to all action plans on a 3 monthly basis until completion.

HIW Quality Checks/Inspections: Reviews and inspections

Improvement Actions relating to HIW reviews



Source: AMAT 03/02/2025

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

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	Complete
12	141/234 (60%)	7/11 (64%)	0	0	4	4	8	18	6	0	3	225

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

HIW Quality Checks/Inspections: Open reviews and inspections

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

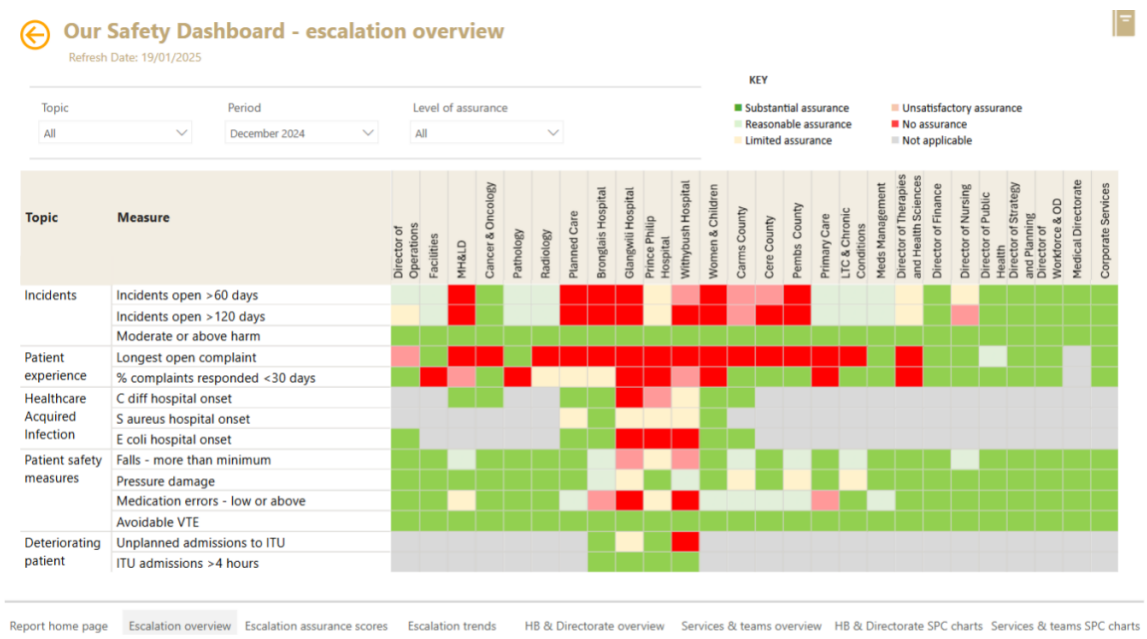
Code	Title	Type	Date of inspection	Origin	Recommendations	Actions
Healthcare Inspectorate Wales (HIW)/2024/395	Bryngolau Ward, Prince Philip Hospital	New	02/09/2024	Healthcare Inspectorate Wales (HIW)	40	50
Healthcare Inspectorate Wales (HIW)/2024/302	Glangwili Hospital – Morlais Ward	New	01/07/2024	Healthcare Inspectorate Wales (HIW)	9	17
Healthcare Inspectorate Wales (HIW)/2022/17	HIW Bryngofal inspection July 2022	New	31/07/2022	Healthcare Inspectorate Wales (HIW)	19	19
Healthcare Inspectorate Wales (HIW)/2024/396	HIW Children and Young People Mental Health Review	New	05/02/2024	Healthcare Inspectorate Wales (HIW)	20	None
Healthcare Inspectorate Wales (HIW)/2023/152	HIW DNACPR Review (Dec 2023)	New	18/12/2023	Healthcare Inspectorate Wales (HIW)	17	19
Healthcare Inspectorate Wales (HIW)/2022/19	HIW GGH IRMER Inspection (Nov 2022)	New	15/11/2022	Healthcare Inspectorate Wales (HIW)	21	35
Healthcare Inspectorate Wales (HIW)/2023/29	HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)	New	07/03/2023	Healthcare Inspectorate Wales (HIW)	40	32

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

Code	Title	Type	Date of inspection	Origin	Recommendations	Actions
Healthcare Inspectorate Wales (HIW)/2024/86	HIW IRMER Diagnostic Imaging x-ray department Withybush Hospital January 2024	New	31/01/2024	Healthcare Inspectorate Wales (HIW)	9	13
Healthcare Inspectorate Wales (HIW)/2022/50	HIW National Review of Patient Flow (Stroke Pathway)	New	14/03/2022	Healthcare Inspectorate Wales (HIW)	46	53
Healthcare Inspectorate Wales (HIW)/2021/12	HIW St Caradog ward, Withybush Hospital	New	01/08/2021	Healthcare Inspectorate Wales (HIW)	2	3
Healthcare Inspectorate Wales (HIW)/2023/69	HIW St Non, St Caradog, Canolfan Bro Cerwyn WGH	New	16/10/2023	Healthcare Inspectorate Wales (HIW)	19	24
Healthcare Inspectorate Wales (HIW)/2016/146	HIW Thematic Review of Ophthalmology 2015/16 issued January 2016 (HISTORIC REPORT MONITORED BY ASSURANCE AND RISK TEAM)	New	01/01/2016	Healthcare Inspectorate Wales (HIW)	3	3

Our Safety Dashboard - developments

The Performance, Informatics and Quality Assurance and Safety Teams have been working with colleagues to further develop the Our Safety Dashboard. A heat map and an assurance score has been introduced along with additional measures.



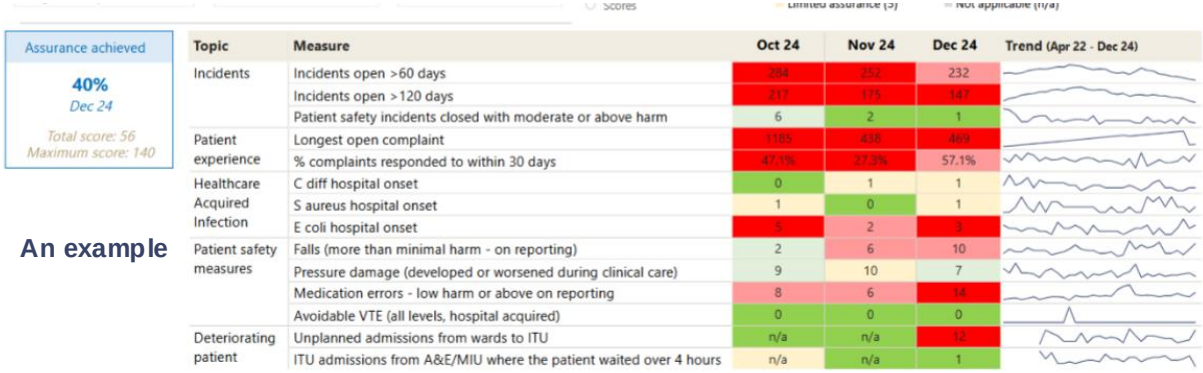
New measures on the dashboard:

- Healthcare Acquired Infection
- Avoidable Venous Thrombo-Embolism (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
- Healthcare Inspectorate Wales (HIW) improvement plans

An example



Quality Improvement Strategic Framework (QISF)2023-2026

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

The QISF was updated in 2023 and approved by Board.

The priority focus of the QISF is the Health Boards Enabling Quality Improvement in Practice (EQIiP)

We are currently running cohort 6 and will be opening submission for cohort 7 in February 2025

To date we have trained over 550 people and supported over 90 projects with over 45 trained improvement coaches

Cohort 6 submissions were not only aligned with the strategic objectives but also the TUEC organisational priorities, we have 11 projects and over 70 participants on cohort 6.

Recent improvements to EQIiP include refresh of the programme and content, update of the programme workbook and delivery of a Health Board Improvement Coach Development programme which had excellent feedback.

Cohort 6 projects:

1. Reducing missed General Practice appointments
2. Hip Fracture 4-hour Target
3. Person Centred Safety Planning
4. Improve patient experience, outcomes and flow within the frailty assessment unit at Glangwili General Hospital
5. To reduce the risk of harm associated with the use Anti-Psychotic medication
6. Pre-operative management of Urinary Tract Infections for Urology patients.
7. Improvement in tracheostomy care in Hywel Dda UHB
8. Optimising Health and Wellbeing in Preparation for Surgery
9. Management of anaemia in pregnancy
10. Prioritisation of medication histories/medicines reconciliation on acute medical units
11. Improvement in Do Not Attempt Cardiopulmonary Resuscitation decision making and communication

RCN Report: Corridor Care Crisis

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

On 16th January 2025, the Royal College of Nursing published a report *On the Frontline of the UK's Corridor Care Crisis*. The report documents the experience of more than 5,000 NHS nursing staff.

The RCN reports that almost 7 in 10 (66.8%) of respondents said they were "delivering care in overcrowded and unsuitable places – such as corridors, converted cupboards and even car parks – on a daily basis."

What is our patient experience data and feedback data telling us?

Common Themes:

1. **Corridor Treatment**:
   - Many patients reported being treated or waiting in hospital corridors due to a lack of available beds. This often led to discomfort and a lack of privacy.
   - Examples include patients spending multiple nights on trolleys in corridors, being bumped by passing beds, and undergoing examinations in public areas.
2. **Chair Usage**:
   - Numerous complaints about the discomfort of chairs in waiting areas, especially for extended periods. Patients often had to sit in hard, plastic chairs for hours or even days.
   - Some patients mentioned the need for better seating options, particularly for those with disabilities or chronic pain.
3. **Trolley Issues**:
   - Patients frequently mentioned being placed on trolleys due to bed shortages. This was often uncomfortable, especially for those with specific medical conditions like chronic back pain.
   - There were also mentions of trolleys being used inappropriately, such as for overnight stays without proper monitoring.

Recommendations from Patients:

- Increase the number of available beds to reduce the need for corridor treatment.
- Improve the quality and comfort of seating in waiting areas.
- Enhance communication between medical staff and patients to keep them informed about their treatment and waiting times.

What actions are we taking?

- The operational management leads have acknowledged the RCN report and are considering improvement actions that can be taken.
- The RCN report has been disseminated, and the issues being experienced within the Health Board will be discussed and considered at the next Senior Nurse and Midwifery Team meeting.
- The Health Board's Boarding Policy has been reviewed and has been placed on the Quality, Safety and Experience Sub-Committee agenda for approval.
- At Glangwili General Hospital (GGH), a weekly 'Big Room' has been established for all disciplines across the site at which issues of patient flow are discussed and improvements actions identified. The Getting It Right First Time (GIRFT) report for GGH is an agenda item for this meeting.
- At WGH and BGH, the findings of the latest GIRFT visit are awaited and it is anticipa[illegible]ement actions will be required to address the recommendations.

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:

- Making a difference for patients
- Patient safety incidents including nationally reported patient safety incidents
- Duty of Candour
- Infection, prevention and control
- Inspections and peer reviews including activity of Healthcare Inspectorate Wales (HIW)
- Improvements to the Our Safety Dashboard
- Quality Improvement Strategic Framework – an update
- RCN Report: On the Frontline of the UK's Corridor Care Crisis

Authors

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

Sections:

1. Making a difference – story taken from the news section of the Health Board website
2. Patient Safety Incident Reporting – Cathie Steele, Interim Assistant Director of Nursing, Assurance and Safeguarding

- 7-minute safety briefing produced by the Quality Assurance and Safety Team

3. Duty of Candour – Cathie Steele, Interim Assistant Director of Nursing, Assurance and Safeguarding
4. Patient experience and patient feedback – Louise O'Connor, Assistant Director for Legal Services and Patient Experience
5. Infection Prevention and Control – Rebecca Richards, Head of Infection Prevention and Control
6. Healthcare Inspectorate Wales and other peer reviews – Caroline Burgin, Patient Safety and Assurance Manager
7. Our safety dashboard - Cathie Steele, Interim Assistant Director of Nursing, Assurance and Safeguarding
8. RCN Report Corridor Care:

- Actions planned provided by Mandy Davies, Assistant Director of Nursing
- Patient feedback data provided by Jeff Bowen, Head of Patient Experience

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

4.2

10 Mins

4.2 - Quality, Safety and Experience Sub Committee

Mark Henwood (Hywel Dda UHB - Interim Medical Director)

Attachments

QSESC Update Report January 2025.pdf

QUALITY, SAFETY & EXPERIENCE

SUB-COMMITTEE (QSESC) UPDATE REPORT

Date of last meeting: 13 January 2025

Quoracy: Met

Report by: Mr James Severs, Chair

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

Alert[1] (may require discussion)

There were no matters to alert the Committee to.

Advise[2] (to monitor)

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

- Long- and short-term body storage capacity concerns within the Health Board, impacted by the revised Medical Examiners Service process, were highlighted as part of the **Human Tissue Authority Assurance** Group update. A piece of work to ascertain demand and capacity is underway by the Directorate and the risk is being reviewed.
- The impact of workforce deficits in Hotel Services on cleaning duties was highlighted during the **Unscheduled Care Directorate Update reports** with the impact on infection rates being monitored. The communication arrangements between Estates and Facilities Management Team and Acute Site Leads (to include MHLD) will be reviewed to explore touch point meetings to support timely response to estate issues on site.
- An assessment of the requirements for staff across the Health Board and current attendance rates for life support training was shared as part of the **Recognition of Acute Deterioration and Resuscitation (RADAR) Group** update. The impact of 'did not attend' rates on training capacity was highlighted. A training needs analysis has been undertaken and a cascade training process commenced which increases capacity for the delivery of training. The Datix Risk Score has since reduced due to mitigating actions that are being undertaken.
- In response to data which shows that Sepsis screening rates dropped during October 2024 at **Glangwili Hospital Unscheduled Care Services.** The Resuscitation and Quality Improvement team are undertaking a programme of work to improve processes, led by National Early Warning Score (NEWS) 2 and a Sepsis Task Group. Mitigating actions include changes to the national sepsis

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[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*.

guidance, the introduction of NEWS 2 and training undertaken by the Critical Care Outreach team (CCOT) around recognition of the deteriorating patient.

Assure[3] (to note)

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

- Quality improvement work has had a positive impact on consistency of completion rates of **Venous Thromboembolic (VTE) Risk Assessments** across the organisation which has been recognised nationally. Discussions are taking place regarding the possibility of the All-Wales VTE E-learning module being mandated for patient facing staff and to consider whether preventable Hospital Acquired Thrombosis (HAT) should be recognised as a Health Board 'Never Event' and reported through the Incident Reporting System to adopt a zero-tolerance approach to preventable HAT.
- Concerns over the slow progress to install water coolers at Emergency Departments for staff and patients to access were raised during the **Nutrition and Hydration Group** update. During the meeting it was noted that the water coolers have now been requisitioned and the installation is planned for week commencing 20 January 2025.
- Health Board wide compliance with **Patient Safety Notices (PSN's) and Alerts (PSA's)**was reported and continue to be tracked by the Quality Assurance and Safety Team (QAST). It was agreed that the Sub Committees Subgroups will be tasked with monitoring areas of compliance for specific PSN and PSA's going forward, and any concerns will be escalated accordingly.
- The Patient Boarding Procedure (a process where suitably identified patients are moved from an emergency admission / assessment area to a receiving ward, with an identified discharge, prior to a bed being available on the receiving ward) has been shared for staff consultation, and in light of the need to implement the procedure urgently due to pressures, the Sub Committee agreed that the written control document is approved via Chair's Action. The impact of the procedure on patient safety will be monitored.

Recommendation

The Quality, Safety & Experience Committee is asked to note the content of the report.

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

4.3

10 Mins

4.3 - Listening and Learning Sub Committee Update Report

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

Attachments

4.3 LLSC Update Report.pdf

LISTENING & LEARNING SUB COMMITTEE UPDATE REPORT

Date of last meeting: [03 February 2025]

Report by: Mark Henwood, Chair

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

Alert

The Sub-Committee considered a range of feedback relating to the experience of service users with disabilities, particularly neuro-divergence, in accessing health care.

The Sub-Committee was pleased to receive presentations on the work undertaken by the Community Outreach Team; and Diversity and Inclusion Team and Outpatients Team.

This was supported by an Ombudsman's thematic report 'Equality Matters' which identified lack of reasonable adjustments; poor communication and outdated policies and procedures across public bodies in Wales. In the cases reviewed, organisations were not fulfilling their duty under the Equality Act 2010 and the Ombudsman reminded bodies that a failure to make a reasonable adjustment for a person with a protected characteristic is a form of discrimination. The Ombudsman made the following recommendations:

- The report is shared with the Equality, Diversity and Inclusion Lead and the relevant Board/Committee with oversight of their organisation's compliance with Equality duties and that they ensure that their organisations:
- Encourage staff to be person centred in their consideration of the needs of the people they provide a service to, including being proactive and anticipating their needs.
- Ensure staff document the considerations and decisions they have made discharging their duties to make reasonable adjustments under the Equality Act.
- Ensure policies are reviewed and kept up to date.
- Ensure staff receive appropriate training, are aware of the policies in place and how to implement them, and that they feel empowered and supported when taking decisions to make reasonable adjustments to meet the needs of service users.
- Ensure staff are aware of who to contact if they need advice or support when addressing equality and human rights issues.

Whilst there was a significant amount of quality improvement work being undertaken across the Health Board, led by the Integrated Autism Service; Diversity and Inclusion and Community Outreach Teams, Quality Improvement Team, there did not

appear to be an overarching Group that had oversight of all the individual work areas involved and to over oversight of the people experience feedback.

Of particular note within the concerns thematic discussion, was the struggle that people with neuro-divergent conditions had in accessing and communicating with the health service. These communication challenges often resulted in relationships breaking down, restrictions being applied in accessing services then leading to complex complaints.

There is an increasing prevalence of neuro-divergent conditions not just in the population we serve, but also within our workforce. It was noted that due to environments in the community, in workplaces and often in health care settings being designed more with neuro-typical people in mind, this can pose significant challenges for neuro-divergent individuals.

It was suggested by the Neurodevelopmental service that a special interest group be established on neuro-divergence, supported by a Learning and Development Strategy. It was noted there had been many expressions of interest in this approach. We know that neuro-divergence affects so many of our staff and patients and if we are to become an understanding and accepting organisation, this would be a mechanism for sharing good practice.

Assure

The Listening and Learning Sub-Committee wish to assure the Quality, Safety and Experience on the following matters:

1) Welsh Risk Pool – Putting Things Right / Concerns Management Assessment

The WRP Assessment process provides a framework for the analysis of an organisation's compliance with the WRP Reimbursement Procedures, the requirements of the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011, the Health & Social Care (Quality & Engagement) (Wales) Act 2020 and other national policies & procedures related to the PTR sector. Following a review in 2023, the 2024 programme of WRP assessments includes a specific area for assessment in relation to Inquests - in acknowledgement of the increased work in this area.

A draft report has been received by the Chief Executive Officer, the following outcome has been noted:

Management of Concerns (Incidents)	REASONABLE ASSURANCE	

Management of Concerns (Complaints & Enquiries)	SUBSTANTIAL ASSURANCE	
Redress Case Management	SUBSTANTIAL ASSURANCE	
Claims Case Management	SUBSTANTIAL ASSURANCE	
Inquest Case Management	SUBSTANTIAL ASSURANCE	
Organisational Learning & Learning from Events	SUBSTANTIAL ASSURANCE	
WRP Reimbursement Process	SUBSTANTIAL ASSURANCE	

The final report and action plan will be submitted with the next Sub-Committee report, once the WRP is satisfied with the proposed actions.

2) Public Services Ombudsman for Wales – three final reports were received by the Sub-Committee as follows:

202304346 & 202402193 –

The Ombudsman found that HDUHB missed opportunities in 2016 and 2018 to inform the Wales Fertility Institute about the patient's history of hydrosalpinx. This was caused by a series of communication failures and an apparent failure to consider the significance of the condition.

The Ombudsman found that HDUHB failed to offer the patient surgery to treat the condition and improve her chances of conceiving through IVF. As a result, the IVF treatment was compromised. The Health Board also failed to explain the significance

and potential impact of the hydrosalpinx to the Patient or her GP. The Ombudsman upheld the complaints against HDUHB.

The Ombudsman found that the patient should have been reviewed by the attending obstetrician when she attended the EPAU on 21 March. The patient should have been prescribed progesterone as hers was a “high risk” pregnancy, in view of her previous late pregnancy loss.

202400981 –

The Patient did not receive care from the Community Midwifery Team when she telephoned on 2 occasions to book in for her care, she was refused an appointment because she was planning to move out of the area.

The patient should have been able to book in for care while she was living in the Health Board area, and was entitled to reassurance and care from midwives at an anxious time in her pregnancy.

The patient should have been referred to a consultant obstetrician, so that she was on the appropriate clinical path for regular assessment and further screening in a more-timely manner during the following weeks. In addition, the Health Board was unable to provide records of the telephone calls, which amounted to maladministration.

Action plans were in place for the above reports, which will be monitored and any concerns regarding compliance will be escalated accordingly.

202400981 – The case which related to concerns about diabetes management was not upheld.

Recommendation

The Committee is asked to note the report. Due to the timing of the Listening and Learning Sub-Committee there has not been an opportunity to take appropriate action to propose to the Committee as part of this paper. A further update will be provided at the meeting.

4.4

10 Mins

4.4 - Urgent and Emergency Care Discharge Management Internal Audit

Ceri Griffiths (Hywel Dda UHB - Interim Assistant Director of Nursing), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)

Attachments

4.4 Discharge Management.pdf

Appendix 1 Discharge Mgnt (Final) IA Report.pdf

Appendix 2 Internal Audit Discharge Actions.pdf

Appendix 3 1298 - WG Discharge guidelines -v1.1 (1).pdf.pdf

Appendix 4 Discharge Patient Information Booklet V1.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:	13 February 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Urgent and Emergency Care Discharge Management Update
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Mr Andrew Carruthers, Chief Operating Officer
SWYDDOG ADRODD: REPORTING OFFICER:	Ms Ceri Griffiths, Interim Assistant Director of Nursing

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 this paper is to provide the Quality, Safety and Experience Committee (QSEC) with an update of the ongoing work around discharge management across urgent and emergency care.

Cefndir / Background

Following two previous internal audits looking at discharge management processes in 2021/2022 and April 2024, the Internal Audit and Assurance team recently undertook a follow up audit on the discharge management processes in place across Hywel Dda University Health Board (HDUHB) in October 2024.

Whilst the audit recognised that positive progress has been made since the previous Internal Audit report (Appendix 1) with two agreed management actions completed, work remains ongoing to address the remaining actions. Testing was also undertaken to seek assurance on the safe, efficient and timely discharge of patients through the accurate and complete documenting of discharge planning within the existing electronic systems (Frontier and Welsh Nursing Care Record (WNCR) and manual patient medical records in line with the *Discharge and Transfer of Care - Adults Policy*.

With an overall finding of **limited** assurance, several areas where identified which required further management attention including:

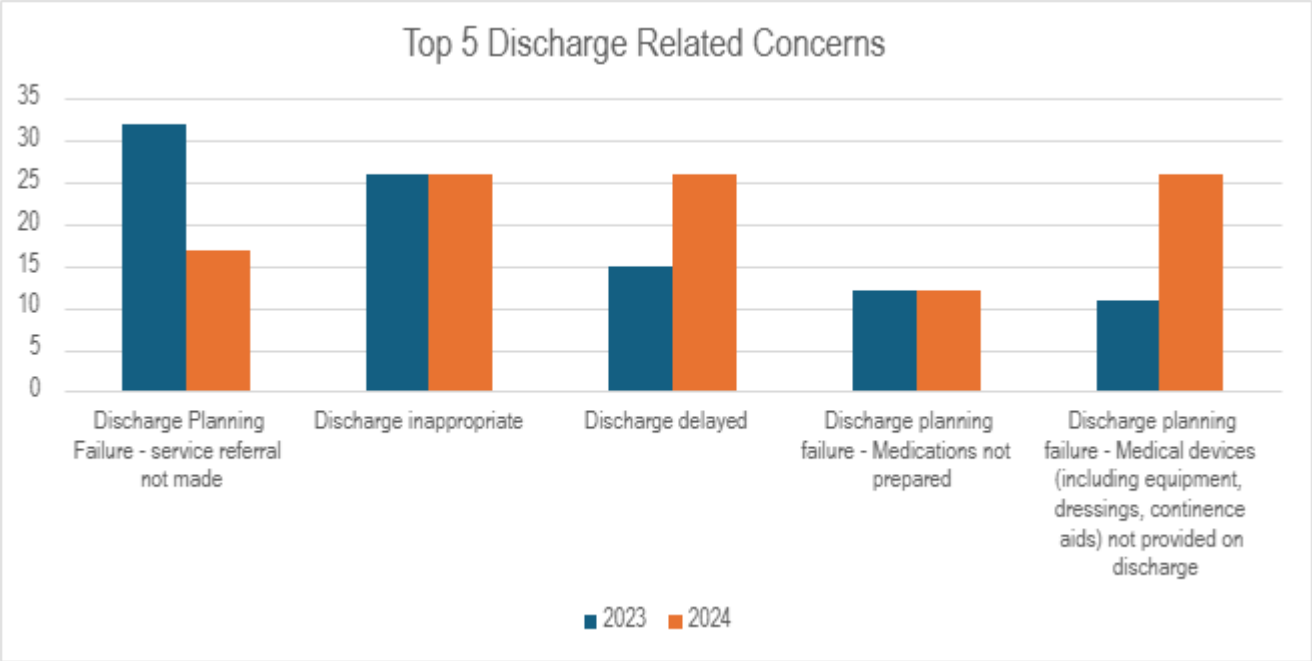
- Instances of incomplete and inaccurate information retained within the Frontier system
- Instances of limited discharge planning documentation within manual and electronic systems
- The adoption of national discharge guidance to replace the extant policy and development of a supporting toolkit is ongoing
- The development of a patient information leaflet following a review of discharge processes across the counties is ongoing

This paper will provide an update against the management actions and assess the impact of the audit against the quality, safety and experience of patients relating to discharge management.

Asesiad / Assessment

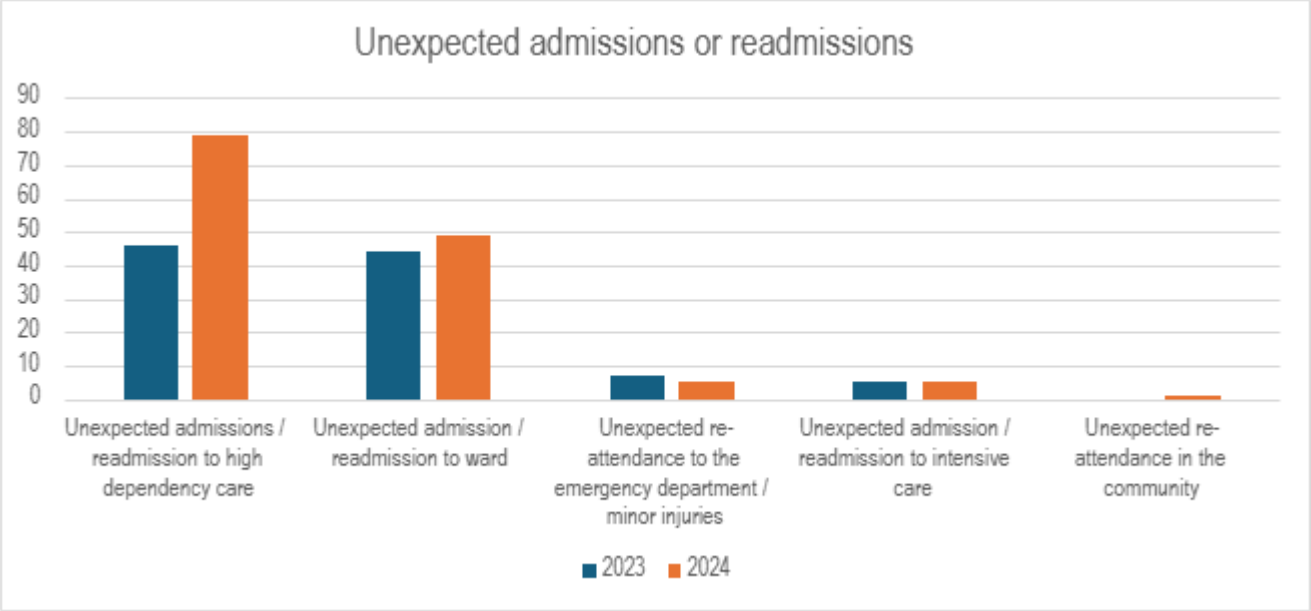
Incidents:

A review was undertaken of concerns relating to discharge management for the period of 01/01/2023 – 31/12/2023 and 01/01/2024 – 31/12/2024.



The top 5 reasons for discharge related incidents for both 2023 and 2024 are shown above. While improvements have been in service referrals for discharge planning, overall discharge planning failures (concerns relating to lack of appropriate equipment, dressings etc provided on discharge) have increased from 11 to 26.

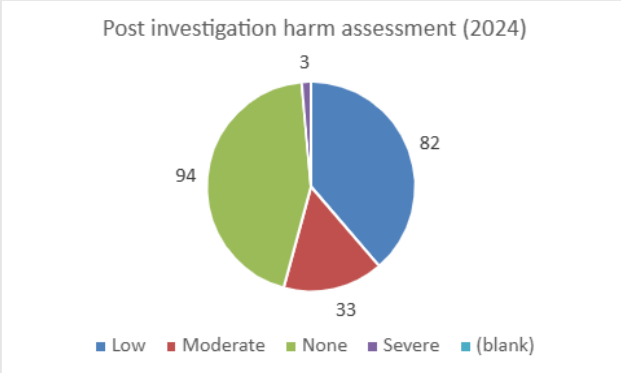
Incidents relating to inappropriate discharges and discharge failure due to medications remain stable, however, overall delays in discharge have increased from 15 in 2023 to 26 in 2024.

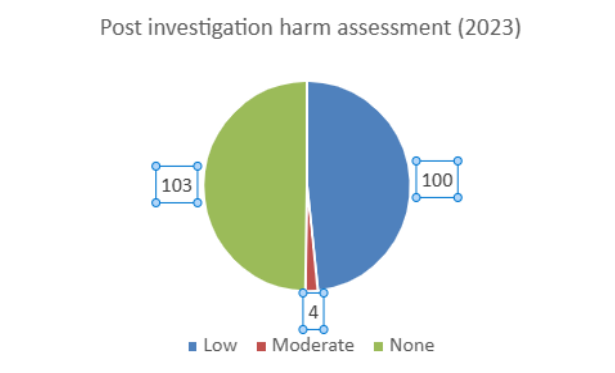


Of the total 102 reported unexpected admissions or readmissions in 2023, 69 were related to midwifery areas including special care baby unit, antenatal wards or labour wards, resulting in 33 cases across unscheduled care. In 2024, the numbers of unexpected admissions or readmissions for unscheduled care reduced to 23 (again excluding midwifery related areas which accounted for a total of 116 cases).

Midwifery areas have not been included in previous discharge management internal audits and a further review of the incidents and concerns identified will be required to identify any areas of concern or any discharge related themes.

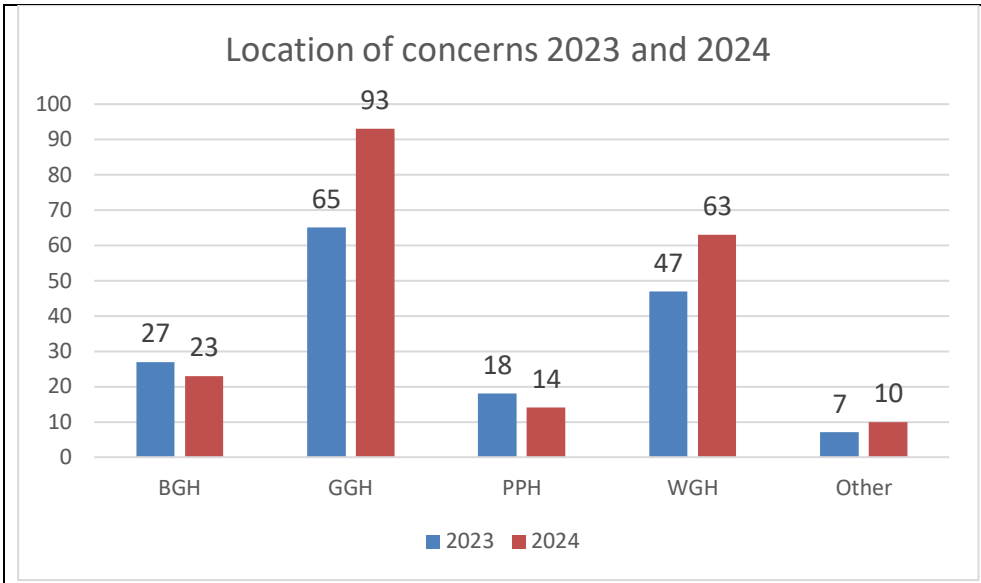
Of the reported incidents in unscheduled care, the majority across both 2023 and 2024 resulted in no or low harm, however, there does appear to have been an increase in both moderate and severe harm in 2024 which will warrant further investigation and ongoing review.





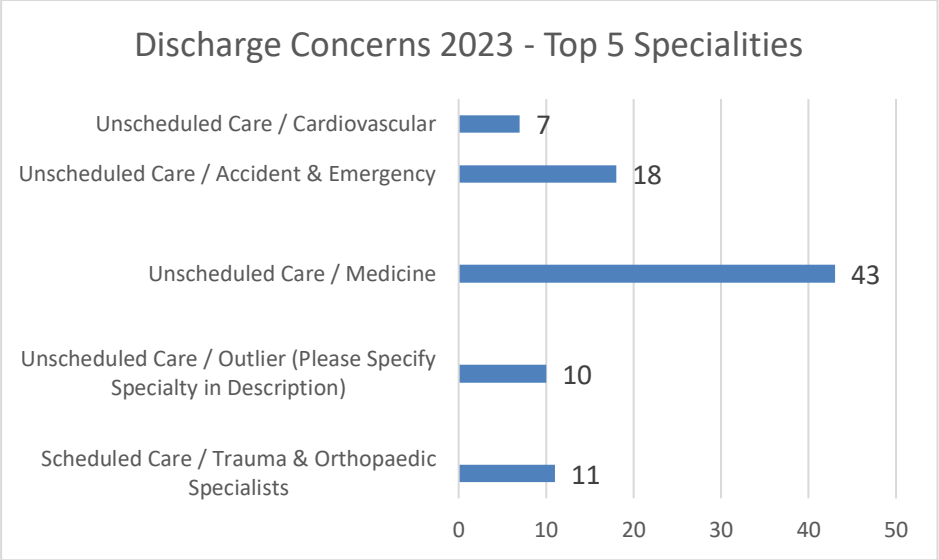
Concerns:

The total number of concerns received relating to discharge was 164 in 2023 and 203 in 2024.

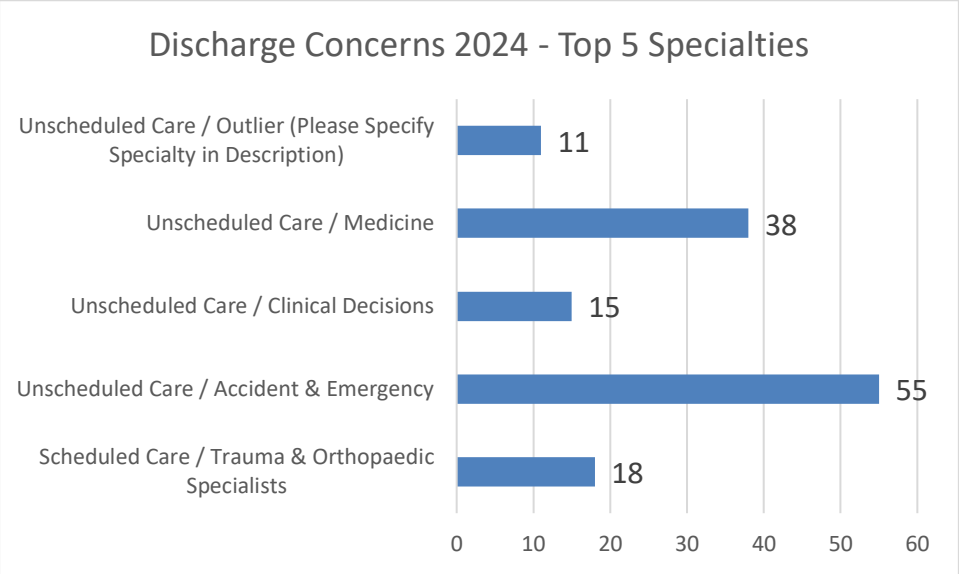


The majority of concerns received in both 2023 and 2024 were from Glangwili Hospital (GGH) and Withybush Hospital (WGH) respectively with a slight decrease noted in Bronglais Hospital (BGH) and Prince Philip Hospital (PPH).

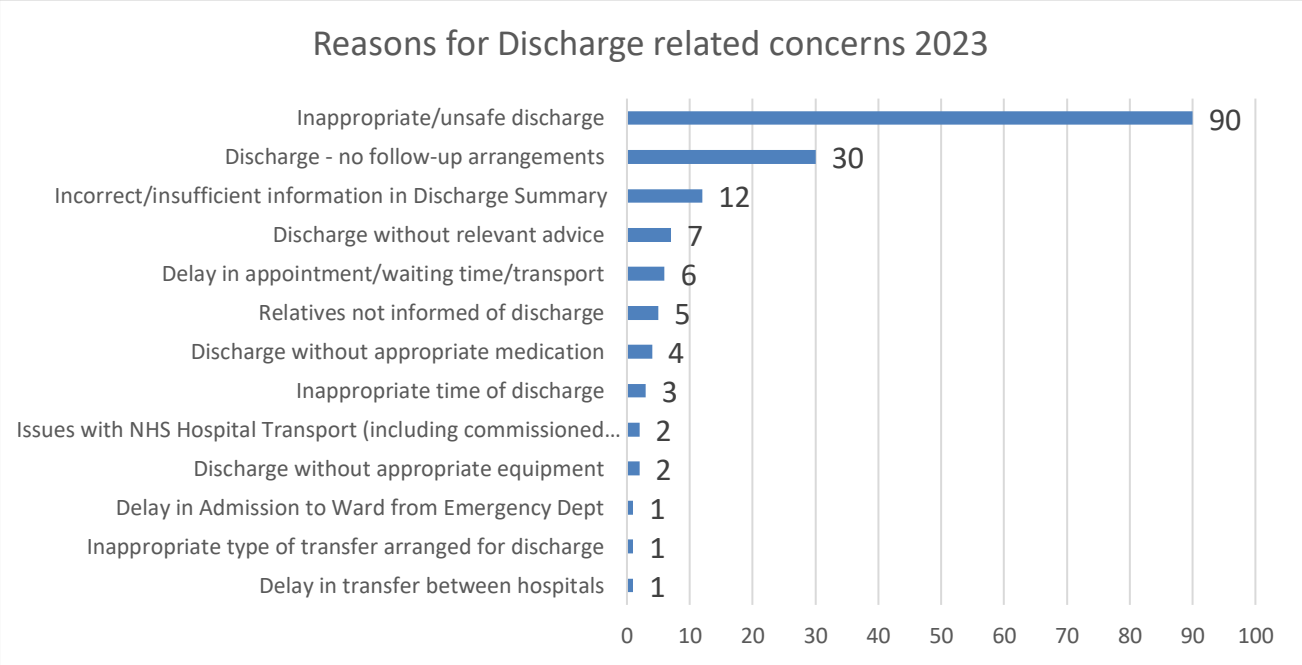
The top 5 locations / specialities for concerns (excluding maternity) are shown below:



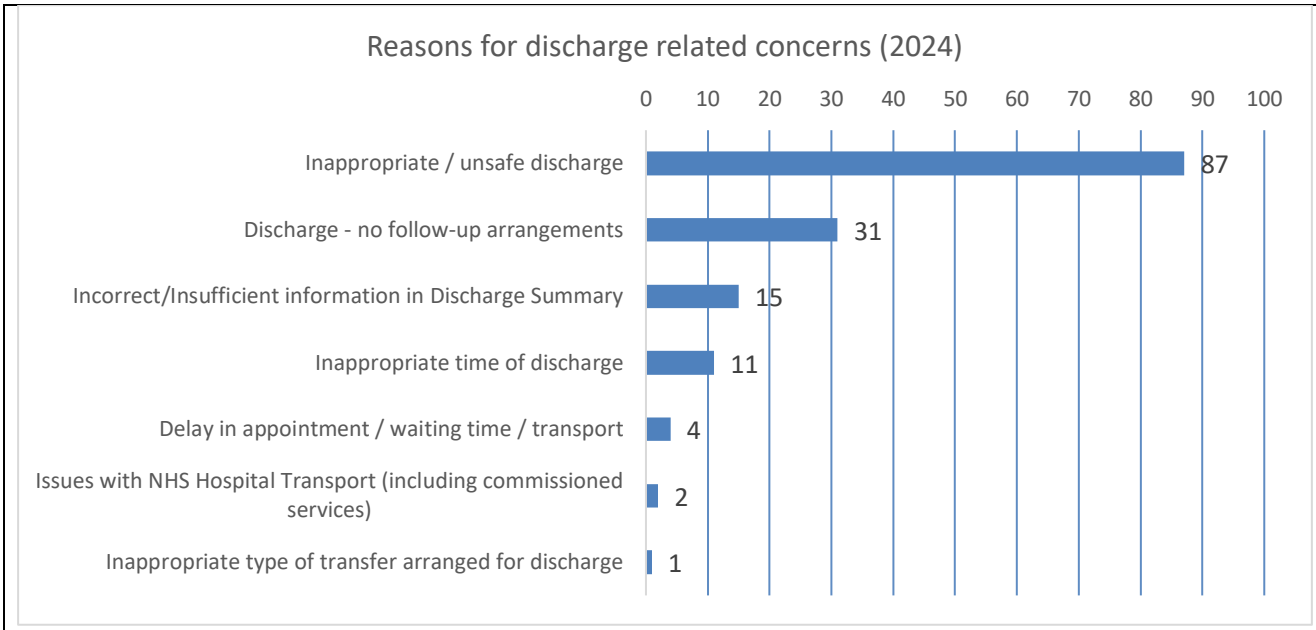
Unscheduled Care / Medicine locations accounted for the majority of concerns in 2023, however, in 2024 the majority of concerns appear to be related to Accident and Emergency settings.



The main reasons for discharge related concerns across both 2023 and 2024 are shown below:



Discharges deemed inappropriate or unsafe continue to be the most common reason, however, from scrutiny of these, many are not upheld following investigation and a similar picture is seen with safeguarding concerns relating to unsafe discharge and may highlight a need for improved communication around clinically led criteria for discharge and discharging at risk.



Overall, the themes around discharge related incidents, concerns and safeguarding remain broadly the same. Poor communication – with patients, families or care providers, lack of or incomplete documentation and lack of timely discharge planning or provision of equipment remain the common themes. The introduction of training and awareness raising of discharge processes with the roll out of the toolkit and the patient information booklet will aim to address these themes and will continue to be monitored.

Progress updates:

1. A summary of the current management actions and updates can be found in the attached document: Appendix 2

2. A key recommendation was to ensure the Discharge and Transfer of Care Policy had been updated. A decision was taken by the Discharge Strategy Group to adopt the national Welsh Government (WG) Discharge Guidelines which has been formally ratified through the Control Written Clinical Documentation Group. (Appendix 3)

3. To support the WG Discharge Guidelines, a multi professional discharge toolkit and SharePoint resource page has been developed. This is in the final stages of consultation and plans in place to roll out awareness raising and training in January and February across all acute sites.

   Key areas of focus in the toolkit have been to re-establish accountability and responsibility for discharge management with the clinical teams and ward areas, reducing reliance on specialist discharge teams and increasing awareness and understanding of discharge processes with all staff. It is expected that this will improve discharge planning and reduce the number of discharge related incidents and concerns currently reported and this will be monitored through nurse staffing levels reviews, directorate quality and safety meetings, safeguarding delivery groups and Urgent and Emergency Care 6 Goals workstreams.

   A link to the draft SharePoint page (staff access only) is attached. Hospital Discharge Toolkit

4. To support ward staff with initiating early discharge based conversations with patients, families and carers, a Discharge Information Booklet has been developed and is currently in the early stages of being piloted across all acute and community sites. Following the pilot, the booklet will be reviewed and then formally rolled out following evaluation (Appendix 4)

5. The use of Frontier and inconsistent recording of patient information / patient status was highlighted for improvement. Quality Improvement practitioners are undertaking monthly audits on compliance with Frontier and is showing an improving picture in terms of compliance and also quality of data being captured. Ad hoc training to staff and aligning white board data with Frontier is also a key focus.

Argymhelliad / Recommendation

The Quality, Safety and Experience Committee are asked to note this report and take assurance that the management response arising from the Internal Audit findings will lead to improved Discharge Management which is progressing and being monitored for patient outcomes and quality 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:	
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	1. Safe 2. Timely 6. Person-Centred 4. Efficient
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply 6. All Apply 6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	3. Striving to deliver and develop excellent services
Amcanion Cynllunio Planning Objectives	

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:	
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:	Quality and patient impacts in terms of poor discharge experience will continue as outlined in the report if processes are not improved.
Gweithlu: Workforce:	Not applicable
Risg: Risk:	The impact of poor discharge management processes on patient flow are highlighted throughout the report and
Cyfreithiol: Legal:	Not applicable
Enw Da: Reputational:	Adverse impact on reputation of the health board
Gyfrinachedd: Privacy:	Not applicable

Cydraddoldeb: Equality:	Not applicable

Discharge Management

Draft Internal Audit Report

2024/25

Hywel Dda University Health Board

Limited Assurance

Contents

Review Reference	HDU-2425-13
Fieldwork	October 2024
Executive Sign Off	November 2024
Audit Committee	December 2024
Executive Lead	Andrew Carruthers, Chief Operating Officer
Audit Team	James Johns, Head of Internal Audit
	Sophie Corbett, Deputy Head of Internal Audit

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

This review has sought to provide assurance on the controls and processes in place for the safe and efficient discharge of patients, including progress in implementing the actions agreed with management to address the issues identified in the previous audit report (HDUHB-2324-05).

Overview

Whilst positive progress has been made since the previous Internal Audit report with two agreed management actions (one 'High' priority & one 'Medium' priority) fully implemented, work remains ongoing to address remaining actions (two 'High' priority & one 'Medium' priority). Testing was also undertaken to seek assurance on the safe, efficient and timely discharge of patients through the accurate and complete documenting of discharge planning within the various electronic systems (Frontier and WNCR) and manual patient medical records in line with the *Discharge and Transfer of Care - Adults Policy*.

We have concluded **limited** assurance on this area with the following matters requiring management attention:

- Instances of incomplete and inaccurate information retained within the Frontier system [High Priority]
- Instances of limited discharge planning documentation within manual and electronic systems [High Priority]
- The adoption of national discharge guidance to replace the extant policy and development of a supporting toolkit is ongoing [Medium Priority]
- The development of a patient information leaflet following a review of discharge processes across the counties is ongoing [Medium Priority]

Full details of matters arising are detailed within the Findings & Agreed Action Plan. The following opportunity for enhancement has been identified that do not impact the overall opinion and are highlighted for management information:

- Exploring opportunities for the rollout of discharge-focused whiteboards at Bronglais General Hospital

Scope & Assurance Summary

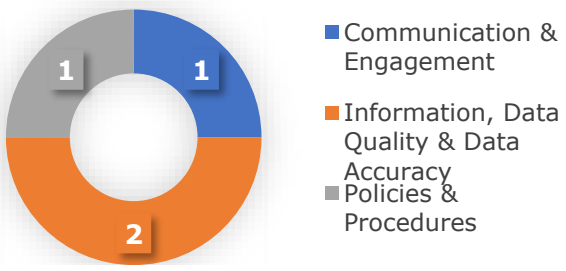
	Objectives	Related Findings	Assurance
1	A Health Board-wide discharge process has been developed, which reflects national requirements and good practice guidance	1 & 2	**Reasonable**
2	The patient discharge process has been consistently implemented across the Health Board and is complied with to ensure that patients are safely and efficiently discharged from hospitals care.	3 & 4	**Limited**

Management Actions

2 High Priority

2 Medium Priority

Themes



Risk Types

Quality or Safety Issues

Findings & Agreed Action Plan

Objective 1: A Health Board-wide discharge process has been developed, which reflects national requirements and good practice guidance	**Reasonable**

Overview / Summary of Observations

The previous Internal Audit report identified four matters arising under this objective and have been followed up as part of this audit review.

Positive steps were taken to fully implement the mapping of discharge processes to understand programmes of work and governance arrangements to identify gaps or areas not captured (Matter Arising 3) and the updating of the Policy Goal 5 roll out action plan (Matter Arising 4).

Actions remain ongoing on the review and updating of the *Discharge and Transfer of Care Adults Policy* (Matter Arising 1), and the review of provisions of health and care services across the three counties into a single, consistent model (Matter Arising 2).

At the time of fieldwork, the Discharge Strategy Group was reviewing whether there was value in adopting national discharge guidance to replace the extant *Discharge and Transfer of Care Adults Policy* in addition to the development of a discharge toolkit to support operational staff in discharge processes. A revised deadline date was set for December 2024.

A review of discharge health and care provisions across the three counties has been undertaken and established the streamlining and standardisation of discharge processes whilst recognising some variances per county and local authority. Work is ongoing to develop a single discharge patient information leaflet to reflect the discharge processes in place with a target date set for December 2024.

New recommendations have been raised where appropriate and supersede those raised in the previous audit report.

Key Findings		Risk & Impact	Agreed Management Action
1	**Discharge Policy and Toolkit** The Discharge Strategy Group felt that there was value in adopting national discharge guidance and developing a discharge toolkit that would be accessible via SharePoint to support operational staff in discharge processes. The existing policy was extended by six-months and a draft of the toolkit was planned for completion in December 2024.	Inconsistent and inappropriate working practices impacting of the safe and timely discharging of patients.	**Agreed Action:** The adoption of the national discharge guidance is well progressed and currently going through the Written Control Document review and approval process and due for completion in January 2025. The development of the toolkit and SharePoint site is well progressed with a completion date on track for December 2024 with a launch date set for due in January 2025.
			Expected Evidence of Implementation: 1) Formal adoption of the national discharge guidance document with evidence of dissemination to staff 2) Completion of the discharge toolkit including the uploading onto the SharePoint site
		Medium Priority	**Officer:** Interim Assistant Director of Nursing

	Theme: Policies & Procedures	Control Design	**Date:** 31st January 2025
2	**Discharge Provisions Across Counties** Work is ongoing to develop a single discharge patient information leaflet to reflect the discharge process in place across the organisation following the streamlining and standardisation of the processes across the three counties. The target date for completion is December 2024.		**Agreed Action:** Work is ongoing in the development of a patient discharge information leaflet and is on course for completion by December 2024.
			Expected Evidence of Implementation: 1) The dissemination of the patient discharge information leaflet to all ward staff
		Medium Priority	**Officer:** Interim Assistant Director of Nursing
	Theme: Communication & Engagement	Control Operation	**Date:** 31st December 2024

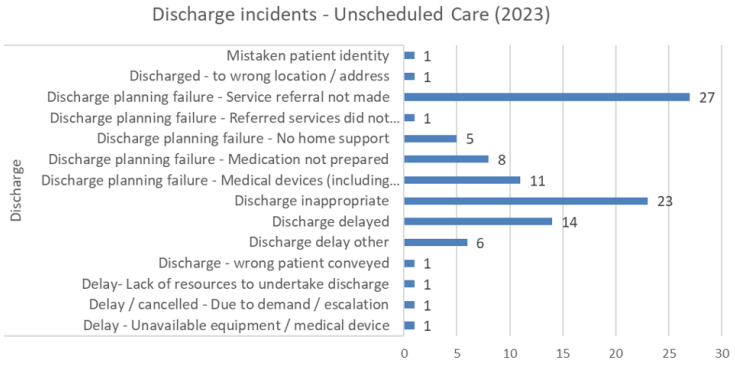
Objective 2: The patient discharge process has been implemented consistently across the Health Board and is complied with to ensure that patients are safely and efficiently discharged from hospital care — **Limited**

Overview / Summary of Observations

Internal Audit visited 10 wards across the four acute hospital sites over the period 10-16 October 2024 and confirmed that the Optimal Hospital Patient Flow Framework and its key principles were embedded into the patient discharge process through regular board rounds and afternoon huddles that were attended by a variety of staffing groups.

Whilst the whiteboards on the sampled ward captured key discharge elements (e.g. D2RA, expected date of discharge (EDD), pathway, actions, etc.) we noted that a project had commenced to develop discharge-focused whiteboard at BGH.

Since the previous Internal Audit report, a hospital discharge review was undertaken by Llais West Wales and a discharge focused quality and safety presentation was submitted to the Operational Planning, Governance and Performance meeting. Both reports highlighted the key complaint themes, such as discharge planning failures and inappropriate/delayed discharge, received by the Health Board in 2023 – see full table below.



Testing was undertaken to ensure evidence of the safe and timely discharge of patients through the accurate recording of planning through the Frontier and WNCR systems, and medical notes. This testing incorporated the matter arising from the previous Internal Audit report regarding the incomplete recording of key discharge information within the Frontier system (Matter Arising 5).

Concluding our review of sampled patient from the Frontier system for the period 10-16 October 2024 identified instances where information was incorrectly recorded or missing, whilst testing of the WNCR system and patient medical records identified limited discharge planning documentation retained on file.

New recommendations have been raised where appropriate and supersede those raised in the previous audit report.

Key Findings		Risk & Impact	Agreed Management Action
3	**Frontier System** Of the total 174 patients, 41 had not been assigned a simple/complex discharge status within 24 hours of arrival on the Frontier system. A detailed sample of 50 patients was tested and identified the following: • seven instances where the patients had not been allocated a D2RA pathway • 15 instances where the D2RA pathway does not appear to match the patients' current medical situation • four instances were identified where an EDD had not been recorded	Inaccurate or incomplete information retain impacting on the safe and timely discharge of patients.	**Agreed Action:** Regular audits to be undertaken by the QIST Team of the Frontier system to identify hot spot wards where issues are identified in completion of the Frontier system records. The QIST Team would link in with any hot spot wards to understand the issue they face and to aid them in their completion of the system through additional training and signposting to the new SharePoint site. **Expected Evidence of Implementation:** 1) Evidence to support the regular auditing of the Frontier system to be undertaken by the QIST Team 2) Engagement with identified hot spot wards including actions to address the identified risks
		High Priority	**Officer:** Improvement and Transformation Lead **Date:** 31st March 2025
	Theme: Information, Data Quality & Data Accuracy	Control Operation	
4	**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.	Inappropriate discharge planning undertaken impacting on the safe and timely discharge of patients.	**Agreed Action:** During the launch period of the SharePoint site, ward staff will be educated on the information and compliance requirements in line with national and local requirements. The SharePoint site will be updated to include the need for ward staff to fully complete the discharge element within the WNCR system. **Expected Evidence of Implementation:**

			1) Evidence of staff education and required compliance with the WNCR system following the development of the SharePoint site 2) A review of WNCR records for to ensure compliance with requirements
		High Priority	**Officer:** Interim Assistant Director of Nursing **Date:** 31st March 2025
	Theme: Information, Data Quality & Data Accuracy	Control Operation	

Appendix A

Assurance Opinion

	**Substantial**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**Unsatisfactory**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Advisory**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Disclaimer

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Hywel Dda University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of the Hywel Dda University Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership]

Inspection Co	Inspection Title	Recommendation	Reference Numbe	Action	Person Responsil	Progress Status	Comments/Updates	Evidence
Internal Audit/2024/397	Internal Audit- Discharge Management Internal Audit Report 2024/25 (Limited)	R1. Discharge Policy and Toolkit The Discharge Strategy Group felt that there was value in adopting national discharge guidance and developing a discharge toolkit that would be accessible via SharePoint to support operational staff in discharge processes. The existing policy was extended by six-months and a draft of the toolkit was planned for completion in December 2024.	Internal Audit/2024/397/MD1/1	The adoption of the national discharge guidance is well progressed and currently going through the Written Control Document review and approval process and due for completion in January 2025. The development of the toolkit and SharePoint site is well progressed with a completion date on track for December 2024 with a launch date set for due in January 2025.	Ms Ceri Griffiths	Fully complete (Awaiting approval)	The WG National Hospital Guidance was taken via CWCDG on 12th December and formally ratified, added to Clinical Documents on 16/12/24 and copy uploaded. Sharepoint page completed and awaiting final comments before launch in January 2025.	20241217081355_1298wgdischargeguidelinesv1.pdf
Internal Audit/2024/249	Internal Audit - Transforming Urgent and Emergency Care – Discharge Management Final Internal Audit Report	R1. The Discharge and Transfer of Care Adults Policy should be promptly reviewed and updated in line with national guidance.	Internal Audit/2024/249/MD1/1	The Discharge Strategy Group will review and update The Discharge and Transfer of Care Adults Policy in line with recent WG National Discharge Guidance, incorporating links to the Reluctant Discharge Policy and Care Home of Choice policy.	Ms Ceri Griffiths	Fully complete (Approved)	The policy is currently being reviewed by the newly established Discharge Strategy Group and aiming to have a draft policy / framework ready by September 2024 which will supersede this policy Revised timescale - Sep-24 13/9/24 - Discharge working group have agreed to adopt the national WG Hospital Discharge Guidance as the overall Discharge policy to go alongside the developing Discharge Toolkit. CG has contacted the control written documentation group to clarify how this policy can be ratified and included on SharePoint - CDCWG are next meeting 12/9/24 and update to follow after that. 24/10/24 - WG Hospital Discharge Guidance out for global consultation (ending 30/10/24). To be taken back through CWDCG once all comments / amendments made. 11/12/2024- After discussion with Internal Audit, this report has now been closed and	20240930120901_hospitaldischargeguidancedecember20231.pdf
Internal Audit/2024/397	Internal Audit- Discharge Management Internal Audit Report 2024/25 (Limited)	R2. Discharge Provisions Across Counties Work is ongoing to develop a single discharge patient information leaflet to reflect the discharge process in place across the organisation following the streamlining and standardisation of the processes across the three counties. The target date for completion is December 2024.	Internal Audit/2024/397/MD2/1	Work is ongoing in the development of a patient discharge information leaflet and is on course for completion by December 2024.	Ms Ceri Griffiths	Fully complete (Awaiting approval)	Discharge Information Booklet developed and to be printed and piloted for 3 months commencing January 2024. Attached is the version agreed for piloting.	20241216131557_dischargepatientinformationbookletv11.pdf

Internal Audit/2024/249	Internal Audit - Transforming Urgent and Emergency Care – Discharge Management Final Internal Audit Report	R2. A review of discharge health and care service provisions across the three counties should be undertaken and aligned into a single, consistent model.	Internal Audit/2024/249/MD2/1	A review of the current discharge processes in line with the principles of optimal hospital flow will be undertaken by the TUEC Programme, QIST and the Discharge Strategy Group to identify areas of variation and to establish a single consistent model for discharge processes, recognising that each county and local authority will have some natural variation.	Ms Ceri Griffiths	Fully complete (Approved)	A review of TUEC has been undertaken by the TUEC (6 Goals) project team and QIST team. QIST team have reviewed all ward areas, there is a slide to demonstrate this and are working with individual wards/sites to further improve. Ward Blueprint with the consistent model is available with supporting documentation and resources e.g. video clips, protocols etc. This will be referenced in the discharge policy / framework. Revised timescale - Sep-24 13/09/24 -QIST team asked to share slide to upload. 13/11/24 - Mapping template and ward based audit tools uploaded and action completed.	20240930114810_exampleofauditoptimalhospitalflowimplemetationstatuswardspecificcopy.xlsx, 20240930121610_v3mappingofdischargegovernanceandreportingstructure.pptx
Internal Audit/2024/249	Internal Audit - Transforming Urgent and Emergency Care – Discharge Management Final Internal Audit Report	R2. A review of discharge health and care service provisions across the three counties should be undertaken and aligned into a single, consistent model.	Internal Audit/2024/249/MD2/2	Review all existing discharge patient information and develop a single Discharge Patient Information Leaflet to be implemented across all acute and community sites. Revised timescale - Dec-24	Ms Ceri Griffiths	Fully complete (Approved)	All current patient information is being collected. Plan to invite representation / set up a small T&F group to work with Llais to develop standardised patient and carer information. Aim to have a draft version by Sept 2024. Additional support has been identified to support specifically with development of patient information. On advice of the Interim Assistant Director of Nursing, completion date revised to December 2024. 24/10/24 - Draft discharge information leaflet developed and shared with Discharge Strategy Group - awaiting comments back by 30/10/24. 13/11/24 - Draft patient and carer discharge information leaflet has been completed with comments back. Plan: Leaflet to be sent for welsh translation; Aim to pilot in December on WGH site; Seek additional feedback from Llais, patient experience team and from pilot. Further Faster slippage funding agreed to pilot the patient information booklets, based on the estimated costs of 20,000 booklets. Final draft version to be	

Internal Audit/2024/249	Internal Audit - Transforming Urgent and Emergency Care – Discharge Management Final Internal Audit Report	R3. A review following the planned mapping exercise by the Discharge Strategy Group should be undertaken across identified workstreams and programmes to ensure clear governance and reporting arrangements are established.	Internal Audit/2024/249/MD3/1	Develop a flowchart of the agreed national discharge processes and pathways in line with the Discharge Requirements document and align with local variations from local authorities and third sector partners.	Ms Ceri Griffiths	Fully complete (Approved)	The discharge toolkit will aim to bring together all the various local and national policies into one place. There are national D2RA pathways that are on the Optimal Flow SharePoint Point which we will be bringing into the toolkit. There are flowcharts associated with each discharge pathway with actions assigned to each area/service – these will be reviewed as part of the toolkit development.	20240930121311_v3mappingofdischargegovernanceandreportingstructure.pptx
Internal Audit/2024/249	Internal Audit - Transforming Urgent and Emergency Care – Discharge Management Final Internal Audit Report	R3. A review following the planned mapping exercise by the Discharge Strategy Group should be undertaken across identified workstreams and programmes to ensure clear governance and reporting arrangements are established.	Internal Audit/2024/249/MD3/2	Develop clear 'action' cards for all staff involved with discharge processes to ensure clarity of roles and responsibilities	Ms Ceri Griffiths	Fully complete (Approved)	18/06/2024 - To be discussed through the Discharge Strategy Group - on the agenda for 20th June 2024. Need to include an implementation and audit plan to monitor if the action cards are being utilised as the current checklist is not being used. 24/06/2024 - The development of action cards was reviewed by the working group and not supported. The plan will now be to clarify roles and responsibilities against pathways and roles. This will now be considered in line with the development of the toolkit and not be developed separately. 30/09/2024 - Draft Toolkit being developed on SharePoint and will include specific roles and responsibilities, removing the need for individual or separate action cards to be developed. Links to the SharePoint page will be shared once toolkit is ready for dissemination. 13/11/24 - SharePoint page has been developed and shared with D/C Strategy Group for comments - once the page is	20241113150717_dischargerolesandresponsibiitiesforsharepointpage.jpg

Internal Audit/2024/249	Internal Audit - Transforming Urgent and Emergency Care – Discharge Management Final Internal Audit Report	R3. A review following the planned mapping exercise by the Discharge Strategy Group should be undertaken across identified workstreams and programmes to ensure clear governance and reporting arrangements are established.	Internal Audit/2024/249/MD3/3	Undertake a review of the current discharge liaison services across the acute and community hospital sites to mitigate variation and establish core principles for service delivery	Ms Ceri Griffiths	Fully complete (Approved)	An initial review was undertaken but it was acknowledged that the requirement for this review had since changed. The function, roles and responsibilities of the Discharge liaison service will now form part of the discharge strategy work. This was the outstanding recommendation from the 1st discharge audit and has not been undertaken so not complete but can be taken forward as an action for the discharge strategy group. review has been completed, with outcomes incorporated in to the Discharge Strategy Work and monitored by the Discharge Strategy Group. The aim is to have the strategy / toolkit ready by September with an emphasis on discharges being ward led with support from specialist services such as discharge liaison services rather than trying to map out roles / service requirements based on patients. 30/09/2024 - A summary of the DLN Service review has been drafted and uploaded as evidence of work against this recommendation.	20240930121801_dlnauditandrisksbartemplateapril2024final.docx
Internal Audit/2024/249	Internal Audit - Transforming Urgent and Emergency Care – Discharge Management Final Internal Audit Report	R4. The Policy Goal 5 Roll Out Action Plan should be updated with commencement and target dates adjusted where delays have occurred in order to provide an accuracy position of the implementation status.	Internal Audit/2024/249/MD4/1	Review and update the Policy Goal 5 action plan and share with the Discharge Strategy Group and Managing Complexity and Conversion Group as part of the TUEC reporting structure.	Ms Ceri Griffiths	Fully complete (Approved)	Completed by QIST and the 6 Goals Workstream has now been revised and will cover off this action. The 6 goals programme is being restructured and relaunched and PG5 work will form part of the inpatient workstream with dedicated workstream and project leads. Each workstream will develop their own workstream plan to deliver the program milestones which form part of the 2024/5 6 Goals Plan.	20240913094344_inpatientresponsesafehospitalcareworkstream3workplan.xlsx
Internal Audit/2024/397	Internal Audit- Discharge Management Internal Audit Report 2024/25 (Limited)	R4. 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.	Internal Audit/2024/397/MD4/1	During the launch period of the SharePoint site, ward staff will be educated on the information and compliance requirements in line with national and local requirements. The SharePoint site will be updated to include the need for ward staff to fully complete the discharge element within the WNCR system.	Ms Ceri Griffiths	In progress		

Internal Audit/2024/249	Internal Audit - Transforming Urgent and Emergency Care – Discharge Management Final Internal Audit Report	R4. The Policy Goal 5 Roll Out Action Plan should be updated with commencement and target dates adjusted where delays have occurred in order to provide an accuracy position of the implementation status.	Internal Audit/2024/249/MD4/2	Optimal Flow Framework Lead to be agreed, Local Operational Leads to be agreed and the Optimal Flow Task & Finish Group be re-established	Ms Ceri Griffiths	Fully complete (Approved)	Programme leads have now been identified for the 4 new workstreams and which now supersede the optimal flow workstream so this action is complete.	
Internal Audit/2024/249	Internal Audit - Transforming Urgent and Emergency Care – Discharge Management Final Internal Audit Report	R4. The Policy Goal 5 Roll Out Action Plan should be updated with commencement and target dates adjusted where delays have occurred in order to provide an accuracy position of the implementation status.	Internal Audit/2024/249/MD4/3	Local robust roll out plans to be developed & implemented by Operational teams, supported by the QIST Practitioners, to ensure consistent application of the Optimal Flow Framework across all acute and community wards.	Ms Ceri Griffiths	Fully complete (Approved)	Policy Goal 5 Rollout - This is complete In terms of roll out it is now rolled out to all acute and community sites where appropriate	
Internal Audit/2024/249	Internal Audit - Transforming Urgent and Emergency Care – Discharge Management Final Internal Audit Report	R5. Ward staff should ensure the Frontier system is promptly and accurately updated to reflect the patients' status as maintained on the whiteboards.	Internal Audit/2024/249/MD5/1	Operational Management Teams to meet with QIST Practitioners to agree local communication / engagement plans ensuring all ward staff are aware of the importance of ensuring that the Frontier system is updated in a timely manner to ensure accuracy of data being collected.	Ms Ceri Griffiths	Fully complete (Approved)	Work is ongoing with operational management triumvirates to ensure that all ward areas are fully engaged with the Frontier platform and the opportunities this provides to improve patient flow and therefore overall performance. A request has been put in to the data quality team to undertake an audit on the data integrity. This needs operational and clinical ownership and communication. Revised Frontier Audit has shown an increasing compliance with ensuring timeliness and accuracy of data being entered onto Frontier demonstrating increased awareness and engagement with Frontier. MP asked to provide copy of recent audit to be uploaded as evidence. Revised timescale - Sep-24	
Internal Audit/2024/249	Internal Audit - Transforming Urgent and Emergency Care – Discharge Management Final Internal Audit Report	R5. Ward staff should ensure the Frontier system is promptly and accurately updated to reflect the patients' status as maintained on the whiteboards.	Internal Audit/2024/249/MD5/2	A review of potential WIFI connectivity issues limiting access to Frontier in some clinical areas to be completed and shared with the Managing Complexity Group and escalated as required.	Ms Ceri Griffiths	Fully complete (Approved)	Completed by QIST team and shared with IT / Digital	20240913094558_frontierimplementationitandadministrativeenablers.pptx

Internal Audit/2024/249	Internal Audit - Transforming Urgent and Emergency Care – Discharge Management Final Internal Audit Report	R6. An audit of the Frontier system should be undertaken to establish whether the data is complete and accurately reflects patients status on the ward. Where issues are identified, consideration should be given to establishing the circumstances and implementing actions to address any issues, such as additional training.	Internal Audit/2024/249/MD6/1	Regular (bi-monthly) spot audits to be implemented by Senior Nurse Managers in clinical areas using Frontier to review compliance and accuracy with capturing data including EDD, D2RA Pathway and R2G.	Ms Ceri Griffiths	Fully complete (Approved)	Board round audit template developed by QIST can be adapted for use by the senior nurse managers. Can be included as part of ongoing Goal 5 implementation and monitoring/ assurance of Optimal Hospital Flow workstream. Regular audits are being undertaken and latest audit Aug/Sept has demonstrated improvements in compliance and accuracy of data being collected. MP to share results of recent audit to be uploaded as evidence. CG to check if audit template has been adapted for use by SNMs or whether this will be audited regularly through the 6Goals workstreams. 30/09/2024 - QIST teams are working closely with ward areas for ongoing audit of compliance with optimal hospital flow including Frontier. This is in place across all 7 sites (acute and community) and is updated at a minimum monthly. Given the close oversight from this audit, another SNM audit is currently not felt to be required. An example of the audit tool has	20240930114528_exampleofauditoptimalhospitalflowimplemetationstatuswardspecificcopy.xlsx

Inspection code	Inspection title	Inspection origin	Recommendation description	Reference numbers
		Internal Audit		

Action description	Sites	Services	Service filtering	Responsible person	Date raised from	Date raised to
				Ceri Griffiths		

Action ratings	Progress statuses	Priority types	Approval boards	Risks	Barriers	View my actions only
						Yes

Hospital Discharge Guidelines (adoption of WG guidelines Sept 2024)

Policy information

Policy number: 1298
Classification: Clinical./corporate
Supersedes: 370 Discharge and transfer of care policy

Local Safety Standard for Invasive Policys (LOCSSIP) reference: n/a
National Safety Standards for Invasive Policys (NatSSIPs) standards: n/a
Version number: 01
Date of Equality Impact Assessment: 11.11.2024

Approval information

Approved by: Clinical Written Control Documentation Group
Date of approval: 19.12.2024
Date made active 19.12.2024
Review date: 12.12.2027

Summary of document:
This document sets out WG guidance on Hospital Discharge standards for health, social care, third and independent sector partners in Wales. All partners are expected to adhere to, and deliver, these standards to support safe, timely and efficient discharge of patients either to their own homes or on to the next stages of care

Scope:
This WG guidance applies to all HDUHB staff involved in the care and discharge of adults from acute and community inpatients settings

To be read in conjunction with:
141 – Independent Medical Capacity Service Policyv (opens in a new tab)
163 – Deprivation of Liberty Standards (opens in a new tab)
195 – Clinical record keeping Policy (opens in a new tab)
868 – All Wales Safeguarding Procedures (opens in a new tab)
309 – Continuing NHS Healthcare (CHC) Operational Policy to support the National Framework for implementation of CHC (opens in a new tab)
548 – Care Home of Choice Policy (opens in a new tab)

811 - Mental Capacity Act Practice Guidelines (opens in a new tab)

NG27: Transition between inpatient hospital settings and community or care home settings for adults with social care needs

Overview | Transition between inpatient hospital settings and community or care home settings for adults with social care needs | Guidance | NICE

NG53: Transition between inpatient mental health settings and community or care home settings

Overview | Transition between inpatient mental health settings and community or care home settings | Guidance | NICE

CG136: Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services

Recommendations | Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services | Guidance | NICE

NG94: Emergency and acute medical care in over 16s: service delivery and organisation

Overview | Emergency and acute medical care in over 16s: service delivery and organisation | Guidance | NICE

QS136: Transition between inpatient hospital settings and community or care home settings for adults with social care needs

Overview | Transition between inpatient hospital settings and community or care home settings for adults with social care needs | Quality standards | NICE

QS159: Transition between inpatient mental health settings and community or care home settings

Overview | Transition between inpatient mental health settings and community or care home settings | Quality standards | NICE

Patient information:

Owning group:
Senior Nurse Management team 12.12.2024

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

Reviews and updates:
01 – new adopted document
1.1 – updated with minimal changes 19.12.204

Keywords
Hospital discharge

Glossary of terms

Keypoints:
This document sets out guidance on Hospital Discharge standards for health, social care, third and independent sector partners in Wales.

AIM

This national guidance has been developed to support staff with ensuring patient discharges are safe, timely and appropriate, in line with national policies and guidance documents. This guidance outlines the responsibilities and requirements of all staff working with and involved with discharge planning of adult patients from acute and hospital inpatient settings

OBJECTIVES

The aim of this document will be achieved by the following objectives:

1. To enable a consistent approach across HDUHB to the delivery of the the Welsh Government Hospital Discharge Guidance (September 2024)
2. Development of a HDUHB Discharge Toolkit SharePoint page to bring together all discharge related resources to support staff to meet the objectives of the Hosptial Discharge Guidance
3. Provision of training, guidance and support to all healthcare professionals involved in Hosptial discharge planning and delivery
4. To outline the governance and escalation processes for delayed packages of care and discharges from acute settings

SCOPE

This guidance applies to all HDUHB staff involved in the care and discharge of adults from acute and community inpatients settings

WELSH GOVERNMENT HOSPITAL DISCHARGE GUIDELINE:

Welsh Government Hospital Discharge Guidance dated September 2024 (opens in a new tab)

ROLES AND RESPONSIBILITIES – HEALTH BOARD

Chief Executive
The Chief Executive Officer and Board hold ultimate responsibility for assurance, safety and improvement within the Health Board and have a duty for setting Health Board priorities and requirements.

Executive Director of Nursing & Midwifery and Patient Experience
The Executive Director of Nursing, Midwifery & Patient Experience will take the lead responsibility on behalf of the HDUHB for the strategic direction and development of the Hospital Discharge Guidance She/he will also work with education and training providers to influence the development of appropriate training programmes to ensure professionals are competent and safe to practice.

Chief Operating Officer / Deputy Chief Operating Officer/ Service Directors of ClinicaL Care Groups will be responsible for:
the localised implementation of the Hospital discharge Guidance by working with consultant colleagues, nursing teams and therapy leads to influence practice and improve processes to maximise bed capacity and reduce avoidable delays.

The Heads of Nursing, Adult Mental Health Services, Heads of Therapies and Clinical Support Services will work in partnership with the Service Delivery and Senior Nurse Managers to ensure that the said policy is operationalised.

Hospital Site Teams

- Ensuring that the principles of optimal hospital and patient flow are embedded into clinical areas / wards and sites.
- Providing support to clinical areas and teams where significant or ongoing challenges are impacting on patient flow**.**

The /System Service Group General Managers have overall responsibility for the monitoring of performance associated with the discharge and transfer of patients, how it impacts upon reducing average length of stay (ALOS), delayed transfers of care (DTOC), bed capacity and patient flow.

They will also be responsible for the full implementation of Estimated Date of Discharge (EDD), and for creating an environment in which multi-agency and partnership working flourishes to assist the process and patient experience.

Discharge Liaison Nurses
The Discharge Liaison Nurse (DLN) role is designed to support both patients and ward staff in the application of discharging patients with complex health and social care needs. The DLNs are responsible for providing effective communication between all members of the multidisciplinary team and associate departments and are responsible for supporting clinical areas with identifying complex discharge issues and delays in the entire diagnostic, treatment and care process whilst being proactive in generating solutions which meet both the patients, family members/carers needs in order to facilitate a safe discharge from hospital.

Medical Consultant /General Practitioner
Overall legal responsibility for a patient's medical care remains with the named consultant during admission, inpatient stay and discharge.

- Overall accountability and responsibility for determining whether patients are clinically optimised for discharge utilising criteria led discharge guidance
- Setting Estimated Dates of Discharge
- Participate / Lead on daily board rounds
- Give due consideration to any Best Interest Decisions
- Set clear goals of the discharge criteria for the MDT to follow

Ward Staff

Ward staff have overall responsibility for discharge planning with support from Discharge Liaison and other specialist teams as required for complex discharges.

- Responsible for embedding the principles of optimal hospital and patient flow into ward processes
- Establishing and ensuring daily board rounds and afternoon huddles are held daily with appropriate representation
- Attending daily board rounds and afternoon huddles
- Awareness and familiarisation of discharge toolkit and related discharge policies
- Ensuring patients, families and carers are kept informed of all discharge planning and are provided with / signposted to appropriate resources and information
- Responsible for ensuring staff knowledge and understanding of discharge processes
- Provision of or release of staff to attend discharge planning training
- Ward performance with early discharges and increasing weekend discharges
- Ensuring quality and safety of discharge planning
- Ensuring patients and families are involved with discharge planning

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

Your Discharge from Hospital

Information booklet for patients, relatives and unpaid carers.

Patient name (printed):	
Ward:	
Expected date of discharge:	
Issued by:	
Date issued to patient:	

Contents

Why am I in hospital?

You are here because you need treatment that can only be provided in hospital. Most people are admitted to hospital through the emergency department or as a planned surgery. Initially you may be cared for in an assessment ward, before moving to a different area of the hospital. This is to make sure you receive the most appropriate care for your needs.

What might I expect when in hospital?

Early conversations

There will be a lot of different people involved in your care, including doctors, nurses and therapists and they will discuss your treatment plans and care needs with you. We know returning home as soon as you are able too can promote healing, comfort and a quicker return to daily routines. Shortly after you arrive in hospital, we will begin discussing and planning your discharge. We will involve your carers, family and/or friends in conversations if you would like them to be included.

'Expected date of discharge' (EDD)

Soon after you arrive in hospital we will discuss and agree with you an 'expected date of discharge' (expected date you will leave hospital) which will be reviewed every day during your stay.

What matters to you

During your stay, we want to understand what truly matters to you. We will have a 'What Matters to Me' conversation with you, your family and unpaid carers. These discussions give you a chance to share what is most important to you, whether that's personal routines, family connections, goals for recovery, or comfort measures. By understanding what matters to you, our team can tailor your care to support you in the best way possible and ensure your experience aligns closely with our values and priorities. Has your family/unpaid carer had the support from the Carer Officer to support you in the discharge process?

What if I need extra support?

Most people return home from hospital without needing any additional support. If extra support is needed to get you home, or to an alternative care setting, this will be discussed with you as part of your discharge planning. It might involve additional assessments either in the hospital, an alternative care setting or at home to identify what level of support you need.

Please provide the name and number of the person you have chosen as your representative in the box below. A representative is a relative/unpaid carer or friend who can be contacted to discuss plans relating to your discharge from hospital:

Contact name:	
Contact number:	

Your family/unpaid carer may also need some extra support to help you when you have been discharged. This might include some practical help but also might include emotional support for them in their own right. They can be referred to the Carers Officer assigned to the hospital or to the county's carers information services.

How can I stay active in hospital?

Staying active, even while you are in hospital can help you feel better, sleep better, and get you back to doing the things you love to do. Our team can show you easy and safe ways to move around. Keep moving to feel better and leave hospital sooner.

Dress for Success!

Changing out of your PJs and into your regular clothes can boost your mood and help you feel more like yourself

Move your Body, Boost Your Recovery!

Gentle activities like walking, stretching, or even just sitting up can help you stay strong, improve circulation, and prevent problems like weakness, stiffness and even infections.

When can I leave hospital?

It is important that you are in the right place at the right time for the best recovery possible, and the team caring for you have agreed that you no longer need hospital care, and it is safe for you to either return home or to another care setting.

Once your clinical team agree that acute medical care is no longer needed, we will work together for your discharge, to support you in returning home or to another care setting . It is important that you leave hospital in a timely, well-planned way.

If you require additional support such as care, therapy or equipment in order to leave hospital, we will arrange this with you. Please let a member of staff know as soon as you arrive if there are any issues that may affect your discharge so that we can plan well in advance. If you are homeless, or do not have safe secure housing to return to, please let us know, so that we can help you find a safe place to stay when you are able to be discharged.

What happens if I am leaving hospital?

The team caring for you will discuss transport and other arrangements with you (and your unpaid carers, family and/or friends if you wish).

The team will also discuss when you should be assessed for the provision of any long-term care and support. You may be required to contribute towards the cost of your care and support if you need it.

How am I leaving hospital?

- Can a family/ friend/unpaid carer take you home?
- Can you catch the bus?
- Are you able to get a taxi?

- Staff will try to assist you by giving you information about transfer options
- Arriving by ambulance does not mean you will need patient transport to get home
- Access to patient transport is based on medical need and we follow government eligibility guidance

- Patient transport booked on the day may take up to three hours to arrive
- If you have transport booked with the hospital, but later make other arrangements to get home, please let staff know
- Remember to take all of your belongings with you

What if I need medication to take home?

Your team will write a discharge prescription which will be dispensed by the pharmacy department. You will be given a discharge summary, which is a letter that contains details of your ongoing medication. A copy of this letter will also be sent electronically to your GP.

If you need help with your medication on discharge or have any questions about your medicines the pharmacy team are available on the ward. When you go home we advise you book a medicines review with your local community pharmacy – these can take place over the phone as well as in person. If you require information in a different language or another format please let us know

What if I need more care and support?

You may need some additional care to help you in your recovery, or practical support such as help with shopping which the team can help advise you with.

If you need more care and support now than when you came into hospital, the team caring for you will discuss options for how you receive that care and support following discharge. The team will also discuss when you should be assessed for the provision of any long-term care and support. You may be required to contribute towards the cost of your care and support if you need it.

What if I cannot return to my own home?

Most patients can return to their own home when leaving the hospital. This will always be the first option considered in planning for your discharge. If you cannot return home immediately and your future care or treatment needs are unclear, you will be transferred to a suitable temporary place of care for assessment of your longer-term needs. We will discuss the available options with you and your family/unpaid carer and aim to move you within 24 hours.

If your preferred choice is not immediately available, you will not be able to remain in the acute hospital. You will be transferred to an appropriate place of care until your home of choice becomes available. Community assessment placements are available in your area and may be in a nursing or residential home.

You will continue to receive the necessary treatment, care or assessment to help you return home or to find an appropriate alternative care setting such as a long term residential or nursing home. This will give you and your family/unpaid carer the time to make important decisions whilst you are looked after in an appropriate environment.

Staying in hospital once you are well enough to leave can impact on your health.

- You are more likely to acquire a hospital acquired infection.
- Older people are more likely to become confused in hospital. This confusion can have a lot of side effects, including making dementia worse.
- Unfamiliar surroundings and confusion make it more likely that patients will fall whilst they are in hospital. We do all we can to prevent this from happening but there are 250,000 inpatient falls every year in the UK. Falling can cause injuries that mean patients will spend even longer in hospital. Many of these patients would not have fallen if they had been in familiar surroundings.

What happens on the day of my discharge?

- You may be provided with a supply of medication if you do not have sufficient medication at home or they have been changed. Please request further supplies from your GP surgery before you run out of medication. You will be given a discharge summary, which is a letter that contains details of your ongoing medication. A copy of this letter will also be sent to your GP.

- If you require any additional care or any follow up appointments after you go home, the ward staff will provide you with all the information you need to contact the services

- You may be transferred to the Discharge Lounge (if available) which is a comfortable environment where you can be cared for while you are waiting to leave hospital. Refreshments are available, including hot and cold beverages, and a selection of sandwiches and snacks. There is a television and a selection of books and magazines. If you need to take medication while you are there, staff can administer this, along with oxygen and insulin. The team can also provide information and advice on any medication you are taking home with you.

What should I consider in preparation for discharge?

- Have you made arrangements for transport and someone to collect you from the hospital to take you home or to an alternative care setting?

- Have you reminded the person collecting you from hospital to bring your outdoor clothes and shoes?

- Have you got a door key to get into your house?

- Do you have a fit note or medical certificate if you require one?

- Do you have your take home medication? Have you been given enough information about any changes or new medication you are being given to take with you?

- Are you and your family/unpaid carer clear about what will happen next with your care? E.g. Follow up appointment or District nurse visit.

- Do you know who to contact if you have any concerns once you have been discharged?

- Do you have the equipment you need at home (Walking Aid, Shower Chair, etc.)

- Does your family/unpaid carer need any support in their own right?

What happens after I have left hospital?

If you have any concerns or questions about your health following discharge you can:

- Visit NHS 111 online: 111.nhs.uk or call 111 if you urgently need medical help or advice but it is not a life-threatening situation.
- Visit NHS 111 online or call 111 if you are not sure which NHS service you need.
- Speak to your GP practice
- Only attend the A&E Department or ring 999 if it is an emergency / life threatening
- Access support information for unpaid carers from the Carers Support West Wales website

Who can I contact after I have left hospital?

After you have left hospital, if you need to speak to someone, please contact:

4.5

10 Mins

4.5 - Allergy Testing Service

Mark Henwood (Hywel Dda UHB - Interim Medical Director)

Attachments

4.5 QSEC Allergy Service.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:**	13 February 2025
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Provision of an Allergy Service
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Mr Mark Henwood, Interim Medical Director
SWYDDOG ADRODD: **REPORTING OFFICER:**	Mr Mark Henwood, Interim Medical Director

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 this report is to provide the Quality, Safety and Experience Committee (QSEC), with an update on the provision of an allergy (not drug related) service for patients from within Hywel Dda.

Cefndir / Background

The NHS Wales Prior Approval Policy was approved in January 2018 and adopted by Hywel Dda UHB in May 2018. The policy sets out the national context and provide clarity for referring clinicians when routine treatment is required outside of local services or established contractual arrangements.
Such a request will normally fall within one of the following categories:

- Second opinion
- Lack of local/commissioned service provision/expertise
- Clinical continuity of care (considered on a case by case basis)
- Transfer back to the NHS following self-funding in the private sector
- Re-referral following a previous tertiary referral
- Students
- Veteran

For Hywel Dda adult residents there is no locally provided allergy service. Patients from within Hywel Dda UHB who require input from an allergy service are referred to University Hospital Birmingham NHS Foundation Trust (Birmingham FT) via the “Prior Approval” process.

Prior to (Nov 2023) 2024, the service was provided by Cardiff and Vale UHB. The service was provided in the clinical immunology and allergy service where the waiting list (all stages) for clinical immunology and allergy in Oct 2023 was 221 patients with 120 patients > 36 weeks.

Asesiad / Assessment

The following table shows the number of patients who have been referred to an allergy service via the prior approval process.

Specialty Type	Activity	Location/Provider	Referring source
Allergy Testing	52	Birmingham	44 GPS 8 Consultant/ Nurse Specialist
Consultation	63	Birmingham	55 GPS 8 Consultant/ Nurse Specialist
Patch Testing	1	Birmingham	1 GP
Referrals 24-25	115		

The review of the information received indicates that there are 62 patients currently waiting (as at the end of November 24) to be seen in University Hospitals Birmingham FT. with the longest wait being 37 weeks.

A search of CIVICA has identified 5 feedback records and 2 complaints opened in 2023 which related to a delay in accessing allergy testing services (this was prior to the move to the service being provided at Birmingham FT). No feedback has been received in 2024 relating to the availability of allergy testing.

Further work is being undertaken to ensure the quality and outcomes for patients referred for an allergy service at Birmingham FT. The progress and findings will be discussed at the Integrated Quality, Performance, and Finance Delivery Group.

Argymhelliad / Recommendation

The Quality, Safety and Experience Committee, is asked to receive assurance from this update that there is no evidence at this time of a negative impact on patient experience and safety relating to the allergy service provided through Birmingham FT. The committee is asked to support IQPFD receiving an update and considering the findings and, if applicable, further actions required.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality:	1. Leadership 2. Culture and valuing people 5. Whole systems persepctive

Quality and Engagement Act (sharepoint.com)	
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	Not Applicable 6a Clinical services plan
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:	Data from Finance Team
Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau yr ymgynghorwyd â nhw cyn Cyfarfod y Pwyllgor: Parties / Committees consulted prior to In Committee Meeting:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No new financial impact identified
Ansawdd / Gofal Claf: Quality / Patient Care:	
Gweithlu: Workforce:	No impact identified
Risg: Risk:	The service is provided by a prior approval process. This is a similar position to other Health Boards
Cyfreithiol: Legal:	No impact identified

Enw Da: Reputational:	No impact identified
Gyfrinachedd: Privacy:	No impact identified
Cydraddoldeb: Equality:	Distance for travel may impact on some with protected characteristics

5

5 - Risks and Matters for Escalation to Board

Anna Lewis (Hywel Dda UHB - Independent Board Member)

None to report

6

6 - For Information

6.1 **5 Mins**

6.1 - Withyhedge Update

Attachments

6.1 Withyhedge QSEC Feb 2025.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:	13 February 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Withyhedge Environmental Incident Management Update
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Dr Ardiana Gjini, Executive Director of Public Health
SWYDDOG ADRODD: REPORTING OFFICER:	Megan Harris, Consultant in Public Health Geri Arthur, Health Protection Manager

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 is for assurance and provides an update to the Committee on the situation at Withyhedge Landfill site near Haverfordwest.

An Incident Management Group was set up in April 2024, consisting of Pembrokeshire County Council (PCC), Public Health Wales(PHW), National Resources Wales (NRW), Hywel Dda University Health Board (HDUHB), and other agencies as relevant to operate under the Environmental Health Incident Management Team (IMT) Terms of Reference. The IMT has been Chaired by PHW or PCC.

The IMT has been in operation for over a year in response to issues raised of malodours and potential contamination of a local water source by the landfill at Withyhedge. Natural resources Wales is the regulator and Chair of the IMT.

The IMT held a series of engagement sessions in December 2024 and this report seeks to provide background to the Committee and assurance on the work being done as part of the IMT.

Cefndir / Background

The Withyhedge site is located at Bowling Farm, Rudbaxton which is approximately 4 miles north of Haverfordwest in Pembrokeshire. It's been operated since March 2022 by Resources Management (UK) Ltd, (RML) part of the Dauson Environmental Group which owns several other associated companies. The site currently operates under environmental permit: EPR/MP3330WP. The site is permitted to handle non-hazardous landfill and covers approximately 53 hectares. The site is managed in two phases, which are subdivided into 18 individual cells.

Since October 2023, NRW have been receiving 20-30 complaints per day of malodour, these have significantly reduced over time. Complaints have included 40 people detailing apparent

health effects such as stinging eyes, sore throats, headaches and exacerbations of existing respiratory conditions, although local GP practices have been contacted, and report no significant increase in consultations for health issues that may be associated with the landfill. Only 4 people have been reported to have attended their GP with health issues they ascribe to the site.

There have also been concerns about potential pollution of the water in Rudbaxton Brook due to overflow from a containment pond on site. The malodour is likely to be caused by the uncontrolled release of landfill gas and emissions from previously uncapped portions of the site and/or leakage of liquid leachate into surrounding watercourses. The site is now fully capped.

A local pressure group called 'Stop the Stink' has formed which communicates via Facebook. Pembrokeshire County Council (PCC) now have a named person as part of the group that they communicate with. The Facebook group advises that there is no point in contacting healthcare providers as they won't confirm that health issues are caused by the site. This is contrary to the message we as a health board, and all partners, have tried to promote which is that you should contact you healthcare provider if you have health issues, whatever you think the cause may be.

The site voluntarily stopped taking waste in May 2024 and is planning to recommence waste acceptance which is likely to cause anxiety and concern to local residents. Although complaints have reduced, they are still coming into NRW. There is a phone line and reporting form on the NRW website. The site is due to reopen at the beginning of January 2025 and the reopening of the site will likely again cause additional tensions locally.

Asesiad / Assessment

The air quality subgroup (AQG) of the IMT have agreed that the monitoring carried out so far indicates that there have been occasions where the levels of hydrogen sulphide have been above the World Health Organisation (WHO) threshold for 'annoyance', annoyance used here is a technical term. They acknowledge the distress of the people living in the area whilst trying to reassure them that the levels are not harmful. This is in terms of physical health and is not commenting on the effects on people's mental wellbeing. These assessments have not been well received by some local community members.

Reports have also indicated that there are likely to be other sources of hydrogen sulphide in an area with a large agricultural base and other odours and sources of odours have been noted both during site visits and when responding to reports of odours. Issues around investigation have been hampered by people reporting odours several days after they have occurred or being non-specific about where they have occurred which makes verification and investigation difficult. The local community have been critical of PHW's assessment of the independent monitoring reports, as while they state the amounts detected are not at harmful levels, they are unable to state this categorically which is often the case in public health messaging which is often trying to quantify uncertainty. At present the reports are produced from PHW monthly after the IMT have reviewed them.

Local GP surgeries and respiratory services within the health board have not reported a significant increase in consultations. However, there has been feedback on access to appointments and resident's view of the need for urgent appointments not being facilitated by the GP surgeries.

The local community do not understand why the site has not been closed and why this is not possible, also the fact it would not end the current nuisance. In addition, they possibly do not appreciate the legal duties of the regulator, the limits to the powers of both NRW and PCC, and the need to act fairly and proportionately to all parties and allow the operator a chance to remedy the situation. The site will need to be managed actively for decades after it is closed. Orphan landfills where the site operator has gone out of business or they have mismanaged the site and been stripped of their licence, are a significant issue for local authorities who will be required to manage them in their stead. Operating licenses often extend to 30 years post the site being closed to waste acceptance, continuing to produce gases that need to be managed.

The IMT have discussed the possibility that there is likely to be significant anxiety in the local community when RML recommence accepting waste. NRW have reviewed the new waste cell on the site and reviewed all documentation to ensure compliance. The IMT held a local engagement session for the community to enable them to air concerns and receive as much reassurance as possible. However, even a well-run and compliant site is likely to produce some odour and the local population are now 'sensitised' to odours, a phenomenon described in the literature.

Due to the high level of anxiety and dissatisfaction by the local community as well as the high political profile, a number of engagement meetings were held during December.

The political climate has slightly calmed following the election and change in First Minister, however there is likely to be concern that all appropriate action, both technical and legal has been taken and that there is no repetition of the situation of winter 2023/4. A briefing for local politicians was held on 4th December and was attended by representatives of the local MP, MS/ASau, and Councillors in advance of the public drop-in session on 5th December.

During the engagement session, local people expressed concern about the difficulty in following our advice to contact 111 or their GP. Call handlers at 111 have said they are unable to help and advised contacting their GP. People have struggled to get GP appointments. The local MP also raised this as a general issue during the session and has had meetings with Primary Care representatives in HDUHB.

The Health Board have no regulatory or enforcement role in this dispute. However, it is the health of our local population potentially affected, including the anxiety. PHW may have a role if a risk to human health can be demonstrated but this has not been the case so far, despite the ongoing monitoring.

The main risk to the Health Board is reputational, as the local population believe that health services should be doing more. Some local residents believe incorrectly that PHW should be able to shut down the site and may not differentiate between locally based public health and the national service.

Argymhelliad / Recommendation

The Committee is asked to take assurance that the Incident Management Team, Chaired by Natural Resource's Wales, continues to assess and respond to the potential impact on population health. HDUHB Public Health remains engaged in the IMT for Withyhedge and will continue to monitor the situation and update as required.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	
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
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	1. Leadership
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:	NRW – Natural Resources Wales PCC- Pembrokeshire County Council PHW – Public Health Wales IMT – Incident Management Team as described in the Managing Public Health Risks from Environmental Incidents: Guidance for Wales v4.0b AQG – Air Quality Group which is a sub-group of the IMT RML – Resources Management Ltd, the landfill site operator
Rhestr Termau: Glossary of Terms:	NRW – Natural Resources Wales PCC- Pembrokeshire County Council PHW – Public Health Wales IMT – Incident Management Team as described in the Managing Public Health Risks from Environmental Incidents: Guidance for Wales v4.0b

	AQG – Air Quality Group which is a sub-group of the IMT RML – Resources Management Ltd, the landfill site operator Leachate is a liquid that drains (or leaches) from a landfill. It varies in composition based on the age of the landfill and the type of waste that is contained in the landfill. It usually contains both dissolved and suspended material.
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:	Nil
Ansawdd / Gofal Claf: Quality / Patient Care:	Nil
Gweithlu: Workforce:	Nil
Risg: Risk:	Nil
Cyfreithiol: Legal:	Nil
Enw Da: Reputational:	There has been considerable media interest. NRW are the lead agency in regard to this incident. Several government ministers were involved in the initial stages of this incident, including the previous First Minister, and the site lies within the remit of the current First Minister. Since the recent changes in Welsh Government, media attention has lessened and has been focussed on the roles of NRW and PHW.
Gyfrinachedd: Privacy:	Nil
Cydraddoldeb: Equality:	Nil

6.2 **5 Mins**

6.2 - QSEC Work Plan 2024-25

Attachments

Draft QSEC Work Programme 2024-2025 V3.pdf

QUALITY SAFETY & EXPERIENCE COMMITTEE WORK SCHEDULE APRIL 2024 – MARCH 2025

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 2024 – March 2025

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2024	11 June 2024	15 August 2024	8 October 2024	5 December 2024	13 February 2025
Governance								
Welcome and Apologies	**Chair**	**All**	✓	✓	✓	✓	✓	✓
Declarations of Interests	**Chair**	**CSO**	✓	✓	✓	✓	✓	✓
Minutes from Previous Meeting and Matters Arising not on Agenda	**Chair**	**CSO**	✓	✓	✓	✓	✓	✓
Table of Actions (ToA)	**Chair**	**CSO**	✓	✓	✓	✓	✓	✓
Review of Terms of Reference (TORs)	**Chair**	**CSO**		✓		✓		
Annual Review of Sub Committees TORs	**Chair**	**CSO**			✓			
Self-Assessment outcome of actions from Work Shop- Six month review of actions August 2026	**Chair**	**JW**						Defer April 2025
Outcome of Self-Assessment Presentation	**Chair**	**Chair**					✓	
Behaviours Framework	**AL**	**SD**	✓					

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2024	11 June 2024	15 August 2024	8 October 2024	5 December 2024	13 February 2025
Patient/Staff Story	**LOC**		✓ Safer Care Collaborative Staff story	✓ Rheumotology	✓ Oncology	✓ Integrated Care Centre	✓ Paediatrics BGH	
Policies for Approval (as required)	**All**	**All**	✓	✓	✓	✓ Incident Reporting Procedure	✓ Mental Capacity Act Strategy	✓
Targeted Intervention Progress Report - TBC	**Shaun Ayres**	**Executive Leads**						✓
Assurance								
Annual Report on Committee's Activity	**AL/SD**	**All**	✓					
Annual Report on Sub-Committee's activity for incorporating into QSEC's Annual Report	**SD**	**SD LOC**		✓				
Fragile Service Update Report *(TI 32, 33, & 35)*	**SD**	**SG/CS**					✓	
Learning Framework Report *(TI 48)*	**SD**	**CS**					✓	
Presentation on revised operational governance arrangements	**AC**			✓				

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2024	11 June 2024	15 August 2024	8 October 2024	5 December 2024	13 February 2025
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 six 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 • Paediatrics Service Changes BGH • WHC's overview *(every other meeting) (TI 52)*	**SD**	**CS**	✓	✓	✓	✓	✓	✓
National Nosocomial COVID-19 Programme End of Programme Learning Report,	**SD**	**CS**			✓		✓	
Duty of Quality and Candour Annual Report 2024	**SD**	**CS**			✓			
Nurse Staffing Levels (Wales) Act: Assurance Reports (as required) –Annual Report 2023/24 and Spring Calculation Cycle	**SD**	**HH**				✓		

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2024	11 June 2024	15 August 2024	8 October 2024	5 December 2024	13 February 2025
Nurse Staffing Levels Impact of Reduction of Agency and Bank Staff on quality, safety and patient experience interim report	**SD**	**HH**						✓ (impact of full year report in August 2025)
Patient Acuity i- Welsh Levels of Care Impact on Nurse Staffing Levels	**SD**	**HH**				✓		
Quality Engagement Act	**SD**	**CS**				✓		
Urgent and Emergency Care Discharge Management Internal Audit	**AC**	**CG/MD**			✓			✓ Metrics to evidence quality improvement
Paediatric Occupational Therapy Referral to Treatment Time Action Plan Update	**JS**	**LR**	✓		✓		✓	
Mental Health and Learning Disabilities and Public Health 1) Review of unexpected deaths / suicides to ascertain changes in patterns or trends.	**AG**	**BTP/CJ**	✓					
Understanding the Quality and Experience Impact Realised to Date	**KJ**	**CG**	✓					

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2024	11 June 2024	15 August 2024	8 October 2024	5 December 2024	13 February 2025
through Transforming UEC								
Thematic Report on care home fragilities and closures including the impact on length of stay at hospitals for patients and quality assurance for out of area referrals	**JP**					✓		
Primary Care Quality and Safety Governance and HIW Inspection reports.	**JP**	**RB**			✓			✓
Withybush Creche Care Inspectorate Wales Inspection and action plan	**AC**	**RE**		✓		✓		
Rheumatology Deep Dive	**AC**						✓	
Cleanliness Standards Audit report and Action Plan	**AC**	**RE**		✓			✓	
Integrated Quality Impact Assessment Process and Terms of Reference	**SD**	**CS**		✓				
NHS Exec Review of Neurodevelopment Service, Pyschology and Psychological Intervention for Children and Young People	**AC**	**LC/AL**	✓ Action Plan					
Upper GI Surgery (Quality Panel)	**MH**	**CL**			D	✓		
Community Nursing	**SD**	**Tracey Evans/ Sarah Cameron**				✓		
Nosocomial Review COVID 19 Review Action Plan- learning shared	**Operational Leads**					✓ opportunity for shared learning		✓

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2024	11 June 2024	15 August 2024	8 October 2024	5 December 2024	13 February 2025
						across organisation to be embedded as part of new operational structure		
Obstetrics Sonography (Quality Panel)	**GRD/KG**				D			
Compliance with Additional Learning Needs Act	**JS**	**LJ**	✓				✓	
Allergies Testing Service	**AC**						✓	
ASD Assessments for CYP/ Young Adults	**AC**	**AL**			✓			
GIRFT Report Orthopaedic Update (report and action plan)	**AC**		✓					
Infected Blood Inquiry findings	**SD**					✓		
GIRFT report General Surgery (Include report and action plan)	**MH**	**AC**	✓					
Veteran Health	**SD/AC**	**LH/ BL**					✓	
Oncology Deep Dive	**AC/ JP**	**GB/LH**		D	✓		✓	
Stroke Services Access Times	**JS**			✓				
Q&S impact of RAAC – metrics	**AC**	**BA**	✓					

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2024	11 June 2024	15 August 2024	8 October 2024	5 December 2024	13 February 2025
Pembrokeshire Child Practice Review	**SD**	**MND**			✓			
Risks								
Corporate Risks Assigned to QSEC	**Executive leads**	**RW (report author)**	✓		✓		✓	
Assessing and Prioritising Fragile Services	**SD/ SG**			✓				
Sub Committee Update Reports								
Quality, Safety and Experience	✓	✓	✓	✓	✓	✓	✓	✓
Listening and Learning:	✓	✓	✓	D	✓	✓	✓	✓
• To include developments in response to the Communication themes presented in Dec 23 • Reports on quality and safety matters (case studies if possible) on Speaking up Safely				D	✓			
For Information								

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2024	11 June 2024	15 August 2024	8 October 2024	5 December 2024	13 February 2025
HIW Annual Report							✓	
WHSCC QPS Joint Chairs Report			✓	✓	✓	✓	✓	✓
IQPD Minutes			✓	✓	✓	✓	✓	✓
Work plan 2024/25			✓	✓	✓	✓	✓	✓
Patient Experience Report			✓	✓	✓	✓	✓	✓
Agenda setting meeting with Chair and Exec Lead to include discussion on deep dives on new risks (at least 6 weeks before the meeting)	**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	**CSO**	**CSO**	✓	✓	✓	✓	✓	✓

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2024	11 June 2024	15 August 2024	8 October 2024	5 December 2024	13 February 2025
next meeting and RAG rate								
Record and track the TOA as part of the decision tracker	**CSO**	**CSO**	✓	✓	✓	✓	✓	✓
Produce written update report for QSEC and Board	**CSO**	**CSO**	✓	✓	✓	✓	✓	✓
Prepare schedule of meetings	**CSO**	**CSO**					✓	
QSEC Annual Work Programme	**CSO**	**CSO**	✓	✓	✓	✓	✓	✓

Sub Committees:

- Quality, Safety and Experience Sub-Committee
- Listening and Learning Sub-Committee

Sub Groups:

Medicines Management Operational Group (MMOG)

Initials

SD- Sharon Daniel	CSO-Katie Lewis	AL- Anna Lewis	LOC- Louise O'Connor	MH- Mark Henwood
AC- Andrew Carruthers	BA- Bethan Andrews	CS- Cathie Steele	SG- Subhamay Ghosh	BTP- Rebecca Temple Purcell
HH- Helen Humphreys	CG- Ceri Griffiths	KJ- Keith Jones	RW- Rachel Williams	AG- Ardiana Gjini
KG- Kathy Greaves	GRD- Gail Roberts Davies	CL- Caroline Lewis		

6.3 **5 Mins**

6.3 - Welsh Government Integrated Quality, Planning and Delivery minutes

Attachments

WG IQPD meeting.pdf

Health Social Care and Early Years Group
Welsh Government

Integrated Quality, Planning and Delivery Meeting
Hywel Dda University Health Board
Note of meeting: 13 January 2025

Llywodraeth Cymru
Welsh Government

1. Welcome, introduction and apologies.

Members were welcomed and apologies noted.

2. Notes and actions of last meeting

The notes and actions of the last meeting were agreed.

The health board provided the attached trajectory relating to clinical coding.

24.25 Trajectory.xlsx

3. Maternity and neonatal

1.0 IQPD -Maternity and Neonatal Review

The health board reported compliance with birthrate plus across the three hospital sites. There is one vacancy in community in Carmarthen and 0.8 community in Bronglais and the health board is looking to recruit. There is one consultant post in Glangwili and one locum post to be advertised.

Paediatric workforce, Bronglais and Withybush are fully compliant. In Glangwili, the SAS rota is under review. Neonatal workforce shows the health board is BAPM compliant. There is one QIS post to be advertised. For HDU, current compliance is 84%, but this will rise to 92% after the 2025 courses. For ITU, current compliance is 68% and the health board is aiming for 75%. All deficits are covered by bank staff.

PROMPT training for 2023-24, the health board was above target for midwives and obstetricians, but there is a challenge around anaesthetics, and there is a plan in place for 2024/25 (September to August). The health board is aiming to achieve 25% to 30% compliance each quarter.

For foetal surveillance, the health board reported 91% for 2023-24 but is currently at 23% for midwives and 30% for obstetricians for quarter 1 2024-25.

The health board reported 96% compliance for NLS / BLS in 2023-24 and for NALS was 100% in December 2024.

In 2024, the health board reported three NRIs, one was related to a never event, one was stenography related, and one was HIV related. One NRI is in the process of being reported following a case on New Year's Eve. Between three and five complaints are received each month. There was one additional SSI in Bronglais in 2024.

There were five still births reported in 2024, two are under investigation, two were due to communication and one was non-compliance of national guidance around foetal growth surveillance. There were three neonatal deaths reported in 2024, two of whom died outside of Hywel Dda and joint reviews are underway.

There were no maternal deaths in 2024.

Everybody is offered the opportunity to have a post mortem, and there has been a 29% uptake. In 2024, there was one HIE 3 and one HIE 2.

There were zero actions outstanding following HIW inspection and the Llais action plan has been completed.

Patient feedback and CIVICA – 89% rated as good or very good

Digital Maternity Cymru system should be fully integrated by March 2026, with the business case having undergone the necessary governance by March 2025.

NNAP data – Glangwili is showing positive comparisons with UK data and the health board is aware of the areas that need improvement.

4. Women's Health

2.0 IQPD Children and young people u

The health board is working with the clinical network following the publication of the Women's Health Plan (WHP). The WHP is included in the annual planning cycle and is a priority area and the health board is in the process of appointing key individuals. The health board has a pelvic health group already in place and will be looking to amend the terms of reference to broaden it out to cover all women's health.

5. Children and Young People

The health board receives feedback through CIVICA from Children and Young People (CYP) and families. The health board has successfully rolled out a Gems pilot in PACU where they receive an idea from patients and families, and this has been rolled out to SCBU. Ideas are reviewed monthly, with any quick wins instigated immediately.

The health board has worked with Aberystwyth University to evaluate an epilepsy specialist nurse role that has provided a 45% return on investment for the health board, though is only supporting a third of children and young people through the role.

On supporting patients waiting for speech and language therapy, the health board uses the three Ts approach and is on target to have zero patients waiting over 14 weeks by the end of January. The other therapy services use a similar approach.

Performance – there are expected to be 240 breaches across occupational therapy at the end of March. There is an action plan in place and the health board is looking what additional actions it can put in place.
Acute paeds – the health board is working towards a maximum wait of 36 weeks by March for first outpatient and there are no stage 4 waits.

ADHD – improvements have been seen over the last year. 1st assessment is in community paeds and the health board is working towards the 80% target and is on course to achieve 60% by the end of March. Concerns remain about demand outstripping the capacity available.

6. Population health

3.0 IQPD - Population Health -

A board seminar was held just before Christmas and considered how the health board could strengthen their approach to become a more population health focused board.

The health board is looking at pre-school and schools to improve and strengthen health promotion and healthy eating. Three quarters of schools have taken part. The annual Director of Public Health report focussed on CYP this year.

Health inequalities – working across the region, looking at smoking cessation and substance misuse. There is a dedicated service for children. This work is being used in the development of the Clinical Services Plan.

In terms of judging progress, action plans have been developed based on the recommendations and there are monitoring mechanisms in place to monitor through the partnership groups.

7. Limited assurance reports

An update on the actions was provided. The audit committee is ensuring that the organisation completes actions, and these are reviewed every 6 to 9 months to ensure progress and embed learning.

8. Quality and safety

5.0 IQPD - Quality and safety - Jan 2025.

Patient feedback scores have remained stable. The health board is progressing the pilot of CIVICA in primary care and OoH.

Complaint performance has been maintained. The percentage dealt with through early resolution is increasing.

There are no new Public Interest reports or regulation 28 issues.

NRI closure compliance is improving, learning has been shared. The health board provided an update on Duty of Candour and the teams focus on those reported as moderate harm and above.

In terms of HIW reports, the health board is making progress with 15 actions overdue and nine partially complete but overdue.

Major incident from storm Darragh has been reported.

9. Mental health

The full set of inpatient metrics data has been supplied to NHS Executive colleagues. The health board is working to develop a mental health quality dashboard. There were a number of environmental actions highlighted in the Bryngolau report which are being resolved.

10. Urgent and emergency care

1.0 TI - UEC 6G Jan 25.pptx

Ambulance arrivals at hospital have increased. The health board recognises the need to make use of clinical streaming hubs. Despite ambulance numbers going up, there has been a reduction on lost minutes, with some progress being seen at Glangwili. There are still long waits for time to triage and time to clinician.

The pathways of care delays are improving with reductions seen in days delayed, as well as reductions in the number of patents having to stay in hospital over 21 days.

There are 26 measures being used to monitor successes in the 12-week plan. Weekly ‘big room’ meetings have started and there has been success around SDEC and criteria led discharge. Medical staffing at the front door remains a challenge and the health board is recruiting six consultant posts.

11. Planned care

2.0 TI - IPQD Planned Care Jan 2025.pptx

The December position will show an improvement, and the health board was confident they would achieve the March 2025 targets. The health board has seen a reduction in the overall list size.

In terms of 104-week waits, orthopaedics is the area of risk. of up to 100 patients.

12. Cancer

3.0 TI-IQPD Cancer Slides Dec 24.pptx

The health board has reported an improved position for November, with performance at 55.5% and is aiming for 60% for December. There have been improvements seen in a number of tumour sites.

13. AOB

4.0 TI - IP&C - Nov-Dec 2024.pptx

IPC - There was an increase in reported numbers in November. The position is expected to further improve throughout January. There had been several outbreaks over the last couple of months due to flu. Increased cleaning and infection control is ongoing.

Action:

14. Date of next meeting

Tuesday 11 February 2025, 09:00 via teams

Action log

Action	Responsible	Update

Attendance – need to update

List of attendees and noted apologies		
NHS Executive	**Welsh Government**	**HDUHB**
Gareth Lee	Jeremy Griffith (Chair)	Alyn Morgan
James Davis	Richard Desir	Andrew Carruthers
Brett Denning	Martyn Rees	Angharad Davies
Dave Semmens	Gareth Evans (Secretariat)	Ardiana Gjini
Andy Long	Olivia Shorrocks	Bethan Lewis
	Pushpinder Mangat	Bruce Bolam
	Aled Brown	Carly Hill
	Stuart Hackwell	Cathie Steele
	Janine Hale	Cerian Llewellyn

	Brent Shurn	Dana Scott
		Gareth Cottrell
		Mandy Davies
		Lee Davies
		Janice Cole-Williams
		Jo Bradburn
		Keith Jones
		Lisa Humphrey
		Liz Caroll
		Louise O'Connor
		Mandy Davies
		Mandi Chesterman
		Marilize Preez
		Olwen Morgan
		Peter Skitt
		Rebecca Temple-Purcell
		Sharon Daniel
		Shaun Ayres
		Simon Chiffi
		Thomas Alexander
		Rebecca Richards
Apologies		
Cathy Dowling (Andy Long deputising)	Anna Kuczynska	James Severs
Rhiannon Jones	Samia Edmonds	Lisa Gostling
Claire Harding	Karen Jewell	Huw Thomas
		Mark Henwood (Carly Hill will be representing)
		Joanne Wilson

7

0 Mins

7 - Date of Next Meeting - 8 April 2025

For discussion