Date	**14/08/2025**
Time	**09:30 - 12:30**
Location	**Microsoft Teams Meeting/ Ystwyth Boardroom**

Quality, Safety & Experience Committee Meeting

HDD_Quality, Safety & Experience Committee

NHS Wales

Agenda - 14 August 2025

1 Governance

09:30, 20 min

1.1 Declarations of Interest

Anna Lewis (Hywel Dda UHB - Independent Board Member)

1.2 Minutes from the Previous Meeting and Table of Actions

Anna Lewis (Hywel Dda UHB - Independent Board Member)

1.3 Self-Assessment - Six month review of actions

Anna Lewis (Hywel Dda UHB - Independent Board Member)

1.4 Assurance on Governance Arrangements Report - Executive Leads

1.5 Targeted Intervention Progress Report

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

1.6 Quality and Safety Governance Arrangements

Sharon Daniel (Hywel Dda UHB - Executive Director of Nursing, Quality & Patient Experience), James Severs (Hywel Dda UHB - Executive Director of Allied Health Professions and Health Science), Mark Henwood (Hywel Dda UHB - Executive Medical Director)

1.7 Patient Story- Verbal

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

2 Risk

30 min

2.1 Cleanliness Standards Audit report and Action Plan

Simon Chiffi (Hywel Dda UHB - Head of Operations), James Severs (Hywel Dda UHB - Executive Director of Allied Health Professions and Health Science)

2.2 Sonography - The impact on patient experience and clinical outcomes due to Risk 787: Workforce Pressures in Ultrasound Services

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

3 Assurance

1 hr

3.1 Quality Assurance Report

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

3.2 Duty of Quality Annual Report 2024/25- To Follow

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

3.3 Quality, Safety and Experience Sub Committee and Terms of Reference for Annual Review

James Severs (Hywel Dda UHB - Executive Director of Allied Health Professions and Health Science)

3.4 Listening and Learning Sub Committee Update Report

Mark Henwood (Hywel Dda UHB - Executive Medical Director)

3.5 Epilepsy Service in Mental Health and Learning Disabilities

Liz Carroll (Hywel Dda UHB - Service Director MH&LD Clinical Care Group), Olwen Morgan (Hywel Dda UHB - Assistant Director of Nursing)

3.6 Women's Health

Dana Scott (Hywel Dda UHB - Director of Midwifery & Professional Governance for Women & Children)

3.7 Section 136 Suite- Mental Health and Learning Disabilities

Kay Isaacs (Hywel Dda UHB - Assistant Service Director- MHLD Clinical Care Group)

4 **Policy for Approval: 1133 Service User Access Policy Psychological Therapies**

Kay Isaacs (Hywel Dda UHB - Assistant Service Director- MHLD Clinical Care Group), Andrew Homfray (Hywel Dda UHB - Interim Service Delivery Manager)

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5 **For Information**

5.1 **JCC Quality, Safety and Outcomes Sub-Committee Highlight Report**

5.2 **Patient Experience Report**

5.3 **Work Plan 2025/26**

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6 **Date of Next Meeting : 9:30am 9 October 2025**

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1

09:30, 20 Mins

1 - Governance

1.1

09:50,

1.1 - Declarations of Interest

Anna Lewis (Hywel Dda UHB - Independent Board Member)

1.2

1.2 - Minutes from the Previous Meeting and Table of Actions

Anna Lewis (Hywel Dda UHB - Independent Board Member)

Attachments

2025-06-10 - Quality, Safety Experience Committee Meeting - Minutes (2).pdf

Table of Actions QSEC 10 June 2025.pdf

DRAFT MINUTES OF THE QUALITY, SAFETY & EXPERIENCE COMMITTEE

Date of Meeting:	**09:30, Tuesday 10 June 2025**
Venue:	**Microsoft Teams Meeting/ Ystwyth Boardroom**

Present:
Anna Lewis (Independent Member and Chair of the Committee)
Eleanor Marks (Health Board Vice Chair)
Chantal Patel (Health Board Independent Member)

In Attendance:
Andrew Carruthers (Chief Operating Officer)
Bethan Lewis (Assistant Director of Public Health Strategic Business and Operations)
Caroline Burgin (Patient Safety and Assurance Manager)
Cathie Steele (Interim Assistant Director of Nursing Assurance and Safeguarding)
Donna Major, Nurse Cadog Ward
Helen Humphreys (Head of Nursing for Professional Standards and Regulation)
James Severs (Executive Director of Allied Health Professions and Health Science)
Jill Paterson (Director of Primary Care, Community and Long-Term Care)
Joanne Wilson (Director of Corporate Governance)
Katie Lewis (Committee Services Officer- Minutes)
Louise O'Connor (Assistant Director of Patient and Legal Services)
Mandy Davies (Assistant Director of Nursing & Quality Improvement)
Olwen Morgan (Assistant Director of Nursing)
Paula Goode (Service Director for Planned and Specialist Care)
Sharon Daniel (Executive Director of Nursing, Quality & Patient Experience)
Sarah Williams, Senior Sister, Cadog Ward
Subhamay Ghosh (Associate Medical Director for Quality & Safety)
Urvisha Perez (Audit Wales) (Observing)

Apologies:
Michael Imperato (Independent Board Member)
Sarah Harraway (Independent Board Member)
Ardiana Gjini (Executive Director of Public Health)
Amanda Glanville (Assistant Director of People Development)

Minutes Ref.	Item	Action
	Governance	
QSEC 25 (17)	**Declarations of Interest**	
	There were no declarations of interest.	
QSEC 25 (18)	**Minutes from the Previous Meeting and Table of Actions**	
	The minutes of the previous meeting were reviewed and approved as an accurate record.	

In terms of Action QSEC 25 (04): Developing local data that provides a focus on clinical outcomes and potential harm for patients due to the current Unscheduled Care service configurations, Mrs Anna Lewis sought assurance that clinical outcomes for patients will be included within the dataset that is currently in development. In response, Mrs Sharon Daniel confirmed that Dr Subhamay Ghosh and Ms Sian Hopkins in the Quality Improvement team are currently undertaking a piece of work to review national literature and developing a proposal for metrics to capture this data which will align with the Safe, Timely, Equitable, Effective, Efficient, Person Centred (STEEEP) Domains.

Decision: The minutes and table of actions from the previous meeting were approved as an accurate record.

QSEC 25 (19) Targeted Intervention Progress Report- Executive Leads

Mrs Sharon Daniel presented the Targeted Intervention Progress Report and passed on a special thank you to Mr Shaun Ayres for preparing the slides which provide an update on the criteria specifically aligned to quality, safety and experience domains as part of the areas of escalation, which are monitored via a tracker. It was noted that where there may be gaps in the tracker, this may be due to delay in process and not necessarily a gap in practice, however, there continues to be challenges in a number of areas including infection prevention, patient communication and mental health services.

Reflecting upon the many different components of the report, Mrs Patel queried how they feed into the wider organisation, providing mental health services as an example where, although there is a lot of information and activity reported, it is not explicitly clear what is being done to resolve concerns. In terms of internal processes, Mrs Daniel advised that the 'Improving Together' sessions take place with each Clinical Care Group to scrutinise and monitor performance and activity against the domains for de-escalation. Specific Targeted Intervention meetings take place with each Clinical Care Group, and they are also asked to provide update reports from the integrated governance groups which monitor quality through to the Integrated Quality Finance and Performance Delivery Groups (IQFPD) and Executive Team.

Thanking Mrs Daniel for clarifying the reporting structure, Mrs Patel queried the impact of this and whether the Health Board is capturing and monitoring progress and whether the revised governance is having an improvement on performance and quality service delivery. In response, Mrs Wilson advised that each de-escalation criterion is mapped to each Clinical Care Group and the respective Executive Lead is responsible for monitoring whether the actions underway are having a positive impact and making the necessary improvements.

Mrs. Lewis reflected upon the content of the report and queried, in the absence of a trajectory, whether it is possible that the Health Board has become process heavy and impact light. Mrs Lewis asked whether there will, at some stage, be a review on whether the processes and reporting structures are having a material impact on delivering better quality patient experience for the population.

In response, and with reference to the patient access times in Mental Health Service (as raised by Mrs Patel), Mr. Carruthers explained several challenges, for example Welsh Government have explicitly recognised that some performance targets that have been set are not achievable which raises questions as to why the reporting is effective.

Thanking Mr Carruthers for providing further context, Mrs Lewis raised concern that as a member of the public reading the information shared, there is a vast amount of activity happening which continues to not meet the necessary targets that should be deliverable. On the same subject, Ms Eleanor Marks suggested that if the target is not feasible, then the focus should shift to improving the delivery of care for the population. Mr Carruthers acknowledged this, and in this case, the Clinical Care Group Director is undertaking a piece of work on an improved model and alternative options for service delivery. There is a Ministerial Summit for Mental Health Services in the coming week which will provide an opportunity for strategic considerations.

From a quality and safety perspective, Mrs Daniel reiterated that each care group have a trajectory for monitoring improvements, and these are evidenced via metrics however recognised that improvements are not always made at the pace required.

In terms of the number of groups that have been established, Mrs Patel reflected upon the cost and staff time taken up to facilitate and attend these different meetings, and whether a route cause analysis should take place on why the organisation cannot make changes at a quicker pace. Highlighting that this a wider conversation that is not going to be resolved within this Committee, Mrs Lewis felt that it has been important to give the concerns the attention they deserve as the Committee's assurance function is dependent on a valuable measurement system which is not felt to be available from a patient perspective.

Ms Eleanor Marks commented that the report highlights ongoing service pressures and there is a common theme of high sickness rates within several Board and Committee reports recently, for example the recently reported 12.5% staff sickness in Glangwili Hospital. Ms Marks sought assurance that there is work underway to understand why this is the case. Providing some context, Mrs. Morgan advised that there are challenges in Theatres in Glangwili Hospital at present, due to several issues including workforce model challenges and long-standing cultural challenges. A theatre staffing review has been undertaken, and the recommendation is

that an uplift maybe required for nurses, operating department practitioners and non-registered staff. The sickness rates are being impacted by staffing pressures.

The Chair suggested that a report and improvement plan which provides an understanding of the high sickness rates and cultural challenges in Theatres in Glangwili Hospital is scheduled for the next People, Organisational Development Committee and the Chair of QSEC will provide feedback on the outcome. **OM/KL**

Mrs Lewis highlighted that key headlines within the report are lacking in tangible evidence, providing the C-difficile infection rates as an example where it is claimed that improvements have been made without sufficient evidence or a trend analysis. Referring to the update whereby 'March 2025 performance achieved' the target threshold with six cases. February recorded four cases, demonstrating that interventions are having measurable impact, in fact suggests a deteriorating position. Mrs Lewis highlighted that it will be helpful to have a statistical process control (SPC) chart to provide the necessary assurance as the figures could in fact be a natural fluctuation. Mrs Lewis raised concern regarding Committee and Board level reports making claims which are not appropriately evidenced.

Reflecting upon Mrs Lewis's comment, Mrs Daniel explained that as the numbers are small, it has been challenging to demonstrate improvement. The hospital's Epidemiologist helpfully collates the information, and these comments will be fed back in terms of ensuring terminology is evidenced. Mrs. Daniel explained that the number of infections has been low and consistent for several months, and the Health Board have not experienced the significant spike that other Health Boards across Wales have, however this position will continue to be monitored closely. Mrs Lewis commented that it is helpful to know that there is the right expertise in the organisation to monitor and review the numbers, however the Committee needs evidence for these types of headlines that fall under targeted intervention (TI) requirements.

Regarding infection prevention and control, Mrs Lewis queried whether the correlation between the standards of cleanliness and infection rates is being tracked, providing significant concerns regarding the standard of cleanliness that was visible during a recent visit to the maternity post-partum Dinefwr Ward at Glangwili Hospital. Mrs Lewis asked whether there is data available to suggest that Dinefwr is a hot spot for infections and also how the Health Board allocates capital budgets according to infection prevention needs. Mrs Daniel confirmed that for infections such as C-difficile, there is a lot of evidence that suggests the environment has a big impact on cross infections. The C- difficile rates for wards and areas are monitored via the Infection Prevention Control Steering Group. It was also noted that the Health Board are not an outlier in post-partum infection rates and are not seeing a high number of Datix incidents in this area.

In response to Mrs Lewis' query regarding prioritising capital budgets according to infection prevention needs, Mrs Daniel advised that the data is collated via Synbiotics system which is reported via the Integrated Quality, Finance and Delivery Group. Mr Carruthers expanded that there have been significant challenges with infrastructure and funding major repairs which have required prioritisation in recent years, and this has caused real challenges in terms of flexibility for discretionary capital funding. Mrs Lewis queried how prominently the failing estate and inadequate capital investment is being raised during discussions with Welsh Government and in response Mrs Daniel explained this is raised regularly, particularly in terms of ventilation. A review of the identification of estate deficiencies will take place by executive colleagues and consideration will be given to how feedback from Safety WalkRounds is incorporated in to quality improvement plans. **SD/LD**

In terms of the recommendation in the TI slides that the Committee should receive detailed improvement plans for the patient communication strategy development across planned care services, as this represents a critical requirement for multiple de-escalation criteria, Ms Lewis queried who is leading on this work which would be confirmed ahead of the next meeting for an update. Mrs O'Connor undertook to link in with the lead to ensure alignment with the new patient experience framework. **SH/ OM**

Ms Eleanor Marks requested an update on the progress of the work to review the methods of contact with patients, highlighting a variation of letters and text messages being sent to patients. Mr Carruthers advised there is a piece of work to change the default patient communication to text messages unless the patient contacts the Health Board to 'opt out' recognising this will be impacted further by Royal Mail changing to a three day a week service. Mr Carruthers has asked for a plan to be developed over the next six weeks and expects that significant progress will be made over the next six months. The Committee asked that this is tracked via the table of actions for an update on when an improvement plan can be expected and assurance that this is being picked up via the Digital Committee. **AC**

<u>Decision</u>: The Committee noted the update and will continue to monitor the position.

QSEC 25 (20) **Patient/ Staff Story- Unscheduled Emergency Care**

Mrs Louise O'Connor verbally presented a patient story that was previously presented at the Listening and Learning Sub Committee relating to a patients' experience of the Emergency Department. Prior to sharing the story Mrs O'Connor felt it was important to note that 70% of patient feedback received within Hywel Dda comes from this part of the organisation and emergency care, with 90% of that feedback felt to be positive and cited the caring nature and professionalism of staff.

‘The patient woke in the early hours of the morning feeling uncomfortable and became violently sick after taking some pain killers and after 5 hours called an ambulance following advice from 111. The patient was taken to hospital to check whether he had experienced a heart attack.’

The theme from the story related to nutrition and hydration, waiting room conditions, including seating, lack of blankets, toilet facilities, dignity and respect; lack of attention/care for patients waiting due to capacity, and a perceived growing culture of acceptance amongst staff due to continued pressures.

Thanking Mrs O’Connor for sharing the patient story, Mrs Lewis asked if there is any way to convey the Committee’s thanks for sharing their experience and reflected upon the consequences and impact on people when the system is over and above capacity. The systemic issues require transformation, and Mrs Lewis asked Mr Andrew Carruthers to share an update on the programme of work underway.

Mr Carruthers updated Members that an accelerated programme of care is underway, and three work streams have been established to concentrate on the following: Access, in terms of managing demand and implementing processes to sign post patients to appropriate pathways of care. The second work stream will focus on environment and address the issues raised in the patient story, and the third will focus on patient flow. Fortnightly progress updates are scheduled to be reported to Executive Team meetings.

Mr Carruthers highlighted that a large proportion of patients attending A&E can receive care via alternative pathways and the ambition is to reduce attendance to Emergency Departments by 50% by the winter period. The intention is to take steps towards a more scheduled approach for unscheduled care activity to reduce waits and triage patients more effectively. Work is underway to accelerate the shift of patient presentation to primary and community services as part of the new strategy and model. In managing better access at the front door there is an opportunity to provide a better experience for those patients who attend via an ambulance. Regional opportunities are being explored in collaboration with Swansea Bay University Health Board on the single point of contact for the emergency care pathway. A workshop has been arranged for 23 June to discuss opportunities.

Thanking Mr Carruthers for the update, Mrs Lewis reflected on the scale of the challenge and complexities of moving from an individual patient story to explaining the whole system transformation response.

Reflecting upon the patient story, Mrs Sharon Daniel provided an update that development of the unscheduled emergency care dashboard and how the metrics will capture this type of

experience as this feedback is a great source of knowledge and provides insight into what matters most to patients and will be used more effectively to improve services.

With reference to the patient describing topping up other patients' water jugs etc, Mrs Patel queried whether the use of volunteers has been explored. In response, Mrs Daniel advised that the third sector do provide this support which is helpful for the Emergency Department teams however it is not consistent enough to provide the level of service required.

Mrs Daniel provided an update that the 'Big Room' discussions in the Emergency Departments have been well received by staff which provides space for discussion on learning, sharing experience and opportunities for improvement.

Mr Carruthers advised Members that a Board Seminar has been arranged the following week and the Clinical Lead for Acute Medicine will be in attendance to discuss the vision for education and the direct access model for emergency care pathway via an NHS App. CGI (Strategic partners) have been involved in developing the solution in Canada and the person who has led on this will attend the Seminar to share learning and answer any questions.

QSEC 25 (21) **QSEC Terms of Reference for Annual Review**

The Committee approved the Terms of Reference with a request by the Chair to re-word section 3.27 regarding the Committee referring quality and safety matters to other Committees. **CSO**

Decision: The Committee approved the Terms of Reference with minor amendment to section 3.27

Risk

QSEC 25 (22) **Corporate Risk Report- Executive Leads**

Ms Anna Lewis requested the following:

- An opening sentence for each Risk update that explicitly states whether the risk has increased or decreased and why, before providing the background should be included. **JW**
- To condense the narrative in the update column and to make the table /report landscape.
- To review the wording in the update provided for Risk 1664: Ophthalmology Staffing "The current impact has been scored as 4 because patients suffering irreversible sight loss is a reality" with the service.

In terms of Risk 1859 relating to poor patient outcomes due to inability to effectively recognise acute deterioration, Mrs Lewis noted there has been a lot of work in this area however

highlighted that the Committee do not have the data on whether the incidents of cardiac arrests have returned to previous levels following the spike, and wondered if it is too premature to reduce this risk without this information. In agreement, Mrs Daniel shared that the increase in training and 'Call 4 Concern' pilot are positive mitigations however the data has not been confirmed to clarify if this is having impact on the number of incidents. Mrs Lewis asked that the data is included as opposed to the expectation that the risk will reduce. Ms Cathie Steele explained that the data required is Medical Examiners Team emergency calls as opposed to Datix incidents.

Referring to Risk 797 and the challenge with workforce pressures in Ultrasound services, Mrs Lewis shared an update on her recent visit to maternity services whereby staff were forthcoming to highlight this ongoing challenge. The senior midwives had confirmed that there is data available which provides examples of the consequences and impact of the challenges, which Ms Lewis had previously requested to be shared with the Committee. Ms Lewis asked that the Executive Team undertake a further discussion with the team and present the data at the next meeting for transparency on the clinical outcomes and opportunities being explored to address the workforce challenges. **AC**

In terms of the gaps in staffing, Mrs Lewis queried where decisions are being made to suggest creative new ways of working due to the ongoing shortfalls. Referring to Obstetrics in particular, Mrs Daniel explained that training programmes are underway for midwives within the Health Board however due to the training programme taking two-years the challenges cannot be resolved in a short timescale. Workforce plans need to be cognisant of this demand.

Noting that the Health Education Inspectorate Wales workforce numbers are expected to remain static next year, Mrs Patel queried how the Health Board are aligning these assumptions with future work force planning. Mrs Daniel explained that the commissioning process and Workforce Plan is overseen by the Director of Midwifery, and planning is adjusted accordingly.

In terms of Risk 1810 – The risk that the current aseptic unit at Withybush will be forced to close before the South-West manufacturing hub is operational, Mrs Anna Lewis queried whether there is a contingency plan in place. Providing context, Ms Jill Paterson advised that the unit developments are unfortunately behind schedule which is causing an ongoing increase to the risk of closure of the Aseptic Unit due to non-compliance with Quality Assurance of Aseptic Preparation Services (QAAPS) standards. Ms Paterson explained that the Health Board rely on very few staff to maintain the current Unit and there is also an ongoing risk in terms of their capacity and workload. In terms of available cover, the Directorate are training individuals to support.

Ms Paterson advised that isolators have been purchased and if the Unit was to close these could be utilised to mitigate the risks. A demountable unit at Withybush is also being progressed which would provide increased production and storage of stock for the future. Ms Paterson feels that the Committee is right to express concern around this fragility and the team are doing everything they can locally to mitigate the risks as far as possible during the progression of the longer-term solution.

On a more general point regarding the management of the Risk Register, Mrs Lewis raised concern regarding deadlines being pushed back too often and queried whether the process requires review to ensure they are recalibrated to account for the moving nature for all risks and allow the Committee to carry out its function more effectively to provide assurance to the Board which will be considered. **JW**

Decision:

- The Committee agreed to advise Board of Risk 1810 - Risk to delivering effective and timely cancer service due to Aseptic Unit challenges and actions underway to mitigate the risks which will continue to be monitored by the Committee.
- The Committee requested a report on the clinical outcomes data for the staffing short falls in Sonography Services to be shared at the next meeting.
- The Committee received assurance from all other Corporate Risks reported and actions underway to mitigate the risks.

QSEC 25 (22) Occupational Therapies Paediatric Improvement Action Plan - Deferred

Assurance

QSEC 25 (23) Fragile Services Report

Mrs Sharon Daniel presented an update on the development of the framework to define levels of service fragility across the Health Board since the previous update to Committee in December 2024. The process combines elements of traditional risk management and insights from the Maturity Matrix to develop a set of criteria that was adapted and shared with the Committee last year. The purpose is for the prioritisation of service fragility and to help services develop a future vision to manage risks and for investment control for the wider organisation.

Mrs Mandy Davies explained that the Fragility Framework has aligned well with the Clinical Care Group structure to provide a tool to

understand their level of fragilities and when this becomes a critical escalation and also allows scrutiny of service management.

Decision: The Committee noted the addition of the Fragile Services Register, Improvement Plan and Quality Impact Assessment as part of the revised Fragile Services Framework to support achievement of the de-escalation criteria actions.

QSEC 25 (24) Auditor General Report on Cancer Services

Ms Paula Goode joined the meeting and presented the key highlights from the Auditor General Report on Cancer Services including the following.

- The standards for breast and cervical screening are not currently being met and this is an area of focus as part of the local cancer transformation programme.
- In Wales, there is an over emphasis on the 62-day target rather than the 28 days to diagnosis target which will also be a key element of change within the transformation programme through the development of an optimal pathway approach.
- The demand on services is increasing and is set to continue to rise and local plans need to reflect this.
- There are outdated IT systems which cause data quality issues. This is generally a national issue across cancer services. There are a lot of administrative validation and data cleansing required to ensure accurate patient tracking.

Mrs Joanne Wilson advised Members that the Auditor General report is a national report and Audit Wales will be undertaking a local audit which will be reported via Audit and Risk Assurance Committee. The relative findings can be forward planned for discussion at a future QSEC meeting. **CSO**

Reflecting upon the content of the report, Mrs Anna Lewis was struck by the challenges with significant capacity issues in diagnostics services and the impact on the Health Board's overall cancer performance. In terms of challenges, Ms Goode reflected upon her experience while working in England, that an issue that she feels is unique to Wales is the categorisation process of urgent and unscheduled care diagnostics which Ms Goode believes should be categorised separately for appropriate patient prioritisation.

In terms of patient communication within diagnostics, which is an area that lot of patients and families mention as an area that requires improvement, in terms of long waits to receive updates on treatment plans. Mrs O'Connor queried what is being undertaken to make improvements in this area. In response, Ms Goode felt that this is a really important point, as although the conversion rates for patients who go through the pathway are relatively low compared to the total volume, those patients, even the ones who are not diagnosed with cancer, suffer the same level of anxiety and stress. The first step will be to actively make changes to reduce waiting times for diagnostics as well as implementing a revised process to confirm key workers for

each patient who they can talk to with any questions or concerns. Mrs O'Connor agreed and suggested maybe there is something the teams can work on collaboratively to provide information to patients at the outset that prepares people to manage expectations.

In terms of inequity of access to screening across the region, which is linked with Public Health, Mrs Anna Lewis asked for an update on this. In response, Ms Bethan Lewis is aware that the Director of Public Health is in discussion with Public Health Wales who deliver the screening service to provide them with support with accessibility and planning to make the necessary improvements for equitable access.

Decision: The Committee received assurance from the content of the report relating to the Health Board's Response to the Auditor General Report on Cancer Services.

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

Ms Cathie Steele presented the following key highlights from the Quality Assurance Report:

- An investigation into incident reporting across the Health Board indicates that reporting of pressure damage and moisture damage are the top classifications for the reduction in incident reporting. A decision was made in December 2023 to not report these categories on admission to hospital unless the patient has been under the clinical care of the NHS, which accounts for the reduction in numbers reported via DATIX.
- The team have undertaken a data cleansing exercise which has impacted upon the numbers of incident reporting.
- Staff survey results have indicated that staff members feel uncomfortable in reporting incidents, and the Clinical Care Groups have been asked to reinforce how important it is to report incidents at their team meetings. This piece of work aligns to the Speak up Safely agenda which the Health Board continue to embed across the organisation.
- A recent Health Inspectorate Wales inspection was undertaken at the maternity unit at Glangwili hospital, and the Health Board are awaiting the final report. Ni immediate assurances were requested.
- Concerns were recently raised by Health Inspectorate Wales (HIW) on timely response to letters seeking immediate assurance following concerns. Ms Steele has shared the dates within the report. A meeting was held with the Clinical Executives, Director of Corporate Governance, Chief Operating Officer and Chief Executive to discuss actions being taken in response to their concerns raised. Some of the concerns included incidents of whistleblowing from members of staff within the organisation and some concerns regarding not receiving adequate assurance in response letters. During the meeting, Mrs Daniel advised that HIW were keen to learn more about the progress of the Clinical Services Plan and

the new operational governance structure. Members noted that there has been a change in engagement links with HIW recently due to sickness absence and Ms Vanessa Davies has been invited to observe future QSEC meetings going forward. The role of the Board and governance arrangements was discussed during the meeting. The letter from HIW and Health Board response and actions will be included within the next Quality Assurance Report. **CS**

Highlighting the significant positive updates shared with Board and the Committees over the last few months on nurse staffing levels reaching full complement and all the hard work undertaken to reach this point, Mrs Patel queried why the data within the slides on nurse staffing levels on various wards indicates such a high number of 'not met/ not appropriate'. Ms Steele advised that there are a number of different factors, for example sickness rates, study leave or perhaps levels of acuity may be higher than routinely expected. Mrs Daniel advised there is also an element of professional judgement, with many newly qualified nurses gaining experience in making these types of assessments.

Discussion took place on the overdue HIW actions detailed on Appendix 1, and feedback for the Clinical Care Groups on ensuring the responses to the recommendations are SMART and actionable so that they do not remain on the tracker for longer than needed due to obscure technicalities.

Decision: The Committee received assurance from the Quality Assurance Report and requested an update on the recent HIW concerns raised on quality governance to be included in the next iteration.

QSEC 25 (26) **Duty of Candour Report 2024/25**

Thanking Ms Steele for the informative report, Mrs Lewis commented that it would be helpful to express the Health Board's commitment to the spirit of the Duty of Candour as well as the process more consistently through the report, if possible, as it is quite process focussed. **CS**

In terms of providing the number of times the Duty has been triggered in the previous year, Mrs Anna Lewis asked whether there is a way of contextualising the information to provide the number of times the Duty has been triggered compared with the total number of patient interactions. **CS**

Decision: The Committee noted the content of the report and supported the next steps to present the report to Annual General Meeting in September 2025.

QSEC 25 (27) **Quality, Safety and Experience Sub Committee and Annual Report 2024/25**

Mr James Severs presented the Quality, Safety and Experience Sub Committee Annual Report 2024/25 and update report.

Mrs Anna Lewis raised concern regarding low attendance from the Medical Directorate which is made explicit via the table of attendance within the Annual Review Report and sought assurance that this is being addressed by the Medical Director. Mr Severs confirmed this has been highlighted and Mr Henwood acknowledged the challenges and will undertake relevant discussions with the team.

Mr Severs requested a few minor amendments within the Annual Review Report in terms of job titles and undertook to make the amendment following the meeting.

Decision: The Committee noted the content of the report and approved the annual review report 2024/25.

QSEC 25 (28) **Listening and Learning Sub Committee Update Report, Annual Report 2024/25 and Patient Experience Framework**

Mrs Louise O'Connor presented the Listening and Learning Sub Committee update report, Annual Report 2024/25 and recently developed Patient Experience framework.

Mrs O'Connor provided assurance that the patient feedback relating to unscheduled and emergency care highlighted via the Listening and Leaning Update report will feed into the Emergency Department Environmental Workstream that has been established.

Members attention was drawn to the Patient Experience Framework which was recently presented at Public Board and has been shared with Committee Members for information. It is anticipated that the implementation of this Framework comes with challenges but is timely in terms of the establishment of the new Clinical Care Groups and Clinical Services Plan developments.

Mrs O'Connor believes that there are opportunities to build into the governance arrangements to ensure that feedback is taken account of and informs decision making and planning going forward. If approved today, Mrs O Connor advised that the next steps will to be to carry out a self-assessment for the Framework at Care Groups and operational level initially which will inform corporate action planning.

Reflecting upon the content of the report, Mrs Lewis asked rhetorically how much longer issues with blankets, seating and nutrition and hydration are going to continue to be the most common themes at Emergency Departments. Mrs Lewis commended Mrs O'Connor for highlighting the perceived growing culture of acceptance for the failings amongst staff, which is a dangerous position to be in, and the Committee need to continue to be challenging about that and encourage staff to do the same.

Decision: The Committee discussed and received assurance from the content of the report and approved the annual review report 2024/25.

QSEC 25 (29) **CHKS Report**

Dr Subhamay Ghosh presented the key highlights from the CHKS report and provided assurance that a working group has been established to review and respond to the data on readmissions, non-elective efficiency and maternity with multi-disciplinary representation.

A meeting has recently taken place with CHKs to discuss issues in terms of discrepancies within the report which are being resolved.

Dr Ghosh updated Members that actions are being undertaken to understand the data accurately, to identify and address any areas of improvement, ensure SMART actions are in place and will bring an update back to a future Committee meeting.

Decision: The Committee received assurance that further actions are being undertaken to understand the data accurately and the action plan will be presented at a future meeting. **SG**

QSEC 25 (30) **Getting it Right First Time (GIRFT) Governance Review**

Mrs Joanne Wilson presented the process for receiving and escalating GIRFT reviews that are undertaken within the Health Board. The Chair sought assurance that learning and the strengthening of leadership approach has been undertaken to avoid previous failings happening again. Mr Carruthers provided assurance that a restructure has taken place which has enhanced leadership capacity and capability across the organisation. A programme of work on Organisational Development is starting on 2 July 2025 for senior leaders.

Decision: The Committee received assurance from the governance review undertaken into how GIRFT reports and other external reports that do not have a pre-defined process are received into the operational and corporate structures of the Health Board, and the revised processes in place to ensure these are appropriately tracked and implemented within the organisation.

QSEC 25 (31) **Cleanliness Standards Audit report and Action Plan- Deferred**

QSEC 25 (32) **Nurse Staffing Levels Spring Cycle**

Ms Helen Humphreys presented the Annual Nurse Staffing Cycles Report, highlighting that the report sets out the changes the workforce and the financial impact of the spring cycle.

Ms Donna Major and Ms Sarah Williams joined the meeting to provide a presentation on the Cadog Ward frailty unit and steps

undertaken to adopt different ways of working and escalating challenges to respond to staff shortages. The key focus has been to build and retain the team which has had positive impact on staff morale and efficiency. There have been significant improvements in quality care reported and patient experience and quality indicators have demonstrated through changes made on the Unit.

Due to timing, the Committee could not discuss the presentation at length. The Chair apologised to the team and kindly invited the team back to a future meeting to discuss the learning and improvements. Mrs Lewis also congratulated Ms Donna Major for winning the NHS Nurse of the Year Award and passed on a special thanks on behalf of the Committee for all of her hard work.

Decision: The Committee received assurance that:

- The Health Board is meeting its statutory 'duty to calculate' responsibility in respect of the nurse staffing level in all wards that fall under the inclusion criteria of Section 25B of the Nurse Staffing Levels (Wales) Act 2016.

- By receiving this report, the Health Board is meeting its statutory duty to provide a written update of the nurse staffing level of each individual ward.

For Information

QSEC 25 (33) **QSEC Work Plan 2025/26**

- Shared for information

QSEC 25 (34) **Joint Commissioning Committee Quality and Safety Highlight Report**

- Shared for information

QSEC 25 (35) **Date of Next Meeting: 14 August 2025**

TABLE OF ACTIONS FROM
QUALITY, SAFETY & EXPERIENCE COMMITTEE (QSEC) MEETING
HELD ON 10 JUNE 2025

Reference	Item	Responsible	Timescale	Update
QSEC 25 (17)	**Targeted Intervention (TI) Progress Report:** • To consider scheduling a report which includes an improvement plan for the high sickness rates and cultural challenges in Theatres in Glangwili Hospital to the People, Organisational Development Committee (PODCC).	**EM/ LG/ OM**	**June 2025**	**Complete**
QSEC 25 (17)	**Targeted Intervention (TI) Progress Report:** • To share with the Committee a plan for the development of a 'patient communication strategy' across planned care services which represents a critical requirement for multiple de-escalation criteria.	**SH/MD**	**August 2025**	**In Progress:** The Executive Director of Nursing, Quality and Patient Experience has commissioned a project to draw together the workstreams of the Waiting List Support Service, Patient Advice and Liaison Service (PALS) and planned care to review all patient communication channels to provide an improvement trajectory as required. Once the project scope is completed this will be available for review by the Committee.
QSEC 25 (17)	**Targeted Intervention (TI) Progress Report:** • To undertake a review of the identification of estate deficiencies and consider how feedback from safety WalkRounds feeds into the process.	**CS**	**August 2025**	**Complete:** A meeting has been arranged between interim Assistant Director of Nursing Assurance and Safeguarding, Quality Assurance Service Team, Infection, Prevention and Control and Estates and Capital to agree the coordinated prioritisation process.
QSEC 25 (17)	**Targeted Intervention (TI) Progress Report:** • To refer the plan to change the default patient communication method to text messages (unless the patient contacts	**AC**	**June 2025**	

	the Health Board to 'opt out') to the Digital and Innovation Committee.			**Complete:** Forward planned for discussion at the Digital and Innovation Committee agenda setting meeting.
QSEC 25 (21)	**Terms of Reference for Annual Review** • Minor amendment to section 3.27 Refer quality & safety matters which fall within the remit of other Committees accordingly.	**KL**	**August 2025**	**Complete**
QSEC 25 (22)	**Corporate Risk Report** To incorporate the following changes for future reports: • To include an opening sentence for each Risk update which explicitly states whether the risk has increased or decreased and why before providing the background. • To condense the narrative in the update column and to make the table / report landscape. • To amend Risk 1664: Ophthalmology Staffing and remove reference to reducing the risk because people are suffering irreversible sight loss.	**RW** **RW** **RW/AC**	**August 2025**	**Complete:** Going forward Corporate Risks will be reported via the Governance Assurance Report. (Agenda item 1.4)
QSEC 25 (24)	**Auditor General Report on Cancer Services** • To share a report on the Patient Reported Outcome Measures piece of work undertaken at a future QSEC meeting.	**PG/ DB**		**Complete:** The scheduling of the report will be agreed during the QSEC agenda setting meeting.
QSEC 25 (25)	**Quality Assurance Report** • To include an update on the concerns raised by Health Inspectorate Wales (HIW) on quality governance within the next Quality Assurance Report.	**CS**	**August 2025**	**Complete:** Agenda Item 3.1

QSEC 25 (29)	**CHKS Update Report** • To forward plan an update to QSEC on the action plan in response to findings from the CHKS report.	**SG**	**August 2025**	**Complete:** The scheduling of the report will be agreed during the QSEC agenda setting meeting.
QSEC 25 (32)	**Nurse Staffing Levels Spring Cycle** • To schedule the presentation on Cadog Ward staff nursing levels as a staff story for the next QSEC meeting.	**KL**	**August 2025**	**In Progress:** Due to unavoidable commitments from the nursing staff, the patient story has been rearranged for October 2025.

AC: Andrew Carruthers	EM: Eleanor Marks	SG: Subhamay Ghosh	KL: Katie Lewis	PG: Paula Goode	CS: Cathie Steele
JW: Joanne Wilson	SD: Sharon Daniel	SH: Stephanie Hire	MD: Mandy Davies		

1.3

1.3 - Self-Assessment - Six month review of actions

Anna Lewis (Hywel Dda UHB - Independent Board Member)

Attachments

1.3 QSEC SA 6 Month update Aug 25.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	14 August 2025
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Quality, Safety and Experience Committee (QSEC) Self-Assessment Outcome Report 2024/25 – Progress Update
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Anna Lewis, QSEC Chair Sharon Daniel, Executive Director of Nursing, Quality, and Patient Experience
SWYDDOG ADRODD: **REPORTING OFFICER:**	Joanne Wilson, Director of Corporate Governance/Board Secretary Charlotte Wilmshurst, Assistant Director of Assurance and Risk

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to provide an update to the actions agreed by the Quality, Safety and Experience Committee (QSEC) in response to the outcomes from the QSEC Self-Assessment 2024/25 process.

Cefndir / Background

In February 2025 QSEC received a report which presented the outcomes of the QSEC Self-Assessment 2024/25 process. For QSEC, this involved:

- Short digital form 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

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

- Matters alerted to the Board
- IM Reflective sessions
- Auditor/Regulator feedback

Asesiad / Assessment

The following actions were agreed in response to the outcomes of the QSEC Self-Assessment 2024/25:

Action	By whom	By when	Progress
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~~ Complete	Within the assessment part of the committee template the author of the paper is required to consider the alignment to the strategic objectives. The strategic objectives will be available for consideration at each agenda planning meeting. Particular focus will be on priority 7 as recommended.
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	Complete	A proposal to de-establish the Quality, Safety and Experience Sub-Committee is being presented to QSEC on 14.08.25.
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 of the Committee (*Priority 1, 2, 3 & 6*)	Chief Operating Officer/Director of Quality, Safety and Patient Experience/ Director of Corporate Governance	Apr 25 Partially complete	Following the organisational change and introduction of Clinical Care Groups, a workshop with the CCG Service Directors, Assistant Directors of Nursing, Quality and Patient Safety and other representatives was held on 9th April and repeated on 10th April 2025. The workshop led by the Executive Director of Nursing and interim Assistant Director of Nursing Assurance and Safeguarding focused on the duty of quality, quality governance arrangements within the CCG, reporting requirements to the Quality, Safety and Experience Sub-Committee and the templates developed to support use of STEEEP

			in report writing. The workshop also considered how the organisational Quality Management System can be used to support discussions and papers. In addition to this quality focused workshop, Corporate Governance training, which includes report writing, with Clinical Care Groups (CCG's) is currently underway. Three out of the five CCGs (Mental Health and Learning Disabilities, Estates and Facilities, Community and Integrated Medicine) have already received training.
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	Complete	Regular updates forward planned on QSEC work plan
Further focus through Board Development for the below areas: -Independent Members effectively managing the boundary between scrutiny and operational	Director of Corporate Governance /Director of Workforce & OD	Complete	Being taken forward by the Board Development Sessions.

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)*			
To ensure the priorities for 2025/26 are considered when setting agenda and requesting papers	Director of Nursing, Quality, and Patient Experience	Complete	Discussed at agenda setting meetings
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	Complete	Piloted at April 2025 QSEC meeting using MS Forms. One response received. Agreed not to take forward.

Argymhelliad / Recommendation

The Committee is asked to take an assurance from the progress made against the actions being undertaken 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

1.4

1.4 - Assurance on Governance Arrangements Report - Executive Leads

•Corporate Risks
• Operational Risks
• Internal and External Audit Reports
• Monitoring of Ministerial Directions
• Monitoring of Welsh Health Circulars (WHCs)

Attachments

QSEC CRR MD Report - July 2025.pptx

Appendix 1 - Corporate Risk Register - July 2025.pdf

Assurance on Governance Arrangements

Quality, Safety and Experience Committee August 2025

Situation

This report provides the Quality, Safety & Experience Committee (QSEC) with the current status of the Corporate risks and Ministerial Directions (MDs) within its remit. The Committee is asked to seek assurance from the Lead Executive Directors that risks are being managed effectively, and that we are compliant with MDs issued to the Health Board. At the time of reporting, there are no Ministerial Directions aligned to QSEC.

Corporate Risks:
9

Ministerial Directions
0

Risk Management - Overview

Effective risk management requires a ‘monitoring and review’ structure to be in place to ensure that risks are effectively identified and assessed, and that appropriate controls and responses are in place.

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

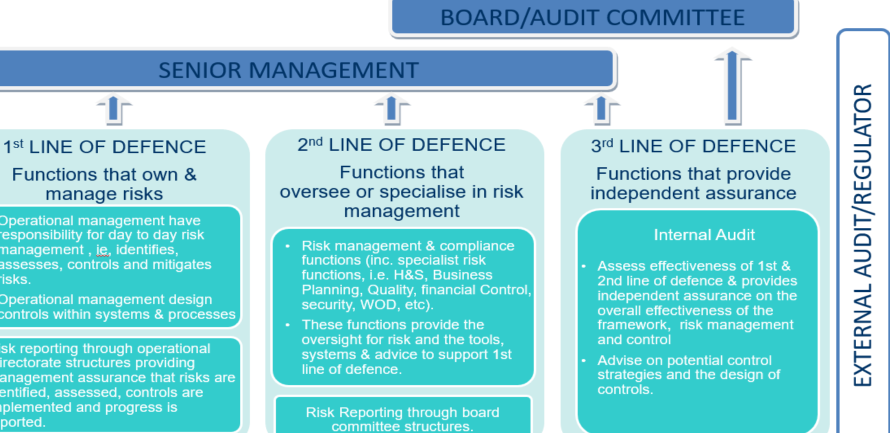
The Health Board operates within the widely accepted “Three Lines of Defence” model to ensure the appropriate responsibility is allocate for the management, reporting and escalation of risk.

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

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

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

A revised approach to risk tolerance was agreed by the Board at its meeting in March 2025 to reflect the organisation’s readiness to bear the risk after risk treatment, in order to achieve its objectives. Risk leads are required to provide a rationale for the target risk score (TRS), and an expected date when the TRS will be achieved. These are mandatory fields on Datix as of 1 July 2025, and therefore where risks do not currently have this detail, risk leads will be asked to provide by the next report to QSEC.



Corporate Risks Assigned to QSEC

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

HYWEL DDA RISK HEAT MAP					
	LIKELIHOOD →				
IMPACT ↓	RARE 1	UNLIKELY 2	POSSIBLE 3	LIKELY 4	ALMOST CERTAIN 5
CATASTROPHIC 5			1531 (→) 1810 (→) 1859 (→)	1027 (→)	
MAJOR 4				684(→) 1708 (→) 1664 (→)	797 (→) 1032 (→)
MODERATE 3					
MINOR 2					
NEGLIGIBLE 1					

Each risk on the Corporate Risk Register (CRR) has been mapped to a Board level Committee to ensure that risks on the CRR are being managed appropriately, taking into account gaps in controls, planned actions and agreed tolerances, and to provide assurance to the Board through their update report on the management of these risks.

These risks have been identified by individual Directors via a top down and bottom-up approach and are either:

- Associated with the delivery of the Health Board objectives; or
- Significant escalated operational risks that are of significant concern and require corporate oversight and management.

There are 9 risks currently aligned to QSEC (out of the 21 that are on the CRR as of 21 July 2025).

The following slide provides a summary of the reportable corporate risks aligned to QSEC. The Corporate Risk Register attached at **Appendix 1**, provides full detail of the risk, including control measures in place, a risk action plan to further manage and mitigate the risk, and sources of assurance.

Corporate Risks assigned to QSEC

Risk Reference & Title	Lead Director	Current Risk Score (CRS)	Target Risk Score (TRS)	Expected Date to Achieve TRS
1027 – Risk to delivery of timely urgent and emergency care due to demand exceeding current capacity	Chief Operating Officer	**20** →	**8**	31/03/2026
797 - Risk to the ability to deliver ultrasound services due to workforce pressures	Chief Operating Officer	**20** →	**12**	30/07/2026
1032 - Risk of timely diagnosis and treatment of Mental Health and Learning Disabilities clients due to demand and capacity	Chief Operating Officer	**20** →	**20**	TRS met as at July 2025
684 - Risk to the timely investment and replacement of Radiology equipment and supporting infrastructure	Chief Operating Officer	**16** →	**8**	Not known
1664 - Risk to ophthalmology service delivery due to a national shortage Consultant Ophthalmologists and the inability to recruit	Chief Operating Officer	**16** →	**10**	31/03/2027
1708 - Risk of increasing fragility in primary care contractor services due to external factors	Chief Operating Officer	**16** →	**12**	TBC
1531 - Risk of being unable to safely support the Consultant on-call rota at WGH & GGH due to workforce pressures	Chief Operating Officer	**15** →	**5**	TBC
1810 - Risk to delivering effective and timely cancer service due to Aseptic Unit facilities being non-compliant with Quality Assurance of Aseptic Preparation Services Standards	Chief Operating Officer	**15** →	**5**	30/09/2026
1859 - Risk of poor patient outcomes and experience due to inability to effectively recognise and manage acute deterioration	Executive Director of N[illegible]ity & Patient E[illegible]	**15** →	**10**	31/12/2025

Corporate Risks assigned to QSEC

Risk 1027 - Risk to delivery of timely urgent and emergency care due to demand exceeding current capacity	
Rationale for Current Risk Score (20)	Rationale for Target Risk Score (8)
Levels of urgent and emergency pathway capacity pressures continue at significantly escalated levels. The situation remains at high levels of risk escalation across our acute sites on a daily basis. Early signs of improvement against key UEC metrics but still outside target requirements. Recent external reviews (NHS Executive Same Day Emergency Care (SDEC) Review, NHS Executive Emergency Department (ED) Review and GIRFT Review on ED) continue to identify concerns with patient flow and quality of service, with a Ministerial Advisory Group (MAG) review received in March 2025.	An expected date of March 2026 has been noted to achieve the target risk score of 8 to allow transformation changes to embed.

797 - Risk to the ability to deliver ultrasound services due to workforce pressures	
Rationale for Current Risk Score (20)	Rationale for Target Risk Score (12)
Service remains fragile. Long term vacancies and maternity leave further impacting fragility. 2 potential retirements which constitute a significant percentage of the workforce. There will be an inability to secure high-cost agency staff due to the current financial climate of the Health Board. However, in the event of recovery monies being made available we will be able to re-initiate the current ultrasound insourcing contract. vacancies have been advertised and appointed as training posts under Annex 21 posts, with trainees expected to qualify in September 2026. May 2025 position has improved slightly for Urgent Suspected Cancer (USC) due to funding received.	The annual plan describing Radiology's demand and capacity work was approved at the March 2025 Board meeting and Radiology are working with executives as of April 2025 to answer queries in relation to the agreed investment. Improvement was seen during Q4 of 2024 and Q1 2025 due to insourcing at additional cost.

1032 - Risk of timely diagnosis and treatment of MH&LD clients due to demand and capacity	
Rationale for Current Risk Score (20)	Rationale for Target Risk Score (20)
The service is experiencing significant waiting times because of increasing demand levels which are exceeding pre-pandemic levels, compounded by the longer-term impacts of Covid. Demand exceeds capacity. Recommendations received from NHS Executive in relation to Children's Neurodevelopmental (ND) services are in the process of being implemented. The Clinical Care Group is working with the Children, Women and Family Clinical Service Group to implement these.	A reduction in the CRS is dependant on securing a regional, strategic approach to creating whole system, needs-led integrated services, in addition to an uplift in recurring funding for Children's ND service, a date for which cannot be provided at this time. Without a credible and deliverable plan, a TRS cannot be provided as at July 2025.

Corporate Risks assigned to QSEC

684 - Risk to the timely investment and replacement of Radiology equipment and supporting infrastructure

Rationale for Current Risk Score (16)	Rationale for Target Risk Score (8)
Aged imaging equipment routinely breaks down causing disruption to diagnostic imaging services across all sites with a significant impact on the Health Board's ability to meet its Referral to Treatment (RTT) target and causing delays in diagnosis and treatment for patients. A plan and rolling programme for the installation of additional equipment is in place. There is a continuous process locally by which equipment is prioritised for replacement.	Once the Nuclear Medicine Single Photon Emission Computed Tomography (SPECT) scanner, the 2nd CT scanner at GGH, and Dual-Energy X-Ray Absorptiometry (DEXA) scanner at BGH have been replaced, the risk score will decrease. This is dependent on WG funding being agreed and the required additional infrastructure in place for machinery to be operational. Without a credible and deliverable plan, a TRS cannot be provided as at July 2025.

1664 - Risk to ophthalmology service delivery due to a national shortage Consultant Ophthalmologists and the inability to recruit

Rationale for Current Risk Score (16)	Rationale for Target Risk Score (10)
Increased demand and reduced capacity continues to be a challenge. Balancing Eye Care Measures for R1 (high risk) patients with Ministerial Measures for longest waiting patients presents a conflicting priority to the service with limited capacity. The current non-medical workforce establishment is not aligned to service needs and workforce challenges have led to an impact on the Health Board's ability to deliver services within the Ophthalmology Referral to Treatment (RTT) plan. Recruitment difficulties have led to the Consultant on-call rota being covered by four substantive Consultants with a gap of two.	A trajectory for the recovery of the R1 Eye Care Measures target has been outlined and the required investment was secured in May 2025 which will allow the service to recover to 65% by March 2026 if all posts are recruited into and all estates needs are met.

1708 - Risk of increasing fragility in primary care contractor services due to external factors

Rationale for Current Risk Score (16)	Rationale for Target Risk Score (12)
The number of complaints received has increased due to returned dental contracts, and while the Health Board is currently containing the demand for urgent dental care, other patients are detrimentally impacted. Any further contracts returned will exacerbate this situation. The capacity of the Health Board to absorb further contract reform will impact on the ability to effectively deliver services and could have a detrimental impact on staff welfare.	A high dependency on external factors makes reduction of the risk score challenging. It is unlikely to be achieved without the approval of the Primary Care Strategy and successful conclusion of contract negotiations with professional contractor groups.

Corporate Risks assigned to QSEC

1531 - Risk of being unable to safely support the Consultant on-call rota at WGH & GGH due to workforce pressures

Rationale for Current Risk Score (16)	Rationale for Target Risk Score (5)
Although the rota in WGH has been stabilised, gaps in the service remain. An NHS locum colorectal consultant was appointed in April 2025, to commence in post in August 2025. The Upper GI substantive consultant posts have been advertised and are currently being shortlisted. Interviews and stakeholder panel are due to take place in August 2025. The substantive colorectal consultant post will be advertised in readiness for the end date of the appointed NHS locum. The service has submitted a request for the Medacs locum at GGH to be extended until the end of August and the NHS locum at WGH to be extended for 6 months, to maintain the service while we recruit substantively.	TRS based on Clinical Services Plan work to identify and approve a sustainable solution and reduce likelihood of rota collapse and of not being able to provide a safe and sustainable emergency general surgery service to patients. The risk score will reduce on the appointment of substantive consultants.

1810 - Risk to delivering effective and timely cancer service due to Aseptic Unit facilities being non-compliant with QAAPS.

Rationale for Current Risk Score (15)	Rationale for Target Risk Score (8)
Withybush Aseptic unit is the only remaining functional unit that can manufacture cancer treatments in the Health Board, with facilities that are currently non-compliant with regulatory standards. An audit by the National Pharmacy Quality Assurance Lead was performed in February 2024 confirmed the facilities were a high risk to patient safety, and the unit is at risk of forced closure. The most recent audit performed during February 2025 highlighted that there is also insufficient resource available to maintain the Quality System against the standards due to staffing fragilities within the service.	Based on funding for new aseptic unit by WG (for HB to comply with regulatory standards and prepare cancer therapy until the Transforming Access to Medicines (TrAMS) South West manufacturing hub is operational), approval of Business Justification Case, unit being operational (Feb 2026), and workforce fragilities addressed (Sept 2026).

1859 - Risk of poor patient outcomes and experience due to inability to effectively recognise and manage acute deterioration

Rationale for Current Risk Score (15)	Rationale for Target Risk Score (10)
Whilst concerns relating to cardiac arrests and unplanned admissions are decreasing, an Acute Physical Deterioration Implementation Network being established (supported by a Clinical Reference Group), and an audit tool developed to monitor National Early Warning Scores (NEWS), compliance rates for Level 3 Resuscitation Training has never been greater than 60%. Staff availability to attend resuscitation training is problematic due to operational pressures and demand. There is therefore a need to identify the most appropriate training level, method of delivery and meeting mandatory requirements.	Recruitment into Resuscitation Team and establishment of a supported cascade training process will increase training compliance by October 2025 to >60%. >85% would enable the risk score to be reduced further to 5. Aim is to reduce cardiac arrest rates across all sites and unplanned admissions into ITU from ward areas by October 2025.

Recommendations

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

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

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SAFE | SUSTAINABLE | ACCESSIBLE | KIND

Risk Ref	Risk (for more detail see individual risk entries)	Executive Director	Domain	Previous Risk Score	Risk Score Jul-25	Trend	Target Risk Score (tolerable score)	Expected Date of achieving Target Risk Score
1027	Risk to delivery of timely urgent and emergency care due to demand exceeding current capacity	Carruthers, Andrew	Safety - Patient, Staff or Public	4×5=20	4×5=20	→	2×4=8	31/03/2026
797	Risk to the ability to deliver ultrasound services due to workforce pressures	Carruthers, Andrew	Safety - Patient, Staff or Public	5×4=20	5×4=20	→	3×4=12	30/07/2026
1032	Risk of timely diagnosis and treatment of MH&LD clients due to demand and capacity	Carruthers, Andrew	Safety - Patient, Staff or Public	5×4=20	5×4=20	→	5×4=20	TRS met as at July 2025
684	Risk to the timely investment and replacement of Radiology equipment and supporting infrastructure	Carruthers, Andrew	Service/Business interruption/disruption	4×4=16	4×4=16	→	2×4=8	Not known
1664	Risk to ophthalmology service delivery due to a national shortage Consultant Ophthalmologists and the inability to recruit	Carruthers, Andrew	Safety - Patient, Staff or Public	4×4=16	4×4=16	→	2×5=10	31/03/2027
1708	Risk of increasing fragility in primary care contractor services due to external factors	Carruthers, Andrew	Service/Business interruption/disruption	4×4=16	4×4=16	→	3×4=12	TBC
1531	Risk of being unable to safely support the Consultant on-call rota at WGH & GGH due to workforce pressures	Carruthers, Andrew	Safety - Patient, Staff or Public	3×5=15	3×5=15	→	1×5=5	TBC
1810	Risk to delivering effective and timely cancer service due to Aseptic Unit facilities being non-compliant with QAAPS.	Carruthers, Andrew	Service/Business interruption/disruption	3×5=15	3×5=15	→	1×5=5	30/09/2026
1859	Risk of poor patient outcomes and experience due to inability to effectively recognise and manage acute deterioration	Daniel, Sharon	Safety - Patient, Staff or Public	3×5=15	3×5=15	→	2×5=10	31/12/2025

Assurance Key:

3 Lines of Defence (Assurance)		
1st Line	Business Management	Tends to be detailed assurance but lack independence
2nd Line	Corporate Oversight	Less detailed but slightly more independent
3rd Line	Independent Assurance	Often less detail but truly independent

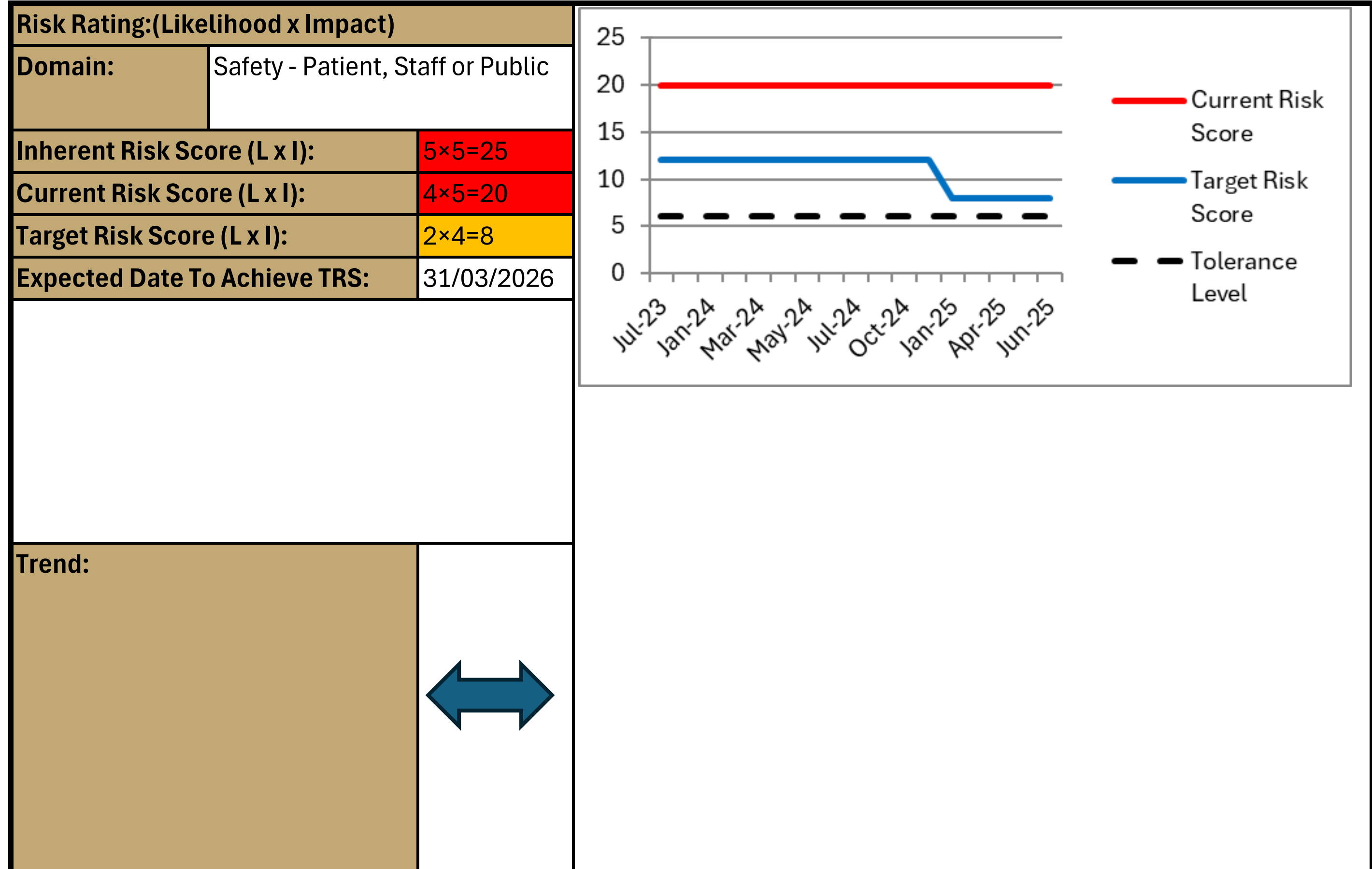
Key - Assurance Required		*NB Assurance Map will tell you if you have sufficient sources of assurance not what those sources are telling you*
(blue)	Detailed review of relevant information	
(pink)	Medium level review	
(purple)	Cursory or narrow scope of review	

Key - Control RAG rating	
LOW	Significant concerns over the adequacy/effectiveness of the controls in place in proportion to the risks
MEDIUM	Some areas of concern over the adequacy/effectiveness of the controls in place in proportion to the risks
HIGH	Controls in place assessed as adequate/effective and in proportion to the risk
INSUFFICIENT	Insufficient information at present to judge the adequacy/effectiveness of the controls

Date Risk Identified:	Nov-20	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Jun-25
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	Quality, Safety and Experience Committee	**Date of Next Review:**	Jul-25

Risk ID:	**1027**	**Corporate Risk Description:**	There is a risk to the consistent delivery of timely and high quality urgent and emergency care. This is caused by significant fragility across the urgent and emergency care (UEC) system (acute, primary care (including out of hours), community and social care services), related to workforce compromise and increasing levels of demand and acuity. This could lead to an impact/affect on the quality of care provided to patients, significant clinical deterioration, delays in care and poorer outcomes, increased incidents of a serious nature relating to ambulance handover delays and overcrowding at Emergency Departments (ED) and delayed ambulance response to community emergency calls, increasing pressure of adverse publicity/reduction in stakeholder confidence and increased scrutiny from regulators.
Does this risk link to any Directorate (operational) risks?	1649, 1406, 1548, 1210, 750, 205, 86, 820, 232, 1298, 1281, 906, 1380, 1116, 878, 839, 1167, 1223, 111, 114, 199, 523, 136, 200, 1115, 1078, 572, 1295, 1231, 966, 967, 565, 852, 1295, 1435, 1377, 1083, 180, 1424, 1417, 1309, 291, 118, 925, 119, 1245, 695		

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	5×5=25
Current Risk Score (L x I):	4×5=20
Target Risk Score (L x I):	2×4=8
Expected Date To Achieve TRS:	31/03/2026
Trend:	⬌



Rationale for CURRENT Risk Score:

Levels of urgent and emergency pathway capacity pressures continue at significantly escalated levels. Workforce deficits, handover delays, 4- and 12-hour performance, bed occupancy rates and significant pressures on wider community and social care capacity are all demonstrating lack of sustainable improvement. The situation remains at high levels of risk escalation across our acute sites on a daily basis.

Whilst some positive progress has been achieved in reducing ambulance handover delays and pathways of care delays, Glangwili Hospital (GGH), Bronglais (BGH) and Withybush (WGH) remain a major pressure in the UEC system.

Whilst recent experience suggests early signs of improvement against key UEC metrics, these remain outside target requirements. Data for May 2025 highlighted that the number of ambulance handovers taking over one hour was 1059, which is significantly over the TI target of 680.

Additionally May's data highlighted a breach in the percentage of patients spending 12 hours of more in A&E / MIU, with the actual figure of 8% noted against the TI target of 7%. The median time to assessment by a clinical decision maker was 70mins (April 79mins), exceeding the TI target of 60 minutes. The Health Board was also over target in relation to Pathway of Care Delays, with actual figure of 234 exceeding the target of 174. As such, the current risk score remains unchanged as at June 2025, pending further review.

Recent external reviews (NHS Executive Same Day Emergency Care (SDEC) Review, NHS Executive ED Review and GIRFT Review on ED) continue to identify concerns with patient flow and quality of service, with a Ministerial Advisory Group (MAG) review received in March 2025.

Rationale for TARGET Risk Score:

The Target Risk Score of 8 reflects the confidence in the delivery of 6 Goals Programme and the Accelerated Transformation Programme to address the significant issues across the health and care system.

Plans for improvement during 2025/26 are reflected in the HB's Annual Plan, approved by the Board in March 2025, and are informing next year's Annual Plan. The 6 goals plan has been approved by WG in March 2025.

TI measures such as ambulance handovers and 12 hour delays in ED will need to improve in order to reduce the current risk score, for a consecutive period of three months.

UEC Transformation Acceleration Group (TAG) meeting weekly and reporting fortnightly into Formal Executive Team.

An expected date of March 2026 has been noted to achieve the target risk score of 8, to allow the transformation change to embed.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Live Operational Dashboard in place and twice HB wide escalation meeting. # Reviews of patients admitted to surged areas to ensure patient acuity and dependency is monitored and controlled. Surge and boarding recorded on the twice a day escalation report. # Frontier system in place for recording DPOC and red days flagging required assessments to support discharge, within continued education at ward level ensuring consistent approach to Board Rounds and Patient Safety Huddles. # Surge beds continue as per escalation and risk assessment of site demand and acuity (where staffing allows). A daily review of the use of surge beds via patient flow meetings to facilitate step down of beds. # Regular reviews of long stay patients over 7 days at weekly meetings across all hospital sites with associated actions in collaboration with social care partners. # Regular advice on discharge planning and complex care management is provided to ward based staff through Community Discharge Liaison teams, social services and the Long Term Care Team support. # Discharge arrangements are in place on all sites with a strategic review underway. # Standardised board rounds processes in place on all sites and D2RA processes are embedded with a 77% D2RA rate (Sep24).	# Fragility of Care Home Sector such as financial viability, staffing deficits, recruitment and retention of workforce. # Significant paucity of domiciliary care/social care availability due to recruitment and retention of staff. # Inability to handover ambulances to release them back for use within community due to lack of flow in acute sites. # Need to have better understanding of ED presentations to ensure development of alternative pathways in primary care / community to prevent ED attendance. # Ability to influence public mind set / expectation and culture in terms of use of NHS resource and 'Home First' Ability. # Gap in communication between secondary and primary care that could lead to poor discharge outcomes. # Clarity regarding roles and	Delivery of 6 Goals Programme and Plan via the workstreams and closer working with WAST and primary care 1. Development of Regional Clinical Streaming Hub (CSH) for Health Professionals & Care Homes delivering 24/7 urgent care advice & support and onward referral to local deliver/resource hubs where appropriate	Skitt, Peter	31/10/2025	Piloting a 7 day model on the CSH across the Health Board as part of winter planning (utilising overtime and additional shifts) with an evaluation being finalised by end of May 2025. The plan to produce a business case for substantive arrangements is including in the Accelerated UEC Transformation work to be delivered by October 2025.
		Develop a consultant led ED medical provision that is fit for purpose and meets the D&C requirements utilising all professions.	Skitt, Peter	~~31/03/2025~~ 30/09/2025	Discussions have started, with a lead for the discussion appointed. Lead ED Consultant had gone out to advert as of May 2025 (closing June 2025) following previous advertisement unsuccessful. advised appointment date of September 2025.
		Utilise the risk stratification data set across the system proactively with the population	Skitt, Peter	~~30/04/2025~~ 31/10/2025	Part of First Home Hub plan and work is underway. Data is being used in primary care multi-disciplinary team meetings across the Health Board and WGH, and requires further embedding to ensure the impact within acute sector is realised.

# Criteria-led discharge guidance and principles piloted across HB (Sep24). # Integrated Regional Winter Plans developed to manage whole system pressures over the winter period and communicated. # An operationally focussed 6 Goals Urgent and Emergency Care (UEC) programme with governance structure agreed where all UEC improvement is coordinated. # Welsh Ambulance Services NHS Trust involved in all 6 Goals UEC workstreams. # 111 and 111 press 2 (MH) implemented across Hywel Dda. # Regional Integration Fund projects in place across Regional Partnership Board (RPB) footprint, along with Further Faster projects to ensure alignment with Ministerial objectives. # Whole system approach to deploy HB staff to ensure continuity of patient care. # Care Home Risk & Escalation Policy to support failing care homes to be applied as required. # Domiciliary Care Risk and Escalation Policy approved by Integrated Executive Group and implemented across the RPB region. # Establishment of a Discharge to Recover and Assess (D2RA) Group which reports to the the 6 Goals Programme with a detailed D2RA improvement plan in place. # Establishment of a D2RA Escalation Transfer panel which provides senior oversight of delays at county level, assesses risk of the delay to the patient and organisation in terms of flow compromise # SRO in place to lead agreed 6 Goals for UEC programme. # Agreed SDEC model in place to maximise impact on admission avoidance. NHS Executive review with associate actions are part of the 6 goals UEC programme. # Local streaming (Home First) hubs developed with a HB wide approach agreed with clinical triage and screening systems in place, including APP	responsibilities for discharge planning and coordination. # The inability to risk stratify for people at moderate to high risk of admission in the community to implement proactive anticipatory care plans to support avoidance of exacerbation / decompensation and hence increased risk of hospital admission. # Optimising our bedded facilities in the community. # Need to develop 24/7 integrated urgent primary care service aligned to Home First hubs. # Insufficient IPC single rooms across community and acute sites, negatively impacting on patient flow. # Lack of level 1 / 2 falls response service during out of hours across the Health Board. # Fragility of senior medical cover at EDs across the acute sites. # Need to create a Health Board wide Frailty approach and appoint a Clinical Lead for Frailty. # 7 day services within the Community are required, particularly around Clinical Streaming Hubs and level 1 /2 Falls.	Review of Community bed based hospital capacity, with a view to ensuring proactive case load management and estate as part of the Alternative Care Model work. Develop & implement strategy for Alternative Care Community (ACP) Provision across the West Wales region.	Skitt, Peter	31/10/2025	Initial planning and audit of capacity has been completed. Length of stay data being gathered by County Leads.
		Enhancements to local delivery / resource hubs to support the CSH providing access to enhanced community care services, third sector services and other pathways to provide safe alternatives to admission. Integration with GP OOHs and APP resources	Skitt, Peter	31/10/2025	Discussions ongoing on providing a single clinical streaming hub across the Health Board footprint, with response resources locally based at cluster level as a phased approach to introducing the care at home blueprint, as described during the 6 Goals review meetings. This will feature strongly in the Accelerated USC Transformation work.
		Development & implementation of consistent approach to Front Door Streaming / Assessment Units focused on our Frail Elderly cohort based on good practice and lessons learnt from Withybush Puffin / South Pembrokeshire model.	Skitt, Peter	31/12/2025	SDEC services available on all sites for medical patients. Surgical SDECs piloted in Glangwili and Bronglais (with further expansion during the next 6 months). Ongoing discussion with Glangwili relating to frailty provision, and further work required in Bronglais (nurse-led frailty team at the front door).
		Development and implementation of HDUHB optimal SDEC model following on from lessons learnt from peer review and alignment with CSH and local resource hubs.	Skitt, Peter	31/10/2025	An SBAR has been developed to standardise the approach across the Health Board, which is to be discussed at the CCG July 2025 meeting.
		Continued implementation of Optimal Flow Framework including Community sites supported by Frontier digital platform.	Skitt, Peter	31/10/2025	On track with roll out plan, and ensuring that all sites are using the framework is ongoing. This work will also feed in to the E-Obs and patient flow project going forward.

Navigator in place.

Direct referral into SDEC in place.

OOH Pilot clinical streaming via GP route ongoing as of January 2025 with a view to full completion at the end of the month

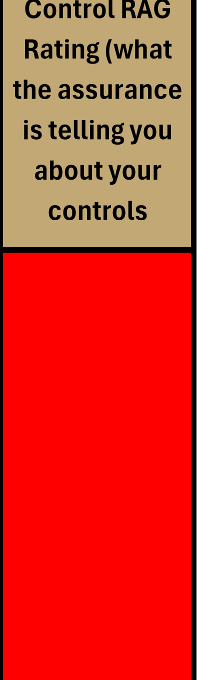
Clinical Care Group structure in place where this risk is discussed at the quality meeting.

#UEC Transformation Acceleration Group (TAG) meeting weekly and reporting fortnightly into Formal Executive Team.

Regional Discharge Strategy Group established, providing oversight of all current work streams, and ongoing work on national and local policies

Regional POCD group established January 2025 with a focus on reviewing trends and themes to inform regional and local action plans

Action	By Who	By When	Progress
Implementation of 7 focused areas within ED Quality statement.	Skitt, Peter	31/03/2026	Clinical lead for ED post currently out to advert. ED Quality Statement Action group in place, who report 6 weekly to Welsh Government. Action plan developed and in place, forming the basis of updates to WG, based around the national toolkit.
Develop West Wales Hospital @ Home model to ensure consistent approach and delivery.	Skitt, Peter	30/09/2025	Phased approach to the delivery of the model, with strategic document currently being developed, to be agreed by clinical leads and 6 Goals advisory group.
Develop robust regional Trusted Assessor (TA) Model to ensuring consistent approach to assessment across the region - residents can be an inpatient at any of the 4 x general hospital sites.	Skitt, Peter	31/10/2025	Trusted Assessor regional group in place focussing on the model and reporting required to Welsh Government, aligned to further faster monies. A National Audit is to take place in Summer 2025 on Trusted Assessors across the West Wales region.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level		
Ambulance handovers within 15 minutes Ambulance handovers over 1 hour Ambulance handovers over 4 hours	Medically optimised and ready to transfer patients are reported 3 times daily on situation reports	1st			
	Daily performance data overseen by service management	1st			
	Workstream Delivery Plans overseen by 6 Goals Programme	2nd			

Gaps in ASSURANCES				
Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
None identified.				

4 & 12 hour waits in A&E Time to triage in A&E Time to see a Doctor in A&E Pathway of care delays	6 Goals Programme / UEC IQFPD 3As report into IQFPD	2nd								
	Bi-annual reports to SDODC on progress on delivery plans and outcomes (and to Board via update report)	2nd								
	IPAR Performance Report to SDODC & Board	2nd								
	IA review on Transforming Urgent and Emergency Care	3rd								
	NHS Executive Same Day Emergency Care (SDEC) Review	3rd								
	NHS Executive ED Review	3rd								
	GIRFT Review on ED	3rd								
	MAG review	3rd								

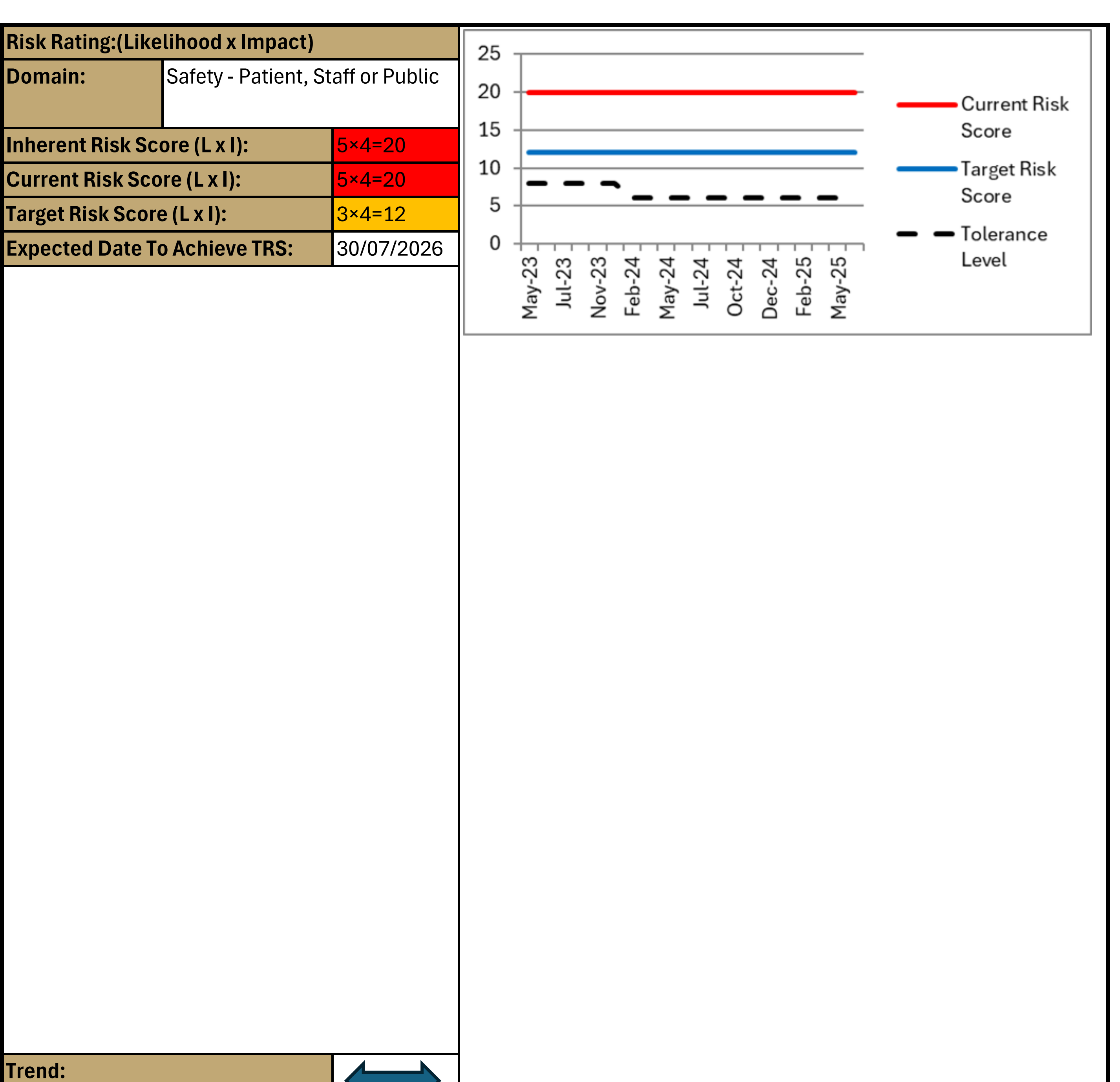
Date Risk Identified:	Nov-19
Strategic Objective:	

Executive Director Owner:	Carruthers, Andrew	Date of Review:	Jul-25
Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Aug-25

Risk ID:	797	Corporate Risk Description:	There is a risk of being unable to provide a full range of ultrasound services including obstetric and non-obstetric ultrasound across the Health Board. This is caused by workforce pipeline and retention: the retirement and resignation of current sonography staff, low availability of sonographers UK wide, and the inability to recruit to due national shortages of qualified staff, and the inability release existing workforce to train and develop to meet both current and future service demands. Current pressures are also leading to existing staff harm due to repetitive strain injuries (RSI). demand and capacity: there is a gap between funded establishment and demand for ultrasound services This could lead to an impact/affect on patient safety: delays in diagnosis which could result in detrimental outcomes for patients, inability to meet diagnostic targets and cancer pathway targets, and an inability to hold clinics to meet demand in ante natal screening services within required timescales and to implement national scanning guidance. workforce: An impact on staff health and wellbeing in terms of the volume of patients examined within a shift/overtime, which could lead to increased incidents of staff stress and burnout. This could ultimately lead to increased errors when performing the dynamic diagnostic test. This could also lead to increased RIDDOR reporting due to the harm being caused to staff. compliance and litigation: increased instances of RIDDOR and health and safety reporting could trigger monitoring actions by relevant regulator. In the case of obstetric ultrasound, this could lead to failure to detect in utero anomalies, life long, limiting or changing duration which places the Health Board at significant risk of litigation

Does this risk link to any Directorate (operational) risks?	1557, 1349, 1658, 1936, 2068

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	5×4=20
Target Risk Score (L x I):	3×4=12
Expected Date To Achieve TRS:	30/07/2026
Trend:	



Rationale for CURRENT Risk Score:	Rationale for TARGET Risk Score:
Despite best efforts, the service remains fragile. As of January 2025, remaining vacancies have been advertised and appointed as training posts under Annex 21 posts, with trainees expected to qualify in September 2026 If all vacancies were recruited to, the Health Board would still not have the capacity to meet current demand (as at end March 2025) there were 1,110 patients waiting 8 weeks plus for non-obstetric ultrasound (February 2024:1288, March 2024:917, April 2024:962,May 2024:731,June 2024 608, July 2024 555, December 2024: 1,960, Jan 2025: 2,301). Reduction in 2025 due to insourcing ultrasound services Long term vacancies exist in Withybush with maternity leave which started in summer of 2024 impacting the fragility further. There are 2 potential retirements at PPH in the near future and a number in BGH, which constitute a significant percentage of the workforce. There will be an inability to secure high cost agency staff due to the current financial climate of the Health Board. However, in the event of recovery monies being made available we will be able to re-initiate the current ultrasound insourcing contract Three Radiographer sonographers and two Midwife sonographers commenced training in January 2024, however training takes two years to complete for Radiographer Sonographers and 1 year for midwife sonographers (obstetric only). Since receiving funding in April 2025, the May 2025 position has improved slightly for USC: 33% of ultrasound USC's carried out and reported in 7 days (March 2025: 13%), 48.77% carried out and reported in 14 days at end May 2025 (March: 37.53%).	The actions below will not in themselves reduce this risk significantly. Demand and capacity and the current establishment review is being undertaken by the Ultrasound control group via a needs assessment which was due to be completed by the end of Autumn 2024. It is likely that these reviews will lead to a need for further investment and additional funding to establish a sustainable service model to include a robust perpetual training programme, that will enable the Health Board to met expected diagnostic waiting times targets. Radiology wide demand and capacity work has been undertaken by the Radiology Department which has included the non-obstetric element and has been described in the 2025-2026 annual plan and as of 24/01/2025 an accompanying paper for Board consideration requesting workforce investment in Radiology was submitted on 11/02/2025 and describes the plan for recruitment and expansion of training in all areas of Radiology, including Ultrasound. The annual plan was approved at the March Board meeting and Radiology are working with executives as of April 2025 to answer queries in relation to the agreed investment. Improvement has been seen during Q4 of 2024 and Q1 2025 due to the insourcing at additional cost.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS** **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Process in place for the movement of staff across the Health Board to maintain capacity where possible. Conversion of room to increase capacity @ GGH Employment of Physiotherapists and Midwives to undertake scanning within scope of expertise Utilising insourced ultrasound service to reduce backlogs of patients waiting >8weeks (recovery funded). Rolling bank adverts for sonographers. Clinical Educator in post, facilitating the expansion of training across site. Monitoring of cancer patient pathways with ultrasound requirements via weekly Cancer Watchtower, and monthly Cancer and Radiology escalation meetings. Meetings chaired by General Manager of Planned Care and Cancer Services. Continuous recruitment and training of sonographers within current establishment Annex 21 process in place, commencing in January of each year, to train over a period of 2 years sonographers Funding to improve USC times was received in April 2025, both insourcing and 1 WTE sonographer. Locum sonographers have also been utilised.	Inability to recruit and retain sufficient numbers of trained staff. Whilst staff are on the Annex 21 programme, they are not fully qualified until completion of 2 years training and preceptorship (these gaps are covered by insourcing during this period of time) While process in place regarding the movement in staff, due to current staffing levels and pressures, this is not being implemented, however the teams across sites are collaborating and look at all possibilities when gaps in rota arise and are foreseen. Whilst an Ultrasound Control Group is in place, meetings are infrequent due to availability of attendees.	Develop and implement a plan to help alleviate pressures through increasing the number of growth scan checks undertaken by midwives.	Llewellyn, Cerian	~~31/12/2022~~ ~~31/10/2023~~ ~~31/01/2024~~ ~~30/06/2024~~ ~~31/01/2025~~ 31/01/2026	The date of completion of this action has been changed to 31/01/2026 as the midwife identified for training did not start until Jan 2025 due to lack of process to support the clinical aspects and a change in maternity management. Maternity and child health are required to advise of the plan to utilise the skills of the trainee midwife sonographer and also any plans to train more staff. June 2025: Midwife sonographer is now undertaking required training and expected to qualify in January 2026.
		Train members of staff to become sonographers, the number of which dependant on capacity to take training.	Roberts-Davies, Gail	~~31/03/2020~~ ~~31/12/2022~~ ~~01/02/2023~~ ~~30/09/2024~~ 31/01/2026	April 2025: Approval of annual plan in April , however additional recovery funding has not yet been sourced. Current phasing when signed off will allow the recruitment of 1 additional Sonographer due to the need to fund recovery from recurrent monies. June 2025: Plans to train more staff in 2025-27 via Annex 21 (at least 2 more training posts)

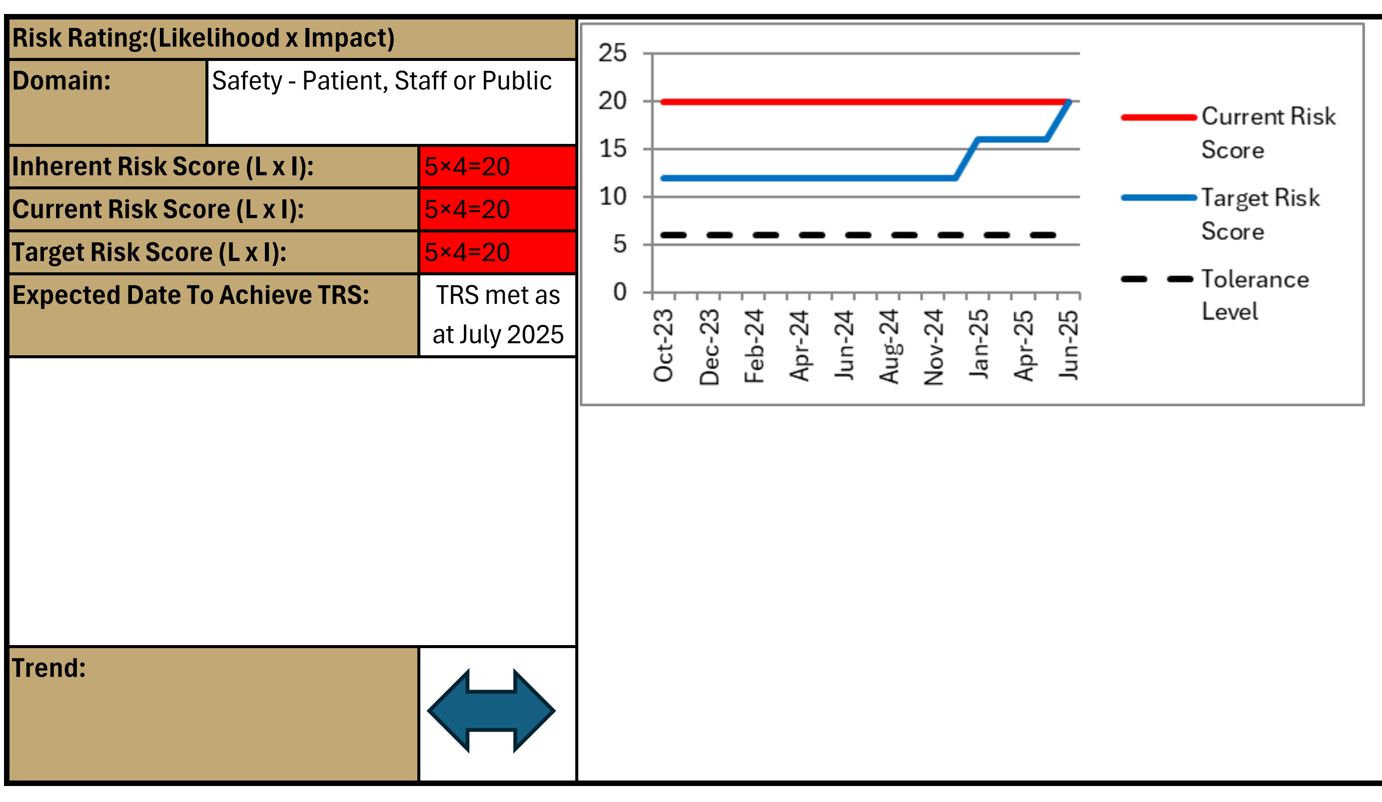
		Action	By Who	By When	Progress
		Await outcome of Radiology Annual Plan and request for additional workforce investment to enact next phase of recruitment to train.	Roberts-Davies, Gail	Completed	08/04 update. Approval of annual plan, however additional recovery funding has not yet been sourced. Current phasing when signed off will allow the recruitment of 1 additional Sonographer due to the need to fund recovery from recurrent monies.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Non-Obs ultrasound - longest wait 53 weeks as at end March 2025 with 1,110 patients waiting over 8 weeks. Radiology Dashboard IPAR Reports WG Cancer PTL, reported monthly	Management review of sonography and SCP diagnostic waiting times	1st			Sonography Report to Acute Leadership Group (ALG) and Operation Planning and Delivery Programme meeting					
	Monthly review of USC performance undertaken monthly (13.82% of ultrasound USC's carried out and reported in 7 days, 37.53% carried out and reported in 14 days at end March 2025), included in the IPAR & reported to WG	1st								
	Performance monitored at Executive Improving Together Sessions	2nd								
	Performance monitored via IPAR, overseen SDODC & Board	2nd								
	Ultrasound Services Internal Audit, July 2024 reasonable assurance provided	3rd								

Date Risk Identified:	Nov-20	Executive Director Owner:	Carruthers, Andrew	Date of Review:	Jun-25
Strategic Objective:	4. The best health and wellbeing for our individuals and families and our communities and 5. Safe and sustainable and accessible and kind care	Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Jul-25

Risk ID:	1032	Corporate Risk Description:	There is a risk to the delivery of timely diagnosis to those on the ASD waiting lists within required timescales - Welsh Government performance standard of 26 weeks. This is caused by an increase in referrals, with demand outstripping capacity and lack of sustainable external funding. This could lead to an impact/affect on those currently awaiting diagnosis and intervention, resulting in delays in care and appropriate support and signposting in a timely manner which may lead to poorer patient outcomes, and delayed adjustments to educational needs. There will also be an impact on the ability of the Health Board to meet Welsh Government targets (diagnosis of ASD within 26 weeks) and the ability to meet the Health Board agreed trajectory of 1% improvement per month which could lead to increased scrutiny from regulators, and escalation from Welsh Government. This in turn could result in adverse publicity and a reduction in stakeholder confidence.
Does this risk link to any Directorate (operational) risks?			138, 1249, 1286, 1287, 1392, 1455, 1422, 1524, 1290, 1260, 1699, 1745, 1414

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	5×4=20
Target Risk Score (L x I):	5×4=20
Expected Date To Achieve TRS:	TRS met as at July 2025
Trend:	⬌



Rationale for CURRENT Risk Score:

The service is experiencing significant waiting times as a result of increasing demand levels which are exceeding pre-pandemic levels, compounded by the longer term impacts of Covid. Demand exceeds capacity. Some posts continue to be funded on fixed term basis which can make staff retention challenging along with having to train new incoming staff.

Recommendations received from NHS Executive in relation to Children's ND services are in the process of being implemented. The Clinical Care Group is working with the Children, Women and Family Clinical Service Group to implement these.

For Autism Spectrum Disorder (ASD), a meeting took place with the NHS Executive to establish trajectories, along with the commissioned service which since have been agreed in March 2023. The NHS Executive were unable to provide trajectories, therefore Health Board has agreed to a 1% monthly improvement trajectory.

In order to move to whole-system, needs-led approaches, this requires regional collaboration and commitment to prioritise innovative, integrated ways of working, focusing on social models of health. Until this is in place, ND will remain a 'health' problem and exponential demand likely to continue.

Rationale for TARGET Risk Score:

The Clinical Care Group has prioritised implementation of WPAS in Children's ASD service which has enabled improved reporting and waiting list management and to determine trajectories of improvement in waiting times. However, the target risk score has increased.

In July 2024, WG announced that ND services across Wales were unable to meet waiting time targets for CYP ND unless rapid, transformational whole-system change was implemented. While trajectory plans are in place, the Health Board has recognised WG targets will not be achieved by the service in its current format, with a further deteriorating position in performance anticipated, compounded by the end of procurement contracts with external providers in March 2025.

The target risk score will be dependent on securing a regional, strategic approach to creating whole system, needs-led integrated services, in addition to an uplift in recurring funding for Children's ND service to develop alternative clinical and support pathways; permission to explore and implement use of artificial intelligence and other digital innovations well as having access to appropriate clinical venues.

A target risk date cannot be provided at this time

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Use of IT/virtual platforms such as Attend Anywhere when appropriate to encourage blended approach to working. Additional WG funding received in 2022/23/24/25 for ND services - currently awaiting confirmation for the next three year cycle. Weekly Autism Advice Hubs in place for parent carers and CYP Rolling programme of workshops offering advice and support around neuro-divergence for parents of children aged 2-11 years and 12 years and over awaiting diagnostic assessment. Monthly meetings to meet recommendations of NHS Executive's Action Plan in respect of CYP ND services in place. ND Service Delivery Manager appointed and in place to help improve performance and drive innovative practice in line with WG policy and legislation. Workforce stabilised with no retention issues. Workforce Management Group established and workforce plans in place.	Although dedicated premises have been sourced for ASD services, there is limited clinical space and Estate issues remain a challenge as identified in the risk narrative. Additional funding received in 2022/23 for ND service on fixed term annual basis until 2025. Awaiting ministerial directive on allocation of additional monies 2025/2026 Current resource does not provide sufficient capacity to meet demand. Current procurement exercise to outsource portion of diagnostic assessments to external provider for children and adult services ends March 2025 and will further negatively impact trajectory.	Development of a MH/LD essential training framework to reflect training needs across MH/LD services based on a systematic Training Needs Analysis that can be reviewed at regular intervals and monitored for compliance.	Temple-Purcell, Rebecca	Completed	New Action

Workforce Management Group established and workforce plans in place. Trajectories have been agreed for Children's ND by NHS Executive and systems in place to monitor waiting lists at service level performance-management meetings, IPAR and Clinical Care Group BPPP meetings. Use of HB Third Party Contractor to send out Keeping in touch letters to those on ASD waiting lists on a 3-4 monthly basis confirming place on waiting list and signposting to sources of support including access to ND services and other services while waiting. Use of Covid recovery monies to outsource portion of diagnostic assessments over a 3 year period 2022-2025 for all ages Additional NDIP, WG & Health Board slippage funding secured to outsource a further portion of diagnostic assessments for all-age ADHD and ASD assessments in 2025. Quarterly meetings with the NHS Executive, Welsh Government and Service Leads at the Health Board. SMS text functionality in place for ND to improve attendance and decrease instances of non attendance. Support workers recruited in to Children's ND service. "Rapid Access to Diagnosis " (service improvement initiative) currently being piloted in Children's ND. Started in April 2025.	Rapid Design Event to achieve critical, systemic and needs led transformation of children's ND services held on 27th and 28th of November 2024. Awaiting outcome report from Welsh Government. Keeping in Touch letters not being sent as of May 2025 - there is a contract monitoring meeting taking place as they haven't been meeting the standards set.	ND specific HB internet and intranet pages in development to give guidance and support whilst neuro-divergent individuals and parent carers are waiting.	vaughan, Catherine	~~31/10/2024~~ ~~31/12/2024~~ ~~31/03/2025~~ 30/09/2025	Series of meetings held with Communications team and ND services prioritised to include children's ADHD, Adult ADHD, Integrated Autism Service and Children's ASD service Website remains in development, although all material ready. Adult IAS and Childrens ND content now ready. Awaiting final go live. Children's ADHD and Adult ADHD website has been launched. Digital accessibility issues are being worked through. Due to go live September 2025.
Developed an Early Years pathways for Health Visitors. Social Care and Education Interface Meeting with Carmarthenshire Local Authority to stem the flow (promoting a needs-led approach). Fixed term contracts have been agreed for staff until the end of March 2026. Additional resource for admin cover to ND services for a 12 month period. Website developed for all-age ND services		Grow your own' scheme is coming into place with funding provided in academic year 23/24 for 3 places on the Clinical Psychologist programme (3 year programme).	Carroll, Mrs Liz	~~31/12/2024~~ 31/12/2027	Three year training programme with graduates during 2027.

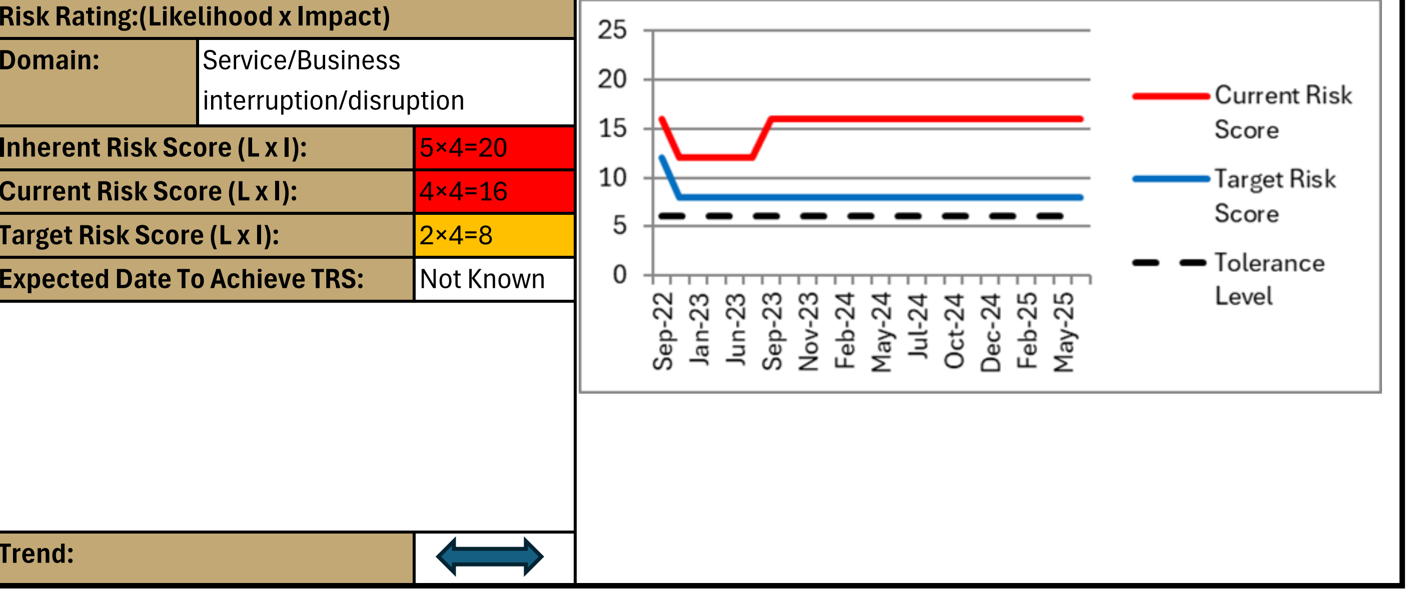
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Welsh Government performance indicators along with internal monitoring arrangements will be used to ensure the actions are having the desires effect or whether there is more that needs to be done.	Management monitoring of referrals	1st			Update - Risk 1032: Mental Health and Learning Disabilities Waiting Lists - QSEC (Oct21) MHLD progress update on Planning Objective 5G - Board (Mar22) Papers have been presented at the Quality Safety and Experience Assurance Committee with a further update paper provided for the December 2021 meeting outlining control measures to manage the waiting times that the Directorate have at present. A	System to improve analysis of patient experience				
	Monthly MH&LD Business Planning and Performance Group overseeing performance	2nd								
	MH&LD QSE Group overseeing patient outcomes	2nd								
	Update - Risk 1032: Mental Health and Learning Disabilities Waiting Lists - QSEC	2nd								
	W-PAS Internal Audit (reasonable assurance(	3rd								
	An update was requested by the Chair and provided for the August Quality, Safety, Assurance Committee.									

	An updated paper was submitted to the March 2025 Board meeting.				paper was presented at Board Seminar in March 2025 to provide assurance on current waiting times and control measures.					
	Rapid Access Pilot Steering Group (add as action - look at other pathway options/digital) - renamed ASD Task and Finish group and run weekly, sponsored by Executives									

Date Risk Identified:	Jan-19	Executive Director Owner:	Carruthers, Andrew	Date of Review:	Jul-25
Strategic Objective:	N/A - Operational Risk	Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Aug-25

Risk ID:	684	Corporate Risk Description:	There is a risk to the radiology service provision from breakdown of key radiology imaging equipment and associated infrastructure to enable equipment to function. This is caused by equipment not being replaced in line with RCR (Royal College of Radiologists) and other guidelines, and also lack of suitable physical space and electrical infrastructure. This could lead to an impact/affect on patient flows resulting from delays in diagnosis and treatments, delays in discharges, increased waiting times on cancer pathways, increased staffing costs to minimise the impact on patients when breakdowns occur and increased number of SCP breaches and breaches over 8 weeks due to increased downtime. Increased risk of IR(ME)R notifiable radiation incidents due to increased breakdowns as a result of malfunctions during exposures.
Does this risk link to any Directorate (operational) risks?	925, 114, 1668, 1785		

Risk Rating:(Likelihood x Impact)	
Domain:	Service/Business interruption/disruption
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	4×4=16
Target Risk Score (L x I):	2×4=8
Expected Date To Achieve TRS:	Not Known
Trend:	⟺



Rationale for CURRENT Risk Score:	Rationale for TARGET Risk Score:
The Health Board's stock of aged imaging equipment routinely breaks down causing disruption to diagnostic imaging services across all sites which has a significant impact on the Health Board's ability to meet its Referral to Treatment (RTT) target and impact to patients can include delays in diagnosis and treatment. CT and MR scanners have been replaced and has reduced the frequency of machine downtime compared to previous experience. The risk score is noted as 16 reflecting that some equipment has been installed and is operational, however further investment is required due to recurrent breakdowns of aged key imaging equipment. A plan and rolling programme for the installation of additional equipment is in place. There is a continuous process locally by which equipment is prioritised for replacement. Gamma camera at Withybush General Hospital is the only scanner of its nature in the Health Board, and has experienced a series of breakdowns in 2023 and 2024 due to intermittent failures which resulted in several HIW reportable IRMER incidents. This item of equipment is on the current priority list of items to replace as at February 2025. While a new CT scanner has been obtained and installed at Glangwili, the original CT scanner is having regular breakdowns. The technology on this scanner is also now out of date and impacts directly on the resilience of the service at our major trauma site in the Health Board. Like-for-like replacement of existing equipment is not necessarily a cost effective method of maintaining services and in certain circumstances does not meet updated regulatory compliance or meet the requirements of maintenance warranty agreements. This means there will need to be upgraded infrastructure such as air handling units, water chiller systems and the size/accommodation for modalities at an initial increased cost but representing long term savings and service resilience overall. April 2025 The DEXA unit at BGH is aged and with the advent of trabeculae bone scoring, any new scanner will have a larger footprint compared with the current scanner and along with necessary shielding required, this may mean that the current DEXA room will be unsuitable to accommodate any new scanner. The technology gap has widened between	WG funding has been secured to replace a fluoroscopy unit and a CR x-ray unit at WGH along with a much needed MRI upgrade at PPH during the 24-25 financial year. With more modern equipment, breakdowns will be less likely and less significant in terms of downtime together with a reduced impact on the diagnostic services at the remaining hospital sites. Improved business continuity plans will also help reduce the impact of equipment breakdown across the UHB. Due to the nature of the release of funding which is usually in Q3/Q4 of the financial year it is difficult to plan large installations due to the speed at which the replacement need to be completed. This means that sometimes equipment of lesser priority is replaced before the bigger installations which have a greater need. The number 1 replacement priority in the Health Board is to replace the Nuclear Medicine SPECT scanner. This is a service risk as it is the only scanner in the HB (Risk 1706, score 20) and has suffered frequent breakdowns since June 2023. A specific task and finish group has been convened to forward plan the replacement in anticipation of WG funding. The second CT scanner at GGH is a second priority as this is relied upon to undertake outpatient work and as a back up scanner. This is aged and is having increasing breakdown outages with long lead time to source parts. In addition to this the variation between the DEXA services provided via the SBUHB SLA and at BGH has been made worse by the fact that the Swansea scanner now undertakes Trabecular Bone Scoring (TBS) which is a new and very important way of assessing bone structure. The BGH scanner is unable to do this and there have been a few recent cases of patients who have recently had a DXA in BGH who are now having another DXA in the SBUHB mobile unit because we need obtain the TBS results. The version of windows which this scanner runs on is no longer supported and so is a further risk to the Health Board. Once the Nuclear Med SPECT-CT scanner, the 2nd CT scanner at GGH and the DEXA scanner at BGH have been replaced we would look to seek permission to reduce this risk score and to move the risk directorate level. This is dependent on WG funding, and may not be complete until the end of the 26-27 financial year due to the additional infrastructure required.

the services provided at Swansea with concerns raised by referring clinicians.

The only HB Nuclear Medicine SPECT scanner is overdue for replacement and remains a significant risk to continuity of service provision. The equipment replacement Task & Finish team are currently looking into options and specifications in readiness for potential funding which was discussed at the National Imaging Equipment and Capital Priorities (NIECP) Group review panel on 02/04/2025. Correspondence was received from WG in May 2025 that Nuclear Medicine would be a priority for this year following provision of costing.

June 2025
Due to limitations caused by lack of appropriate physical space and insufficient electrical infrastructure, the costing for replacing the Gamma Camera at WGH has exceeded the expected amount available from WG (£8.6m) within current 2025/25 financial year and therefore the window for funding has been closed.

This delay in replacement scheme is further impacting our ability to comply with NRW specification for Nuclear Medicine Department (NRW report 2023/24).

Future plans will need to be coordinated with Estates to provide more electrical supply and equipment to ensure site meets current and future specifications of Radiology's Nuclear Medicine plans.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Service maintenance contracts in place and regularly reviewed to ensure value for money is maintained. # The difficult to source spares can be obtained through bespoke manufacture but this invariably results in inherent delays in returning equipment to service. # Regular quality assurance checks (eg daily checks). # Use of other equipment/transfer of patients across UHB during times of breakdown. # Ability to change working arrangements following breakdowns to minimise impact to patients. # Site business continuity plans in place. # Disaster recovery plan in place. # Replacement programme has been re-profiled by risk, usage and is influenced by service reports. # Escalation process in place for service disruptions/breakdowns. # National Imaging and Capital Priorities Group ensures there is a robust governance process to support a national, sustainable clinically focused capital equipment programme across Wales. This will ensure that all HB's in Wales agree to a prioritisation process which will allow for timely equipment procurement and delivery to support healthcare demands across Wales. # All equipment at main sites are now DR and so will be compliant with the RISP project # Additional WGH EOY funding was secured (23-24 financial year) and replaced aged US units and upgraded the software on MRI scanners at BGH and WGH providing latest technology.	Limitation of spare parts for some older equipment leading to extended outages. This issue has been compounded by Brexit. Increased use of site contingency plans puts pressures on patient flows, discharges, diagnosis at other sites. Reliance on AWCP for replacement of equipment. Inability to undertake specific replacements at this time due to the additional infrastructure required National Imaging and Capital Priorities Group outcomes do not always align with the Health Board priorities, and is subject to negotiations within the group.	Installation of replacement Gamma Camera, WGH Gamma camera is 9 years old and the only scanner in the Health Board providing a regional service. Recurrent breakdowns are resulting in HIW reportable incidents.	Roberts-Davies, Gail	~~31/07/2024~~ ~~30/06/2025~~ ~~31/03/2026~~ 31/03/2027	No funding allocated as of 09/02/2024 This will not be replaced in the 24/25 financial year. A specific T&F group is due to be set up as of June 24 to plan the necessary accommodation improvements required. July 2024 the T&F group has been set up and meets weekly Feb 2025 there is a draft plan for replacement. Business continuity plans being explored. The plan has been rejected by WAG for 25/26 due to cost and the electrical instruction T&F looking to alternative sites and will resubmit for funding in 26/27.
		Replacement of aged CT Scanner at GGH	Procter, Sarah	~~31/03/2024~~ ~~31/07/2024~~ ~~30/06/2025~~ 31/07/2026	Awaiting confirmation of funding as at December 2023. No funding allocated as of 09/02/2024 This will not be replaced in the 24/25 financial year. Following a National Equipment Capital Priorities Group Meeting held on 02/04/2025, The CT replacement of the aged at GGH has been recommended, however funding has not yet been formally agreed.

			Replacement of Fluoroscopy room, WGH	Whitecross, Faith	~~31/03/2024~~ ~~31/07/2024~~ ~~31/03/2025~~ 31/08/2025	Additional infrastructure required to replace this piece of equipment and so will not be completed until the 2025-2026 financial year. Update feb 25: funding approved for installation of fluoroscopy equipment 25/26 financial year.
			Replacement of CR X-ray Room 1, WGH	Roberts-Davies, Gail	Completed	Ageing equipment. In order to remain in service, this replacement must be completed by August 2026 due to the end of current Fuji contract. This will not be replaced in the 2023/24 financial year Confirmation that this piece of equipment will be replaced in the 24/25 financial year was received late May '24- action will be closed when this piece of equipment is operational. Equipment replacement complete as of 08/04/2025- awaiting acceptance testing. Update 04/07/2025 confirmation from Site Lead Faith Whitecross that the acceptance testing was completed 02.04.2025. SQ

Replacement of CR X-Ray room, Llandovery Hospital	Osell, Fiona	~~31/03/2024~~ ~~31/07/2024~~ ~~30/06/2025~~ ~~01/12/2025~~ 31/03/2026	Equipment on site is incompatible with the incoming PACS system X Ray room continues to be in use one day per week (Tuesdays) staffed by 1 Radiographer (B5 or B6). Regular maintenance of equipment continues and required QA testing. In order to remain in service, this replacement must be completed by August 2026 due to the end of current Fuji contract. This will not be replaced in the 2025/2026 financial year. Progression of this project reliant upon the outcome of the clinical services plan which is out to consultation
Replacement of Mammography Units, BGH and WGH	Roberts-Davies, Gail	~~31/03/2024~~ ~~31/07/2024~~ ~~30/06/2025~~ 31/03/2027	Ageing equipment, exacerbated by the failure of Securview. These will not be replaced in the 23/24 financial year These will not be replaced in the 2024/2025 financial year These will not be replaced in the 2025/2026 financial year

Upgrade or replacement of MRI scanner, GGH	Procter, Sarah	~~31/03/2024~~ ~~30/06/2025~~ 31/03/2026	Ageing equipment with increasing failures, with new technologies now available. Awaiting confirmation of funding as at April 2024. This will not be replaced in the 24/25 financial year. Following a National Equipment Capital Priorities Group Meeting held on 02/04/2025, The MRI upgrade of the aged scanner at GGH has been recommended, however funding has not yet been formally agreed.
To replace the DEXA scanner at BGH and ensuring suitable accommodation is found to meet regulatory compliance for a larger more modern scanner.	Edwards, David	~~31/03/2024~~ ~~30/09/2024~~ ~~30/09/2025~~ 31/03/2026	Unit is 17 years old, and previously funded via charitable funds This has been added to the imaging priorities list and end of year additional funding projects as relative replacement costs are not high, however the infrastructure enablement costs are additional and a suitable location to accommodate a larger scanner needs to be found. Following a National Equipment Capital Priorities Group Meeting held on 02/04/2025, The replacement of the aged DEXA scanner at BGH has been recommended, however funding has not yet been formally agreed.

		Collaboration with Estates to ensure requirements for Radiology at all sites are considered and are integral to future decision-making for site allocation	Procter, Sarah	30/09/2025	This action has been added following a request from QSEC in June 2025 to consider how we include the nature of our Estate within this risk. Initial communication to be established in June 2025 to agree on timelines for future workplan. Estates are currently part of Task & Finish Group, however Head of Engineering to be invited. Further actions to be added based on outcomes.

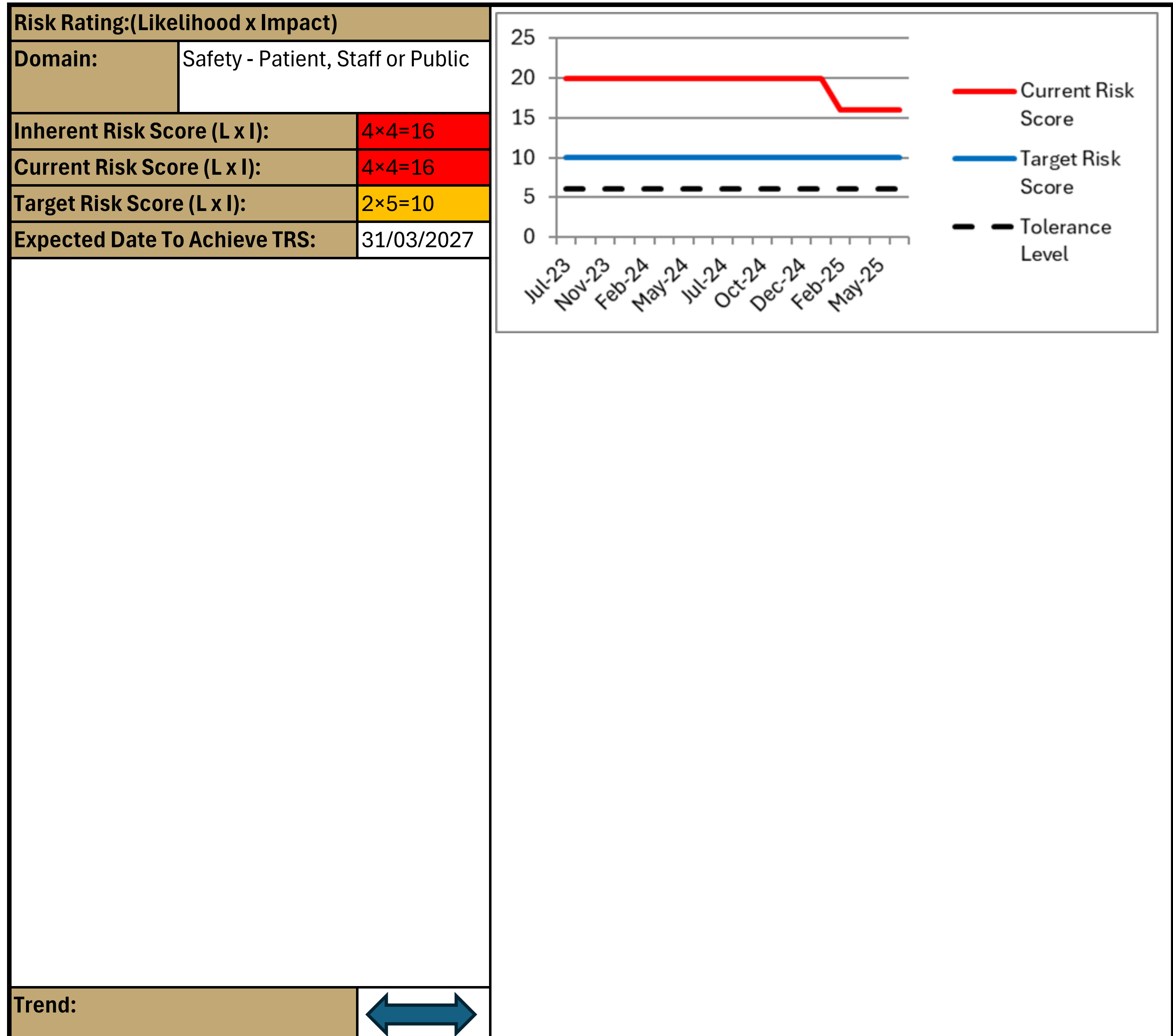
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Reduction of waiting times to under 8 weeks. No SCP diagnostic breaches.	Monthly reports on equipment downtime and overtime costs	1st			Radiology Equipment SBAR - Executive Team Mar19 Further updates CEIMT Feb20 Further updates CEIMT Sep20 Radiology Diagnostic Imaging update to Capital Sub-Committee presented September 2024	Lack of process of formal post breakdown review.				
	IPAR report	2nd								

Date Risk Identified:	May-23	Executive Director Owner:	Carruthers, Andrew	Date of Review:	Jun-25
Strategic Objective:	5. Safe and sustainable and accessible and kind care	Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Jul-25

Risk ID:	1664	Corporate Risk Description:	There is a risk to service sustainability in Ophthalmology across the Health Board, and the inability to provide timely care to patients with Glaucoma, wet Age Related Macular Degeneration (wAMD), Vitreoretinal and Cataracts. This is ongoing 25/04/2025 This is caused by a national shortage of Consultant Ophthalmologists and the inability to recruit to vacancies. The workforce position is exacerbated by nursing and medical staffing constraints and a reduction in service capacity due to lack of physical space, and long-term funding. Recruitment difficulties are leading to the Consultant on-call rota being covered by four substantive Consultants with 2 gaps in the rota. To ensure the delivery of the Ophthalmology service the Consultants undertake additional duty hours. This is a fragile on call structure which is impacted by sickness and annual leave. This could lead to an impact/affect on ability to deliver services within the Ophthalmology Referral to Treatment (RTT) plan, and the ability of the Health Board to comply with Welsh Government Eye Care Measures (ECMs). This impacts the ability to provide timely diagnosis and treatment, directly impacting on patient safety, with the potential for sight loss and long-term lifestyle impacts. The Health Board's ability to progress with the implementation of recommendations raised by various regulators and inspectorates is affected by the recruitment and estates issues, which in turn could lead to adverse publicity and reduction in stakeholder confidence, with increased scrutiny/escalation from Welsh Government. The service have undertaken successful recruitment of one consultant and specialty Drs which has improved capability and capacity in part. Regional conversation has been commenced regarding 2 Regional substantive Consultant posts.

Does this risk link to any Directorate (operational) risks?	

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	4×4=16
Current Risk Score (L x I):	4×4=16
Target Risk Score (L x I):	2×5=10
Expected Date To Achieve TRS:	31/03/2027
Trend:	⟷



Rationale for CURRENT Risk Score:	Rationale for TARGET Risk Score:
Increased demand and reduced capacity continues to be a challenge. Balancing Eye Care Measures for R1 patients (high risk) with Ministerial Measures for longest waiting patients presents a conflicting priority to the service with limited capacity. The service has provided additional AMD sessions on a weekend, however these additional sessions have not been enough to meet the demand across all counties in the Health Board (HB). Patient delays continue across the HB. AMD continues to be prioritised impacting on the provision of general clinics, having an impact on the wider ophthalmology service and patient experience. The current non-medical workforce establishment is not aligned to service needs. The current R1 delivery at 35%. The WG target for R1 delivery is 95%. The service as at July 2025 is expected to reach 0 patients waiting at stage 1 52 weeks, however there has been a breach of 35 patients. The stage 4 104 weeks, is breach of 8. There is a plan in place for quarter 2 with a current threat of 25 patients at 104 weeks due to theatre cancellations and single handed surgeons managing sub-specialties. 7523 patients have been 100% delayed for their follow up appointment. The current impact has been scored as 4 because patients are experiencing harm and the current likelihood has been scored 4 as ophthalmology is a fragile service. It is unlikely that this risk will be able to be significantly reduced without considerable investment.	the service has been able to reduce the impact score of this risk as whilst the consequences to the patient remains high, however an SBAR for the recovery of the R1 Eye Care Measures target has been produced which demonstrates a trajectory for recovery and the required investment has been secured. Once implemented this will allow the service to recover to a 65% R1 delivery target allowing the likelihood score to be reduced to a 3 which would reduce the overall score to 15. The investment has been secured in May 2025 which will allow the service to recover to 65% by March 2026 if all posts are recruited into and all estates needs are met. Further development would be required to reach a 95% R1 delivery score, which would reduce the likelihood to a 2. With the required investment in Glaucoma and IVT with the additional workforce and focused management of the waiting lists, the HB will potentially reduce the likelihood score on this risk to a 2. The service also will meet their ministerial measures targets by the end of quarter 1.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)
The service is included within the Health Board's Clinical Service Plan (CSP). This will produce efficiency gains but will not secure additional resources. Active recruitment to vacancies, grow your own initiatives to secure Substantive Consultants and develop Consultants for the future. Regional discussion around 2 Regional Substantive posts, with SBAR being produced. Collaborative working with Swansea Bay to deliver a Regional solution to address the workforce and estates constraints. Sub groups to be formulated to address, Glaucoma, AMD, Vitreoretinal, paediatric and cataract pathways. Additional capacity has been funded for the delivery of Wet Age related Macular Degeneration (AMD). and has reduced the breach from 10 weeks to 8 weeks by March 2025. IVT outsourcing commenced in February 2025 and continues. Eye Care Measures SBAR approved by board to further develop IVT service delivery. Additional capacity has been funded for the delivery of Cataract surgery to maintain the 104 week wait for 2025/2026. Continued Identification of patients suitable to undergo transfer out to the community to Wales General Ophthalmic Services (WGOS) for Glaucoma and Medical Retina. Continued Validation of waiting lists to remove any patients who no longer require treatment through the scheduled Care validation team. Eye Care Collaborative Group meets quarterly to oversee performance against eye care standards. Eye Care Measures co-ordinator in place to oversee and manage the

Gaps in CONTROLS				
Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Whilst recurring money has been invested into glaucoma and cataract services previously, there still remains areas of the service (e.g. Glaucoma, AMD, Cataract, Paediatrics, Corneal and VR) that require investment. The ARCH programme closed, with a regional conversation around a regional clinical workshop to consider opportunities for a long-term regional model. Central investment in Estates, Infrastructure and Workforce is required to develop a sustainable service.	Roll out and implementation of National Electronic Patient Record for Ophthalmology.	Barreiro, Marta	~~30/07/2021~~ ~~31/03/2022~~ ~~31/05/2022~~ ~~30/09/2022~~ ~~31/10/2023~~ ~~31/12/2023~~ ~~31/03/2024~~ ~~15/07/2024~~ 31/03/2027	Issues identified in the planning phase around data governance. DHCW are working to resolve issues. Update provided by the DHCW in September 2024 outlining options available and potential funding required to deliver. Regional planning scoped and aligned programme now proposed with Swansea Bay UHB, but is unlikely to be implemented before 2027. Further funding may be required from each HB to implement this model.
Recovery funding is non-recurring and reviewed annually, this restricts delivery planning. There are concerns in data quality due to referral processes and system use.	Refurbish and establish a nursing team in the Outpatient Department in Amman Valley Hospital to provide intravitreal treatment for the patients currently attending the day theatre area for their treatment. This will ensure continuity of care for those patients when cataract surgery activity is returned to day theatre.	Coppack, Victoria	Completed	Capital bid was secured and work to improve physical space at Amman Valley Hospital (AVH) was completed in March 2022. IVT recovery SBAR presented to the Board with associated workforce and drug costs identified. Long term funding is being considered as part of the annual plan.
	Remodelling the capacity and demand associated with Wet AMD and Amman Valley	Coppack, Victoria	Completed	Remodelling exercise complete. Ongoing costs associated with additional activity. SBAR to outline recovery of IVT service has been presented to Board with short term funding secured, with findings being incorporated in to annual planning process for 2025/26.

management of all R1 referrals. Review of data quality inclusive of Health Risk Factor (HRF) code and clinical codes ongoing to improve data quality. Highly trained Optometrists working collaboratively with the Secondary Care Eye Service to reduce referrals to secondary care. Ongoing training of Optometrists within secondary care to continue to develop this service for continued delivery of WGOS. Ongoing arrangement of Optometrists enrolling in prescribing training to develop further Independent prescribers in the community. GIRFT review undertaken on the Ophthalmology service with progress made against recommendations raised monitored and updated via AMAT. Performance dashboards in place to monitor performance daily. The service albeit still requires investment and continued work with Swansea Bay ref Regional working which is in its infancy in development		Implement virtual review clinics for patients undergoing Hydroxychloroquine (HCQ) treatment.	Coppack, Victoria	~~30/09/2022~~ ~~31/10/2023~~ ~~30/11/2023~~ ~~31/03/2024~~ ~~30/06/2024~~ ~~30/09/2024~~ 31/03/2026	Validation of HCQ patient commenced in November 2023. Longest wait HCQ patients have been identified for tech review, however workforce pressures are negatively impacting on service delivery. Clinic spaces to be secured for patient review. This is an interim measure until WGOS 4 for HCQ can be rolled out. This will follow the roll out of Glaucoma and Medical Retina. HCQ qualified Optometrists will need to be in place in the community to proceed.
		Alignment in the Delivery of Eye Care Measures and Ministerial Measures and effective management of Ophthalmology waiting lists.	Coppack, Victoria	31/03/2027	A Regional Programme Board has now been established. Ophthalmology has commenced a Regional Eye Care Programme. The Regional Eye Care Programme will meet bi-monthly to monitor and progress a Regional solution to the challenges faced in HDUHB and SBUHB, this will be fed to the Regional Programme Board. Identified first steps are to form sub-groups for the review of Paediatric Ophthalmology, Glaucoma, AMD and on call out of hours delivery.
		Long-term investment required for IVT and Glaucoma Delivery to recover R1 position	Jones, Keith -	31/01/2026	New action - progress update to be provided at next risk review.
		Regional solutions to workforce gaps and estates to be explored through Regional programme	Coppack, Victoria	31/03/2027	2nd Regional meeting booked February 2025 Update 18/02/2025 - meeting rescheduled to 14/03/2025
		Orthoptist posts to be recruited into	Coppack, Victoria	30/09/2025	Band 6 Orthoptist is now onboarding after successful interview. Band 8A JD is being review prior to submitting to Agenda For Change (A4C) panel.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Eye care measures monthly report. GIRFT review Cataracts. GIRFT review Glaucoma. Weekly RTT Optimisation to review Ministerial Measures.	WPAS	1st			SBAR for IVT Service Delivery & SBAR for recovery of R1 position (October 2024) Revised RISK SBAR to condense risks submitted to Board for decision.					
	GIRFT action plan cataracts	1st								
	GIRFT action plan Glaucoma	1st								
	WPAS, scheduled care performance indicators	1st								

Date Risk Identified:	Jul-23
Strategic Objective:	

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Jun-25
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Jul-25

Risk ID:	**1708**	**Corporate Risk Description:**	There is a risk of increasing fragility in Primary Care Contractor services. This is caused by several factors including pay-affecting Government decisions, which impacts on succession planning for contractor professions. There are further challenges in relation to premises not being fit for purpose, and not having the capacity to flex to a more modern approach to service delivery e.g. MDT working. In addition, contract reform against the background of significant pressures on the wider system, and exacerbated by financial pressures for the independent contractor business model. This could lead to an impact/affect on undermining the independent contractor model, and therefore the ability for patients to access timely and local primary care services, with potential for demand exceeding capacity. If service users are unable to access these services, this may lead to additional pressures on other primary care services, and wider Health Board services such as Out of Hours and Urgent and Emergency Care. As a result of contract terminations, there will be a detrimental impact on the financial position of the directorate relating to dental contracts.

Does this risk link to any Directorate (operational) risks?	1688, 1451, 1403, 1164, 1660, 933, 800. 912, 1823, 1869, 1109, 1851, 1823, 1993

Risk Rating:(Likelihood x Impact)	
Domain:	Service/Business interruption/disruption
Inherent Risk Score (L x I):	4×4=16
Current Risk Score (L x I):	4×4=16
Target Risk Score (L x I):	3×4=12
Expected Date To Achieve TRS:	TBC
Trend:	⟷

Rationale for CURRENT Risk Score:	Rationale for TARGET Risk Score:
8 dental contracts have been returned to the Health Board in the last 12 months, of which four contracts (totalling £958,500) confirmed as being awarded by NHS Wales Shared Services Partnership (NWSSP) Procurement Services in May 2024. In addition, a further 8 dental practices have not signed up to the contract reform, and signalling that they will return contracts once reform negotiations have concluded. The number of complaints received from the public has increased due to returned contracts, and while the Health Board is currently containing the demand for urgent dental care, it is recognised that patients who don't fall in to this category but require a level of dental care are detrimentally impacted, and that any further contracts returned will exacerbate this situation. The capacity of the Health Board in terms of staffing to absorb further contract reform will impact on the ability to effectively deliver services, and a detrimental impact on staff welfare. There has been increased demand in urgent dental appointments resulting in appointments for the week being booked up early within the same week. The Dental Access Portal (DAP) was successfully rolled out in Hywel Dda UHB in November 2024. 2 General Medical Service (GMS) contracts have been returned to the Health Board in the last 12 months. However from previous contract terminations, 2 of the 3 GMS contracts have become Health Board managed practices, resulting in additional financial pressures as the workforce is salaried. The third practice has been awarded as of 1st April 2024 after a successful procurement process. The outcome of the contract which was returned in April 2024 was presented and agreed by Board in July 2024, with decision made to manage list dispersal. It is recognised that any further managed practices would likely have a negative impact on the GMS budget. Implementation plans are in place with Ophthalmology to support the transition of patients into Welsh General Optometric Service (WGOS4) (clinical pathways for Glaucoma, HCQ and Medical Retina) as part of the new Optometry contract implementation which commenced in September 2024.	Achievement of the target score is subject to the development and agreement of a Primary Care Strategy at Board alongside successful national contract negotiations and subsequent implementation across the Primary Care contractor professional groups. There is a high dependency on external factors which make the reduction of the risk score challenging. It is unlikely that the risk score will reduce to the target risk score within 12 months without the approval of the Primary Care Strategy. Successful conclusion of contract negotiations with professional contractor groups also required.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Primary Care Academy in place, which looks at workforce planning, training and development needs and opportunities 5 Facet Survey completed in 2022 to establish a baseline for the GMS estate GMS and Dental Practices undertake annual reporting which includes reviews of statutory compliance requirements 0.25 FTE Primary Care Development Manager for estates in post but with a focus on GMS Escalation tool for GMS and Community Pharmacy (SITREP) Continue effective engagement with struggling practices to support with their issues through close working relationships developed with practices. Programme of practice visits to review Estates provision, and if remedial action is required Requests sent to contractors to assess potential risk of RAAC, with outcomes reported to WG Nationally agreed Breach Management process in place for Community Pharmacies. Requests for contract variation (termination, merger, branch surgery closure etc) are considered in line with national guidance, with panels convened as stipulated. Recommendations are taken through the Primary Care Contract Review Group with papers to Board when required.	Requests for support on addressing the GMS sustainability agenda are with the Strategic Programme for Primary Care as a result of a review paper across all Health Boards on their sustainability pressures. National work on the development of the escalation tool for Dental and Optometry is ongoing but not live. Five Facet Survey and annual reporting of practices has highlighted non-compliance with statutory requirements such as Health and Safety, Fire and IP&C which have now all been completed, however this is a statutory requirement for the practices to complete. Limited requirements for practices to disclose information to the Health Board about their sustainability pressures, and rare for practices to disclose financial details (reliant on engagement and good will as this is not a contractual requirement). Insufficient resources to support the estates development across all Primary	Establish workforce plan and recruitment strategy in line with the development of the national Primary Care Workforce Strategy and as a component of the Primary Care Strategy.	Hughes, Samantha	~~31/03/2024~~ ~~31/03/2025~~ 30/09/2025	Workforce planning continues. GP Practice workforce plans using data from Welsh National Workforce Reporting System (WNWRS) have been pulled together at Cluster level for Collaborative consideration. This information now needs to inform and align to the Primary Care Workforce Strategy. Support is being provided to the Directorate with this work from colleagues in Workforce, and is also discussed via the Primary Care Academy. Through Strategic Programme for Primary Care (SPPC) fund, a Primary Care Workforce Planner has been appointed on a fixed term basis until March 2026, who will commence work on the workforce plan. Whilst contact has been made with GP Practices to start this work the initial uptake of the offer of support has been low, however that could be attributed to the end of year contractual submissions taking priority.

Strategic Programme for Primary Care (SPCC) bids approved for 2024/25 and 2025/26 to support workforce initiatives A series of patient facing videos have been developed with Pocket Medic to support patient education in accessing Primary Care Services Whilst Community Pharmacy Breach Management process in place, which has been reviewed in light of appeals process. GMS contract management review process in place, reviewing escalation status, sustainability assurance framework and business continuity plans. Data is reviewed and challenged where necessary by Primary Care Service Managers.	Care services, particularly with independent contractors. Due to national review of Premises Directions, there is no improvement grant funding for 2024/25. Whilst Community Pharmacy Breach Management process in place, which has been reviewed in light of appeals process. Whilst RAAC declarations were requested, these were not mandatory for contractors to respond, and therefore effectiveness of responding to outcomes. Whilst challenge is provided via GMS contract reviews, feedback not consistently addressed by practices.	To develop the Primary Care Strategy in consultation with statutory stakeholders and consultees, to cover areas including: •Workforce •Sustainable provision of Primary Care services •Estates •Managing contractual change •Developing pathways and new services •Improving access to services across all contractor professions	Bond, Rhian	~~30/09/2024~~ ~~31/03/2025~~ 30/09/2025	Paper submitted to Board in September 2023 setting out the scope of the Primary Care Strategy, with papers presented to Board at regular intervals. A further paper was presented to SDODC in October 2024. Work is ongoing to establish a mechanism to develop a Clinical Reference Group to secure views from across the contractor professions as well as community service staff.
		Consider the potential to deliver a wider range of salaried NHS Dental Services through the Community Dental Service.	Owens, Mary	~~30/04/2024~~ ~~30/06/2024~~ ~~31/10/2024~~ ~~31/03/2025~~ 30/09/2025	As of April 2025 Welsh Government have issued a public consultation document on the future of NHS dental services provision. The Health Board will be seeking to provide a robust response. To enact the proposed changes of an integrated dental service there is the potential to need to consider an OCP in the current CDS service to ensure that the delivery model can be flexible to the demands of the service.

		Implement the Managed Practice Strategy plan will give greater system resilience.	Swinfield, Anna	~~30/04/2024~~ ~~30/10/2024~~ ~~31/01/2025~~ ~~31/03/2025~~ 30/09/2025	The tender process for Neyland and Johnston concluded without a contract award. Re-procurement exercise completed in September 2024 with no success. Review of Managed Practice Strategy to be undertaken in line with the development of the Primary and Community Services Strategic Plan. The introduction of a locum rate card in Autumn 2024 has seen an increase in salaried GP posts with two of the six managed practices operating with minimal locum reliance.

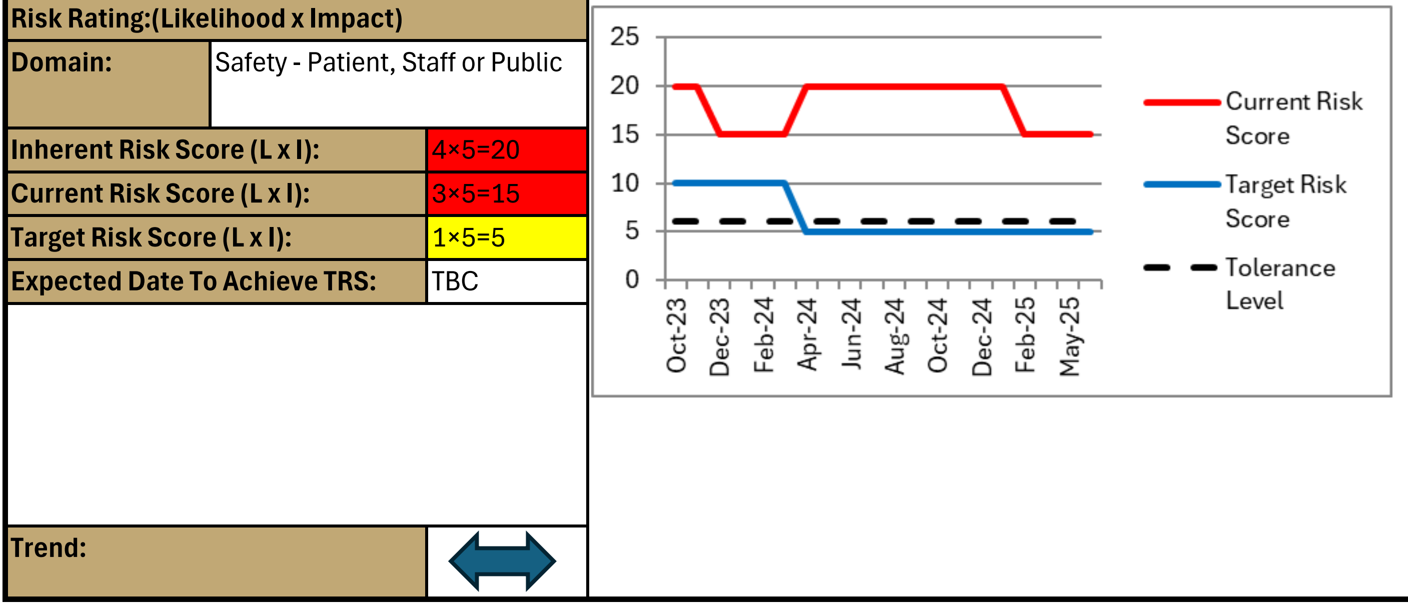
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Sustainability Matrix Contract performance to monitor volume metrics (identifies if dental practices have issues in service delivery), with Primary Care Service Managers reviewing the escalation statuses of practices which is a contractual requirement. Those practices escalated to Level 4 are contacted requesting assurance around their reported level, to identify the potential for any support and where appropriate to challenge the reported level of escalation. Monthly assurance	GMS practices are asked to complete a WG sustainability matrix every 6 months to track the main risk areas and this contributes to a heatmap. Practices are also asked to report regularly on operational pressures	1st			OQSEC Primary Care Exception Report	Varying levels of engagement from practices in the regular reporting of operational pressures.				
	Dental Management Team undertake annual reviews	1st								
	GMS Practices are part of a rolling visiting programme, based on their annual return which is risk assessed against a framework of any other issues or concerns identified	1st								

reports and Dental Assurance Framework - Business Service Authority dashboards, to identify outliers	PCSMs tasked with regular discussions with Practices that report L4 to understand the issues	1st								

Date Risk Identified:	Nov-22	Executive Director Owner:	Carruthers, Andrew	Date of Review:	Jun-25
Strategic Objective:		Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Jul-25

Risk ID:	1531	Corporate Risk Description:	There is a risk of being unable to provide a safe and sustainable general surgery consultant on-call rota at WGH and GGH. This is caused by Unsustainable and fragile rotas, with a difficulty to recruit into substantive posts. This could lead to an impact/affect on on the ability to provide an emergency general surgery service at WGH and GGH affecting patient experience, causing clinical delays and poor outcomes for patients. The wellbeing of remaining consultants who are already working to full capacity is also affected and there is an increased expenditure on agency locum consultants and internal locum rates above the HB card rate. Consultants working additional on call locum weeks is resulting in a reduction in elective activity in OPD, endoscopy and theatre. This could have a negative impact on RTT and SCP targets.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	4×5=20
Current Risk Score (L x I):	3×5=15
Target Risk Score (L x I):	1×5=5
Expected Date To Achieve TRS:	TBC
Trend:	⟺



Rationale for CURRENT Risk Score:	Rationale for TARGET Risk Score:
Whilst this risk is relating to workforce issues, the domain for the risk is patient safety. The reason for this decision is that, although the rota in WGH has been stabilised, gaps in the service remain e.g. Upper Gastrointestinal (GI). The risk to emergency Upper GI patients at WGH is due to no Upper GI specialists on site and no Endoscopic Retrograde Cholangiopancreatography (ERCP) service on the site. An SBAR has been populated, highlighting the risk to emergency Upper GI patients in WGH. This is also on the risk register, Risk 2067. The recommendation from the senior clinical team is for these patients to be admitted directly to GGH. This SBAR was presented at Acute Leadership Group (ALG) on 25/09/2024, at the Quality, Safety and Experience Committee (QSEC) on 08/10/2024 and at the Scheduled Care Quality, Safety and Experience (QSE) meeting on 29/01/2025. The concern is that the GGH clinical team have absorbed the patients that cannot be treated at WGH, without additional resource and this is currently exacerbated by the rota gaps on the GGH consultant on-call rota. As this situation has not changed, the current risk score remains the same. The consultant on-call rota at WGH remains a 1:4 with 2 substantive consultants and 2 NHS locum consultants on the rota, 1 of which is an internal associate specialist upgraded to a locum consultant. At GGH, the consultant on-call rota is a 1:8 with one gap and one consultant only participating in 50% of the rota. The 1 full gap is currently being covered by a Medacs agency locum consultant, an NHS locum colorectal consultant has been appointed to fill this gap, with the hope of a start date in August 2025. The 50% gap is being covered by an internal locum at the health board card rate. There are 3 NHS locum consultants participating in this rota. An options appraisal was presented to board in November 2024 and there was an urgent meeting between the	The target risk score is based on the work currently being undertaken as part of the Clinical Services Plan to identify and approve a more sustainable solution in order to reduce the likelihood of rota collapse and reduce the risk of not being able to provide a safe and sustainable emergency general surgery service to patients in the south of the Health Board. The effectiveness of revised rota arrangements will depend on several factors including availability of a labour market. The risk score will reduce on the appointment of substantive consultants. Achievement of the target risk score is dependant on the outcomes of the Clinical Services Plan which will inform future plans or the successful appointment of substantive upper GI consultants to the current model at WGH.

An options appraisal was presented to board in November 2024 and there was an urgent meeting between the Clinical Care Group and Executives in early 2025. The outcome of this was the approval to advertise the posts to fill the gaps. This supersedes the content of a previous SBAR presented at various Executive committees as the plan is no longer to amalgamate rotas, at least in the short term.

Proposals relating to service changes and the amalgamation of the rotas were presented to ALG in October 2024, with the requirement to engage with relevant stakeholders noted as an action. An options appraisal paper was presented to Board in November 2024 via the Clinical Service Plan (CSP).

Following the Scheduled Care March 2025 Escalation Meeting, where the immediate risk of the GGH rota collapsing was highlighted, due to the internal consultants withdrawing from covering the 1 gap on the rota, an urgent executive meeting was arranged for 12 March 2025. The outcome of the meeting was to appoint a substantive colorectal consultant to the GGH rota and for 2 substantive Upper GI consultants in a dual location role across WGH and GGH. It was recognised that this would take some time, there was an agreement that the service would recruit a Medacs locum consultant immediately, to cover the upcoming gap in April and in parallel, advertise an NHS locum colorectal consultant to GGH. On the appointment of the locum consultant at GGH, the agency locum will be terminated. On the appointment of the substantive consultants at WGH, the NHS locums will be terminated.

An NHS locum colorectal consultant was appointed on 30 April 2025, to commence in post in August 2025. The Upper GI substantive consultant posts have been advertised and are currently being shortlisted. Interviews and stakeholder panel are due to take place on the 14th and 15th of August 2025. The substantive colorectal consultant post will be advertised in readiness for the end date of the NHS locum that has been appointed. With this is mind, the service has submitted a request for the Medacs locum at GGH to be extended until the end of August and the NHS locum at WGH to be extended for 6 months, to maintain the service while we recruit substantively.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Rotas monitored daily by the service delivery team When there is sickness or unexpected leave, due to emergency circumstances, the management team work to cover as follows: 1. Internal Additional Hours (ADH) on the site with the gap. 2. Internal ADH from the other sites across the health board. 3. In the event of steps 1 & 2 being unsuccessful, the service would escalate for agreement on transferring the surgical out of hours on call take to another site. (WGH to GGH) 4. Ensuring that all stakeholders are aware, including site teams, medical teams, WAST, any supporting services as appropriate. Proactive sickness management Escalation to clinical leads	Potential inability to recruit to all 3 substantive consultant posts scheduled for April 2025. The Consultants at GGH also provide the support to the junior and SAS level doctors at PPH for the elective pathway. The NHS locum in place at WGH is only on a 6 month fixed term contract. No rota co-ordinator in place at GGH to support rota management, and currently undertaken by Service Manager	Review the longer term sustainability of general surgery on-call rotas across Hywel dda (recommendation from Getting it Right First Time (GIRFT) review in Jan23)	Lewis, Caroline	Completed	The senior consultant leads for general surgery have suggested that the WGH and GGH on call rotas are amalgamated to one site. This would provide an increase of consultants on the rota to either a 1:10 (the 3 WGH consultants and the 7 GGH consultants) or a 1:12 (the 3 WGH consultants, 7 GGH consultants and 2 newly recruited posts). This recommendation is in line with the GIRFT report. SBAR's have bee drafted by the service to describe the fragility of the rotas.

On appointment, new consultants undertake an induction with Hospital Director at WGH and Clinical Director for Scheduled Care. SOP in place for the transfer and repatriation of patients Engagement with WGH Medical Staff Committee and public on changes to services	There is a risk of consultants requesting rates that are higher than the HB card rate, going forward as they have been covering multiple gaps on the rota for a prolonged time.	To develop an options appraisal paper with all relevant stakeholders, including WAST, Primary Care, and site teams	Hire, Stephanie	Completed	A discussion was due to be held live at the health board planning session on 09/1/25, this did not take place due to the clinical lead and clinical director not being able to attend. The EGS situation is regularly reviewed and appropriate action is taken by the service as and when required. It also forms part of the fragile services, which is discussed at escalation. We are awaiting confirmation as to when or if the stakeholder discussion will take place. Following the executive meeting on 12/03/2025 and the agreement to recruit substantive consultants into the gaps on the rotas, this options appraisal paper is no longer required. This will need to be reviewed, if the service is unable to recuit suitable candidates.
		To hold interviews to appoint NHS locum consultant	Lewis, David	Completed	Job descriptions have been sent for Royal College approval in April 2025.
		To agree job descriptions and advertise for three substantive consultant posts	Lewis, David	Completed	The two substantive upper GI consultant posts have been advertised and shortlisting is currently being undertaken. If there are suitable candidates, interviews will take place on 14th and 15th August. The substantive lower GI consultant post will be advertised in Spring 2026, in readiness for the end date of the NHS locum that has been appointed.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
	WGH Medical Staff Committee established to develop models of sustainability	1st			Management team have presented an SBAR to Acute Leadership Group (Feb23) SBAR to Executive Team and OPDP to agree 1:3 rota (Mar23) General Surgery Report to Board (Mar23) Management team to present updated SBAR to Acute Leadership Group (Oct23 & Nov23) Management team to present updated SBAR to Corporate Directorate Group (Apr24) Upper GI service SBAR presented at ALG (Sep24) Upper GI service SBAR	Assurance to Board on communication and repatriation arrangements				
	Reported to monthly General Surgery Business Meetings on each site (BGH/GGH/WGH)	2nd								
	Reported to bi-monthly Scheduled Care Quality, Safety and Experience Group through exception reporting	2nd								

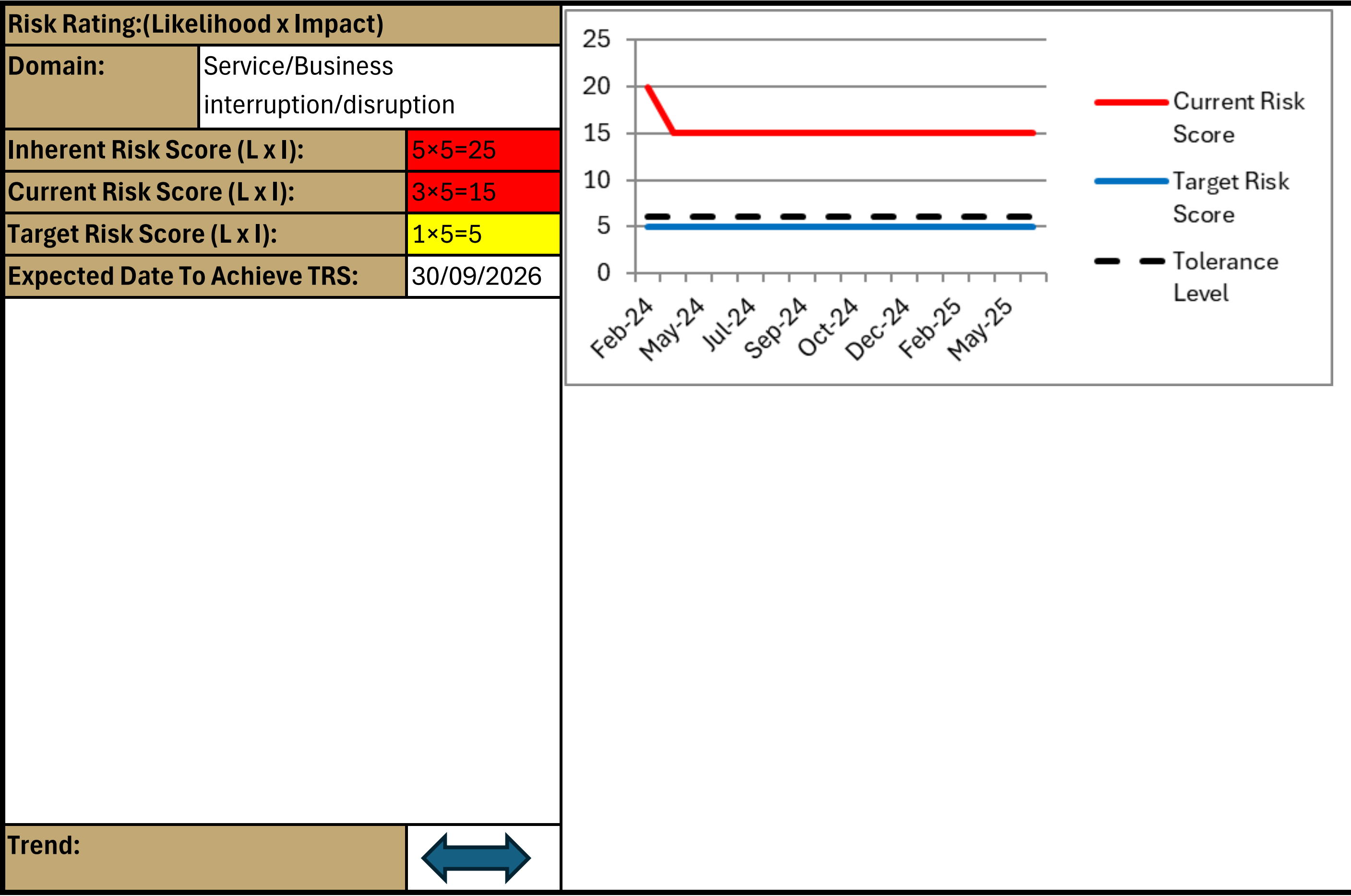
	Assurance to be reported to the Board following introduction of temporary rota	2nd			presented at Quality, Safety and Experience committee Meeting (Oct24) Updated SBAR to Executive Team (Nov24) Upper GI service SBAR presented at scheduled care directorate QSEAC (Jan25)						
	GIRFT report on General Surgery which raised the sustainability of general surgery across 3 sites in Hywel Dda - final report awaited										

Date Risk Identified:	Feb-24
Strategic Objective:	

Executive Director Owner:	Carruthers, Andrew	Date of Review:	Jul-25
Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Aug-25

Risk ID:	1810	Principal Risk Description:	There is a risk that the Health Board will be unable to continue manufacturing cancer treatments for our patients. This is caused by the facilities of the Pharmacy Aseptic Unit being non-compliant with Quality Assurance of Aseptic Preparation Services (QAAPS) standards 5th edition (published 2016) and therefore at risk of closure, exacerbated by a fragile workforce within the service. This could lead to an impact/affect on the Health Board's ability to provide all the cancer treatments currently offered. The Health Board would be entirely reliant on outsourcing cancer therapy from commercial suppliers. A fully outsourced service would cost an additional c£1 each year. Some therapies cannot be outsourced, meaning Hywel Dda could not offer over 500 cancer treatments each year. This would have a significant negative impact on patient care as patients would either be required to travel further from home to neighbouring Health Boards to receive their treatment (dependant on their capacity to absorb the additional demand) or would be offered less clinically appropriate treatments at Hywel Dda, negatively affecting clinical outcomes. The closure of the Aseptic unit would directly impact the ability of the Health Board to achieve ministerial priorities and targets such as the Single Cancer Pathway, A Healthier Wales, etc.
Does this risk link to any Directorate (operational) risks?			2004, 374, 1350, 716

Risk Rating:(Likelihood x Impact)	
Domain:	Service/Business interruption/disruption
Inherent Risk Score (L x I):	5×5=25
Current Risk Score (L x I):	3×5=15
Target Risk Score (L x I):	1×5=5
Expected Date To Achieve TRS:	30/09/2026
Trend:	



Rationale for CURRENT Risk Score:	Rationale for TARGET Risk Score:
Withybush Aseptic unit is the only functional unit that can manufacture cancer treatments remaining in the Health Board. The facilities of Withybush Aseptic unit are currently non-compliant with regulatory standards. An audit by the National Pharmacy Quality Assurance Lead was performed in February 2024 confirmed the facilities were a high risk to patient safety, and the unit is at risk of forced closure. The most recent audit performed during February 2025 highlighted that there is also insufficient resource available to maintain the Quality System against the standards due to staffing fragilities within the service. Short term control measures have been implemented by the Health Board's aseptic team to reduce the risk of immediate forced closure (see control measures). The controls are currently successfully minimising the amount of microbial contamination present within the unit, demonstrated by ongoing daily/weekly/monthly environmental monitoring. However, as the unit and equipment are beyond their useful expected life, there will come a time where the control measures will no longer be sufficient to allow the safe running of the unit. If the stringent controls fail at limiting the amount of microbial contamination, the unit may be forced to close. As part of the Transforming Access to Medicines (TrAMS) project programme, a regional manufacturing hub will be built in South West Wales that will prepare cancer therapy for Hywel Dda patients. The hub was originally estimated to open during 2028, however there have been delays to the project plan and the opening date is currently unknown. There is therefore a high risk that the current Aseptic unit at Withybush will be forced to close before the South West TrAMS manufacturing hub is operational. In this case, there would be no means of obtaining certain cancer therapy for Hywel Dda patients to be administered within the Health Board locality.	The target risk score is based on the premise that funding for a new aseptic unit is approved by Welsh Government. The unit would be compliant with regulatory standards and once operational, it would be extremely unlikely for the unit to be forced to close. A new unit would allow the Health Board to continue to safely prepare cancer therapy until the TrAMS South West manufacturing hub is operational. On approval of the Business Justification Case, it is anticipated that the current risk score could be reduced to 10 once the unit is operational, expected to be February 2026. Achievement of the Target Risk Score of 5 is expected once workforce fragilities have been addressed, anticipated to September 2026.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Transfer of the radiopharmacy service to Singleton Hospital in October 2022; this means less overall activity through the Withybush Aseptic unit reducing the risk of contamination and errors. More time and resource provided to the Quality System (i.e. internal audits, investigation of near misses and microbial growths, maintaining SOPs). Increased training of aseptic staff to develop their skills and knowledge. Increase outsourcing from commercial suppliers; this limits the volume of products prepared within the unit, allowing products that must be made in-house to be prepared safely. New pharmaceutical isolators have been procured to replace the existing isolators that are beyond their working life of 10 years. The new isolators will be stored with the intention of installing into the demountable unit (if funding is secured) or will be installed into the existing unit if the current isolators fail mitigating the risk of equipment failure causing prolonged service disruption. Removal of outsourced dispensing from the Aseptic unit; this minimises the risk of contamination and potential for error. Preparation of products near to the time of use; this limits the pre-administration storage time. More stringent gowning process; this minimises contamination risk. More stringent cleaning and monitoring programmes; this minimises contamination risk and allows early detection of microbial growth.	Controls are reliant on a key group of skilled staff (i.e to maintain Quality System, to follow cleaning and monitoring procedures) therefore subject to key person dependencies. Findings from the audit undertaken in February 2025 highlighted the fragility of the workforce due to key person dependencies which could detrimentally impact on the service. Limited accommodation to employ additional staff to expand workforce within the existing unit at WGH. Limited accommodation to store starting materials and finished products or to perform the associated tasks that are required to safely supply cancer treatments. Between 2021 and 2023, the number of cancer treatments requiring aseptic preparation at Hywel Dda increased from 12,718 to 16,648 (average of 14% increase each year). There is limited space within the Pharmacy at WGH to manage this increase in demand. Lack of funding to build a new unit at WGH.	To submit revised business case for demountable unit to Welsh Government (estimated £2.89m).	Morgan, Cerith	Completed	As part of the tendering process, no suppliers had submitted a bid for the contract for the demountable aseptic unit as of 03/09/2024. The tender was repackaged to the principal contractor of the project (Lewis Construction) noting the following specialist cleanroom subcontractors; Angstrom, Enbloc, Scitech, T-squared, Cleanroom projects. The quality of the submissions was scored by members of the project team and representatives from NWSSP on 20.11.2024. As no suppliers submitted a bid during the original tender return, this may have an impact on the project timelines. The BJC was presented at Public Board 30th January and approved for submission to WG for scrutiny. WG provided BJC scrutiny comments to the HB on 20th March 2025 with the HB responding on 15th April. Awaiting WG response to HB's scrutiny return.

Oversight and steer from Capital Sub-Committee.	Progress dependent on feedback received from Welsh Government	To work with estates and capital planning team to source temporary accommodation at Withybush to increase the storage capacity for outsourced cancer therapy. This will help the aseptics service to meet the increasing demand for cancer therapy and will allow cost efficiencies related to outsourcing to be achieved whilst the business case for a demountable aseptic unit is being developed.	Morgan, Cerith	Completed	Capital bids proforma submitted to Health Board capital planning team 11/06/2024. Ratification paper signed off and contract awarded to Portakabin on 02/08/2024. 05.09.2024, awaiting for contract to be signed by the Head of Service - Procurement before order can be placed. Portacabin has now been installed and now awaiting fittings to be installed by the company before unit is operational.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Audit Reports from annual audits detailing areas of non-compliance KPI Dashboard in place to provide continuous oversight of unit performance, updated monthly.	Annual Audits by Lead Quality Assurance Pharmacist (NWSSP) .	3rd			Capital Sub Committee (22nd January 2024). MMOG report to QSEC for Feb 2024. BJC Board January 2025.					
	Quarterly self-assessments undertaken by Lead Aseptic Pharmacist, with outcomes fed back to Lead Quality Assurance Pharmacist at NWSSP	1st								
	Bi-monthly Senior Pharmacist Leads Business Meeting .	2nd								

Date Risk Identified:	May-24
Strategic Objective:	

Executive Director Owner:	Daniel, Sharon	Date of Review:	Jun-25
Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Jul-25

Risk ID:	1859	Corporate Risk Description:	There is a risk that patients are at increased risk of poor outcomes, and a poor patient experience. This is caused by the Health Board's inability to effectively recognise and manage acute deterioration. This could lead to an impact/affect on increased length of stays, increased admissions to Critical Care, increased risk of cardiac arrests for patients, and poorer patient outcomes who may experience permanent injuries or irreversible health effects.
Does this risk link to any Directorate (operational) risks?			1758

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	5×5=25
Current Risk Score (L x I):	3×5=15
Target Risk Score (L x I):	2×5=10
Expected Date To Achieve TRS:	31/12/2025
Trend:	⟺

Rationale for CURRENT Risk Score:	Rationale for TARGET Risk Score:
There were specific concerns relating to Glangwili General Hospital (GGH) and Withybush General Hospital (WGH) in relation to Cardiac Arrests and unplanned admissions. There was an increase in Cardiac Arrest rates in GGH in the period Jan - Dec 2024 (35) compared to the same period Jan - Oct 2023 (15). In the first 6 months of 2025 (Jan - June) there has been a significant decrease in the Cardiac Arrest rates in GGH compared to the same period 2024. In 2025 = 9, in 2024 = 19. There had been an increase (22%) in unplanned admissions at WGH, with 92 noted in 2024 (71 noted for 2023). In the first 6 months of 2025 (Jan - June) there has been a reduction in the number of unplanned admissions into WGH ITU compared to the same period in 2024. In 2025 = 39, in 2024 = 52. A Task & Finish group in WGH has been put in place to implement Treatment Escalation Plans (TEPs) and GGH are exploring how to run a similar project. There are also concerns across the Health Board as a whole relating to the National Early Warning Scores (NEWS), and appropriate escalation where required as part of observation processes. An audit tool on AMAT has been developed to review on a monthly basis NEWS charts on wards and identify good practice and areas for improvement. An Acute Physical Deterioration Implementation Network has been established and a Clinical Reference Group (CRG) will support the Network with expertise and evidence based decision making to develop national documentation measure and approaches to change and improve training. The CRG will inform direction, sense check thinking and provide a consensus view on acute deterioration across all age groups in Wales. With the support of the CRG the Health Board is on track to implement early warning scores as directed by the Welsh Health Circular by September 2025. As of 1st June 2025, compliance rates for Level 3 Resuscitation Training Adults is 54% (unchanged since April 2025), Paediatrics 38% (32% April 2025), and Level 2 Training is at 50% (51% April 2025). While there is no set compliance target, compliance has never been greater than 60%. Staff availability to attend resuscitation training is problematic due to operational pressures and demand, therefore, need to identify the most appropriate training level and method to deliver to meet mandatory requirements. All planned actions to mitigate the risk are being processed within set dates/timeframes although many remain long term. Current controls are managing the risk and the increasing awareness of gaps in assurance and local actions to mitigate and manage the risk have been established.	The full implementation of the actions noted in the risk action plan will support the reduction in the likelihood and impact score of this risk to a target risk of 10. With recruitment into the Resus Team and the establishment of a supported Cascade Training process the aim will be to see an increase in training compliance in both Level 2 & Level 3 training by October 2025 to >60%. This will enable the risk to be reduced to the Target Risk Score of 10, >85% would enable the risk score to be reduced further to 5. We will aim to see a reduction in Cardiac Arrest rates across all 4 sites and unplanned admissions into ITU from ward areas by October 2025.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)
Governance structures in place eg RADAR Group (Recognition of Acute Deterioration and Resuscitation). Increased awareness of gaps in assurance and local actions in place to manage and mitigate the risk. T&F Group chaired by HB RADAR Lead with focus on Sepsis, DNA/CPR group chaired by Deputy Medical Director. RADAR directly reports to Operational QSE. Local RADAR groups (across all sites, counties, MHLD and Paediatrics) which report to HB wide RADAR group - chaired by a commission. Mechanisms in place across all sites to monitor cardiac arrest rates. Health Board Resus policy in place (currently under review and updated to reflect National Guidance) All Wales DNA/CPR policy in place and has been uploaded onto the Health Board intranet. Clinical Lead Nurse for Acute Deterioration 1WTE Dedicated Resuscitation Team in place, consisting of 5.2WTE across the Health Board (acute, community, mental health and primary care) and one 1WTE admin support Networks in place across the wider HB, including support from QIST (Quality Improvement Service Transformation) and practice development. Organisational training plan in place, including mandatory training Critical Outreach Services in GGH and WGH (not in place at PPH / BGH), managed by Planned Care Directorate (i.e not fully linked to Acute Deterioration resource) New Acute Kidney Injury (AKI) Lead appointed for GGH (12 months)

Gaps in CONTROLS				
Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
No treatment escalation plans in place Call for Concern is being piloted but only for inpatient adult patients only and at the moment is only across 2 sites. Training demand outstrips capacity to deliver the mandatory level of training recommended by the Resus Council Inconsistent application of policies and processes eg DNA/CPR, sepsis assessment tool, National Early Warning Score (NEWS). Reliance on manual / paper based documentation to record patient deterioration and subsequent escalation Critical Outreach Services not in place at PPH / BGH Inability to release staff to complete L2 and L3 training High number of newly qualified new nurses to the HB including overseas requiring support to develop their expertise in recognising acute deterioration.	Health Board Recognition of Acute Deterioration and Resuscitation (RADAR) group to develop a workplan to address gaps in control to improve the recognition and management of acute deterioration across the Health Board.	Davies, Mandy	~~30/09/2024~~ ~~30/11/2024~~ ~~30/04/2025~~ 30/09/2025	Quarterly meetings in place, and sub-groups being established to report to Recognition of Acute Deterioration and Resuscitation (RADAR) group on sepsis, NEWS, treatment escalation plans, call for concern (Martha's Law) DNA/CPR, acute kidney injury (AKI). Agenda at August meeting didn't allow for discussion on the development of a workplan. Plan is to confirm RADAR Action Plan at next meeting 20Mar25, with risk actions to be updated accordingly. Update as of April 2025: Health Board RADAR Lead has stepped down and awaiting a replacement to be identified. No scheduled meetings planned at the current time in respect of an overarching Health Board group as awaiting new Lead. Health Board RADAR group met on 19th June - arrangements for leadership of this group have been confirmed and the Medical Director will now lead this group from the next meeting with additional support from the Medical Lead for Sepsis and Acute Deterioration, Dr Vicky Hughes. Workplan will be presented and confirmed at the next meeting.

Dedicated resource in Quality Improvement Team monitoring AKI alerts for the Health Board Bi-monthly scrutiny meetings have been set up in GGH, BGH and WGH to review Cardiac arrests. Cardiac arrest reviews presented at Medical Education sessions Review of feedback from any Medical Examiner reviews, highlighting issues relating to resuscitation/cardiac arrests and lessons learned. Call for Concern are being piloted in GGH and WGH for inpatient adult patients. Process for implementation in Paediatrics, Mental Health and remaining sites under review.		Develop an organisation-wide training needs analysis to appropriately identify staff across all staff groups complete the most appropriate level of training to improve recognition and management of acute deterioration.	Wastell, David	Completed	The directorate is working with ESR to ensure that staff training attendance is accurately recorded. Work is ongoing with individual line managers to identify the training needs of all their staff groups across all four sites and community. Meetings commenced with all senior nurse managers to discuss current training uptake and training needs to identify the most appropriate training for each staff group across acute and community. Meetings are to be arranged with Heads of Service for other clinical services. As at June 2024, it has been identified that 84 ILS sessions are required in order to ensure compliance with targets for GGH alone. Heads of Nursing requested to discuss training attendance with all ward sisters, and to appropriately prioritise. Monthly analysis of training available, and attendance to be shared with Heads of Service and Senior Nurse Managers. The provision of training continues at current levels, given current resource availability. TNA taken to QSESC advising in January 2025, with further discussion at SNMT and QSESC on cascading this.

To implement an electronic observations systems across the Health Board to capture real-time bedsite capture of patient assessments and monitoring, in line with the Health Board's Digital Plan	Williams, Carolyn	30/09/2025	Tender process completed. Business case presented to Board in July 2024, with a view to implement on a site by site basis over in 18 months, in line with the current Digital Plan. Board approved the business case in Sept 24 however funding has not yet been identified to enable the project to proceed.
As part of the Quality Dashboard, agree the matrix needed for patient deterioration. Include these matrix in the Health Board Quality Dashboard to inform escalation and create a specific dashboard for RADAR (Recognition of Acute Deterioration and Resuscitation).	Wastell, David	~~30/05/2025~~ 30/09/2025	Meeting of 25th July 2024 has identified the following supporting metrics for the dashboard: sepsis, AKI, NEWS audits, cardiac arrests, number of MET calls, treatment escalation plans are in place, call for concern rates and training compliance for ILS and BLS for each Directorate. Senior Nurse for Resuscitation and Acute Patient Deterioration is working with Performance Team to agree the process for data collection to inform the Dashboard, and identifying methods to prioritise the dashboard data via a RAG system. As of 16th May, work remains ongoing.

			Put in place process for Health Board compliance with Martha's Rule by establishing a Task and Finish Group to implement Call for Concern	Wastell, David	~~31/03/2025~~ 31/12/2025	Task and Finish Group is in place, chaired by Anna Chiffi. SOP Patient leaflet is being developed and a pilot was due to commence in GGH in Feb25. This pilot will test the process to roll out across the organisation for Adult Inpatients. Pilot scheme at GGH is aiming to be completed by March 2025, with a view to rolling out to other three acute sites by December 2025.
			Put in place All Wales Policy for treatment escalation plans to enable safe and effective care management when patient deteriorating.	Wastell, David	~~31/12/2024~~ ~~30/06/2025~~ 30/09/2025	Discussed at Health Board Recognition of Acute Deterioration and Resuscitation (RADAR) group Group (March 2024) - no agreement to move forward with proposed pilot in Withybush. Discussed at Withybush RADAR meeting in July 2024 where agreement reached for pilot. Task and Finish group being established by Lead for Critical Care Outreach in Withybush to devise an implementation plan. RADAR to review following evaluation and consider roll out across other sites. As of January 2025, the situation remains unchanged. TEPS sub group meetings have been held at WGH but there is no set plan at the moment to implement or trial.

		Implement a model for CASCADE training for basic life support and monitor impact on basic life support training compliance rates.	Wastell, David	Completed	Model devised by Resuscitation Team - first training session held. 6 Cascade Trainers from across the Health Board Community Teams, trained in July 2024. Training will continue. Training session for Midwife Cascade Trainers in development, with plans for health visitors and school nurses for February 2025.
		Following assessment and interpretation of the All Wales Direction, the Health Board is engaging in National work, namely roll out of NEWS2 and Call 4 Concern and contribute to the National Improvement for Acute Deterioration being led through the Safe Care Partnership.	Wastell, David	~~30/09/2024~~ ~~30/03/2025~~ 30/09/2025	Launch of this initiative on 17th September 2024 (World Patient Safety Day). WHCs have been received in relation to NEWS2 and Call 4 Concern. A group led by the Assistant Director of Nursing for Acute Inpatient Services is designing a first phase approach to pilot Call 4 Concern from November 2024. All Wales Safe Care Partnership meeting held on 22 October 2024 to design a national improvement programme for acute deterioration, which the Health Board are engaged in and are contributing towards. National group not yet established as of November 2024. Advised at national level NEWS2 will be launched September 2025. Health Board Task & Finish Group, chaired by Mandy Davies, established to address WHC in relation to implementation of EWS across the Health Board by September 2025. Membership of this group includes

					Medical and Nursing and Therapy Leadership. Executive Lead and Sponsor is Mark Henwood and implementation lead is David Wastell. A plan is in place and actions being taken to implement changeover as of 16th July across the Health Board.
		Work to improve compliance with Sepsis Bundles at the front door.	Wastell, David	31/12/2025	Ongoing quality improvement in place. Has demonstrated improvements in Glangwili and Prince Phillip and now being used in Withybush. Reviewing process for assessing impact on patient outcomes as a result of the response and management of sepsis.

Improve compliance with DNACPR National Guidance	Steele, Cathie	~~30/10/2024~~ ~~31/05/2025~~ 30/09/2025	DNACPR Review Group formed and actions identified including development of a SharePoint page (which is now complete) and undertaken an improvement project through EQIiP (complete). Annual audits undertaken by junior doctors, and reviews of medical examiner reports and cardiac arrest to identify learnings. More robust communication between mortality review group and RADAR being established. Training needs have been identified in relation to DNACPR and patients who are considered having learning disabilities, or diagnosed with dementia. Work is commencing with the MHLD directorate to progress this. A full action plan as been agreed in response to the HIW National Report on DNACPR (see AMAT)
Development of an Acute Deterioration Sharepoint page for all advice, guidance, updates, for staff on issues relating to resuscitation, DNACPR, sepsis, call for concern, MET calls, training, etc.	Wastell, David	~~31/05/2025~~ 31/08/2025	Senior nurse for acute deterioration is working with Interim ADN for Quality and Safety to develop SharePoint page. As of 16th May, work is ongoing with the development of the Sharepoint page.
Trial starting in October 2024 for 3 months re NEWS Audit, NEWS Charts - 5 charts every ward, every month on every site utilising the AMaT system. To review compliance and whether escalation processes are being followed with outcomes being fed back to wards.	Wastell, David	Completed	Training plan developed and was rolled out in March 2025 with 1st audits completed in March and April. The full audit will now start in May on all wards on all four acute sites. Meeting with Clinical Audit on 30th April 2025 to look at developing action plans on AMaT.

		Acute Deterioration E-learning modules - topics include NEWS, sepsis, DNACPR and A-E assessment being developed by the Lead Nurse for Acute Deterioration in conjunction with NHS Executive and other leads. Work to develop a process for using these modules with clinical areas in response to issues of concern.	Wastell, David	~~31/01/2025~~ ~~30/06/2025~~ 30/09/2025	Currently awaiting national updates in order to progress with this action. Links to the modules have still not been established (as of June 2025) because the guidance around NEWS2 and Sepsis is still under development.
		Review efficacy of local RADAR groups, and frequency of meetings being held	Davies, Mandy	~~30/06/2025~~ 30/09/2025	Support being given to Chair of RADAR to liaise with Chairs of local RADAR groups delays due to limited availability and operational pressures. As of June 2025, Mark Henwood is the Executive Sponsor and will be working with Mandy Davies and Vicky Hughes to undertake this review. Ongoing.
		Develop standardised template to report into Health Board RADAR group	Wastell, David	Completed	Template developed following meetings with Chairs of local RADAR.
		To develop mechanisms to review and monitor the Acute Deterioration position via Escalation Framework via the Quality domain (including the implementation of the Safety Dashboard)	Davies, Mandy	~~30/06/2025~~ 30/09/2025	Senior Nurse for Resuscitation and Acute Patient Deterioration is working with Performance Team to agree the process for data collection to inform the Dashboard, and identifying methods to prioritise the dashboard data via a RAG system.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Training compliance via ESR Cardiac Arrest Audits	RRAILS Audits undertaken by ward staff monthly, and inform the Nursing dashboards	1st			RADAR Group Update to QSESC,May 2025.	Ward based NEWS audits in place but may be unreliable as self assessed.	Once dashboards in place, to develop a monthly audit process to address key hotspots / areas of concern relating to RAILS	Wastell, David	30/09/2025	Next RADAR meeting scheduled for 20 March 2025.
	Review of DATIX incidents, complaints, cardiac arrest reports and Medical Examiners reports relating to acute deterioration	1st								
	Outreach review all unplanned admissions to Intensive Care	1st								
	RADAR Group	2nd								
	T&F Group/Oversight Group chaired by Assistant Director of Nursing and Quality Improvement with focus on Early Warning Scores and Sepsis	2nd								
	DNAR/CPR group chaired by Deputy Medical Director - group needs to be re-established (as of June 2025).	2nd								

1.5

1.5 - Targeted Intervention Progress Report

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

Attachments

1.5 De-escalation Criteria Progress Update August.pptx

QSEC - Inspection actions.pdf

Quality, Safety and Experience Committee
Escalation De-escalation Criteria Progress Update
14th August 2025

Introduction

Hywel Dda University Health Board (HDdUHB) remains under a targeted intervention framework as part of the Welsh Government's escalation arrangements for NHS bodies. This report provides an update for the Quality, Safety and Experience Committee (QSEC) on the twelve de-escalation criteria that span service fragility, clinical leadership, infection prevention and patient experience under the remit of QSEC. Each criterion summarises the underlying issue, sets out the latest evidence drawn from Board papers, dashboards and inspection reports, and then gives a judgment of Alert, Advise or Assure. The purpose of the report is to be transparent about progress, highlight where performance is improving and identify areas that still require focused attention. It builds on the Health Board's commitment to compassionate leadership and continuous improvement and is intended to support decision-making about the next steps in the escalation journey.

Targeted Intervention (TI)-2025/547/MD1/3 – Understanding drivers of service fragility

TI-2025/547/MD1/3 – Understanding drivers of service fragility
Lead executive: Sharon Daniel

Issue - The Board must be able to spot early signs of service fragility by triangulating staffing data, feedback from staff and patients, incident reports, mortality reviews and feedback from regulators.

Current status - The Fragile Services Framework rolled out this year uses a heat-map to assess fragility and route high-risk services to the Integrated Quality, Financial Performance and Delivery (IQFPD) Group, QESC and, if necessary, the Board. Initial pilots in diabetes and ultrasound services have generated improvement plans and a Fragile Services Oversight Group has been established. However, some clinical teams still rely on informal intelligence rather than systematic triangulation, and a corporate log of all external recommendations has not yet been created.

Rationale: *Advise* - The methodology is sensible, and early implementation is underway, but the framework is not yet embedded across all services. Consolidating a central register of fragile services (which has been developed) and routinely reporting fragility scores to the Board will be important next steps.

TI-2025/547/MD2/1 – Leadership and improvement planning for fragile services

TI-2025/547/MD2/1 – Leadership and improvement planning for fragile services
Lead executive: Mrs Sharon Daniel

Issue - Fragile services need clear clinical leadership, integrated improvement plans and dedicated project-management and transformation support.

Current status - Under the new framework each fragile service is expected to appoint a clinical lead and agree an improvement plan. Diabetes and ultrasound services have established improvement groups, and a Fragile Services Oversight Group monitors progress. Nevertheless, several services have yet to appoint formal leads or secure sufficient project-management capacity, and improvement plans are at varying stages of maturity.

Rationale - *Advise* – Oversight structures exist, but stronger and clearly aligned clinical leadership and fully resourced improvement programmes are required in every fragile service before assurance can be offered.

TI-2025/547/MD3/1 – Discharging external recommendations

TI-2025/547/MD3/1 – Discharging External Recommendations
Lead Executive: Mrs Sharon Daniel

Issue
Royal College reviews, Healthcare Inspectorate Wales (HIW) inspections and other external reviews have generated multiple recommendations that need to be closed or planned into the Health Board's longer-term improvement programme.
Current Status:
The Health Board has established comprehensive tracking systems through the Audit Management and Tracking system (AMaT), which provides direct access for leads to update progress and upload evidence. Significant measurable progress has been demonstrated, with overdue HIW actions reducing from 51 in February 2024 to 22 by August 2025 (57% reduction), whilst actions in progress decreased from 119 to 25 (79% reduction).

Following the May 2025 HIW correspondence regarding collective concerns about quality governance arrangements, the Health Board engaged in enhanced dialogue with HIW. The Health Board responded comprehensively to HIW's request for assurance in June 2025, with multiple touchpoints maintained throughout the period including responses to concerns about paediatric workforce, mental health provision, radiology staffing and ward assurance.

The tracking infrastructure has been independently verified as robust. However, consistent application and compliance with established processes remains variable across directorates. Whilst individual services maintain action plans, ensuring timely closure and embedding of learning requires strengthened accountability mechanisms at operational level.

TI-2025/547/MD3/1 – Discharging external recommendations

Progress Evidence

The AMaT system currently tracks all external recommendations with the following status (August 2025):

- 22 overdue actions (down from 51 in February 2024)
- 5 partially complete overdue (down from 17)
- 25 in progress (down from 119)
- 152 completed actions from open inspections

This demonstrates that whilst the systems are effective, continued focus on timely implementation and closure remains essential. The reduction in overdue actions by 57% evidences that the improvement trajectory is positive when appropriate focus and resources are applied

Rationale: Alert

The Health Board has demonstrated significant progress in reducing the backlog of overdue actions and establishing effective oversight mechanisms. The tracking systems and governance structures are in place and functioning. The recommendation is to ensure that we can further strengthen accountability and compliance:

- Clear designation of named individuals responsible for each action with defined authority to implement changes

- Realistic timescales agreed with operational teams based on resource availability

- Monthly directorate-level reviews of aged actions with escalation to executives for actions over 6 months old (this will be tracked through our revised internal escalation framework)

TI-2025/547/MD4/1 – Board oversight and response to fragile services

TI-2025/547/MD4/1 – Board oversight and response to fragile services
Lead executive: Ms Sharon Daniels

Issue – The Board must be sighted on fragile services and take timely action to mitigate risks.

Current status - The Board endorsed the Fragile Services Framework in July 2025 and agreed escalation thresholds. Fragility assessments are now reviewed by the IQFPD Group, and services scoring red or amber are then escalated to QESC and then Board. However, there is not yet a regular dashboard for the Board summarising fragility scores, improvement milestones and risk trajectories. However, this is being developed as set out in the July 2025 Board paper.

Rationale: *Advise* - escalation routes are defined and early reports have been provided, but systematic, routine Board oversight of fragile services needs to be embedded to move to assurance.

TI-2025/547/MD5/3 – Handling Unscheduled Emergency Care (UEC) concerns, complaints and incidents

TI-2025/547/MD5/3 – Handling UEC concerns, complaints and incidents
Lead executive: Mrs Sharon Daniel

Issue - Urgent and Emergency Care (UEC) remains a high risk on the corporate risk register, and the Health Board must demonstrate that it responds effectively to incidents, complaints and concerns.

Current status - The UEC risk has seen early improvements, but performance remains outside target requirements. HIW acknowledged cultural and leadership concerns and now meets monthly with the Health Board; overdue HIW actions have fallen from 51 to 17 and actions in progress from 119 to 25. The incident dashboard (Our Performance Dashboard) for unplanned care shows that Accident & Emergency (GGH) and the Emergency & Urgent Care Centre hold the largest number of open incidents (around 350 and 158 respectively), with accident/injury, pressure damage and IV-fluid errors among the most common categories. Reported incidents by month have stabilised around 120–200 per month since 2023 and almost all directorates now close over 94 % of incidents. Nonetheless, several incidents remain open for over 600 days, suggesting delays in investigation and learning. The longest open complaint regarding Accident and Emergency is 489 days; whilst the investigation has been completed, timely response to the complaint remains a concern.

Rationale: *Advise* – Timely closure of incidents is improving, however the volume of open incidents and the length of time some remain unresolved indicate that learning from events is not consistently timely. UEC teams should prioritise the oldest incidents and ensure learning panels are widely used. Similarly, early resolution of complaints raised and timely responses to complaints would demonstrate effective management of all concerns raised.

TI-2025/547/MD6/1 – Reducing Clostridioides difficile infections

TI-2025/547/MD6/1 – Reducing Clostridioides difficile infections
Lead executive: Mrs Sharon Daniel

Issue - The TI de-escalation criterion requires a 25 % reduction from the Q3 2023 baseline of eight C. difficile cases with hospital onset to a maximum of six cases per month, sustained for three months.

Current status - Between January and June 2025 the Board reported monthly C. difficile counts of 8, 4, 6, 8, 8 and 10 cases. The average (7.3 cases per month) remains above the six-per-month target, and the June 2025 spike of 10 cases indicates ongoing volatility (to note, there has due to increased incidence of norovirus been increased testing which has led to incidental CDiff infection being identified). Infection-prevention slides show that 28 of 48 C. difficile cases during April–June were hospital-onset, with the remainder community-onset, and that Carmarthenshire accounted for 16 of these hospital cases. Environmental cleaning challenges, particularly at Prince Philip Hospital (PPH), continue; deep cleaning and hydrogen-peroxide vapour (HPV) decontamination are being conducted, and patients have been identified for faecal microbiota transplant (FMT) therapy pending supply. Mandatory aseptic technique training stands at 75 % and no new outbreaks have been reported since the last update.

Rationale: *Alert* - despite active improvement work, the reduction target has not been achieved and hospital-onset cases remain high. A strengthened antimicrobial stewardship programme, consistent ward-level cleaning and timely access to FMT are needed to realise the required sustained reductions.

TI-2025/547/MD7/1 – Reducing Staphylococcus aureus bacteraemia

TI-2025/547/MD7/1 – Reducing Staphylococcus aureus bacteraemia
Lead executive: Mrs Sharon Daniel

Issue - The target is a 33% reduction in hospital-onset Staphylococcus aureus bacteraemia from a baseline of three cases per month to no more than two cases per month, sustained for three months.

Current status - From January to June 2025 the Escalation Report reported 2, 4, 4, 3, 3 and 3 hospital-onset S. aureus cases respectively, averaging 3.2 per month. In the same(April to June) period 31 patients were diagnosed across the region, but only nine were hospital-onset; the remainder occurred in the community. Most sources related to wounds, musculoskeletal sites or lines/devices. Aseptic non-touch technique (ANTT) compliance is 82.6 % (this is the e-learning element of the training only and IPSSG have supported the recommendation that there be discussion to include the assessment element of the training on ESR so that full reporting can be achieved), and line-care audits are ongoing.

Rationale: *Alert* - although hospital-onset cases are low in absolute numbers, the average remains above the two-per-month target and improvement has plateaued. Achieving the reduction will require more consistent adherence to line-care bundles and targeted action in wards with recurrent cases.

TI-2025/547/MD8/1 – Reducing Escherichia coli bacteraemia

TI-2025/547/MD8/1 – Reducing Escherichia coli bacteraemia
Lead executive: Ms Sharon Daniel

Issue - A 25 % reduction from the baseline of 6.7 cases per month means hospital-onset E. coli bacteraemia should not exceed five cases per month.

Current status - The first six months of 2025 recorded 0, 5, 8, 6, 5 and 7 hospital-onset E. coli cases, averaging 5.2 per month. Monthly infection report slides show that, of 83 E. coli cases between April and June, only 19 were hospital-onset while 64 were community-onset; urinary tract infections were the predominant source, followed by biliary tract infections and catheter-associated urinary tract infection (CAUTI).

***Rationale: Alert* –** the average remains just above the five-per-month threshold and performance is inconsistent. Reductions will rely on focused efforts to prevent urinary and biliary infections, including catheter-care audits, hydration initiatives and public-health interventions for community cases (although acknowledging that community infections is outside of the scope of escalation).

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

TI-2025/547/MD9/1 – Addressing root causes of HCAIs
Lead executive: Mrs Sharon Daniel

Issue - Beyond meeting numerical targets, the Health Board must demonstrate that it understands and addresses the underlying drivers of hospital-acquired infections (HCAIs).

Current status - The Infection Prevention Strategic Steering Group oversees a comprehensive programme. Quality-planning measures include an annual work plan, compliance with Welsh Health Circulars (WHCs) on antimicrobial resistance and HCAI improvement, and collaboration with public health and community services. Quality control efforts involve standardising assurance meetings across care groups, reviewing policies and benchmarking against national C. difficile frameworks. Quality-improvement activities include reinstated environmental audits, observational audits and action plans, deep cleaning and hydrogen-peroxide vapour decontamination at PPH, purchase of HPV units through targeted estates funding, and monthly HCAI assurance meetings with learning panels. The July slides also note that 75 % of staff have completed level-2 mandatory training and that ANTT audits are profiled across clinical care groups. Despite this robust infrastructure, challenges remain: environmental cleaning is hampered by ageing estates and staffing shortages; community-onset infections account for the majority of C. difficile, S. aureus and E. coli cases; and FMT supply constraints risk delaying treatment for recurrent C. difficile.

Rationale: *Alert* - the Health Board has implemented extensive quality-improvement initiatives and has seen some positives, yet infection rates have not sustainably fallen below thresholds. Tackling environmental limitations, reduction in the use of surge space, improving hand-hygiene compliance and strengthening community infection-prevention partnerships will be key to addressing root causes.

TI-2025/547/MD10/1 – Planned care: concerns, complaints, incidents and patient feedback

TI-2025/547/MD10/1 – Planned care: concerns, complaints, incidents and patient feedback
Lead executive: Mrs Sharon Daniel

Issue - Planned care services, including outpatient clinics and theatres, must manage incidents and complaints effectively while implementing recovery plans for lengthy waiting lists.

Current status - Quality dashboards for planned and specialist care show that incidents by month have fluctuated between 120 and 200 since 2023. Top open-incident categories include maternity adverse occurrences (147 cases), assessment/diagnosis (145) and access/admission issues (114). The longest open incidents have been outstanding for over 600–900 days, indicating delays in closure. Complaint dashboards reveal that new complaints received each month oscillate between 60 and 100, with peaks in June and October 2024. Ophthalmology, orthopaedics and gynaecology carry the highest numbers of open complaints, and some cases have been open for more than 350 days. Improvement actions taken during 2025 include insourcing and training posts for ultrasound, investment to support ophthalmology recovery, and planned replacement of ageing radiology equipment and a new aseptic unit to open in February 2026. On the positive side, there have been zero cataract pathway breaches since Q1 2025, diagnostic waits have reduced by 18 % and Single Cancer Pathway performance has improved above 60 %. However, only 38.15 % of complaints in 2025/26 were closed within 30 days, demonstrating slow complaint resolution.

Rationale: *Advise* - recovery plans are delivering improvements in waiting times and diagnostic performance (which is a theme within complaints and patient feedback), but the volume and duration of open incidents and complaints highlight weaknesses in implementation of the agreed management process and patient-experience management. Strengthening complaint-handling processes, improving communication with patients and increasing timely investigation of incidents and should be priorities before assurance can be given.

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

TI-2025/547/MD11/1 – Prompt responses to inspections, incidents and regulatory notices
Lead executive: Mrs Sharon Daniel

Issue - The Health Board must demonstrate that it responds promptly to HIW inspections, never-events, coroners' reports and Regulation 28 notifications.

Current status - The Beacon dashboard records no never-events in 2025, three in 2024 and four in 2023, and 100 % compliance with patient safety notices. The July HIW activity report notes only two HIW inspections between May and July 2025 and highlights a significant reduction in overdue actions (down from 51 to 17) and actions in progress (119 to 25). A Welsh Government letter confirms that monthly meetings with HIW have been established to share concerns and track progress.

Rationale: *Advise* – the Board has demonstrated a proactive and timely response to regulatory requests, with no never-events being reported in 2025 and a steep decline in overdue HIW actions. However, there are number of HIW recommendations that remain unaddressed and clarity around actions, milestones and owners are required. The reason this is not an Alert (as other HIW based criteria are Alert) is because of zero never events.

TI-2025/547/MD12/1 – Improved patient and family feedback

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

TI-2025/547/MD12/1 – Improved patient and family feedback
Lead executive: Mrs Sharon Daniel

Issue -The Health Board aims to increase the proportion of complaints resolved within 30 days and to use patient-experience feedback to inform service improvement.

Current status - Only 38.15 % of complaints have been resolved within 30 days in 2025/26. The People's Experience Framework and the Fragile Services Framework incorporate patient-feedback data, but the impact of these initiatives is not yet evident. Open-complaint dashboards show cases waiting over 350 days for closure. Work is underway to improve the timeliness of responses and to reduce the number of open complaints.

Rationale: ***Alert*** **-** initiatives to improve patient and family feedback are progressing, yet current performance against the 30-day standard and the persistence of long-standing complaints highlight the need for further focus or additional actions/considerations. The Health Board should prioritise increasing early resolution of complaints, responding to and closing aged complaints, communicating outcomes to families promptly and embedding learning into service improvements.

Conclusion

Overall, the evidence indicates that the Health Board is making steady but uneven progress against the targeted-intervention criteria. Board engagement, clinical leadership and regulatory responsiveness have strengthened, and there are early signs of improvement in urgent care complaints/incidents, planned care and infection-prevention governance. However, most of the infection-reduction targets remain unmet, fragile-service oversight is not yet fully embedded, and the volume and duration of open incidents and complaints could undermine public confidence. No criterion relating to prompt response to inspections and regulatory notices currently merits an Assure rating. A number of the criteria require ongoing support and monitoring: several attract an Alert rating because key outcomes have not been achieved, while others are graded Advise to reflect progress that has not yet matured into full assurance, but the numbers suggest that there are early impacts. The next steps for the Health Board include establishing a comprehensive tracker for HIW complaints which are clear around the actions/milestones owners and have realistic and deliverables timescales. The on-going rolling out the Fragile Services Framework across all care groups, accelerating actions to reduce hospital-acquired infections, and improving the timeliness of complaint handling and incident closure are essential to support de-escalation within the respective domains. By addressing these system-wide issues while sustaining the positive momentum already achieved, the Health Board can move closer to de-escalation from targeted intervention under the Performance and Outcomes within the Hywel Dda University Health Board Escalation Framework.

Recommendation

- The Committee is asked to acknowledge the measurable progress demonstrated across several criteria, particularly the 57% reduction in overdue HIW actions and improvements in regulatory responsiveness.
- The Committee is asked to note that whilst positive trajectories are evident, six criteria remain at Alert status requiring focused intervention. These Alert areas encompass infection prevention targets not being met, gaps in the systematic discharge of external recommendations and low complaint resolution rates.
- The Committee is requested to endorse the prioritised actions (or any actions/recommendations as amended by the Committee) for the Alert criteria, particularly the need for strengthened antimicrobial actions, mechanisms for external recommendations, and accelerated complaint resolution processes.

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

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

Recommendation	Reference Number	Action	Person Responsib	Lead Person	Date Raised	Original Due Date	Current Due Date	Due Date Change	Date Last Updatec	Last Updated By	Action Rating	Progress Status
Evidence that the health board has the appropriate mechanism to understand the drivers behind a fragile service through the triangulation of key data points, including staffing levels, staff and patient feedback, concerns, incidents, stakeholder feedback (HIW, Audit Wales, HMC, Royal Colleges, Llais etc), mortality reviews, duty of quality / candour, infection protection control, performance, clinical and medical leadership.	Targeted intervention/2025/547 /MD1/3	Evidence that the health board has the appropriate mechanism to understand the drivers behind a fragile service through the triangulation of key data points, including staffing levels, staff and patient feedback, concerns, incidents, stakeholder feedback (HIW, Audit Wales, HMC, Royal Colleges, Llais etc), mortality reviews, duty of quality / candour, infection protection control, performance, clinical and medical leadership. Please provide a summary of the progress so far and the next steps.	Mr Lee Davies	Mr Lee Davies	29/07/2025	01/08/2025	01/08/2025		29/07/2025	Mrs Katrina Davies	Amber	In progress
Fragile services are supported by strong clinical leadership, have an effective integrated improvement plan, project management structure and effective transformation support.	Targeted intervention/2025/547 /MD2/1	Fragile services are supported by strong clinical leadership, have an effective integrated improvement plan, project management structure and effective transformation support Please provide a summary of the progress so far and the next steps.	Ms Sharon Daniel	Ms Sharon Daniel	14/07/2025	24/07/2025	01/08/2025	01/01/1900	29/07/2025	Mrs Katrina Davies	Amber	In progress
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.	Targeted intervention/2025/547 /MD3/1	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. Please provide a summary of the progress so far and the next steps	Ms Sharon Daniel	Ms Sharon Daniel	14/07/2025	24/07/2025	01/08/2025	01/01/1900	29/07/2025	Mrs Katrina Davies	Amber	In progress
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.	Targeted intervention/2025/547 /MD4/1	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. Please provide a summary of the progress so far and the next steps	Mr Lee Davies	Mr Lee Davies	14/07/2025	24/07/2025	01/08/2025	01/01/1900	29/07/2025	Mrs Katrina Davies	Amber	In progress

Assessment of health board response and handling of concerns, complaints, incidents and patient experience feedback related to UEC. Assessment of declared BCIs, including reasons why, actions taken, and lessons learnt.	Targeted intervention/2025/547/MD5/3	Assessment of health board response and handling of concerns, complaints, incidents and patient experience feedback related to UEC. Assessment of declared BCIs, including reasons why, actions taken, and lessons learnt. Please provide a summary of the progress so far and the next steps	Ms Sharon Daniel	Ms Sharon Daniel	14/07/2025	24/07/2025	01/08/2025	01/01/1900	29/07/2025	Mrs Katrina Davies	Amber	In progress	
C-Diff: reduce the number of hospital onset infections by 25% and maintain for 3 months (from a baseline of the average number of cases in quarter 3 of 8 cases to no more than 6 per month)	Targeted intervention/2025/547/MD6/1	C-Diff: reduce the number of hospital onset infections by 25% and maintain for 3 months (from a baseline of the average number of cases in quarter 3 of 8 cases to no more than 6 per month) Please provide a summary of the progress so far and the next steps	Ms Sharon Daniel	Ms Sharon Daniel	14/07/2025	24/07/2025	01/08/2025	01/01/1900	29/07/2025	Mrs Katrina Davies	Amber	In progress	

Staph aureus: reduce the number of hospital onset infections by 33% and maintain for 3 months (from a baseline of the average number of cases in quarter 3 of 3 cases to no more than 2 per month)	Targeted intervention/2025/547/MD7/1	Staph aureus: reduce the number of hospital onset infections by 33% and maintain for 3 months (from a baseline of the average number of cases in quarter 3 of 3 cases to no more than 2 per month) Please provide a summary of the progress so far and the next steps	Ms Sharon Daniel	Ms Sharon Daniel	14/07/2025	24/07/2025	01/08/2025	01/01/1900	29/07/2025	Mrs Katrina Davies	Amber	In progress
E-coli: reduce the number of hospital onset infections by 25% and maintain for 3 months (from a baseline of the average number of cases in quarter 3 of 7 cases to no more than 5 per month)	Targeted intervention/2025/547/MD8/1	E-coli: reduce the number of hospital onset infections by 25% and maintain for 3 months (from a baseline of the average number of cases in quarter 3 of 7 cases to no more than 5 per month) Please provide a summary of the progress so far and the next steps	Ms Sharon Daniel	Ms Sharon Daniel	14/07/2025	24/07/2025	01/08/2025	01/01/1900	29/07/2025	Mrs Katrina Davies	Amber	In progress

Addressing the root cause of HCAIs and having effective response mechanisms	Targeted intervention/2025/547/MD9/1	Addressing the root cause of HCAIs and having effective response mechanisms. Please provide a summary of the progress so far and the next steps	Ms Sharon Daniel	Ms Sharon Daniel	14/07/2025	24/07/2025	01/08/2025	01/01/1900	29/07/2025	Mrs Katrina Davies	Amber	In progress
Assessment of health board response and handling of concerns, complaints, incidents and patient experience feedback related to planned care.	Targeted intervention/2025/547/MD10/1	Assessment of health board response and handling of concerns, complaints, incidents and patient experience feedback related to planned care. Please provide a summary of the progress so far and the next steps	Ms Sharon Daniel	Ms Sharon Daniel	14/07/2025	24/07/2025	01/08/2025	01/01/1900	29/07/2025	Mrs Katrina Davies	Amber	In progress

Demonstrate a prompt response to any HIW inspections, concerns, incidents, never-events, coroners requests and regulation 28s.	Targeted intervention/2025/547/MD11/1	Demonstrate a prompt response to any HIW inspections, concerns, incidents, never-events, coroners requests and regulation 28s. Please provide a summary of the progress so far and the next steps	Ms Sharon Daniel	Ms Sharon Daniel	14/07/2025	24/07/2025	01/08/2025	01/01/1900	29/07/2025	Mrs Katrina Davies	Amber	In progress
Improved patient and family feedback.	Targeted intervention/2025/547/MD12/1	Improved patient and family feedback. Please provide a summary of the progress so far and the next steps	Ms Sharon Daniel	Ms Sharon Daniel	14/07/2025	24/07/2025	01/08/2025	01/01/1900	29/07/2025	Mrs Katrina Davies	Amber	In progress

1.6

1.6 - Quality and Safety Governance Arrangements

Sharon Daniel (Hywel Dda UHB - Executive Director of Nursing, Quality & Patient Experience), James Severs (Hywel Dda UHB - Executive Director of Allied Health Professions and Health Science), Mark Henwood (Hywel Dda UHB - Executive Medical Director)

Attachments

1.6 Quality and Safety Governance Arrangements Final.pdf

Appendix A - CCG IGG QHS Standard Agenda (002).pdf

Appendix B - CCG Quality Report to QSEC Amended 190525.pdf

Appendix C - Quality Safety Intelligence Sub Group ToRs v3.3 310725.pdf

Appendix D - Comparison between QSESC TORs and revised QSIG IQFPD CCG TORs~.pdf

Appendix E QSIG Draft Agenda 290725.pdf

Appendix F QSIG Draft Work Programme 2025 26 300725.pdf

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	14 August 2025
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Proposed Quality & Safety Governance Arrangements
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Sharon Daniel, Director of Nursing, Quality and Patient Experience
SWYDDOG ADRODD: **REPORTING OFFICER:**	James Severs, Director of Allied Health Professions and Health Science Mark Henwood, Medical Director Andrew Carruthers, Chief Operating Officer

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this paper is to share the proposed revised and strengthened quality & safety governance arrangements across the operational arm of the Health Board to manage any potential gaps, inconsistencies or duplication in reporting.

This paper will set out the justification for these proposals, and the changes that have been made to ensure the Quality, Safety and Experience Committee (QSEC) can receive the necessary assurance required from the operational governance arrangements now in place to enable it to approve the dis-establishment of its Quality, Safety and Experience Sub-Committee (QSESC).

Cefndir / Background

It is acknowledged that, for some time, the Quality, Safety & Experience Sub-Committee (QSESC) has not been operating effectively in its current establishment within the assurance arm of the Health Board as a Sub-Committee of Quality, Safety & Experience Committee (QSEC).

Since August 2024, the following 9 groups have reported directly into QSESC, via a Triple A report, every other meeting, however the tendency from these 9 groups has been to report on operational matters, which it is considered would be better managed within the Health Board's operational arm.

- Effective Clinical Practice Advisory Panel
- Medicines Management Operational Group
- Human Tissue Authority Assurance Group
- Mental Capacity Act & Consent Group
- Nutrition & Hydration Group
- RADAR Group
- Medical Devices Group

- Infection Prevention Strategic Steering Group
- Strategic Safeguarding Group

Prior to April 2025, QSESC also received Triple A reports directly from the Acute Directorate, Mental Health & Learning Disabilities Directorate and Primary & Community Services Directorate Quality Governance Groups. These were scheduled to every other QSESC meeting. Again however, the tendency had been to report on operational matters into the assurance arm of the Health Board.

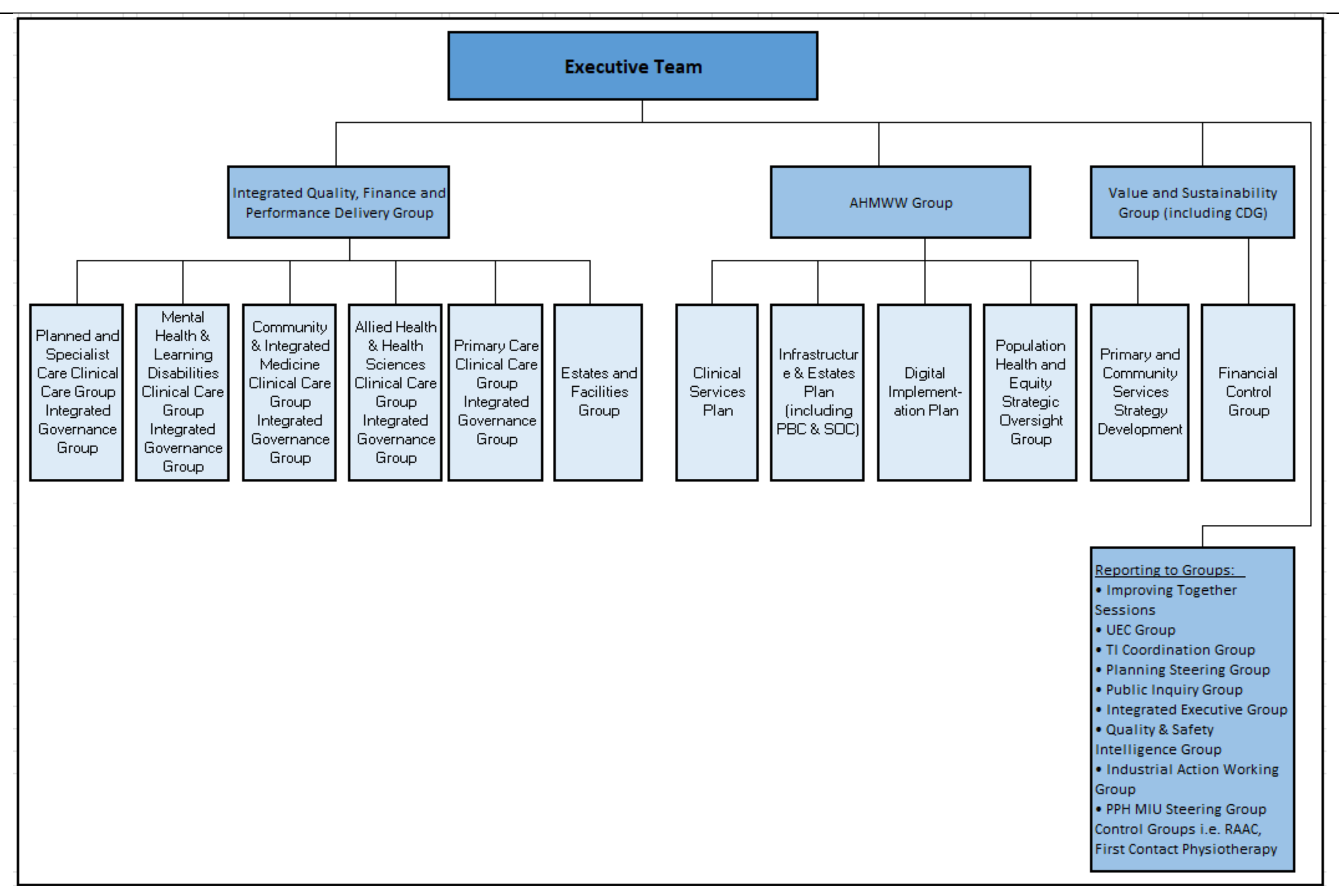
Since the establishment of the new Operational structure within the Health Board from April 2025, 6 Clinical Care Groups have replaced these previous Directorates, and are required, through the operational governance arrangements that have been put in place, to report monthly on their quality and safety arrangements through their Integrated Governance Group meetings to the Integrated Quality, Finance, Performance & Delivery Group (IQFPDG), which in turn reports into Executive Team. In addition to this, the Clinical Care Groups have been requested to provide a Quality Governance Assurance Report to QSESC on a 6 monthly rotational basis on QSESC's agenda.

In light of these new operational governance arrangements, discussions have been held with the Health Board's Clinical Executive Directors, the Chief Operating Officer and the Health Board's wider Executive Team, to inform this proposal which will aim to strengthen and streamline quality & safety governance arrangements across both the operational and the assurance arm of the Health Board, and to ensure there are no gaps, inconsistencies or duplication.

Asesiad / Assessment

New Operational Governance Arrangements Since April 2025

An organogram depicting the reporting arrangements between the 6 Clinical Care Groups Integrated Governance Groups and IQFPDG (and upward to Executive Team) is set out overleaf:



IQFPDG alternates its fortnightly meetings between a focus on business planning, performance & people once a month, and quality, health & safety once a month. It has been agreed that when IQFPDG is focused on quality, health & safety, chairing will be undertaken by a Clinical Executive Director i.e. the Director of Allied Health Professions & Health Science, with the Chief Operating Officer chairing the business planning, performance & people focused IQFPDG meetings.

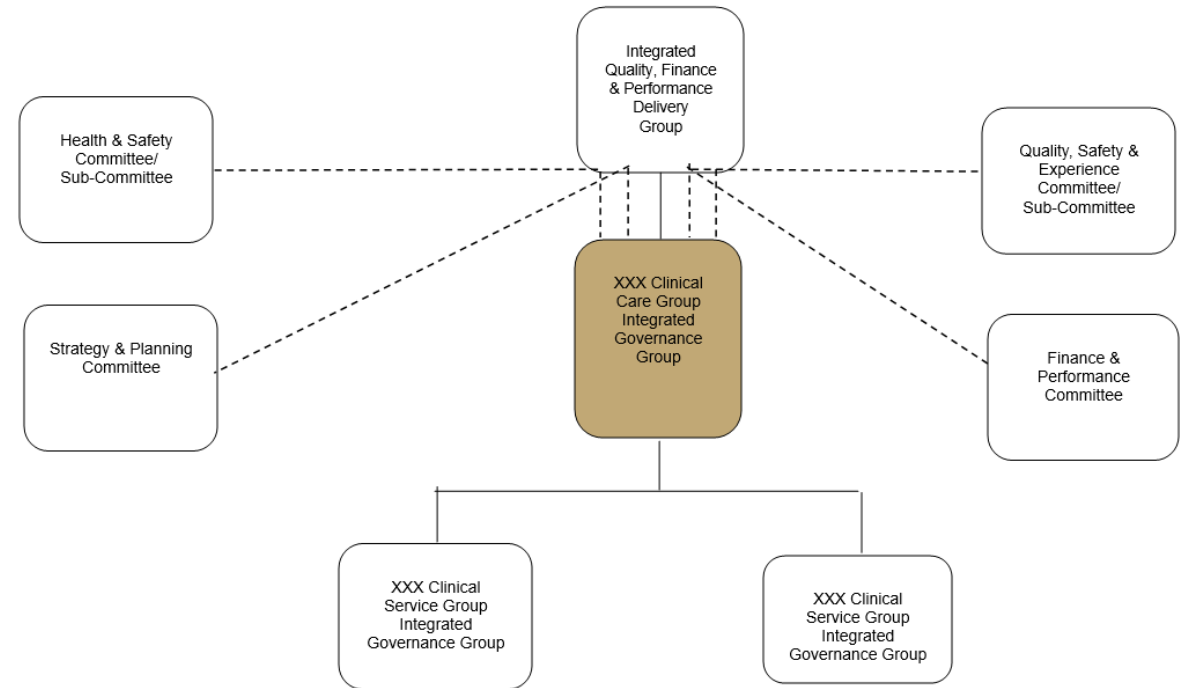
Clinical Care Groups are required to maintain the same meeting rhythm with their Integrated Governance Groups to ensure there is no gap in reporting into IQFPDG. Similar to the chairing arrangements within IQFPDG, chairing of the Clinical Care Groups Integrated Governance Groups, when focused on quality, health & safety, will be undertaken by their Assistant Directors of Nursing, Patient Safety, Quality & Experience/Assistant Director of Quality, Safety and Experience (with the Clinical Care Groups Service Directors chairing their business planning, performance & people focused Integrated Governance Group meetings).

Standard agendas have been issued for Clinical Care Groups to follow for their quality, health & safety Integrated Governance Group meetings, to instruct them on the types of reports they need to include for discussion i.e. a patient story; concerns reports; learning from events; mortality reviews; external audits and regulatory reports; etc. See Appendix A.

While Clinical Care Groups Integrated Governance Groups are directly accountable to the IQFPDG, it is anticipated that elements of their work will also feed into the Health Board's assurance arm. For example, quality and safety matters would be reported to the Quality, Safety & Experience Committee; health and safety matters to the Health & Safety Committee; financial/performance matters to the Finance and Performance Committee; and planning matters or proposed service changes, etc, to the Strategy and Planning Committee.

Where appropriate and when timing allows, IQFPDG will direct where papers will need to be prepared for relevant Committees of the Board, and endorsement from the IQFPDG may be necessary for the progression of a range of operational matters through the Health Board's governance framework and pathways.

See organogram below:



Following the establishment of the Operational structure in April 2025, a revised 'assurance style' reporting template has been introduced for the Clinical Care Groups to submit, on rotation to the Quality & Safety Sub-Committee (QSESC), again placed at 6 monthly intervals, on QSEC's agenda *CCG Quality Report to QSEC* See Appendix B.

Proposed Quality & Safety Governance Arrangements Across the Health Board's Operational and Assurance Arms

Since the introduction of the new operational governance arrangements, discussions have been held with the Health Board's Clinical Executive Directors and Chief Operating Officer to consider how best to address any gaps, inconsistencies or duplication in terms of quality & safety governance arrangements across both the operational and the assurance arm of the Health Board, and to consider where best to hold discussions on quality data.

To this end, and to strengthen operational quality and safety governance arrangements, it has been agreed that the Health Board's Quality & Safety Intelligence Group (QSIG), previously an advisory group reporting into Executive Team, will move to becoming an intelligence–led group reporting into IQFPDG.

It is recognised that the Quality & Safety Intelligence Group, currently comprising HDdUHB's Clinical Executive Directors together with Deputy and Associate Directors, would need to adopt a more formal approach in terms of a maintenance of its monthly meeting rhythms in order that the 'intelligence' from QSIG can be brought regularly to IQFPDG to provide the context for its monthly quality, health & safety focused meetings, through a composite 'intelligence' report, based on the Quality & Safety Dashboard, the monthly escalation levels for functions for the

Quality domain with de-escalation criteria for Clinical Care Groups, and any other concerns or issues related to quality performance with proposed actions for IQFPDG to agree for the CCGs.

This would enable the Clinical Care Groups Service Directors and Assistant Directors of Nursing, Quality and Experience/Assistant Director of Quality, Safety and Experience present at IQFPDG, to be directly informed of the quality & safety issues within their specific areas in order that the service can then operationalise any responses that may be required.

Cross-organisational learning across CCGs will also be facilitated at IQFPDG as a 'home' for discussion and cross-pollination of insights and ideas with the aim of avoiding siloed solutions.

It is anticipated that QSIG would continue to issue 'outcome letters' from its discussions to the Clinical Care Group Service Directors to follow up on any action required within their respective services.

In addition, a summary report of the Quality & Safety intelligence would be reported to Executive Team, appended to the routine IQFPDG Update Report, providing an overview of any issues that needed actions agreed through IQFPDG for Clinical Care Groups to take forward.

It is also proposed that the 9 operational groups currently reporting into QSESC should, more appropriately, report into the operational arm of the Health Board, through the Quality & Safety Intelligence Group, alongside QSIG's current reporting group, the Fragile Services Oversight Group. This would require a change to the reporting arrangements within these 9 operational groups' Terms of Reference, approval of these Terms of Reference at the next scheduled meeting of QSIG, and a conversation with their Chairs on QSIG's expectations of how these reporting groups will operate going forward.

This would also require changes to be made to QSIG's membership in terms of the addition of the Chairs of these 9 reporting groups, as well as including the Chair of the Medical Exposures Group, as identified by the clinical Executive Directors.

QSIG would, in turn, incorporate into their composite intelligence report to IQFPDG, any issues from the 11 operational groups and the proposed actions required for IQFPDG to agree for the Clinical Care Groups.

To manage the additional workload involved for QSIG, and to manage IQFPDG's agenda, it is proposed that the 11 reporting groups maintain their current bi-monthly meeting rhythm and report in, on rotation - 3 groups every 4 months, to QSIG's agenda with 3 of the reporting groups' data reported to IQFPDG once every 4 months.

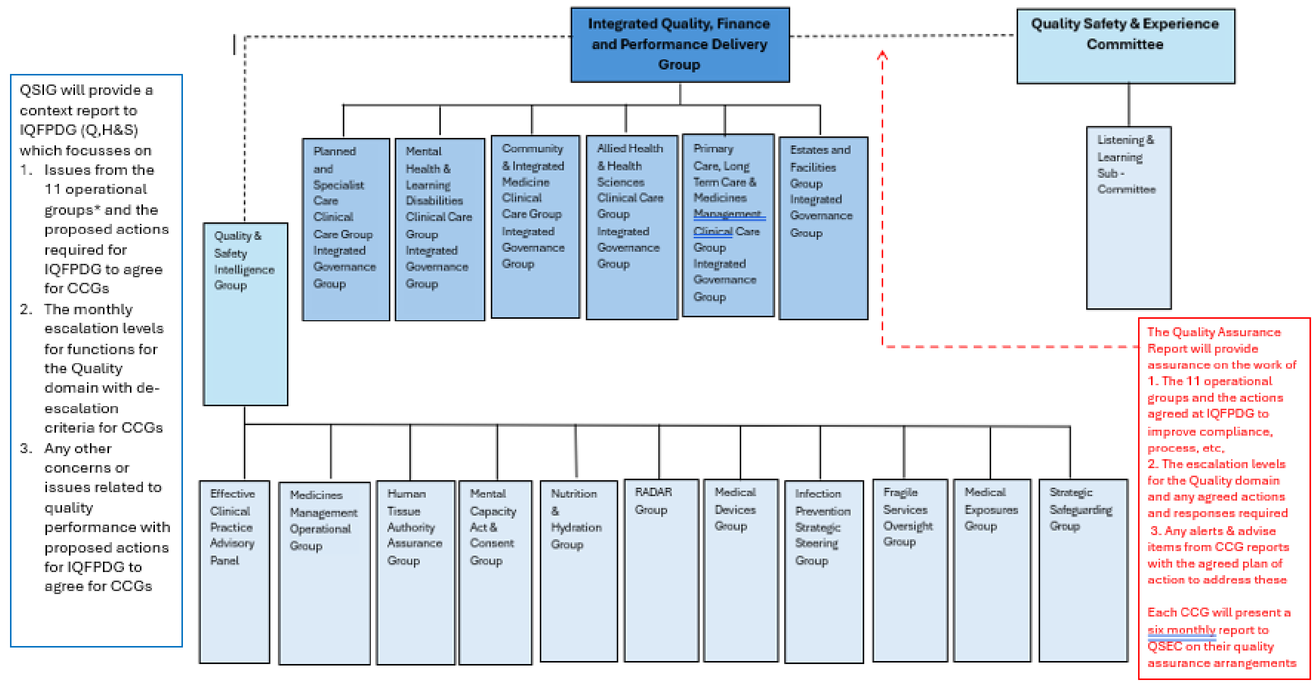
Links into the Health Board's assurance arm would also be made via a quality assurance report to QSEC, constructed by the Interim Assistant Director of Nursing Assurance & Safeguarding, drawing out the key issues from the intelligence provided for the 11 reporting groups (3 times per year) and any alert and advise items from the 6 Clinical Care Group 3As reports with the agreed plan of action to address these. This report would also provide an assurance on the work involved, including an assurance on QIA Panels, and the actions agreed at IQFPDG to improve quality and safety, compliance, etc, as well as the escalation levels for the Quality domain and any agreed actions and responses required.

In respect of safeguarding and infection prevention & control, QSEC will receive additional assurance, on a 6 monthly basis, on both these matters through separate assurance reports which will be added to the QSEC workplan.

As an example of how matters would be reported through these new quality & safety governance arrangements, should the Infection Prevention Strategic Safeguarding Group (IPSSG) raise an issue regarding handwashing compliance, this will be reported up from IPSSG to QSIG where the actions that would need to be taken to address any areas of non-compliance would be included in the composite intelligence report presented to IQFPDG for discussion with the relevant CCG Service Directors and Assistant Directors of Nursing, Quality and Experience/Assistant Director of Quality, Safety and Experience. Once any required operational or management response has been identified, and addressed, this will be included in the 6 monthly infection prevention & control report to QSEC to provide an assurance on any improvements that have been made.

In addition to the Quality Assurance report, QSEC will also receive a six monthly assurance report from each CCG, and Public Health, on their quality governance arrangements. As outlined above, these reports are currently provided to QSESC. This will enable QSEC to gain assurance direct from each CCG.

An organogram illustrating these proposed arrangements is set out below:



Given these proposed Quality & Safety governance arrangements across the Health Board's operational arm, it is proposed to dis-establish QSESC, moving its functions and its 9 reporting groups under QSIG, whose extended remit it is expected will address the likelihood of any gaps associated with QSESC's dis-establishment.

Dis-establishing QSESC will also enable the revised operational governance arrangements to be appropriately supported and implemented, as it is recognised that there would not be sufficient capacity to support both from within current corporate and operational teams.

Should this proposal receive QSEC's approval, these new arrangements are included in the revised QSIG's Terms of Reference at Appendix C.

A comparison undertaken of QSESC's and QSIG's Terms of Reference to determine where QSESC's responsibilities are covered off by either by QSIG, IQFPD, or the CCGs themselves,

has concluded that no gaps will be introduced by dis-establishing QSESC. A table to support this has been crafted to accompany this report (see Appendix D).

A draft agenda and draft annual workplan have been developed for QSIG and are attached, for information, at Appendices E and F.

For QSEC's further assurance, these arrangements will be reviewed by Internal Audit in 2026/27.

Argymhelliad / Recommendation

QSEC is requested to:

- Receive an assurance that QSESC's previous functions have been mapped to the new proposed approach, with due consideration to its governance requirements and accountabilities, with enhanced reporting arrangements to QSEC in place;
- **APPROVE** the dis-establishment of QSESC;
- **NOTE** that, for further assurance, a report will be presented to QSEC in 6 months' time to provide an update on the effective implementation of these new operational quality & safety arrangements.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	12.1: These Terms of Reference and operating arrangements shall be reviewed on at least an annual basis by the Committee for approval by the Board.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	Not Applicable

Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	QSEC Terms of Reference Establishment/Dis-establishment of Committees/Sub-Committees (SOP for the Management of Board and Committees)
Rhestr Termau: Glossary of Terms:	Contained within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	Director of Corporate Governance (Board Secretary) Assistant Director of Assurance and Risk Executive Team Quality & Safety Intelligence Group

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No direct impacts
Ansawdd / Gofal Claf: Quality / Patient Care:	The intention of this report is to improve quality & safety governance arrangements to drive improvements within clinical services
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

Standard Agenda for the XXX Clinical Care Group Integrated Governance Group (focus on Quality, Health & Safety)

Governance

1. Welcome and Apologies

2. Declaration of Interests

3. Notes of the Previous Meeting

4. Table of Actions/Matters Arising

Urgent/Emerging Issues

5.

Safety & Experience

6. Patient Story *Link in with Patient Experience Team.*

7. Harms Dashboard

8. Concerns Report *Overview of incidents, complaints, claims, Medical Examiners concerns, Ombudsman cases, police investigations, coroners' inquests, Regulation 28 – or any other feedback received – with a focus on learning arising from these as well as understanding progress against any action plans, key risks and mitigation arrangements.*

9. Learning from Events (including Serious Concerns, Walkrounds and Observations of Patient Care – improvement and learning action plans To be an agenda item until action plan is fully closed (actions must be SMART). New serious concerns should be included within the Clinical Care Group report to IQFPDG and/or QSEC/QSESC when action plans completed or reported as completed).

10. Mortality Reviews (Clinical Care Group or Clinical Service Group level) *To include learning and actions. May also include morbidity reviews.*

11. Infection, Prevention and Control *Consider any outbreak incidents, outcomes from MRSA/Cdiff reviews. PPE guidance, particularly in light of COVID-19. Review environmental audits associated with IPC.*

12. Safeguarding Update from Clinical Care Group/Clinical Service Groups *Any escalation from Delivery Groups – needing to be considered at IGG.*

13. Population Health and Outcomes

Quality and Effective Clinical Practice

14. Clinical Audit (Clinical Care Group or Clinical Service Group level Consider Clinical Care Group/Clinical Service Group audit plan. Discuss any published National audit recommendations.

15. NICE and other National Guidance (including New Interventional Procedures, INNU and NatSSIP's/LocSSIPs) To include learning and actions. May also include morbidity reviews.

16. Safety Alerts and Safety Notices *To include implementation and monitoring of Safety Alerts relevant to Clinical Care Group/Clinical Service Group.*

17. Welsh Health Circulars (and other national guidance)

18. Quality Impact Assessments/Integrated Impact Assessments

19. R&D Activity Update *E.g. the activity being undertaken at a Clinical Care Group/Clinical Service Group level*

Health & Safety

20. Compliance with legislation and standards in respect of health and safety
21. Staff incidents and RIDDOR
22. Health and Safety Inspection/Audit findings
23. Health and Safety training compliance e.g. Manual Handling, Reducing Restrictive Practice/Violence and Aggression
24. Relevant Health and Safety Executive reports

External Audit and Regulatory Reports *Sign off of draft reports and management responses/action plans will need to be through groups where meetings are missed, Chair's Action will need to be taken and reported to the next meeting.*

25. Audit Reports *Progress against the agreed audit plan and any changes to practice as a consequence.*

26. Healthcare Inspectorate Wales Reviews/Reports *To be an agenda item until action plan is fully closed (actions must be SMART). New HIW reports should be included within the Clinical Care Group/Clinical Service Group report to QSEC/QSESC and when action plans completed reported as completed.*

27. Relevant Care Inspectorate Wales Reports *If relevant to the Clinical Care Group/Clinical Service Group, discuss published reports, outcome from any recent visits.*

28. Getting It Right First Time Reviews (GIRFT) *If relevant to the Clinical Care Group/Clinical Service Group, discuss recommendations.*

29. Peer Reviews *If relevant to the Clinical Care Group/Clinical Service Group, discuss outcome of internal/external published reviews, learning.*

30. Royal College Reports *If relevant to the Clinical Care Group/Clinical Service Group, discuss recommendations.*

31. Other *E.g. accreditation issues, thematic analysis of triangulated information at Clinical Care Group/Clinical Service Group level.*

Risk, Impact and Fragility Assessment

32. Clinical Care Group/Clinical Service Group/Risks Update *To include previously identified risks, their scores, and mitigation, and from any other discussions on concerns, complaints, and incidents – to consider whether these identify any further risks). Inclusive of new risks for consideration of adding to Clinical Care Group/Clinical Service Group Risk Register, risks to be closed.*

33. Quality Impact Assessments/Integrated Impact Assessments

34. Fragility Assessments

Portfolio/Service Assurance Exception Reports

35. Exception reports from individual service areas *To include areas requiring discussion from individual service area e.g. Issues for escalation/discussion. Good Practice, Wider learning.*

For Information

36.

Items for Sharing/Escalation

To agree items for sharing to:

37. XXX Clinical Care Group Integrated Governance Group (focus on Business Planning, Performance & People)
38. Other Clinical Care Groups Integrated Governance Groups

To agree items for escalation to:

39. Integrated Quality, Finance and Performance Delivery Group (IQFPDG) *To include any proposed items for Quality, Safety & Experience Sub-Committee/Committee and/or the Health & Safety Sub-Committee/Committee, following IQFPDG's review.*

40. Effective Clinical Practice Advisory Panel

Any Other (Urgent) Business

Date and Time of Next Meeting

APPENDIX B

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	Click here to enter a date.
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	*Insert* Clinical Care Group Quality Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	
SWYDDOG ADRODD: **REPORTING OFFICER:**	

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Choose an item.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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

Cefndir / Background

An example of what could be included in this section
The *insert* Clinical Care Group – *give a description of what Service Groups are in the* Clinical *Care Group*

The aim of the *insert* Clinical Care Group in summary is to:

- Ensure there is a process in place to continually monitor and review its risk register, acting to mitigate quality and safety risks on an ongoing basis;
- Maintain an open culture of improving quality, safety and patient experience across all teams and all staff;
- Promote a positive culture of staff engagement, development and understanding of everyone's responsibility for safe, quality care and
- Foster a culture of psychological safety within *insert* Clinical Care Group in order to promote collaboration, trust, innovation and personal growth.

Meeting the Duty of Quality is the highest priority for the Clinical Care Group and its governance structures and oversight has developed significantly. The Service Director, Associate Medical Director and Assistant Director of Nursing lead the agenda which is aligned to the six domains of quality as defined by the Duty of Quality Statutory Guidance 2023. This report is set out under each of these domains.

Asesiad / Assessment

This section should be an assessment of the Clinical Care Groups current position. It should be written from the perspective of quality and provide evidence to help inform decision making. Where risks or issues are described it should detail what the Clinical Care Group is doing to address the risks or issues.

Quality Assurance

Please give an assessment of the Clinical Care Group's quality governance arrangements e.g. The *insert* Clinical Care Group's Integrated Governance Group (focused on Quality, Health & Safety) are planned every month, and are well represented by medical, nursing and managerial staff across all Clinical Service Groups, as well as other multi-disciplinary colleagues from across the Health Board, all of which take an active part in the meetings and shape the overall agenda. The Group's Terms of Reference and Work Plan are reviewed annually and it is supported by sub groups covering ….

Each Clinical Service Group also holds monthly Integrated Governance Group (focused on Quality, Health & Safety), and further work is underway to strengthen this structure and reporting to the Clinical Care Group's Integrated Governance Group (focused on Quality, Health & Safety).

Safe Care

This section should include:

- Incident reporting using graphs from the Our Safety Dashboard (themes, management etc)
- Nationally reportable incidents including an overview of what the Clinical Care Group is currently investigating, what has been learnt on ones closed since the last report and improvement action plans currently open
- Compliance with patient safety notices and alerts
- Peer review relevant to the Clinical Care Group. AMAT graphs can be used
- Safeguarding
- Infection prevention and control
- Mortality reviews
- Inquests including any Reg 28 Prevention of Future Deaths Report
- Claims and redress (relating to safe care)
- Relevant risk recorded on the risk register (high or extreme risks)

Timely

This section should include:

- The issues within each service group e.g. waiting times, access etc. Patient experience feedback should be used to support the issues
- Relevant risk recorded on the risk register (high or extreme risks)

- Claims and redress (relating to timely care)

Effective

This section should include:

- Quality improvement
- Clinical Audit
- Relevant risk recorded on the risk register (high or extreme risks)

Evidence based

This section

- Compliance with national guidelines e.g. NICE, Welsh Government Quality Standards etc. Data graphs from AMAT can be used to support this paragraph.
- Relevant risk recorded on the risk register (high or extreme risks)

Equitable

This section:

- Complaints related to equitable care and actions being taken
- Relevant risk recorded on the risk register (high or extreme risks)

Person Centred

This section should include:

- Person experience (CIVICA data and 'you said, we did' etc)
- Complaints (themes, management etc)
- PSOW
- HIW reports
- Llais reports
- Relevant risk recorded on the risk register (high or extreme risks)

Argymhelliad / Recommendation

(N.B. Only one of the following directions should be identified for the Committee):

- Decision – i.e. reaching a conclusion after the consideration of options
- Assurance – i.e. whether an assurance, or otherwise, can be taken from the report
- Discussion – i.e. examine and consider the implications of a matter
- For Information

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

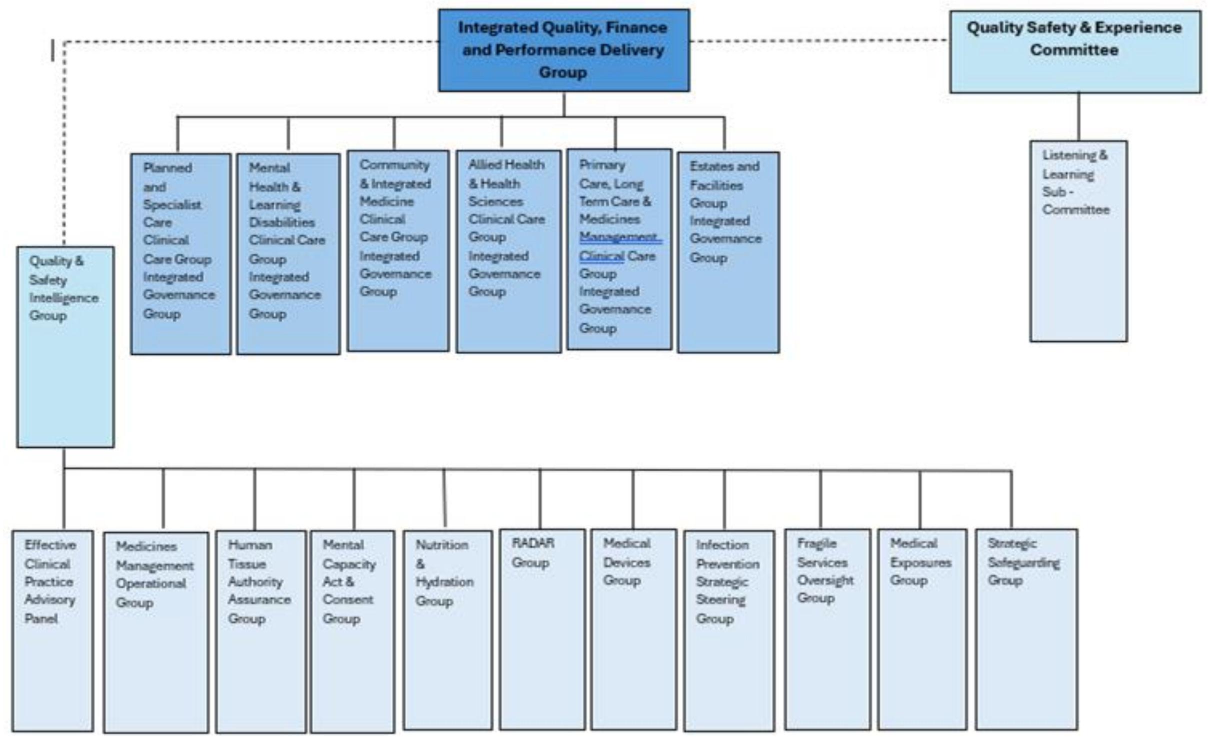
Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Parthau Ansawdd: Domains of Quality	Choose an item. Choose an item.

Quality and Engagement Act (sharepoint.com)	Choose an item. Choose an item.
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	Choose an item. Choose an item. Choose an item. Choose an item.
Amcanion Strategol y BIP: UHB Strategic Objectives:	Choose an item. Choose an item. Choose an item. Choose an item.
Amcanion Cynllunio Planning Objectives	Choose an item. Choose an item. Choose an item. Choose an item.
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	Choose an item. Choose an item. Choose an item. Choose an item.

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	e.g. financial impact or capital requirements: (if yes, please complete relevant section of the Integrated Impact Assessment Template available via the link below) Integrated Impact Assessment Template
Ansawdd / Gofal Claf: Quality / Patient Care:	e.g. adverse quality and/or patient care outcomes/impacts: (if yes, please complete relevant section of the Integrated Impact Assessment Template available via the link below) Integrated Impact Assessment Template

Gweithlu: **Workforce:**	e.g. adverse existing or future staffing impacts: (if yes, please complete relevant section of the Integrated Impact Assessment Template available via the link below) Integrated Impact Assessment Template
Risg: **Risk:**	e.g. risks identified and plans to mitigate risks: (if yes, please complete relevant section of the Integrated Impact Assessment Template available via the link below) Integrated Impact Assessment Template
Cyfreithiol: **Legal:**	e.g. legal impacts or likelihood of legal challenge: (if yes, please complete relevant section of the Integrated Impact Assessment Template available via the link below) Integrated Impact Assessment Template
Enw Da: **Reputational:**	e.g. potential for political or media interest or public opposition: (if yes, please complete relevant section of the Integrated Impact Assessment Template available via the link below) Integrated Impact Assessment Template
Gyfrinachedd: **Privacy:**	e.g. potential impact on individual's privacy rights or confidentiality and/or the potential for an information security risk due to the way in which information is being used/shared, etc: (if yes, please complete relevant section of the Integrated Impact Assessment Template available via the link below) Integrated Impact Assessment Template
Cydraddoldeb: **Equality:**	e.g. potential negative/positive impacts identified in the Equality Impact Assessment (EqIA) documentation – follow link below • Has EqIA screening been undertaken? Yes/No (if yes, please supply copy, if no please state reason) • Has a full EqIA been undertaken? Yes/No (if yes please supply copy, if no please state reason) Equality Impact Assessment



TERMS OF REFERENCE

QUALITY AND SAFETY INTELLIGENCE GROUP

Version	Issued to:	Date	Comments
V1.0	Executive Team	November 2021	Approved version
V1.1	Integrated Quality, Finance and Performance Delivery Group (IQFPDG)	12/06/2024	For Approval
V2.0	Executive Team Integrated Quality, Finance and Performance Delivery Group (IQFPDG)	21/08/2024	Approved version
V3.0	Quality, Safety and Intelligence Group		
V3.1	Quality, Safety and Intelligence Group	05/02/2025	For Review
V3.2	Quality and Safety Intelligence Group	07/07/2025	For Review
V3.3	Quality, Safety & Experience Committee	14/08/2025	For Assurance

1. CONSTITUTION

1.1 The Quality and Safety Intelligence Group has been established as an intelligence-led Advisory Group to the Integrated Quality, Finance & Performance Delivery Group (IQFPDG) and constituted from 12th June 2024.

2. PURPOSE

2.1 The Quality and Safety Intelligence Group will monitor the quality and safety arrangements within Operational services, ensuring that the clinical Executive Directors are aware of, and have the opportunity, to review Quality and Safety data and discuss any patient safety related or other significant issues which have the potential to impact on quality and patient safety. This review of data will be linked to the established escalation arrangements to improve the effectiveness of operational services, and ultimately the quality and safety of care.

The Quality and Safety Intelligence Group will:

2.1.1 Discuss significant issues arising or that have the potential to impact on patient safety, particularly those within the Health Board's most fragile services. This may include serious incidents, complaints, and risks that have been reported through the Datix Cymru reporting system, through quality, safety and experience concerns that have been raised by the service, or through other intelligence gathering mechanisms.

2.1.2 Utilising established and developing metrics agree triggers within the Quality and Intelligence data e.g. Medical Examiner, deteriorating patient/Cardiac arrest, hospital acquired Infection, hospital acquired VTE, issues relating to DNACPR.

2.1.3 Review dashboard/dataset and analysis, and identify any areas where immediate action is required to protect the safety of patients and staff

2.1.4 Identify further action required based upon the information available which may require escalations, including investigation, deep dive request to relevant Groups or Sub-Groups, etc.

3. OPERATIONAL RESPONSIBILITIES

The Quality and Safety and Intelligence Group will:

3.1 Ensure oversight of those performance measures that focus on the delivery of quality and safe services within the NHS Wales Performance Framework.

3.2 Oversee and agree the escalation levels for the domain of quality of the internal Improving together framework, providing clear de-escalation criteria and areas of improvement to Clinical Care Groups and Clinical Service Groups classed as providing either 'limited' or 'no assurance.

3.3 Make use of key performance indicators/metrics, including triangulation with patient feedback, surveys and patient stories, to evaluate what is working well and what is not, focusing on exceptions, both positive and negative.

3.4 Request further information/deep dives regarding any issue of concern to inform decision-making.

3.5 Ensure appropriate improvement actions are conveyed where performance is not meeting expectations.

3.6 Detect any trends to mitigate issues before they arise or reduce the impact of risk.

3.7 Provide a Quality and Safety Intelligence Report to the Integrated Quality, Finance and Performance Delivery Group, in regard to all of the above, setting out the improvement actions required.

3.8 Receive updates from each of its reporting groups indicating the Health Board's position against the required legislation or standards, and agreed performance metrics/outcome measures in place, identifying any gaps in achieving these/compliance, and how these will be addressed through any actions required.

3.9 Horizon scan and feedback from national groups to ensure local awareness and development of measures linked to delivery of the quality, safety and experience agenda.

3.10 In respect of areas of concern raised by services the Group will seek to address those concerns raised by services through a variety of sources including, but not limited to the following:

- Quality and Safety Dashboard
- Performance Dashboard
- Listening and Learning Sub-Committee

4. MEMBERSHIP

4.1 The membership of the Quality and Safety Intelligence Group shall comprise:

Title
Director of Nursing Quality, Safety and Experience (Chair)
Director of Allied Health Professions and Health Science (Vice Chair)
Medical Director
Deputy Director of Allied Health Professions
Deputy Director of Health Science
Deputy Medical Director for Acute Services
Deputy Medical Director for Primary Care
Associate Medical Director for Quality & Safety
Assistant Director of Nursing for Assurance, & Safeguarding
Assistant Director for Patient Experience & Legal Services
Assistant Director of Nursing, Quality Improvement
Head of Quality and Governance
Head of Clinical Effectiveness
Chairs of Reporting Groups (Attending on Rotation to Present Update Reports)
Chair, Effective Clinical Practice Advisory Panel
Chair, Medicines Management Operational Group

Chair, Human Tissue Authority Assurance Group
Chair, Mental Capacity Act & Consent Group
Chair, Nutrition & Hydration Group
Chair, RADAR Group
Chair, Medical Devices Group
Chair, Infection Prevention Strategic Steering Group
Chair, Fragile Services Oversight Group
Chair, Medical Exposures Group
Chair, Strategic Safeguarding Group
In Attendance
Secretariat

4.2 The membership of the Group will be reviewed on an annual basis.

5. QUORUM AND ATTENDANCE

5.1 A quorum shall consist of no less than a third of the membership and must include as a minimum two clinical Executive Directors and one deputy Clinical Director, together with the Chair (or representative) of the 3 Reporting Groups required to attend on rotation at each meeting to present their respective update reports.

5.2 Any senior officer of the Health Board may be invited to attend by the Group where it is felt appropriate to do so.

5.3 The Group may also co-opt additional independent external 'experts' from outside the organisation to provide specialist knowledge.

5.4 Should any member be unavailable to attend, they may nominate a deputy to attend in their place, subject to the agreement of the Chair.

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

6. AGENDA AND PAPERS

6.1 The Quality and Safety Intelligence Group's agenda will be standardised and based around identified risks, matters arising from previous meetings. Issues emerging throughout the year and requests from Group members will be added to the agenda as necessary.

6.2 Dashboards and datasets will be utilised and will be available to all members in advance of the meeting.

6.3 The agenda and papers for meetings will be distributed six days in advance of the meeting.

6.4 Draft action notes and tracking log will be circulated to members within seven days to check the accuracy.

6.5 Outcome letters from the Group will be issued to the relevant Clinical Care Group/Clinical Service Group or other Operational service to follow up on any action required.

7. FREQUENCY OF MEETINGS

7.1 The Quality and Safety Intelligence Group will meet monthly. Additional meetings will be arranged as determined by the Chair of the Group.

7.2 The Chair of the Group, in discussion with the Quality Safety and Assurance Team shall determine the time and the place of meetings of the Group and procedures of such meetings.

8. ACCOUNTABILITY, RESPONSIBILITY AND AUTHORITY

8.1 The Quality and Safety Intelligence Group is accountable for its performance in exercising the functions set out in these terms of reference.

8.2 The Group shall embed the University Health Board's vision, corporate standards, priorities and requirements, e.g. equality and human rights, through the conduct of its business.

8.3 The requirements for the conduct of business as set out in the University Health Board's Standing Orders are equally applicable to the operation of the Group.

8.4 The Group's Chair, supported by the Group's Secretary, shall:
- 8.4.1 Report formally, regularly and on a timely basis to the Integrated Quality, Finance and Performance Delivery Group on the Group's activities through the submission of a Quality Intelligence Report.
- 8.4.2 Bring to Integrated Quality, Finance and Performance Delivery Group's specific attention any significant matters under consideration by the Group.

9. REPORTING

9.1 The Quality and Safety Intelligence Group may establish reporting groups or task and finish groups to carry out on its behalf specific aspects of the Group's business. The Group will receive an update following each of its reporting groups meetings detailing the business undertaken on its behalf.

9.2 The following Groups report directly to the Quality and Safety Intelligence Group:

- 9.2.1 Effective Clinical Practice Advisory Panel
- 9.2.2 Medicines Management Operational Group
- 9.2.3 Human Tissue Authority Assurance Group
- 9.2.4 Mental Capacity Act & Consent Group
- 9.2.5 Nutrition & Hydration Group
- 9.2.6 RADAR Group
- 9.2.7 Medical Devices Group
- 9.2.8 Infection Prevention Strategic Steering Group
- 9.2.9 Fragile Services Oversight Group
- 9.2.10 Medical Exposures Group

9.2.11 Strategic Safeguarding Group

9.3 These Groups shall maintain their current bi-monthly meeting rhythm and:

9.3.1 Report, formally, regularly and on rotation (i.e. every 4 months) to the Quality and Safety Intelligence Group on their work programme activities, compliance with legislation/standards and agreed performance metrics/outcomes measures.

10. SECRETARIAL SUPPORT

10.1 The secretariat will be provided by the Quality Assurance and Safety Team.

11. REVIEW DATE

11.1 These terms of reference and operating arrangements shall be reviewed on at least an annual basis by the Quality and Safety Intelligence Group.

Comparison between the Quality, Safety & Experience Sub-Committee Terms of Reference and the revised Quality & Safety Intelligence Group Terms of Reference

Responsibilities from Section 2 of QSESC TORs	Alignment to QSIG/IQFPDG/CCGs/other arrangements
2.1 The Quality, Safety & Experience Sub-Committee will, as delegated by the Quality, Safety and Experience Committee, monitor the quality, safety and experience governance arrangements of Acute, Mental Health & Learning Disabilities and Primary and Community services. In doing so, the sub-committee will hold services accountable for the management and mitigation of those quality and safety issues, thus allowing the Quality, Safety and Experience Committee to be strategically focused and provide upward assurance to the Board.	**Section in bold included in the revised QSIG TORs as follows (QSIG will not hold the services accountable as this will be the role of IQFPDG):** 2.1 The Quality and Safety Intelligence Group will **monitor the quality and safety arrangements within Operational services,** ensuring that the clinical Executive Directors are aware of, and have the opportunity, to review Quality and Safety data and discuss any patient safety related or other significant issues which have the potential to impact on quality and patient safety. This review of data will be linked to the established escalation arrangements to improve the effectiveness of operational services, and ultimately the quality and safety of care. The Quality and Safety Intelligence Group will: 2.1.1 Discuss significant issues arising or that have the potential to impact on patient safety, particularly those within the Health Board's most fragile services. This may include serious incidents, complaints, and risks that have been reported through the Datix Cymru reporting system, through quality, safety and experience concerns that have been raised by the service, or through other intelligence gathering mechanisms. 2.1.2 Utilising established and developing metrics agree triggers within the Quality and Intelligence data e.g. Medical Examiner, deteriorating patient/Cardiac arrest, hospital acquired Infection, hospital acquired VTE, issues relating to DNACPR. 2.1.3 Review dashboard/dataset and

	analysis, and identify any areas where immediate action is required to protect the safety of patients and staff 2.1.4 Identify further action required based upon the information available which may require escalations, including investigation, deep dive request to relevant Groups or Sub-Groups, etc.
Responsibilities from Section 3 of QSESC TORs	**Alignment to QSIG/IQFPDG/CCGs/other arrangements**
3.1 Aligned to the Duty of Quality and Health & Care Quality Standards, the sub-committee will monitor the quality, safety and experience of care delivered to patients. **Data triangulation from the Quality & Safety and Performance Dashboards reviewed by the Quality Safety Intelligence Group (QSIG) will inform this alongside patient feedback, surveys and patient stories**. Lack of assurance and resolution is escalated to the Integrated Quality, Planning, Finance and Delivery Group (IQPFD) to inform the Escalation and Directorate Improving Together processes and to Board via the Quality, Safety and Experience Committee.	Section in bold has been included in the revised QSIG TORs as follows: 3.3 Make use of key performance indicators/metrics, **including triangulation with patient feedback, surveys and patient stories**, to evaluate what is working well and what is not, focusing on exceptions, both positive and negative.
3.2 Where re-directed by the Listening & Learning Sub-Committee, monitor concerns (incidents, complaints, and claims) ensuring that they are being managed in a robust and timely manner at service level, agreeing mitigating actions where required.	This is covered by QSIG TORs: 3.10 In respect of areas of concern raised by services the Group will seek to address those concerns raised by services through a variety of sources including, but not limited to the following: • Quality and Safety Dashboard • Performance Dashboard • Listening and Learning Sub-Committee
3.3 Request a deep dive report. • When action plans following investigations into serious incidents and concerns and the identification of lessons learned breach the agreed timescales. Ensuring actions are completed in a robust and timely manner and seek assurance that learning is disseminated and	This is covered by QSIG TORs: 3.4 Request further information/deep dive regarding any issue of concern to inform decision-making.

embedded across all the Health Board's activities as appropriate. • To consider themes arising from triangulated information at service specific level and agree and monitor any action plans required to deliver improvements.	This is covered by QSIG TORs: 3.3 Make use of key performance indicators/metrics, including triangulation with patient feedback, surveys and patient stories, to evaluate what is working well and what is not, focusing on exceptions, both positive and negative.
3.4 Ensure and monitor compliance with recommendations from external reviews and national guidance, including HIW, Royal Colleges, NICE, NSFs, National Confidential Enquiries, outcome reviews and national clinical audits and Health Board clinical written control documents.	This is undertaken by CCGs in their CCG IGG meeting with issues escalated to IQFPDG as part of 3As report Assurances on processes would also be provided to QSEC on a 6 monthly basis in the CCG Quality Governance Arrangements Assurance Report Compliance is also monitored through internal escalation process which would be discussed at QSIG. This is in QSIG TORs: 3.2 Oversee and agree the escalation levels for the domain of quality of the internal Improving together framework, providing clear de-escalation criteria and areas of improvement to Clinical Care Groups and Clinical Service Groups classed as providing either 'limited' or 'no assurance.
3.5 Inform and monitor progress against agreed performance indicators in the Quality & Safety Dashboard and the Performance Dashboard as identified by QSIG.	This would be covered by QSIG TORs: 3.1 Ensure oversight of those performance measures that focus on the delivery of quality and safe services within the NHS Wales Performance Framework. 3.3 Make use of key performance indicators/metrics, including triangulation with patient feedback, surveys and patient stories, to evaluate what is working well and what is not, focusing on exceptions, both positive and negative
3.6 Seek clarification and assurance on the management of operational risks that have been aligned to the Sub-Committee where the risk tolerance is exceeded or where there is a lack of timely action. Lack of assurance and resolution is escalated to the Quality, Safety and Experience Committee.	This is undertaken by CCGs in their CCG IGG meeting with issues escalated to IQFPDG as part of 3As report Assurances on processes would also be provided to QSEC on a 6 monthly basis in the CCG Quality Governance Arrangements Assurance Report

	Risk Register reports would be provided through the Assurance and Risk Report to QSEC
3.7 Aligned to the Domains of the Duty of Quality receive Directorate /Site Exception Risk Reports and seek assurance on new elements of a directorate risk which requires consideration on a broader scale. Any risk escalated should clearly reference the risk as noted on the register	This is undertaken by CCGs in their CCG IGG meeting with issues escalated to IQFPDG as part of 3As report Assurances on processes would also be provided to QSEC on a 6 monthly basis in the CCG Quality Governance Arrangements Assurance Report
3.8 Receive assurance from the Advisory Groups reporting to the Sub-Committee and consider how escalated issues are addressed/resolved.	The advisory groups would report into QSIG in the new arrangements and have been added to the revised QSIG TORs: 3.8 Receive updates from each of its reporting groups indicating the Health Board's position against the required legislation or standards, and agreed performance metrics/outcome measures in place, identifying any gaps in achieving these/compliance, and how these will be addressed through any actions required.
3.9 Receive position reports on: • Quality Impact Assessment Panel • Risk Register • Key Risks associated with preventing harm to patients determined through Triangulation of data.	Assurance on QIA process would be provided in the regular Quality Assurance Report to QSEC Risk Register reports would be provided through the Assurance and Risk Report to QSEC. Risk Registers are also reviewed by CCGs in their CCG IGG meeting with issues escalated to IQFPDG as part of 3As report Assurance on Key Risks would be provided by CCG IGGs with issues escalated to IQFPDG as part of 3As report. Assurances on key risks would also be provided to QSEC on a 6 monthly basis in the CCG Quality Governance Arrangements Assurance Report
3.10 Assure itself that clinical written control documentation, which falls within the remit of the Sub-Committee, has been adopted, developed, or reviewed in line with HDdUHB Policy 190 – Written Control Documentation prior to approving it.	This is undertaken by CCGs in their CCG IGG meeting with issues escalated to IQFPDG as part of 3As report Policy approval would be undertaken by QSEC and is already covered in QSEC TORs: 3.22 Approve policies and plans within the scope of the Committee, having taken an assurance that the quality and safety of

	patient care has been considered within these policies and plans.
3.11 Develop an annual work plan, responding to operational service priorities, consistent with the strategic direction for the organisation, for approval by the Quality, Safety and Experience Committee. Oversee delivery to improve the quality, safety and effectiveness of care delivered and enhance the patient experience.	Not on QSIG TORs but an annual workplan would be developed to inform agendas.
3.12 Inform the work plans for Advisory Groups and vice versa.	Clear direction and guidance would be provided by QSIG on the requirements of these groups This has been added to the revised QSIG TORs: 3.10 Receive updates from each of its reporting groups indicating the Health Board's position against the required legislation or standards, and agreed performance metrics/outcome measures in place, identifying any gaps in achieving these/compliance, and how these will be addressed through any actions required.
3.13 Address any other requirements stipulated by the Quality, Safety and Experience Committee.	These would be fed into QSIG following QSEC meetings by the Clinical Executive Directors
3.14 Agree issues to be escalated to the IQPFD Group	This has been included in the revised QSIG TORs: 3.7 Provide a Quality and Safety Intelligence Report to the Integrated Quality, Finance and Performance Delivery Group, in regard to all of the above, setting out the improvement actions required.

Appendix E

Quality and Safety Intelligence Group Agenda

Date and time of meeting	XXX
Venue	Via Teams

Time	Item	Presenter
X:XX	**Introduction and Apologies**	
	1. Welcome and apologies (verbal)	Chair
	2. Declaration of interests (verbal)	All
X:XX	**Preliminary Matters**	
	3. Notes of the Previous Meeting held on XX XXXX XXXX	Chair
	4. Matters Arising and Table of Actions from the meeting held on XX XXXX XXXX	Chair
X:XX	**Quality & Safety Intelligence**	
	5. Escalation/Quality Dashboard	Interim Assistant Director of Nursing Assurance & Safeguarding
	6. Fragile Services (linked to Clinical Services Plan)	Director of Nursing, Quality & Patient Experience
	7. Emerging Issues	Director of Nursing, Quality & Patient Experience/All
X:XX	**Updates from Reporting Groups**	
	8. XXXX Group	XXXX Group Chair
	9. XXXX Group	XXXX Group Chair
	10. XXXX Group	XXXX Group Chair
X:XX	**Matters for Escalation/Assurance Reporting**	
	11. IQFPDG Intelligence Report QSIG	Director of Nursing, Quality & Patient Experience

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	12. Items to Include in QAST Report for QSEC	Chair/All
X:XX	**Annual Work Plan**	
	13. QSIG Annual Work Plan	Director of Nursing, Quality & Patient Experience
X:XX	**For Information**	
	14.	Chair/All
X:XX	**Any Other Business**	
	15.	All
X:XX	**Date and Time of Next Meeting**	
	X:XX XX XXXX XX	

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QUALITY AND SAFETY INTELLIGENCE GROUP WORK PLAN 2025/2026

The following table sets out the Group's proposed work programme for 2025/26, including standing agenda items denoted by *.

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	11 Sept 2025	XX Oct 2025	13 Nov 2025	XX Dec 2025	15 Jan 2026	XX Feb 2026	12 March 2026	XX April 2026
GOVERNANCE										
Apologies for Absence*	**Chair**	**All**	✓	✓	✓	✓	✓	✓	✓	✓
Declarations of Interests*	**Chair**	**All**	✓	✓	✓	✓	✓	✓	✓	✓
Notes from Previous Meeting*	**Chair**	**CSO**	✓	✓	✓	✓	✓	✓	✓	✓
Table of Actions & Matters Arising*	**Chair**	**CSO**	✓	✓	✓	✓	✓	✓	✓	✓
Annual Review of Terms of Reference (TORs)	**Chair**	**CSO**							✓	
QSIG Annual Workplan*	**Chair**	**CSO**	✓	✓	✓	✓	✓	✓	✓	✓
Annual Review of Reporting Groups Terms of Reference										
• Recognition of Acute Deterioration and Resuscitation (RADAR)	**HM**	**DW**	✓							
• Mental Capacity Act & Consent Group	**MP**	**MP**	✓							
• Medical Devices Group	**JW**		✓							
• Medicines Management Operational Group	**SG**	**SB**	✓							
• Nutrition and Hydration Group	**MD**	**KT**	✓							
• Effective Clinical Practice Group	**SG**	**DE**	✓							
• Infection Prevention Strategic Steering Group	**SD**	**CS**	✓							
• Strategic Safeguarding Group	**SD**	**MND**	✓							
• Human Tissue Authority Assurance Group	**JS**	**CB**	✓							
• Fragile Services Oversight Group			✓							

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AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	11 Sept 2025	XX Oct 2025	13 Nov 2025	XX Dec 2025	15 Jan 2026	XX Feb 2026	12 March 2026	XX April 2026
• Medical Exposure Group	**JA**	**KT**	✓							
QUALITY & SAFETY INTELLIGENCE										
Escalation/Quality Dashboard*	**CS**		✓	✓	✓	✓	✓	✓	✓	✓
Fragile Services (linked to Clinical Services Plan)*	**SD**		✓	✓	✓	✓	✓	✓	✓	✓
Emerging Issues*	**SD/All**		✓	✓	✓	✓	✓	✓	✓	✓
QSIG REPORTING GROUP UPDATES*										
Recognition of Acute Deterioration and Resuscitation. (RADAR)		**ALI**	✓				✓			
Mental Capacity Act & Consent Group	**AC**	**GC**	✓				✓			
Medical Devices Group	**JS**	**JW**	✓				✓			
Medicines Management Operational Group	**SG**	**SB**		✓				✓		
Nutrition & Hydration Group	**MR**	**MD**		✓				✓		
Effective Clinical Practice Group	**SG**	**DE**		✓				✓		
Infection Prevention Strategic Steering Group					✓				✓	
Strategic Safeguarding Group					✓				✓	
Human Tissue Authority Assurance Group	**JS**	**DJ**			✓				✓	
Fragile Services Oversight Group	**SG**	**SB**				✓				✓
Medical Exposure Group	**JA**	**KT**				✓				✓
MATTERS FOR ESCALATION/ASSURANCE REPORTING										
IQFPDG Intelligence Report QSIG*	**Chair**	**CS**	✓	✓	✓	✓	✓	✓	✓	✓

DRAFT

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	11 Sept 2025	XX Oct 2025	13 Nov 2025	XX Dec 2025	15 Jan 2026	XX Feb 2026	12 March 2026	XX April 2026
Items to Include in QAST Report for QSEC*	**Chair/ All**	**CSO**	✓	✓	✓	✓	✓	✓	✓	✓
ADMINISTRATION										
Agenda setting meeting with QSIG Chair/Exec Lead (at least 4 weeks before the meeting)	**CSO**	**CSO**	✓	✓	✓	✓	✓	✓	✓	✓
Call for papers (at least 3 weeks before the meeting to receive papers at least 10 days before the meeting)	**CSO**	**CSO**	✓	✓	✓	✓	✓	✓	✓	✓
Disseminate agenda & papers 6 days prior to the meeting	**CSO**	**CSO**	✓	✓	✓	✓	✓	✓	✓	✓
Type up notes and TOA within 6 days of the meeting	**CSO**	**CSO**	✓	✓	✓	✓	✓	✓	✓	✓
Circulate notes & TOA to QSIG Members for comments within 7 days of the meeting	**CSO**	**CSO**	✓	✓	✓	✓	✓	✓	✓	✓
Check & send final version of minutes to QSIG Chair/Exec Lead following comments received.	**CSO**	**CSO**	✓	✓	✓	✓	✓	✓	✓	✓
Chase updates on TOA before the next meeting	**CSO**	**CSO**	✓	✓	✓	✓	✓	✓	✓	✓
Prepare schedule of meetings	**CSO**	**CSO**						✓		

DRAFT

1.7

1.7 - Patient Story- Verbal

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

2

30 Mins

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2 - Risk

2.1

2.1 - Cleanliness Standards Audit report and Action Plan

Simon Chiffi (Hywel Dda UHB - Head of Operations), James Severs (Hywel Dda UHB - Executive Director of Allied Health Professions and Health Science)

Attachments

2.1 Standards of Cleanliness.pdf

GIG CYMRU NHS WALES | 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:**	14 August 2025
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Standards of Cleanliness Internal Audit and Action Plan
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	James Severs, Executive Director of Allied Health Professions and Health Science
SWYDDOG ADRODD: **REPORTING OFFICER:**	Simon Chiffi, Head of Operations (Estates and Facilities)

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 interim update for assurance that progress is being made in relation to the internal audit report on Standards of Cleanliness for 2024/25.

The Committee is being asked to note the content of this interim update report and take assurance that progress is being made to complete actions by the deadlines provided.

Cefndir / Background

On 24 June 2025, the Audit and Risk Assurance Committee (ARAC) received the internal audit report on Standards of Cleanliness for 2024/25. This was a follow up review to assess progress in implementing the management actions identified in the previous internal audit report.

The internal audit assessment for both the 2023/24 and 2024/25 resulted in limited assurance.

At ARAC on 24 June 2025, it was agreed that an interim update be presented to ARAC and QSEC for assurance that the management actions identified for the 2024/25 internal audit report were on track.

Asesiad / Assessment

There are 6 management actions for the Health Board to address in response to the internal audit assessment 2024/25 which include 2 high priority actions and 4 medium priority actions.

In order to demonstrate progress of actions, enabling actions for the Estates and Facilities Clinical Care Group and internal audit management actions have been identified and separated below:

Estates and Facilities Clinical Care Group - Enabling Actions

Strengthening Leadership Capacity
Assistant Director (1.0 WTE) has been seconded into the Facilities Service to increase senior leadership capacity while senior leadership structure is reviewed.
Consultant Practitioner of Infection Prevention has been seconded into the Facilities Service to provide expert advice and senior leadership from an Infection Prevention and Control perspective to improve operational standards and compliance.

Strengthening Governance

In June 2025, a new 'Cleaning Standards Sub-Group' was established to monitor progress of the management actions identified from the internal audit report. The weekly meeting is chaired by an Assistant Director and has representation from Nursing and Facilities teams.

The group has an agreed terms of reference, operationally reporting twice monthly via the Estates and Facilities Integrated Governance Group to ensure issues relating to operational delivery are identified and resolved at the earliest opportunity, and from an assurance perspective reporting via Infection, Prevention Strategic Steering Group (IPSSG) with Board level oversight from QSEC.

Internal Audit - Management Actions

The table below shows progress of management actions from internal audit.

Agreed Action	Timescale	Progress update	On track to achieve timescale
1.Review the governance for IPC to align with the new Clinical Care Group Structure, including a review of the terms of reference and reporting arrangements for the Environmental Hygiene Group.	31 Oct 25	IP&C reports are now being presented to each Clinical Care Group focusing on Quality, Health and Safety with representation from the IP&C team present at each meeting. On 15 July 2025, Estates and Facilities Clinical Care Group agreed for the Chair of the Environmental Hygiene Group (EHG) will report to the Estates and Facilities Clinical Care Group on Quality, Health and Safety. On 18 July 2025, the EHG recognised the need to review its Terms of Reference. The Executive Director of Allied Health Professions and Health Science (responsible for Facilities) and Executive Director of Nursing, Quality and Patient Experience (responsible for IPC) will meet to review governance with arrangements with governance team in August 2025. Governance Review Meeting has been scheduled for 11 August 2025 with Executive Director of Allied Health Professions and Health Science and the Executive Director of Nursing, Quality and Patient Experience alongside IP&C and Facilities colleagues to review and agree IP&C reporting and agree a way forward for the governance structures.	

2.Training compliance plans are being developed for each site, this will identify the training to be provided and timescales for achieving compliance. Compliance will be monitored through the Estates Facilities Care Group governance structures.	31 Aug 25	Each site has a specific training compliance plan. These are being owned and monitored by dedicated training supervisors that are based at each site and held on an MS Teams Channel for each site. Training supervisors are currently updating their plans to ascertain current compliance and trajectories for achieving compliance. These plans will be submitted to the Cleaning Standards Subgroup by week commencing 11 August and presented to the Estates and Facilities Clinical Care Group (Quality, Health & Safety) by the Head of Facilities on 19 August 2025.	
3.A plan and trajectory for rolling out the new model of cleaning provision across all sites will be developed.	31 Aug 25	A Workforce Stabilisation Group was established in February 2025 to review the current model of cleaning provision across the Health Board and develop ideas for improvement. Roll-out plans and the trajectory for Prince Philip Hospital (PPH) and Glangwili Hospital (GGH) were developed and presented to the Executive Team on 2 June 2025. Following feedback from Trade Union Representatives and the Executive Team, these plans are currently being updated to include more staff engagement and an evaluation of a trial that took place in PPH to separate ward-based catering and cleaning duties. The plans and trajectories for Bronglais Hospital (BGH) and WGH are currently being developed, following a piece of work to map and scope out existing ways of working as well as a review of rosters. The plans and trajectories for each site will be presented to the Estates and Facilities Clinical Care Group on 19 August 2025.	
4.Spot checks will be undertaken as part of the cleaning audit process to ensure compliance with the cleaning schedules. We will continue working towards a digital cleaning schedule for all wards on Synbiotix.	31 Jul 25	Cleaning schedules have been developed for each area across all sites. To ensure that these are implemented and monitored appropriately, a Cleaning Schedule Compliance Standard Operating Procedure (SOP) has been developed and approved by the Environmental Hygiene Group (EHG). The new SOP will also be presented to the Estates and Facilities Clinical Care Group for approval on 19 August 2025. The SOP includes quarterly spot checks to be undertaken by the Quality Assurance Manager as well as weekly monitoring by Monitoring Supervisors to record the completion of cleaning schedules.	

		Although work continues to progress towards a digital cleaning schedule for all wards on Synbiotix, the Cleaning Standards Sub-Group acknowledges the need to formalise this plan and gain the necessary input from other teams to ensure progress is made in a timely manner. The Facilities Project Manager has produced a project plan to continue working towards a digital cleaning schedule utilising Synbiotix which will be discussed and presented at the Estates and Facilities Clinical Care Group on 4 August 2025.	
5.Following the successful trial of a designated auditing supervisor at PPH this is now being implemented at the other three acute hospital sites. New model of cleaning provision (see key finding 3) will seek to improve cleaning standards and audit scores.	31 Jul 25	All 4 acute hospital sites have a dedicated auditing supervisor in place.	
6.As per key finding 1, governance structures and reporting arrangements will be reviewed to align with the new CCG structure. We will seek to incorporate the role of the existing Synbiotix meetings into the Environmental Hygiene Group and include Estates representation on this group. This links to key finding 1 – review of the governance arrangements.	31 Oct 25	Governance Review Meeting has been scheduled for 11 August 2025 with Executive Director of Allied Health Professions and Health Science and the Executive Director of Nursing, Quality and Patient Experience alongside IP&C and Facilities colleagues to review and agree IP&C reporting and agree a way forward for the governance structures. On 18 July 2025 at Environmental Hygiene Group (EHG), it was agreed to incorporate the current Synbiotix meetings into the monthly EHG meetings as standing agenda items. EHG will continue to monitor Environmental Cleaning matters and the Estates Operational Management Team will discuss Estates-based concerns. The data from both Groups will be formally presented within the performance reports that the Estates and Facilities Clinical Care Group scrutinises monthly by the Head of Facilities and Head of Maintenance and Engineering.	

Further to the management actions outlined above, there are other significant pieces of work being undertaken to add value to the form and function of the facilities service across the Health Board. Examples of the work which will support the overarching improvement to the facilities service are outlined below:

Facilities Induction
The Facilities Team is working with the Learning and Development Team to develop a fit for purpose induction process for all new starters into the Domestic Team. Funding has been secured from Health Education Improvement Wales (HEIW) to support the recruitment of an Education and Development Officer on a fixed-term basis to support the design, delivery and evaluation of a new induction programme for facilities staff across the Health Board. This will align well with the training plans that have now been developed for each site and will enable a proactive approach to training and development for all domestic staff.

New Facilities Manager Role
Following review of the leadership and management structures within the facilities service, it has been identified, there is a significant lack of leadership capacity within the facilities function. This has a detrimental impact on the leaders in post, but also the ability to undertake core management duties, for example, ensuring appropriate supervision of team members/ PADRs and timely management of absence. The Facilities Manager (4.0 WTE, Band 8a) roles will provide local leadership to local teams across the Health Board and will report via the Head of Facilities. Recruitment plan is underway with interviews scheduled for late September 2025.

Supervisory Role Review
The Facilities Team is currently reviewing the Domestic Supervisor (Band 3) role and responsibilities. A Task and Finish Group has been established to review the job description and person specification, undertake a review of the rota and working patterns, facilitate focus groups with supervisors as well as triangulating with the rich data collated via our Organisational Development Relationship Manager. A report with recommendations will be presented to the Executive Director of Allied Health Professions and Health Science by 31 August 2025.

Standard Operating Procedures
The Health Board approved an Environmental Hygiene Policy in 2024 which sets out details for providing cleaning services and assessing environmental cleanliness, in line with the National Standards for Cleaning in NHS Wales (2009). In order to ensure its effective implementation, a suite of SOP's need to be developed, approved and implemented. The SOP will provide guidance and support to operational staff with clear expectations and processes in areas such as Auditing and Monitoring, Training and Induction, Stock, Products and Equipment and Use of The Cleaning Manual.

Argymhelliad / Recommendation

The Committee is asked to take assurance that progress is being made to implement the actions arising from the internal audit report 2024/25 on Standards of Cleanliness.

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:	No applicable.

Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	1. Safe 2. Timely 3. Effective 6. Person-Centred
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	1. Leadership 2. Culture and valuing people 5. Whole systems persepctive 4. Learning, improvement and research
Amcanion Strategol y BIP: UHB Strategic Objectives:	3. Great care 1. Striving teams 2. Healthier communities All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply
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:	Environmental Hygiene Policy in 2024
Rhestr Termau: Glossary of Terms:	Contained within the body of the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	Audit, Risk and Assurance Committee 24 June 2025

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Main costs are for additional site based 8A Facility Managers. This has been worked through with Finance Business partners, agreement with Executive Director and supported via Financial Control Group
Ansawdd / Gofal Claf: Quality / Patient Care:	Improved grip and control in all areas and quality of cleaning performance, striving towards 2009 All Wales Cleaning Standards.

Gweithlu: **Workforce:**	Positive staff impacts in terms of morale and ability to complete tasks and maintain quality of service.
Risg: **Risk:**	Contained in body of report
Cyfreithiol: **Legal:**	Demonstration of compliance with Internal Audit and progress.
Enw Da: **Reputational:**	Ability to complete Internal Audit action plan and reduce reputational damage to Health Board.
Gyfrinachedd: **Privacy:**	No direct impacts
Cydraddoldeb: **Equality:**	No direct impacts

2.2

2.2 - Sonography - The impact on patient experience and clinical outcomes due to Risk 787: Workforce Pressures in Ultrasound Services

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

Attachments

2.3 Sonography Risk 787.pdf

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	14 August 2025
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Obstetric Ultrasound Service (Risk 797)
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Andrew Carruthers, Chief Operating Officer
SWYDDOG ADRODD: **REPORTING OFFICER:**	Sarah Quarrie Service Director, Planned and Specialist Service Care Group Dana Scott, Director of Midwifery Professional Governance Lead

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Quality, Safety and Experience Committee requested a report on the impact on clinical outcomes for patients due to the staffing short falls in Obstetrics Ultrasound Services (Risk 787) during the meeting on 10 June 2025 following the Chair's recent visit to maternity services whereby staff were forthcoming to highlight the ongoing challenges within Sonography Services and the clinical impact on patients.

Cefndir / Background

Impact on Patient Experience

The current pressures within the obstetric ultrasound service are having a noticeable effect on women's experiences of care. Feedback from patients has highlighted:

- Delays and changes to scan appointments, which in some cases has led to uncertainty or distress, particularly where communication around location or timing could have been clearer.
- Travel between sites has occasionally been necessary to ensure timely scanning, which, while clinically necessary, can create additional logistical and emotional challenges for some families.
- Informal concerns and feedback received via QR code mechanisms reflect that, while several women receive safe and compassionate care, timeliness and consistency of information are areas for improvement.

Impact on Clinical Outcomes

Clinical outcomes have also been influenced by workforce capacity and service fragility:

- Detection rates of babies with growth restriction (<3rd centile) improved from 53% (2023) to 58% (2024) following realignment with national Royal College of Obstetricians and Gynaecologists (RCOG) guidance. While this demonstrates progress, there remains further opportunity to close the gap to the national average (61%).
- The Terms of Reference for an internal deep dive into fetal detection rates, quality of adhered to standards of Ultra Sound Services (USS) practice and governance have been developed and is now progressing, This review is due to be completed by end of September 2025.The outcome of the review will determine the governance pathways to support midwife/ sonographers with robust oversight, audit and learning.
- Sadly, there have been cases of still birth where retrospective reviews found that growth monitoring did not fully align with national guidance. These events are deeply distressing for all involved and have prompted proportionate internal and national reporting, with learning used to shape improvement actions.
- In Quarter 4, 2024, of the 43 term admissions to the neonatal unit, approximately 24% were babies with growth restriction, suggesting earlier detection may have supported more tailored intrapartum care and potentially reduced neonatal admissions.

Impact on ways of working

Workforce outcomes and career progression:

- Midwives undertaking sonography training are currently required to relinquish their maternity roles and transition to working soley within the radiology department.
- Midwives are unable to provide midwifery care or advice as part of their sonography role; this increases the women's footfall through the services as women are referred to antenatal clinic to discuss scan results.
- Repetitive strain injury (RSI) is generally more prevalent among sonographers working in obstetric than in general medical sonography, (at the 2010 International Society of Ultrasound in Obstetrics and Gynecology congress, 65% reported RSI injury, with female operators, reporting rates of 70%. A systemic review found a pooled prevalence of 75.8% for musculoskeletal among nearly 14.000 sonographers worldwide, with high rates in neck (63.7%) shoulder (60.1%) and wrist (44.4%) (Zangiabadi et al 2024), The comparative figures indicating elevated risk to obstetric scanning techniques involved increased workforce pressure and longer scan duration.
- The difference is due to a combination of biomechanical, ergonomic and workload-specific factors associated with obstetric factors.
- Key reasons why RSI is higher in Obstetric sonography.
    1. Increased scan duration and frequency
    2. Challenging ergonomics
    3. Static muscle loading
    4. Repetitive hand and wrist movements
    5. Emotional and cognitive load

Impact on Workforce and Service Resilience

The ultrasound workforce continues to operate under considerable pressure:

- The service currently includes one part-time midwife sonographer, with a second trainee in post whose completion is expected in early 2026, a second midwife sonographer not currently on clinical duties, with a retire and return midwife operating as a sonographer. In the main, sonographers are registered radiographers with an additional qualification in medical ultrasound.

- It takes 1 year to complete Obstetrics and Gynaecology USS training. With a new service model more staff could be trained to support the maternity and women's health, over a short period of time. There are two elements to this proposed service change; firstly, recommendations on workforce will be extrapolated from the deep dive which is currently in progress, and secondly, the Director of Midwifery is in the process of developing a 5-year strategy for maternity and midwifery services which will be underpinned by workforce. This strategy, if accepted by the Executive Team, will be launched by April 2026. The strategic plan will be underpinned by the pathway to excellence, the Marmot principles and perinatal workforce plan inclusive of Mat/Neo safety plan. This will form the basic framework for individualised maternity care.
- While commendable progress has been made in developing training pathways and governance structures, capacity remains limited, particularly for growth scans in high-risk pregnancies, which do not have a recognised alternative.
- Multidisciplinary prioritisation of scan appointments has become essential to ensure safe care within available resource, supported by close working between maternity and radiology colleagues.
- While current arrangements reflect significant staff commitment, a longer-term plan is needed to ensure resilience, sustainability, and equitable access across all Health Board sites, this forms part of the longer-term strategic plan as mentioned above.
- Decrease in job satisfaction with midwives not being able to practice holistically. Staff are being employed part time so they can maintain both professional skills until such times Maternity Services have a midwifery/ sonography model.
- Increase risk of repetitive strain injury.

Asesiad / Assessment

While the USS service has made notable strides in aligning with national standards, capacity constraints continue to impact timely access, continuity of care, and equity of experience.

A few actions are already underway to strengthen the service, including:

- Ongoing investment in midwife sonographer training
- Enhanced collaborative governance between maternity and radiology
- Regular peer audit and learning
- Continued review of incidents to inform safe service improvement

Further strengthening the workforce model, with a clear plan for succession and expansion, would help support a more consistent service offer across the Health Board and ensure the best possible outcomes for women and babies.

- While birth numbers are on the decline globally; complexity related to pregnancy has increased demand for serial scans and surveillance which has created increase demand on third trimester scanning.
- Increased job satisfaction and career development

The current focus and review of obstetric ultrasound should provide assurance that every aspect of pregnancy and experience is being considered and taken seriously. Collaborative working across the teams and systems to develop cohesive working and learning is a priority.

Maternity is in the process of developing a 5-year strategy, and midwifery sonography services will form part of this strategy. The strategy should be completed for executive sign and implementation by March 2026.

Argymhelliad / Recommendation

The Committee is asked to

- Take assurance from the review and progress to mitigate the challenges in the Obstetric Ultrasound Service (Risk 797).
- Support the internal review process within Radiology.
- Support the strategic workforce plan to train more midwife sonographers.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.2 Seek assurance on the management of risks within the Corporate Risk Register (CRR) and Directorate level risks allocated to the Committee and provide assurance to the Board that risks are being managed effectively and report any areas of significant concern e.g. where risk tolerance is exceeded, lack of timely action.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	797 12 Extreme
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	4. Learning, improvement and research Not Applicable
Amcanion Strategol y BIP: UHB Strategic Objectives:	1. Striving teams
Amcanion Cynllunio Planning Objectives	1 Workforce Stabilisation
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	5. Offer a diverse range of employment opportunities which support people to fulfill their potential

Gwybodaeth Ychwanegol:
Further Information:

Ar sail tystiolaeth: Evidence Base:	Risk 797 on the Datix Risk Register
Rhestr Termau: Glossary of Terms:	Contained within the body of the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	Steering Group, CCG,

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

Cydraddoldeb: **Equality:**	Contained within the report

3

60 Mins

3 - Assurance

3.1

3.1 - Quality Assurance Report

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

Attachments

3.1 QS Assurance Report Aug2025.pdf

App 1 Aug 2025 - Overdue HIW Actions.pdf

App 2 QSEC 2025.16.05 - HIW to CEO P.Kloer HDUHB - Provider Meeting - Conce~.pdf

App 2b QSEC Aug25 HIW meeting response letter 09 06 2025 v.1.0.pdf

Quality and Safety Assurance Report

Quality, Safety and Experience Committee

June 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.

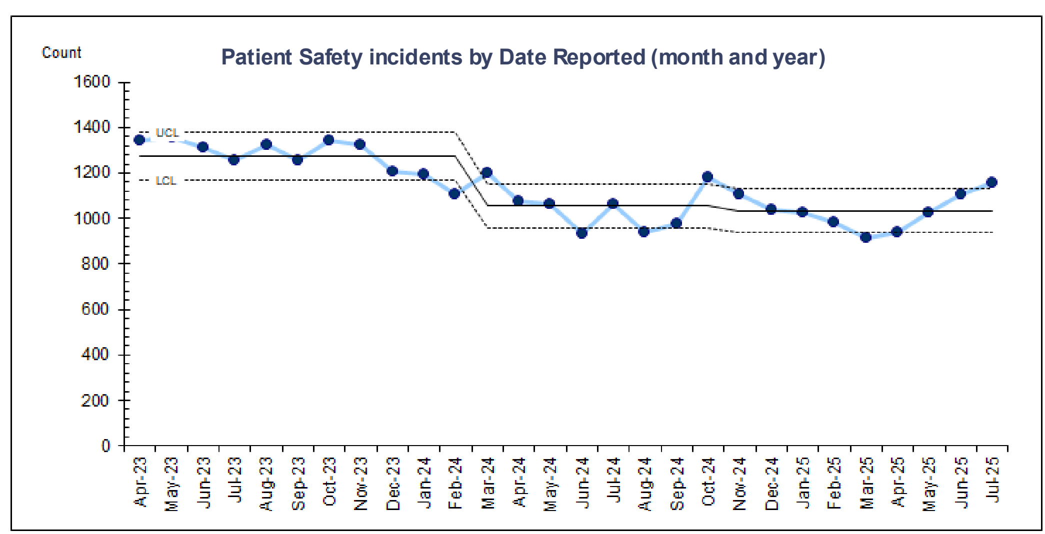
This report provides information on:

- Patient safety incidents
- Nationally reported patient safety incidents
- Duty of Candour
- Patient Experience including demographics
- Infection, prevention and control
- Inspections and peer reviews including activity of Healthcare Inspectorate Wales (HIW)
- Speak Up, Making Meaningful Change
- Welsh Health Circulars

Patient Safety Incident Reporting

There were 15,183 incidents reported on Datix Cymru in Hywel Dda UHB between 1st August 2024 and 31st July 2025. Of these, 12,397 were Patient Safety Incidents.

Of the 12,397 patient safety incidents reported, 9,662 have been closed. 83 (0.9%) were closed as moderate, severe or catastrophic harm.



*Change to pressure damage reporting in Nov 2023

The top 3 incident classifications (patient safety incidents reported between 01/08/2024 and 31/07/2025 and closed as moderate, severe or catastrophic harm) were pressure damage (21); accident or injury (12); and assessment, investigation and diagnosis (9) and treatment and procedure (9). This can be broken down further into the categories.

Pressure ulcer developed or worsened during care in this clinical care area/caseload	18
Slip, trip or fall	11
Treatment or procedure issues	8

Exploring the themes within lessons learned

A review, using the support of AI, identified the main themes, within the lessons learned of patient safety incidents reported between 01/08/2024 and 31/07/2025 and closed, were the critical importance of accurate and timely documentation, effective communication and teamwork, adherence to protocols and risk assessments, robust medication management, and ongoing staff training. Patient-centred care, individualised support, and continuous learning from incidents are also emphasised as key to improving safety and quality. Environmental safety and encouraging patient involvement further support a comprehensive approach to care.

- **Accurate and Timely Documentation:** Maintaining thorough, clear, and timely documentation is repeatedly emphasized as essential for patient care, risk assessments, incident reporting, and effective communication among staff.
- **Adherence to Protocols and Risk Assessments:** Following established protocols, conducting regular risk assessments, and implementing safety procedures are consistently identified as key strategies to prevent errors and ensure patient safety.
- **Effective Communication and Teamwork:** Clear communication and strong teamwork among staff, with patients, families, and across departments are highlighted as crucial for safe, coordinated, and efficient care.
- **Ongoing Staff Training, Education, and Supervision:** Continuous staff education, regular training updates, supervision, and sharing of lessons learned are emphasized to maintain high standards of care and prevent recurrence of incidents.
- **Medication Management and Safety:** Careful medication administration, double-checking, and adherence to drug-related procedures are highlighted to prevent errors and ensure patient safety.

These themes have been shared with:

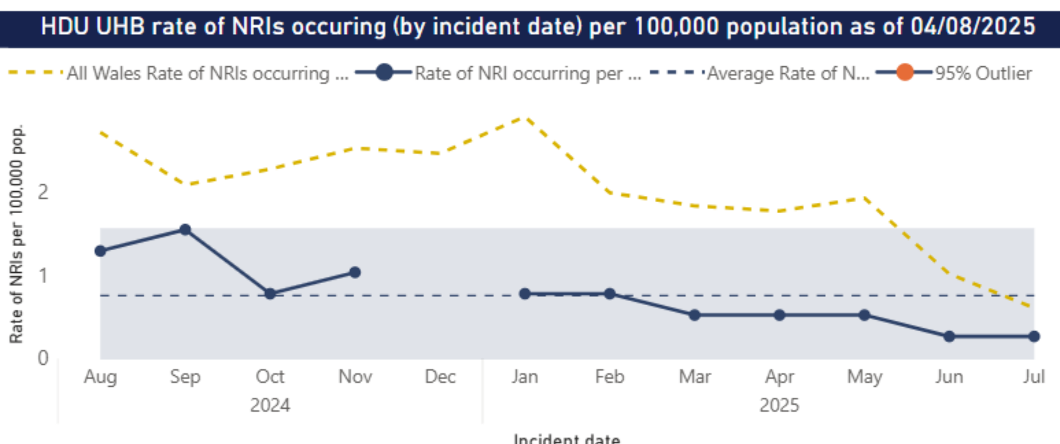
- Clinical Care Groups for consideration through the routine quality report to the Integrated Quality, Performance and Financial Delivery Group
- Departments and Wards through a new newsletter.

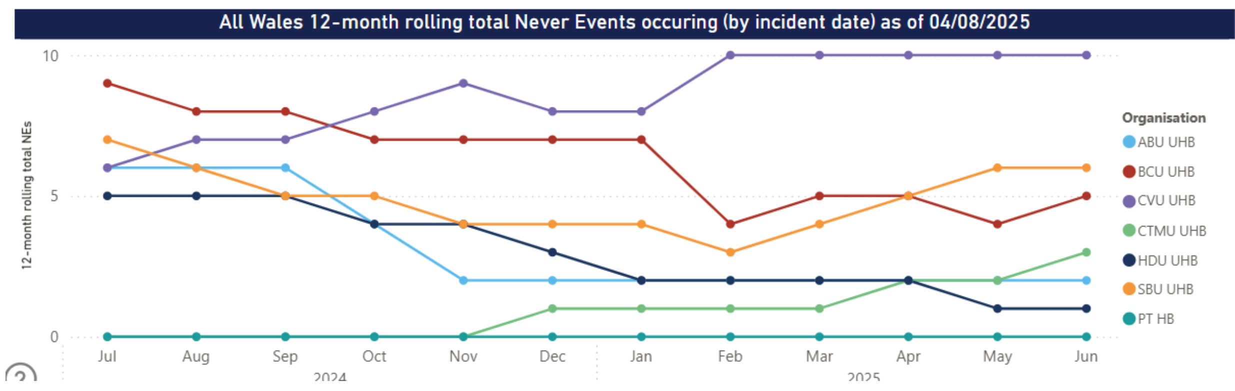
Diogel
Safe

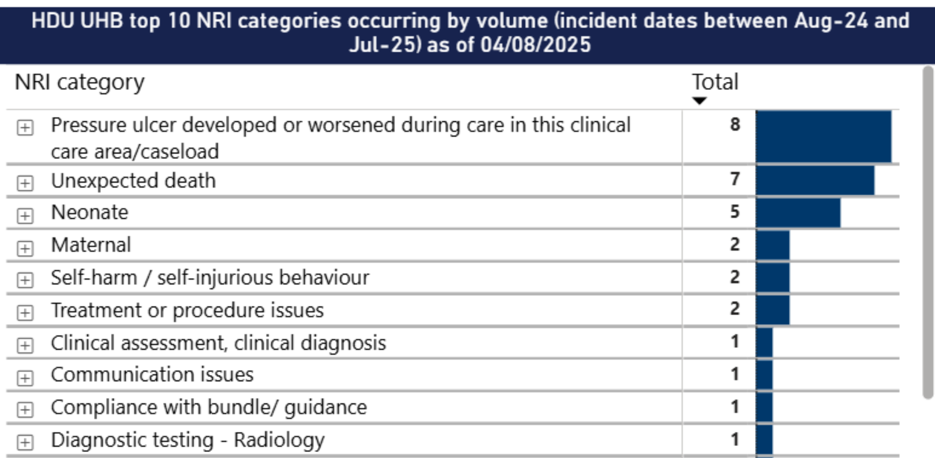
Nationally Reportable Incidents

There were 62 Patient Safety Incidents reported to the NHS Executive between 1st August 2024 and 31st July 2025.

In May 2023, an updated NHS Wales National Policy on Patient Safety Incident Reporting and Management was published. The Policy provides clear guidance on what types of incident should be nationally reported, and how this should occur. There are 5 principles for reporting; must reports; outcome/harm; number of patients or service users involved; learning opportunities; and joint decision making around reporting and investigation







HDU UHB top 10 NRI categories occurring by volume (incident dates between Aug-24 and Jul-25) as of 04/08/2025

NRI category	Total
Pressure ulcer developed or worsened during care in this clinical care area/caseload	8
Unexpected death	7
Neonate	5
Maternal	2
Self-harm / self-injurious behaviour	2
Treatment or procedure issues	2
Clinical assessment, clinical diagnosis	1
Communication issues	1
Compliance with bundle/ guidance	1
Diagnostic testing - Radiology	1

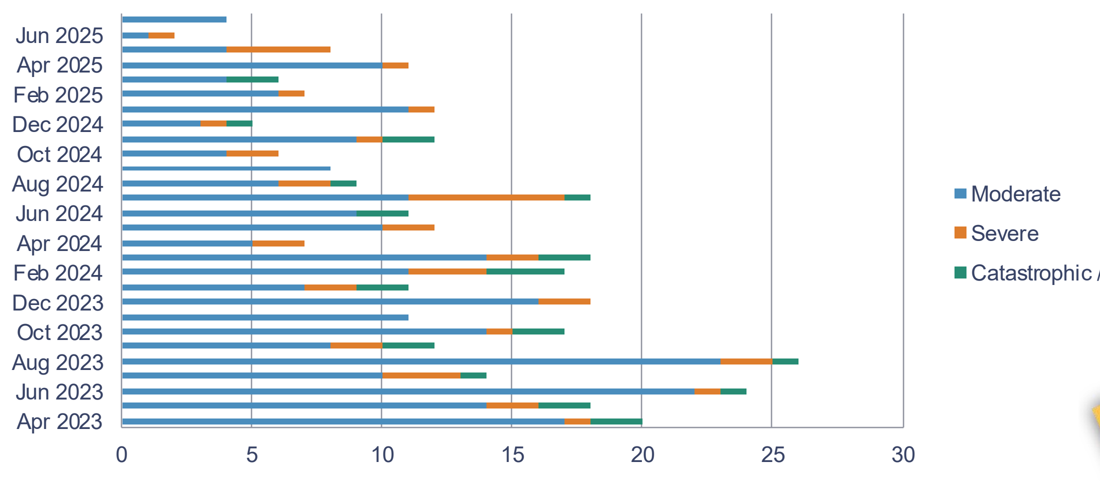
HDU UHB Never Events reported to NHS Executive (Jul-24 to Jun-25) as of 04/08/2025

Year	2024						2025					
Never Event	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Retained foreign object post procedure	0	1	0	0	0	0	0	0	0	0	0	0
Total	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

The Quality Assurance and Safety Team arrange incident management groups (IMG) when severe or catastrophic harm is reported. Consideration of reporting is given during the IMG.

The team have also added an additional check in their validation of incidents closed by Clinical Care Groups

Duty of Candour



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

		Harm post investigation					
		None	Low	Moderate	Severe	Catastrophic / Death	Total
Manager's interim harm assessment	Moderate	14	47	140	3	1	205
	Severe	1	6	4	8	3	22
	Catastrophic / Death	2	5	1	2	3	13
	Total	17	58	145	13	7	240

Diogel
Safe

Top 3 incident classifications

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

Classification	Count
Pressure Damage, Moisture Damage	**55**
Pressure ulcer developed or worsened during care in this clinical care area/caseload	48
Pressure ulcer present before admission to this clinical care area/caseload	4
Pressure from medical device present before admission to this clinical care area/caseload	2
Pressure from medical device developed or worsened in this clinical care area/caseload	1
Accident, Injury	**43**
Contact with object or animal	
Slip, trip or fall	41
Patient injury	1
Maternity adverse occurrence	**29**
Maternity adverse occurrence - Neonate	12
Maternity adverse occurrence -Maternal	[illegible]

Learning identified:

- Importance of Accurate Documentation and Record Keeping
- Effective Communication and Multidisciplinary Collaboration
- Timely Risk Assessment and Early Intervention
- Adherence to Protocols, Policies, and Training
- Patient-Centred Care and Informed Decision-Making

Service User Feedback ‘at a Glance’: April 2025 – May 2025

We continue to receive many positive stories and comments about the services provided by our caring and compassionate staff. We are continually sharing and celebrating these achievements across the organisation.

NHS People’s Experience Framework

40935 individuals were sent our new NHS Wales People’s Experience Friends and Family Test Survey, in the format required by the People’s Experience Framework.

6354 responded representing a **15 %** response rate. **86.2% gave a Very Good or Good response** to the How would you rate your overall experience question.

1549 were sent the NHS Wales People Experience Survey (PES).

Concerns related to waiting times and care provided in corridors in A&E. A higher number of service users completed the survey during this period, and more were satisfied with the care received.

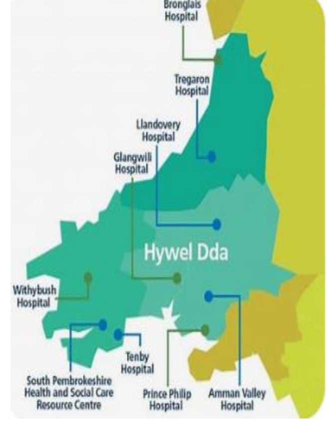
203 compliments were received direct to wards, departments or Chief Executive/ Chair’s 0ffice. These frequently highlight the professionalism and compassionate care provided by healthcare teams. Example received about Bronglais Hospital, Endoscopy Team - *“Excellent team, very professional and caring. A big thank you to all concerned. As a healthcare professional myself, I found the whole experience reassuring”.*

Complaints and enquires: 981 new cases were received into Patient Support Services. Of these, **538** were received as **new complaints and 443 as enquiries.** The main reasons for enquiries/early resolutions related to appointments / waiting list queries, attitude and behaviour and communication inefficiencies.
During the period a total of **263 complaints were closed. 160** were responded to **within 5 working** days through the early resolution process.

Public Services Ombudsman

- In the period April/ May 2025 there has been one new investigation. This will look at the medical management of a patient with pancreatitis and whether a cancer diagnosis should have been made earlier.
- There were 9 instances where the Ombudsman decided not to investigate.
- There were 2 complaints made to the Ombudsman prematurely.
- In the same period, there were 4 early resolution agreements made between the Health Board and the Ombudsman.
- There have been no final reports received in April/ May 2025.

1307 calls were made to the 0300 0200 159 Patient support number of which 53 were via the medium of Welsh.



Patient feedback – Demographics

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Gender Distribution

Female respondents gave the most feedback, with a strong lean toward positive sentiment. Male feedback was more balanced but slightly more negative. Responses from non-binary or undisclosed genders were fewer and evenly spread across sentiment types.

Age Group Trends

Older age groups, particularly those aged 55 and above, are more prominently represented in both positive and negative feedback. Notably, the 55–64 age group shows a higher proportion of negative comments. In contrast, younger age groups (16–34) are less represented overall but tend to report more positive experiences. The 45–54 age group presents a balanced sentiment distribution, while the 35–44 group shows a slight preference for positive feedback.

Disability Status and Sentiment

Respondents without disabilities were more likely to give positive feedback. Those with limitations ("Yes, a little" or "Yes, a lot") tended to share mixed or negative experiences, highlighting potential gaps in accessibility and service adequacy. A few who didn't disclose their status leaned positive, though the sample was small.

Ethnic Group Representation

Most feedback came from Welsh, English, or British respondents, who generally reported positive experiences. In contrast, responses from minority ethnic groups were more varied—particularly those identifying as "Any other Asian background," who expressed more negative sentiment, suggesting possible disparities for further exploration.

Infection Prevention and Control (IPC): Quality Management System (QMS)

Quality Planning

- Organisation Annual Plan
- Annual Infection Prevention and Control (IP&C) work plan
- Infection Prevention Strategic Steering Group (IPSSG) Work Plan
- Consideration and implementation of Welsh Health Circulars (WHC) relating to IP&C and Public Health
- Consideration and action plan for WHC Antimicrobial Resistant (AMR) and Healthcare Acquired Infection (HCAI) Improvement Goals 2024/25
- Working with the Public Health team and primary care/ community services to prevent infection in high-risk populations/ community settings

Quality Control

- Standardisation of assurance/ scrutiny groups in progress
- Reports to and from Clinical Care Groups (CCGs) and subgroups of IPSSG
- Review of Health Board IPC policies
- Self-assessment against C.diff Framework for Wales and attendance at Wales C. diff Focus Forum Meeting.
- Engagement in the C diff Learning Collaborative - Co Design Event
- Review of data sets against TI reduction expectations- disseminated to all services and use of safety dashboards
- Review by AMG and antibiotic pharmacists of compliance to SSTF for each acute site

Quality Improvement

- Assurance/ scrutiny meetings held-all hospital onset/ HCAI are discussed and learning obtained/ action plans implemented, themes derived with a move to learning panels
- Working with managed practices- presenting infographics for infections/ sources/ learning
- Environmental audit programme re-established for high-risk areas. Working with clinical audit team to establish this on AMat
- Observational audits conducted and action plans produced
- Review of Synbiotix scores in relation to IPC audit programme
- Successful trail of HPV units with purchase through SESN 24/18 - Welsh Government (Capital, Estates & Facilities) Targeted ESTATES FUND phased over 2 years for 4 acute sites.
- Deep clean and HPV of PPH linked to C.diff clusters ongoing
- HCID/infectious disease pathway training dates schedules for July and August

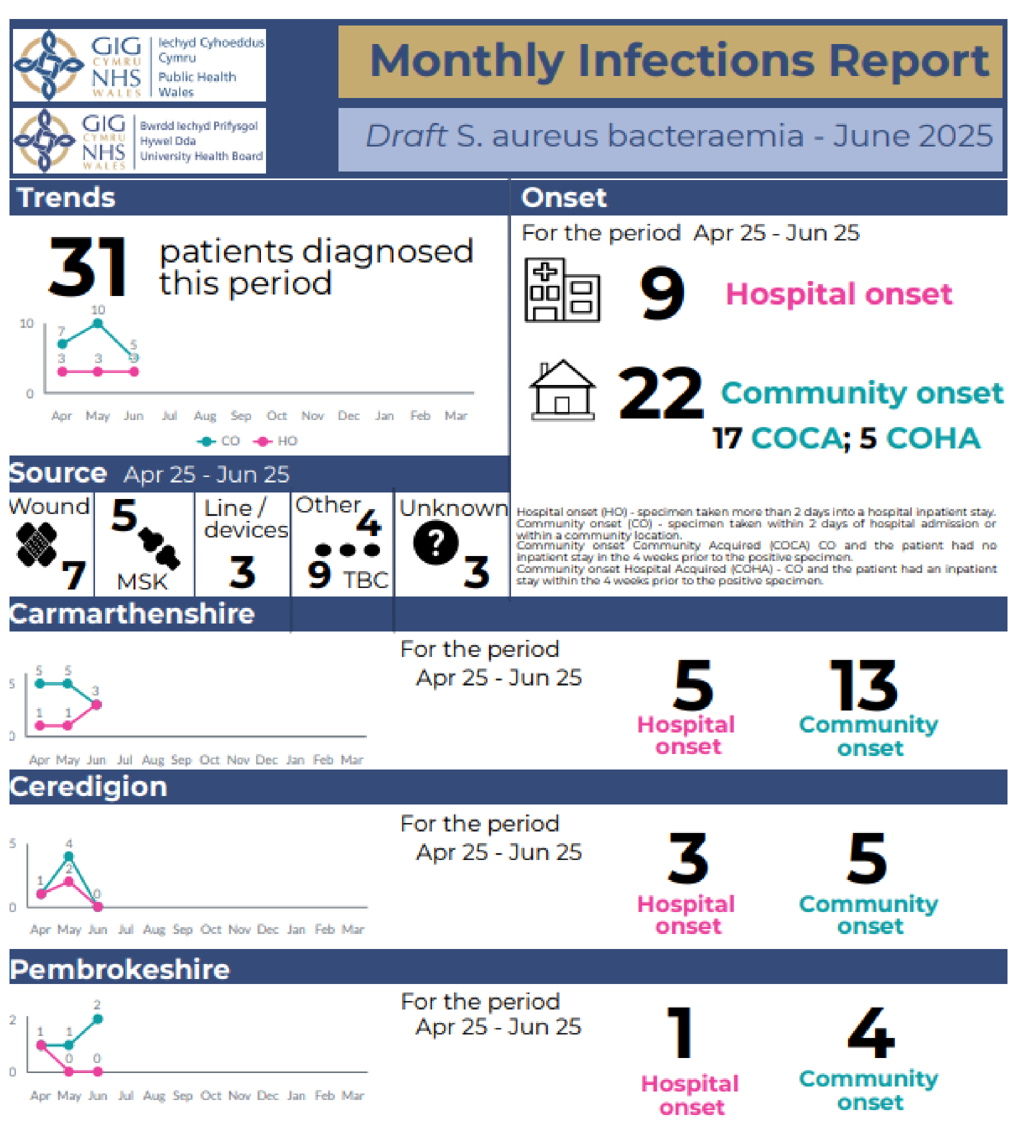
IP&C QMS continued

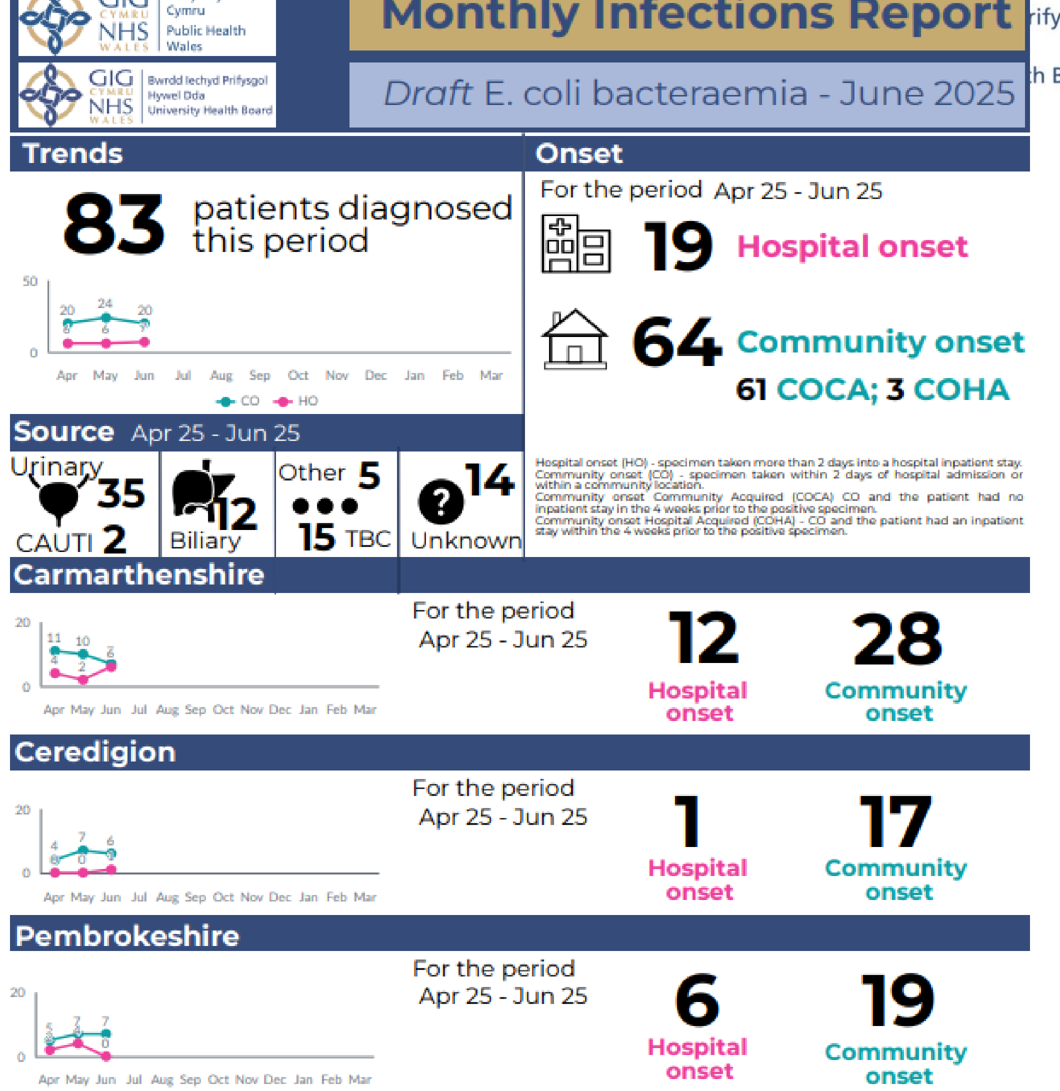
Quality Assurance

	Measure	De-escalation criteria	Baseline	Baseline	Goal	Latest position					
						Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Infections	Number of laboratory confirmed C.difficile cases with hospital onset	25% reduction, maintained for 3 months	8	Baseline (average Q3 23/24)	6	8	4	6	8	8	10
	Number of laboratory confirmed S.aureus bacteramia cases with hospital onset	33% reduction, maintained for 3 months	3	Baseline (average Q3 23/24)	2	4	4	4	3	3	3
	Number of laboratory confirmed E.coli bacteramia cases with hospital onset	25% reduction, maintained for 3 months	7	Baseline (average Q3 23/24)	5	0	5	8	6	5	7

[1] Based of population size of Hywel Dda UHB as a proportion of all Wales population (mid year 2022 population estimate sized used)
[2] Based on all Wales rating as at 7/2/24 (taken from Beacon dashboard)

- All CCGs to review progress against the HB Safety Dashboard
- Review of monthly data from HARP with internal HB analysis and scrutiny and use of infographics
- ANTT 82.57% compliance with HB critical care and other inpatient areas seeking accreditation
- Level 2 mandatory training at 75%. Mandatory training rates now reported at CCG meetings
- Deep cleaning and HPV for PPH on all wards continues.
- Work has commenced on review of community onset infections- working with managed practices and analysis of HCAIs.
- There have been no outbreaks since the last IQPD update





Actions:

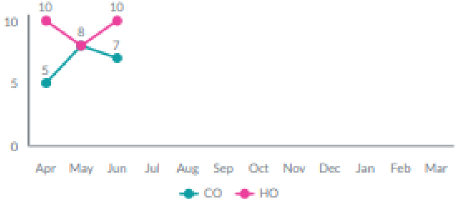
- ANTT compliance profiled and reported to all CCGs monthly
- Hand hygiene encompassing bare below the elbow profiled and validation audits as indicated
- Ward manager/ Senior nurse hand hygiene audits now on AMAT

Monthly Infections Report

Draft C. difficile - June 2025

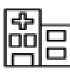
Trends

48 patients diagnosed this period



Onset

For the period Apr 25 - Jun 25



28 Hospital onset

20 Community onset

11 COCA; 3 COIA; 6 COHA

Hospital Onset (HO) - specimen taken more than 2 days into a hospital inpatient stay.
Community Onset (CO) - specimen taken within 2 days of hospital admission or within a community location.
Community Onset Community Acquired (COCA) CO and the patient had no inpatient stay in the 12 weeks prior to the positive specimen.
Community Onset Indeterminate Acquisition (COIA) CO and the patient had and inpatient stay more than 4 weeks but less than 12 weeks prior to the positive specimen.
Community Onset Hospital Acquired (COHA) - CO and the patient had an inpatient stay within the 4 weeks prior to the positive specimen.

Carmarthenshire

For the period Apr 25 - Jun 25

16 Hospital onset

14 Community onset

Ceredigion

For the period Apr 25 - Jun 25

7 Hospital onset

3 Community onset

Pembrokeshire

For the period Apr 25 - Jun 25

5 Hospital onset

3 Community onset

GIG CYMRU NHS WALES Iechyd Cyhoeddus Cymru Public Health Wales
GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Monthly Infections Report

Draft E. coli bacteraemia - June 2025

Actions:

- Deep cleaning of PPH using enhanced technology in Carmarthenshire continues to address the hospital onset C.dificile concerns
- Patients within the HB have been identified for FMT, awaiting supply as all FMT from supplier has been assigned.
- Engagement with the C diff Learning Collaborative - Co Design Event to understand national issues
- All cases discussed at HCAI assurance meetings monthly and the CDI Improvement group continues
- Environmental cleaning continues to be a challenge on all sites due to staff availability, ageing estates and surge/ boarding. Ongoing OCP in Estates and Hotel Facilities CCG

HIW / CIW / HTA inspection activity:
21/05/2025 – 21/07/2025

There have now been 2 inspections the first in Maternity Glangwili between 13th and 14th May 2025; but no new reports published by Health Inspectorate Wales (HIW) or the Human Tissue Authority (HTA) relating to the Health Board in the period 21st May to 29th July 2025. The second inspection is taking place currently in EUCC at BGH as of 28/07/2025. Feedback is expected to be held on 30th July 2025.

The draft report for the maternity inspection has been received, and the Health Board have provided factual accuracy comments and an improvement plan for the inspection which was mostly positive, with no immediate actions arising. The Health Board awaits the publication of the report in due course.

As an update to the last report, the Health Board have received the following letters from HIW requesting assurance during the period. We also offer a conversation where more than one contact has been received:

Date of letter	HIW ref	Matter
20/05/2025	13271	Paediatric Medical Workforce – request for update on recruitment progress
20/05/2025	13274	St Non's Ward – request for update
20/05/2025	13272	North Ceredigion Mental Health provision – request for further information
06/06/2025	13747	WGH / Mental Health family concern
11/06/2025	13391	Critical Care – queries re public consultation
11/06/2025	13274	St Non's ward – further details requested / discussed with HIW in a meeting

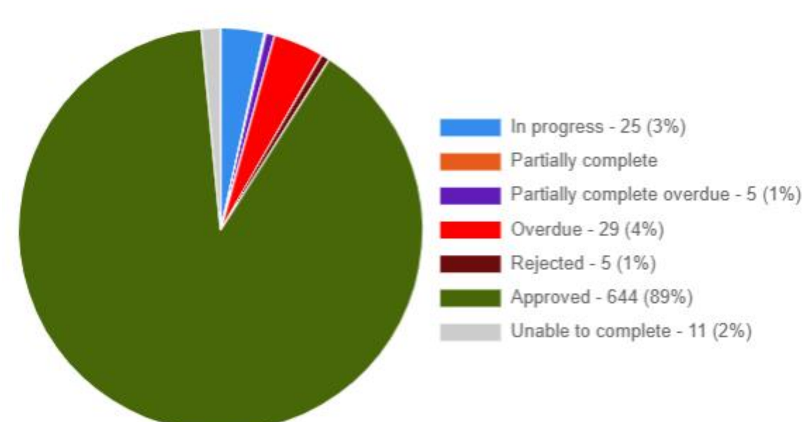
Date of letter	HIW ref	Matter
08/07/2025	13747	WGH / Mental Health family concern – update requested
08/07/2025	14043	GGH Radiology anonymous staffing concerns
18/07/2025	14165	WGH Ward 10 assurance – assurance re provision for food and water and support for patients on ward
24/07/2025	13747	WGH / Mental Health family concern – outcome date requested. Responded to 29/07/25 to advise plan to share on 8th Aug 25.

At the QSEC meeting in June 2025, it was agreed that the letter from HIW dated 16th May and the response to HIW providing the information requested in the meeting held by HIW with the Health Board CEO would be shared with committee members as an appendix to this report. The response letter to HIW has been attached as appendix 2.

HIW Quality Checks/Inspections: Reviews and inspections

Improvement Actions relating to HIW reviews

Source: AMaT 07/08/2025



	Overdue	Partially complete (overdue)
Estates and Facilities	0	2
Mental Health and Learning Disabilities	16	3
Operational Allied Health and Health Science	5	0
Planned and Specialist Care	1	0

	Position Feb 2024	Position as at 07/08/2025
Overdue	51	22
Partially complete (overdue)	17	5
Partially complete	1	1
In progress	119	25

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
9	97/168 (58%)	1/1 (100%)	0	0	25	1	5	29	5	0	5	152

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
27	248/248 (100%)	18/18 (100%)	0	0	0	0	0	0	6	0	0	492

HIW Quality Checks/Inspections: Open reviews and inspections

Code	Title	MD	SD	WN	PIR	Actions							
						In progress	Partially complete	Partially complete (Overdue)	Overdue	Unable to complete	Completed (awaiting approval)	Rejected	Completed
Healthcare Inspectorate Wales (HIW)/2024/395	Bryngolau Ward, Prince Philip Hospital	38/40 (95%)	0	0	0	0	0	1	1	0	0	0	49
Healthcare Inspectorate Wales (HIW)/2024/396	HIW Children and Young People Mental Health Review	0/9 (0%)	0	0	0	14	0	0	9	0	0	0	0
Healthcare Inspectorate Wales (HIW)/2022/19	HIW GGH IRMER Inspection (Nov 2022)	19/21 (90%)	0	0	0	0	0	0	2	0	0	0	34
Healthcare Inspectorate Wales (HIW)/2025/565	HIW GGH Maternity Services 03924	0/13 (0%)	0	0	0	11	0	0	1	0	0	0	0
Healthcare Inspectorate Wales (HIW)/2024/302	HIW Glangwili Hospital – Morlais Ward inspection	7/9 (78%)	0	0	0	0	0	1	1	0	0	0	16
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)	14/40 (35%)	0	0	0	0	0	2	7	4	0	0	20
Healthcare Inspectorate Wales (HIW)/2024/86	HIW IRMER Diagnostic Imaging x-ray department Withybush Hospital January 2024	6/9 (67%)	0	0	0	0	1	0	2	1	0	0	10
Healthcare Inspectorate Wales (HIW)/2023/69	HIW St Non, St Caradog, Canolfan Bro Cerwyn WGH	11/18 (61%)	1/1 (100%)	0	0	0	0	1	2	0	0	1	21
Healthcare Inspectorate Wales (HIW)/2024/498	IRMER Regulations	2/9 (22%)	0	0	0	0	0	0	4	0	0	4	2

Speak Up, Making Meaningful Change

NHS Wales introduced its Speak Up agenda to promote a culture of openness, safety, and continuous learning. The aim is to empower staff at all levels to raise concerns confidently, whether it's about patient care, workforce wellbeing, or systemic issues—without fear of reprisal. By ensuring staff voices are heard, the agenda strengthens public trust, supports professional accountability, and helps prevent future failures in care. It's a proactive step toward creating a more compassionate, responsive health service for everyone in Wales.

A full paper providing an update on the continued implementation and advancement of the Speak Up, Make Meaningful Change (SUMMC) agenda will be presented at the People, Organisational Development and Culture Committee (PODCC) on 18th August 2025 and at Listening and Learning Sub-Committee on 7th August, to discuss integration of the feedback.. The following slides provide a summary of the full paper to be received by the PODCC Committee.

Steps taken to create a culture where staff feel able to speak up:

- Launch of SUMMC (October 2024) and the Working in Confidence (WIC) Platform
- Consideration of staff survey results and development of action plan to improve areas highlighted
- Creation of a Voices Network

SUMMC continued

The National Staff Survey 2024 outlined progress made, it is encouraging to find that:

- **75 %** agreed or strongly agreed that the organisation encourages staff to report errors, near misses or incidents. **+4.6 %** on 2023 survey
- **76.2 %** felt secure to speak up around unethical behaviours. Aligning to the 2023 result and in line with all Wales result.
- **51.2%** felt that the organisation treats staff involved in error, near miss or incident fairly, a huge increase from 2023 by **+12.8 %**
- When errors, near misses or incidents are reports, my organisation takes appropriate action, so they don't not happen again rose from **50.4 %** in 2023 to **57.7 %** in 2024.

The survey findings also indicate that further efforts are required to fully embed a culture of speaking up across the organisation:

- **55.7 %** felt safe to speak up around anything that concerned them. Which was **+ 4%** against the 2023 result but still **-2.8%** on all Wales average.

The Patient Safety theme also showed signs of encouragement where -

- There was a **12.2%** swing in staff feeling the organisation treated staff involved in an error, near miss or incident fairly.
- **7.1%** increase in staff feeling that the organisation took appropriate actions when errors, near misses or incidents are reported.
- **9.8%** more staff felt that they were given feedback about changes made in response to errors, near misses and incidents.

SUMMC continued

Patient safety				
13b) My organisation treats staff who are involved in an error, near miss or incident, fairly.	2023	38.1%	43.7%	13.6%
	2024	50.3%	51.8%	14.4%
13c) My organisation encourages us to report errors, near misses or incidents.	2023	69.7%	73.5%	9.3%
	2024	74.2%	76.1%	10.5%
13d) When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.	2023	50.0%	52.6%	12.2%
	2024	57.1%	57.2%	15.1%
13e) We are given feedback about changes made in response to reported errors, near misses and incidents.	2023	36.1%	42.7%	23.0%
	2024	45.9%	48.4%	25.2%

While these findings within the results of the staff survey are highly encouraging, it remains concerning that a significant proportion of survey respondents still reported feeling adversely affected by the patient safety-related questions. This highlights the need for continued focus on fostering a psychologically safe environment where staff feel confident to speak up.

SUMMC continued

SUMMC Statistics

- Creation of 39 new user accounts between January and June 2025, with 34 successfully activated on the WIC platform. This uptake indicates that colleagues are increasingly engaging with the system, supported by ongoing workshops and development sessions designed to enhance familiarity and confidence in its use.
- 22 active responders on the WIC platform, enabling timely and effective responses to concerns raised, reflecting a growing commitment to collaborative communication and continuous improvement.
- In the last 6 months:

Concerns raised	Closed	Open	Average time to first respond	Average time to close
27	22	5	2 days	30 days

- Currently, open conversations relate to the following areas:
  - Bullying and Harassment
  - Breach of Confidentiality
  - Values and Behaviours
  - Patient Safety
  - Clinical Concerns
  - Other

SUMMC continued

Time period	Concerns raised	Closed	Open	Average time to first respond	Average time to close
January 25 - June 25	27 (+42%)	22 (+16%)	5	2 days	30 days
July 24 - December 24	19 (+90%)	19 (+90%)	0	4 days	43 days
January 24 - June 24	10	10	0	1 day	56 days

Speak Up continued

Concern Category	Jan 24 - Jun 24	Jul 24 – Dec 24	Jan 25 – Jul 25	Difference
Bullying and Harassment	1	4	6	+2
Leadership and Management	4	3	4	+1
Other	4	4	4	
Benefits, Rewards and Recognition	0	1	1	
Resources to do my Job	0	1	2	+1
Discrimination	1	2	0	-1
Patient Safety	0	0	2	+2
Thinking of leaving	0	0	1	-1
Values/Behaviours	0	4	4	
Clinical Concerns	0	0	1	+1
Support around Finances	0	0	1	+1
Wellbeing	0	0	1	+1

Category breakdown

- The largest increase in concerns being raised is within the Bullying and Harassment category and Benefits, Rewards and Recognition, conversely Values/Behaviours and Discrimination have both reduced over the last 6 months.
- The inclusion of Patient Safety and Clinical Concerns as categories, in which only the Speak Up Guardian can access to respond, has seen just a small number of concerns raised. The majority were appropriately signposted to be reported as incidents through Datix (the Guardians did not feel that an informal process could be utilised to resolve the issue). The other has been escalated up to the Executive Director of Nursing to gain a suitable response to the concern raised.

SUMMC continued

Evolving the Agenda

Learning Event held 16th July 2025

- Responders, SUG, and members of the Voices Network was held on 16 July
- Reflect on current practices and support continuous improvement in the implementation and management of the agenda.
- Areas discussed included:
  - Leadership
  - Minding the gap – meeting the needs of our multigenerational workforce
  - Fostering psychological safety
    - Development of a Standardised Meeting Narrative
    - Establishment of a Leadership Peer Network
    - Collaborative Measurement Framework
    - Speak-Up Support Toolkit
    - Speak-Up Guardians
    - Storytelling
- The People Experience Framework
- Listening and Learning Sub-Committee – including learning from SUMMC and WIC

Implementation of Welsh Health Circulars (WHCs)

There are 18 open WHCs aligned to QSEC as at July 2025. Four new WHCs have been issued since the previous report to Committee and one WHC (032-22: Further extending the use of Blueteq in secondary care) has been reassigned to the Digital, Data and Innovation Committee as it pertains to the rollout of a new digital system.

All WHCs are managed via the Audit Management and Tracking system (AMaT), which gives leads direct access to update and upload relevant evidence to demonstrate compliance with their requirements.

Each WHC is assigned a RAG status – the table below provides the definition for each category, along with the number of WHCs assigned to each category as at July 2025, and the number of WHCs noted as completed since the previous report:

RAG Status	Definition	Number of WHCs
Red	Behind schedule to the timescale provided by the Lead officer or as stipulated in the WHC, or a plan (with date for implementation) is not yet in place.	8
Amber	A plan is in place and on schedule to be completed by the timescale provided by the Lead Officer (if a timescale is not provided within the WHC)	8
Green	Completed	5
External	Considered to be outside the gift of the Health Board to currently implement, for example reliant on an external organisation to implement.	2

Oversight of the delivery of WHCs has been included in new Clinical Care Group (CCG) Terms of Reference, with the requirement to escalate appropriately instances of non-compliance.

The timely implementation of WHCs is included within the Governance domain of the Health Board's internal escalation framework, with services escalated in instances of non-compliance.

WHCs behind schedule (Red)

Welsh Health Circular	Clinical Care Group / Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	Reason for Red Status	Impact of non-compliance according to risk assessment	Next Steps
006-18: Framework of Action for Wales, 2017-2020 (*Not Available Online*) – **issued Feb 2018**	Planned and Specialist Care	Chief Operating Officer / CCG Director for Planned and Specialist Care	Service unable implement due to funding requirements **Original Completion Date**: 30/04/2022 **Revised Completion Date**: Not Known	**Risk Ref :**1457 **Current Risk Score:** 12 **Impacts:** Patients unable to access specialist care in a timely manner, closer to home; Additional pressures on GP capacity	WHC requirements and supporting systems and process to be incorporated into the Annual Planning work stream for 2025/26.
033-18: Airborne Isolation Room Requirements – **issued July 2018**	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	Service unable to provide implementation date due to capital funding requirements **Original Completion Date**: 31/07/2021 **Revised Completion Date**: Not Known	**Risk Ref:** 1640 **Current Risk Score:** 15 **Impacts:** Increased risk of transmission of infectious diseases	To complete a QIA pending discussions at July's Nursing Core Team meeting. To escalate the inability to proceed with implementation via the NQPE Core Team meeting structure to agree next steps.
017-19: Living with persistent pain in Wales guidance – **issued May 2019**	Planned and Specialist Care	Chief Operating Officer / CCG Director for Planned and Specialist Care	Revised completion date of **31 January 2026** provided to allow time to progress the medical pain service to meet guidelines, improve waiting list and demand and capacity. A review of how to upscale the service and evidence of progress to date has been attached to AMaT. **Original Completion Date:** 31/01/2025 **Revised Completion Date:** 31/01/2026	**Risk Ref:** 2120 **Current Risk Score:** 12 **Impacts: :** Patients unable to access specialist care in a timely manner, breaches in achieving RTT	Draft QIA to be sent to the QAST team
009-21: School Entry Hearing Screening pathway - **issued March 2021**	Planned and Specialist Care	Chief Operating Officer / CCG Director for Planned and Specialist Care	Service unable to provide implementation date due to funding requirements **Original Completion Date**: 31/01/2023 **Revised Completion Da**[illegible]	**Risk Ref:** 1456 **Current Risk Score:** 8 **Impacts:** Detrimental impact on quality, accuracy and consistency of screening services provided	WHC requirements and supporting systems and process to be incorporated into the Annual Planning work stream for 2025/26.

WHCs behind schedule (Red) - continued

Welsh Health Circular	Clinical Care Group / Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	Reason for Red Status	Impact of non-compliance according to risk assessment	Next Steps
004-22: Guidance for the provision of continence containment products for children and young people: a consensus document – **issued October 2022**	Planned and Specialist Care	Chief Operating Officer / CCG Director for Planned and Specialist Care	Original implementation date of 31 July 2023 lapsed, with revised completion date of **31 Aug 2025 provided** **Original Completion Date:** 31/07/2023 **Revised Completion Date:** 31/05/2025	**Risk Ref:** 1615 **Current Risk Score:** 12 **Impacts:** Right to independence for children and young people; Access to the same services as their peers	Nursing post that will enable the CCG to comply with WHC requirements approved by Financial Control Group in February 2025. The timeline for implementation has been set as August 2025 to account for the recruitment process.
019-22: Non-Specialised Paediatric Orthopaedic Services - **issued June 2022**	Planned and Specialist Care	Chief Operating Officer / CCG Director for Planned and Specialist Care	At Planned Care's January 2025 escalation meeting, an action was discussed to re-assign the WHC to Primary Care as elements relating to Planned Care had been completed. **Original Completion Date:** 30/04/2025 **Revised Completion Date:** Not Known	No risk noted on Datix.	Service lead to upload relevant evidence to AMAT to support the closure of actions relating to Orthopaedics. Orthopaedic service lead to liaise with colleagues in Primary Care highlighting outstanding actions prior to transferring ownership
006-24: National Clinical Guideline for Stroke, for the UK and Ireland – **issued March 2024**	Community and Integrated Medicine	Chief Operating Officer / CCG Director for Community and Integrated Medicine	Service unable to provide an implementation date pending progression of the wider Clinical Service Plan **Original Completion Date:** 30/04/2025 **Revised Completion Date:** Not Known	**Risk Ref:** 233 **Current Risk Score:** 12 **Impacts:** Delayed assessment and treatment of patients; Increased length of stays	To complete QIA
006-25: Recording of Mental Health Outcome Measures – **issued May 2025**	Mental Health and Learning Disabilities	Chief Operating Officer / Director of Mental Health & Learning Disabilities	First Task & Finish Group planned for 30 July 2025, following which the CCG will be able to provide an implementation date. Foundation work is underway. **Original Completion Date:** TBC **Revised Completio**	TBC	To provide an implementation date for the completion of the WHC.

WHCs in Progress (Amber)

Welsh Health Circular	Clinical Care Group/Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	UHB Implementation Date
030-23: New 2023 National Safety Standards for Invasive Procedures (NatSSIPS2) by the Centre for Perioperative Care (CPOC) and Patient Safety Notice PSN 034 – **issued August 2023**	Medical Director	Medical Director	Sep-26
002-24: Standards for Competency Assurance of Non-Medical Prescribers in Wales – **issued March 2024**	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Care	Mar-26
016-24: Healthy Child Wales Programme: for school aged children – **issued April 2024**	Planned and Specialist Care	Chief Operating Officer / CCG Director for Planned and Specialist Care	~~Apr-26~~ Sep-26
035-24: Standardising the management of acute deterioration – **issued September 2024**	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	Sep-25
040-24: Adopting a patient and family-initiated escalation approach – **issued October 2024**	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	Sep-25
041-24: Ambulance patient handover guidance – **issued October 2024**	Community and Integrated Medicine	Chief Operating Officer / CCG Director for Community and Integrated Medicine	Dec-25
017-25: Tranexamic Acid use: Recommendation 7a of the Infected Blood Inquiry (IBI) – **issued May 2025***	Chief Operating Officer / Director of Operational Allied Health Professions and Health Sciences	Operational Allied Health Professions and Health Sciences	Jan-26
018-25: Tirzepatide (Mounjaro®) for the management of obesity and overweight – **issued May 2025**	Operational Allied Health Professions and Health Sciences	Chief Operating Officer / Director of Operational Allied Health Professions and Health Sciences	Jul-25

** Actions which were assigned to the Pathology service have been completed with evidence approved by the Director of Operational Allied Health Professions & Health Sciences. The remaining actions in this WHC sit within the remit of the Theatres service, who have advised of a 6-month timescale for compliance, therefore the WHC is in the process of being reassigned to the Planned and Specialist Care CCG and will be reflected in the next update to the Committee.*

WHCs implemented since previous meeting (Green)

Welsh Health Circular	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	Clinical Care Group/Executive Function	UHB Implementation Date
017-22: Wales rare diseases action plan 2022 to 2026 – **issued June 2022**	Medical Director	Medical Director	Dec-26
041-23: Wales rare diseases action plan refresh 2022 to 2026 – **issued January 2024**	Medical Director	Medical Director	Dec-26
025-24: NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme for 2024/25 – **issued June 2024**	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	Mar-25
001-25: NHS Wales Sustainability Conference and Awards 2025 - **issued March 2025**	CEOs Office (Welsh Language)	Director of Communications	Apr-25
002-25: Timelines and Responsibilities for the Implementation of Early Warning Scores (EWS) to identify Acute Deterioration - **issued February 2025**	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	Sep-25

External WHCs

Welsh Health Circular	Clinical Care Group/Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	Reason for External Status	UHB Implementation Date
026-18: Phase 2 – primary care quality and delivery measures **– issued July 2018**	Primary Care, Community Strategy and Long Term Care	Chief Operating Officer / Director of Primary Care, Community and Long Term Care	National work around this transformational model was suspended due to the COVID-19 pandemic and has never progressed further. Currently the Primary Care quality and delivery measures within the new dashboards are being used as equivalent quality indicators. As such, the implementation date for this WHC is currently noted as not known.	N/K
040-23: The NHS Wales: Newborn and Infant Physical Examination Cymru (NIPEC) **– issued September 2023**	Planned and Specialist Care	Chief Operating Officer / CCG Director for Planned and Specialist Care	The service is currently compliant with all aspects of this WHC apart from the data capture requirements, for which no national system is currently available. An all-Wales data system is awaited. As such, the implementation date for this WHC is currently noted as not known.	N/K

Recommendations

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

The Quality, Safety and Experience Committee is asked to take assurance that processes are in place to review, monitor and improve the quality of our service through:

- Patient safety incidents
- Nationally reported patient safety incidents
- Duty of Candour
- Patient Experience including demographics
- Infection, prevention and control
- Inspections and peer reviews including activity of Healthcare Inspectorate Wales (HIW)
- Speak Up, Making Meaningful Change
- Welsh Health Circulars

Authors

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

Sections:

1. Patient Safety Incident Reporting – Cathie Steele, Interim Assistant Director of Nursing, Assurance and Safeguarding
2. Nationally reportable incidents – Cathie Steele, Interim Assistant Director of Nursing, Assurance and Safeguarding
3. Duty of Candour – Cathie Steele, Interim Assistant Director of Nursing, Assurance and Safeguarding
4. Patient experience 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 – Caroline Burgin, Patient Safety and Assurance
7. Speak Up, Making Meaningful Change – Robert Blake, Head of Culture / Workforce Experience
8. Welsh Health Circulars – Rachel Williams, Head of Assurance and Risk

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.

Reference Number	Inspection Title	Recommendation	Action	Clinical Care Group	Original Due Date	Current Due Date	Date Last Updated	Last Updated By	Progress Status	Risk Ref
Healthcare Inspectorate Wales (HIW)/2022/19/MD15/2	HIW GGH IRMER Inspection (Nov 2022)	The employer is required to provide HIW with details of the action taken to improve the ratification process for locally produced documentation so that information does not conflict with the employer's written procedure	To source a document control system.	Operational Allied Health and Health Science	30/09/2023	30/09/2023	23/04/2025	Head of Radiology	Overdue	Ref 1399
Healthcare Inspectorate Wales (HIW)/2023/29/MD1/1	HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)	The health board must ensure that full and comprehensive mental health assessments and physical health assessments are always being completed in a timely manner, in line with the Mental Health (Wales) Measure 2010 under the Mental Health Act 1983.	a)Development of standards for physical health screening to be incorporated into Service Specifications.	Mental Health and Learning Disabilities	29/09/2023	29/09/2023	01/07/2025	Assurance and Risk Officer	Partially complete (Overdue)	
Healthcare Inspectorate Wales (HIW)/2023/29/MD25/3		The health board must take action to manage the risks of insufficient staff numbers and temporary staffing needs on inpatient mental health wards.	p)Pilot application of the SAFECARE tool across an individual mental health inpatient ward to inform an approach to full implementation.	Mental Health and Learning Disabilities	30/11/2023	30/11/2023	23/05/2025	Assistant Director of Nursing, Quality and Patient Experience for Mental Health and Learning Disabilities	Overdue	
Healthcare Inspectorate Wales (HIW)/2023/29/MD25/4			q)Development of MH/LD targeted actions through the MH/LD Workforce Group to feed into board wide recruitment and retention plans.	Mental Health and Learning Disabilities	31/12/2023	31/12/2023	01/07/2025	Assurance and Risk Officer	Overdue	
Healthcare Inspectorate Wales (HIW)/2023/29/MD26/2		The health board must provide HIW with an update on how it is assured that community teams within its mental health services have sufficient capacity to meet their patient caseloads.	s)Undertake evaluation of the current caseload weighting tool in place across community mental health teams to determine use and effectiveness.	Mental Health and Learning Disabilities	30/09/2023	30/09/2023	01/07/2025	Assurance and Risk Officer	Overdue	
Healthcare Inspectorate Wales (HIW)/2023/29/MD32/1		The health board must consider undertaking a training needs analysis for inpatient and community mental health staff, to identify any training gaps and help ensure all staff have the appropriate knowledge and skills to effectively undertake their role.	u)Development of a MH/LD essential training framework to reflect training needs across MH/LD services based on a systematic TNA that can be reviewed at regular intervals and monitored for compliance.	Mental Health and Learning Disabilities	30/11/2023	30/11/2023	01/07/2025	Assurance and Risk Officer	Overdue	
Healthcare Inspectorate Wales (HIW)/2023/29/MD34/1		The health board should ensure there is adequate and consistent engagement with all staff around the audit arrangements in place across its mental health services, and that staff are made aware of all audit result and any actions required for improvement.	w)Develop a Directorate audit framework and plan, with the support of the Clinical Audit Team, that reflects local ward/team based audits and wider Health Board requirements to include:- -Testing assurance of consistent implementation of CAT and Physical Health Screening -Testing assurance of appropriate completion of WARRN -Routine reporting and monitoring of compliance with routine offer of carers assessments -Audit of compliance with Ward Round (MDT Review) standards -Routine report and monitoring of compliance with communication of discharge notifications, discharge letters and discharge summaries against NICE guideline standards -Record Keeping Documentation Audit to include completion and uploading of discharge checklists and communication of discharge plans -Testing assurance of the quality of discharge letters -Routine reporting and monitoring of compliance with 72 hour follow up	Mental Health and Learning Disabilities	31/12/2023	31/12/2023	01/07/2025	Assurance and Risk Officer	Partially complete (Overdue)	
Healthcare Inspectorate Wales (HIW)/2023/29/MD6/1		The health board must ensure the inpatient ward round structure and arrangements in place allow for sufficient time for patients to be adequately discussed.	e)Coproduce a set of standards to underpin Ward MDT Review process to include a plan for implementation (including consistent approach to enabling service user and carer views within this process and consistent approach to documentation and communication of outcomes from ward reviews and discharge planning) and monitoring.	Mental Health and Learning Disabilities	29/09/2023	29/09/2023	01/07/2025	Assurance and Risk Officer	Overdue	
Healthcare Inspectorate Wales (HIW)/2023/29/MD8/1		The health board must ensure that all relevant staff complete training for timely and effective communication and information sharing relating to the patient discharge process.	h)Develop a training resource to provide guidance to all relevant staff on standards associated with the discharge planning and process.	Mental Health and Learning Disabilities	31/10/2023	31/10/2023	01/07/2025	Assurance and Risk Officer	Overdue	
Healthcare Inspectorate Wales (HIW)/2023/69/MD10/4	HIW St Non, St Caradog, Canolfan Bro Cerwyn WGH	The Health Board must address the environmental issues and resolve them in a prompt and timely manner: 1) Mould and poor ventilation in both laundry rooms 2) Glass window cracked in St Non's leading into the courtyard requires replacing; 3) Sluice macerator on both wards needs to be fixed or replaced as both currently not working , 4) Occupational therapy room needs to be decluttered and tidied up and not used as a storage room; 5) Wrong signage on some doors in St Caradog which could pose a risk if fire alarms locations are activated; 6) Review of handrails in the ward area and bathrooms on St Non ward to ensure handrails are available, appropriate, and safe for the patient group; 7) Thermostats covers in some patient rooms on St Non are missing and need replacing.	Handrails are in place in courtyard and corridors on st Non Ward. Review of handrail needs in bedrooms and bathrooms and how these can be addressed using anti ligature handrail products to be undertaken	Estates and Facilities	31/01/2024	31/01/2024	18/06/2025	Estates Manager	Partially complete (Overdue)	
Healthcare Inspectorate Wales (HIW)/2023/69/MD13/1	HIW St Non, St Caradog, Canolfan Bro Cerwyn WGH	The health board must ensure that safe holds are described in detail and that patient observations are recorded post any restraint or medical intervention in patient notes	To undertake a Directorate wide audit of Rapid Tranquilisation against standards for physical health monitoring within the Health Boards Rapid Tranquilisation Policy.	Mental Health and Learning Disabilities	31/03/2024	31/03/2024	19/11/2024	Quality Assurance and Safety Team	Overdue	
Healthcare Inspectorate Wales (HIW)/2024/302/MD6/1	HIW Glangwili Hospital – Morlais Ward inspection	The health board must ensure that the outstanding actions identified following the fire safety audit in February 2024 are completed and sustained.	To review the recommendations from the fire safety audit and agree an implementation plan.	Estates and Facilities	31/12/2024	31/12/2024	06/08/2025	Quality Assurance and Safety Team	Partially complete (Overdue)	
Healthcare Inspectorate Wales (HIW)/2024/395/MD33/1	Bryngolau Ward, Prince Philip Hospital	The health board should consider the staff feedback about suggestions for training and implement regular, individualised training needs assessments.	Develop and deliver bespoke Older Adult Mental Health Clinical Risk training specifically around self-harm and suicidality, to all OAMH Wards.	Mental Health and Learning Disabilities	31/03/2025	31/03/2025	08/05/2025	Head of Service for Older Adult Mental Health	Partially complete (Overdue)	
Healthcare Inspectorate Wales (HIW)/2024/396/MD2/1	HIW Children and Young People Mental Health Review	Health boards must: Ensure their CAMHS teams reflect on their communication processes with parents, carers and referrers, and ensure timely communication and advice is provided, once a referral for assessment has been made.	A multi-disciplinary task & finish group will be established to review all initial contact letters to ensure support / advise services are up to date	Mental Health and Learning Disabilities	04/08/2025	04/08/2025	27/02/2025	Quality Assurance and Safety Team	Overdue	
Healthcare Inspectorate Wales (HIW)/2024/396/MD2/2			Group will ensure that all correspondence to parents / carers / YP (standard letter, email, text) will be within 5 working days	Mental Health and Learning Disabilities	04/08/2025	04/08/2025	27/02/2025	Quality Assurance and Safety Team	Overdue	
Healthcare Inspectorate Wales (HIW)/2024/396/MD32/1		Health boards must explore the options available within their local CAMHS teams to facilitate a strengthened approach for communication and partnership working with GP clusters and/ or directly with GP practices.	S-CAMHS will discuss with GP Clusters to discuss an agreed approach to partnership working and improving communication, including the suggestion of a regular (bi-monthly) forum	Mental Health and Learning Disabilities	04/08/2025	04/08/2025	27/02/2025	Quality Assurance and Safety Team	Overdue	

Healthcare Inspectorate Wales (HIW)/2024/396/MD32/2			S-CAMHS will deliver S-CAMHS Roadshows in each locality area	Mental Health and Learning Disabilities	04/08/2025	04/08/2025	27/02/2025	Quality Assurance and Safety Team	Overdue	
Healthcare Inspectorate Wales (HIW)/2024/396/MD33/1		Health boards must adopt flexible, proactive measures to ensure children and young people who miss CAMHS appointments or show poor engagement are not automatically discharged without assessing their individual circumstances. Strategies should target harder-to-reach groups and complex care cases to prevent mental health deterioration, safeguarding their well-being and safety.	S-CAMHS will ensure the relevant Policies are up to date and all staff are aware of the current policy	Mental Health and Learning Disabilities	04/08/2025	04/08/2025	27/02/2025	Quality Assurance and Safety Team	Overdue	
Healthcare Inspectorate Wales (HIW)/2024/396/MD35/1		Health boards should ensure they review their methods of co-production of services with children and young people, and parents and carers.	S-CAMHS will continue to offer support for the Future MINDS Forum already established and ensure co-Production is a priority in reviewing Service Improvements, Policies and partake in recruitment	Mental Health and Learning Disabilities	04/08/2025	04/08/2025	27/02/2025	Quality Assurance and Safety Team	Overdue	
Healthcare Inspectorate Wales (HIW)/2024/396/MD8/1		Health boards must ensure that all CAMHS teams regularly review the availability of support services within their locality, across boundaries, and online. This should ensure that when signposting individuals to other services, the options provided are current, accessible, and relevant to meet their needs.	T&F Group to review all current information of support/ advise and websites to ensure up to date and Repeat on a 6 monthly basis and reviewed by CAMHS QSEG	Mental Health and Learning Disabilities	04/08/2025	04/08/2025	27/02/2025	Quality Assurance and Safety Team	Overdue	
Healthcare Inspectorate Wales (HIW)/2024/396/MD9/1		Health boards must review their referral outcome processes, including the letter templates and the sufficiency of information provided to better inform and engage patients, families, and referrers.	A multi-disciplinary task & finish group will be established to review all initial contact letters to ensure support / advise services are up to date	Mental Health and Learning Disabilities	04/08/2025	04/08/2025	27/02/2025	Quality Assurance and Safety Team	Overdue	
Healthcare Inspectorate Wales (HIW)/2024/396/MD9/2			Group will ensure that all correspondence to parents / carers / YP (standard letter, email, text) will be within 5 working days	Mental Health and Learning Disabilities	04/08/2025	04/08/2025	27/02/2025	Quality Assurance and Safety Team	Overdue	
Healthcare Inspectorate Wales (HIW)/2024/498/MD2/1	IRMER Regulations	Identify areas where more than one employer may be involved with and exposure and consider if the co-operation regulation needs actions. e.g. referrer (GP referrals), operator (third party imaging providers) or practitioner (out of hours practitioner service) has a different employer; to other duty holders	Co-operation between employers: consider where relevant	Operational Allied Health and Health Science	31/07/2025	31/07/2025	23/05/2025	Quality Assurance and Safety Team	Overdue	
Healthcare Inspectorate Wales (HIW)/2024/498/MD4/1		Particular relevance to new employer procedure re making, amending and cancelling referrals. However duty is to comply with all EPs so implies they must be available to referrers. Also recommended that where possible referrers are informed of this new duty. Might also be impacted by co-operation between employers	All referrers need to have access to employers procedures and be made aware they must comply	Operational Allied Health and Health Science	31/07/2025	31/07/2025	23/05/2025	Quality Assurance and Safety Team	Overdue	
Healthcare Inspectorate Wales (HIW)/2024/498/MD9/1		Schedule 3 is re-organised with changes to core and specific training. Training in the amendment changes is required plus discipline specific review with additions to the "all modalities" elements probably most significant. A plan to cover any additions will be required.	Review training needs of practitioners and operators	Operational Allied Health and Health Science	30/06/2025	30/06/2025	23/05/2025	Quality Assurance and Safety Team	Overdue	
Healthcare Inspectorate Wales (HIW)/2024/86/MD4/1	HIW IRMER Diagnostic Imaging x-ray department Withybush Hospital January 2024	The Employer is required to provide HIW with details of action taken to ensure that all written documentation in place include the required level of detail as set out within the employer's procedure for Quality Assurance programme document control.	1. A document control system needs to be sourced	Operational Allied Health and Health Science	31/12/2024	31/12/2024	14/05/2025	Quality Assurance and Safety Team	Overdue	1399 on risk register
Healthcare Inspectorate Wales (HIW)/2025/565/MD7/1	HIW GGH Maternity Services 03924	The health board should ensure that all hand gel containers in ward areas and at the entrances contain hand gel to minimise the risk of infection to service users, visitors and staff.	In collaboration with Hotel Services all staff to be reminded that in the event that a hand gel is not readily available this should be escalated and replaced without delay	Planned and Specialist Care	30/07/2025	30/07/2025	16/07/2025	Quality Assurance and Safety Team	Overdue	

OFFICIAL SENSITIVE

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Phil Kloer
Chief Executive
Hywel Dda University Health Board

Via Email: Philip.Kloer@wales.nhs.uk

16 May 2025

Dear Phil

Provider meeting to discuss overall concerns received by Healthcare Inspectorate Wales, and the quality governance arrangements in place at Hywel Dda University Health Board

On 7 May 2025, in accordance with its escalation process, Healthcare Inspectorate Wales (HIW) held a meeting in line with its Service of Concern (SOC) Process for NHS Bodies in Wales. The meeting was held to discuss several concerns HIW has received between 1 January and 6 May 2025, which relate to several directorates within Hywel Dda University Health Board (the health board).

During the SOC meeting, and in line with our escalation process, the number of concerns received over recent months from different directorates across the health board were considered as a whole. We acknowledge that the health board has provided us with assurance for individual concerns. However, collectively, these have impacted our confidence in the health boards quality governance arrangements and staff concerns escalation process. We, therefore, considered whether the designation as a Service Requiring Significant Improvement (SRSI) was required.

We concluded the meeting with the decision that designation as an SRSI would not be applied at this stage. Instead, HIW is providing the health board with an opportunity to engage with us in a meeting, to discuss and clarify the concerns collectively and the assurances we need around the quality governance arrangements and staff concerns escalation processes in place.

We require executive attendance at a scheduled meeting, which will enable a constructive two-way discussion on how the health board can provide HIW with the

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www.hiw.org.uk / www.agic.org.uk

assurance needed. This meeting will take place over Microsoft Teams at 15:00 on Wednesday 4 June 2025. Please inform HIW by Friday 23 May 2025 who from the health board will attend the meeting, however, it is our expectation that some key members of the executive team will attend.

Our intention in making use of our SOC process is to support improvement, enabling HIW to identify the most effective and appropriate method of seeking ongoing assurances and engagement around the health board's governance processes.

Please do not hesitate to contact me should you wish to discuss this letter further, via email, vanessa.davies008@gov.wales or by telephone, 0300 062 8163.

Yours sincerely

V. L. Davies

Vanessa Davies
Head of NHS Assurance
Healthcare Inspectorate Wales

Cc.

Neil Wooding, Chair
Sharon Daniel, Executive Director of Nursing
Mark Henwood, Interim Executive Medical Director

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Ein cyf/Our ref: QAST / HIW / CB
Gofynnwch am/Please ask for: Caroline Burgin
Rhif Ffôn /Telephone: 01267 674013
Dyddiad/Date: 11th June 2025

Swyddfeydd Corfforaethol, Adeilad Ystwyth
Hafan Derwen, Parc Dewi Sant, Heol Ffynnon Job
Caerfyrddin, Sir Gaerfyrddin, SA31 3BB

Corporate Offices, Ystwyth Building
Hafan Derwen, St Davids Park, Job's Well Road,
Carmarthen, Carmarthenshire, SA31 3BB

PRIVATE AND CONFIDENTIAL

Vanessa Davies
Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

Dear Vanessa,

Re: **Documentation as agreed in meeting on 3rd June 2025.**

Thank you for meeting with us on 4th June and for providing us with the opportunity to respond to the concerns raised in the letter dated 16th May 2025. We take your concerns very seriously. As agreed in the meeting please find enclosed the documents that were referred to in the discussion. Due to the volume of these documents, we have tried to cross reference them with the area of discussion.

- OD programme for operational staff (attachment A)
- New governance arrangements (attachment B1 – B14)
- Organogram for operational services (attachment C)
- Copy of quality and corporate governance training (attachment D)
- Escalation and oversight of performance arrangements - The EITS (Executive Improving Together Sessions) slide deck for the Nursing Quality and Patient Experience function has been provided as an example, the format for other functions is the same. We have enclosed a Quality Safety Intelligence Group (QSIG) agenda 20/05/2025 which includes an item for discussion of the escalation scores in the Quality Domain. We have also enclosed the Quality Assurance report for QSEC with the appendix demonstrating another way how HIW improvement plans are monitored (attachment E1-E4)
- The new EITS escalation framework (attachment F1-F2)
- QISG TORs and the discussions on how this group will continue its efficiency in the governance arrangements (attachment G1- G4)
- Safety dashboard extract (attachment H)

- Fragile services framework (attachment I). The fragile services framework was presented to QSEC on 10/06/2025 and here is a link to the paper. https://hduhb.nhs.wales/about-us/governance-arrangements/board-committees/quality-safety-and-experience-committee-qsec/qsec-10-june-2025/4-1-fragile-services-report/
- EDI (Equality, Diversity and Inclusion) taskforce board paper (attachment J)
- Speaking up Safely process (attachment K1-K3)
- Quality Impact Assessment process (attachment L1-L3)
- Professional forum (attachment M1-M3)
- Work on incidents (attachment N) (slides 3-7)
- QMS (attachment O and further information in attachment D)

Sharon Daniel, Executive Director of Nursing, Quality and Patient Experience, is looking forward to continuing to work with Vanessa. Our meeting on 4th June and the discussions were conveyed and discussed in the Heath Board's Quality, Safety and Experience Committee this week. If you have any queries on the attachments, please contact Cathie Steele or Caroline Burgin.

Yours sincerely

Phil Kloer
Chief Executive Officer

3.2

3.2 - Duty of Quality Annual Report 2024/25- To Follow

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

3.3

3.3 - Quality, Safety and Experience Sub Committee and Terms of Reference for Annual Review

James Severs (Hywel Dda UHB - Executive Director of Allied Health Professions and Health Science)

For approval

Attachments

QSESC Update Report July25 v1.pdf

QSESC Terms of Reference for approval August 2025 (002).pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

QUALITY, SAFETY & EXPERIENCE SUB-COMMITTEE (QSESC) UPDATE REPORT

Date of last meeting: 15 July 2025

Quoracy: Met

Report by: Mr Mark Henwood, Vice Chair

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

Alert[1] (may require discussion)

The Quality, Safety & Experience Sub-Committee had no matters of which to **alert** the Committee.

Advise[2] (to monitor)

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

- The progress to complete the actions and recommendations from the Ministerial Advisory Group report on NHS Wales Performance and Productivity was shared as part of the **Community and Integrated Medicine Clinical Care Group (CIMCCG) Report**. The report demonstrated the significant improvements required across the system but particularly in relation to Emergency departments (ED). Urgent quality improvement initiatives are underway to resolve the actions via the Accelerated Programme of Care Workstreams. An update on progress is being considered for presentation at the Integrated Quality Finance and Performance (IQFPD) Group meeting in August 2025.

- System General Managers have been asked to review outstanding actions for the **Getting it Right First Time (GIRFT)** recommendations for Emergency Medicine and submit a detailed plan outlining the trajectory for completion by 31 July 2025, in light of concerns raised regarding the 15 outstanding actions.

- Limitations in body storage capacity across the Health Board mortuaries was highlighted as part of the **Human Tissue Authority Assurance Group Update Report.** In response, Sub-groups are being established to explore and develop short, medium and long-term solutions to address these capacity challenges and to identify the associated financial implications for consideration by the Executive Team.

---

[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.*

- **Assure[3] (to note)**

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

- An overview of the newly established governance arrangements aimed at supporting effective monitoring of quality, safety and patient experience, particularly in relation to progress to meet the Duty of Quality, was presented for the following Clinical Care Groups during the meeting:

    - CIMCCG
    - Operational Allied Health Services (OAHSCCG)
    - Estates and Facilities (EFCCG)
    - Public Health Directorate (PHD)

Detailed reports were presented outlining the CCG's operational risks, incident trends, infection prevention and control metrics, compliance with Welsh Health Circulars, and data on complaints and claims, along with other aspects of the Safe, Timely, Equitable, Efficient, Evidence Based and Person Centred (STEEEP) domains. The key highlights discussed during the meeting included the following:

- The **Infection Prevention Control Steering Group** is considering an investigation to understand the recent reduction in community onset infections, in contrast to the continued levels of hospital onset infections reported via the CIMCCG.

- In response to the 'limited assurance' findings for the Standards of Cleanliness Audit and Health and Safety Regulations Audit, **EFCCG** has developed detailed action logs. A lessons learnt report will follow upon completion. Additionally, a meeting involving Assistant Directors of Nursing, Executive Leads, Infection Prevention Control (IPC) and **EFCCG** representatives is planned to strengthen business planning, review infection prevention and control governance arrangements and draft a plan for presentation at Executive Team.

- The **Public Health Directorate** reported significant changes to the routine childhood vaccination schedule and to the selective hepatitis programme, effective from 1 July 202, with further amendments planned from 1 January 2026. These changes are designed to optimise the protection for children and align with current public health priorities.

- A comprehensive review of current provision and access options has been undertaken to inform service improvements for future **workforce flu vaccinations.**

- Challenges related to staffing deficits within Facilities, which have been reported as impacting patient **nutrition and hydration,** are being scoped. An **urgent** improvement plan is being developed collaboratively between the Dietetics and Facilities teams.

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

- As the meeting was not quorate and minor amendments to the Membership were identified, it was agreed that the Sub Committee's **Terms of Reference** would be updated and circulated for approval via Chair's Action. Proposals aimed at strengthening and streamlining quality and safety governance arrangements across both the operational and the assurance functions of the Health Board are currently under consideration by the Executive Team, ahead of presentation to QSEC for approval.

Recommendation

The Quality, Safety & Experience Committee is asked to:

- Approve the Quality, Safety & Experience Sub-Committee Terms of Reference.
- Note the 'advise' items and receive assurance from the 'assure' items.

- Healthcare Professionals Forum (HPF)
- Health Board Partnership Forum (HBPF)
- Stakeholder Reference Group (SRG)

HYWEL DDA UNIVERSITY HEALTH BOARD

- AUDIT & RISK ASSURANCE COMMITTEE (ARAC)
- CHARITABLE FUNDS COMMITTEE (CFC)
- DIGITAL, DATA & INNOVATION COMMITTEE (DDIC)
- ETHICS PANEL (EP)
- HEALTH & SAFETY COMMITTEE (HSC)
- MENTAL HEALTH LEGISLATION COMMITTEE (MHLC)
- PEOPLE, OD & CULTURE COMMITTEE (PODCC)
- STRATEGY & PLANNING COMMITTEE (SPC)
- FINANCE & PERFORMANCE COMMITTEE (FPC)
- QUALITY, SAFETY & EXPERIENCE COMMITTEE (QSEC)
  - Quality Safety & Experience Sub Committee (QSESC)
    - Effective Clinical Practice Group
    - Medicines Management Operational Group
    - Human Tissue Authority Group
    - Infection Prevention Strategic Steering Group
    - Strategic Safeguarding Group
    - Mental Capacity Act & Consent Group
    - Nutrition and Hydration Group
    - Recognition of Acute Deterioration &Resuscitation (RADAR) Group
    - Medical Devices Group
  - Listening & Learning Sub Committee
- REMUNERATION & TERMS OF SERVICE COMMITTEE (RTSC

QUALITY, SAFETY & EXPERIENCE SUB-COMMITTEE

DRAFT TERMS OF REFERENCE

Version	Issued to:	Date	Comments
V0.1	**Quality, Safety & Experience Assurance Committee Workshop**	29.05.2018	
V0.2	**Operational Quality Safety and Experience Assurance Sub Committee**	10.07.2018	Approved
V0.3	**Operational Quality Safety and Experience Assurance Sub Committee**	20.09.2018	Approved
V0.4	**Quality, Safety & Experience Assurance Committee**	16.10.2018	Approved
V0.5	**Operational Quality Safety and Experience Assurance Sub Committee**	24.01.2019	Approved
V0.6	**Quality, Safety & Experience Assurance Committee**	05.02.2019	Approved via Chairs Action 28.03.2019
V0.7	**Operational Quality Safety and Experience Assurance Sub Committee**	03.09.2020	Approved
V0.8	**Quality, Safety & Experience Assurance Committee**	06.10.2020	Approved

V.10

V0.9	**Operational Quality Safety and Experience Sub Committee**	06.07.2021	Approved
V0.9	**Quality, Safety & Experience Committee**	10.08.2021	Approved
V10	**Operational Quality, Safety and Experience Sub Committee**	02.11.2021	Approved
V10	**Quality, Safety, Experience Committee**	07.12.2021	Approved
V11	**Operational Quality, Safety and Experience Sub-Committee**	06.07.2023	Approved
V11	**Quality, Safety, Experience Committee**	08.08.2023	Approved
V12	**Operational Quality, Safety and Experience Sub-Committee**	14.05.24	Approved
V13	**Quality, Safety and Experience Committee**	11.06.2024	Approved
V14	**Quality, Safety and Experience Committee**	15.08.2024	Approved
V15	**Quality, Safety and Experience Sub Committee**	06.08.2025	Approved via Chair's Action
V15	**Quality, Safety and Experience Committee**	14.08.2025	For Approval

1. Constitution

1.1 The Quality, Safety & Experience Sub-Committee has been established as a Sub-Committee of the Quality, Safety & Experience Committee and constituted from 1 September 2024, replacing the Operational Quality, Safety & Experience Sub-Committee. From June 2018 the Operational Quality, Safety & Experience Sub-Committee replaced the Primary & Community Services Quality, Safety & Experience Sub-Committee. From September 2020, the Operational Quality, Safety & Experience Sub-Committee subsumed the Mental Health and Learning Disabilities Quality, Safety & Experience Sub-Committee.

2. Purpose

2.1 The Quality, Safety & Experience Sub-Committee will, as delegated by the Quality, Safety and Experience Committee, monitor ~~the~~ operational quality, safety and experience governance arrangements ~~Acute, Mental Health & Learning Disabilities and Primary and Community services~~. In doing so, the sub-committee will hold services accountable for the management and mitigation of those quality and safety issues, thus allowing the Quality, Safety and Experience Committee to be strategically focused and provide upward assurance to the Board.

3. Key Responsibilities

3.1 Aligned to the Duty of Quality and Health & Care Quality Standards, the sub-committee will monitor the quality, safety and experience of care delivered to patients. Data triangulation from the Quality & Safety and Performance Dashboards reviewed by the Quality Safety Intelligence Group (QSIG) will inform this alongside patient feedback, surveys and patient stories. Lack of assurance and resolution is escalated to the Integrated Quality, Planning, Finance and Delivery Group (IQPFD) to inform the Escalation and Directorate Improving Together processes and to Board via the Quality, Safety and Experience Committee.

3.2 Where re-directed by the Listening & Learning Sub-Committee, monitor concerns (incidents, complaints, and claims) ensuring that they are being managed in a robust and timely manner at service level, agreeing mitigating actions where required.

3.3 Request a deep dive report.

- When action plans following investigations into serious incidents and concerns and the identification of lessons learned breach the agreed timescales. Ensuring actions are completed in a robust and timely manner and seek assurance that learning is disseminated and embedded across all the Health Board's activities as appropriate.
- To consider themes arising from triangulated information at service specific level and agree and monitor any action plans required to deliver improvements.

3.4 Ensure and monitor compliance with recommendations from external reviews and national guidance, including HIW, Royal Colleges, NICE, NSFs, National Confidential Enquiries, outcome reviews and national clinical audits and Health Board clinical written control documents.

3.5 Inform and monitor progress against agreed performance indicators in the Quality & Safety Dashboard and the Performance Dashboard as identified by QSIG.

3.6 Seek clarification and assurance on the management of operational risks that have been aligned to the Sub-Committee where the risk tolerance is exceeded or where there is a lack of timely action. Lack of assurance and resolution is escalated to the Quality, Safety and Experience Committee.

3.7 Aligned to the Domains of the Duty of Quality receive Clinical Care Group Quality Assurance Reports ~~and seek assurance on new elements of a directorate risk which requires consideration on a broader scale. Any risk escalated should clearly reference the risk as noted on the register~~.

3.8 Receive assurance from the Advisory Groups reporting to the Sub-Committee and consider how escalated issues are addressed/resolved.

3.9 Receive position reports on:
- Quality Impact Assessment Panel
- Risk Register
- Key Risks associated with preventing harm to patients determined through Triangulation of data.

3.10 Assure itself that clinical written control documentation, which falls within the remit of the Sub-Committee, has been adopted, developed, or reviewed in line with HDdUHB Policy 190 – Written Control Documentation prior to approving it.

3.11 Develop an annual work plan, responding to operational service priorities, consistent with the strategic direction for the organisation, for approval by the Quality, Safety and Experience Committee. Oversee delivery to improve the quality, safety and effectiveness of care delivered and enhance the patient experience.

3.12 Inform the work plans for Advisory Groups and vice versa.

3.13 Address any other requirements stipulated by the Quality, Safety and Experience Committee.

3.14 Agree issues to be escalated to the IQPFD Group.

4. Membership

4.1 The membership of the Sub-Committee shall comprise:

Title
Executive Director of Allied Health Professionals and Healthcare Sciences (Chair)
Executive Medical Director (Vice-Chair)
Executive Director of Nursing, Quality and Patient Experience
Assistant Director of Nursing, Quality, Assurance and Safeguarding/ Head of Quality and Governance
Assistant Director, Legal and Patient Support
Associate Medical Directors from each Clinical Care Group
~~Deputy Medical Director – Acute Services~~
Deputy Medical Director – Primary Care & Community Services
~~Assistant Director of Nursing, Acute Services~~
Associate Medical Director, Quality & Safety
Deputy Director of Allied Health Professionals
Deputy Director of Health Science
~~Digital Director~~
Assistant Director of Public Health
Director of Midwifery
Clinical Director of Pharmacy and Medicines Management
Deputy Chief Operating Officer
Assistant Director of Workforce
Assistant Director of Assurance and Risk
~~County Directors~~
Senior Nurse, Infection Prevention
Representative from each Clinical Care Group (Assistant Director of Nursing)
Assistant Director of Primary Care
Chairs of Advisory Groups

4.2 The membership of the Sub-Committee will be reviewed on an annual basis.

5. Quorum and Attendance

5.1 A quorum shall consist of no less than a third of the membership, one of whom must be the Chair or Vice Chair of the Sub-Committee, together with representation from Clinical Professions (Medicine, Nursing. Allied Health Professionals and Health Sciences) and each Directorate/Care Group.

5.2 Any senior officer of the UHB or partner organisation may, where appropriate, be invited to attend, for either all or part of a meeting, to assist with discussions on a particular matter.

5.3 The Sub-Committee may also co-opt additional independent external 'experts' from outside the organisation to provide specialist skills.

5.4 Should any officer member be unavailable to attend, they may nominate a fully briefed deputy to attend in their place, subject to the agreement of the Chair.

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

5.6 internal experts on subject matters will be invited when required.

6. Agenda and Papers

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

6.2 The agenda will be based around the Sub Committee work plan, identified risks, matters arising from previous meetings, issues emerging throughout the year and requests from Sub Committee members. Following approval, the agenda and timetable for request for papers will be circulated to all Sub Committee members.

6.3 All papers must be approved by the Lead/relevant Director.

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

6.5 A draft Table of Actions will be issued within two days of the meeting. The minutes and Table of Actions will be circulated to the Chair within seven days to check the accuracy, prior to sending to Members to review within the next seven days.

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

7. Frequency of Meetings

7.1 The Sub-Committee will meet bi-monthly and shall agree an annual schedule of meetings. Any additional meetings will be arranged as determined by the Chair of the Sub-Committee.

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

8. Accountability, Responsibility and Authority

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

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

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

9. Reporting

9.1 The Sub-Committee, through its Chair and members, shall work closely with the Board's other committees, including joint /Sub Committees and groups to provide advice and assurance to the Board through the:

9.1.1 joint planning and co-ordination of Board and Committee business; and
9.1.2 sharing of information;

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

9.3 The Sub-Committee may, subject to the approval of the Quality, Safety & Experience Committee, establish groups or task and finish groups to carry out on its behalf specific aspects of Sub-Committee business. The Sub-Committee will receive an update following each group's meetings detailing the business undertaken on its behalf. The following groups have been established:

9.3.1 Recognition of Acute Deterioration and Resuscitation Group
9.3.2 Nutrition and Hydration Group
9.3.3 Mental Capacity Act and Consent Group
9.3.4 Medical Devices Group (including Point of Care Testing and Ultrasound Governance)
9.3.5 Strategic Safeguarding Group
9.3.6 Infection Prevention Strategic Steering Group
9.3.7 Human Tissue Authority Group
9.3.8 Radiation Protection Group
9.3.9 Effective Clinical Practice Group

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

9.4.1 Report formally, regularly and on a timely basis to the Quality, Safety & Experience Committee on the Sub-Committee's activities. This includes the submission of Sub-Committee update report, as well as the presentation of an annual report within 6 weeks of the end of the financial year.
9.4.2 Bring to the Quality, Safety & Experience Committee's specific attention any significant matters under consideration by the Sub-Committee.
9.4.3 Bring to the Integrated Quality, Finance, Planning and Delivery Group's attention any significant matters arising from the quality metrics or matters discussed at the Sub-Committee.

10. Secretarial Support

10.1 The Sub-Committee Secretary shall be determined by the Director of Corporate Governance /Board Secretary.

11. Review Date

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

3.4

3.4 - Listening and Learning Sub Committee Update Report

Mark Henwood (Hywel Dda UHB - Executive Medical Director)

For approval

Attachments

3.4 LLSC Update report august 2025.docx

Appendix 1 568-Production_UseofSurveysGuideline-ext5.6.25.pdf

LISTENING AND LEARNING SUB COMMITTEE UPDATE REPORT/ ADRODDIAD DIWEDDARU'R LISTENING AND LEARNING

Date of last meeting/ Dyddiad y cyfarfod diwethaf: 11 August 2025

Quoracy/ Cworwm: Yes

Report by/ Adroddiad gan: Mark Henwood, Medical Director

KEY DISCUSSION POINTS AND MATTERS FROM THE DISCUSSION AT THE MEETING/ PWYNTIAU TRAFOD ALLWEDDOL A MATERION I'W HUWCHGYFEIRIO O'R DRAFODAETH YN Y CYFARFOD:

Alert[1] (may require discussion)/ **Rhybuddio** (efallai y bydd angen trafodaeth)

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

Advise[2] (to monitor)/ **Cynghori** (i fonitro)

The Sub Committee wish to **advise** members of the Committee that:

A broad spectrum of feedback centered on the theme of communication was reviewed, encompassing patient experience, complaints, Ombudsman cases, incidents, redress cases, and inquests.

Communication has emerged as a recurrent concern across multiple feedback channels. The Board has recognised this trend and tasked both the Listening & Learning Sub-Committee and the Quality, Safety & Experience Committee with analysing the underlying themes to inform targeted improvement initiatives aimed at enhancing communication, care quality, and patient experience.

Communication was frequently cited as a contributing factor to suboptimal care and negative experiences. Notably:

- 75% of communication-related issues originated within main hospital sites particularly during
  - Discharge processes
  - Appointment scheduling and follow-up
  - End-of-life care
  - Diagnostic pathways (e.g., cancer care and treatment planning)
- Clinical concerns were often accompanied by issues related to staff attitude and behaviour, underscoring the strong link between patient experience and perceived care quality.

The patient story and feedback analysis highlighted the profound impact of poor communication on patient trust, confidence, and compliance. The Sub-Committee emphasised the importance of understanding staff-related factors contributing to

[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*.

communication challenges, recognising that these may reflect broader systemic or wellbeing issues. Staff experience and engagement will be integral to the improvement strategy.

Emerging Themes

- Confusing or dismissive communication from clinical staff
- Limited involvement in care planning and treatment decisions
- Unhelpful interactions with reception staff
- Extended waiting times, especially in A&E and follow-up care (notably affecting younger adults and individuals with disabilities)
- Appointment scheduling difficulties and cancellations
- Ineffective inter-departmental communication and unclear explanations
- Information gaps due to poor handovers
- Challenges in multi-disciplinary and inter-agency communication
- Facility-related concerns (e.g., parking, waiting area comfort, privacy), particularly among older adults.
- Reports of staff rudeness or lack of empathy, especially from female respondents
- Inadequate documentation and record-keeping

Priority Actions

- Enhance communication and customer care training for all staff, including reflective practice and compassionate communication.
- Expand communication channels, particularly for waiting list management.
- Strengthen data analysis capabilities to identify trends and hotspots.
- Improve inter-departmental communication protocols.
- Review and reinforce communication standards and best practices.

A communication workstream will be established to oversee the development and implementation of the improvement plan.

Assure[3] (to note)/ Sicrhau (i nodi)

The Sub-Committee wish to assure members of the Committee that:

An update was provided on the development of the **Speak Up Safely** process. The Sub-Committee agreed to formally incorporate "Speaking Up" as a standing agenda item. The format for receiving feedback (e.g., reports, case studies) will be standardised to ensure consistency and impact.

<u>Guideline 568 – Production and Use of Surveys (Appendix 1)</u>

Guideline 568 outlines the process for developing, approving, and deploying surveys across stakeholder groups. It aims to enhance organisational insight into patient and staff experiences and inform service and organisational development. The updating of this guidance has been delayed due to the awaited all Wales National People's

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

Experience Survey and People's Experience Framework. The guidance has been updated to reflect the revised national requirements.

The Sub-Committee approved the Guideline for consultation. Final approval will be sought from the Quality, Safety & Experience Committee in October 2025.
The Quality, Safety and Experience Committee is requested to approve an extension of Guideline 568 until 31 October 2025.

Complaints Procedures

Following the Welsh Risk Pool's December 2024 assessment into the NHS (Concerns, Complaints and Redress) Arrangements 2011, the Health Board will begin recording the names of staff involved in complaints via the Datix system. This will support reflective practice, inform annual reviews, and enable monitoring of recurring concerns. A protocol for this process has been approved by the Sub-Committee.

RESOLVE – Follow-Up Communication with Patients

In response to Welsh Risk Pool recommendations, the Sub-Committee approved an aide-memoire for complaint handlers to improve follow-up communication. This aims to support a more holistic review process and facilitate joint decision-making in unresolved cases.

Review of Risks/ Adolygiad o Risgiau

Contained within the report.

Sharing of learning/ Rhannu dysgu

Contained within the report.

Recommendation/ Argymhelliad

The Committee is asked to:
- Note the contents of this report
- Approve the extension of Guideline 568 until 31 October 2025

Date of next meeting/ Dyddiad y cyfarfod nesaf: To be confirmed.

Production and Use of Surveys Guideline

Patient Experience, Public and Patient Engagement and Staff Surveys

Guideline Number:	568	Supersedes:		Classification	Corporate

Version No:	Date of EqIA:	Approved by:	Date Approved:	Date made active:	Review Date:
1	17/02/17	QSEAC	15/08/2017	13/09/2017	15/08/2020
		Extended by QSEAC for review to be completed	10/08/2021 14.02.2023	18/08/2021 20.02.23	31/12/2021 14.09.2023
		Extended by QSEC for review	05.12.2023 15.8.2024 5.12.2024	30.10.2023 19.8.2024 16.12.2024	07.12.2023 15.11.2024 5.6.2025

Brief summary of Document:	This document sets out guidance for the production and use of surveys

Scope	This guidance provides advice on the production and provision of surveys for patients, their relatives and carers; the public and for staff. This guidance applies to those members of staff that are employed by the Hywel Dda University Health Board, both permanent and non-permanent, and for whom the Health Board have legal responsibility including contractors and those who undertake work on behalf on contractors.

To be read in conjunction with:	153 - Equality and Diversity Policy 333 - Welsh Language Policy

Owning Group	Improving Experience Sub Committee

Reviews and Updates		
Version no:	Summary of Amendments:	Date Approved:
1	New Guideline	15/08/2017

Keywords	Survey, Questionnaire, Patient Satisfaction, Research, Public, Patient, Engage, Involve, Staff

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1. AIM

To provide clear process and guidance for the development, ratification and use of surveys across Hywel Dda University Health Board (UHB). This includes the provision of surveys for patients, their relatives, carers, the public and staff members.

2. OBJECTIVES

- To provide a quality assurance process for all surveys developed by the Health Board ensuring they follow good practice, are supported by a process of good governance and portray a positive, professional image of the organisation.

- To ensure staff are aware of the Health Board requirements and standards for producing good quality, effective patient experience; public and patient engagement; and corporate and staff surveys.

- To ensure surveys used by the Health Board contribute to a wider organisational understanding of patient experience, service development and organisational development.

- To support staff in the production and management of surveys through better awareness of the standards for producing good quality, effective surveys.

- To provide a consistent approach to the UHB's corporate Survey Monkey account.

3. SCOPE

This guidance applies to those members of staff that are employed by the Hywel Dda University Health Board, both permanent and non-permanent, and for whom the Health Board have legal responsibility including contractors and those who undertake work on behalf of contractors.

Surveys not covered by this policy

This guidance may be used to support the use of patient surveys as part of formal research or clinical audit however further advice should be sought from the Clinical Audit and Research and Development departments.

4. BACKGROUND

The use of surveys should form part of a planned departmental programme of patient experience, patient and public engagement and staff engagement initiatives, and can be one a range of tools used to gather patient, public or staff views.

Surveys should not be used as an opportunity to ask whatever is wished. Questions must be relevant and appropriate to the area being considered and designed with sensitivity, recognising the needs of the individuals completing them. They must not cause offence or make judgements either directly or implied on individual behaviour. Other sources of data must be considered, for example the clinical notes, where more appropriate.

Surveys can be used to collect quantitative or qualitative information, usually through the use of structured questions. Surveys, when well designed, can provide meaningful information and insights to inform and guide future directions.

Departments should be mindful of the needs of different groups in the population, especially those with protected characteristics and ensure that appropriate adjustments are made.

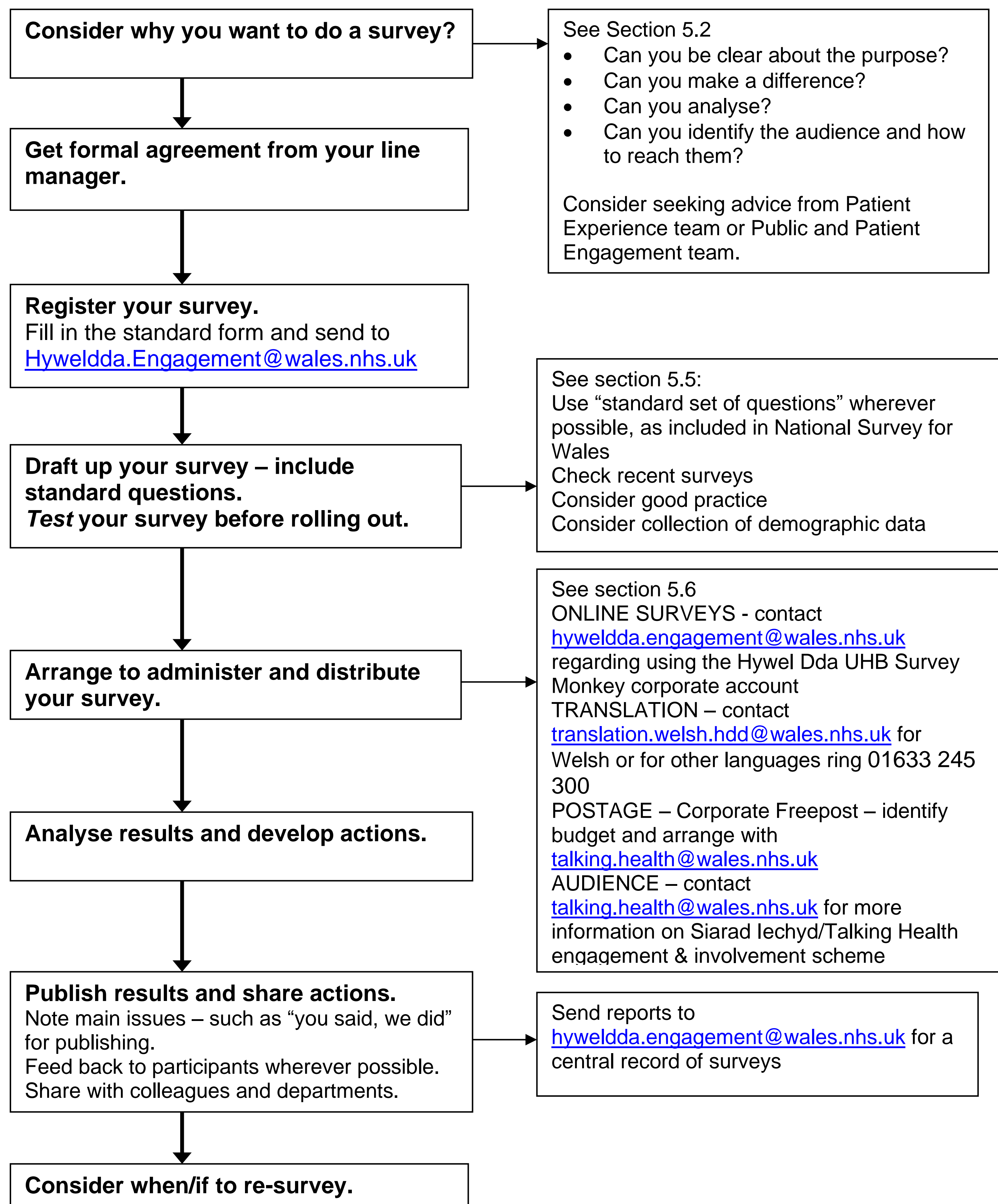
As new technologies, such as web-based survey software, make it easier to conduct surveys, this also increases the potential for duplication of efforts and over-surveying, which can reduce response rates and validity, and create unnecessary survey burden.

Increasing the management of surveys within the UHB would serve to improve the quality and timing of surveys and help the UHB get the most out of survey results.

Other methods of seeking and understanding patient, public or staff views may sometimes be more appropriate and include the use of patient stories and other mechanisms such as focus groups.

5. SURVEY PROCESS

5.1 Survey process flowchart



5.2 Consider why you want to do a survey?

Unclear goals lead to unclear results, and having spent time and effort developing the survey it is important that the set of results provide real decision–enhancing value. Good surveys have focused objectives that are easily understood. Spend time up front to identify, in writing:

- What is the aim of this survey?
- Why are you creating this survey?
- What do you hope to accomplish with this survey?
- How will you use the data you are collecting?
- What decisions do you hope to impact with the results of this survey? (This will help you identify what data you need to collect in order to make these decisions.)

Consider seeking advice from the Patient Experience team or the Public and Patient Engagement team.

5.3 Get formal agreement from your line manager

Ensure that you get formal agreement to proceed from your line manager. This will include approval of the need for the survey and the potential time and costs that may be incurred.

5.4 Register your survey

Please fill in the standard survey registration form (Appendix 1) and send to Hyweldda.Engagement@wales.nhs.uk

5.5 Draft up your survey – including standard questions (if possible)

Advice on drafting survey questions

Once you have considered the purpose of the survey (Section 5.2) you should take time to carefully consider and write your questions.

There is more advice in Appendix 2 on writing good surveys. The types of issues you should consider are to keep the survey as short as possible and consider what you need to know with what would be interesting to know; use plain language and try to avoid jargon and abbreviations; don't assume, explain issues if needed; start with easier questions to get the respondent involved; avoid leading or loaded questions; use closed questions wherever possible as they are easier to analyse with yes/no, rating scales but also include open ended questions to provide opportunities for useful qualitative information and insights.

Patient Experience standard questions:

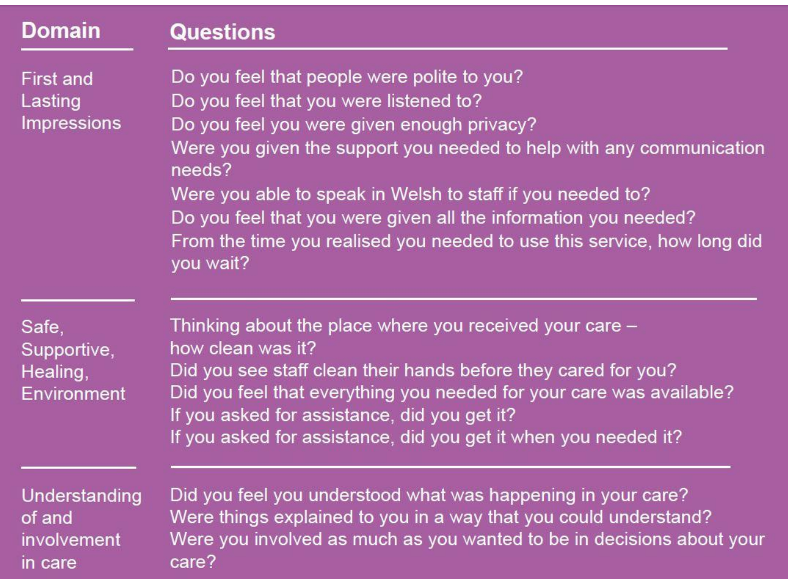
Use a "standard set of questions" wherever possible such as those included in the National Survey for Wales, which have been agreed following Together for Health stating that 'Wales will agree a national way of measuring patient satisfaction'.

In May 2013 the Health Minister issued a Framework for Assuring Service User Experience to NHS organisations. The Framework is intended to provide assurance to Boards that organisations are meeting the needs of service users and using service user experience to improve health outcomes. It identifies a set of core principles that underpin patient experience work and recommends a four quadrant model to build on existing expertise and resources.

In July 2013 the Chief Nursing Officer issued core service user experience questions to NHS Wales which were developed to support survey work across all care settings, to help ensure a consistent approach to determining service user experience across Wales. All NHS organisations are expected to use the core questions to complement their patient feedback methods, based on the Framework for Assuring Service User Experience four quadrant approach. Information gained

from the questions and resulting service improvements should be included in patient experience reports to Boards and the Annual Quality Statement.

The 2013 framework was updated following 'Trusted to Care' and 'Using the Gift of complaints' and in the light of the revised Health and Care Standards. It includes the need to gain feedback from concerns, complaints, compliments and clinical incidents. The updated framework was issued in December 2015 on a Welsh Health Circular (WHC/2015/061).



Domain	Questions
First and Lasting Impressions	Do you feel that people were polite to you? Do you feel that you were listened to? Do you feel you were given enough privacy? Were you given the support you needed to help with any communication needs? Were you able to speak in Welsh to staff if you needed to? Do you feel that you were given all the information you needed? From the time you realised you needed to use this service, how long did you wait?
Safe, Supportive, Healing, Environment	Thinking about the place where you received your care – how clean was it? Did you see staff clean their hands before they cared for you? Did you feel that everything you needed for your care was available? If you asked for assistance, did you get it? If you asked for assistance, did you get it when you needed it?
Understanding of and involvement in care	Did you feel you understood what was happening in your care? Were things explained to you in a way that you could understand? Were you involved as much as you wanted to be in decisions about your care?

For more information on the process for developing the questions and for a copy of the core questions go to:
http://www.wales.nhs.uk/governance-emanual/public-and-patient-involvement

For more advice on drafting up your survey questions see Appendix 2 for tips on writing good surveys.

You may wish to seek advice from the Patient Experience team or the Public and Patient Engagement team.

Collecting demographic data
It is important to consider if your survey requires the collection of demographic data. It may be useful to collect this information to identify the demographics of those surveyed and any potential gaps.

For more information on collecting demographic data go to:
http://bit.ly/2kDtnLN
http://www.stonewall.org.uk/sites/default/files/getting_it_right_with_your_trans_service_users_and_customers.pdf

Test your survey before rolling out
Before you send the survey to real respondents, ask a sample group of respondents to take the survey (not people who were involved in creating it). After they've completed it, ask them if they had problems understanding any questions or had answers that were not available on the list of choices. It's much easier to change the survey before you send it than afterwards.

5.6 Arrange to administer your survey

Departments should be mindful of the needs of different groups in the population, especially those with protected characteristics and ensure that appropriate adjustments are made.

You will need to arrange to administer your survey from within your own resources in terms of preparation, distribution and evaluation.

Translation - You will need to consider the requirements of the Welsh Language Strategy for any surveys to patients or the public. All surveys to patients or the public must be available in Welsh and English with no priority given to either language. For support with translation contact: translation.welsh.hdd@wales.nhs.uk. For advice on the Welsh Language Scheme contact the Welsh Language team.

If other languages are required the Health Board has a partnership agreement with Police & Crime Commissioner for Gwent (previously known as WITS) for all Foreign language interpretations. Telephone 01633 245300 for more support.

Survey Monkey – The organisation has a licence to the online survey tool called Survey Monkey. This provides an electronic mechanism for developing, issuing and analysing survey data. Providing an option for electronic feedback can encourage some people to respond yet will also be a potential barrier for those who are less IT literate.

It is recommended that various options are offered to people to support them in completing the survey in a way that best meets their personal requirements.

The UHB has a corporate Survey Monkey unlimited account which allows an increased number of questions and better analysis.

To access the Survey Monkey corporate account you must register your survey with hyweldda.engagement@wales.nhs.uk to be issued with further information and the password.

Support and advice can be offered from the Public & Patient Engagement team or Patient Experience team, especially if you are new to Survey Monkey, but they will not be able to offer administrative support.

Postage costs – The UHB has a Freepost address so that posting surveys back would be at the cost of the UHB and not the individual. You will be required to identify a budget for recharging the costs to your area/department. To arrange the use of Freepost contact: talking.health@wales.nhs.uk

Audience - Have you identified your survey respondents and how to reach them? You are likely to have regular access to the audience of your survey as they are relevant to your working area and have ways to distribute your survey.

The Health Board has an involvement and engagement scheme called Siarad Iechyd/Talking Health which members of the public and staff can join and many of the members are willing to respond to surveys. If you think this group could be helpful please contact the Public and Patient Engagement team on talking.health@wales.nhs.uk for more information.

5.7 Analyse results and develop actions

The process for analysing the data from survey returns should be identified before starting the survey. There is no dedicated support for this but advice can be sought from the Patient Experience Team or the Public and Patient Engagement Team.

Using a package such as Survey Monkey better supports this process as there are analysis tools within the programme.

5.8 Publish results and share actions

s with all improvement work, it is essential to do something as a result, as should have been considered during planning the survey. You should consider the feedback to review and improve current services or to consider changing services or processes.

Survey results should be discussed at a service/departmental level and any identified actions built in to the delivery plans for that area. It may also be appropriate to report to the corporate governance processes.

Including the experiences of patients as a core element of our quality improvement rather than as an additional extra is important.

It is good practice to share the results of your survey with those you have surveyed. This may be through a variety of methods as will best suit the survey and service, for example, direct feedback to correspondents, inclusion in newsletters, information on posters in waiting areas. It is also good practice to share any improvements or changes that develop following consideration of the survey results. It is important that people are made aware they have made a contribution to any improvements in services as a result of their input through the survey.

You may wish to summarise the main issues as – “you said, we did” - for sharing with respondents.

Please send any reports and actions to hyweldda.engagement@wales.nhs.uk for recording. This will provide a valuable library of resources for future engagement. Some questions could be reused at a future time but also aim to avoid duplication where similar questions have already been asked recently. It will also help ensure that the UHB is aware of the work and can reflect this in annual reporting mechanisms.

5.9 Consider when/if to re-survey

Actions should be regularly reviewed at the service level and changes made as a result monitored and reported within the corporate governance processes.

Sharing learning on an organisational basis will encourage wider improvement across the organisation.

Depending on the service and developments undertaken you may wish to re-survey to test whether they have resulted in improvement.

6. TRAINING

Training and support will be available on an ad hoc basis on request from the Patient Experience Team and the Public and Patient Engagement Team.

7. FURTHER SUPPORT

Further support can be obtained via the Patient Experience Team or the Public & Patient Engagement Team – Hyweldda.engagement@wales.nhs.uk or 01554 899056.

8. APPENDIX 1 - REGISTER YOUR SURVEY FORM

Name:	
Job Title:	
Service Area/Directorate:	
Department:	
Contact details:	
Name of Line manager:	
Survey approved by line manager:	Yes/No/TBC
Proposed title of survey:	
Purpose of the survey (topic, objectives, issues to be addressed, etc):	
Target population	
Intended sample size:	
How the survey will be distributed / approach to be used (e.g. online/ interviews etc):	
How survey participants will be approached (e.g. direct request, online notice):	
Proposed start & end time	
Frequency of the survey (will it be a one-time survey or administered on a cycle?):	
How the data will be used, (by Department/ Committee)	
How the results will be communicated (e.g. report, newsletter)	
I understand that a copy of my report may be put on the intranet unless otherwise requested.	Agree/ No not agree Comment:

9. APPENDIX 2 - ADVICE ON WRITING GOOD SURVEYS

Clearly define the purpose of your survey. Advance planning helps ensure that the survey asks the right questions to meet the objective and generate useful data.

Note the purpose of the survey. To ensure focused responses it can help if you outline at the beginning of the survey the reason you are asking questions and how you will use the results.

Keep it short. Draw a mental line between what you "must know" and what would be "interesting to know." There is also a third category of information that "doesn’t matter."

Keep it simple. Plain language is a must. Use words that are direct and familiar to the respondents. Try not to use jargon or technical concepts.

Spell it out. Do not ask questions that assume the respondents are familiar with the specifics of the issue. Include details or additional information if necessary. Titles, abbreviations and product names are often sources of misunderstanding. When in doubt, spell it out.

Start with easy questions. Start the survey with questions that are likely to be easy to answer to get the respondent involved. Yes/No questions or simple multiple choice questions are ideal to get started with. Rating scales should come later. Open-ended questions usually come last as they give the respondent the opportunity to reflect on the topic throughout the survey.

General before specific. The issues raised in one question can influence how people think about the next question. It’s a good idea to ask general questions first and move on to more specific questions later.

Avoid Leading Questions. You don't want to lead your respondents into answering a certain way based on the wording of the questions. *EXAMPLE:* We have recently upgraded our equipment to world class levels. What are your thoughts on the world class equipment? *REPLACE WITH*: What are your thoughts on the changes to our equipment?

Avoid Loaded Questions. These types of questions work through emotionally charged items like words, stereotypes, etc. This too can push respondents towards a specific answer choice.

Use closed questions whenever possible: Specific choices (e.g. Yes or No), make it easier to analyse results. Closed ended questions can take the form of yes/no, multiple choice or rating scale. Open-ended survey questions allow people to answer a question in their own words. Open-ended questions are great additional questions and may provide useful qualitative information and insights.

Test-drive your survey. Before you send the survey to real respondents, ask a sample group of respondents to take the survey (not people who were involved in creating it). After they’ve completed it, ask them if they had problems understanding any questions or had answers that were not available on the list of choices. It’s much easier to change the questionnaire before you send it than after!

Consider sending reminders. While not appropriate for all surveys, sending out reminders can often provide a significant boost in response rates. This is easier with online surveys.

3.5

3.5 - Epilepsy Service in Mental Health and Learning Disabilities

Liz Carroll (Hywel Dda UHB - Service Director MH&LD Clinical Care Group), Olwen Morgan (Hywel Dda UHB - Assistant Director of Nursing)

Attachments

3.5 SBAR Learning Disabilities Epilepsy Pathway (1).pdf

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	14 AUGUST 2025
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Learning Disabilities Epilepsy Pathway
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Sharon Daniel, Executive Director of Nursing, Quality & Patient Experience
SWYDDOG ADRODD: **REPORTING OFFICER:**	Olwen Morgan, Assistant Director of Nursing, Quality & Patient Experience, Planned Care & Specialist Services

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of the report is to present an update to the Committee on the external review into the epilepsy care pathway and respond to concerns raised by families regarding the epilepsy care pathway provision for their adult children, who also have a Learning Disability (LD).

Concerns relate to ongoing difficulties in accessing neurology services with the appropriate expertise in managing individuals with both Learning Disabilities and Epilepsy. These challenges have highlighted the need for a comprehensive review of the clinical pathway to ensure that service users are supported across all parts of the system—community, primary, and secondary care.

Cefndir / Background

Following the External Review, a Learning Disabilities Service Improvement Programme (LDSIP) was undertaken and a new service model developed.

Work to implement the recommendations from the external peer review of adult services for individuals with a Learning Disability and Epilepsy is close to completion. Most actions have been delivered, with only one remaining item outstanding.

This final task involves analysing the original stakeholder survey to establish a baseline for future service evaluations. Access to the survey data was delayed due to circumstances beyond the control of the health board, this has now been resolved. Analysis of the responses is underway and is expected to be completed by the end of September. The findings will support the task and finish group in shaping the next phase of service improvement.

The new service model adopts a health facilitation and educational approach to supporting mainstream health services to ensure that people with learning disabilities receive fair, equal and person-centred access to health care. The development of clinical pathways supports this approach.

A report summarising progress of the LDSIP and included the nursing and allied health professional posts required for the new structure was presented to the Executive Team in December 2024. Approval was provided to progress with recruitment.

Current progress:

- Occupational Therapy, Physiotherapy and Speech & Language Team posts all recruited.
- Band 6 Community Learning Disability (CLDT) nursing posts recruited.
- 2.7 Whole Time Equivalent Band 6 vacant nursing posts in the Health Facilitation and Liaison (HFLT) team recruitment progressing to interview.
- 3 newly registered nurses commencing in CLDT from September 2025.
- 3 Band 3 Healthcare Support Worker (HCSW) posts being filled via redeployment as part of Organisational Change Process.

Updated Epilepsy Care Plans and Risk Assessments were developed to facilitate consistency for person centred care. A Patient Initiated Follow Up (PIFU) is in place for those who access Community Learning Disability Team (CLDT) nursing, informing the annual review of their care plan and risk assessment. This strives to better support individuals and carers to have ownership of their care plan and to initiate a review when needed.

The Learning Disabilities Service has a LD non-medical prescriber Pharmacist, who supports CLDTs as well as the LD Epilepsy Specialist Nurse (LDESN) with specialist advice regarding anti-epileptic medication, associated side effects and medical interaction.

Asesiad / Assessment

The Health Board does not currently provide a specialist Learning Disability Epilepsy Service.

A Learning Disabilities Epilepsy Specialist Nurse (LDESN) supports the CLDTs, Neurology and Primary Care Services. The Health Board has employed an LD Pharmacist who works alongside our CLDTs and the Learning Disabilities Specialist Nurse (LDSN). GP's or Consultant Psychiatrists will refer to Neurology as per any other referral required for Epilepsy / first seizure. Additional support from the LDESN or CLDT is available if requested by the neurologist.

Ongoing challenges remain in accessing neurology services with the appropriate expertise in managing individuals with both Learning Disabilities and Epilepsy. Currently some individuals cared for within Learning Disabilities Service are also under the care of Neurology due to the complexities of their epilepsy, whilst others are awaiting a neurology assessment.

These challenges have highlighted the need for a comprehensive review of the clinical pathway to ensure that service users are supported across all parts of the system—community, primary, and secondary care.

A Learning Disability Epilepsy Task & Finish Group has been established to review and improve the epilepsy care pathway for individuals with Learning Disabilities and Epilepsy within Hywel Dda University Health Board (HDUHB). The group will facilitate collaboration with Swansea Bay UHB (SBUHB) and establish a Service Level Agreement. The Group will ensure a more equitable and effective service by addressing key concerns and integrating Quality Improvement methodologies.

At the first meeting on 6th August, the T&F Group focused on the recent Ombudsman Report and the response to its findings and recommendations. Identification and inclusion of key stakeholders including Llais, service users and SBUHB reps was agreed. The next meeting to approve the response to the Ombudsman Report is scheduled for 11th August. Pathway workstreams will be agreed at the next meeting.

The Learning Disability Epilepsy Services Pathway Task & Finish Group will report to the Integrated Quality, Finance and Performance Delivery Group (IQFPD).

Argymhelliad / Recommendation

The Committee is asked to note the update and take assurance from the plan to review and improve the pathway for individuals with Learning Disabilities and Epilepsy.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	2.2 Provide evidence based and timely advice to the Board to assist it in discharging its functions and meeting its responsibilities with regard to the quality and safety of health care provided and secured by the University Health Board.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Risk:1181; score 20 Risk: 818; score 16
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	

**Gwybodaeth Ychwanegol:
Further Information:**

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No direct impacts
Ansawdd / Gofal Claf: Quality / Patient Care:	Please see report
Gweithlu: Workforce:	No direct impacts
Risg: Risk:	Please see report
Cyfreithiol: Legal:	Not Applicable
Enw Da: Reputational:	Not Applicable
Gyfrinachedd: Privacy:	Not Applicable
Cydraddoldeb: Equality:	Yes, impact on equity of access to an epilepsy service for people with a learning disability.

3.6

3.6 - Women's Health

Dana Scott (Hywel Dda UHB - Director of Midwifery & Professional Governance for Women & Children)

Attachments

3.6 Women's Health.pdf

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	14 August 2025
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Women's Health Plan
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Andrew Carruthers, Chief Operating Officer
SWYDDOG ADRODD: **REPORTING OFFICER:**	Paula Goode Service Director Planned and Specialist Service Care Group Dana Scott Director of Midwifery Professional Governance Lead and Senior Responsible Officer

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 provides an update to the Quality, Safety and Experience Committee (QSEC) on the current implementation status, risks, and recommendations relating to the Women's Health Plan.

Cefndir / Background

Hywel Dda University Health Board is required to implement a Women's Health Hub (WHH) in line with the NHS Wales Women's Health Plan by 31 March 2026

Triage of GP referrals could be screened by GP's with appropriate qualifications to determine the appropriate pathway to hub or secondary care. This will ensure referral to the appropriate pathway for women, improving efficiency within the referral process.

Secondary care services are currently progressing an Outpatients Transformation Project; A review of the gynaecology referral list aims to benchmark referrals against established health pathways and identify conditions that are suitable for management within a Women's Health Hub.

The Women's Health Plan Steering Group is currently reviewing the WHH Implementation Guide, including principles of access, scope and appropriate interface between primary and secondary care, as outlined in the consultation document, (Consultation ends August 29, 2025)

A recent local training needs analysis, informed by a skills and confidence survey, has identified notable gaps in clinical competence and preparedness within the primary care workforce to manage women's health autonomously.

Business cases are currently being developed in alignment with final funding cycle deadline of August 29, 2025.The current funding envelope of £300k is available to support training, upskilling initiatives or capital expenditure.

The proposed hubs will be primary care led, county-based hubs with travelling PGwER (Practitioner with extended roles) hosted weekly in local surgeries equipped for gynaecological assessment. Conditions likely to be referred to the hubs include:

- Long-Acting Reversible Contraception (LARC),
- Heavy Menstrual Bleeding (HMB),
- Pre Menstrual Dysphoric Disorder (PMDD)
- Pelvic Pain,
- Menopause
- Vulval derm and
- Poly Cystic Ovary Syndrome

These clinics will be General Practitioner (GP) led with Secondary Care Consultant oversight for clinical support, upskilling and training of primary care team.

A Risks, Assumptions, Issues and Dependencies (RAID) log is in place to systematically record risks, assumptions, issues and dependencies, including mitigation action.

The WHH is a key deliverable of the NHS Wales Women's Health Plan. It is intended to function as a single point of access to integrated, multidisciplinary women's health services delivered outside of the secondary care setting.

Phase 1 clinical priorities include menstrual health, contraception/postnatal contraception, abortion care and menopause care.

The national guidance outlines clear expectations around service scope, data integration, access equity, workforce training, and co-production.

A review of referral patterns and training needs assessments (TNA) were undertaken to inform implementation plans. 49 responses were received for contraception and 31 for menstrual health.

Analysis of the TNA indicates that while a minority of clinicians feel confident managing women's health issues, the majority (approx. 65%) report a need for further training particularly in the management of complex cases such as Long-Acting Reversible contraception(LARC) fitting, Pre Menstrual Dysphoric Disorder (PMDD), and menopause care requiring testosterone initiation. Although it is reported that approximately 50% of GP'S can provide LARC.

A new questionnaire has been developed for a short survey regarding proposed Hubs. This should be concluded prior to Business case submissions by the end of August 2025.

Asesiad / Assessment

The current proposal for a county-led model is well aligned with the local context and population-based care philosophy. However, training gaps and service complexity requirements present a risk to safe and equitable delivery.

The Women's Health Hubs National Implementation Guide, (Currently in Consultation) emphasises co-produced, multidisciplinary care and encourages **collaborative models between primary and secondary care.**

Our local vision aligns well with national strategy in terms of digital integration (Egton Medical Information System (EMIS) Community), equity and coproduction, and emphasis on prevention.

However, capacity limitations and clinical confidence gaps suggest that implementation success is dependent on targeted upskilling, workforce development, and secondary care partnership.

Summary of Training needs analysis Contraception and Menstrual Health.

• A total of 49 responses were received for Contraception and 31 for Menstrual Health

• Respondents were assessed on confidence managing cases independently and need for upskilling.

Key findings

•35% Confident to manage women's health independently

•65% would like or need upskilling to manage more complex presentations

Confidence by clinical area

Contraception (49 responses)

•30-40% confident

•60-70% require or desire further training

Menstrual Health (31 responses)

•35-40% confident

•60-65% would like or need upskilling

Confidence lower in managing complex presentations.

There is a risk of overwhelming WHH with care needs that could be more appropriately delivered within Primary Care. This is informed by the TNA, which identified low levels of confidence within primary care in managing both low and complex presentations.

The Hybrid Collaborative Model will consist of count-based HUBS with travelling clinicians, primarily GPs with extended training, Nurses an HCA, this model will be supported by Secondary care Consultants, to provide guidance, upskilling and training to bridge the skills and confidence gap.

Next steps:

1. Reframe the WHH model as a hybrid collaborative model (primary care-led, with secondary care oversight and specialist input). (implementation by March 2026)
2. Establish a phased workforce development plan targeting contraception, menopause, trauma-informed care and complex menstrual health. (results from Audit by August 25, 2025)
3. Invest in structured education programmes using national e-learning and PROM/PREM data to assess impact. (negotiate with Value Based HealthCare (VBHC) team to understand resource allocation)
4. Develop action plans from PROM/PREM data to drive improvements, (developed for wider discussion with VBHC Team)
5. Ensure WHH service redesign includes outreach, digitally enabled services, and pop-ups to meet the needs of rural and underserved communities., (Travelling clinician agreed funding to be established end August 2025)

6. Bring a revised implementation plan to QSEC for assurance in Q3 2025.

The implementation of the WHH, is monitored by an established steering group, with oversight by Welsh Government Women's Health Programme network. A RAID log is used to manage and monitor all risks associated with the project.

Argymhelliad / Recommendation

The Committee is asked to take assurance from the progress to implement a Women's Health Hub (WHH) in line with the NHS Wales Women's Health Plan by 31 March 2026.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.9 Provide assurance to the Board in relation to improving the experience of patients, including for those services provided by other organisations or in a partnership arrangement.
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)	1. Safe
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	5. Whole systems persepctive
Amcanion Strategol y BIP: UHB Strategic Objectives:	2. Healthier communities
Amcanion Cynllunio Planning Objectives	1 Workforce Stabilisation 7 Primary and community strategic plan
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	5. Offer a diverse range of employment opportunities which support people to fulfill their potential

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Steering group oversight and implementations sub group
Rhestr Termau: Glossary of Terms:	Included within the body of the report

Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	Steering Group, CCG,

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

3.7

3.7 - Section 136 Suite- Mental Health and Learning Disabilities

Kay Isaacs (Hywel Dda UHB - Assistant Service Director- MHLD Clinical Care Group)

Attachments

3.8 Section 136 Suite.pdf

Appendix 1 S136 Suite QIA (with panel notes 21-07-2025).pdf

Appendix 2- Full EqIA Forming a single Adult S136 Suite in Carmarthenshire.pdf

Appendix 3- S136 Options Appraisal Hywel Dda UHB October 2024 v6 1.pptx

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	14 August 2025
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Section 136 Place of Safety Option Appraisal and Conclusion
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Andrew Carruthers, Chief Operating Officer
SWYDDOG ADRODD: **REPORTING OFFICER:**	Liz Carroll – Service Director MHLD Clinical Care Group Kay Isaacs Service Assistant Director for MHLD Clinical Care Group

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

Section 136 (S136) is a section of the Mental Health Act (MHA) that allows a police officer to convey an individual they suspect to be mentally disordered in a public place, without a warrant, to a place of safety. Hywel Dda University Health Board is required to provide a place of safety in order that an assessment is undertaken within the required timeframe under the Act. In 2023, the Health and Safety Committee recommended a review be undertaken of the designated places of safety across the then, Directorate of Mental Health and Learning Disabilities (MHLD). The review was undertaken jointly by the MHLD Directorate and the Health, Safety and Security Team which encompassed site visits, triangulation of information and data analysis in relation to S136 activity and related incidents reported over the previous two years.

On completion of the review, environmental improvements were required at each S136 place of safety as well as an immediate action to temporarily close the Gorwelion Community Place of Safety due to safety concerns. The place of safety for children and young persons required immediate environmental actions to be undertaken but could remain on Morlais Ward, Glangwili hospital. There was a recommendation to consider potential benefits in having a centralised place of safety for adults in an appropriate environment and with a dedicated staff resource.

In respect of the recommendation to consider a centralised place of safety, an option appraisal process was undertaken by health and relevant external stakeholders to determine a future place of safety arrangement for adults.

The Committee are asked to consider the conclusion of the option appraisal and note the Quality Impact Assessment (QIA) and Equality Impact Assessment (EIA) assessments ahead of submission to Board.

Cefndir / Background

Historically, MHLD has provided S136 places of safety in all three counties. Two in Carmarthenshire, Carmarthen and Llanelli, one in Pembrokeshire, Haverfordwest and one in

Ceredigion, Aberystwyth. The Child and Adolescent Mental Health (CAMHS) place of safety is located on Morlais Ward, Glangwili Hospital, Carmarthen and is not included for consideration in this paper.

Data is routinely collated in respect of the number of individuals detained under S136 of the MHA and this data is monitored at the Mental Health Legislation Scrutiny Group (MHLSG) with a paper submitted to Mental Health Legislation Committee (MHLC) to provide an update in respect of governance, assurance and risk.

It is not possible to predict when an individual will be detained under the Act, nor can the police provide a notice period of less than an hour before an individual will arrive at the place of safety. There is a legal requirement for police to consult with a mental health clinician prior to use of S136 but urgent situations allow the police to proceed without consultation when there is a perceived risk to the individual or others. Consultation affords the opportunity to consider less restrictive options for assessment which is good practice and referenced in the MHA Code of Practice. To ensure consultation happens, mental health and police, have robust processes in place to facilitate this.

Use of S136 of the MHA for 20024/2025 occurred on 160 occasions with the percentage that were consulted on before use of the Act at 77%. The highest proportion were adults 85%, older adults 5% with children 10%.

Carmarthenshire was the location for most detentions and this is captured below.

Carmarthenshire	43%
Pembrokeshire	28%
Ceredigion	21%
Out of Area	8%

The main issues for the Health Board to consider are the environmental requirements and the ability to provide appropriate staffing in respect to the place of safety provision. Lack of location suitability and an unsafe staffing resource are currently the respective reasons why the place of safety in Aberystwyth and Haverfordwest are temporarily closed. Since the pandemic the place of safety has been centralised to Bryngofal ward, Llanelli, Carmarthenshire and has remained there whilst the joint review by mental health and the Health, Safety and Security team was undertaken and this arrangement has continued during the optional appraisal multi-agency review.

Required standards for Section 136 of the Mental Health Act 1983 (England and Wales) Reference; Royal College of Psychiatrists (RCoP)

The RCoP recommends a minimum of two mental healthcare professionals immediately available to receive the individual from the police at the place of safety and staff must be able to safely manage challenging behaviour without police support. Consideration should be given to having dedicated Section 136 staff who can be assigned to other wards or teams when not required. Extra staff should be available at short notice if required. In most cases the police should be free to leave within one hour, or once all staff are satisfied, they can safely manage the individual. Mental healthcare staff competences should include physical health assessment, risk assessments, physical restraint and the administration of medication as well as the care and comfort of the person.

The MH&LD Clinical Care Group are also exploring how, when not utilised for an individual detained under S136 the location can be used to assess the mental health of individuals away

from an Emergency Department (ED) when there is no physical requirement for them to attend there.

Historically, there was no identified funding for the staffing resource required to care for individuals detained in the place of safety. This has now been rectified following approval of the MH&LD Inpatient Workforce Stabilisation paper.

Asesiad / Assessment

Multiagency Stakeholder Group Option Appraisal to determine S136 Place of Safety Arrangements

The following options were considered by the multi-agency stakeholders which consisted of health representatives from the Clinical Care Group for Mental Health, Mental Health Act Administration Team, Dyfed Powys Police, local authorities, Carmarthenshire, Pembrokeshire, Ceredigion, West Wales Action for Mental Health (WWAMH) and Llais. As S136 is not a service and there is not a defined group of individuals that can be identified for detention under S136, WWAMH and Llais were able to contribute from the perspective of a person with lived experience at this stage, but if approval was provided by Board and in accordance with Welsh Government guidelines, public engagement may be required for a period of up to 8 weeks.

The following options were considered.

Option 1 - change nothing, maintain S136 place of safety locations as they were.
Option 2 - A single site adjacent to Bryngofal ward on the Prince Philip Site Llanelli
Option 3- A single site adjacent to the Psychiatric Intensive Care Unit and the Low Secure Unit at Hafan Derwen St David's Park, Carmarthen
Option 4- A single site adjacent to Morlais ward on the Glangwili site Carmarthen
Option 5- Utilise Sanctuary Service

The benefit considerations were categorised into patient and staff benefits in respect of health, local authority, and police alongside financial considerations. The negative and risk considerations are categorised under patient experience, quality & Safety, sustainability and finance.

Option Three – a single site located on Hafan Derwen, St David's Park, Carmarthen was concluded on completion of the appraisal as the recommended option to proceed with for the following reasons;

- The Health Board is only required to provide a Place of Safety for S136 detentions.
- Budget provided for the staffing resource required, will fund **one** place of safety only.
- The Hafan Derwen location enables immediate staff support from 2 wards when acute risk management is needed
- The clinical environment on the Hafan Derwen site is compatible with point of ligature health and safety requirements
- Geographically, for Hywel Dda's three counties, Carmarthen is the most central point.

The Section 136 Quality Impact Assessment has been submitted as appendix 1. A summary of key themes arising from the Quality Impact Assessment are as follows:

Centralised Provision & Co-location

- Positioning the suite at Hafan Derwen alongside Psychiatric Intensive Care Unit (PICU) and Low Secure Unit (LSU) enhances clinical oversight and inter-service coordination.
- Provides access to broader holistic care and hospital resources (e.g., medication, medical staff, A&E).

Staffing & Safety Enhancement

- Dedicated HCSW establishment supports compliance with national standards and ensures safe, skilled care.
- Facilitates better staff back-up arrangements and lowers overall staffing costs if concentrated to a single suite.

Physical Environment & Safety

- Environmentally safer design with some adjustments needed for entrance safety.
- Reduces environmental risks and supports quicker escalation of care when needed.

Accessibility & Travel Impact

- Central Carmarthen location improves travel times for individuals and multi agency professionals from Ceredigion and Pembrokeshire.
- Travel times increase for Llanelli-based individuals, though current arrangements have not led to Mental Health Act time breaches.
- Offers the ability to divert Section 136 cases from Glangwilli Hospital A&E more efficiently.

Resource Efficiency & Service Capacity

- Consolidating S136 sites improves resource utilisation however constrains capacity.
- Ongoing monitoring required to understand impact on alternative places of safety (e.g. custody, A&E).

Multi-Agency Collaboration & Support

- If only a single site is feasible, Carmarthen's location benefits multi-agency professionals who travel from across the 3 HDUHB counties.
- Transportation options for non-detained individuals will be considered individually to support safe discharge.

The Quality Impact Assessment Panel reviewing the QIA noted the statutory power that Section 136 affords police to detain individuals they believe are experiencing a mental health crisis and take them to a designated place of safety—meaning that access to these services is not elective or voluntary, but initiated by police intervention to safeguard the individual and the public. The panel supported the QIA conclusion that relocating to a single suite will improve operational safety, compliance, and holistic care opportunities. Although travel implications exist for certain areas, benefits in centralised access, efficiency, and enhanced staff support justify the change, pending ongoing impact monitoring, particularly around A&E's.

The Section 136 Equality Impact Assessment has been submitted as appendix 2.

The Options Appraisal presentation has been submitted as appendix 3.

Argymhelliad / Recommendation

To receive assurance that due process has been followed in collaboration with key stakeholders for the centralised relocation of the S136 place of safety to Carmarthen, Carmarthenshire.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	2.2 Provide evidence based and timely advice to the Board to assist it in discharging its functions and meeting its responsibilities with regard to the quality and safety of health care provided and secured by the University Health Board.
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: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	3. Great care
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 Ceisiadau Gofal Sylfaenol: Parties / Committees consulted	

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

Duty of Quality
Quality-driven decision-making tool

Part 1 - Quality Impact Assessment Toolkit

Overview & Guidance

This initial assessment should be completed to quantify potential impacts on quality or safety aspects (either positive, negative, or neutral/no impact), from any strategic decisions e.g. policy decisions, business cases, service improvements and changes, or efficiency savings projects that will affect operational services.

When completing the checklist consider the impact that the change will bring about in the long term. Also consider any impacts that might occur whilst the change is being implemented. For example, the project may be to introduce a new clinical pathway into an existing team, this will reduce waiting times for patients and result in smaller caseloads which are both long-term positive impacts. However, to introduce the new pathway staff working arrangement will need to change which may increase staff turnover resulting in patient waiting times for treatment increasing both are short term negative impacts. The QIA should reflect both the short-term and long-term impacts.

For the approval process and to ensure you are using the current version of the tool, please visit the QIA SharePoint page
https://nhswales365.sharepoint.com/sites/HDD_Nursing-assurance-and-safety/SitePages/Quality-Impact-Assessment.aspx

The tool once approved by the Directorate Triumvirate should be submitted to patient.safety@wales.nhs.uk for consideration at the QIA Panel

Strategic Decision / Organisational Activity / Project Title:	**Section 136 Review**
Name and role of lead:	**Rebecca Temple-Purcell, Assistant Director of Nursing MH&LD**
Executive sponsor:	

Description of Strategic Decision / Project:	
Broadly outline what is being proposed and the decision that needs to be made	The Health Board currently and on a temproary basis uses a single adult S136 place of safety located in Bryngofal Ward, Llanelli and an age-appropriate suite in Morlais Ward, Glangwili District General Hospital (DGH), Carmarthen. Historical arrangements have been to provide adult places of safety at Gorwelion Community Mental Health Centre (CMHC), Aberystwyth, Ceredigion, and on Cwm Seren Ward, Hafan Derwen, Carmarthen. There was formerly a Section 136 suite located on St. Caradog Ward, Brocerwyn, Haverfordwest, Pembrokeshire, however this was temporarily closed in February 2023 due to staffing capacity issues. In September 2023 a review of the S136 facilities was undertaken jointly by the Mental Health and Learning Disability (MH&LD) Directorate and the Health, Safety and Security Team to check environmental conditions and operational arrangements of the service and facilities. This included risks and impacts associated with staff and patient safety. The review included site visits, together with information relating to S136 activity and incidents reported over the last 2 years. In order to mitigate the patient, health, safety, environmental and staffing risks that were highlighted as part of the review, minor works was undertaken to facilitate moving the age appropriate S136 space within Morlais Ward and a decision was made on 26th October 2023 to temporarily stand down the alternative/community place of safety at Gorwelion with immediate effect and to stop use of Cwm Seren. As a consequence to this action, all adults detained under S136 requiring a place of safety in a mental health environment have been diverted to the S136 facility based on Bryngofal Ward, Llanelli.
Why is the proposal / decision needed	The health and safety review highlighted that there are potential benefits in forming a single place of safety where the environment, staff resources, support and collaborative work with partner agencies, could be consistently provided. A multi-agency group has been established to include representatives from Carmarthenshire County Council, Pembrokeshire County Council, Ceredigion County Council, Dyfed Powys Police, Third Sector and mental health services. The purpose of the multi-agency Group has been to oversee a review of the provision of Section 136 facilities across the Hywel Dda region. The conclusion and recommendation from the review, in the absence of a feasible option to sustain S136 provision in each county, has been to change the location of the temporary single place of safety in Llanelli to Carmarthen.
What are the drivers and influencing factors around the decision to be made? (e.g. legislation, national policy, professional body guidance, cost savings, ministerial priorities, quality standards, incidents etc)	Drivers were the outcome to the health and safety review undertaken jointly by the MHLD Directorate and the Health, Safety and Security Team. This included site visits, triangulated with information regarding S136 activity and related incidents reported over the previous 2 years. The following National guidance and best practice standards were consulted as part of the review: • Health Building Note 03 - 01: Adult acute mental health units • Guidance for Commissioners: service provision for section 136 of the Mental Health Act 1983, Royal College of Psychiatrist The purpose of the review was to check environmental conditions and operational arrangements of the service and facilities. This included the risks and impacts associated with staff and patient safety.
Who is directly affected by this proposal / decision? Please also consider people who may be indirectly affected	Service Users, Family/Carers, Health Board, Local Authority, Dyfed Powys Police staff, Section 12 doctors that undertake assessments on behalf of the Health Board.
How have you engaged with the people affected? If you have not yet engaged, what are your plans?	Following the health and safety review, a report with its findings and recommendations was shared with MH&LD Triumvirate, Heads of Service and Senior Nurse Managers. The temporary closure was discussed with the affected staff working on the alternative/community 'place of safety' at Gorwelion by the Senior Nurse Manager in Gorwelion. A multi-agency meeting was held with police, local authorities, St. John Ambulance and mental health services on 12th October 2023 to discuss the findings of the report and agree a plan to divert S136 cases from Gorwelion to a single place of safety in Carmarthenshire. On 22nd November 2023 a meeting was held with a representative of Llais to inform them of the temporary closure. Since then multi agency partners including the LAs from the 3 counties, Police and a representative from West Wales Action for Mental Health who has undertaken engagement with service users and carers about experiences of S136, have participated in a multi agency group to develop and review options for future S136 provision. A best option has been developed, to be taken through board to seek approval for formal public engagement on the plan.
How does the proposal / decision impact on delivery of the organisation's strategic objectives or ministerial priorities?	This proposal supports the annual work plan for the MH&LD CCG with regard to providing a single point of assessment and further developing the Single Point of Contact 111 press 2 service.
Is the proposal / decision planned to be temporary or permanent?	The proposal to create a single place of safety at Hafan Derwn, Carmarthen will be permanent.

Has this Quality Impact Assessment been completed in collaboration with the clinical team(s) that the project will affect?	Yes / No
	YES

This tool was developed by the Quality Assurance and Safety Team using ideas from Rotherham, Doncaster and Humberside NHS Trust QSIA tool and the NHS (Wales) Executive beta tool
https://www.rdash.nhs.uk/wp-content/uploads/2022/10/QSIA-Policy-v1.pdf

For advice and guidance using this tool, please contact Olwen Morgan, Assistant Director of Nursing, Cathie Steele, Head of Quality and Governance or Caroline Burgin, Patient Safety and Assurance Manager.

Health & Care Quality Standard	Possible considerations for this standard	Risk Score (current risk before change)			Tick impact			Does this impact link with a Quality Enabler? If yes, please list the enabler(s)? (Leadership, Workforce, Culture, Information, Learning improvement and research, Whole-system perspective)	Risk Score (after proposed change)			Description of impact
		Likeihood 1 - 5	Impact 1 - 5	Overall score	Positive	Neutral	Negative		Likeihood 1 - 5	Impact 1 - 5	Overall score	
Safe	It has not been possible to provide county based S136 facilities for some time due to there not being a dedicated establishment for S136 provision compounded by significant staffing deficits both in inpatients and in Ceredgion Community Mental Health Services where historical S136 provision has been sited. As set out in the review, environmental conditions including having appropriate staffing in the Gorwelion S136 facility are unsafe and cannot be mitigated against in a timely manner. There is a risk to patient safety as well as privacy and dignity concerns due to the physical location of the age appropriate S136 facility on Morlais Ward and the environment. These temporary closures and diversion of S136 patients to a single place of safety in Carmarthenshire, improves staff and patient safety, health and well-being though compliance with H&S regulations. There is potential for enforcement action including Improvement Notices/Prosecutions and claims due to breaches in legislation.	4	4	16	✓			Workforce	3	2	6	A single site, adult S136 suite co located with 2 other inpatient units on the Hafan Derwen site, with a dedicated HCSW staffing establishment, minimises safety risks associated with Staffing the S136 suite and addresses competencies needed in line with 'Standards on the use of Section 136 of the Mental Health Act 1983 (England and Wales)' and 'Guidance for commissioners: service provision for Section 136 of the Mental Health Act 1983', including appropriate back up when required. Environmental safety risks are significantly reduced however some adaption to the environment is required to create a safer entrance.
Timely	The historical position of having a S136 facility in each locality minimises time required to convey indiviudals to the place of safety and eases access by county based Approved Mental Health Professionals (AMHPs) who coordinate assessment however this has not been feasible for sometime and is judged to be an unfeasible option moving forwards. The current temporary single place of safety in Llanelli, causes an increase in travel time and a delay in assessment and treatement for individuals and staff in Ceredigion and Pembrokeshire.	4	3	12	✓			Whole System Perspective	3	3	9	Formally moving away from having places of safety in each of the 3 localities does impact on the timeliness of travel and access to assessment however current arrangements with a single place of safety in Llanelli have not resulted in time breaches under the MHA 1983. Changing location of the current, adult S136 place of safety facility in Llanelli to a single place of safety on the Hafan Derwen site, Carmarthen, will reduce distance and travelling times for some indiviudals, particularly for indiviudals and staff from Ceredigion and Pembrokeshire counties however will increase distance and travelling times for others, particularly individuals and staff from Llanelli. Basing the S136 in Carmarthen provides quicker access to A&E at Glangwilli in the event of physical health deterioration and offers opportunities to more easily divert S136 cases taken to Glangwilli A&E in the first instance.

Health & Care Quality Standard	Possible considerations for this standard	Risk Score (current risk before change)			Tick impact			Does this impact link with a Quality Enabler? If yes, please list the enabler(s)? (Leadership, Workforce, Culture, Information, Learning improvement and research, Whole-system perspective)	Risk Score (after proposed change)			Description of impact
		Likelihood 1 - 5	Impact 1 - 5	Overall score	Positive	Neutral	Negative		Likelihood 1 - 5	Impact 1 - 5	Overall score	
Effective	The historical provision of S136 suites across each county included providing a community based place of safety at Gorwelion community mental health centre in Ceredigion which when in use diverted staff from the Crisis Intervention Home Treatment team in Ceredigion creating a buisness continuity risk and unpredictable, temporary removal of mental health critical services.	3	3	9	✓			Whole System Perspective	2	3	6	A single site, adult S136 suite on the Hafan Derwen site, Carmarthen enhances staff and patient safety, without compomising other essential services and facilitates provision of additional staffing back up, when required. Reducing the number of sites providing a S136 facility makes more effective use of resources. This does limit the mental health services capacity for accommodating indiviudals subject to S136 and will require ongoing monitoring of any impact on use of other places of safety that sit outside of mental health (Eg A&E and custody facilities). Having the single site in Carmarthen is a more central point for professionals/multi agency partners from across the three counties to travel to in comparison to the current temporary single site on Bryngofal Ward in Llanelli.
Efficient	The historical provision of S136 suites across each county and current temporary single place of safety on Bryngofal Ward Llanelli has been reliant on diverting staff from other essential services or using temporary staffing which has impacted on high levels of variable pay spending. Establishing dedicated establishments (as is required to meet commissioning standards) in order to ensure safe provision of S136 suites across each county is not cost efficient given the current level of S136 activity.	4	4	16	✓			Workforce	2	2	4	A single, adult S136 suite on the Hafan Derwen site, in Carmarthen will decrease the required Health Board Staffing costs to ensure delivery of a safe service. Its co location with PICU and LSU will generate benefits and efficiencies with staffing and clinical oversight.

Health & Care Quality Standard	Possible considerations for this standard	Risk Score (current risk before change)			Tick impact			Does this impact link with a Quality Enabler? If yes, please list the enabler(s)? (Leadership, Workforce, Culture, Information, Learning improvement and research, Whole-system perspective)	Risk Score (after proposed change)			Description of impact
		Likelihood 1 - 5	Impact 1 - 5	Overall score	Positive	Neutral	Negative		Likelihood 1 - 5	Impact 1 - 5	Overall score	
Equitable	Individuals detained under S136 of the Mental Health Act from across Health Board counties will continue to be conveyed to a place of safety within the Health Board footprint.	3	3	9		✓			3	3	9	Has an EQIA screening tool been undertaken? Yes Has a full EQIA been undertaken? Yes Please provide a summary below: EQIA, completed and approved at the MH&LD CCG Business Performance Assurance Group **Link to full EQIA when published**
Person-centred	The historical position of having a S136 facility in each locality reduces traveling time home for indiviudals if not detained and potentially makes it easier for families/carers to provide support however however this has not been feasible for sometime and is judged to be an unfeasible option moving forwards. The current temporary single place of safety in Llanelli, causes an increase in travel time for family/carers travelling to support from Ceredigon and Pembrokeshire.	4	4	16	✓				3	3	9	A single, adult S136 suite on the Hafan Derwen site, Carmarthen will facilitate access to a wider range of holistic services to support individuals, in some instances access to medication, wider hospital services and medical staff etc. Options to facilitate transportation home for indiviudals who are not detained and are unable to access support from their family/carers will be looked at on a case by case basis.

Full Assessment

Strategic Decision / Organisational Activity / Project Title:	Section 136 Place of Safety Option Appraisal	Name and role of lead:		Becky Temple-Purcell	Driver for change	Recommendation from S136 review

Health & Care Quality Standard (pick from drop down list)	Health & Care Quality Enabler (Leadership, Workforce, Culture, Information, Learning improvement and research, Whole-system perspective) Please list all applicable	Description of Risk	Inherent RISK Score			Current Mitigation	Current RISK Score			Monitoring Arrangements							Target RISK score			Escalation Arrangements		
			Likelihood 1 - 5	Impact 1 - 5	Overall score		Likelihood 1 - 5	Impact 1 - 5	Overall score	Owner	Quality Indicator How will you measure the healthcare quality? What can indicate a change in the quality?	Current baseline of indicator The current achievement level of the indicator	Trigger for escalation The trigger level at which the impact is escalated	Actions Actions to be taken once the trigger is breached	Monitoring Committee (This will usually be local governance arrangements and DITS	Frequency How often	Likelihood 1 - 5	Impact 1 - 5	Overall score	Date Escalated	Where Escalated	Further action to be taken
Safe	Workforce	Delivery of Safe and effective care	4	4	16	Temp Centralised POS	3	4	12	MH/LD	No 136 breaches	MHA Monitoring	Breach	Incident Report	Legislation Comm	Each 136	3	2	6			
					0				0										0			
					0				0										0			
					0				0										0			
					0				0										0			

Audit Trail of Comments

Date	Name	Comments

QIA Panel Use Only

Considered and supported by:	**Name**	**Supported**	**Comments (if not supported)**	Date
Deputy Director of Health Science	Jon Arthur	See comments	Has the geography of the UHB been fully considered- appreciate the drive for centralisation but will this provide an equitable service for patients/ Yes considered at pane.	21/07/2025
Head of Strategic Partnerships	Anna Bird	See comments	A full EQIA has been completed and was quality assured by the Diversity and Inclusion team dated	21/07/2025
Associate Medical Director for Quality and Safety	Subhamay Ghosh			
Assistant Director of Nursing, Assurance & Safegauarding	Cathie Steele	See comments	It would be useful to see the EQIA and consideration of erquity. How willl service users be transported to hafen Derwen for the assessment? Has the proposal been discussed with DPP and other partners?	18/07/2025
Consultant in Public Health Medicine	Michael Thomas			

Considered and approved by Clinical Executive:	**Name**	**Supported**	**Comments (if applicable)**	Date
Director of Nursing, Quality and Patient Experience	Sharon Daniel	Yes	Based on comments below	21/07/2025
Medical Director	Mark Henwood	Yes		
Director of Therapies and Health Science	James Severs	Yes		

Date presented to panel	21/07/2025
Chair of Panel	Sharon Daniel
Notes of panel discussion	Section 136 of the Mental Health Act 1983 is the key legislation that governs how individuals can be detained by police if they appear to be experiencing a mental health crisis in a public place and need immediate care or control. Section 136 is a legal power, not a voluntary or consent-based process. The Health and Care Act 2022 strengthens patient choice in broader NHS services, but it doesn't override the emergency powers of Section 136. A coprehensive EQIA has been considered re the impact on staff. Panel requested contiuaton of collection of data to understand the demand ofor the service

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Hywel Dda University Health Board
Equality Impact Assessment (EqIA)

Service Director and Clinical Care Group	Liz Carroll – Service Director of Mental Health and Learning Disabilities
Service Area	MH&LD

What is an Equality Impact Assessment (EqIA)?

An EqIA is a scrutiny tool which is used to ensure that when making decisions related to creating or changing projects, practices and policies, the decisions made are fair and do not discriminate against any protected group defined under the Equality Act 2010.

Why do they have to be completed?

All public authorities in Wales are **legally required** under the Public Sector Equality Duty 2011 to **demonstrate that due regard** has been given in accordance with the Equality Act 2010 with the need to:

- Eliminate discrimination
- Advance equality of opportunity
- Foster good relations

When should they be completed?

A fully completed EqIA, or if applicable an EqIA Screening, must be produced before the Health Board is asked to make decisions about:

- Changes to the way health services are delivered
- The development of a new service
- Clinical or non-clinical policy document/guidance

Completion of an EqIA or EqIA Screening is monitored as part of the Health Boards escalation process, and forms part of the Quality Impact Assessment process. An EqIA is a living document and should be regularly reviewed and updated in light of new information, emerging evidence or stakeholder engagement.

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

It is recognised that certain proposals or decisions will require a wider consideration of potential impacts, particularly those relating to service change or potential major investment. For large scale projects and strategic decisions you will also need to consider undertaking an Equality and Health Impact Assessment. Please contact the Diversity and Inclusion (D&I) team if you require further clarity.

Please note: The D&I team will save a copy of the completed form for reference. If any changes are made after the date of review, it is the Clinical Care Group's responsibility to update the EqIA and inform the D&I team.

Support
For further support please visit the EqIA Sharepoint or contact:
Email: Inclusion.hdd@wales.nhs.uk
Tel: 01554 899055

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Section 1: Overview

1.	**What are you Equality Impact assessing?**	Forming a single Adult S136 Suite in Carmarthenshire.
2.	**Brief Aims and Description of the procedure/ proposal/ project/ policy:**	In line with the Mental Health Act (1983) requirements, Hywel Dda University Health Board provides Section 136 (S136) place of safety facilities for individuals who have been detained under S136 of the Mental Health Act by the Police following concerns that they are suffering from a mental disorder.
3.	**Who is involved in undertaking this EqIA? (names/job titles)**	Sophie Rees, Service Improvement Support Manager, Service Transformation and Partnerships Team, MH & LD Clinical Care Group. Rebecca Temple-Purcell – Assistant Director of Nursing, Patient Safety, Quality and Experience, MH & LD Kay Isaacs – Assistant Service Director of MH & LD
4.	**Is the procedure/ proposal/ project/ policy related to other policies/ areas of work?**	Inter-agency Protocol – S136 MHA 1983, Mentally Disordered Persons Found in Public Places Policing and Crime Act 2017 Mental Health Measure 2010 Code of Practice MHA Code of Practice Welsh Health Care Standards Right Care, Right Person
5.	**Is this a new EqIA or an updated EqIA?**	New ☒ Updated ☐ Date of original or last version of the EqIA: Please give details / explain any amendments.
6.	**Who will be affected by the procedure/ proposal/ project/ policy development?**	Persons detained under S136 Carers Mental Health Staffing receiving S136 persons. Dyfed Powys Police Officers who implement the S136

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

	(Consider staff as well as the population, patients, carers and family members who may be affected to different degrees)	Dyfed Powys Police Custody officers receiving the S136 Accident & Emergency staff Pembrokeshire, Carmarthenshire, and Ceredigion Local Authorities Approved Mental Health Professional Section 12 Approved Doctors Welsh Ambulance Service Trust St Johns Ambulance Service Third Sector Organisations
7.	**What might help/hinder the success of the procedure/ proposal/ project/ policy?**	Lack of awareness, reliance on electronic storage systems to access policy. Raising awareness through Quality Assurance forums and meetings. Senior Managers cascading information and reference to the policy in line management supervision.

Section 2: Human Rights

Human Rights: The Human Rights Act contains 15 Articles (or rights), all of which NHS organisations have a duty to act compatibly with and to respect, protect and fulfil. The 6 rights that are particularly relevant to healthcare are listed below.

Depending on the **procedure/ proposal/ project/ policy** you are considering, you may find the examples below helpful in relation to the Articles.

Consider, is the procedure/ proposal/ project/ policy relevant to:	Yes	No
Article 2: The right to life. **Example**: The protection and promotion of the safety and welfare of patients and staff; issues of patient restraint and control.	√	
Article 3: The right not to be tortured or treated in an inhuman or degrading way. **Example**: Issues of dignity and privacy; the protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers; Issues of patient restraint and control	√	
Article 5: The right to liberty **Example**: Issues of patient choice, control, empowerment and independence; issues of patient restraint and control	√	

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Article 6: The right to a fair trial **Example**: issues of patient choice, control, empowerment and independence	√	
Article 8: The right to respect for private and family life, home and correspondence. **Example**: Issues of dignity and privacy; the protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers; the right of a patient or employee to enjoy their family and/or private life	√	
Article 11: The right to freedom of thought, conscience and religion **Example**: The protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers	√	

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Section 3: Gathering of Evidence and Assessment of Potential Impact

How will the procedure/ proposal/ project/ policy impact on Age: Is it likely to affect older and younger people in different ways or affect one age group and not another?	**Positive**	
	Negative	
	No Impact	√

Guidance

Remove population data if not relevant to EqIA and upload relevant data.

Population Data

County	Carms		Cere		Pembs		Total		Summary
Age	value	%	value	%	value	%	value	%	All three regions that comprise the Hywel Dda area have seen an increase in the average age of their population between the last two population censuses, Ceredigion (has seen an increase by 5 years to 47), Pembrokeshire (increase by 3 years to 48) and Carmarthenshire (increase by 2 years to 42). People, population and community - Office for National Statistics (ons.gov.uk)
Total: All usual residents	187,897	100	71,474	100	123,360	100	382,731	100.0	
Aged 4 years and under	9,057	4.8	2,709	3.8	5,583	4.5	17,349	4.4	
Aged 5 to 9 years	10,274	5.5	3,288	4.6	6,731	5.5	20,293	5.2	
Aged 10 to 15 years	13,080	7	4,086	5.7	8,495	6.9	25,661	6.5	
Aged 16 to 19 years	7,799	4.2	4,129	5.8	4,889	4	16,817	4.7	
Aged 20 to 24 years	8,820	4.7	6,366	8.9	5,621	4.6	20,807	6.1	
Aged 25 to 34 years	20,692	11	7,107	9.9	12,907	10.5	40,706	10.5	
Aged 35 to 49 years	31,802	16.9	10,145	14.2	19,461	15.8	61,408	15.6	
Aged 50 to 64 years	40,906	21.8	15,256	21.3	27,331	22.2	83,493	21.8	
Aged 65 to 74 years	24,603	13.1	9,942	13.9	17,445	14.1	51,990	13.7	
Aged 75 to 84 years	15,247	8.1	6,097	8.5	10,855	8.8	32,199	8.5	
Aged 85 years and over	5,617	3	2,349	3.3	4,042	3.3	12,008	3.2	

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

<table>
<tr>
<td>Insert an age breakdown of those affected. This data can be recorded in table or free text format.

If no information is available, please state that here, including how you plan to address any identified data gaps in the future.</td>
<td>

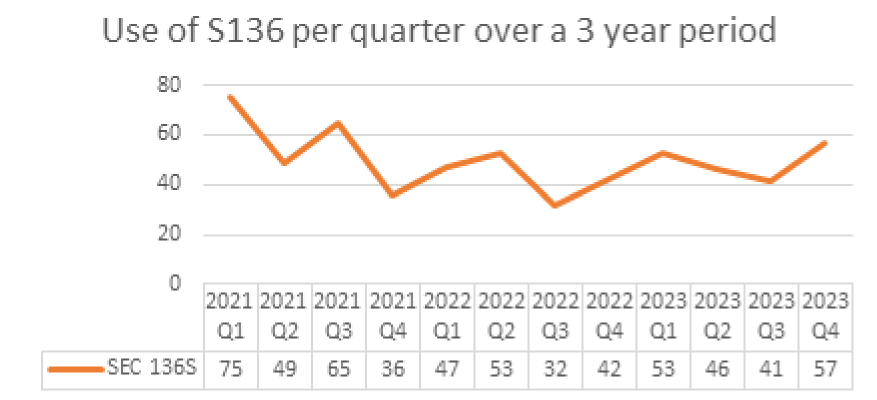
Patient data

Service User Impact

In line with the Mental Health Act (1983) requirements, Hywel Dda University Health Board provides Section 136 (S136) place of safety facilities for individuals who have been detained under S136 of the Mental Health Act. The powers of S136 provide authority for a police officer who finds a person who appears to be suffering from mental disorder, in a place to which the public has access, to remove them to a place of safety.

Mental health issues can affect anyone at any age. The increase in mental health crisis amongst the population is widely reported in the media and particularly prevalent in younger persons. The use of S136 is not age restricted however younger persons (those under 30) appear to be more likely to be placed on S136.

The table below shows the use of S136 per quarter during the period April 2021- March 2023.



Source MH&LD Internal reporting

The age range demonstrated by % within Hywel Dda during April 2021 and March 2023 can be seen below:

Total of S136 use from April 2021-March 2023	**591**
Older Adult	1.4%
Adult	91.6%
S-CAMHS	7%

</td>
</tr>
</table>

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

<table>
<tr><td></td><td>Source MH&LD Internal reporting</td></tr>
<tr><td>Insert breakdown of staff age in the specific service/ area of work.

If no information is available, please state that here including how you plan to address any identified data gaps in the future.</td><td>

Staff data

Mental Health and Learning Disabilities Clinical Care Group Age Range Breakdown

From the table below we can see that the Clinical Care Group workforce age ranges closely mirror that of the health board workforce age range, with 19.6% of the Clinical Care Group over the age of 55.

<table>
<tr><th>Age Band</th><th>Headcount</th><th>%</th></tr>
<tr><td><=20 Years</td><td>3</td><td>0.2%</td></tr>
<tr><td>21-25</td><td>53</td><td>4.2%</td></tr>
<tr><td>26-30</td><td>128</td><td>10.2%</td></tr>
<tr><td>31-35</td><td>164</td><td>13.0%</td></tr>
<tr><td>36-40</td><td>168</td><td>13.3%</td></tr>
<tr><td>41-45</td><td>140</td><td>11.1%</td></tr>
<tr><td>46-50</td><td>175</td><td>13.9%</td></tr>
<tr><td>51-55</td><td>182</td><td>14.5%</td></tr>
<tr><td>56-60</td><td>146</td><td>11.6%</td></tr>
<tr><td>61-65</td><td>80</td><td>6.4%</td></tr>
<tr><td>66-70</td><td>13</td><td>1.0%</td></tr>
<tr><td>>=71 Years</td><td>7</td><td>0.6%</td></tr>
<tr><td>Grand Total</td><td>1,259</td><td>100.0%</td></tr>
</table>
Source: Internal Mental Health and Learning Disability Reporting.

The Highest workforce age demographic with the Mental Health and Learning Disabilities Clinical Care Group is 51-55 highlighting the need for succession planning to encourage newer staff to join the service to enable continuity of service for the growing trend in Mental Health prevalence. The health board's Annual Workforce equality report sets out to support the following initiatives:

• Apprenticeship Academy
• Kick start scheme to engage with local communities
</td></tr>
</table>

<table>
<tr><td></td><td colspan="2">

- Continue to develop Stakeholder Engagement with partnering organisations to promote opportunities and increase accessibility
- Job Description language revision
- Identify the characteristics of work that are important to people aged 24 and under, and people aged 50 and over to explore actions that can be taken to attract and retain workers in the age profiles.

The review and updates to the procedure reflect recommendations from the 2020 National Review “Beyond the Call” and are in line with the Mental Health Act code of practice for Wales 2016. The updates will not be outside the remit of current roles and responsibilities.</td></tr>
<tr><td>Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.</td><td>Negative Impact
•
•
•</td><td>Opportunities for improvement / mitigation
•
•
•</td></tr>
<tr><td>Provide a brief summary of the positive impacts you have identified.</td><td colspan="2">Positive Impact
•
•</td></tr>
<tr><td>If you have determined no impact, please provide a brief explanation.</td><td colspan="2">No Impact
No impact is foreseen for individuals under 18yrs old as there are no proposed changes to the existing age appropriate S136 provision.

No impact is foreseen for individuals 18yrs+ in Carmarthenshire as the proposal is to deliver S136 provisions in Carmarthenshire.

No greater or lesser impact on Pembrokeshire and Ceredigion individuals 18yrs+ is foreseen. Individuals who require S136 services will still receive them, however these will be delivered in an alternative location.</td></tr>
</table>

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

	No greater or lesser impact on staff ages is foreseen, the provision of S136 will apply to all Staff regardless of age and mental health service area.

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy impact on Disability: Those with a physical disability, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes.	**Positive**	
	Negative	
	No Impact	√

Guidance

Remove population data if not relevant to EqIA.

Population Data

	Carms	Cere	Pembs	Total
Disabled under the Equality Act: Day-to-day activities limited a lot	21225	6686	12522	40463
Disabled under the Equality Act: Day-to-day activities limited a little	21897	8951	14651	45499
Total with a disability	43152	15637	27173	85,963
Total population	187,895	71,474	123,366	382,735
Percentage of population with a disability	23%	22%	22%	22%

People, population and community - Office for National Statistics (ons.gov.uk)

Insert data for those affected. Include data on the disabilities listed above. (The aging population may have significant levels of age-related disabilities.)

If no information is available, please state that here, including how you plan to address any identified data gaps in the future.

Patient data

Service User Impact

From Census data (2021) records of people on local authority registers or claiming certain benefits, a reasonable indication of the numbers in the region living with serious illness or disability is as follows:

In the West Wales (HDdUHB) region over 22,000 people (18-64) are entitled to Personal Independence Payment (PIP); 10,000 people are entitled to Disability Living Allowance (DLA) and over 13,500 people are entitled to Attendance Allowance (AA). With approximately 2,588 adults (16+) living with a moderate or severe learning disability (LD).

According to Welsh Government records, in 2019, there were 9,444 people with physical or sensory disabilities on local authority registers in West Wales, 1,679 of those are aged between 18 and 64 and are registered with a physical disability and a further 1,744 aged between 18 and 64 are registered as having physical and sensory disabilities.
According to a National Survey for Wales, 71% of the Hywel Dda population report ‘very good or good general health’. 21% report their general health as ‘Fair’ with 9% reporting their general health to be ‘bad or very bad’.

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

	Illness				Type of illness				
	Any longstanding illnesses	2 or more longstanding illnesses	Limited at all by longstanding illness	Limited a lot by longstanding illness	Musculoskeletal complaints	Heart and circulatory complaints	Endocrine and metabolic diseases	Respiratory system complaints	Mental disorders
Hywel Dda University Health Board	49%	21%	34%	20%	17%	14%	8%	8%	9%

General health and illness by local authority and health board,, 2016-17 to 2019-20 (gov.wales)

From the table we can see that just under half of the Hywel Dda population report longstanding Health Conditions:

No data is collected on this characteristic during the S136 process.

Insert breakdown of staff with a disability who may be affected by your specific service/area of work.

If no information is available, please state that here including how you plan to address any identified data gaps in the future.

Staff data
Workforce Impact

Hywel Dda Health Board workforce disability data

The percentage of staff identifying as having a disability has decreased in by 0.48%. As of 31 March 2021, 2.20% of staff identified as having a disability.

The percentage of staff preferring not to answer has remained the same since 2019/20, (reported as 0.02%).
23% of the Hywel Dda population have a limiting long-term illness or disability. This compares to 2.20% of the workforce.

Those staff whose records are not recorded on ESR has fallen by 4.89%. A total of 24% of the workforce are not recorded on ESR which makes drawing a conclusion on the data more difficult.
Annual Workforce Equality Report 2020-21 Final Version for Board 23.8.21.pptx (sharepoint.com)

Mental Health and Learning Disabilities Clinical Care Group Workforce disability data

Disability?	Headcount	%
No	979	77.8%
Learning disability/difficulty	21	1.7%

	Long-standing illness	11	0.9%
	Mental Health Condition	8	0.6%
	Not Declared	68	5.4%
	Other	8	0.6%
	Physical Impairment	6	0.5%
	Prefer Not to Answer	5	0.4%
	Sensory Impairment	3	0.2%
	Yes - Unspecified	5	0.4%
	Unspecified	*145*	*11.5%*
	Grand Total	**1,259**	**100.0%**

Source: Internal Mental Health and Learning Disability Reporting.

5.4% of the Clinical Care Group workforce have not declared if they do/ do not have a disability, with a further 11.5% recorded as unspecified which again makes drawing a conclusion on the data more difficult.

Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.	**Negative Impact** • • •	**Opportunities for improvement / mitigation** • • •
Provide a summary of the positive impacts you have identified.	**Positive Impact**	
If you have determined no impact, please	**No Impact** No impact is foreseen for individuals under 18yrs old as there are no proposed changes to the existing age appropriate S136 provision.	

provide a brief explanation.	No impact is foreseen for individuals 18yrs+ with this characteristic in Carmarthenshire as the proposal is to deliver S136 provisions in Carmarthenshire. No greater or lesser impact on Pembrokeshire and Ceredigion individuals 18yrs+ with this characteristic is foreseen. Individuals who require S136 services will still receive them, however these will be delivered in an alternative location. No greater or lesser impact is foreseen, the S136 provisions will apply to all services users regardless of mental health service area and whether they identify or have previously identified as having a disability. The procedure promotes multi-agency consistency in the risk assessment, reporting and response processes when service users require S136 provisions. The procedure has been developed in line with equality and human rights legislation which the following policy acknowledges Equality, Diversity and Inclusion Policy.

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy impact on Gender Reassignment: Consider the potential impact on individuals who have undergone, intend to undergo or are currently undergoing gender reassignment; and those who do not intend to undergo medical treatment but wish to live in a different gender from their gender at birth.	**Positive**	
	Negative	
	No Impact	√

Guidance

Remove population data if not relevant to EqIA.

Population Data

County	Carms		Cere		Pembs		Total	
Gender	value	%	value	%	value	%	value	%
Gender identity the same as sex registered at birth	144,924	93.2	55,874	91.02	95,794	93.41	296,592	92.54
Gender identity different from sex registered at birth but no specific identity given	210	0.14	84	0.14	121	0.12	415	0.13
Trans woman	93	0.06	73	0.12	58	0.06	224	0.08
Trans man	90	0.06	62	0.1	66	0.06	218	0.73
Non-binary	60	0.04	143	0.23	40	0.04	243	0.1
All other gender identities	38	0.02	66	0.11	32	0.03	136	0.05
Not answered	10,072	6.48	5,087	8.29	6,438	6.28	21,597	7.01

People, population and community - Office for National Statistics (ons.gov.uk)

Insert evidence of what proportion of those affected identify as a gender that is different to their sex registered at birth. This data can be recorded in table or free text format.

If no information is available, please state that here, including how you plan to address any

Patient data

Service User Data

No data currently collected by the service around this protected characteristic.

Service User Impact

The service has been developed to ensure the Health Board operates in line with equality and human rights legislation which the following policy acknowledges: Equality, Diversity and Inclusion Policy.

The service does not discriminate and will be open to all regardless of their gender identity, with the Health Boards values embedded firmly in all they do:

- Putting people at the heart of everything we do
- Striving to deliver and develop excellent services
- Working together to be the best we can be

identified data gaps in the future.	
Insert breakdown of staff gender reassignment information affected by your specific service/area of work. If no information is available, please state that here including how you plan to address any identified data gaps in the future.	**Staff data** **Workforce Data** **Hywel Dda Health Board Workforce Data** No specific workforce data is collected around this protected characteristic, however, is monitored as part of the wider Health Board workforce equality reporting. **Mental Health and Learning Disabilities Clinical Care Group Workforce Data** No Clinical Care Group level data is collected around this protected characteristic. **Workforce Impact** Mandatory Staff induction training which includes 'Treat Me Fairly' - This course will help staff to recognise the value of their contribution in providing an excellent standard of service that is fair and meets individual needs whist treating everyone with dignity and respect. Other Health Board training available includes: ▪ Equality & Diversity Awareness and Unconscious Bias (Diverse Cymru) ▪ Introduction to Allyship, Delivering Inclusive Services & Allies Programme Parts 1 & 2 (Stonewall Cymru) Resources for staff support can be found on the health board website: Equality, diversity and inclusion - Hywel Dda University Health Board (NHS. Wales) which includes specific learning around gender reassignment: Home | Gendered Intelligence There is an Inclusive recruitment policy in place to ensure no discrimination against staff with this characteristic: Working for Us - Inclusive-Recruitment---Sexual-Orientation-and-Gender-Identity--English--.pdf - All Documents (sharepoint.com) The health board promotes and highlights key dates throughout the year and support available, including Transgender Day of Remembrance. To promote awareness, the Enfys staff network is promoted via Global emails and on the staff Facebook page.

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.	**Negative Impact** • • •	**Opportunities for improvement / mitigation** • • •
Provide a summary of the positive impacts you have identified.	**Positive Impact**	
If you have determined no impact, please provide a brief explanation.	**No Impact** It is perceived that no greater or lesser impact is foreseen, the provision of S136 will apply to all services users regardless of mental health service area and gender and it will not affect the support provided by the service. No greater or lesser impact to the workforce is foreseen. The Health Boards Supporting Transgender Staff Policy outlines workplace guidelines for addressing the needs and issues that arise in the workplace when a trans person is recruited or transitions during their term of employment.	

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

<table>
<tr><td colspan="2">How will the procedure/ proposal/ project/ policy impact on Marriage and Civil Partnership</td><td>Positive
Negative
No Impact</td><td>

√</td></tr>
<tr><td>Guidance

Remove population data if not relevant to EqIA.</td><td colspan="3">Population Data

Under the Equality Act, the characteristic of Marriage and Civil Partnerships is only protected in the workplace/ employment.

In Carmarthenshire, 32.4% of people never married or registered a civil partnership, against 47.3% of people who are married or on a civil partnership. The remaining 20.3% either had their legal partnership status dissolved, are separated or are surviving their partner.
How life has changed in Carmarthenshire: Census 2021 (ons.gov.uk)

In Ceredigion, 38.7% of people never married or registered a civil partnership, against 43.1% of people who are married or on a civil partnership. The remaining 18.2% either had their legal partnership status dissolved, are separated or are surviving their partner.
How life has changed in Ceredigion: Census 2021 (ons.gov.uk)

In Pembrokeshire, 31.8% of people never married or registered a civil partnership, against 47.3% of people who are married or on a civil partnership. The remaining 21% either had their legal partnership status dissolved, are separated or are surviving their partner.
How life has changed in Pembrokeshire: Census 2021 (ons.gov.uk)</td></tr>
<tr><td>If data is available insert evidence of those that are affected are Married or are in a Civil Partnership. This data can be recorded in table or free text format.

If no information is available, please state that here, including how you plan to address any</td><td colspan="3">Patient data

Service User Impact

The table below shows the number of people in West Wales by county who are registered within a Marital or Civil Partnership:

<table><tr><td>All usual residents Carmarthenshire aged 16+</td><td>150,763</td></tr><tr><td>Single (never married or never registered a same-sex civil partnership)</td><td>44,478</td></tr><tr><td>Married</td><td>74,636</td></tr><tr><td>In a registered same-sex civil partnership</td><td>205</td></tr><tr><td>Separated (but still legally married or still legally in a same-sex civil partnership)</td><td>2,977</td></tr><tr><td>Divorced or formerly in a same-sex civil partnership which is now legally dissolved</td><td>15,017</td></tr><tr><td>Widowed or surviving partner from a same-sex civil partnership</td><td>13,450</td></tr></table></td></tr>
</table>

identified data gaps in the future.	**All usual residents Pembrokeshire aged 16+** 100,362 Single (never married or never registered a same-sex civil partnership) 28,538 Married 50,580 In a registered same-sex civil partnership 133 Separated (but still legally married or still legally in a same-sex civil partnership) 2,159 Divorced or formerly in a same-sex civil partnership which is now legally dissolved 10,162 Widowed or surviving partner from a same-sex civil partnership 8,790 **All usual residents Ceredigion aged 16+** 64,692 Single (never married or never registered a same-sex civil partnership) 25,047 Married 27,711 In a registered same-sex civil partnership 113 Separated (but still legally married or still legally in a same-sex civil partnership) 1,218 Divorced or formerly in a same-sex civil partnership which is now legally dissolved 5,525 Widowed or surviving partner from a same-sex civil partnership 5,078 Data Viewer - Nomis - Official Census and Labour Market Statistics (nomisweb.co.uk) It can be assumed that a number of Service Users across the Mental Health and Learning Disability Clinical Care Group will be either married or in a civil partnership.
Insert breakdown of staff marriage / civil partnership information affected by your specific service/area of work. If no information is available, please state that here including how you	**Staff data** **Workforce Impact** Compared to 31st March 2020 the percentage of staff detailing marital status information has increased by 0.25% by 31st March 2021. Those staff whose records are not recorded on ESR has decreased by 0.25% for the period. Annual Workforce Equality Report 2020-21 Final Version for Board 23.8.21.pptx (sharepoint.com) No Clinical Care Group level data is collected around this protected characteristic, however, is monitored as part of the wider Health Board workforce equality reporting.

<table>
<tr><td>plan to address any identified data gaps in the future.</td><td colspan="2">It can be assumed that a number of staff working across the Mental Health and Learning Disability Clinical Care Group will be either married or in a civil partnership.

The review and updates to the procedure reflect recommendations from the 2020 National Review ‘Beyond the Call’ and are in line with the Mental Health Act code of practice for Wales 2016. The updates will not be outside the remit of current roles and responsibilities.

The procedure has been developed in line with equality and human rights legislation which the following policy acknowledges Equality, Diversity and Inclusion Policy.</td></tr>
<tr><td>Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.</td><td>Negative Impact
•
•
•</td><td>Opportunities for improvement / mitigation
•
•
•</td></tr>
<tr><td>Provide a summary of the positive impacts you have identified.</td><td colspan="2">Positive Impact</td></tr>
<tr><td>If you have determined no impact, please provide a brief explanation.</td><td colspan="2">No Impact
It is perceived that no greater or lesser impact is foreseen, the provision of S136 will apply to all services users regardless of mental health service area and marital or civil partnership status.

Whether an individual is single, married, or in a civil partnership it will not affect the support provided by the service.

No impact is foreseen for individuals under 18yrs old single, married, or in a civil partnership as there are no proposed changes to the existing age appropriate S136 provision.</td></tr>
</table>

	No impact is foreseen for individuals 18yrs+ single, married, or in a civil partnership in Carmarthenshire as the proposal is to deliver S136 provisions in Carmarthenshire. No greater or lesser impact on Pembrokeshire and Ceredigion individuals 18yrs+ single, married, or in a civil partnership is foreseen. Individuals who require S136 services will still receive them, however these will be delivered in an alternative location. It is perceived that no greater or lesser impact to staff on the basis of their marital or civil partnership status, the provisions of S136 will apply to all Staff regardless of mental health service area and their marital or civil partnership status.

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

<table>
<tr><td colspan="2" rowspan="3">How will the procedure/ proposal/ project/ policy impact Pregnancy and Maternity
Maternity covers the period of 26 weeks after having a baby, whether or not they are on Maternity Leave.</td><td>Positive</td><td></td></tr>
<tr><td>Negative</td><td></td></tr>
<tr><td>No Impact</td><td>√</td></tr>
<tr><td>Guidance

Remove population data if not relevant to EqIA.</td><td colspan="3">Population Data (Wales)

Births in England and Wales: summary tables - Office for National Statistics (ons.gov.uk)</td></tr>
<tr><td>If data is available insert evidence of those that are affected are Married or are in a Civil Partnership This data can be recorded in table or free text format.

If no information is available, please state that here, including how you plan to address any identified data gaps in the future.</td><td colspan="3">Patient data
As many as one in five women develop a mental health problem during pregnancy or in the first year after the birth of their baby. Maternal mental health problems can range from anxiety, low mood, and depression to psychosis. Depression and anxiety are the most common mental health problems during pregnancy, with around 12% of women experiencing depression and 13% experiencing anxiety; many women will experience both. Depression and anxiety also affect 15-20% of women in the first year after childbirth.
Maternal mental health problems – the impact in numbers (theconversation.com)

<u>National Population Data</u>

Wales statistics in 2021 relating to Pregnancy and Maternity and Mental Health found the following:
There were 28,879 live births, an increase of 0.3% from 2020 29% of pregnant women reported that they had a mental health condition at their initial assessment. Younger pregnant women (aged 24 or younger) reported a higher percentage of mental health conditions than other age groups 30% of pregnant women were obese (recorded as having a BMI of 30 or more) at their initial assessment 15% of pregnant women were recorded as being a smoker at their initial assessment Maternity and birth statistics: 2021 | GOV.WALES</td></tr>
</table>

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

<table>
<tr>
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<td>

<u>**Local Population Data**</u>

The following table shows the number of live births recorded for the year 2015 in the Hywel Dda Footprint.

Hywel Dda University Local Health Board	Ceredigion	632
	Pembrokeshire	1,180
	Carmarthenshire	1,855

Live births by area and age of mother (gov.wales)

In 2021, 29% of women in the Hywel Dda footprint reported a mental health condition at their initial assessment which mirrors the national statistics recorded for Wales in the same year.

<u>**Service User Data**</u>

No data currently collected by the service around this protected characteristic.

</td>
</tr>
<tr>
<td>Insert breakdown of staff marriage / civil partnership information affected by your specific service/area of work.

If no information is available, please state that here including how you plan to address any identified data gaps in the future.</td>
<td>

Staff data

<u>**Workforce Data**</u>
Hywel Dda Health Board Workforce Data

As of the 31st March 2021 the percentage of employees on leave due to maternity and adoption showed a decrease of 0.05% compared to 31st March 2020. With only two individuals out of 1,189 left following a period of maternity or adoption leave.

HDUHB Headcount by Pregnancy & Maternity/Adoption Leave		
	Headcount	%
Maternity & Adoption	438	3.50%

Annual Workforce Equality Report 2020-21 Final Version for Board 23.8.21.pptx (sharepoint.com)

Mental Health and Learning Disabilities Workforce Data

</td>
</tr>
</table>

<table>
<tr><td></td><td colspan="2">No Clinical Care Group level data is collected around this protected characteristic, however, is monitored as part of the wider Health Board workforce equality reporting</td></tr>
<tr><td>Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.</td><td>Negative Impact
•
•
•</td><td>Opportunities for improvement / mitigation
•
•
•</td></tr>
<tr><td>Provide a summary of the positive impacts you have identified.</td><td colspan="2">Positive Impact</td></tr>
<tr><td>If you have determined no impact, please provide a brief explanation.</td><td colspan="2">No Impact
Service User Impact

No greater or lesser impact on pregnancy or maternity. The service has been developed to ensure the Health Board operates in line with equality and human rights legislation which the following policy acknowledges: Equality, Diversity and Inclusion Policy.

No impact is foreseen for individuals under 18yrs old with this characteristic as the existing age appropriate S136 provision is centralised in Carmarthenshire.

No impact is foreseen for individuals 18yrs+ with this characteristic in Carmarthenshire as the proposal is to deliver S136 provisions in Carmarthenshire.

No greater or lesser impact on Pembrokeshire and Ceredigion individuals 18yrs+ with this characteristic is foreseen. Individuals who require S136 services will still receive them, however these will be delivered in an alternative location.</td></tr>
</table>

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

	Workforce Impact No greater or lesser impact on pregnancy or maternity. The positive actions identified to support Pregnant Staff or those on maternity leave are detailed within the annual workforce equality Report. • All pregnant staff and those returning from maternity and adoption leave have equal access to training opportunities for career progression • Promotion of flexible working options for those returning from maternity or adoption leave • Improvement strategies around retaining employees following periods of maternity or adoption leave

How will the procedure/ proposal/ project/ policy on Race/Ethnicity or Nationality People of a different race, nationality, colour, culture or ethnic origin including non-English / Welsh speakers, Gypsies/Travellers, asylum seekers and migrant workers. Also includes citizenship.		
	Positive	
	Negative	
	No Impact	√

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Guidance	Population Data
Remove population data if not relevant to EqIA.	(see table below)

Population Data

County	Carms		Cere		Pembs		Total	
Ethnicity	Value	%	Value	%	Value	%	Value	%
Total: All usual residents	187,898	100	71,473	100	123,359	100	382,730	100
Asian, Asian British or Asian Welsh	2,321	1.2	1,096	1.5	1,159	0.9	4,576	1.2
Black, Black British, Black Welsh, Caribbean or African	455	0.2	366	0.5	244	0.2	1,065	0.3
Mixed or Multiple ethnic groups	1,756	0.9	867	1.2	1,162	0.9	3,785	1
White	182,652	97.2	68,776	96.2	120,375	97.6	371,803	97
Gypsy or Traveller	450	0.2	55	0.08	585	0.5	1,090	0.3
Another ethnic group	714	0.4	368	0.5	419	0.3	1,501	0.4

People, population and community - Office for National Statistics (ons.gov.uk)

If data is available insert a breakdown of Race / Ethnicity or Nationality of those that are affected.

If no information is available, please state that here, including how you plan to address any identified data gaps in the future.

Patient data

National evidence indicates that people from Black, Asian, and Minority Ethnic backgrounds, (BAME) – including Gypsies and Travellers are disproportionately represented among mental health service users.

Rates of mental health problems can be higher for some BAME groups than for White people. As well as the factors that can affect everyone's mental health, people from BAME communities may also contend with racism, inequality, and mental health stigma.

- Black men are more likely to have experienced a psychotic disorder in the last year than White men
- Black people are four times more likely to be detained under the Mental Health Act than White people
- Older South Asian women are an at-risk group for suicide
- Refugees and asylum seekers are more likely to experience mental health problems than the general population, including higher rates of depression, anxiety, and PTSD

Some groups have better mental health. For example:

- People of Indian, Pakistani, and African-Caribbean origin showed higher levels of mental well-being than other ethnic groups

- Suicidal thoughts and self-harm were less common in Asian people than in White people
- Mental ill-health is lower among Chinese people than among White people

Different communities understand and talk about mental health in different ways. In some communities, mental health problems are rarely recognised or spoken about. They may be seen as shameful or embarrassing. This can discourage people from talking about their mental health or seeing their GP for help.

Research shows BAME people can face barriers to getting help, including:

- not recognising they have a mental illness because mental health was stigmatised or never talked about in their community
- not knowing that help is available or where to go to get it
- language barriers
- turning to family or friends rather than professional support, especially for people who don't trust formal healthcare services
- financial barriers, such as paying for private counselling
- not feeling listened to or understood by healthcare professionals
- White professionals who do not understand their experiences of racism or discrimination

Black, Asian and minority ethnic (BAME) communities (mentalhealth.org.uk)

National Population Data

Ethnicity data reported in June 2022 by Stats Wales shows that, 5.1% of people identify as Black, Asian or a Minority Ethnic.

Location	White	Black, Asian, and Minority Ethnic	Percentage of people who are Black, Asian, and Minority Ethnic
Wales	**2973,800**	**158,400**	**5.1%**

Ethnicity by area and ethnic group (gov.wales)

Local Population Data

Local Ethnicity data reported in June 2022 for the Hywel Dda footprint shows a greater percentage of White people living in each county.

Location	White	Black, Asian, and Minority Ethnic	Percentage of people who are Black, Asian, and Minority Ethnic
Pembrokeshire	**125,000**	**1,600**	**1.5%**
Carmarthen	**176,900**	**5,600**	**3.1%**
Ceredigion	**74,800**	**1,100**	**1.5%**

Ethnicity by area and ethnic group (gov.wales)

<table>
<tr>
<td></td>
<td>It should be noted that the data collected on Black, Asian and Ethnic Minorities is not considered robust due to a low engagement in responses.

The number of detentions for Q,2,3,4 2024 and Q1 2025 comprised of 160 detentions, 159 white British and 1 Chinese national.

Service User Data

No data is collected by the service around this protected characteristic.</td>
</tr>
<tr>
<td>Insert breakdown of the Race/Ethnicity or Nationality of the staff affected by your specific service/area of work.

If no information is available, please state that here including how you plan to address any identified data gaps in the future.</td>
<td>Staff data

No greater or lesser impact is foreseen on Race/ Ethnicity or nationality.

Mandatory Staff induction training which includes ‘Treat Me Fairly’ - This course will help staff to recognise the value of their contribution in providing an excellent standard of service that is fair and meets individual needs whist treating everyone with dignity and respect.
Other Health Board training available includes:
▪ Equality & Diversity Awareness and Unconscious Bias (Diverse Cymru)
▪ Introduction to Allyship, Delivering Inclusive Services & Allies Programme Parts 1 & 2 (Stonewall Cymru)
Resources for staff support can be found on the health board website: Equality, diversity and inclusion - Hywel Dda University Health Board (NHS. Wales)

Positive Actions identified in the Annual Workforce Equality report include-
• BAME Staff Network established- members can be kept up to date with news, information, and training opportunities
• Further promotion and engagement with ongoing projects: ‘Active Bystander Pilot’ and ‘Reverse mentoring’
• ‘Inclusive requirement’ Training to include guidance on the equality principle4s and use of discriminatory words in job descriptions and person specifications.</td>
</tr>
</table>

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<tr><td>If you have determined no impact, please provide a brief explanation.</td><td colspan="2">No Impact
No greater or lesser impact is foreseen on Race/ Ethnicity or nationality. The service has been developed to ensure the Health Board operates in line with equality and human rights legislation which the following policy acknowledges: Equality, Diversity and Inclusion Policy.

The service does not discriminate and is available to anyone regardless of their Race, Ethnicity or National Identity. Anybody entering the service will receive the same standard of care regardless of their background and cultural beliefs.

As standard all documentation and information issued to Patients is available in English and Welsh, with a translation service available within the health board for other languages.

The Health Board has a process to ensure that people have easy access across the organisation to accredited interpretation and translation services for Welsh, community languages, Braille and British Sign Language, outlined in the Interpretation and Translation Policy. There are a number of translation tools available which include a language Line, Insight App and Attend Anywhere Video Consultation.

No impact is foreseen for individuals under 18yrs old with this characteristic as the existing age appropriate S136 provision is centralised in Carmarthenshire.</td></tr>
</table>

	No impact is foreseen for individuals 18yrs+ with this characteristic in Carmarthenshire as the proposal is to deliver S136 provisions in Carmarthenshire. No greater or lesser impact on Pembrokeshire and Ceredigion individuals 18yrs+ with this characteristic is foreseen. Individuals who require S136 services will still receive them, however these will be delivered in an alternative location.

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy impact on Religion or Belief (or non-belief) The term 'religion or belief' includes a religious or philosophical belief, including ethical veganism.	**Positive**	
	Negative	
	No Impact	√

Guidance

Remove population data if not relevant to EqIA.

Population Data

County	Carms		Cere		Pembs		Total	
Religion	Value	%	Value	%	Value	%	Value	%
Total: All usual residents	187,899	100	71,476	100	123,363	100	382,738	100
No religion	83,409	44.4	30,749	43	52,998	43	167,1560	43.5
Christian	89,378	47.6	33,409	46.7	60,174	48.8	182,961	47.7
Buddhist	557	0.3	378	0.5	462	0.4	1,397	0.4
Hindu	419	0.2	158	0.2	161	0.1	738	0.2
Jewish	103	0.1	75	0.1	58	0	236	0.1
Muslim	1,026	0.5	515	0.7	587	0.5	2,128	0.6
Sikh	177	0.1	35	0	32	0	244	0.0
Other religion	1,127	0.6	677	0.9	746	0.6	2,550	0.7
Not answered	11,703	6.2	5,480	7.7	8,145	6.6	25,328	6.8

People, population and community - Office for National Statistics (ons.gov.uk)

If data is available insert a breakdown of the Religion or Belief (or non-belief) of those affected. This data can be recorded in table or free text format.

If no information is available, please state that here, including how you plan to address any

Patient data

Wider research suggests that in better treating and understanding service users religious and cultural needs can contribute to their wellbeing and has been seen to reduce Length of Stay in hospital.

Research indicates that higher levels of religious belief and practice (known in social science as "Religiosity") is associated with better mental health. In particular, the research suggests that higher levels of religiosity are linked with lower rates of depression, anxiety, substance misuse, and suicidal behaviour.
Religiosity is also linked with better physical health and subjective well-being.
Religion and Mental Health: What Is the Link? | Psychology Today

National Population Data

identified data gaps in the future.	According to wellbeing Wales 2022, for the first time in Wales (2018 to 2020), the proportion of the population stating they had no religion (49.9%) was higher than the proportion identifying as Christian (45.8%), though these figures varied by region. 1.7% of the population identified as Muslim and 2.4% identified with another religion (apart from Christian). A more equal Wales [HTML] | GOV.WALES

Location	No Religion	Christian	Buddhist	Hindu	Jewish	Muslim	Sikh	Other Religion	Religion Not Stated
All Wales	982,997	1,763,299	9,117	10,434	2,064	45,950	2,962	12,705	233,928

Data Viewer - Nomis - Official Census and Labour Market Statistics (nomisweb.co.uk)

Local Population Data

This table provides information that classifies usual residents by religion in the Hywel dda footprint as at census day, 27 March 2011.

Location	No Religion	Christian	Buddhist	Hindu	Jewish	Muslim	Sikh	Other Religion	Religion Not Stated
Pembrokeshire	33,442	77,162	422	230	50	425	36	648	10,024
Carmarthenshire	53,036	113,534	420	351	82	625	125	945	14,659
Ceredigion	23,329	43,981	355	197	64	521	30	742	6,703

Data Viewer - Nomis - Official Census and Labour Market Statistics (nomisweb.co.uk)

Service User Data

No data is collected by the service around this protected characteristic.

Insert breakdown of Religion or Belief (or non-belief) of staff affected by your specific service/area of work. If no information is available, please state that here including how you plan to address any	**Staff data** **Workforce Data** **Hywel Dda Health Board Workforce Data** Conclusions following the analysis of data in the Annual Workforce Equality report shows that Compared to 31st March 2020 the percentage of staff identifying as having a specific religion or belief has risen by 3.55% as of 31st March 2021. The percentage of staff choosing not to disclose this information has fallen by 0.35%. The percentage of staff identifying as having other religious belief has also risen by 0.80% for the reporting period. The workforce profile of Hywel Dda shows, around 41% are Christian, 24% would be of other religion, around 19% preferred not to say. 16% of the workforce are not recorded on ESR which has fallen by 4% in the recording period, 1,994 employees do not have their religious belief recorded on ESR which makes drawing a conclusion on the data more difficult.

identified data gaps in the future.

	Headcount	%
Atheism	1,673	13.36%
Buddhism	49	0.39%
Christianity	5,141	41.04%
Hinduism	62	0.49%
Islam	114	0.91%
Judaism	4	0.03%
Sikhism	2	0.02%
Other	1,150	9.18%
I Do Not wish To Disclose My Religion/Belief	2,337	18.66%
Not Recorded on ESR	1,994	15.92%
Total	12,526	100%

Annual Workforce Equality Report 2020-21 Final Version for Board 23.8.21.pptx (sharepoint.com)

Mental Health and Learning Disabilities Workforce Data

Clinical Care Group level data closely mirrors that of the health board data profile with the highest recorded religion as Christianity (35.9%) with a higher percentage (19.3%) of staff not wishing to disclose their religion or belief.

Religious Belief	Headcount	%
Atheism	273	21.7%
Buddhism	5	0.4%
Christianity	452	35.9%
Hinduism	7	0.6%
I do not wish to disclose my religion/belief	243	19.3%
Islam	16	1.3%
Judaism	2	0.2%
Other	148	11.8%
Unspecified	*113*	*9.0%*
Grand Total	**1,259**	**100.0%**

Source: Internal Mental Health and Learning Disability Reporting.

<table>
<tr><td rowspan="1">Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.</td><td>Negative Impact</td><td>Opportunities for improvement / mitigation</td></tr>
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Service User Impact

No greater or lesser impact on Religion or Belief. The service has been developed to ensure the Health Board operates in line with equality and human rights legislation which the following policy acknowledges: Equality, Diversity and Inclusion Policy.

The service does not discriminate and is available to anyone regardless of their religion or belief. Anybody entering the service will receive the same standard of care. The health Boards Chaplaincy service supports patients, staff and visitors and respects people of all religions and cultural beliefs as well as those who have no faith.

No impact is foreseen for individuals under 18yrs old regardless of their religion or belief as there are no proposed changes to the existing age appropriate S136 provision.

No impact is foreseen for individuals 18yrs+ regardless of their religion or belief in Carmarthenshire as the proposal is to deliver S136 provisions in Carmarthenshire.

No greater or lesser impact on Pembrokeshire and Ceredigion individuals 18yrs+ regardless of their religion or belief is foreseen. Individuals who require S136 services will still receive them, however these will be delivered in an alternative location.

Workforce Impact</td></tr>
</table>

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

	No greater or lesser impact on religion or belief is foreseen. All health board staff receive induction training that informs diversity and inclusion. Anybody entering the service will receive the same standard of care regardless of their religion or belief. Positive actions identified in the annual equality report highlight the following: The health board publishes a Celebrating diversity calendar which 10,000+ members of health board staff, new recruits and volunteers receive. It is used proactively to celebrate key dates including religious festivals and non-religious awareness days. The organisational development team introduced a programme of reverse monitoring for Board and executive Team members. Each of these actions drive forward the commitment to promote equality, diversity and inclusion in the workplace and is evidence of the commitment to the strategic Equality Plan objectives- leadership by all. The Advisory Group and network participated in a national conference on workplace Equality and are using this learning to stimulate local actions. The health board is committed to improving how they support people of all faiths and improving recruitment and retention around those with a wide range of cultural or religious beliefs.

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy impact on Sex Consider whether those affected are mostly male or female and where it applies to both equally does it affect one differently to the other?	**Positive**	
	Negative	
	No Impact	√

Guidance

Remove population data if not relevant to EqIA.

Population Data

County	Carms		Cere		Pembs		Total	
Gender	Value	%	Value	%	Value	%	Value	%
All persons	187,897	100	71,475	100	123,360	100	382,732	100.0
Male	91,685	48.8	34,963	48.9	60,071	48.7	186,719	48.8
Female	96,212	51.2	36,512	51.1	63,289	51.3	196,013	51.2

People, population and community - Office for National Statistics (ons.gov.uk)

If data is available insert a breakdown of the Sex of those affected. This data can be recorded in table or free text format.

If no information is available, please state that here, including how you plan to address any identified data gaps in the future.

Patient data

Service User Impact

The latest population estimates for the West Wales region are 389,719 for mid-2020, which is an increase of 1.34% since the 2017 population assessment. This comprises of 191,368 males (49.1%) and 198,351 females (50.9%).

The registered practice populations for Carmarthenshire, Pembrokeshire and Ceredigion reflect that the Hywel Dda population is around 50% male and 50% female, as seen in the tables below:

The number of detentions for Q2,3,4 2024 and Q1 2025 comprised of 160 detentions, 43% Male, 57% Female.

Registered practice populations as of 31st March 2022:

Carmarthenshire		
	Male	**Female**
Age 18-64	52273	52540
Over 65	20390	23122
Total	**72663**	**75662**
%	**49%**	**51%**

Pembrokeshire		
	Male	**Female**
Age 18-64	34248	33917
Over 65	14683	16587
Total	**48931**	**50504**
%	**49%**	**51%**

Ceredigion		
	Male	**Female**
Age 18-64	27888	26655
Over 65	11234	12416
Total	**39122**	**39071**
%	**50.04%**	**49.96%**

Insert breakdown of the Sex of staff affected by your specific service/area of work.

If no information is available, please state that here including how you plan to address any identified data gaps in the future.

Staff data

Workforce Impact

Around 50% of the Hywel Dda population are male and 50% female. This is significantly different from the health board workforce profile being 78% female and 22% male. However, the health board profile mirrors the national trend of the majority of the NHS workforce being female.

	Headcount	%
Female	9,726	77.65%
Male	2,800	22.35%
Total	12,526	100%

Clinical Care Group level data closely mirrors that of the wider Health board workforce profile with 76% of the workforce being female.

Gender	Headcount	%
Female	966	76.7%

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Male	293	23.3%	
Grand Total	1,259	100.0%	

Source MH&LD Internal reporting

<table>
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No impact is foreseen for individuals under 18yrs old as there are no proposed changes to the existing age appropriate S136 provision.

No impact is foreseen for individuals 18yrs+, regardless of sex, in Carmarthenshire as the proposal is to deliver S136 provisions in Carmarthenshire.

No greater or lesser impact on Pembrokeshire and Ceredigion individuals 18yrs+, regardless of sex, is foreseen. Individuals who require S136 services will still receive them, however these will be delivered in an alternative location.

The procedure promotes multi-agency consistency in the risk assessment, reporting and response processes when service users go missing from services provided by the mental health and learning disability Clinical Care Group and has been developed in line with equality and human rights legislation which the following policy acknowledges Equality, Diversity and Inclusion Policy.

<u>Workforce Impact</u></td></tr>
</table>

	No greater or lesser impact on gender is foreseen. As part of the annual Workforce equality Report, the health board identifies the following as key actions: • Improvement around recruitment and attract males and females in 'Non-traditional posts' • Improve promotion around flexible working options including part time • Review employee relations cases for trends to identify any future action which may need to be taken • Produce Pay gender gap report to identify disparities and help work towards mitigating them

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy impact on Sexual Orientation Whether a person's sexual attraction is towards their own sex, the opposite sex or either.	**Positive**	
	Negative	
	No Impact	√

Guidance

Remove population data if not relevant to EqIA.

Population Data

	County							
	Carms		**Ceredigion**		**Pembs**		**Totals**	
Sexual Orientation	Value	%	Value	%	Value	%	Value	%
Total: All usual residents aged 16 years and over	155,485	100	61,390	100	102,550	100	319,425	100.0
Straight or Heterosexual	139,511	89.7	51,998	84.7	92,094	89.8	283,603	88.1
Gay or Lesbian	1,845	1.2	941	1.5	1,093	1.1	3,879	1.3
Bisexual	1,500	1.0	1,617	2.6	1,050	1	4,167	1.5
Pansexual	120	0.1	150	0.2	80	0.1	350	0.2
Asexual	79	0.1	140	0.2	52	0.1	271	0.1
Queer	23	0.0	49	0.1	12	0	84	0.0
All other sexual orientations	100	0.1	90	0.1	75	0.1	265	0.1

People, population and community - Office for National Statistics (ons.gov.uk)

If data is available insert a breakdown of the Sexual Orientation of those affected. This data can be recorded in table or free text format.

If no information is available, please state that here, including how you plan to address any identified data gaps in the future.

Patient data

Mental health problems such as depression, self-harm, alcohol and drug abuse and suicidal thoughts can affect anyone, but they're more common among people who are LGBTIQ+. things LGBTIQ+ people go through can affect their mental health, such as discrimination, homophobia or transphobia, social isolation, rejection, and difficult experiences of coming out.

LGBTIQ+ people: statistics | Mental Health Foundation

The latest National Survey for Wales results available (2019-20) indicate that people who are lesbian, gay, or bisexual are about twice as likely to report feeling lonely (particularly emotional loneliness) than others. They are also more likely to report having experienced discrimination at work.

Sexual orientation was judged to be a motivating factor in 884 hate crimes recorded by police in Wales in 2020-21, which is up 16% from 763 in 2019-20 reporting period. This represents 19% of all recorded hate crimes, the same proportion as in the previous year.
Wellbeing of Wales, 2022 | GOV.WALES

National Population Data

	The number of people in Wales who identify as lesbian, gay, or bisexual, or who chose not to identify as straight (heterosexual) are rising, with same-sex marriages now much more common than same-sex civil partnerships. In 2020, 94.3% of the population of Wales identified as heterosexual, with 4.2% identifying as gay or lesbian, bisexual or another sexuality which has doubled since 2016. Wellbeing of Wales, 2022 | GOV.WALES **Local Population Data** Although survey-based estimates at national level are regularly published, there is currently no reliable data on sexual orientation at a local level. A White paper was presented to parliament in 2018 which outlined the proposal from the Office for National Statistics to collect information on sexual orientation in the Census 2021 to meet the needs for better equality monitoring. ONS research and consultation showed a clear need for information on sexual orientation, to support work on policy development and service provision and to allow local authorities to meet and monitor their requirements under the Equality Act 2010. **Service User Data** No data is collected by the service around this protected characteristic.
Insert breakdown of the Sexual Orientation of staff affected by your specific service/area of work. If no information is available, please state that here including how you plan to address any identified data gaps in the future.	**Staff data** **Workforce Data** **Hywel Dda Health Board Workforce Data** Compared to the 31st March 2020, the percentage of staff identifying as bisexual has decreased by 0.38%. The percentage of staff identifying as gay, or lesbian has increased by 0.15% as of 31st March 2021.The percentage of staff identifying as heterosexual or straight has increased by 4.88% for the reporting period. The percentage of staff choosing not to disclose this information has increased by 1.30%. Those staff whose records are not recorded on ESR has fallen by 4.03%. A total of 16% of the workforce are not recorded on ESR which makes drawing a conclusion on the data more difficult. **Mental Health and Learning Disabilities Workforce Data**

Sexual Orientation	Headcount	%
Bisexual	13	1.0%
Gay or Lesbian	21	1.7%
Heterosexual or straight	979	77.8%
Not stated (person asked but declined to provide a response)	127	10.1%
Other sexual orientation not listed	4	0.3%
Undecided	2	0.2%
Unspecified	*113*	*9.0%*
Grand Total	**1,259**	**100.0%**

Source: Internal Mental Health and Learning Disability Reporting.

Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.	**Negative Impact** • • •	**Opportunities for improvement / mitigation** • • •
Provide a summary of the positive impacts you have identified.	**Positive Impact** • • •	
If you have determined no impact, please provide a brief explanation.	**No Impact** **Service User Impact** No impact is foreseen for individuals under 18yrs old regardless of sexual orientation as there are no proposed changes to the existing age appropriate S136 provision.	

	No impact is foreseen for individuals 18yrs+ regardless of sexual orientation in Carmarthenshire as the proposal is to deliver S136 provisions in Carmarthenshire. No greater or lesser impact on Pembrokeshire and Ceredigion individuals 18yrs+ regardless of sexual orientation is foreseen. Individuals who require S136 services will still receive them, however these will be delivered in an alternative location. The service has been developed to ensure the Health Board operates in line with equality and human rights legislation which the following policy acknowledges Equality, Diversity and Inclusion Policy. **Workforce Impact** No greater or lesser impact on sexual orientation foreseen. The Health Board has a policy regarding Equality and Diversity Policy and all staff complete mandatory training during their induction which includes 'Treat Me Fairly' - This course will help staff to recognise the value of their contribution in providing an excellent standard of service that is fair and meets individual needs whist treating everyone with dignity and respect. Other Health Board training available includes: ▪ Equality & Diversity Awareness and Unconscious Bias (Diverse Cymru) ▪ Introduction to Allyship, Delivering Inclusive Services & Allies Programme Parts 1 & 2 (Stonewall Cymru) Additionally, as part of the Annual Workforce Equality Report positive actions highlighted • Subscription fees to the Stonewall Cymru Diversity Champions Programme • Continue to support the health boards LGBTQ+ staff Network- ENFYS • Specialist consultancy sessions from Stonewall

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy impact on Armed Forces Consider members of the Armed Forces and their families, whose health needs may be impacted long after they have left the Armed Forces and returned to civilian life. Also consider their unique experiences when accessing and using day-to-day public and private services compared to the general population. It could be through 'unfamiliarity with civilian life, or frequent moves around the country and the subsequent difficulties in maintaining support networks, for example, members of the Armed Forces can find accessing such goods and services challenging.' For a comprehensive guide to the Armed Forces Covenant Duty and supporting resource please see: **Armed-Forces-Covenant-duty-statutory-guidance**	**Positive**	
	Negative	
	No Impact	√

Guidance Remove population data if not relevant to EqIA.	**Population Data**

	Carmarthenshire (%)	Pembrokeshire (%)	Ceredigion (%)	Hywel Dda (%)
Regular	3.6	4.5	3	3.7
Reserve	0.9	0.9	0.9	0.9
Both	0.2	0.2	0.2	0.2
Total	4.7	5.7	4.1	4.8

People, population and community - Office for National Statistics (ons.gov.uk)

If data is available insert evidence of what proportion of those affected are members of the Armed Forces Community. This data can be recorded in table or free text format. If no information is available, please state that here, including how you plan to address any	**Patient data** **No known data available**

<table>
<tr><td>identified data gaps in the future.</td><td colspan="2"></td></tr>
<tr><td>Insert data to show the proportion of staff affected by your specific service/area of work that are a member of the Armed Forces community. If no information is available, please state that here including how you plan to address any identified data gaps in the future.</td><td colspan="2">Staff data

No known data available</td></tr>
<tr><td>Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.</td><td>Negative Impact
•
•
•</td><td>Opportunities for improvement / mitigation
•
•
•</td></tr>
<tr><td>Provide a summary of the positive impacts you have identified.</td><td colspan="2">Positive Impact
•
•
•</td></tr>
</table>

If you have determined no impact, please provide a brief explanation.	**No Impact** No impact is foreseen for individuals under 18yrs old with this characteristic as there are no proposed changes to the existing age appropriate S136 provision. No impact is foreseen for individuals 18yrs+ with this characteristic in Carmarthenshire as the proposal is to deliver S136 provisions in Carmarthenshire. No greater or lesser impact on Pembrokeshire and Ceredigion individuals 18yrs+ with this characteristic is foreseen. Individuals who require S136 services will still receive them, however these will be delivered in an alternative location.

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Socio-economic Deprivation Consider those on low income, economically inactive, unemployed or unable to work due to ill-health. Also consider people living in areas known to exhibit poor economic and/or health indicators and individuals who are unable to access services and facilities. Food/ fuel poverty and personal or household debt should also be considered. For a comprehensive guide to the Socio-Economic Duty in Wales and supporting resource please see: **https://gov.wales/more-equal-wales-socio-economic-duty**	**Positive**	
	Negative	√
	No Impact	

Guidance

Remove population data if not relevant to EqIA.

Population Data

	County							
	Carms		Ceredigion		Pembs		Hywel Dda	
Economic Factor	Value	%	Value	%	Value	%	Total value	%
Economically active – In employment (this includes full time students)	81,952	52.7	30,119	49.1	52,765	51.5	164,836	51.1
Economically active - Unemployed	3,922	2.5	1,845	3	2,769	2.7	8,536	2.73
Economically inactive	69,613	44.8	29,428	47.9	47,017	45.8	146,058	46.16

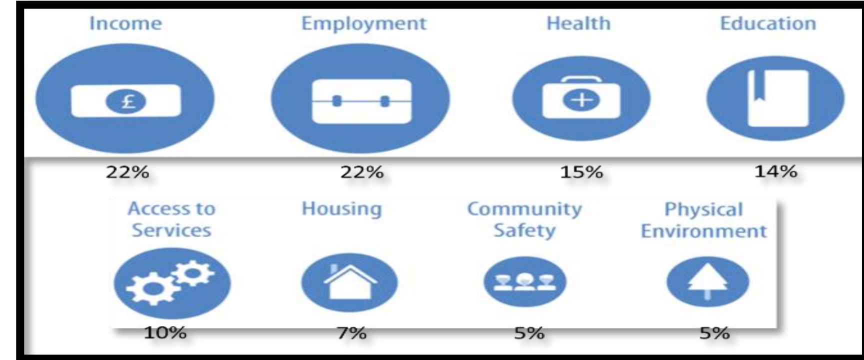
In its vast majority, Carmarthenshire, Pembrokeshire and Ceredigion areas have been ranked 'least deprived' or as second 'least deprived' in Wales. There are a number of areas identified as being nearer 'most deprived', which are concentrated around Pembroke, Pembroke Dock, Milford, Cardigan, Llanelli and Kidwelly.
(Welsh Index of Multiple Deprivation 2019).
Welsh Index of Multiple Deprivation (WIMD) 2019: results report (gov.wales)

If data is available insert evidence of what proportion of those that are affected are experiencing socio-economic deprivation. This data can be recorded in

Patient data

According to The British Journal of Psychiatry (2006), individuals in lower socio-economic groups have an increased prevalence of common mental disorders. The Welsh Government in its strategy "Together for Mental Health" drew upon research which indicates that many mental health problems start in early life, often as a result of deprivation including poverty, insecure attachments, trauma, loss, or abuse. Those affected often have fewer qualifications, find it harder to both obtain and stay in work, have lower incomes and are more likely to be homeless or poorly housed.

As defined by the Welsh Index of Multiple Deprivation (WIMD) there are 8 types of deprivation.

table or free text format. If no information is available, please state that here, including how you plan to address any identified data gaps in the future.	 Out of the most deprived lower output areas within Wales, 12% of these, fall within the Hywel Dda Area: Tyisha, Llanelli Pembroke Dock Glanymor Haverfordwest: Garth Bigyn, Llanelli Pembroke: Monkton Cardigan Llwynhendy, Llanelli Due to the rurality of Hywel Dda, people are more likely to suffer from poor: ▪ Access to services ▪ Digital infrastructure ▪ Fuel Poverty Many of the people in the 18-64 age group are healthy adults, however, within this population there are considerable numbers with significant health concerns or physical disabilities, exacerbated by socio and economic risk factors that have a negative impact on their health and therefore on demand for services.
Insert data to show the proportion of staff affected by your specific service/area of work that are	**Staff data** **Workforce Data** Data in relation to this protected characteristic is not captured at health board, Clinical Care Group, or service level.

<table>
<tr><td>experiencing socio-economic deprivation. If no information is available, please state that here including how you plan to address any identified data gaps in the future.</td><td colspan="2"></td></tr>
<tr><td>Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.</td><td>Negative Impact
Service Users/carers/family support

It is perceived that there will be a negative impact due to the potential additional distance to travel home in scenarios where admission is not required following assessment for individuals in Ceredigion and Pembrokeshire.

.</td><td>Opportunities for improvement / mitigation

Admission/access to beds process not impacted by proposed change to S136 provision.
Service Level Agreement in place with St Johns Ambulance Service to support in the transportation in situations where no alternative is available.</td></tr>
<tr><td>Provide a summary of the positive impacts you have identified.</td><td colspan="2">Positive Impact</td></tr>
<tr><td>If you have determined no impact, please provide a brief explanation.</td><td colspan="2">No Impact
Workforce
No greater or lesser impact identified. Any issues or challenges identified will be monitored and supported on an individual basis through Supervisions and PADR processes.</td></tr>
</table>

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

<table>
<tr><td colspan="2">Welsh Language
Please note opportunities for persons to use the Welsh language and treating the Welsh language no less favourably than the English language.</td><td>Positive
Negative
No Impact</td><td>

√</td></tr>
<tr><td>Guidance

Remove population data if not relevant to EqIA.</td><td colspan="3">Population Data

According to Welsh Census 2022 data, it is estimated that 45% of people aged three or older had some level of Welsh language skills. This figure equates to around 172,000 people.

Definition of whether a person has Welsh language skills (as recorded in the Census 2022).

If a person can or does do any of the following:
Understand spoken Welsh
Speak Welsh
Read Welsh
Write Welsh
<table><tr><th>Area</th><th>Percentage of people who can speak Welsh</th></tr><tr><td>Carmarthenshire</td><td>53.3</td></tr><tr><td>Pembrokeshire</td><td>25.2</td></tr><tr><td>Ceredigion</td><td>56.4</td></tr><tr><td>Hywel Dda</td><td>45</td></tr></table>People, population and community - Office for National Statistics (ons.gov.uk)</td></tr>
<tr><td>If data is available insert evidence of what proportion of those that are affected use the Welsh Language.</td><td colspan="3">Patient data

During a CTLD caseload data collection exercise carried out in October 2021, information for all service users supported by the 4 CTLDs was collated and analysed. This included culture/ethnic origin (English/Welsh speakers).
For, approximately 5% of individuals on CTLD caseloads, the preferred language was Welsh.</td></tr>
</table>

This data can be recorded in table or free text format. If no information is available, please state that here, including how you plan to address any identified data gaps in the future.	
If data is available insert evidence of what proportion of staff affected by your specific service/area of work use the Welsh Language. This data can be recorded in table or free text format. If no information is available, please state that here including how you plan to address any identified data gaps in the future.	**Staff data** **Hywel Dda Workforce Welsh Language:** (see table below) The Welsh Language User Survey 2018 reported that 46% of the population of Hywel Dda were able to speak Welsh. The workforce data above shows us that 26% of the workforce have skills at intermediate level or higher and 31% of the workforce do not speak Welsh.

Staff Group	0 - No eSkills	1 - Entry	2 - Foundation	3 - Intermediate	4 - Higher	5 - Proficiency	Not recorded on ESR	Grand Total
Add Prof Scientific and Technic	113	92	34	19	40	78	14	390
Additional Clinical Services	824	691	267	262	261	359	369	3,033
Administrative and Clerical	603	649	222	203	183	182	139	2,181
Allied Health Professionals	205	178	72	44	64	92	35	690
Estates and Ancillary	460	290	120	104	108	200	231	1,513
Healthcare Scientists	55	42	15	13	30	29	10	194
Medical and Dental	375	83	22	14	6	22	465	987
Nursing and Midwifery Registered	1,212	765	339	268	279	427	247	3,537
Students	0	0	0	0	0	1	0	1
Grand Total	3,847	2,790	1,901	927	971	1,390	1,510	12,526
%	31%	22%	9%	7%	8%	11%	12%	100%

<table>
<tr><td>Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.</td><td>Negative Impact
•
•</td><td>Opportunities for improvement / mitigation
•
•
•</td></tr>
<tr><td>Provide a summary of the positive impacts you have identified.</td><td colspan="2">Positive Impact
•
•
•</td></tr>
<tr><td>If you have determined no impact, please provide a brief explanation.</td><td colspan="2">No Impact
No impact is foreseen. However, where an individual’s preferred language is Welsh, every effort will be made to allocate a Welsh speaking member of staff to their care.

Any documentation issued to patients and carers will continue to be bilingual in both Welsh and English.

This will be reviewed, and any new or additional information will be considered.

As the changes being made to the service model will not be outside the remit of current roles and responsibilities, there will be no impact to staff on a basis of their ability to speak Welsh or not
This will be reviewed, and any new or additional information will be considered.</td></tr>
</table>

Additional considerations

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

In addition to the above protected characteristics please consider impact on the following:

- **Vulnerable groups (homeless and vulnerably housed, Gypsy, Roma and Travellers, Refugees, Asylum Seekers)**
- **Unpaid Carers**
- **Individuals and communities who experience Digital Exclusion**
- **Rural and Urban communities**

Negative Impact **Service Users/carers/family support**	**Opportunities for improvement / mitigation**
It is perceived that there will be a negative impact due to the potential additional distance to travel home in scenarios where admission is not required following assessment for individuals in Ceredigion and Pembrokeshire.	Admission/access to beds process not impacted by proposed change to S136 provision. Service Level Agreement in place with St Johns Ambulance Service to support in the transportation in situations where no alternative is available.

Intersectionality

It is important to consider breaking the analysis down by more than one protected characteristic. This is often referred to as 'intersectionality'. Many people will have more than one protected characteristic and, certain aspects of who we are, for example, our race, gender, faith and socio-economic status can increase our positive experiences or contribute to negative experiences, made worse by the combined effects of multiple discrimination, barriers and challenges.

Example: The experiences of a Muslim woman will differ from that of a Muslim man and of a non-Muslim woman. An EqIA may separately identify impacts for Muslim people under Religion or Belief and the impacts for men and women under Sex, but it is also important to recognise that the combined impacts could be very different for a Muslim woman compared to a Muslim man or a non-Muslim woman.

Have you identified any specific additional impacts regarding intersectionality e.g., age and sex, disability and sexual orientation? No

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Section 4: Assessment of Scale of Impact

This section requires you to assign a score to the evidence gathered and potential impact identified above. Once this score has been assigned the Decision column will assist in identifying the areas of highest risk, which will allow appropriate prioritisation of any mitigating action required.
(Scoring Chart A x Scoring Chart B = Scoring Chart C)

Scoring Chart A: Evidence Available	
3	Existing data/research
2	Anecdotal/awareness data only
1	No evidence or suggestion

Scoring Chart B: Potential Impact	
-3	High negative
-2	Medium negative
-1	Low negative
0	No impact
+1	Low positive
+2	Medium positive
+3	High Positive

Scoring Chart C: Impact	
-6 to -9	High Impact (H)
-3 to -5	Medium Impact (M)
-1 to -2	Low Impact (L)
0	No Impact (N)
1 to 9	Positive Impact (P)

Protected Characteristic	Scoring Chart A Evidence: Existing Information to suggest some groups affected.	Scoring Chart B Potential Impact: Nature, profile, scale, cost, numbers affected, significance. Insert one overall score	Scoring Chart C Decision: Multiply 'evidence' score by 'potential impact' score.
Age	**3**	**0**	**0**
Disability	**1**	**0**	**0**
Gender Reassignment	**1**	**0**	**0**
Marriage and Civil Partnership	**2**	**0**	**0**
Pregnancy and Maternity	**1**	**0**	**0**
Race/Ethnicity or Nationality	**1**	**0**	**0**
Religion or Belief	**1**	**0**	**0**
Sex	**1**	**0**	**0**

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Sexual Orientation	**1**	**0**	**0**
Armed Forces	**1**	**0**	**0**
Socio-Economic Deprivation	**1**	**-2**	**-2**
Welsh Language	**1**	**0**	**0**

Section 5: Outcome and Actions
This section should be used to detail and monitor any actions identified in sections 1-4.

Will the procedure/ proposal/ project/ policy be adopted? **If no, please give reasons and any alternative action(s) agreed.**	Yes
If a negative impact cannot be mitigated and it is proposed that HDUHB move forward with the plan/ project/ proposal regardless, please provide your justification for this.	N/A

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

	Actions • Some actions have been populated for further elaboration, please delete as appropriate and add any additional actions identified. • Include any remedial changes that have been made to reduce or eliminate the effects of potential or actual negative impact, as well as any arrangements to collect data or undertake further research.	**Assigned to**	**Target Review Date**	**Completion Date**	**Comments/ Update**
1.					
2.					
3.					
4.					
5.					
6.					

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

<table>
<tr><td rowspan="5">EqIA Completed by:</td><td>Name/s</td><td>Sophie Rees</td></tr>
<tr><td>Title</td><td>Service Improvement Support Manager</td></tr>
<tr><td>Team / Division</td><td>Service Transformation and Partnerships</td></tr>
<tr><td>Contact details</td><td>Sophie.rees12@wales.nhs.uk</td></tr>
<tr><td>Date</td><td>14th November 2024</td></tr>
<tr><td rowspan="5">EqIA Authorised by/Owned by:
Usually the Clinical Care Group lead would be the owner of the procedure/ proposal/ project/ policy
Responsible for the accuracy of the data captured in this EqIA as well as progressing any actions recorded in Section 5</td><td>Name</td><td>Rebecca Temple-Purcell</td></tr>
<tr><td>Title</td><td>Assistant Director of Nursing, Patient Safety, Quality and Experience, MH & LD</td></tr>
<tr><td>Team / Division</td><td>MH&LD</td></tr>
<tr><td>Contact details</td><td>Rebecca.Temple-Purcell@wales.nhs.uk</td></tr>
<tr><td>Date</td><td></td></tr>
<tr><td rowspan="4">Screening Approved at MH&LD IGG CCG BPPP:</td><td>Name</td><td>E. Carroll
Liz Carroll</td></tr>
<tr><td>Title</td><td>Service Director, MHLD</td></tr>
<tr><td>Team / Division</td><td>Liz.Carroll@wales.nhs.uk</td></tr>
<tr><td>Contact details</td><td>01.07.2025</td></tr>
<tr><td rowspan="5">Guidance has been provided by Diversity & Inclusion Team:</td><td>Name</td><td>Alan Winter</td></tr>
<tr><td>Title</td><td>Senior Diversity and Inclusion Officer</td></tr>
<tr><td>Team</td><td>Strategic Partnership Diversity & Inclusion</td></tr>
<tr><td>Contact details</td><td>Alan.Winter@wales.nhs.uk</td></tr>
<tr><td>Date</td><td>16/7/2025</td></tr>
<tr><td>Diversity and Inclusion Team additional Comments:</td><td colspan="2"></td></tr>
</table>

Please note: The D&I team will save a copy of the completed form for reference. If any changes are made after the date of review, it is the Clinical Care Group's responsibility to update the EqIA and inform the D&I team.

S136 Options Appraisal

27th June 2027

Option 1 – Do Nothing - Maintain S136 services as is

- 1 X age-appropriate suite, Morlais Ward, Carmarthen
- 1 X adult S136 suite, Bryngofal Ward, Llanelli
- 1 X adult alternative/community place of safety, Gorwelion, Aberystwyth (Remove temporary closure arrangement and reopen)
- 1 X adult S136 suite, St Caradog, Pembrokeshire (Remove temporary arrangement and reopen)

Benefits	Benefit Category
An adult S136 suite available in each Local Authority area ensures equitable access to S136 suites for all patients regardless of where they reside, promoting equality and consistent support across diverse communities.	Patient Benefit
An adult S136 suite available in each Local Authority area enhances timely access to mental health assessment and treatment, through providing services based closer to home, and therefore quicker to get to.	Patient Benefit Clinical Benefit
An adult S136 suite available in each Local Authority area reduces travel and resource time for Police and Local Authority partners, streamlining operations and promoting efficient use of resources.	Financial Benefit Staff Benefit
An adult S136 suite available in each Local Authority area reduces travel time home for patients who are not admitted to hospital and makes it easier for carers/family to provide support.	Patient & Family/Carer Benefit

Risks	Risk Category
There is a risk to safety and business continuity due to the environment and staffing model in the adult alternative/community place of Safety in Gorwelion, as this facility does not meet the standards defined through the professional guidance and has limited back up services and additional staff resources due to the geographical location of the facility.	Quality & Safety Service Sustainability
There is a risk to service capacity, delivery, and business continuity due to the staffing model in the adult alternative/community place of safety in Gorwelion, as this facility is staffed utilising the existing Crisis Team which impacts their service capacity and delivery.	Quality & Safety Patient Experience Service Sustainability
There is a risk to service delivery and business continuity due to the staffing challenges in the adult alternative/community place of safety in Gorwelion a this means that the facility is often closed, especially overnight providing an inconsistent service provision.	Quality & Safety Patient Experience Service Sustainability

Option 1 – Do Nothing - Maintain S136 services as is

Risks	Risk Category
There are health and safety risks to patients and staff highlighted in the H&S review which could not be mitigated without the temporary closure of the adult alternative/community place of safety and the relocation of the age appropriate S136 suite on Morlais Ward.	• Quality & Safety • Patient experience • Service Sustainability
There is a risk to service capacity, delivery, and business continuity by reinstating the adult S136 suite on St Caradog ward, Pembrokeshire, which will result in the loss of 1X inpatient surge bed.	• Quality & Safety • Service Sustainability
There is a risk to service delivery and business continuity due to the staffing challenges in St Caradog, Pembrokeshire, as this meant the facility was often closed providing an inconsistent service provision which resulted in its temporary closure. Its not been possible to sustain this service to date and is unlike possible to sustain in future.	• Service Sustainability • Quality & Safety • Patient Experience
There is a risk to service sustainability and financial sustainability as the absence of a staffing budget for the S136 suites necessitates reliance on bank and/or agency staffing.	• Finance • Service Sustainability

Risks	Risk Category
The use of agency Health Care Support Workers (HCSW's) poses a quality and assurance risk due to their lack of a professional registration.	• Quality & Safety
The recruitment and management of HCSW's through bank/agency raises concerns in ensuring adequate training and qualifications to support in a S136 suite.	• Quality & Safety
The continued use of agency HCSW's to support S136 suites poses a reputational risk given the national stance advocating the removal of this.	• Reputational
There is a risk associated with the need to identify capital funding for the required work, posing potential challenges to project financial planning and successful implementation.	• Finance • Service Sustainability
Implementation of RCRP phase 3 will change the transportation of patients on S136. Alternative transportation will need to be considered and will impact on patient waiting/travelling times. Police may still be required for transport due to violence/aggression, or to follow another vehicle.	• Service Sustainability • Patient Experience • Finance

Option 1 – Do Nothing - Maintain S136 services as is

Recurrent Costs

To sustain 1 X S136 suite (24/7) for one individual would require a staffing establishment of 11.2 Whole Time Equivalent (WTE) Band 3 Health Care Support Worker (HCSW). Please note there are no additional staffing costs for age-appropriate S136 on Morlais Ward.

Therefore, staffing costs for Option 1 would require a staffing establishment of 33.6 WTE staff Per Annum as set out in the table below.

Site	Staff	**Unit Cost (1 WTE)** (Top of scale)	**WTE**	**1 X S136 (24/7)** Full Year Effect
Bryngofal Ward, Llanelli	Band 3 HCSW	£38,408	11.2	£430,170
St. Caradog Ward, Pembrokeshire	Band 3 HCSW	£38,408	11.2	£430,170
Gorwelion, Ceredigion	Band 3 HCSW	£38,408	11.2	£430,170
			Total	£1,290,510

Capital Costs	
Morlais Ward, Carmarthen	£22,000
Bryngofal Ward, Llanelli	£0
St Caradog Ward, Pembrokeshire	TBC
Gorwellion, Ceredigion	TBC
Total	

Recurrent Costs + Capital Costs = £

(Figures are inclusive of 26.92% enhanced hours and Headroom)

Option 2- A single site S136 Suite, Bryngofal, Llanelli

- 1 X adult single site, S136 suite in Bryngofal Ward, Llanelli.
- Maintain age appropriate S136 suite on Morlais Ward, Carmarthen.
- Permanent closure of adult alternative/community place of safety in Gorwelion, Ceredigion.
- Permanent closure of adult S136 suite on St Caradog Ward, Pembrokeshire.

Benefits	Benefit Category
A single site, adult S136 suite in Llanelli will decrease the required Staffing costs by the health board.	Financial Benefit
A single site adult S136 suite on Bryngofal offers the benefit of enhanced staff safety by being adjacent to a ward which provides additional backup resources e.g. contingency for urgent situations such as RPI, BLS and to facilitate staff breaks.	Patient Benefit Staff Benefit
A single site, adult S136 suite on Bryngofal minimises risks associated with Staffing the S136 suite with Healthcare Support Workers and addresses competencies needed in line with 'Standards on the use of Section 136 of the Mental Health Act 1983 (England and Wales)' and 'Guidance for commissioners: service provision for Section 136 of the Mental Health Act 1983'.	Patient Benefit Staff Benefit Clinical Benefit

Option 2- A single site, S136 Suite, Bryngofal, Llanelli

Risks	Risk Category	Risks	Risk Category
There is a risk to patients in Ceredigion and Pembrokeshire due to a delay in assessment caused by the need to travel to a single site, adult S136 suite in Llanelli. The delay may impede timely intervention, cause potential exacerbation of their mental health condition, increased distress, and heightened anxiety.	• Quality & Safety • Patient experience	There is a risk to service capacity and financial sustainability as a single site, adult S136 suite in Llanelli would increase travel time, resource time and costs for Police and Local Authority partners in Ceredigion and Pembrokeshire.	• Finance • Service Sustainability
There is a risk to service delivery and business continuity as the adult S136 suite on Bryngofal only has capacity to support with one individual at any one time, therefore the S136 suite may be unavailable if there is more than one S136 case.	• Quality & Safety • Patient experience • Service Sustainability	Lack of car parking spaces on site would delay the undertaking of timely assessments if visiting professionals such as doctors or AMPs are finding difficulty accessing parking.	• Patient experience
There is a risk to service sustainability and financial sustainability as there is no staffing budget for the single site, adult S136 suite on Bryngofal and Morlais Ward.	• Finance • Service Sustainability	There is a risk of increased service demand on Carmarthenshire Local Authority for Mental Health Act Assessment as a result of the adult S136 suite in their county.	• Finance • Service Sustainability
There is a risk associated with the need to identify capital funding for the required work, posing potential challenges to project financial planning and successful implementation.	• Finance • Service Sustainability	There is a risk that likely overnight closure of the MIU in Prince Philip Hospital, will impact service capacity and delivery in a single site, adult S136 suite in Llanelli.	• Patient experience • Service Sustainability
		Implementation of RCRP phase 3 will change the transportation of patients on S136. Alternative transportation will need to be considered and will impact on patient waiting/travelling times. Police may still be required for transport due to violence/aggression, or to follow another vehicle.	• Finance • Service Sustainability • Patient experience

Option 2- A single site, S136 Suite, Bryngofal, Llanelli

Capital Costs

No Capital Costs

Recurrent Costs

To sustain 1 X S136 suite (24/7) for one individual would require a staffing establishment of 11.2 Whole Time Equivalent (WTE) Band 3 Health Care Support Worker (HCSW).

Two locations would require a staffing establishment of 22.4 WTE staff Per Annum.

Site	Staff	**Unit Cost (1 WTE)** (Top of scale)	**WTE**	**1 X S136 (24/7)** Full Year Effect
Bryngofal Ward, Llanelli	Band 3 HCSW	£38,408	11.2	£430,170

(Figures are inclusive of 26.92% enhanced hours and Headroom)

Option 3 - A single site, S136 Suite, Hafan Derwen, Carmarthen

- 1 X adult single site, S136 suite on the Hafan Derwen site in Carmarthen.
- Permanent closure of adult alternative/community place of safety in Gorwelion, Ceredigion.
- Permanent closure of adult S136 suite on St Caradog Ward, Pembrokeshire.
- Permanent closure of adult S136 suite on Bryngofal.
- Maintain age-appropriate bed on Morlais ward.

Benefits	Benefit Category
A single site, adult S136 suite on the Hafan Derwen site, in Carmarthen will decrease the required Staffing costs by the health board.	Financial Benefit
A single site, adult S136 suite on the Hafan Derwen site, Carmarthen offers the benefit of enhancing staff safety by providing additional staffing resources, when required.	Financial Benefit Staff Benefit
A single site, adult S136 suite on the Hafan Derwen site, minimises risks associated with Staffing the S136 suite with Healthcare Support Workers and addresses competencies needed in line with 'Standards on the use of Section 136 of the Mental Health Act 1983 (England and Wales)' and 'Guidance for commissioners: service provision for Section 136 of the Mental Health Act 1983'.	Patient Benefit Staff Benefit Clinical Benefit
A single site, adult S136 suite in Carmarthen offers the advantage of diverting S136 cases away from Accident & Emergency departments.	Patient Benefit
Sufficient car parking spaces on site for visiting professionals such as doctors or AMPs undertaking timely assessments.	Staff Benefit
A single site, adult S136 on the Hafan Derwen Site, Carmarthen allows for 4 (per shift) Registered Mental Health Nurses to be available to provide professional oversite 24/7.	Patient Benefit Staff Benefit Clinical Benefit

Option 3 - A single site, S136 Suite, Hafan Derwen, Carmarthen

Risks	Risk Category
There is a risk to patients in Ceredigion and Pembrokeshire due to a delay in assessment caused by the need to travel to a single site, adult S136 suite in Carmarthen. The delay may impede timely intervention, cause potential exacerbation of their mental health condition, increased distress, and heightened anxiety.	Quality & Safety Patient Experience
There is a risk to service delivery and business continuity as the adult S136 suite in Carmarthen only has capacity to support with one individual at any one time, therefore the S136 suite may be unavailable if there is more than one S136 case.	Service Sustainability Quality & Safety Patient Experience
There is a risk to service sustainability and financial sustainability as there is no staffing budget for the single site, adult S136 suite in Carmarthen and age-appropriate suite on Morlais Ward.	Finance Service Sustainability

Risks	Risk Category
There is a risk to service capacity and financial sustainability as a single site, adult S136 suite in Carmarthen would increase travel time, resource time and costs for Police and Local Authority partners in Ceredigion and Pembrokeshire.	Finance Service Sustainability
There is a risk of increased service demand on Carmarthenshire Local Authority for Mental Health Act Assessment as a result of the adult S136 suite in their county.	Service Sustainability Finance
There is a risk associated with the need to identify capital funding for the required work, posing potential challenges to project financial planning and successful implementation.	Finance Service Sustainability
Implementation of RCRP phase 3 will change the transportation of patients on S136. Alternative transportation will need to be considered and will impact on patient waiting/travelling times. Police may still be required for transport due to violence/aggression, or to follow another vehicle.	Service Sustainability Patient Experience Finance

Option 3 - A single site, S136 Suite, Hafan Derwen, Carmarthen

Recurrent Costs

To sustain 1 X S136 suite (24/7) for one individual would require a staffing establishment of 11.2 Whole Time Equivalent (WTE) Band 3 Health Care Support Worker (HCSW).

Two locations would require a staffing establishment of 22.4 WTE staff Per Annum.

Site	Staff	**Unit Cost (1 WTE)** (Top of scale)	**WTE**	**1 X S136 (24/7)** Full Year Effect
Hafan Derwen, Carmarthen	Band 3 HCSW	£38,408	11.2	£430,170

Capital Costs	
Hafan Derwen, Carmarthen	£135,617

Recurrent Costs + Capital Costs = £ 565,787

(Figures are inclusive of 26.92% enhanced hours and Headroom)

Option 4 - A single site, S136 Suite, Glangwili, Carmarthen

- 1 X adult single site, S136 suite in Glangwili, Carmarthen.
- Permanent closure of adult alternative/community place of safety in Gorwelion, Ceredigion.
- Permanent closure of adult S136 suite on St Caradog Ward, Pembrokeshire.
- Permanent closure of adult S136 suite on Bryngofal.
- Relocate age appropriate S136 suite to alternative location on adjacent Morlais Ward, Carmarthen.

Benefits	Benefit Category
A single site, adult S136 suite in Glangwili, Carmarthen will decrease the required Staffing costs by the health board.	Financial Benefit
A single site, adult S136 suite in Glangwili, Carmarthen offers the benefit of enhancing staff safety by providing additional staffing resources.	Financial Benefit Staff Benefit
A single site, adult S136 suite in Glangwili, Carmarthen minimises risks associated with Staffing the S136 suite with Healthcare Support Workers and addresses competencies needed in line with 'Standards on the use of Section 136 of the Mental Health Act 1983 (England and Wales)' and 'Guidance for commissioners: service provision for Section 136 of the Mental Health Act 1983'.	Patient Benefit Staff Benefit Clinical Benefit
A single site, adult S136 suite in Carmarthen offers the advantage of diverting S136 cases away from Accident & Emergency departments.	Patient Benefit

Option 4 - A single site, S136 Suite, Glangwili, Carmarthen

Risks	Risk Category
There is a risk to patients in Ceredigion and Pembrokeshire due to a delay in assessment caused by the need to travel to a single site, adult S136 suite in Carmarthen. The delay may impede timely intervention, cause potential exacerbation of their mental health condition, increased distress, and heightened anxiety.	Quality & Safety Patient Experience
There is a risk to service delivery and business continuity as the adult S136 suite in Carmarthen only has capacity to support with one individual at any one time, therefore the S136 suite may be unavailable if there is more than one S136 case.	Service Sustainability Quality & Safety Patient Experience
There is a risk to service sustainability and financial sustainability as there is no staffing budget for the single site, adult S136 suite in Carmarthen and age-appropriate suite on Morlais Ward.	Finance Service Sustainability
There is a risk associated with the need to identify capital funding for the required work, posing potential challenges to project financial planning and successful implementation.	Finance Service Sustainability

Risks	Risk Category
There is a risk to service capacity and financial sustainability as a single site, adult S136 suite in Carmarthen would increase travel time, resource time and costs for Police and Local Authority partners in Ceredigion and Pembrokeshire.	Finance Service Sustainability
There is a risk of increased service demand on Carmarthenshire Local Authority for Mental Health Act Assessment as a result of the adult S136 suite in their county.	Service Sustainability Finance
Lack of car parking spaces on site would delay the undertaking of timely assessments if visiting professionals such as doctors or AMPs are finding difficulty accessing parking.	Patient Experience
There is a risk if Registered Mental Health Nurses are required, as would need to be directed from the Morlais Ward, and there are only 2 on duty per shift.	Patient Experience
Implementation of RCRP phase 3 will change the transportation of patients on S136. Alternative transportation will need to be considered and will impact on patient waiting/travelling times. Police may still be required for transport due to violence/aggression, or to follow another vehicle.	Service Sustainability Finance Patient Experience

Option 4 - A single site, S136 Suite, Glangwili, Carmarthen

Recurrent Costs

To sustain 1 X S136 suite (24/7) for one individual would require a staffing establishment of 11.2 Whole Time Equivalent (WTE) Band 3 Health Care Support Worker (HCSW).

Two locations would require a staffing establishment of 22.4 WTE staff Per Annum.

Site	Staff	**Unit Cost (1 WTE)** (Top of scale)	**WTE**	**1 X S136 (24/7)** Full Year Effect
Glangwili, Carmarthen	Band 3 HCSW	£38,408	11.2	£430,170

Capital Costs	
Glangwili, Carmarthen	£309,687

Recurrent Costs + Capital Costs = £739,857

(Figures are inclusive of 26.92% enhanced hours and Headroom)

Option 5 – Utilise existing Sanctuary Services

- Further develop adult and children and young people's Sanctuary services available in each Local Authority area. This would involve extending operating hours from 4 nights per week to 24/7.

Benefits	Benefit Category
A S136 suite available in each Local Authority area ensures equal access to S136 suites for all patients regardless of where they reside, promoting equality and consistent support across diverse communities.	Patient Benefit
A S136 suite available in each Local Authority area enhances timely access to mental health assessment and treatment, through providing services based closer to home, and therefore quicker to get to.	Patient Benefit Clinical Benefit
A S136 suite available in each Local Authority area reduces travel and resource time for Police and Local Authority partners, streamlining operations and promoting efficient use of resources.	Financial Benefit Staff Benefit
A S136 suite available in each Local Authority area reduces travel time home for patients who are not admitted to hospital and makes it easier for carers/family to provide support.	Patient & Family/Carer Benefit

Risks	Risk Category
There is a risk to service sustainability and financial sustainability as there is no staffing budget for the S136 suite.	Finance Service Sustainability
There is a risk to staff safety as the Sanctuary Services would have no back up services and additional staff resources due to the geographical locations of the facilities.	Quality & Safety Service Sustainability
The S136 suite needs to be overseen by Mental Health Professionals, therefore the current staffing model in Sanctuary Services does not meet standards and would require significant overhaul, compromising the philosophy and principles of the Sanctuary approach.	Quality & Safety
The recruitment and management of Sanctuary Staff raises concerns in ensuring adequate training and qualifications to support in a S136 suite.	Quality & Safety
There is a risk of resistance from people accustomed to existing alternative to admission/Sanctuary Services, potentially impacting their trust and engagement with the integrated S136 suite and Sanctuary model.	Service Sustainability Patient Experience
There is a risk to patient safety as well as privacy and dignity concerns as the spaces may serve different functions with this model.	Quality & Safety Patient Experience
Implementation of RCRP phase 3 will change the transportation of patients on S136. Alternative transportation will need to be considered and will impact on patient waiting/travelling times. Police may still be required for transport due to violence/aggression, or to follow another vehicle.	Service Sustainability Patient Experience Finance

Option 5 – Utilise existing Sanctuary Services

Capital Costs

The Directorate currently commissions 3 adult sanctuary services, one in each local authority. An additional 2 CYP sanctuaries have been commissioned in Pembrokeshire and Ceredigion. All buildings meet the environmental requirements for S136 suites; therefore, no additional capital costs would be required.

Recurrent Costs

To provide the current service provision of the 3 adult sanctuary services 24/7 would cost approximately 500,000K per service Per Annum (1.5 million PA).

To extend the 2 current CYP sanctuary services to 24/7 would cost approximately 500,000 per service Per Annum (1 million PA).

Mental Health practitioners would need to be recruited to oversee service delivery 24/7 adding significant cost and create professional supervision challenges.

DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG

SAFE | SUSTAINABLE | ACCESSIBLE | KIND

4

4 - Policy for Approval: 1133 Service User Access Policy Psychological Therapies

Kay Isaacs (Hywel Dda UHB - Assistant Service Director- MHLD Clinical Care Group), Andrew Homfray (Hywel Dda UHB - Interim Service Delivery Manager)

Attachments

4 Policy for Approval Extension 1133.pdf

1133 - Service User Access Policy-Psychological Therapies.pdf

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	14 August 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Extension of policy 1133 – Access to Psychological Therapies
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Andrew Carruthers, Director of Operations
SWYDDOG ADRODD: REPORTING OFFICER:	Andrew Homfray (Interim Service Delivery Manager– Psychological Therapies)

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

In August 2023, the Health Board (HB) implemented the agreed the Access to Psychological Therapies Policy document (1133). This policy applies to all patients waiting to receive Psychological Therapies within the counties of the Health Board. All staff within the service are required to adhere to the contents of the policy to ensure consistent service provision. It sets out the principles and rules for managing patients through their Referral to Treatment (RTT) pathway. This policy had a two year review time scale, however, in 2024, NHS Exec (NHS Performance and Improvement) proposed a ***DRAFT ALL WALES PATIENT ACCESS AND RESPONSE GUIDELINES FOR MENTAL HEALTH SERVICES.*** This all Wales document would supersede our own policy to be in line with their proposed all-Wales approach.

The purpose of this document is to act as a guide to implement consistency and equity in service provision and recording of referral pathways. It will aid in reducing variation and promote evidence-based practice across Wales. This is supported by the requirement to record outcome measures for both PROMs (Patient reported outcome measures) and PREMs (Patient reported experience measures), to encourage and support the therapeutic relationship between service users and practitioners. It also guides value-based practice. This document provides an overview of waiting times management rules for some Mental Health treatments. It is a useful resource to guide referral to treatment pathways to align against response to patients care.

The draft policy has been shared across Wales and accepted by all HB's and would be the natural successor to policy 1133. However it had been expected that the policy document would have been ratified by the NHS Performance and Improvement service prior to the end of the current life cycle of Policy 1133.

This has not occurred in the time scales expected, but we have received assurance from NHS Performance and Improvement team that this policy will be implemented as soon as they are able to. With this information I would like to propose an extension of 6 months to the current policy.

Cefndir / Background

The Integrated Psychological Therapies Service (IPTS) provides several evidence based therapeutic interventions that are delivered by a team of highly skilled and accredited practitioners.

The modalities offered have differing timelines with no linear recovery as this is based on the individual. IPTS delivery aims to provide person-centred, evidence-based care for all clients.

The objective of this Policy is to set out a framework in which the IPTS service will work. It will apply to all Service user/ Patient waiting to receive psychological therapies within the counties of HDdUHB. All staff within the service are required to adhere to the contents of the Policy to ensure consistent service provision. It sets out the principles and rules for managing Service user/ Patient service users/individuals through their referral to treatment (RTT) pathway. The Delivery Unit (DU) will be undertaking an all-Wales review of IPTS services and it is anticipated that from this, there will be further clarity of RTT standards to ensure consistency across Wales.

HDdUHB is monitored and measured against performance regarding the waiting lists and benchmarking of compliance against the Welsh Government (WG) target to ensure that 80% of adults are seen within 26 weeks of receipt of referral. To date, IPTS provides services via telephone consultation, online digital platforms and face to face.

The Policy is also aimed to provide Service user/ Patient with the information they require in order to fully engage with their care and make informed decisions. This information is discussed with Service user/ Patient at the start of treatment by way of an informal contract. Full engagement is required if therapy is to be of full benefit. It is also recognised that due to the nature of the Service user/ Patient's health, that this is taken into consideration when do not attend (DNA) and cannot attend (CNA's) occur, however the Policy aims to give a clear framework to provide a consistent approach.

To further support this the service provides information to patients during their attendance at sessions and provides written (or verbal) information to support this. Contact letters are sent to all patients waiting over 26 weeks for transparency in waiting times and as a supportive function. The service hopes to be able to offer where possible other modes of communication in time, (emails, telephone calls, texts)

Asesiad / Assessment

The Policy references waiting time rules and Referral to treatment (RTT) targets. This enables the performance management of the waiting lists. IPTS is governed by WG targets. The achievement of this target is the responsibility of HDdUHB and the staff within the service. During the waiting time period, it is the role and responsibility of the NHS service staff and the Service user/ Patient to achieve the target. Staff will monitor waiting lists and facilitate clinical duties, whilst Service user/ Patient will ensure engagement and attendance at agreed appointments.

The current policy continues to be fit for purpose and remains a key document supporting the consistent delivery of psychological therapies across HDdUHB.

Argymhelliad / Recommendation

The Committee is requested to approve an extension of the review of the current Access to Psychological Therapies (1133) policy by a further 6 months (to March 2026) with a view of implementing the **ALL WALES PATIENT ACCESS AND RESPONSE GUIDELINES FOR MENTAL HEALTH SERVICES** once agreed through the NHS Performance and Improvement Team.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.22 Approve policies and plans within the scope of the Committee, having taken an assurance that the quality and safety of patient care has been considered within these policies and plans.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	2. Timely 3. Effective 5. Equitable Choose an item.
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	Not Applicable Choose an item. Choose an item. Choose an item.
Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable Choose an item. Choose an item. Choose an item.
Amcanion Cynllunio Planning Objectives	5 Mental health and CAHMS Choose an item. Choose an item. Choose an item.
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 Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	NICE Guidelines Matrics Cymru Patient Access Policy
Rhestr Termau: Glossary of Terms:	Contained in document

Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	MH&LD Written Control Document Group Psychological Therapies Management Group (PTMG) Clinical Lead

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	The SBAR contains elements that are both service improvement, training and the funding for rental of venues to support group therapy provision in community settings, some of which will require investment. However, the PTMG Is not asked to agree financial investment. The PTMG is asked to approve items of relevance according and in line with local and national strategic priorities and service demand / capacity. Items that have funding considerations will then be considered and progressed appropriately through the relevant service CCG / dashboard with a separate SBAR and business plan for financial consideration.
Ansawdd / Gofal Claf: Quality / Patient Care:	Risks are mitigated as any training follows professional standards. Service improvements activities increase governance (both operational and professional). Risk of not having a Strategy creates idiosyncratic practice, uncoordinated training plans, duplication and waste.
Gweithlu: Workforce:	Indicated in the paper.
Risg: Risk:	Risks are mitigated as any training follows professional standards. Service improvements activities increase governance (both operational and professional). Risk of not having a Strategy creates idiosyncratic practice, uncoordinated training plans, duplication and waste.
Cyfreithiol: Legal:	The policy promotes an equitable approach that focuses on promoting equity and also on increasing access for different groups of people.

Enw Da: Reputational:	N/A
Gyfrinachedd: **Privacy:**	All patient information is recorded and stored in compliance with HB and All Wales IG governance and confidential policies.
Cydraddoldeb: **Equality:**	The policy promotes an equitable approach that focuses on promoting equity and also on increasing access for different groups of people. Collection of data on service delivery is required to monitor access in terms of population demographics and diversity. Access for people with protective characteristics will be monitored through the wider service operational recording and audit. Equality impact is monitored through operational service and will be raised at PTMG where appropriate. Service user input on the PTMG is critical to identifying any potential equality issues for service users and upon any decisions and resultant plan of action to address this..

Service User Access Policy - Psychological Therapies

Policy information

Policy number: 1133

Classification:
Corporate
Supersedes:
New Policy

Version number:
1.0

Date of Equality Impact Assessment:
03/04/2023

Approval information

Approved by:
Quality Safety & Experience Committee
Date of approval:
08/08/2023

Date made active:
09/08/2023

Review date
08/08/2025

Summary of document:

The purpose of this policy is to ensure that all patients requiring access to Psychological Therapies in Hywel Dda University Health Board (HDdUHB) are managed equitably and consistently, in line with national waiting time standards. This includes the management of patient referrals, waiting lists,

appointments, and therapeutic interventions. This policy details Welsh Government (WG) targets that the Service aspires to deliver for psychological interventions. All waiting lists are weighted fairly to ensure consistent provision dependent upon wait and need.

Scope:

This policy applies to all patients waiting to receive Psychological Therapies within the counties of HDdUHB. All staff within the service are required to adhere to the contents of the policy to ensure consistent service provision. It sets out the principles and rules for managing patients through their Referral to Treatment (RTT) pathway.

To be read in conjunction with:

Matrix Cymru- Guidance for delivering Evidence-Based Psychological Therapy in Wales – opens in a new tab

Patient information:
Include links to Patient Information Library

Owning group:
MH&LD Written Control Documentation Group /Psychological Therapies Management Group
23.05.2023 *07/11/2022*

Executive Director Job title:
Andrew Carruthers, Director of Operations

Reviews and updates:
1.0- Initial Policy 8.8.2023

Keywords

Integrated Psychological Therapies, Psychological Therapy.

Glossary of terms

26-week referral to treatment target	The Welsh Government waiting times target states that 80% of adults are waiting less than 26 weeks to start a psychological therapy.
Adjustment	A period of time for which the patient is either unavailable, for clinical or social reasons, or where the patient is referred to a service that is outside the scope of RTT.

IPTS	Integrated Psychological Therapies Service.
Clinic outcome	A record of the event of a clinical decision made by a clinician. This decision will not necessarily be made within a clinic environment.
Clock continue	Any events that occur along the patient pathway, but do not constitute a clock start or clock stop within the RTT rules.
Clock reset	An administrative process to change the start of the recorded RTT period to the date of the event causing the reset.
Clock start	An event that commences an RTT period within the RTT rules.
Clock stop	An event that ends an RTT period within the RTT rules.
Could not attend (CNA)	Any patient who contacts the organisation to notify that they will be unable to attend an agreed appointment is recorded as 'could not attend' (CNA).
Decision to treat	A record of the event that a clinical decision to treat a patient has been made.
Decision not to treat	A clinical decision that, at the present time, no treatment is required for the condition for which the patient has been referred. This will normally result in the patient being discharged back to the referring doctor.
Did not attend (DNA)	Patients who have not kept an appointment at any stage along the pathway and have not notified the organisation in advance are identified as 'did not attend' (DNA).
Direct booking	Booking methodology where an agreement of appointment is made through a direct communication between the organisation and patient.
Mutually agreed	Agreed by both the patient and the Health Board.
MDT	Multidisciplinary-Team Meeting

Modality	A clinical and therapeutic treatment modality. It is the process of using certain clinical and therapeutic treatment modalities in psychiatry to achieve a specific goal for individual patient care**.**
Patient pathway	The process of a patient's care for a particular condition across the whole of the NHS, from primary care onwards.
Reasonable offer	Any offer of an appointment mutually agreed between the patient and the Health Board.
Receipt of referral by the HB	The referral is deemed to be received when it first arrives within the secondary or tertiary care.
Referral guidelines	Predetermined written criteria for referral that are formalised and agreed between the healthcare professionals making and receiving the referral.
Referral protocols	Agreements reached and documented locally to identify accepted sources for referrals to specific services.
Referral to treatment (RTT)	The period between a referral being made for a particular condition and treatment being commenced for that condition.
RTT period	The waiting time will be monitored using the concept of a clock, which will start and stop according to the events and transactions that occur along the course of the patient pathway. The measured period of time between a clock start and a clock stop, under RTT rules, which is reported as the RTT waiting time.
Short-term medical condition	A medical condition precluding progression to the next stage of the pathway for less than 21 days.
Social Reasons	A period of unavailability for example due to a holiday or work commitments.

Stage of the pathway	A section of the RTT period. There are four stages: referral to first outpatient appointment; waiting for a diagnostic test; waiting for a subsequent outpatient appointment; waiting from decision to treat to the start of treatment. Stages of the pathway are contiguous, do not have to occur in this order, and any individual stage may occur more than once in any given pathway.
Therapy	**Therapy is** the treatment of mental or physical illness without the use of drugs**.** Talking therapies are psychological treatments for mental and emotional problems such as stress and anxiety.
Therapist	**Therapists**, or psychotherapists, are licensed mental health professionals who specialise in helping patients develop better cognitive and emotional skills, reduce symptoms of mental illness, and cope with various life challenges to improve their lives.

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Introduction

Hywel Dda University Health Board (HDdUHB) is committed to delivering high quality and timely care to patients in the Integrated Psychological Therapies Service (IPTS).

This policy reflects the overall expectations of HDdUHB and local commissioners with regard to the management of referral to treatment, referrals, appointments, therapeutic interventions delivered, outcome measures and defines the principles on which the policy is based. This policy should be read in full by all clinical and non-clinical staff, who must ensure that they comply with both the principles within this policy and any specific instructions within standard operating procedures (SOPs).

Every process in the management of patients waiting for treatment must be clear

and transparent to the staff who manage them and to the patient/patients. It supports staff by affording clear direction in relation to waiting times. HDdUHB is committed to providing services which meet the needs of individuals and does not discriminate against any employee, patient, or visitor.

The policy references waiting time rules and referral to treatment times targets. This enables the performance management of the waiting lists. Integrated Psychological Therapies are governed by Welsh Government targets. The achievement of these target is the responsibility of HDdUHB. During the waiting time period, it is the role and responsibility of the NHS and the patient to achieve the target.

Contact letters are sent to all patients waiting over 26 weeks for transparency in waiting times and as a supportive function.

The Delivery Measure – 80% of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health.

Rationale: Providing timely access to psychological therapies is a key priority within the Together for Mental Health Delivery Plan. The aim is to bring the waiting time for referral to assessment and assessment to treatment for psychological therapy in line with the recommended times for treatment for physical health domains.

Scope

This policy outlines the pathway and accompanying benchmarks related to Psychological Therapies for Adult Mental Health. It is intended to be of interest to and used by all those individuals within HDdUHB who are responsible for referring patients, managing referrals, adding to, and maintaining waiting lists for the purpose of organising and progressing patient access to treatment. It applies to all patients who require access to psychological therapies across IPTS. Communications with patients should be timely, informative, clear, and concise by way of telephone; letter; text.

Where required, arrangements will be made for patients who have specific needs
relating to language, interpretation, translation services; disability; culture and religion.
HDdUHB is committed to providing services which meet the needs of individuals and does not discriminate against any employee, patient, or visitor.

Aim

The aim of this document is to:

- Improve population health and wellbeing through a focus on prevention
- Improve the experience and quality of care for individuals and families

- Increasing Access and Quality in a Prudent NHS to enable timely access and the adherence of waiting time targets
- To ensure a consistent approach to patient access across HDdUHB
- To promote reasonable offers for treatment

Objectives

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

- Meeting patient needs and providing clear information while they are on a waiting list
- Ensure patients receive the right mental health care in a timely manner
- Work collaboratively with shared decisions where appropriate and possible

Scope of the Targets

The Patient Access Policy documents the Health Boards target responsibilities for managing patient access, in line with the national referral to treatment targets (RTT) standards. Our service is subject to waiting time targets set by Welsh Government (WG). The current target is for 80% of individuals to be seen within 26 weeks of referral. The service is committed to meeting this target whilst also not compromising on our values of offering person-centred, formulation driven, and meaningful offers of care.

- IPTS- 80% adults waiting less than 26 weeks to start a psychological therapy
- LPMHSS- 80% mental health assessments undertaken within 28 days (persons aged 18 years+).
- 80% therapeutic interventions started within 28 days following LPMHSS assessment (persons aged 18 years+)

Treatment will commence with an initial assessment and suitability review, followed by a varying number of sessions dependent on the therapeutic modality most suitable. The RTT clock stops following the first session/commencement of treatment. The RTT period is best described as – the patients journey from referral to the service to the start of their treatment.

RTT clock start = ‘Date Referral Received’
RTT clock stop = ‘Appointment Date’ of the first treatment appointment.

If a decision to change the treatment plan occurs, where possible the patient will be seen as quickly as possible to avoid further harm waiting.

Delays in the pathway

All referrals are managed in accordance with the 26-week rule. There is an exception to this in regard to DNAs and CNAs. This is based on clinical judgement and using the three-point rule where failed engagement occurs. All reasonable care is made to encourage and enable the engagement of patients. The RTT period begins on the receipt of a referral into the Service and ends when the initial treatment commences.

Patient initiated delays and clock pauses:

- A patient chooses to delay attendance due to circumstances such as work or family commitments, holidays, pending surgery, etc
- The patient declines three reasonable offers of appointment dates (dependant on circumstances). The clock can be paused until the patient accepts or is discharged
- If a psychoeducational group therapy is offered, this is a reasonable offer and if declined can be discharged, if the risk assessment indicates no further risk to the individual not being offered an alternative one to one. Clinical judgement and client choice will always be taken into consideration
- If the patient has been identified as needing group therapy plus a high intensity intervention, however, declines the group as a pre-treatment for therapy, they will still be placed on the waiting list for the most suitable therapeutic intervention
- It is the responsibility of the therapist to promote the value of attending an evidence-based group therapy as an option, whilst ensuring the service user is fully aware of the benefits to ensure a full understanding
- If a service user is offered an intervention via a digital platform, however declines stating a preference for face to face, consideration can be given based on individual circumstances. However, if clinically and circumstantially (i.e., allowing for technophobia, preference, communication issues such as, autism, access to hardware, software, and reliable broadband), deemed a reasonable offer, the patient must be informed as they can wait, however, the clock will be stopped.

WG guidance for RTT rules within the Mental Health Psychological Service states that the clock stops after the first offer of a Highly Specialist psychological Intervention. The measurable target being - 80% of adults waiting less than 26 weeks to start a psychological therapy.

Events other than treatment, which can end an RTT period, may include a decision made not to commence treatment due to the patient not engaging or ready to engage due to other health issues which would impact on them commencing therapy.

Patients must be given adequate information on the expected timescales, anticipated process, and their responsibilities to assist the NHS to provide efficient and effective treatment of their condition.
Patients will be empowered through this information, to question and monitor their own progress against the target.

Eligibility Criteria

Adults over the age of 18 years, who have been assessed by either primary or secondary care services in adult mental health and identified as in need of psychological assessment and intervention.

Each referral will be scrutinised or assessed for viability of a psychological intervention, with recommendations for treatment, further interventions or recommendations of a more appropriate service or source of support.

The team will discuss re-referrals as to whether an assessment is appropriate to inform intervention. Following discussion with the referrer, recommendations will be made as to the appropriateness of assessment and/or other interventions.

Included in the Scope of the 26-week RTT target	
Military Personnel	The target is that military personnel are included in the scope and should receive access to NHS care for any conditions which are related to their service and are placed on the waiting list. For conditions related to their active service, they are prioritised over people waiting with the same clinical need.
Prisoners	Prisoners are treated with the same waiting time target as all other NHS patients.
Refugees	Refugees are treated with the same waiting time target as all other NHS patients and follow the usual treatment pathway.
Patients who do not normally reside in Wales.	Funding for treatment is based on permanent residency. If treatment is required, funding should be applied for, or care should be taken within their own residential locality NHS provider.

Clinical Responsibilities

Psychological therapists and psychological therapy leads should ensure they are aware of waiting list targets and work with HDdUHB to instigate recovery plans where possible. All are expected to update themselves on national requirements and all specific health board policies and procedures and training updates.

Therapists must ensure that they comply with requirements, record, and gather clinical outcomes with all patients at the start and end of all therapy. This is compulsory as responses are paramount to support governance structures and a requirement to adhere to quality standards.

All interactions with patients should be recorded whether face to face, phone or by letter.

Referrers must ensure that the patient is aware and agrees for a referral to be made. Where required, therapists should advise patients of third sector support available.

Referrals

The RTT period begins at the date the referral is received from a Mental Health Team and by any other healthcare professional, where referral protocols exist. The clock will start on the date that HDdUHB receives the referral.

Referrers must use the most efficient and patient-centered approach to referral that reduces the steps required to reach treatment, based on prudent healthcare principles. As part of the referral information, referrers should include verified up to date patient contact details, including mobile phone numbers and email addresses where available.

Referrers should seek the consent of the patient to be contacted by HDdUHB by such means as text or telephone and indicate if consent has been given. Referrers should include this information in the referral. Health Boards must ensure that the most appropriate individual sees patients to meet the patient's clinical needs once the referral has been accepted.

A decision will be made to accept the referral through a joint assessment process. At times, referrals are deemed unsuitable for treatment for varying reasons.

Accepted referrals will be offered one of the following:

- A group therapy
- A group therapy and review
- A group therapy and 1:1 therapy

All referrals received to the service will be assessed, where any additional needs arising from a disability will be considered, this ensures appropriate adaptations/support can be arranged for those individuals. They will be placed on the waiting list for the most suitable therapeutic intervention according to their individual needs and circumstances.

It may be necessary to engage with other services to ensure that any additional needs are supported, e.g., translation services, British Sign Language training for staff, linking with the autism spectrum disorder (ASD) Service to ensure content delivery can be adapted correctly.

Health Boards should provide up to date information to referrers relating to the patient pathway that will be followed, the likely waiting time and the locations the service will be delivered from, in order that this can be communicated clearly to the patient. Discussion should also be supported by written information for patients either provided during consultation or by signposting where they can get additional information. Health Boards should have systems in place to keep this information up to date and available to referrers.

If a referral is made for a psychological intervention that is not offered by HDdUHB, it should be returned to the referrer with a full explanation and no clock will be started.

When a referral is made to a clinician or specialty that does not treat this condition, however, if the treatment is delivered within HDdUHB, there is a responsibility to direct the referral to the correct clinician/clinical team and the clock does not stop.
Referrals should only be accepted when comprehensively completed, if a referral has insufficient information to enable a clinical decision, the referral should be returned to the referrer. A conversation with the referrer is advisable in the first instance to prevent any unnecessary delay for the patient. The RTT period will continue as this is not related to the patient.

Practitioners will be guided and informed by the National Institute for Health and Care Excellence (NICE) and *Matrics Cymru* in relation to the appropriate number of sessions for any given therapy or clinical presentation. Clinical judgement will be used where appropriate and in consultation during clinical supervision.

The service will link with LPMHSS where needed to ensure a seamless service to support effective patient care.

Referral Pathway

Please see **Appendix 1** for detailed referral pathway.
Referral received from Community Mental Health Team (CMHT), Crisis Team (CRHT) or LPMHSS.

- If received from CMHT, the referral is discussed with IPTS at a multidisciplinary meeting (MDT) in collaboration with IPTS and CMHT staff. If suitable, the client is contacted to arrange an

assessment meeting to determine the most suitable modality

- If received from any other referring team, the referral is discussed with IPTS in an allocated daily meeting. If suitable, the client is contacted to arrange an assessment meeting to determine the most suitable modality

- If received from LPMHSS, the referral is discussed at MDT meeting, and if suitable, the client is contacted to arrange an assessment meeting to determine the most suitable modality

Booking Process

All patient appointments should be booked taking into consideration a patient-focused approach. The booking process needs to be clearly communicated to patients at referral and at the first appointment to ensure patients are clear on their role and responsibility in the local process. Wherever practical, appointments should be made with the involvement of the patient to gain mutual agreement and accommodate their needs. This must be adhered to, even when HDdUHB does not hold complete contact details for the patient.

Opt in process

On receipt of acceptance of referral

- Patients are sent an opt in letter inviting them to a suitability appointment, which can be either a face-to-face or telephone appointment. The letter details the date and time, if this is not suitable clients can telephone to arrange a new appointment (**Appendix 2)**
- As a prompt and in the aim to reduce DNA's, the service sends SMS text reminders to clients 1-2 days prior to the assessment appointment

- If the client has made no contact to cancel their appointment or they DNA then the clinician will telephone them to ask the reason for the DNA. If there is no response an opt in letter **(Appendix 6)** is sent asking them to get in touch within 10 days. If they have had three points of contact with no response, the client will be taken to the next Multi-Disciplinary Meeting (MDT) for a possible discharge. The discharge report is sent to the GP. If no response is gained, the patient is discharged, and details sent to the referrer and GP

Each client is offered an appointment by letter and where possible is telephoned to try to get engagement. Clinical judgement is exercised when discharging a client.

If contact is made, the patient is initially seen for a suitability appointment, they will receive a letter advising them that they are placed on the waiting list (**Appendix 3**). A patient information sheet for the therapy (**Appendix 4)** is included with the waiting list letter.

Patients need to be fully engaged and in agreement about commencing therapy and their role in agreeing dates in keeping with the principles of co-production. This process needs to be clearly explained to the patients when they are referred along with the importance of engagement and attendance. Patients should also be advised of the need for commitment.

Appointments should be sent to patients by means of post (**Appendix 2)** and followed up with a reminder SMS text. New referrals are allocated next suitability appointment inclusive of opt in-letter. Wherever practical, appointments are mutually agreeable, and that the patient has been offered a choice of dates within the agreed timeframes.

Reasonable offer

A reasonable offer to a patient is defined as any date mutually agreed between the patient and the service within working hours.

Patients should be offered appointments at a location of their convenience providing the required service is available there. The offer of appointments at locations away from the patient's local area will be considered reasonable if this was explained to the patient when they were referred or in the receipt of referral acknowledgement.

All dates offered must be recorded and available for subsequent audit. If the required information is not recorded, it will be considered that no reasonable offer has occurred.

An adjustment or reset can be applied where it has not been possible to agree a suitable date within the originally planned booking period*

Refusal of a reasonable offer

A patient may only be deemed to have refused a reasonable offer when up to three appointments appropriately spaced apart and on alternative dates have been offered and a record is available for audit purposes. If no agreement on a date is reached, this can be classed as a refusal of a reasonable offer. This should be relayed to the original referral and patient in a letter and recorded on systems.

Could Not Attend

If the patient makes contact within a reasonable time (24-48hrs prior) to give notice of unavailability to attend the appointment which had been mutually agreed, this is considered a CNA.

The clock start point is reset to the date at which the patient notified the service that they were unable to attend the appointment. There are no restrictions applied regarding the maximum number of times a date can be reset.

If a patient CNAs within any stage of the pathway, a new mutually agreed appointment must be made as soon as the patient is available. The RTT clock will be reset, however they remain on the same pathway. This reset should be communicated to the patient when rebooking the appointment.

If the patient CNAs for a second time whilst on the same pathway of care, they should be categorised as a DNA as they will be deemed to have broken the arrangement to be reasonably available. The therapist should make contact to identify reasons for CNA and lack of engagement and take reasonable steps to facilitate and enable attendance. If they CNA for a third time, consideration must be sought if discharge is appropriate and clinically safe. Appropriate notification of removal must be given to the patient and the referrer.

Did Not Attend

If the patient DNAs, a further appointment is sent seeking confirmation of attendance. If the patient DNAs for a second time, telephone contact is made to seek commitment. If the patient DNAs for a third time, the case is discussed at the MDT meeting, a letter is sent to the patient, and information updated on the electronic systems (**Appendix 5**).

The Directorate's minimum requirement for DNA is that should three consecutive DNAs occur, a letter is sent to the individual concerned and the referrer stating the availability of the service and request that the individual contact the service within ten days, so that arrangements to meet can be made.

If there is no response to this from the individual and or the referrer, then discharge from the service can be made following MDT discussion who will reflect on risk and information on referral.

If contact is made by telephone calls, these must take place on different days, and at least one must be outside normal working hours (Monday - Friday 9 a.m. – 5 p.m.).

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

If the patient has commenced treatment and routinely DNAs, the therapist will discuss this with the patient and where appropriate if the patient is not deemed ready for therapy, the patient will be discharged.

The clock start point is reset to the date the patient did not attend the appointment, there are no restrictions applied regarding the maximum number of times a date can be reset.

If the patient sporadically DNAs with no notice, the patient should be made aware that each time they DNA, the number of treatment sessions will be removed from their pathway of care (10 sessions allocated, DNA x 2 only 8 sessions will be given).

Appropriate notification of removal must be given to the patient and the referrer. Clinical judgement is demonstrated in making an informed decision on whether or not further or more assertive engagement is needed on the basis of the available clinical risk information following each DNA **(Appendix 6).**

Adjustments

When a patient is unavailable to attend due to a short-term medical condition, such as a cold, holiday, or bereavement, an adjustment to the RTT period may be made. While this may be applied by administration, where required should be supported by a suitably qualified healthcare professional, who agrees that a patient has a condition which will be resolved within 21 days. A second 21-day period cannot be applied within the same stage of the pathway.

Maintaining Contact

When a patient reaches 26 weeks of waiting time since referral, a keeping in contact letter will be sent to assure them of the services commitment **(Appendix 7)**.

Responsibilities

Chief Executive

As Accountable Officer, the Chief Executive has overall responsibility for ensuring the health board has appropriate WCDs in place. These WCDs must comply with legislation, meet mandatory requirements, and provide services that are safe, evidenced-based, and sustainable.

Director of Operations

The Director of Operations is responsible for ensuring the requirements within this policy are fulfilled and that all operational responsibilities are in place. Clinical Leads are responsible for ensuring that whilst considering patient care, all patients are managed in accordance with the agreed patient access policy, and they are fully aware of the overarching principles.

Senior Management/Directors

Are responsible for ensuring the patient access policy is disseminated, fully implemented, and adhered to by all staff within their designated areas of managerial responsibility across the Health Board.

Service Delivery Managers (including Service and Business managers)

Are responsible for ensuring the patient access policy is disseminated, fully implemented, and adhered to by all staff within their designated areas of managerial responsibility across the Health Board. They must also ensure all waiting lists under their managerial control are managed in accordance with the rules and regulations. Administrative Support Services Administrative support services such as Waiting List, Health Records, Validation, must ensure that patients are effectively communicated with; all staff are fully aware of the agreed policy, that they comply with agreed guidance and the patient pathway is managed in accordance with the principles.

Psychological Therapies Management Group has the responsibility for reviewing this policy and ensuring there is effective implementation and distribution across the necessary staff groups within the health board.

References

Matrix Cymru- Guidance for delivering Evidence-Based Psychological Therapy in Wales (2017)

Welsh Government Policy Implementation Guidance for Psychological Therapies (2012)

Parts 1 and 2 of the Mental Health (Wales) Measure 2010

Together for Mental Health: A Strategy for Mental Health and Wellbeing in Wales 2021

Appendix 1- IPTS Referral Pathway

IPTS Referral
Pathways.pdf

Appendix 2- Appointment letter

Appointment
letter.doc

Appendix 3- Waiting List Confirmation Letter

Waiting List
Confirmation Letter.d

Appendix 4- Patient Information Leaflets

Patient Information
Leaflets .docx

Appendix 5-DNA Letter

DNA 10 day letter
blank.doc

Appendix 6- Discharge Letter

Discharge
Letter.doc

Appendix 7- 26 Weeks Waiting List Letter

26 week waiting list letter.doc

5

5 - For Information

5.1

5.1 - JCC Quality, Safety and Outcomes Sub-Committee Highlight Report

Attachments

JCC Highlight Report - JCC 20 May 2025 Final.pdf

Joint Commissioning Committee

Highlight Report from the Joint Commissioning Committee

Dyddiad y Cyfarfod / Date of Meeting	20/05/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Jacqui Maunder – Committee Secretary
Cyflwynydd yr Adroddiad / Report Presenter	Stacey Taylor - JCC Deputy Chief Commissioner/Director of Finance
Noddwr yr Adroddiad / Report Sponsor	Huw George JCC Chief Commissioner

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Health Boards	June/July 2025	Noted

1. SITUATION/BACKGROUND

This report had been prepared to provide Health Board (HB) Chief Executive Officer (CEO) Members of the Joint Committee with a summary of the key issues considered by the NHS Wales Joint Commissioning Committee (NWJCC) at its public meeting on 20 May 2025.

Key highlights from the meeting are reported in Section 3.

2. PURPOSE

The Purpose and Role of the Joint Committee (JC) is set out in Paragraphs 2.18 and 2.20 of the NWJCC Standing Orders (SOs).

3. HIGHLIGHT REPORT

(Links to reports highlighted May 2025 – NHS Wales Joint Commissioning Committee)

Status	Update

Alert / Escalate	During the meeting, Members:
	• **Collaborative Commissioning Leadership Group (CCLG)** – Noted that the Terms of Reference for the Collaborative Commissioning Leadership Group (CCLG) included a specific request from HB CEOs that its membership should comprise of Executive Directors from HBs. CEOs were requested to ensure that designated Executive Directors attend to ensure quoracy
	• **Syndrome Without a Name (SWAN)** – Approved recurrent funding for the service
	• **Individual Patient Funding Request (IPFR) Policy** – Approved the updated policy and noted that it will be presented to the 7 x HBs and WG for final approval and adoption from 1 July 2025
	• **Recovered Plasma from Whole Blood Donations for Medicines** – Supported Velindre University NHS Trust/Welsh Blood Service in approaching WG to approve a revised policy position to:
	  ○ Commence supply of plasma recovered from whole blood donations for the manufacture of Immunoglobulin and Albumin products for clinical use in Wales under the terms of a UK-wide contract with Octapharma AG
	  ○ Use the price savings from the contract compared to the commercially sourced equivalent NHS Wales contracts, to cover the additional costs and lost income.
	• **Improving Patient Flow, Oversight and Repatriation in Mental Health Hospitals** – Members noted (i) the impact of a delayed discharge on the patient experience and outcomes and (ii) the longstanding process to recharge HBs for the cost of a medium secure patient placement three months after it has been identified that the patient is ready to move on to the next stage of care. Members approved the recommendation to recharge HBs after one month and to expand this process to cover all mental health placements.
	• **JCC Scheme of Reservation and Delegation of Powers –** Approved the adoption of these for the matters further delegated from the Chief Commissioner, all of which must be formally adopted by the JC and approved by HBs as a schedule to their own SOs. Members approved the financial delegations outlined within the updated financial authorisation matrix.

Status	Update

Advise	• The **Chair's Report** noted the recent end of year appraisal with the Cabinet Secretary for Health & Social Care including the discussion around the establishment and governance of the NWJCC, the progress made in the last 12 months, the priority in quarter 1 and 2 (2025-26) to develop a long-term strategy setting the road map for the Integrated Medium-Term Plan (2026-29) and a focus on recast objectives including quality, safety, culture, strategy, and governance.
	
	• The **Chief Commissioner's Report** included an update on:
	  o **Quarter 4** – the progress made in relation to the transition including the establishment of the new organisational structure (with a 29% vacancy rate that is having an impact on capacity with the NWJCC) and a shift in focus to the delivery of the NWJCC Foundation Plan following its approval (with HB Executive leads identified for each of the strategic priorities)
	  o **CCLG** – working to inform decision-making by the Chief Commissioner and the JC
	  o **Internal Audit** – review undertaken to assess embedding the statutory governance framework and the establishment of operational governance arrangements to provide effective oversight. This report stated that the first year of operation was regarded very positively, the governance framework has largely been established and meetings are more strategic and collaborative than the previous arrangements. The report identified the need for quoracy in CCLG meetings and the need to take forward an organisational development plan to embed values and behaviours and new ways of working
	  o **Annual Accounts** – reflected within governance and accountability arrangements, assurance was provided that the NWJCC Annual Accounts were submitted to CTMUHB and will be presented to their Board for approval on 26 June 2025 which Huw George will attend in his capacity as Accountable Officer.
	
	• Reports from each of the Commissioning Directors:
	  o **Director of Commissioning for Mental Health, Learning Disabilities and Vulnerable Groups** – Members noted:
	    o The findings of the Perinatal Mental Health Utilisation, Forecasting & Modelling Report (working with the Royal College of Psychiatrists Wales)

Status	Update
	○ Commissioning case management for specialised mental health services, the current variation in provision and the work being taken to address this ○ The impact of a fire incident at Taith Newydd low secure unit has had on medium secure bed availability in south Wales and ongoing discussions around this matter ○ Ongoing discussions with Welsh Government (WG) and NHS Wales Performance and Improvement regarding Sexual Assault Referral Centres ○ In relation to Continuing Healthcare, at the request of the Director General for Health and Social Services, the focus will be the deployment of a digital system and the training of CHC assessors, led by other organisations. ○ **Director of Commissioning for Ambulance Services and 111** – Members noted: ○ The outcome of the Emergency Medical Retrieval and Transfer Services (EMRTS) Judicial Review was anticipated by the end of May 2025 ○ The Emergency Ambulance Performance Framework would be implemented from July 2025 with a shift in focus from time-based targets to clinical outcomes ○ The transfer of the Save a Life Cymru programme to the Welsh Ambulance Services University NHS Trust (WAST), to be commissioned through the JCC enabling a more integrated approach and enhanced community cardiac arrest survival ○ The aim of the national handover improvement group to deliver a maximum 45-minute ambulance patient handover time within 6 months, handover improvement was noted as a recommendation in the Ministerial Advisory Group report ○ Capacity issues within the Non-Emergency Patient Transport Service due to HB service reconfiguration, increased patient complexities and increased costs, work is ongoing with WAST and HBs to address this ○ A review of NHS 111 Wales' roster arrangements with a view to better aligning capacity and demand. ○ **Director of Commissioning for Specialised Services**. Members noted: ○ Key commissioning risks and the reporting of services in escalation to the Quality, Safety and Outcomes Sub-Committee for detailed scrutiny ○ Key commissioning achievements including repatriation of Peptide Receptor Radionuclide Therapy (PRRT) for neuroendocrine tumours and the expansion of

Status	Update
	Stereotactic Ablative Body Radiotherapy (SABR) provision in Wales o The Paediatric Intensive Care Unit has been de-escalated to level 2 due to the assurances received in line with the NWJCC Escalation Framework. • **Strategic Development –** Members received a presentation outlining a proposal for the development of the NWJCC Strategy including timelines for engagement and approval process. Work will continue to develop the strategy and to ensure alignment with HB strategies. • **NWJCC Foundation Plan 2025-26 – Implementation Framework** – Members noted a report outlining the implementation framework for the Foundation Plan, including strategic priorities, outcomes, deliverables and milestones.
Assure	• **Governance & Risk Management**: o The Risk Register at 31 March 2025 was received and approved o The Corporate Governance Report was appended with the draft Annual Governance Statement, the Audit Enquiries Letter and the Annual Plan of Committee Business 2025-2026 for approval o Members noted: o The update on the Register of Interests/Related Parties o That the Health Board SOs (and subsequently NWJCC SOs) would be updated to reflect the recently issued Welsh Health Circular which reduced the timescale for publication of board papers to 5 clear days.
Inform	• Members heard the story of a former inpatient's experience in the Mother and Baby Unit at Tonna Hospital. The story presented the challenges as a physically disabled mother and how the unit had worked hard to address the environment, accessibility issues and the staff's willingness to listen and adapt. These lessons would be shared across other commissioned services • The Committee received the Month 12 Finance Report and the Month 12 Operational Performance Report • The Committee noted an update in relation to an extension of the Blueteq Electronic Prior Approval System contract • The Committee received the following assurance reports: o Quality Safety and Outcomes Sub-Committee o Planning Performance & Finance Sub-Committee

Status	Update
	○ Individual Patient Funding Request (IPFR) Panel Assurance Report ○ Welsh Kidney Network Board Assurance Report.
Appendices	None.

4. ASSESSMENT

Objectives / Strategy	
Dolen i Amcan (au) Strategol CBC **Link to JCC Strategic Objectives(s)**	Maximise Value
	Ensure Quality; Reduce Duplication; Improve Equity & Population Health; Facilitate Integration
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / **Link to Wellbeing of Future Generations Act – Wellbeing Goals** 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	A Resilient Wales
	A Healthier Wales
Dolen i Hwyluswyr Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / **Link to Enablers of Quality** (Duty of Quality Statutory Guidance (gov.wales))	Leadership
	Culture and Valuing People; Learning, Improvement and Research; Whole-systems Perspective
Dolen i Feysydd Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / **Link to Domains of Quality** (Duty of Quality Statutory Guidance (gov.wales))	Effective
	Efficient; Equitable; Person-centred; Timely; Safe
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality**	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:

<table>
<tr><td>Have you undertaken a Quality Impact Assessment Screening?</td><td></td><td>This is a summary of the latest meeting of the JCC</td></tr>
<tr><td rowspan="2">Cydraddoldeb
Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /
Equality
Have you undertaken an Equality Impact Assessment Screening?</td><td>Yes: ☒</td><td>No: ☒</td></tr>
<tr><td>Outcome for Equality (delete as appropriate): ~~POSITIVE/~~NEUTRAL~~/NEGATIVE~~

Outcome for Welsh Language (delete as appropriate): ~~POSITIVE/~~NEUTRAL~~/NEGATIVE~~</td><td>If no, please include rationale below:
This is a summary of the latest meeting of the JCC</td></tr>
<tr><td rowspan="2">Cyfreithiol / Legal</td><td colspan="2">There are no specific legal implications related to the activity outlined in this report.</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td rowspan="2">Enw da / Reputational</td><td colspan="2">There is no direct impact on the reputation of the Joint Committee as a result of the activity outlined in this report.</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td rowspan="2">Effaith Adnoddau
(Pobl /Ariannol) /
Resource Impact
(People / Financial)</td><td colspan="2">Yes (Include further detail below)</td></tr>
<tr><td colspan="2">The performance of the services will be used to develop the IMTP and identify the areas where resources may be required.</td></tr>
</table>

5. RECOMMENDATIONS

The Health Board is asked to:

- **Note** the highlights outlined in Section 3 of this report.

5.2

5.2 - Patient Experience Report

Attachments

10. IPCE Report July 2025.pdf

IMPROVING PEOPLE EXPERIENCE REPORT

July 2025

Introduction

Service user feedback is important to monitor the experience of those who access our services and the quality of care that they receive. This allows us to identify areas for improvement, to share good practice and learn from positive experiences.

It is our priority to act on all feedback received as part of our culture of improvement and to demonstrate that we are fulfilling our pledges as set out in the Charter. The Listening and Learning Sub-Committee will oversee the communication and implementation plan for the Charter. The Committee receives feedback from across concerns, compliments and experience.

The following information demonstrates how we are capturing service user feedback by encouraging our service users and providing different ways in which this can be provided. Most importantly, service users should feel that there has been a valuable purpose to them providing their feedback.

A Charter for People and Community Experience - your healthcare, your expectations, our pledge

WE WILL ALWAYS:
Treat you with dignity, respect and kindness.
Communicate with you in a way which meets your individual, language and communication needs.
Keep you informed and involved in decisions about your health and care services, and take into account your wishes and needs.
Provide safe and effective care, in the most appropriate and clean environment.
Ensure that your information is kept secure and confidential.
Support and encourage you to share your experiences of health care, both good and bad, to help us improve the way we do things.

Service User Feedback ‘at a Glance’ April 2025 – May 2025

We continue to receive many positive stories and comments about the services provided by our caring and compassionate sta
We are continually sharing and celebrating these achievements across the organisation. We will share information relating to t
figures later in the report.

<u>NHS People’s Experience Framework</u>

40935 individuals were sent our new NHS Wales People’s Experience Friends and Family Test Survey, in the format required by the People’s Experience Framework.

6354 responded representing a **15 %** response rate. **86.2% gave a Very Good or Good response** to the How would you rate your overall experience? Question

1549 were sent the NHS Wales People Experience Survey (PES).

Concerns related to waiting times and care provided in corridors in A&E. A higher number of service users completed the survey during this period, and more were satisfied with the care received.

203 <u>compliments</u> were received direct to wards, departments or Chief Executive/ Chair’s 0ffice. These frequently highlight the professionalism and compassionate care provided by healthcare teams. Example received about Bronglais Hospital, Endoscopy Team - *“Excellent team, very professional and caring. A big thank you to all concerned. As a healthcare professional myself, I found the whole experience reassuring”.*

<u>Complaints and enquires</u>: 981 new cases were received into Patient Support Services. Of these, **538** were received as **new complaints and 443 as enquiries.** The main reasons for enquiries/early resolutions related to appointments / waiting list queries, attitude and behaviour and communication inefficiencies.

During the period a total of **263 complaints were closed. 160** were responded to **within 5 working** days through the early resolution process.

Public Services Ombudsman

- **In the period April/ May 2025 there has been one new investigation. This will look at the medical management of a patient with pancreatitis and whether a cancer diagnosis should have been made earlier.**
- **There were 9 instances where the Ombudsman decided not to investigate.**
- **There were 2 complaints made to the Ombudsman prematurely.**
- **In the same period, there were 4 early resolution agreements made between the Health Board and the Ombudsman.**
- **There have been no final reports received in April/ May 2025.**

1307 calls were made to the 0300 0200 159 Patient support number of which 53 were via the medium of Welsh.

Patient feedback – Demographics

Gender Distribution

Female respondents gave the most feedback, with a strong lean toward positive sentiment. Male feedback was more balanced but slightly more negative. Responses from non-binary or undisclosed genders were fewer and evenly spread across sentiment types.

Age Group Trends

Older age groups, particularly those aged 55 and above, are more prominently represented in both positive and negative feedback. Notably, the 55–64 age group shows a higher proportion of negative comments. In contrast, younger age groups (16–34) are less represented overall but tend to report more positive experiences. The 45–54 age group presents a balanced sentiment distribution, while the 35–44 group shows a slight preference for positive feedback.

Disability Status and Sentiment

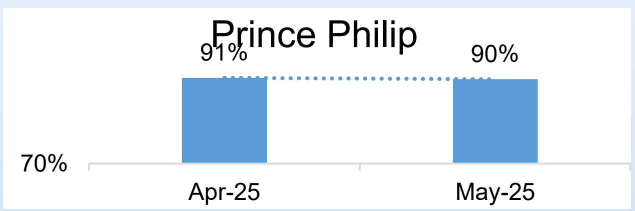
Respondents without disabilities were more likely to give positive feedback. Those with limitations ("Yes, a little" or "Yes, a lot") tended to share mixed or negative experiences, highlighting potential gaps in accessibility and service adequacy. A few who didn't disclose their status leaned positive, though the sample was small.

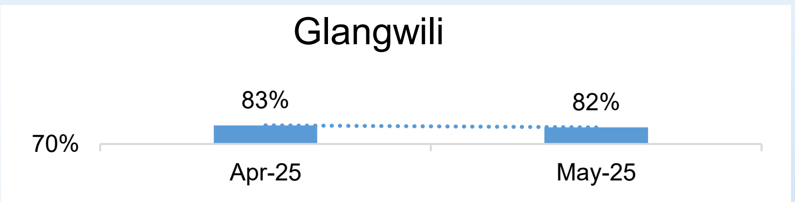
Ethnic Group Representation

Most feedback came from Welsh, English, or British respondents, who generally reported positive experiences. In contrast, responses from minority ethnic groups were more varied—particularly those identifying as "Any other Asian background," who expressed more negative sentiment, suggesting possible disparities for further exploration.

Patient feedback – May – June 2025

Each graph represents this period's performance for different sites. The differences in the data can be attributed to various factors such as operational changes, seasonal variations, patient feedback, and external influences.





The most represented age groups were the 55–64 years, 65–74 years and 75+ years. Very few responses from younger age groups (e.g., 16–24 years: 4 responses). Higher percentage of female responses with a higher percentage of Welsh to English and British.

Acute Medical Assessment Unit (AMU) Staff were described as informative, caring, and efficient. Patients appreciated quick assessments and professional care. However, difficulty reaching the ward by phone, long waiting times and lack of updates during the stay.

Cardio-Respiratory Department Patients felt that Staff were pleasant, efficient, and knowledgeable with timely appointments and clear communication. However, patients felt rushed in their consultations and, also comment about parking issues and lack of follow up.

Cardiology Department patients felt that they had clear explanations and respectful interactions, convenient phone consultations appreciated. However, some patients preferred in-person consultations due to complex conditions.

Chemotherapy Unit patients feedback that the staff were efficient, caring, and well organised. Staff friendly and supportive throughout treatment. No significant negative feedback: patients expressed high satisfaction.

Most responses came from the 55–64, 65–74 and 75+ age group with few responses from younger age groups The majority were female respondents. A majority identified themselves as Welsh and English and Welsh , English and British.

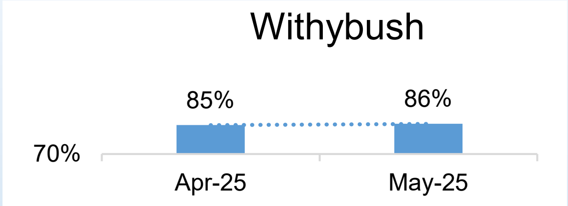
The hospital is highly rated for staff professionalism and care, but issues like waiting times, overcrowding, and communication gaps are affecting patient experience. Older adults are the primary respondents, suggesting a need to engage younger demographics more effectively.

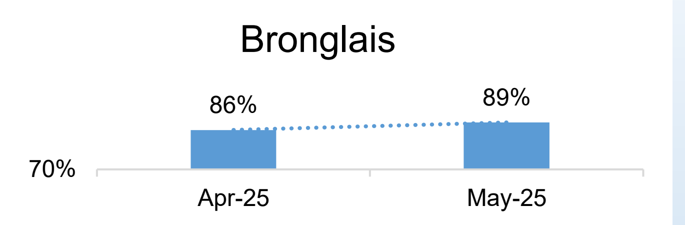
A&E Staff described as caring, attentive, and professional, specific praise for individual clinicians and quick triage. However long waiting times, overcrowding, lack of beds, poor communication including conditions (e.g., seating, cleanliness, noise).

Ambulatory Care Unit -Staff were kind, helpful, and efficient. However Long waits ,lack of updates and discomfort due to inadequate facilities.

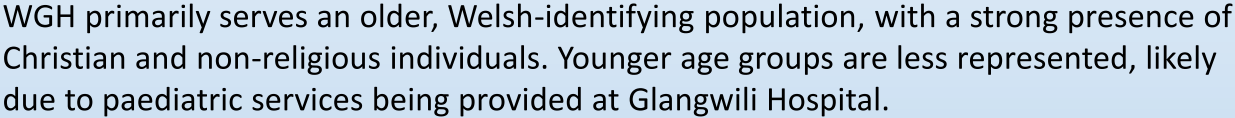
Aberglasney Suite efficient service and clear communication, Staff were friendly and reassuring. However occasional delays and communication issues.

Patient feedback – Overall feedback March 2024 – May2025





WGH primarily serves an older, Welsh-identifying population, with a strong presence of Christian and non-religious individuals. Younger age groups are less represented, likely due to paediatric services being provided at Glangwili Hospital.



A&E Feedback was generally positive, with praise for quick triage and friendly staff. However, concerns were raised about long waits, poor communication, overcrowding.

Inpatient Wards , particularly Ward 4, received favourable feedback for caring staff and cleanliness. Issues included noise, lack of privacy, and discharge delays.

Outpatient Services were mostly satisfied, citing efficient appointments and clear communication. Common complaints involved waiting times, parking, and follow-up.

Same Day Emergency Care Unit (SDEC) was commended for thorough assessments and kind staff, though some patients experienced delays in results and limited bed availability.

Specialist Clinics such as Rheumatology, Physiotherapy, Cardio-Respiratory, Gynaecology, and Colposcopy were praised for compassionate care and clear explanations. Delays and communication gaps were noted.

Day Surgery & Medical Day Unit feedback was mostly positive with smooth procedures and friendly staff, with occasional feedback on delays and lack of refreshments.

A strong representation in the 65–74 and 55–64 age brackets. . The population of responses came from is predominantly Welsh, English and British There is some ethnic diversity, including African, Indian, Chinese, and mixed ethnic backgrounds.

A&E had positive feedback regarding staff, clear communication and efficient and timely care. However, long waiting times, occasional communication breakdowns, bed shortages and inconsistent follow-up care were of concern.

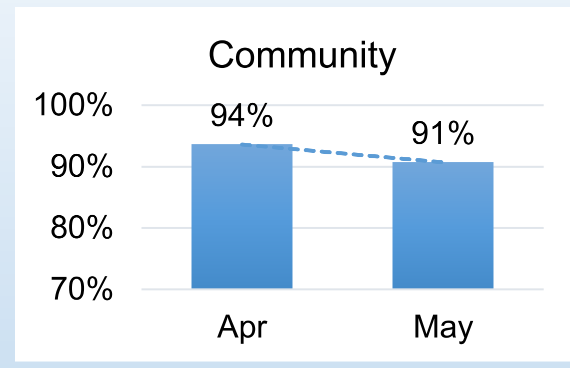
Angharad Ward excellent maternity care, supportive staff, and a child-friendly environment. However, concerns regarding feeling unheard or being passed between staff members.

Cardiac Monitoring Unit Quick access to care and overall efficiency, however limited hygiene facilities.

Cardio-Respiratory Department Feedback showed Friendly and professional staff, timely appointments but concerns regarding difficulty with navigation and parking.

Day Surgery Unit patients felt that staff were Friendly, there was clear communication, and smooth procedural experiences. However, hygiene practices and prolonged pre-operative waiting times.

Patient feedback – Overall feedback March 2024 – May2025



A wide range of feedback, with a strong representation of older female respondents
English as the preferred language, though some Welsh speakers are present.
A mix of Christian denominations, non-religious individuals, and a few from other faiths or who prefer not to say. Many patients praised staff for being kind, professional, and attentive, even under pressure. Some departments, especially MIUs, were noted for quick service and clear communication where patients appreciated being kept informed and having things explained clearly. However; though many comments reflect an understanding of NHS pressures, comments also call for better resourcing and coordination.

Overview

Patient sentiment across services remained broadly stable this period, with a consistent mix of positive, neutral, and negative responses. Commonly cited themes included staff, waiting, care, and nursing, reflecting both appreciation and ongoing concerns around service delivery and delays.

Cardigan Integrated Care Centre and Withybush General Hospital received the highest number of positive responses, indicating strong satisfaction. However, overall community sentiment declined slightly, suggesting a need for continued engagement and improvement. Glangwili General Hospital showed a more polarised response, with a notable volume of both positive and negative feedback. Prince Philip Hospital and Bronglais General Hospital demonstrated a more balanced sentiment, leaning slightly positive.

While the overall trend in patient experience remains positive, recurring trends particularly around waiting times and communication continue to be highlighted. Further detail on communication related feedback is provided later in this report and will be reviewed by the Listening and Learning Sub-Committee at the next meeting in July.

Responses to the Childrens Survey

The Service continue to review the current surveys with a view to substantially shorten the number of questions; however, as these are set at an all-Wales level, revisions are outside the direct control of the Health Board.

The service continue to share their feedback on 'you said - we did' boards so that families know the staff are listening and learning from their experiences.

Parents and carers expressed deep appreciation for the kindness, support, and professionalism demonstrated by staff. They also provided positive feedback regarding the calm atmosphere, cleanliness of the environment, and the quality of communication throughout their stay. However, some respondents highlighted areas for improvement, particularly in enhancing support within the A&E department and improving the quality of food provided.

Children aged 4- 11 Children aged 4- 11 provided positive feedback around the play-room and the games and the friendly staff. However, they responded that they did not like needles and the taste of the medicine

Children aged 11+ praised the food, care and the staff attention. They felt well informed and respected.

Primary Care Patient Experience Survey Feedback – Reflections and Actions

The General Medical Services Unified Contract includes an Access Commitment. This allows GP Practices under the Quality Improvement Framework (QIF) to engage in activities that report on patient access experiences. Patient experience surveys were conducted from November 2024 within the practices. Last report presented in May 2025, highlighted the feedback and actions to be taken in respect of managed practices. The information below is the summary from the independent GP practices, organised by cluster areas:

Amman Gwendraeth Cluster Summary

Category	Details
Common Issues	1) More Face to face appointments 2) Regular GPs for continuity of care 3) Call wait times
Positive Feedback	1) Positive comments about Staff, Nursing team & Clinicians 2) Patients always feel listened to and heard 3) Patients were impressed with access 4) Positive comments around E-consult 5) Positive comments around the service, particularly the efficiency of teams and ease of use.
Actions Taken	1) Open up more face to face appointments so there is an even mix with tele consults. 2) Preferred GP to be added to the patient warning pop up on screen when making an appointment. Staff to be made aware and patients advised that they can request a GP of choice 3) All admin staff present in the mornings to answer the phones until the morning demand has decreased phone provider to provide call back facility.

Llanelli Cluster Summary

Category	Details
Common Issues	• Phone bottleneck at 8:30 • Out of hours arrangements • Care navigation by receptionists
Positives	• Feeling Listened to and being cared for well. • Positive comments relating to reception staff.
Actions Taken	• Introduce a ‘You said, we did’ section (or similar) on website to show areas heard and to provide further education and information to patients • Find ways to divert pressure off the phones and to ensure resource is prioritised during the morning until the queue is cleared. Increase the number of digital forms provided and implementation of ‘self-booking’ appointments for routine procedures such as smears and chronic disease appointments. • Post the responsibilities and roles of a GP receptionist on our website and socials if applicable, explaining why questions are asked. Undertake campaign to promote the importance of a GP Receptionist. • Regular and useful training for the reception team so they can handle difficult situations and have confidence in doing so. • Improve pro active communication on common issues/frustrations such as the wait times for prescriptions and pharmacy arrangements • Reinforce policy that Clinicians can book their own follow up patients rather than divert them to reception to call back. • Moving more appointments to face to face rather than phone consultations..

North Ceredigion Cluster Summary

Category	Details
Common Issues	• Provisions of services bilingually was raised as an issue.
Positive Feedback	• Patients gave positive feedback around their involvement in decisions around their care.
Actions Taken	• Ensure all communications, social media posts, posters, signs etc. are displayed bilingually. • Re-record the answer phone message bilingually to make it less complicated and shorter.

South Ceredigion Cluster Summary

Category	Details
Common Issues	• Issues raised around car parking access at the practice.
Positive Feedback	• Positive feedback on kindness and helpfulness of both clinical and admin staff. • Patients mainly felt they were waiting a fair amount of time.
Actions Taken	• Improving communications with patients, improvements / updates page added to website. • A salaried GP has also been appointed to increase the available appointments on offer. • Receptionist to monitor car park for cars which don't belong to patients.

North Pembrokeshire Cluster Summary

Category	Details
Common Issues	• Access via telephone • Not being able to get an appointment • Issues with secondary care
Positive Feedback	• Staff are helpful • Good communication • Feel listened to • Staff are polite and easy to talk to
Actions Taken	• Increase the number of routine appointments available to patients • Review staffing levels in reception. Additional staff employed. • Review working patterns at reception to take account of busier times to assist with call answering during the busy periods of 8.30 – 10am & 2-3pm.

South Pembrokeshire Cluster Summary

Category	Details
Common Issues	• Larger Car Park • Fewer Locum GP,s • More appointments later in the day for working patients • Greater accessibility in appointment times for blood tests. • Improvement on the building and the inside decor.
Positive Feedback	• Friendly and helpful with staff being pleasant and polite. • Not feeling rushed during appointments • Shorter waiting times • Appreciation of the increase in appointments and the number GP's.
Actions Taken	• Increase in appointments for working patients between 4.45pm and 5.30pm. • Strengthened recruitment efforts. • car parking congestion during 8am to 10.30am due to sample collections schedules, contributing peak time parking pressure. Proposal to acquire equipment that would allow blood tests to be conducted throughout the day. This would not only ease parking but also increase the flexibility of appointment for the • Improvements for our communication systems including patient check in screens and the calling

Tywi/Taf (2Ts) Cluster Summary

Category	Details
Common Issues	• Should have left the old system (patient feedback) • Delays to get prescriptions from practice & pharmacy • Better parking and access
Positive Feedback	• Staff are polite and caring • Doctors and staff are always pleasant and caring, with special mentions to the nurses who are kind, understanding with a gentle and tolerant nature. Quick service, very friendly atmosphere.
Actions Taken	• Share positive / negative feedback from patient responses with all staff members • Evaluate the appointment system to ensure a balanced allocation of both pre-bookable face-to-face and telephone consultants. • Enhance communication with patients by taking a more transparent approach, such as publishing GP activity data on the website. • Continue to adjust the admin rota to ensure sufficient staff coverage for phone lines starting at 8:00am, aiming to meet the goal of answering 90% of appointment-related calls within 2 minutes, based on our phone system reports.

Compliments

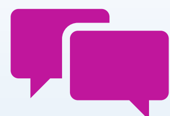
The Patient Experience team continue to visit services to provide teams with certificates of appreciation. Teams provide feedback on how great it feels to receive this recognition and look forward to seeing this every week via the “Feel Good Friday” posts on Viva Engage. **203 compliments** were received for this period, with many sharing thanks regarding to the themes below.

Acute Frailty Unit, Withybush Hospital –
The staff were always asking if they could do anything, being gentle and kind to my mum, doing the extras like brushing her hair. I’ve heard them being so kind and patient with dementia patients even when they were busy. Also looking after me (cups of tea, checking in on me, comfy chair). Medical treatment has also been brilliant, always explaining and asking if what they wanted to do was ok with us too. I can’t speak highly enough of all of them.

Specialist Lung Team –
From the first meeting with them when given terminal lung cancer diagnosis, they have given 110%. On each and every appointment they make me feel like I’m their only patient. They have helped sort out issues with other departments when I wasn’t able to sort it myself. They not only support myself but are there for my family too. Both Beth and Kirsten always have a smile on their faces and I look forward to going to appointments. More people like this are needed in the NHS.

If patients were pleased with their treatment or care they can share their appreciation to an individual staff member or team, by giving them a big thank you by completing our 'Big Thank You' online form which can be located on https://hduhb.nhs.wales/healthcare/services-and-teams/patient-support-services-complaints-feedback/ or th[illegible]ut for the poster in our hospitals.

Communication for this period



Among respondents aged 16–24, 49% reported not always feeling listened to. Similarly, 27.6% of those aged 25–34 expressed comparable concerns. These issues declined significantly with age, with only 6.6% of respondents aged 75 and over reporting similar experiences. Additionally, 7.2% of Welsh-speaking respondents indicated difficulty communicating in their preferred language. Despite these concerns, most respondents rated their overall experience as “Very Good” or “Good

Negative themes

- Confusing or dismissive communication from clinical staff.
- Unhelpful reception staff interactions.
- Long waiting times, particularly in A&E and for follow-up care. This were a major concern for younger adults and individuals with disabilities.
- Appointment issues, including scheduling difficulties and cancellations.
- Poor inter-departmental communication and unclear explanations between departments, patients felt confused and frustrated. Information gaps due to poor handover
- Facility concerns, such as parking, uncomfortable waiting areas, and lack of privacy. This was more frequently mentioned by older adults
- Staff behaviour, including reports of rudeness or lack of empathy, particularly noted by female respondents.

Positive Themes

- Clear, respectful, and informative communication from staff. This was valued by patients with disabilities who appreciated thorough communication
- Professionalism and kindness, with specific praise for individual staff and departments this was praised across all demographics
- Clean and well-maintained facilities this was shared across all demographics

Communication examples for this period

Positive communication feedback	Negative communication feedback
The doctor took time to explain my condition in a way I could understand. I felt reassured and informed.”	*I felt like the doctor wasn’t really listening to me. My concerns were brushed off.”*
All staff were polite and respectful. They listened carefully and answered all my questions.”	*“I waited hours without any information. No one told me what was happening or how long it would take.”*
The nurse was incredibly kind and made me feel at ease during a stressful time.”	*“I was told to wait, but no one explained what for or how long. It was very confusing.”*
Everyone I spoke to—from reception to the consultant—was on the same page. It made the process smooth.”	*“I had to repeat my story multiple times because the departments didn’t seem to communicate with each other.”*
I was offered the option to speak in Welsh, which made me feel more comfortable and understood.”	*I asked to speak in Welsh, but no one was available. I struggled to explain my symptoms properly.”*

Communication overview for this period

Most common positive words

Staff, helpful, friendly, quickly, efficient, kind, professional. This reflects the appreciation for person centered care and timely service.

Most common negative words

Waiting, time, hours, pain, rude, clean, long, seen. This highlights concerns around delays, communication, and environmental conditions.

Accident and Emergency received the highest volume of both positive and negative feedback, this is due to the amount of footfall within the department indicating high engagement but also room for improvement.

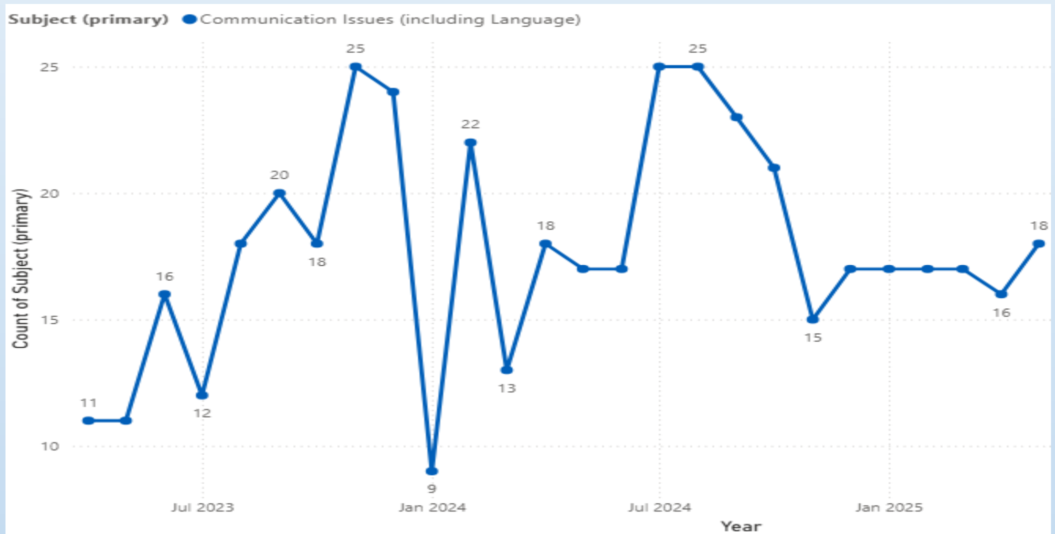
Minor Injuries Unit and Trauma and Orthopaedics also show strong positive feedback, though they still receive notable negative responses.

Services like Cardiology and Gynaecology maintain a high ratio of positive to negative feedback, suggesting relatively strong communication practices.

Feedback on communication was mixed, with some patients reporting positive experiences and others expressing dissatisfaction. As outlined earlier in the report, demographic factors appear to significantly influence these perceptions, and services should take this into account when planning improvements.

Spotlight on Complaints Theme: Communication

The theme of communication within complaints is a significant feature and is an element in almost all of the concerns received. A deeper analysis of the themes and reasons for the communication failures is being undertaken and will be a presented to the Listening and Learning Sub-Committee during July. For this reporting period: there were **34** complaints raised in the period where communication was the main issue – **16** in April and **18** in May 2025. The average (mean) amount in the past two years is 18 per month:



There were a further **22** complaints where communication was part of the complaint, although not the primary issue being reported.

Most communication complaints are about communication with the patient or family, with a small percentage being about communication generally (administrative, for example), or communication between teams and departments.

In the last rolling twelve-month period, 75% of all communication complaints are about issues in the general hospital sites. Nearly 40% are attributed to Glangwili General Hospital.

The service area receiving most communication complaints in Glangwili is A&E, although even this only equates to approximately one complaint per month – relatively low, given the number of patients the Emergency Department treats each day and the extent of communication. Evidence from data suggests that, whilst communication issues remain a main contributor to patient dissatisfaction, it remains widespread across all services rather than being notably attributed to specific teams or services. In the last 12 months, nearly seventy services have received at least one complaint where communication has been the main issue.

Services receiving most communication complaints in last rolling 12-month period

Service	Count
Accident & Emergency	25
Medicine	25
Rheumatology	24
Ophthalmology	20
Urology	16
Gynaecology	15
Trauma & Orthopaedic Specialists	14
Health Records	13
Orthopaedics	11

Complaint regarding communication - administrative oversights and scheduling issues

The patient complained that their scheduled telephone appointment did not run as planned and received a letter the next day to say that it had been cancelled and a new date given. When the date of the new appointment arrived, there was again no telephone call as scheduled, and the patient was later told by the secretary that the doctor had forgotten to call.

Complaint regarding communication during end-of-life care and receiving timely support

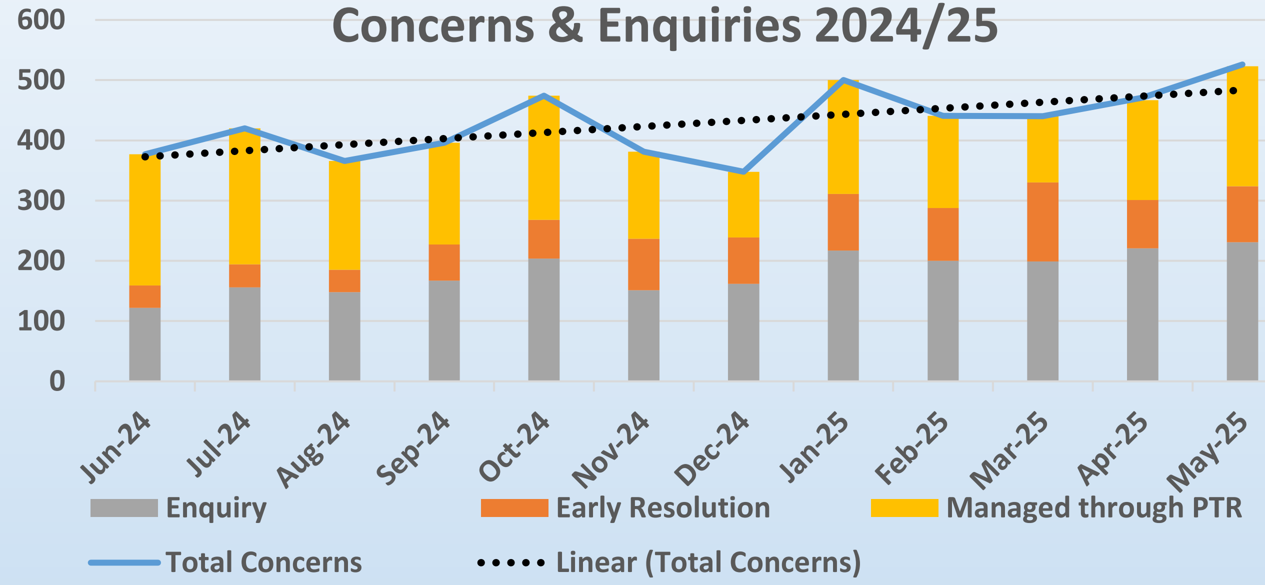
The family reported issues with communication during the patient's end of life care. They were concerned that the patient had been unaware of his prognosis after being diagnosed with cancer. The family had also not been told how to best provide care for the patient and found that explanations from the nursing staff were unclear. Advice and support from Macmillan nurses was difficult to access as the family could not reach them easily.

Complaint regarding communication affecting treatment

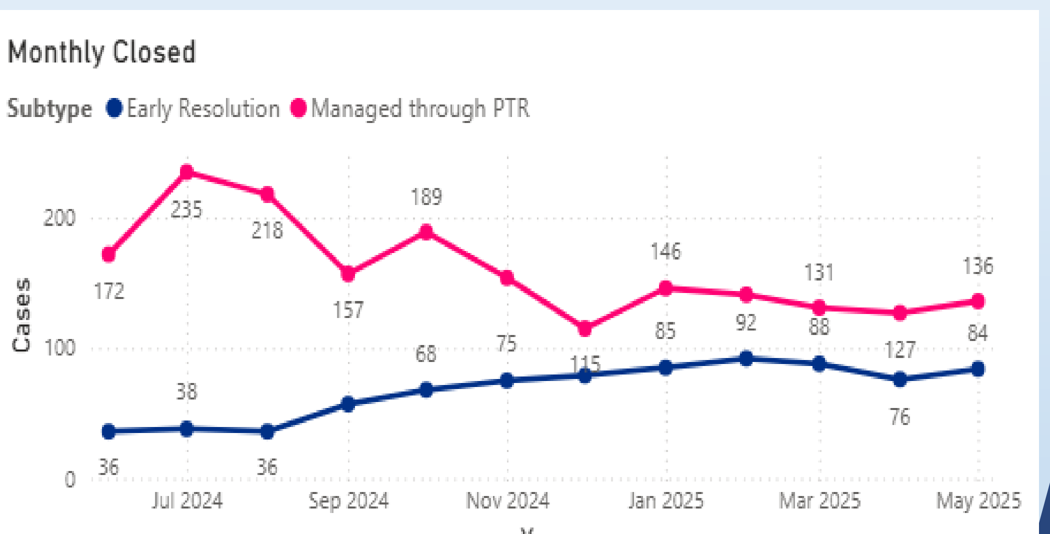
The Health Board acknowledged that there was no evidence to show that the patient had been correctly counselled or advised about the potential for a poor outcome from surgery. Additionally, communication about the risks and benefits of non-operative treatment could not be evidenced either. In this case, the Health Board considered that communication oversights may have impacted upon the patient's treatment.

Summary of Complaints and Concerns - Received April/ May 25

In the reporting period April/May 2025, **538** new concerns and complaints were received by the Health Board in total. Overall, the volume of enquiries, concerns and complaints from patients or their families/carers are increasing



423 concerns and complaints were closed in the period April-May 2025. Of these, **263** were managed as formal complaints and investigated under the Putting Things Right Regulations. The remainder (48%) were resolved through the early resolution process.



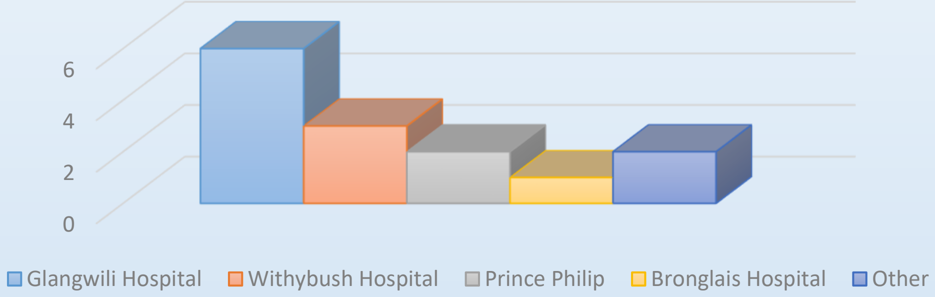
173 of complaints received in the period were managed as early resolution cases, with the aim of being resolved within five working days. The trend towards early resolution is continuing, with a 134% increase this period compared to the comparable period last year.

53% of complaints closed in the period achieved the 30-working day timescale under the formal Complaints and Redress Regulations. The target set by Welsh Government is 75%. The Health Board's performance in this respect has been adversely affected by the increase in cases managed under early resolution. Despite this, it is to the advantage of both Health Board and patients to resolve issues quickly and, where appropriate, without recourse to a formal complaint process.

Summary of Outcomes from Complaints: April/ May 2025

14 cases were escalated to Redress in the reporting period, because failings have, or may have, caused harm to patients. These have occurred at the following sites:

Cases escalated to Redress – April-May 2025

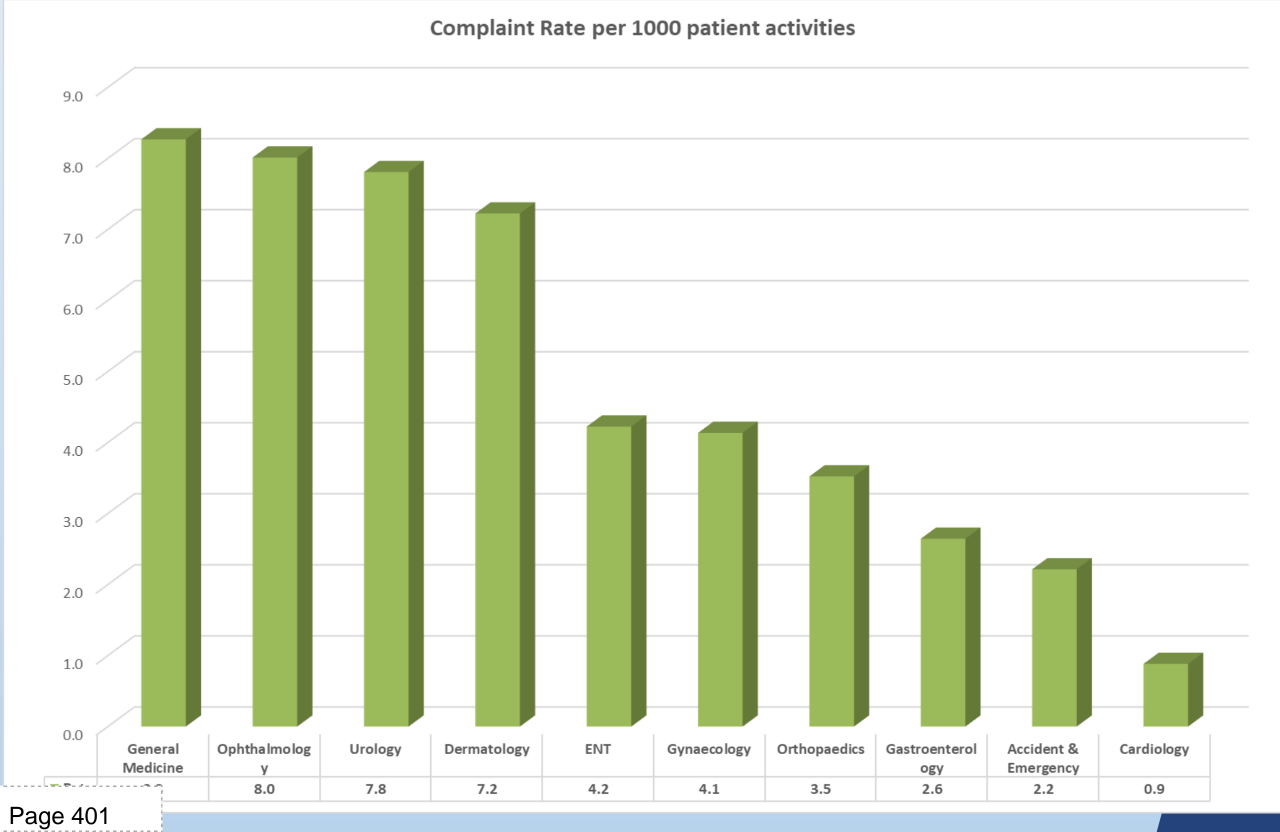


In the same period, **11** complaints were upheld because of errors or omissions in care, but were not found to have caused harm.

The significant failings in care identified in the April/ May 2025 period have centred mostly on Emergency Care, Trauma and Orthopaedics and Obstetrics/ Midwifery. The investigations have identified a delay to surgery, lack of follow-up appointment and a medication error. They have also found issues with surgical/ clinical procedures – with the incorrect treatment of a spinal injury, contact lens replacement and use of forceps during birth. Communication issues were also noted as a reason for upholding complaints.

The top three services receiving most formal (investigated) complaints individually in April/ May 2025 in relation to volume are A&E; Gynaecology; and Ophthalmology.

Work has commenced on agreeing the measurement of activity within services, to provide context around the volume of complaints received. This is currently presented as rate of complaints per 1000 activities. A consistent measurement of activity will need to be agreed prior to embedding this approach further; however, the initial work has returned the following results:.



Learning from the Ombudsman

In the period April/ May 2025 there has been one new investigation started by the Public Services Ombudsman for Wales. This will look at the medical management of a patient with pancreatitis and whether a cancer diagnosis should have been made earlier.

There were 9 instances recorded where complainants escalated their concerns to the Ombudsman and, following review, the Ombudsman decided not to investigate.

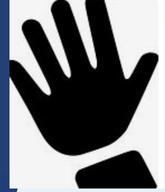
There were 2 complaints made to the Ombudsman prematurely.

In the same period, there were 4 early resolution agreements made between the Health Board and the Ombudsman.

There have been no final reports received in April/ May 2025.

You Said…

…We Did

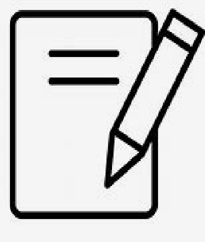


'There was a lack of communication around discharge planning, and no one seemed to be aware of the plans for our relative. We were getting extremely frustrated with having to repeat his pre-admission situation to staff. We just want good communication and to know that there is a safe plan in place for our relative.'

In line with our Health Board's 'Hospital Discharge Toolkit', we work on the principle that planning for hospital discharge or transfer of care should start early in the patient's admission.

Discharge planning is a complex process involving a range of people, and early planning and communication gives us a better opportunity to understand the range of factors we may need to consider for a patient to be discharged home safely. Our 'toolkit' for staff provides a range of resources to make this as safe and effective as possible.

'When visiting A&E at Glangwili, the floor had clearly not been cleaned for some time, there were stains on the walls and I was concerned about infection control measures, given that I was there with an elderly relative.'



Whilst still a very busy area, our Accident & Emergency Department in Glangwili Hospital has recently undergone a refurbishment, with new flooring, ceiling and paintwork making it a more pleasant area in which to wait.

The relatives' room has been refurbished with the help of the 'Wish upon a Star' charity, and the paediatrics room refurbished. Our 'majors' area has new wall murals of Carmarthenshire, adding a pleasant aesthetic touch.

5.3

5.3 - Work Plan 2025/26

Attachments

Draft QSEC Work Programme 2025 26 (3).pdf

QUALITY SAFETY & EXPERIENCE COMMITTEE WORK SCHEDULE APRIL 2025 – MARCH 2026

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 2025 – March 2026

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2025	10 June 2025	15 August 2025	8 October 2025	5 December 2025	13 February 2026
Governance								
Welcome and Apologies	**Chair**	**All**	✓	✓	✓	✓	✓	✓
Declarations of Interests	**Chair**	**CSO**	✓	✓	✓	✓	✓	✓
Minutes from Previous Meeting and Matters Arising not on Agenda	**Chair**	**CSO**	✓	✓	✓	✓	✓	✓
Table of Actions (ToA)	**Chair**	**CSO**	✓	✓	✓	✓	✓	✓
Review of Terms of Reference (TORs)	**Chair**	**CSO**		✓				
Annual Review of Sub Committees TORs	**Chair**	**CSO**		✓				
Assurance On Governance Arrangements Report • Corporate Risks • Operational Risks • Internal and External Audit Reports • Monitoring of Ministerial Directions • Monitoring of Welsh Health Circulars (WHCs)	**Executive Leads**	**RW**	✓	✓	✓	✓	✓	✓

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2025	10 June 2025	15 August 2025	8 October 2025	5 December 2025	13 February 2026
Self-Assessment - Six month review of actions August 2026	**Chair**	**JW**			✓			
Patient/Staff Story	**LOC/ Service Leads**		✓ Urgent and Emergency Care	✓	✓	Staff Story Cadog Ward Frailty Unit	✓	✓
Policies for Approval (as required)	**All**	**All**		✓	✓	✓	✓	✓
Targeted Intervention Progress Report	**SA**	**Executive Leads**	✓	✓	✓	✓	✓	✓
Assurance								
Annual Report on Committee's Activity	**AL/SD**	**All**	✓					
Annual Report from Sub-Committees	**SD**	**SD LOC**		✓				
Fragile Service Update Report *(TI 32, 33, & 35)*	**SD**	**SG/CS**		✓				
Clinical Audit Outcome Reviews	**SD**	**TBC**				✓		
Patient Experience Framework	**SD**	**LOC**		✓				
Learning Framework Report *(TI 48)*	**SD**	**CS**			✓			

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2025	10 June 2025	15 August 2025	8 October 2025	5 December 2025	13 February 2026
Getting it Right First Time Governance Review	**JW**	**JW**		✓				
Duty of Quality Assurance Report incorporating: • External Inspection and peer reviews *(TI34 & 52)* • Nurse Staffing Act Assurance (every 6 months) • Walkrounds (a thematic review on 6 month basis) • Quality Improvement outcomes *(TI 53)* • Quality Impact Assessments *(TI 32, 33)* • Putting things right *(TI 51)* • HCAI *(TI 50)* • Duty of Candour *(TI 54)* • Learning from significant events • Speaking Up reports on quality themes (every 6 months) • Paediatrics Service Changes BGH • WHC's overview *(every other meeting) (TI 52)*	**SD**	**CS**	✓	✓	✓	✓	✓	✓
Unscheduled Emergency Care Deep Dive including GIRFT Reports and Action Plans	**AC**	**PS**	✓			✓		
Mental Health and Learning Disabilities (MHLD) Deep Dive	**AC**	**RTP**	✓					
Epilepsy in Learning Disabilities Services	**AC**	**LC/ KI**			✓			
Sonography - The impact on patient experience and clinical outcomes due	**AC**				✓			

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2025	10 June 2025	15 August 2025	8 October 2025	5 December 2025	13 February 2026
to Risk 787: Workforce Pressures in Ultrasound Services								
Primary Care Quality and Safety and Experience Deep Dive	**JP**	**RB**	✓					
Auditor General Report on Cancer Services	**AC**	**LH**		✓				
Infection Prevention and Control in the Community	**AG**	**MH**	✓					
Update Report on the Quality Improvement Strategic Framework 2023- 2026	**SD**	**MD**	✓					
Planned Care Review- Impact of Long Waits	**AC**	**PG**				✓		
Duty of Candour Annual Report 2024/25	**SD**	**CS**		✓				
Duty of Quality Annual Report 2024/25					✓			
Nurse Staffing Levels (Wales) Act: Assurance Reports (as required) –Annual Report 2024/25 and Spring Calculation Cycle	**SD**	**HH**		✓		✓		
Nurse Staffing Levels Impact of Reduction of Agency and Bank Staff on quality, safety and patient experience annual review report	**SD**	**HH**				✓		
CHKS Report	**MH**	**MH**		✓				
Cleanliness Standards Audit report and Action Plan	**JS**	**SC/ EB**		D	✓			

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2025	10 June 2025	15 August 2025	8 October 2025	5 December 2025	13 February 2026
Outcome from Maternity Business Care – Date tbc	**AC**	**CL**						
Occupational Therapies Paediatric Improvement action plan	**AC**	**PG**		D		✓		
Patient Experience by Demographic	**SD**	**LOC**			✓			
Risks								
Sub Committee Update Reports								
Quality, Safety and Experience	✓	✓	✓	✓	✓ TOR for Annual Review	✓	✓	✓
Listening and Learning:	✓	✓	✓	✓	✓	✓	✓ TOR for Annual Review	✓
For Information								
HIW Annual Report							✓	
JCC Quality Safety Outcomes Sub Committee			✓	✓	✓	✓	✓	✓
Work plan 2025/26			✓	✓	✓	✓	✓	✓
Patient Experience Report			✓	✓	✓	✓	✓	✓
Agenda setting meeting with Chair and Exec Lead to include discussion	**CSO**	**CSO**	✓	✓	✓	✓	✓	✓

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2025	10 June 2025	15 August 2025	8 October 2025	5 December 2025	13 February 2026
on deep dives on new risks (at least 6 weeks before the meeting)								
Draft agenda to go to Executive Team prior to being issued.	**CSO**	**CSO**	✓	✓	✓	✓	✓	✓
Call for papers (at least 4 weeks before the meeting to receive papers at least 14 days before the meeting)	**CSO**	**CSO**	✓	✓	✓	✓	✓	✓
Disseminate agenda and papers 7 days prior to the meeting	**CSO**	**CSO**	✓	✓	✓	✓	✓	✓
Type up minutes and TOA within 7 days of the meeting	**CSO**	**CSO**	✓	✓	✓	✓	✓	✓
Circulate minutes and TOA to Committee for comments, points of accuracy and matters arising within 10 days of the meeting	**CSO**	**CSO**	✓	✓	✓	✓	✓	✓
Check and send final version of minutes to the Committee Chair following comments received.	**CSO**	**CSO**	✓	✓	✓	✓	✓	✓
Chase updates on TOA before the next meeting and RAG rate	**CSO**	**CSO**	✓	✓	✓	✓	✓	✓
Record and track the TOA as part of 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**	✓	✓	✓	✓	✓	✓

Initials

SD- Sharon Daniel	CSO-Katie Lewis	AL- Anna Lewis	LOC- Louise O'Connor	MH- Mark Henwood

AC- Andrew Carruthers	CL: Cerian Llewellyn	CS- Cathie Steele	SG- Subhamay Ghosh	JS- James Severs
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	Ps: Peter Skitt	SC: Simon Chiffi
BL- Bethan Lewis	LC- Liz Carroll	SA- Shaun Ayres	MD- Mandy Davies	LH- Lisa Humphreys

6

6 - Date of Next Meeting : 9:30am 9 October 2025