



**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:	Planned Care & Specialist Services Clinical Care Group Quality Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Andrew Carruthers, Chief Operating Officer
SWYDDOG ADRODD: REPORTING OFFICER:	Paula Goode, Service Director Olwen Morgan, Assistant Director of Nursing, Quality & 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 Planned Care & Specialist Services 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

The Planned Care & Specialist Services Care Group – consists of Children, Women & Family Services, Maternity Services, Specialist Services, Cancer & Outpatient Services.

The aim of the Planned Care & Specialist Services 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 Planned Care & Specialist Services Care Group 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, Quality & Patient Experience 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

Safe

Children, Women & Families and sexual health have a very structured and effective operational model with well-defined services.

Planned Care & Specialist Services is a very large and complex service group, which is proving more challenging in terms of quality governance. The Planned Care & Specialist Services Clinical Care Group (CCG) Quality Governance meetings are well represented by 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. Medical attendance remains a challenge. We are hopeful that with the appointment of Clinical Directors within the CCG, this position will improve.

Each Service Group holds monthly Quality and Safety meetings, and these meetings are maturing in structure and reporting to the Care Group Quality Governance Meeting.

Fragile Services

Planned Care & Specialist Services have a number of fragile services. Deep Dive reviews of Urology, Endoscopy and Dermatology have recently been presented to Extraordinary QSEC

QSEC were assured in terms of management and mitigation plans for Endoscopy and Urology and agreed to advise Board of the concerns relating to Dermatology. A formal fragile services assessment is planned and establishment of a Task & Finish Group to take forward the necessary improvement work.

Summary of Overall Fragility Scoring following Review



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Fragile Service	Risk	Risk Matrix Score	Fragility Score	Total Score	Recommendations
Sustainability and quality of care for Trauma Service	1256	25	16	41	Escalate risk to the corporate risk register. Consider increase of risk score to 25
Emergency General Surgery	1531	15	12	27	Consider reduction of risk score from 15 due to service having plans to mitigate
Carmarthenshire Anaesthetics (Medical Workforce)	1880	9	14	23	Consider separate risk as Anaesthetic staffing is included within the Critical Care risk
Critical Care (PPH)	1880	9	17	26	Separating out 1880 will then provide clarity to what level the PPH Critical care risk is
Ophthalmology Consultant On-Call	1664	16	15	31	1664 is a corporate risk however includes complexities beyond on call rota and therefore remains at a 16
Theatres	2028	20	17	37	Escalate risk to corporate risk register – create action plan and business case.

There are other services awaiting assessment of fragility, these include Dermatology (RR. 2158 (16) and Audiology (WHC) and Theatre Estate.

Whilst the medical on-call fragility in Ophthalmology has decreased, R1 treatment capacity remains a significant risk and challenge for the service.

Increased, 'ring fenced' Trauma capacity has supported consistent and timely access to surgery.

Lack of Orthogeriatrician provision at Glangwili Hospital (GGH) continues to impact the quality of care and outcomes for hip fracture patients. The National Hip Fracture database KP1 for Orthogeriatrician review is 0%. Additionally, compliance against KP5 'not delirious post op' is 4%. **RR.1256 (25)**

A recent report from the clinical health knowledge system has identified that GGH has almost twice the average mortality rate as Wwithybush Hospital (WGH) and Bronglais Hospital (BGH). The increased morbidity and length of stay for post operative trauma patients is resulting in orthopaedic patients being managed on other surgical wards. This has a negative impact on patients care and experience.

Working closely with Planned Care & Specialist Services, the provision of an Orthogeriatrician service in GGH is a priority for the Integrated Community and Medicine Clinical Care Group.

Endoscopy / Gastro / BSW

Joint Advisory Group (JAG) – accreditation deferral.

The accreditation has been deferred to March 2026 – subject to further improvement to the endoscopy surveillance waiting list backlog. The service will report on-going monthly progress through the care group governance structure in advance to further evidence being submitted.

Surveillance – Potential cause of patient harm.

Following clinical validation of the surveillance backlog to date, a root-cause analysis review is currently being undertaken on five patients, to assess whether delayed access to their follow-up procedure has resulted in harm. All five patients were due to have their procedure between 2020-2022, resulting in a potential delay of between 3-5 years. **RR. 1628 (15)**

All patients scheduled for review in 2023 have undergone clerically validation and no further instances of harm have been identified. The risk of harm for patients due to receive follow up procedures in 2024 and 2025 is expected to be lower, given the short delays involved.

To ensure appropriate risk stratification of the waiting list, the service is continuing to clinically validate all patients on the waiting list backlog (considering up to date British Society of Gastroenterology (BSG)/ National Institute of Care Excellence (NICE) guidance and known cancer conversion rates) to support decision making and prioritisation of any high-risk surveillance cases which need expediting.

The root-cause analysis outcomes will be presented at the Endoscopy QSE meeting for review of lessons learnt and escalated through to the Care Group Governance structure

Critical Care Peer Review 17 September 25 – Critical care follow up and rehabilitation.

The Health Board was commended for its thorough and honest self-assessment.

Main Strengths

Strong psychology presence in critical care, with early assessment and coordination of some follow up activity.

Staff engagement in the patient journey and recovery.

Innovative patient engagement initiatives, including pet and music therapy, and patient recovery groups.

A strong commitment to education and shared learning with robust internal training programmes.

Main Areas for Improvement

Significant Allied Health Professionals (AHP) workforce deficits, particularly in occupational therapy, psychology, and speech and language therapy, impacting the delivery of a multidisciplinary rehabilitation pathway. A lack of dedicated AHP staff for critical care has resulted in a limited follow up and rehabilitation service.

Rehabilitation Assessment at Discharge: There is currently no standardised discharge assessment for all specialties identifying areas of concern and focus for rehab planning.

Exploring ways to standardise this would benefit patients to ensure they are assessed and staff by providing a structure to their referral pathways.

Lack of structured follow up clinics across the critical care estate in Hywel Dda have resulted in lack of equitable service provision for patients in the region, when compared with the other health boards in Wales.

Patient Support Groups used to provide a follow up service, but this has now been discontinued. The network recommends seeking funding to recommence these groups ensuring that staff do not pay out of their own pocket for this valuable rehab tool.

Inconsistent use of nationally recommended outcome measures and limited integration of data into service evaluation or quality improvement.

Lack of structured education and training for staff involved in rehabilitation and recovery following critical illness as well as protected time for peer support group participation

An action plan and tracker have been developed against the six improvement actions. two actions are on track for completion by 28 November, one action by 28 January 2026, three further actions currently have no dates assigned.

The action plan is monitored via the Planned Care Service Group Governance Meeting.

Progress from previous recommendations

Domain	Escalation level	Proposed action from Performance Team	Where you were in August 2025	Where you were in September 2025	Where you are at in October 2025	Progress up to October 2025
Governance	2	By 31 st July 2025, overdue risk actions should be reviewed and updated on DATIX.	19 (12%) risk actions overdue	25 (15%) risk actions overdue	29 (16%) risk actions overdue	There has been an increasing trend in overdue risk actions. Needs to be addressed to avoid being escalated back to level 3.
Governance	2	Ensure Welsh Health Circulars (WHCs) improvements are maintained, aiming for <20% overdue by 30th September 2025	56% overdue	50% overdue	25% overdue	25% improvement in one month. Level 1 criteria = < 10% overdue
Quality and safety	2	Reduce the number of incidents open over 120 days within the CCG and develop improvement trajectories to <10 across CCG	Women and children: 96 Planned Care and Cancer: 111	Women and children: 114 Planned Care and Cancer: 113	Women and children: 132 Planned Care and Cancer: 125	Increased for 2 nd consecutive month. Improvements needed to avoid escalation to level 3.
Quality and safety	2	Reduce the number of complaints open over 90 days within the CCG and develop improvement trajectories to <10 across CCG	Women and children: 44 Planned Care and Cancer: 67	Women and children: 39 Planned Care and Cancer: 69	Women and children: 40 Planned Care and Cancer: 69	Very little change seen over 2 months. Improvement work required to get below 10.
Quality and safety	2	Address the 8 NRIs that will be overdue at end of August 2025	4 overdue NRIs	4 overdue NRIs	5 overdue NRIs	Increase of 1. Submissions of outcome forms for 5 remaining overdue NRIs required.
Workforce	2	Reduce 15 overdue pay progressions to no more than 3 by 30 th September 2025	15	18 (8 by over 3 months)	19 (12 by over 3 months)	Overdue pay progressions increased for 2 nd consecutive month.
Population health	3	Increase compliance with referring to Help Me Quit or giving Nicotine Therapy to 70% by 30th November 2025	n/a	11%	29%	Overall, an 18% improvement but still considerably below de-escalation criteria

Whilst it is recognised that significant improvement work has been done in terms of Welsh Health Circular and the CCG has maintained Level 2 in six of the seven domains, it is noted that there is a static or deteriorating trend within six domains. The respective Service Groups have been tasked with undertaking focused actions to improve this position.

Planned Care and Cancer Services Outstanding Mortality Proportionate Investigations.

Total Number of Outstanding investigations is 79 across multiple specialities.

- 2021 – 8
- 2022 – 20
- 2023 – 20
- 2024 – 17
- 2025 – 14

Services reporting highest number of outstanding investigations.

Specialty	Number
Gen Surgery	22
Urology	14
T+O	13
Critical Care	12

This data has been shared with the newly appointed Clinical Director for Planned Care who will share with the respective Clinical leads and service leads to develop an improvement plan

Some of the above only need clarification of detail and discussion in Mortality and Morbidity Meeting.

Timely

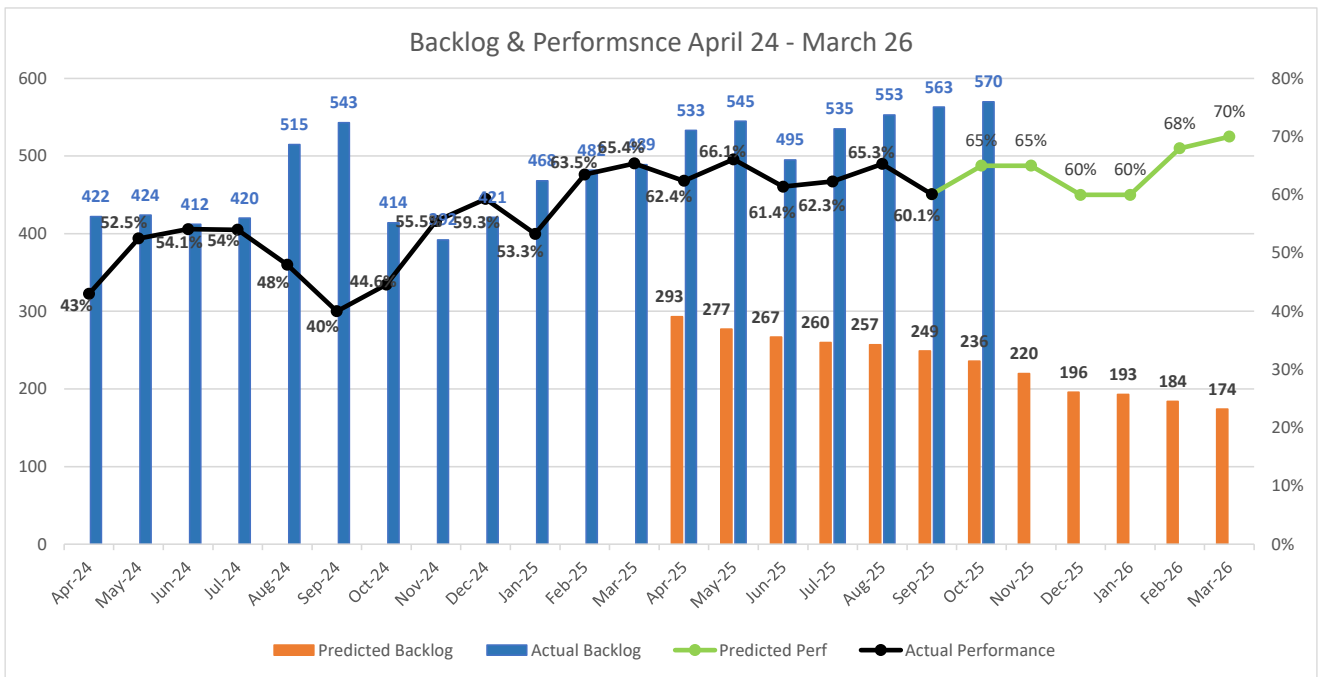
September Performance SCP

Tumour site	Total treated	Treated in target	Treated Out of	Percent age
Head and neck	10	4	6	40%
Upper GI	29	13	16	45%
Lower GI	50	22	28	44%
Lung	30	9	21	30%
Sarcoma	2	1	1	50%
Skin (exc BCC)	176	166	10	94%
Brain/CNS	2	1	1	50%
Breast	37	25	12	68%
Gynaecological	14	3	11	21%
Urological	77	16	61	21%
Haematological (exc acute leukaemia)	21	9	12	43%
Acute leukaemia	0	0	0	0%
Children's	1	1	0	100%
Other	10	6	4	60%
Total Treated	459	276	183	60.1%

The cancer performance for the Health Board is being maintained over 60% but is extremely dependent on a single high volume cancer service – dermatology that makes up 38% of the total treated cancers for the HB. This cancer demand is rising 22% yearly and is the largest in Wales.

The demand for diagnostic imaging and other diagnostic tests is not meeting the demand of cancer patients with average waits for Computed Tomography (CT) up to 6-8 weeks with MRI waits similar. This is not visible through routine monitoring. The Planned Care Group is undertaking deep dive exercises to understand fully the component waits. There is an assumption that the 28-day target is a diagnostic target however, it relates to a target informing the patient of their diagnosis by day 28, there may be multiple diagnostics on this pathway to day 28.

The diagnostic backlog as below is rising. This chart shows patients waiting over 62 days on their 28-day diagnostic pathway.



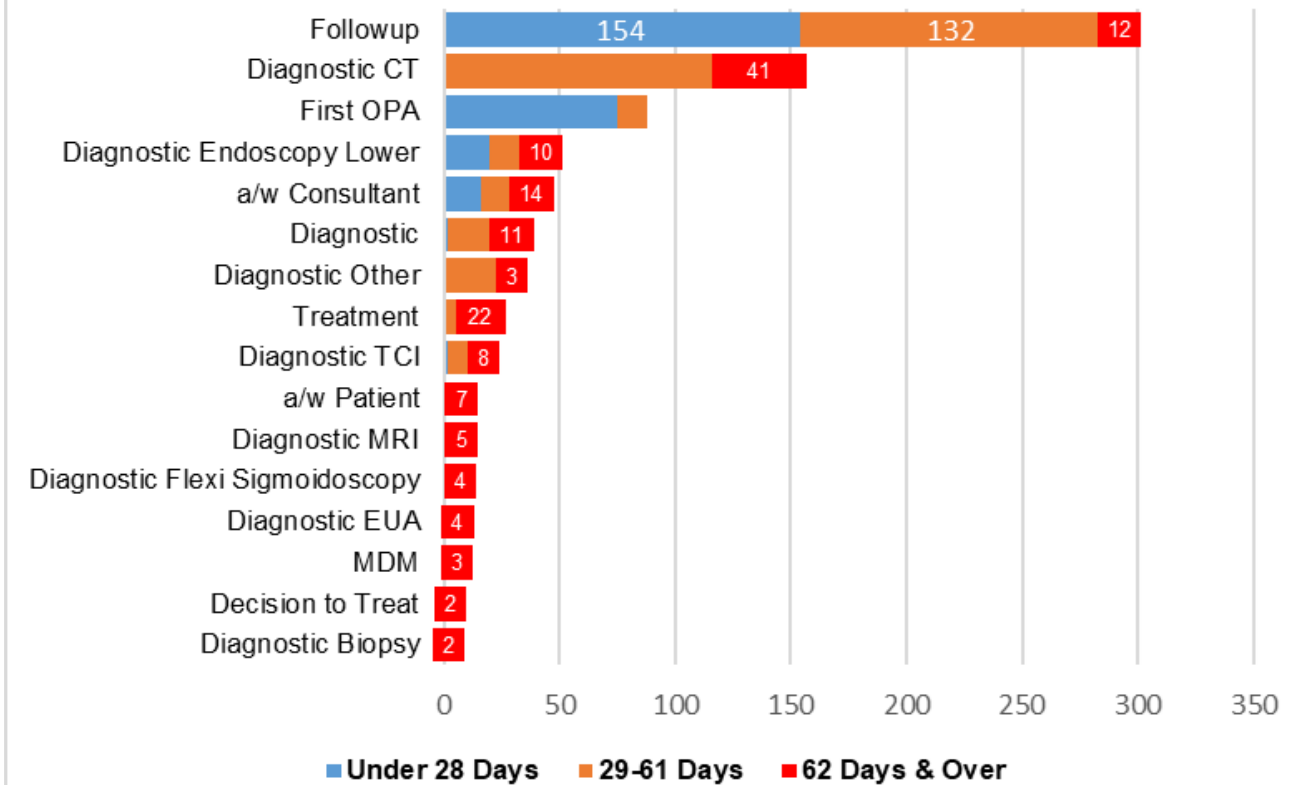
The below graph is an example of the breakdown of the lower GI 62-day cancer pathway, and the component waiting times.

A patient waiting for a CT Colon (item Diagnostic CT) will wait on average 54 days from referral to report. This is driving the red component. What cannot be seen in this graph is that how long they are waiting only that they are waiting over the 28-day target to receive their diagnosis or 62 days. The waiting time for any cancer diagnostic should be no more than 10 days.

A recent new initiative in Urology Prostate Cancer, used outsourcing providers for MRI prostate with excellent results, five days from referral to result Provider 1, 10 days Provider 2.

The Planned Care CCG wish to emphasis a prioritisation of cancer 28-day diagnosis target and cancer diagnostics.

What Next: Lower Gastrointestinal



Clinical Audit Programme

A total of 22 mandatory clinical audit falls within the remit of the care group.

The table below gives a brief overview of the status of the NCAORP audit. There are a number of action plans outstanding for a number of the mandatory audits. Welsh Government expect all projects to be fully participated in including the submission and implementation of appropriate action plans.

It is anticipated that Audit Leads and auditing teams will require support to create and implement action plans for the below projects.

Title	Leads	Status	RAG	Comments
All Wales Audiology	Jane Deans	Up to date	Green	
Comparative Audit of Critical Care Unit Adult Patient Outcomes (ICNARC)	Anthony Smith Gabor Dudas Diane Knight	Action plans overdue	Red	1x Action plan required (report 22/23) 1x Action plan required (report 23/24)
National Hip Fracture Database (NHFD)	Owain Ennis Lianne Gregory	Action plans overdue	Red	1x Action plan required (report 2022) 1x Action plan required (report 2023) 1x Action plan required (report 2024)
National Joint Registry (NJR)	Owain Ennis Lianne Gregory	Action plans overdue	Red	1x Action plan required (report 2022)

				1x Action plan required (report 2023) 1x Action plan required (report 2024) *Data input on hold for GGH & PPH
National Major Trauma Registry (NMTR)	Stuart Gill Diane Knight Claire Hathaway	In progress (on track)		
National Early Inflammatory Arthritis Audit (NEIAA)	Jayne Evans Neil Griffiths	In progress (on track)		
National Emergency Laparotomy Audit (NELA)	Ramesh Khoju Shrestha Caroline Lewis	Action plans overdue		1x Action plan required (report 2021) 1x Action plan required (report 2023) 1x Action plan required (report 2024)
National Bowel Cancer Audit (NBOCA)	Mr Pawan Kumar Dhruva Rao Debra Bennett	Action plans overdue		1x Action plan required (report 2024) 1x Action plan required (report 2025)
Oesophago-Gastric Cancer Audit (NOGCA)	Mr Brendan O'Riordan Debra Bennett	Action plans overdue		1x Action plan required (report 2024) 1x Action plan required (report 2025)
National Pancreatic Cancer Audit (NPaCA)	Mr Brendan O'Riordan Debra Bennett	In progress (on track)		Next report due Nov 2025
National Non-Hodgkin Lymphoma Audit (NNHLA)	Dr Sumant Kundu Debra Bennett	Action plan overdue		1x Action plan required (report 2024)
National Kidney Cancer Audit (NKCA)	Mr Sohail Moosa Debra Bennett	Action plan overdue		1x Action plan required (report 2024)
National Prostate Cancer Audit (NPCA)	Mr Sohail Moosa Neil Griffiths	Action plan overdue		1x Action plan implementation (report 2024)

Title	Leads	Status	RAG	Comments
National Ovarian Cancer Audit	Islam Abdelrahman	Up to date		
National Pregnancy in Diabetes Audit	Dr Lisa Forrest	Up to date		
National Maternity and Perinatal Audit	Cerian Llewellyn	Up to date		
National Paediatric Diabetes Audit	Dr Simon Foutain-Polley	Action plan required		2x action plans overdue 2x action plans required 22 – overdue (close to sign off) 23 – overdue – (close to sign off) 24 – required

				25 - required
National Neonatal Audit Programme	Dr Prem Kumar Pitchaikani	Action plan required		3x action plans to implement 1x action plan required 20-20 - implement 21-21 - implement 22-22 - implement 23-23 - required
Epilepsy 12	Dr Damitha Ratnasinghe Nick Davies	Action plan required		3x action plans required 23 – required 24 - required 25 - required
Children and Young Persons Asthma (CYPA)	Dr Ranjith Perinchery Kulappura	Action plan required		1x action plan overdue 1x action plan required 24 – overdue (actions complete - close to sign off) 25 - required
National Audit of Primary Breast Cancer	Dr Saira Khawaja	Up to date		
National Audit of Metastatic Breast Cancer	TBC	TBC		

National data input (NHFD /NJR) continues to be an outlier when compared to other health boards with the lack of data input resource between September 2024 – September 2025 significantly impacting compliance. Multiple letters of concern have been raised by the NHFD. Administrative support has been in place since September 2025, and overtime offered to administrative staff to support with this.

The National projects highlighted above have been presented at the CCG Governance Meeting and are being reviewed and discussed at the Planned Care & Cancer Services and the Women & Child Health sub-groups. The Associate Medical Director (AMD) is working alongside relevant Clinical Leads and Clinical Directors are leading the improvement actions. Progress will be reported through the CCG Integrated Quality Governance Meeting.

Evidence based

Population Health – Smoking status on admission

Level 3

Reason for escalation	De-escalation criteria
Poor compliance with referring to HMQ and giving NRT with high numbers smoking on hospital grounds (overall level 3).	Level 2: Smoking status recorded on admission: Increase compliance with referring to HMQ and giving NRT to 70% and reduce to 24% or below of patients smoking on hospital grounds.

As 31st October 2025, 29% of smokers were referred to "Help Me Quit" or given nicotine therapy

Service / site (L6)	Total admissions	Smoking status recorded on WNCR	Number of smokers	Referred to "Help Me Quit"	Given nicotine therapy	"Help Me Quit" or nicotine therapy	Smoking on hospital grounds
Women and children: Obstetrics and Gynaecology	95	79 (83%)	5	0 (0%)	0 (0%)	0 (0%)	3 (60%)
Planned Care and Cancer: Theatre Services, Anaesthetics and Critical Care	62	62 (100%)	9	1 (11%)	3 (33%)	4 (44%)	8 (89%)
Total	157	141 (90%)	14	1 (7%)	3 (21%)	4 (29%)	11 (79%)

Performance Team recommendation

Increase compliance with referring to Help Me Quit or giving Nicotine Therapy to 70% by 30th November 2025

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It is recognised that improvement is needed in terms of referrals to the Help Me Quit (HMQ) service. The above data does not include Maternity Services, as they use a different patient record system than Welsh Nursing Care Record (WNCR). The Performance Team is exploring ways to 'collate' and include the Maternity data since smoking cessation is a priority focus throughout antenatal and postnatal care.

Equitable Person Centred

Learning Disabilities (LD) Epilepsy Task & Finish Group.

Following receipt of the Public Service of Wales (PSOW) Public Interest Report of the Health Boards LD Epilepsy Service, the LD Epilepsy T&F Group was established to respond to the recommendations within the Report.

- Within 2 months: Written apologies and breakdown of current care plan to be provided to the seven families. On track for completion within timeframe.
- Within 4 months: Review and Gap analysis of the current Health Board Care Pathway. Exploration of an external, professional review underway.
- Within 4 months: Conduct a thorough review of LD Epilepsy patient information to ensure up to date care plans, risk assessments and emergency medication plans.

Argymhelliad / Recommendation

The Quality, Safety and Experience Committee is asked to take assurance on the quality governance arrangements in place within the Planned Care & Specialist 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 Termiau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofïod: 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:	Contained within the report
Gyfrinachedd: Privacy:	Not Applicable
Cydraddoldeb: Equality:	Not Applicable