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

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	04 December 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Care Group Quality Report – Community and Integrated Medicine Clinical Care Group
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Andrew Carruthers, Chief Operating Officer
SWYDDOG ADRODD: REPORTING OFFICER:	Anna Chiffi, Assistant Director of Nursing, Quality and Patient Experience

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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

The CIMCCG is currently at Level 3 escalation for the quality domain and level 3 for the governance domain. As part of the escalation process, focused efforts are being made to address areas with action plans aimed at improving both the quality of care provided and robustness of governance mechanisms to meet expected standards. This report provides detailed insights into performance trends, highlighting areas that require improvement and actions in place to support this.

Cefndir / Background

The CIMCCG operationally leads and ensures the quality and safety of multiple services spanning Community and Acute settings.

The aim of the 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 the Care Group in order to promote collaboration, trust, innovation and personal growth

Meeting the Duty of Quality is the highest priority for the 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

Quality Assurance

The Clinical Care Group Quality Governance meetings are planned every month, and are well represented by medical, nursing and managerial staff across all 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 Groups Terms of Reference and Work Plan are reviewed annually, and it is supported by subgroups.

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

Quality and Governance Areas of Escalation

Areas for improvement identified through the Health Boards escalation framework relate to 3 areas: complaints management, incident management and closure of overdue actions, timely investigations and improvements in relation to healthcare acquired infection, pressure damage and medication errors and understanding of the learning behind the unplanned admissions from wards to Intensive Therapy Unit (ITU).

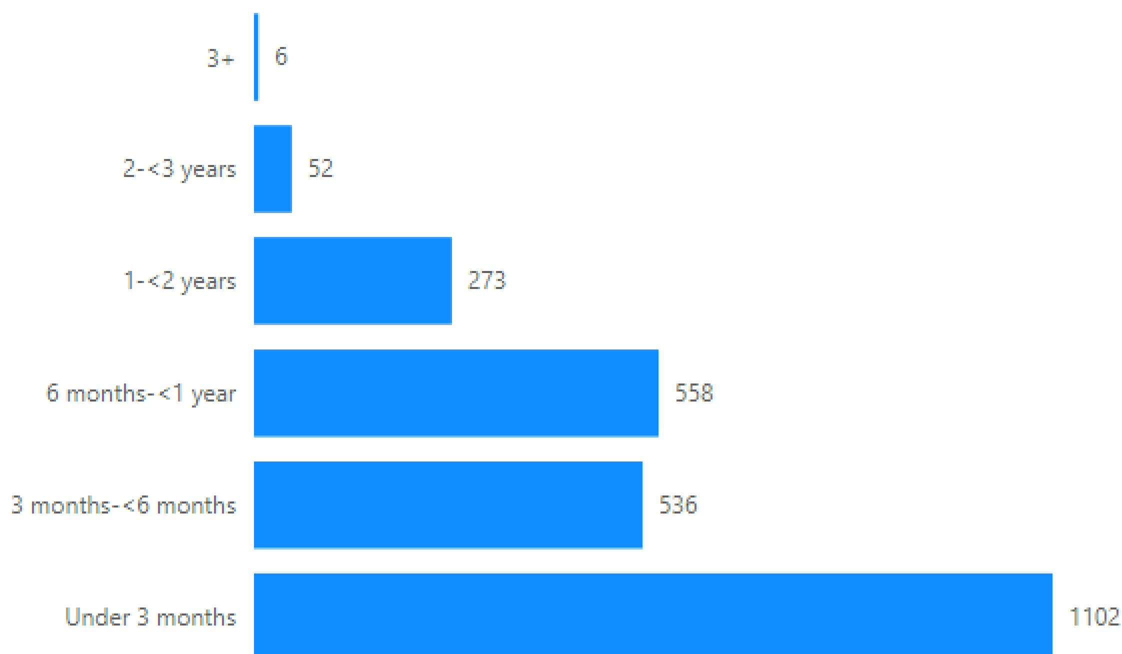
Updates in relation to these areas are contained under relevant STEEEP domains of the report.

A targeted plan with defined actions and owners is in place (see Action Plan Summary below).

Quality & Safety	3	Escalation assurance: 37% (last month 43%) For details please see the Our Safety dashboard. To also note - NRI closure compliance: 2 overdue and longest is 917 days	Incidents: The numbers open over 120 days and 60 days has deteriorated - improvement required Submission of outcome forms for overdue NRIs Complaints: improvement in complaints management Healthcare acquired infection: timely investigation and improvements Duty of Candour: improvement in timeliness of initial management review
Governance	3	Risk Management: 29% risk actions overdue Audits & inspections: Improving position with 38% of recommendations overdue. 75% no revised date WHCs: 1 out 2 overdue (50%)	Risk Management: 90% of risks and risk actions are reviewed within timeframes and compliance achieving TRS dates Audit/inspection recs implemented within timescales: Level 2: >80%, Level 1: >90% WHCs: Level 2: >80%, Level 1: >90%

Safe Care

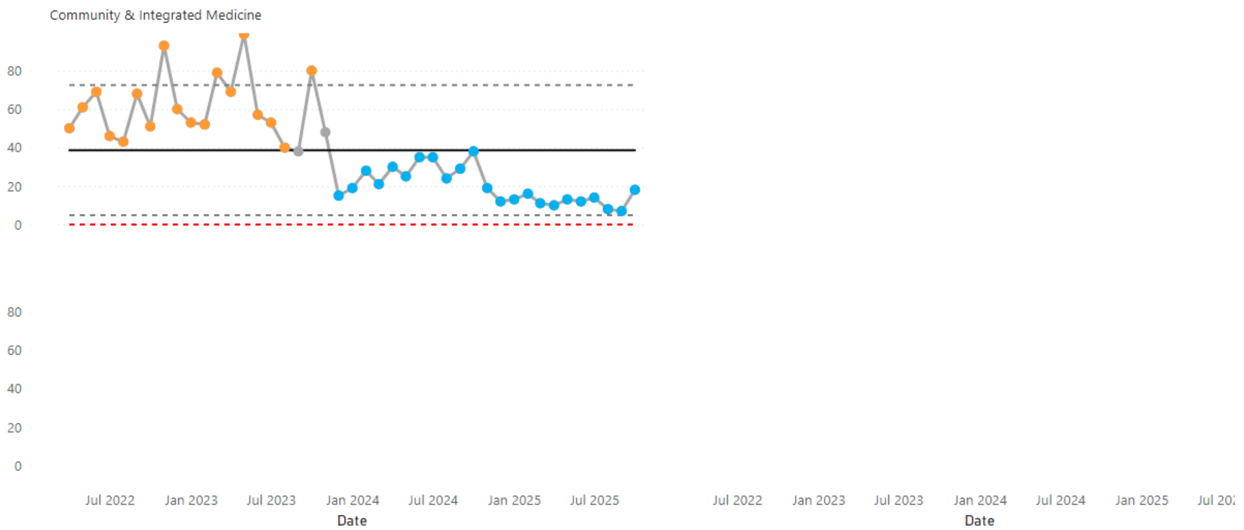
Incident Management



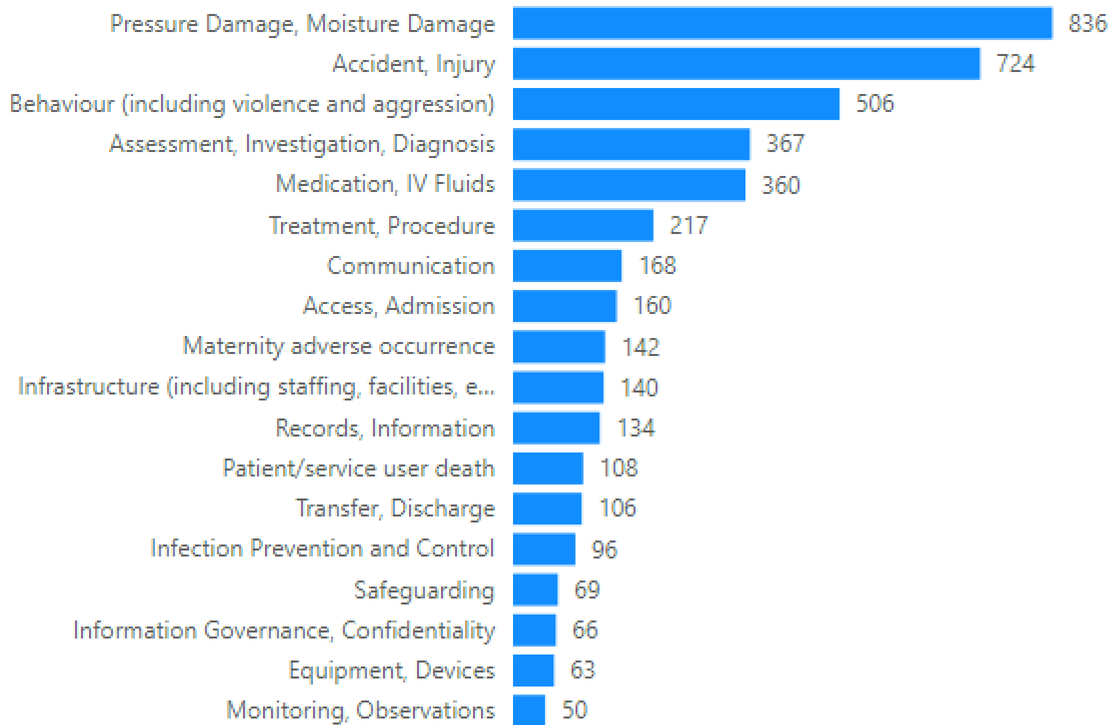
The chart above shows the total number of open incidents across the Clinical Care Group broken down by the length of time open.

While the overall number of open incidents has reduced, we still have a number of incidents open over both 60 and 120 days. Significant work is ongoing to reduce the incidents open over both 60 and 120 days and this focussed approach is demonstrating an improvement in our trajectory. We are holding focused meetings for areas with the highest non-compliance and allocating dedicated time for our ward managers and senior nurses to investigate, review and close. Delays have been noted due to paper-based notes having to be requested back from storage. The chart below shows the number of investigated incidents that are closed with moderate or worse harm. It is encouraging that our scrutiny panels and learning from events are having a positive impact on the severity of harm that is attributed.

- Graph showing total number of investigated incidents causing moderate or worse harm



This month we have hosted our first whole system learning meeting chaired by our Associate Medical Director. This forum will be held on a monthly basis and includes key clinical leads from across our care group services. The ambition of this forum is to provide a platform for learning from incidents, complaints and mortality reviews. This is predominantly achieved through the description of patient stories. Thematic analysis of our incidents will also be presented to this meeting alongside reviewing how we can ensure a more timely approach to closure. The graph below demonstrates our most prevalent themes.



Compliance with patient safety notices and alerts

The following Welsh Health Circular (WHCs) sit with the CIMCCG. All WHCs are managed via Audit Management and Tracking System (AMaT). which leads have access to directly update and upload relevant evidence to demonstrate compliance with their requirements.

Overdue WHCs

Welsh Health Circular	Reason for Red Status (from AMaT)	Impact of non-compliance according to risk assessment	Next Steps
006-24: National Clinical Guideline for Stroke, for the UK and Ireland – **issued March 2024**	The WHC cannot be implemented until the Clinical Services Plan has been completed (Stroke Services are part of this wider plan as there is a current lack of resource, including staffing, equipment and environment).	**Risk Ref:** 233 **Current Risk Score:** 12 **Impacts:** Delayed assessment and treatment of patients; Increased length of stays	**At the last CCG Quality meeting it was discussed that the Stroke Team to review the QIA and a revised QIA to come back through the CCG before being resubmitted.**

In progress) WHCs

Welsh Health Circulars	Update from AMaT	UHB implementation date
041-24 Ambulance patient handover guidance – **issued October 2024**	• Information on Ambulance Handover Guidance circulated with IQFPD Groups, SBAR completed. • Welsh Government Reviewing Ambulance Handover in GGH on the 19th March 2025. Once findings from review are shared with the Health Board we will develop a delivery plan (end of Q1 25/26). • Progress will be monitored by IQFPD and expected completion date end of Q3 25/26.	December 2025

Safeguarding

While safeguarding reviews are ongoing at individual community and acute site level, the Care Group does not feel confident that overall assurance is received through the Care Group Quality and Safety Group. The safeguarding escalation is aligned to the previous Health Board structure and needs aligning to the revised system way of working. Following discussions with other care groups alongside our Executive Director of Nursing, Quality and Patient Experience, it has been confirmed that a revised process is introduced. The CIMCCG will move towards a Care Group wide safeguarding steering group on a quarterly basis. This will be chaired by the Assistant Director of Nursing, Quality and Patient Experience and feed directly into the quality and safety meeting to enable ongoing escalation and assurance.

The Quality and Safety Integrated Governance Group has noted concerns in training compliance for Children Safeguarding, Adult Safeguarding (Level 2 and Level 3) and Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV). This is accompanied by concerns in relation to:
- Operational pressures in Emergency Departments (EDs)
- Continued missed opportunities for children safeguarding referrals
- Restrictive practice review

The revised Care Group approach will support in the review of safeguarding data and evaluate assurance levels and address areas where confidence is lacking.

Infection prevention and control

Department, ward or team	Cumulative cases 2025/26	Cumulative cases 2024/25	Latest in-month cases
GGH AE	92	129	16
BGH Emergency & Urgent Care Centre	50	100	10
WGH Accident and Emergency	75	150	8
PPH AMA Unit	34	68	7

The table above shows the total number of health care acquired infections per month within the top four areas presenting the highest number of cases. The Health Board continues to be monitored under the targeted intervention framework for C. difficile, E.coli and S. aureus infections. Reduction expectations have been set at 40% for C.difficile, 20% E.coli and 25% for S.aureus. The last month has also seen an increase in respiratory outbreaks alongside COVID. A recurring theme in the outbreaks has been the transfer of patients pending screening results without communication of suspected infection. All suspected and confirmed cases of infection should be isolated, and such patients would not be suitable for boarding given 'Our Next Patient' protocol.

Mandatory Asceptic Non-Touch Technique (ANTT) E-learning and 3 yearly practical competency assessment for all staff that perform ANTT procedures.

CIMCCG ANTT compliance- 86.32% %

Infection Prevention and Control Level 2 Mandatory training for clinical staff is available below.

Mortality reviews

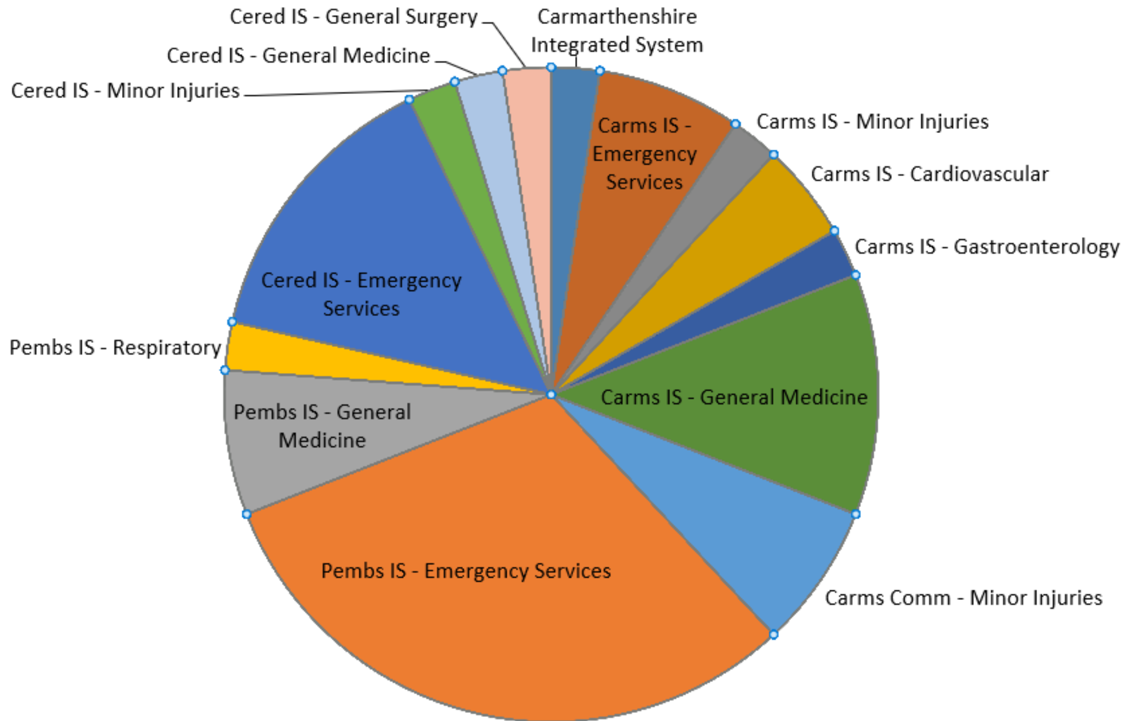
The mortality review figures demonstrate a significant number of unresolved investigations across the three systems dating back to 2021.
Given the complexity and depth of investigation required to thoroughly undertake these reviews, current capacity is insufficient to complete them in a timely manner. The Clinical Care Group has agreed to explore whether there is opportunity to review the current practice and support with additional resource to reduce the backlog of cases. Clinical leads have now been assigned to support in the process alongside the introduction of heads of governance, workforce, innovation and research and teaching and education. This will provide a robust mechanism around mortality, Datix, and complaints from a clinical perspective.

Claims and redress

Across all Health Board services, there are 229 confirmed Clinical Negligence Claims open of which 42 relate to CIM, with estimated damages on Datix of £10.1m and claimant's costs of £2.5m, assuming all claims are proven and settled.

N.B. The Health Board may seek reimbursement of its losses in Claims (*save for the first £25,000 excess*) subject to Approval of a Learning from Events Report.

Confirmed redress claims currently total 59.



Relevant risk recorded on the risk register (high or extreme risks)

Governance escalation- Improvements required for de-escalation

Improvements needed	Current position (as at October 2025 month end) – Level 3 (TBC)
Between 80-89% compliance for risk and risk actions being updated within required timescales for Level 2, over 90% compliance for Level 1.	• 19 of 98 risks overdue (19%) (Level 2- Sept 17%, Aug 19%) • 48 of 167 risk actions overdue (29%) (Level 3 declining position- Sept 32%, Aug 28%)
Relevant risks articulated on risk registers with actions plans in place, and evidence that the CCG is delivering against these (e.g. specific and measurable risk action plans, current score and target risk score clearly articulated, achieving expected target risk dates)	• 6 risks require 'Expected date to achieve TRS' to be added (see slide 6) • 12 risks require 'Rationale for the Target Risk Score' to be added (see slide 7) • 3 risks had been reviewed which had an 'Expected Date to achieve TRS' which has passed and not been revised (see slide 8) • 4 risks have no open risk actions (see slide 9) • Risks are slow to be added to Datix for Carmarthenshire CSG (see slide 13)

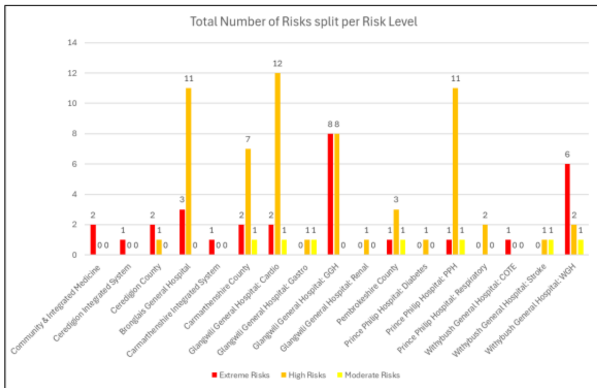
The table below provides a summary of the corporate risk 1027 which sits with CIMCCG. All Corporate risks were reported to Board September 2025.

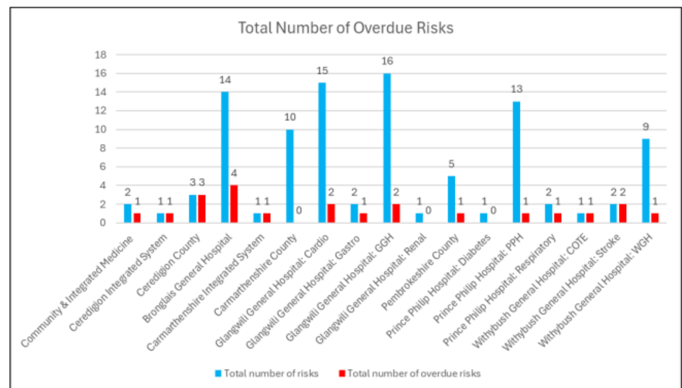
Risk Ref	Title	Date Risk Identified	Current Risk Score	Risk Level (Current)	Target Risk Score	RR - Target Risk Score Expected Date	Directorate	Service/Department	RR - Clinical Sub-Group	Domain	Lead Committee	Date of Review	Review date	Approval status
1027	Risk to delivery of timely urgent and emergency care due to demand exceeding current capacity	19/11/2020	20	Extreme	8	31/03/2026	Community & Integrated Medicine	Community & Integrated Medicine	Community & Integrated Medicine	Safety - Patient, Staff or Public	Quality, Safety and Experience Committee	30/09/2025	30/10/2025	Corporate Risk

The table below provides the number of risks per sub-group and by current risk score level, including those that are overdue for review.

Clinical Service Sub-Group	Total number of risks	Extreme Risks	High Risks	Moderate Risks
Community & Integrated Medicine	2 *(1 overdue- Corporate risk 1027)*	2	0	0
Ceredigion Integrated System	1 *(1 overdue- 2143)*	1	0	0
Ceredigion County	3 *(3 overdue- 1898, 2100, 2101)*	2	1	0
Bronglais General Hospital	14 *(4 overdue- 2141, 2171, 1238, 1764)*	3	11	0
Carmarthenshire Integrated System	1 *(1 overdue- 2110)*	1	0	0
Carmarthenshire County	10	2	7	1
Glangwili General Hospital: Cardio	15 *(2 overdue- 119, 1999)*	2	12	1
Glangwili General Hospital: Gastro	2 *(1 overdue- 2173)*	0	1	1
Glangwili General Hospital: GGH	16 (2 overdue- 2072, 1992)	8	8	0
Glangwili General Hospital: Renal	1	0	1	0
Pembrokeshire County	5 *(1 overdue- 1583)*	1	3	1
Prince Philip Hospital: Diabetes	*1*	0	1	0
Prince Philip Hospital: PPH	*13(1 overdue- 1530)*	1	11	1
Prince Philip Hospital: Respiratory	2 *(1 overdue- 105)*	0	2	0
Withybush General Hospital: COTE	1	1	0	0
Withybush General Hospital: Stroke	2	0	1	1
Withybush General Hospital: WGH	9 *(1 overdue- 1424)*	6	2	1

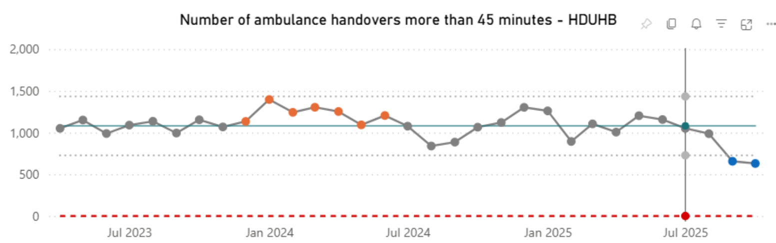
GGH has the highest number of 'extreme' scoring risks with 8, followed by WGH with 6. Cardiology has the highest number of 'high' scoring risks with 12, followed by BGH and PPH with 11 each.





Timely

From 1 October 2025, a new standard was introduced, requiring ambulances to be handed over within 45 minutes of arrival at any of our acute hospital site. Significant planning took place throughout August and September 2025 in an endeavour to achieve this performance metric. The graph below demonstrates the significant improvement achieved both leading up to and following this date. A number of initiatives have supported this development including a reset week focussed on admission avoidance, a reset week dedicated to discharge planning alongside the introduction of 'our next patient', more efficient use of our discharge lounges and criteria led discharge.



Latest period	National target	Target aim	Latest actual	Variation	Assurance	Trajectory
Oct 2025	0	Lower	630.0			

The latest data is showing improvement. However, improvement actions need to be identified and successfully embedded for the target to be met.

Expected performance is between 728 and 1434

Key
- Upper and lower limits
- Mean
- Target
- Ambition

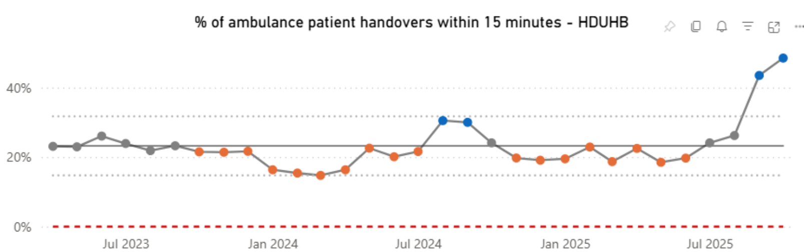
Variation - how are we doing over time
- Improving variation
- Usual variation
- Concerning variation

Assurance - performance against target
- Always hitting target
- Hit and miss target
- Always missing target

Trajectory - performance against our ambition
- Trajectory met
- Within 5% of trajectory
- More than 5% off trajectory

While it is important to acknowledge this improvement in handover performance and recognise the significant amount of work that has contributed to this outcome, it is important to highlight that this has shifted pressure and escalation across other areas in the hospital. Our surge and boarding numbers have increased in a situation of increased sickness amongst staff and infection control concerns within our clinical areas. It is important that we next focus our attention on pathway of care delays in order to maintain progress and ensure optimal patient flow throughout the coming months.

The graph below further demonstrates the improvement in ambulance handover time in less than 15 minutes.



Latest period	National target	Target aim	Latest actual	Variation	Assurance	Trajectory
Oct 2025	0.00%	Higher	48.50%			

The latest data is showing improvement and the target will be consistently met.

Expected performance is between 14.7% and 31.7%

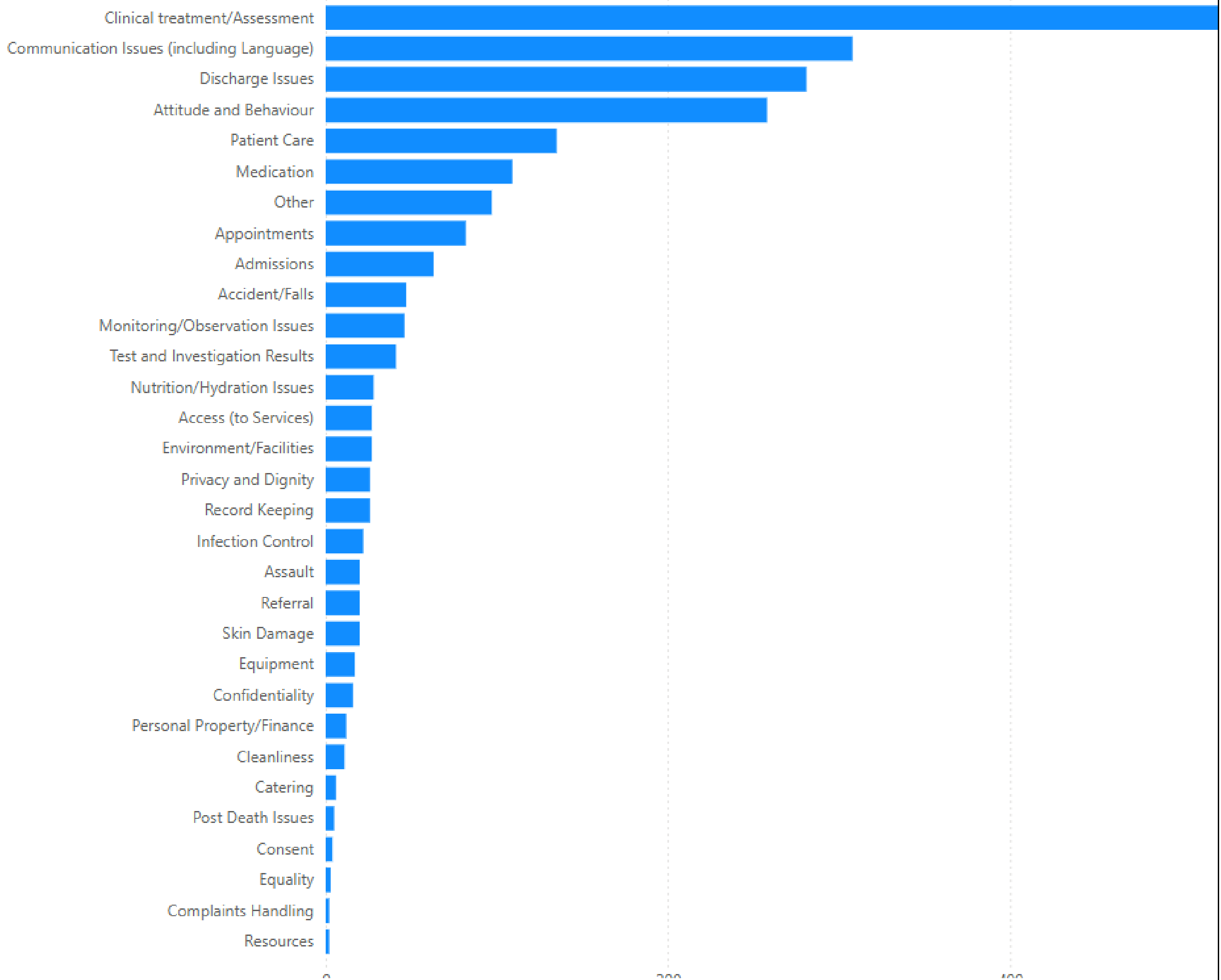
Key
- Upper and lower limits
- Mean
- Target
- Ambition

Variation - how are we doing over time
- Improving variation
- Usual variation
- Concerning variation

Assurance - performance against target
- Always hitting target
- Hit and miss target
- Always missing target

Trajectory - performance against our ambition
- Trajectory met
- Within 5% of trajectory
- More than 5% off trajectory

While there are not specific concerns in relation to timely care, the following graph provides a thematic evaluation which includes timely access to appointments, admissions, and equipment.



Effective

External Audit

Governance escalation- improvements required:

Improvements needed	Current position (as at October 2025 month end) – Level 3 (TBC)
Between 80-89% compliance for level 2, or over 90% compliance for level 1, with achieving original completion dates stipulated against recommendations.	101 of 267 recommendations overdue (38%) at Oct 25, compared to 124 (55%) last month. Whilst an improvement since the previous month, remains at less than 80% compliance. Apart from 4 which are overdue between 12-18 months (with Ceredigion), all others (97) are less than 6 months overdue, compared to 6 overdue between 12-18 months last month (slight improved position).
Where original completion dates have lapsed there is evidence that the service has provided realistic revised completion dates.	Of the 101 overdue recommendations, 76 (75%) do not have revised dates (N/K) at Oct 25, which whilst is an improvement on 106 (85%) noted in September 2025, is still below the 80% compliance target. The N/Ks are a mixture of no updates on AMaT, whilst others have updates and its either not clear what the revised date is, or it is noted that a revised timescale can't provide one at present (e.g. awaiting exec decision). Assurance and Risk Officer will be checking if any overdue recommendations should be amended to 'Pending Decision' on the audit tracker to provide better clarity of progress.
New reports are added onto AMaT with management responses within one month of being received.	*Assurance and Risk Officer awaiting management responses on the following:* • *NHS Exec Assurance Review of Ambulance Patient Handover Process and Compliance with Guidance across NHS Wales* • NHS Executive Report on Urgent and Emergency Care Opportunities: WGH site revisit • *GIRFT GGH- Revisit*

Reports currently open on AMaT assigned to the CCG are included in the table below. Revised implementation dates where applicable to be added to AMaT, and relevant evidence uploaded for completed recommendations. These now include the number of actions and recommendations (as one recommendation may include several actions).

Date of report	Report issued by	Report Title	Original Completion Date	Revised Completion Date	No. of recs in report	Overdue recommendations	Overdue with no completion date (Not known)	In Progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Comment
Jun-24	Peer Review	Getting It Right First Time (GIRFT) - Emergency Medicine	Oct-25	Oct-25	35	19 → (Actions = 25) BGH= 8→ GGH= 7→ WGH= 4↑	14 (Actions = 16) BGH=3 GGH=7 WGH=4	1 ↓ (Actions =1) BGH= 0→ GGH= 0→ WGH= 1↓	11↑ (Actions= 12) BGH= 0 GGH= 5 WGH= 6	2 (Actions =6) BGH=2 GGH=0 WGH=0	0	0	2 (Actions = 2 BGH=1 GGH=0 WGH=1	GIRFT GGH revisit Sept 2025 to be added to AMaT – please can management responses by shared with the Assurance & Risk Officer.
Jun-25	Internal Audit	Discharge Management (Follow Up) Final Internal Audit Report 2024/25	Mar-25	N/K	1	1→ (Actions =1)	1 (Actions =1)	0	0	0	0	0	0	1 recommendation assigned to Anna Chiffi, please update AMaT to confirm action taken and evidence to be uploaded.
May-25	Audit Wales	Urgent and Emergency Care: Arrangements for Managing Demand – Hywel Dda University Health Board	Dec-25	Dec-25	14	5→ (Actions =7)	5 (Actions =6)	3↓ (Actions = 3)	5↑ (Actions =5)	1 (Actions=1)	0	0	0	Awaiting confirmation on who should be the action owner for recommendation 14 moving forward (see slide 9 for more detail)

Date of report	Report issued by	Report Title	Original Completion Date	Revised Completion Date	Number of recs in report	Overdue recommendations	Overdue with no completion date (Not known)	In Progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Comment
Jan-25	Ministerial Advisory Group (MAG)	Ministerial Advisory Group (MAG) - Observations following the site visits of health boards – Hywel Dda UHB- Urgent and Emergency Care (January 2025).	Mar-26	Mar-26	15	7↓ (Actions =22)	7 (Actions =18)	5→ (Actions =5)	2→ (Actions =7)	1 (Actions =1)	0	0	0	When updates are provided on AMaT please state a **clear revised date of completion** in the 'Comments/Updates' section.
Mar-25	Royal College	RCN Workplace Inspection - WGH A&E Department	Aug-25	Aug-25	20	2↓ (Actions =2)	2 (Actions =2)	0→	14→ (Actions =14)	4 (Actions =4)	0	0	0	
Feb-25	Royal College	RCN Health and safety workplace inspection- Corridor care and safe staffing BGH EUCC February 2025	Sep-25	Sep-25	11	4↓ (Actions =4)	4 (Actions = 4)	0→	4↑ (Actions =4)	3 (Actions =5)	0	0	0	

Date of report	Report issued by	Report Title	Original Completion Date	Revised Completion Date	Number of recs in report	Overdue	Not Knowns	In Progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Comment
Oct-24	NHS Wales Executive	NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	Nov-25	Nov-25	58	39↓ (Actions=48)	35 (Actions=42)	0→ (Actions=1)	13↑ (Actions=22)	4 (Actions=5)	0	0	2 (Actions=2	When updates are provided on AMaT please state a **clear revised date of completion** in the 'Comments/Updates' section. Have, or is there a revisit planned?
Mar-25	NHS Wales Executive	NHS Executive Report on Urgent and Emergency Care Opportunities: BGH site	Apr-26	Apr-26	38	17↓ (Actions=15)	7 (Actions =7)	1↓ (Actions =1)	18↑ (Actions=18)	2 (Actions=4)	0	0	0	
Jan-25	NHS Wales Executive	NHS Executive Report on Urgent and Emergency Care Opportunities: PPH site	Aug-25	Aug-25	19	6↓ (Actions =6)	6 (Actions =6)	0→	11↑ (Actions=11)	0	0	0	2 (Actions =2)	Can the WGH management responses from the revisit be shared with the Assurance & Risk Officer for adding to AMaT.
Feb-25	Royal College	RCN Health and Safety Workplace Inspection AMAU Prince Philip Hospital February 2025	May-25	May-25	7	0	0	0	7→ (Actions=11)	0	0	0	0	All recommendations implemented- evidence to be shared with Director of CCG and Assistant Director NQPE for approval
Aug-25	HIW	Mynydd Mawr Ward, Prince Philip Hospital	Oct-25	Oct-25	24	7↑ (Actions=14)	7 (Actions =14)	5↑ (Actions=6)	12↑ (Actions=36)	0	0	0	0 (Actions=1)	Any queries to be signposted to the QAST team for HIW reports.
Jun-25	Public Service Ombudsmen	PSOW 202403652	Dec-25	Dec-25	5	0→	0	4→ (Actions=4)	0	1→ (Actions=1)	0	0	0	Any queries to be signposted to the Ombudsman Case Manager for PSOW reports.
Sep-25	HIW	Derwen Ward, Glangwili General Hospital	Nov-25	Nov-25	9	8 (Actions=14)	8 (Actions=14)	0 (Actions=3)	1 (Actions=23)	0 (Actions=14)	0	0	0	Any queries to be signposted to the QAST team for HIW reports.

Date of report	Report issued by	Report Title	Original Completion Date	Revised Completion Date	Number of recs in report	Overdue	Not Knowns	In Progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Comment
Sep-25	Internal Audit	Validation of Emergency Department Waiting Time Data Final Internal Audit Report 2025/26	Dec-25	Dec-25	6	0	0	5 (Actions=5)	1 (Actions=1)	0	0	0	0	Limited assurance therefore follow up will be undertaken
Aug-25	Audit Wales	Discharge Planning Progress Update – Hywel Dda University Health Board August 2025	Mar-26	Mar-26	1	1 (Actions=2)	1 (Actions=2)	0 (Actions=2)	0	0 (Action=1)	0	0	0	2 actions became overdue at end of Oct 2025, please can an update be provided via AMaT.
Feb-25	Royal College	RCN Health and safety workplace inspection- Emergency Department GGH February 2025	Nov-25	Nov-25	4	0	0	3 (Actions=14)	0	1 (Actions=12)	0	0	0	
Oct-25	HIW	HIW Inspection BGH Emergency Department October 2025	Mar-27	Mar-27	29	20 (Actions=32)	20 (Actions=31)	9 (Actions=35)	0	0 (Actions=7)	0	0	0	Any queries to be signposted to the QAST team for HIW reports.
Mar-24	HEIW	Trauma and Orthopaedics Glangwili Hospital March 2024	Aug-24	Aug-26	8	0	0	0	7 (Actions 10)	0	0	0	1 (Actions=1)	Remaining action sits with Carms, evidence to be uploaded to AMaT to close remaining action.
Total numbers						137 (Actions=192)	117 (Actions=163)	36 (Actions=80)	106 (Actions=174)	10 (Actions=61)	0	0	7 (Actions=8)	

Reports to be added to AMaT:

• NHS Exec Assurance Review of Ambulance Patient Handover Process and Compliance with Guidance across NHS Wales.

Clinical Audit Programme

A total of 16 mandatory clinical audits fall within the remit of this group (previously 13 however, individual Diabetes Components/Audits are now listed separately and the inclusion of the Core, Primary Care National Chronic Obstructive Pulmonary Disease (NCOPD) Audits.

The table below provides a brief overview of the status of each of the NCAORP audits.

	Title	Lead(s)	Status	RAG
CARDIOLOGY	Myocardial Ischaemia National Audit Project (MINAP)	Dr Clive Weston Paul Smith - SDM	All action plans up to date – no outstanding items **Participation concerns**	Amber
	National Heart Failure Audit (NHFA)	Dr Clive Weston Paul Smith - SDM	All action plans up to date – no outstanding items **Participation concerns**	Amber
	National Audit of Cardiac Rehabilitation (NACR)	Dr Clive Weston Paul Smith - SDM	**Action plan implementation (overdue)** 01/01/2022-31/12/2022 Report date: 2023 **Action plan overdue** 01/01/2023-31/12/2023 Report date: 2024	Red
	National Audit of Cardiac Rhythm Management (NACRM)	Dr Clive Weston Paul Smith - SDM	All action plans up to date – no outstanding items	Green
RESPIRATORY	Chronic Obstructive Pulmonary Disease (COPD)	Prof. Keir Lewis Anna Thomas - SDM	All action plans up to date – no outstanding items	Green
	Adult Asthma (AA)	Dr Mark Andrews Anna Thomas - SDM	All action plans up to date – no outstanding items	Green

	Wales Primary Care Audit (Asthma & COPD)	Claire Hurlin, SDM - awaiting clinical lead	All action plans up to date – no outstanding items	Green
	National Lung Cancer Audit (NLCA)	Dr Robin Ghosal Anna Thomas - SDM	**Action plan overdue:** Jan 22 - Dec 22 Jan 23 - Dec 23 Action plans being worked on.	Red
CARE OF THE ELDERLY	National Audit of Dementia (NAD)	No HB Lead BGH – Dr Annette Snell PPH – Dr Andrew Haden GGH – Dr Nicholas Coles WGH – Dr Sarah Davidson SDM – Sally Farr	**Action plan overdue:** 2023 2024 (awaiting 2 sites)	Red
CARE OF THE ELDERLY	Stroke Sentinel National Audit Programme (SSNAP)	Dr Senthil Kumar SDM - Sally Farr	**Action plan overdue:** 2022 2023 2024 Joint undertaking to complete action plans being scheduled.	Red
CARE OF THE ELDERLY	Fracture Liaison Service (FLS)	Dr Will Backen SDM - Sally Farr	All action plans up to date – no outstanding items	Green
CARE OF THE ELDERLY	National Audit of Care at the End of Life (NACEL)	Dr Rebecca Croft SDM - unknown	**Action plan overdue:** 12/04/2021 - 31/05/2021 Report date: 2021/22 01/04/2022 - 31/05/2022 Report date: 2022/23 **Action plan required** 01/01/2024 - 31/12/2024 Report date: 2025	Red
CARE OF THE ELDERLY	National Audit of Inpatient Falls (NAIF)	Anna Chiffi SDM - Sally Farr	**Action plan implementation (overdue):** 2021 2022 2023	Red
DIABETES	National Diabetes Foot Care Audit (NDFA)	Anna Thomas – SDM awaiting new clinical lead	**Action plans overdue:** Apr 21 - Mar 22 Apr 22 - Mar 23	Red

		Action plans are being worked on within the next 2 weeks	
National Core Diabetes Audit (NCDA)	Anna Thomas – SDM awaiting new clinical lead	**No lead. Not being undertaken. SDM adding to Risk Register.**	Red
National Diabetes Inpatient Safety Audit (NDISA)	Anna Thomas – SDM awaiting new clinical lead	**No lead. Not being undertaken. SDM adding to Risk Register.**	Red

The National projects highlighted above are being reviewed and discussed at the system CIM groups.

Meetings were held on 15 October2025 and 10 November 2025 with Clinical Audit leadership and Clinical Leads to discuss progressing NCAORP audits.

A number of action plans have been submitted in recent weeks, with more expected shortly. However, some areas show little or no progress to date and may require additional support.

Evidence based

Nice Guidance

The CIMCCG currently has 48 applicable Nice Guidance statements, with three overdue and actions still outstanding. This has been escalated with System General Managers (GMs) requesting a completion trajectory and details of any associated constraints to be presented to the next CCG meeting.

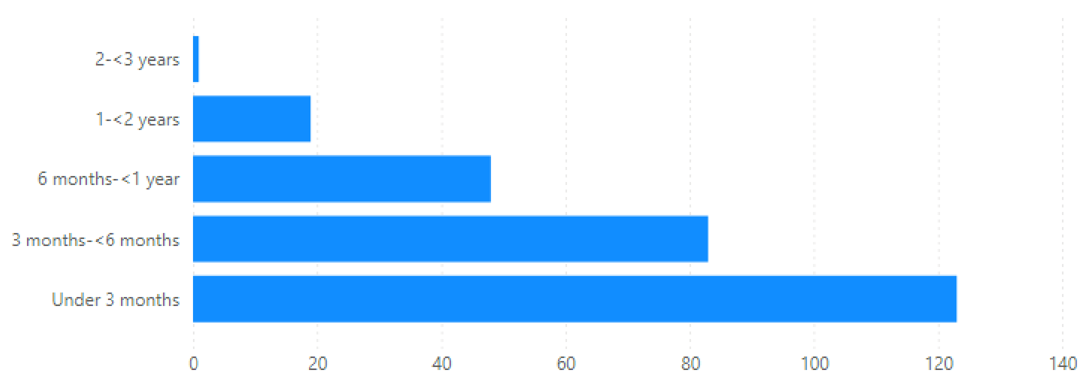
Equitable

No additional updates available.

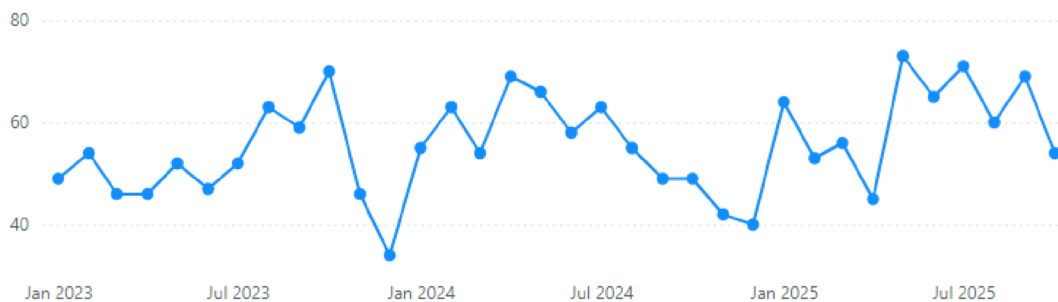
Person Centred

Patient experience

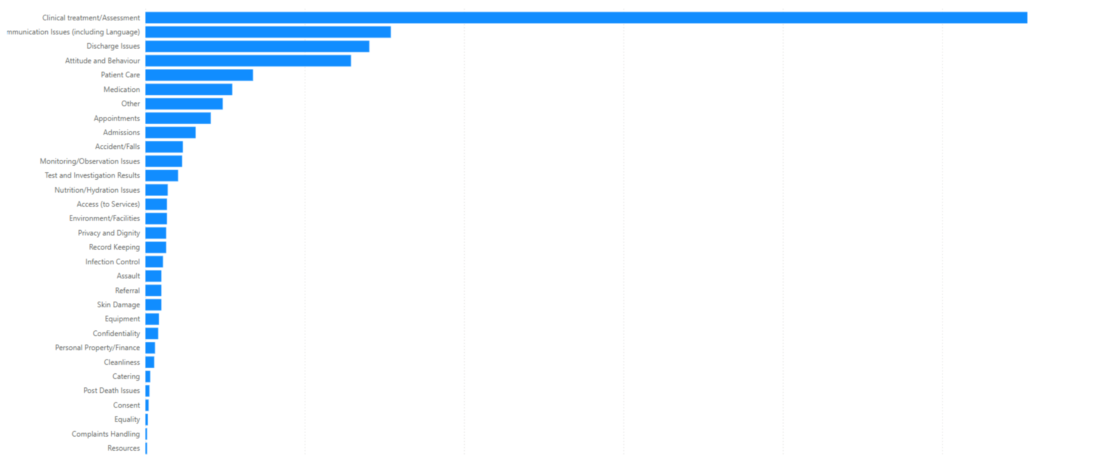
The graph below shows the length of time our complaints have been open.



The graph below shows the number of new complaints received per month.



The most common themes and trends are displayed below.



These themes will be presented to our whole system learning events to ensure robust sharing and understanding of learning following investigation.

Action Plan Summary (targeted areas of escalation)

Domain	Issue/Theme	Key Actions	Owner	Due Date	Status
Safe	Complaints management – timeliness & quality	Weekly tracker review; SOP refresh; training; learning logs to Q&S	CG ADoN	30 April 2026	In progress
Safe	Incident management – overdue actions; HCAI/pressure/ med errors	30-day close focus; safety huddles; targeted IPC & pressure care bundle; meds safety audits	Service Leads	30 April 2026	In progress
Safe	Unplanned ITU transfers	Trigger tool review; case note review; escalation	AMD/ ADoN	28 February 2026	In progress

		criteria refresh; SBAR from wards to outreach			
Timely	Waiting times & access constraints	Capacity & demand review; additional clinics; discharge-to-assess pathways strengthened	Ops Managers	31 March 2026	Planned
Effective	Audit completion & QI measurement	Re-baseline audit plan; QI measurement plan; monthly run charts	Audit Lead	31 January 2026	In progress
Evidence-based	NICE/Standards compliance gaps	AMAT action plans; SOP updates; compliance audits	Clinical Leads	31 March 2026	Planned
Equitable	Interpreter access & reasonable adjustments	Awareness campaign; booking SOP; monitoring; feedback loop	Patient Experience	31 January 2026	In progress
Person-centred	Complaints themes & PSOW learning	Thematic review; learning panels; "You said, we did" publication	PE Team	31 January 2026	In progress

Argymhelliad / Recommendation

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

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	2.1 Scrutinise, assess and seek assurance in relation to the patient impact, quality and health outcomes of the services provided by the Board.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:	

Datix Risk Register Reference and Score:	
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	
Amcanion Strategol y BIP: UHB Strategic Objectives:	
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	

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

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

Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	Not Applicable