



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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	09 April 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Women's Health Plan (WHP) – Progress Update
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Sharon Daniel, Executive Director of Nursing &/ Andrew Carruthers Chief Operating Officer
SWYDDOG ADRODD: REPORTING OFFICER:	Dana Scott Director of Midwifery

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

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

This paper provides the Committee with assurance on Hywel Dda University Health Board's delivery of Year 1 of the NHS Wales Women's Health Plan, including early implementation of the Women's Health Hub approach, and sets out the Year 2 onwards requirements and expectations received from Welsh Government, including the Chief Nursing Officer (CNO) letter dated 30 March 2026 and the national Women's Health Hub Clinical Implementation Guide.

The Committee is asked to take assurance that:

- Year 1 activity has delivered measurable progress in workforce capability, pathway redesign and early outcomes
- Governance arrangements for Year 2 onwards will be explicit and compliant, including Executive Sponsor/Senior Responsible Officer (SRO) and funded Clinical Lead sessions
- The Health Board's Year 2 programme will strengthen hub delivery toward uniform provision and align with national hub standards and measures.

Cefndir / Background

The NHS Wales Women's Health Plan is a national programme with Women's Health Hubs as a ministerial priority; the national Implementation Guide defines the clinical/functional model, essential criteria and the expectation that each Health Board has a pathfinder hub by 31 March 2026 and participates in impact measures.

Welsh Government has confirmed, via the CNO's letter (30 March 2026), that for Year 2 each Health Board must:

- confirm an Executive Sponsor who is also the Senior Responsible Officer (SRO) and who will join the Programme Oversight Board;
- utilise continued funding for Women's Health Clinical Lead sessions (up to two sessions per week), which may be split across two leads (e.g., primary/secondary

care expertise), and ensure Clinical Lead representation through the national Clinical Reference Group and relevant task and finish groups, including Women's Health Hubs.

Asesiad / Assessment

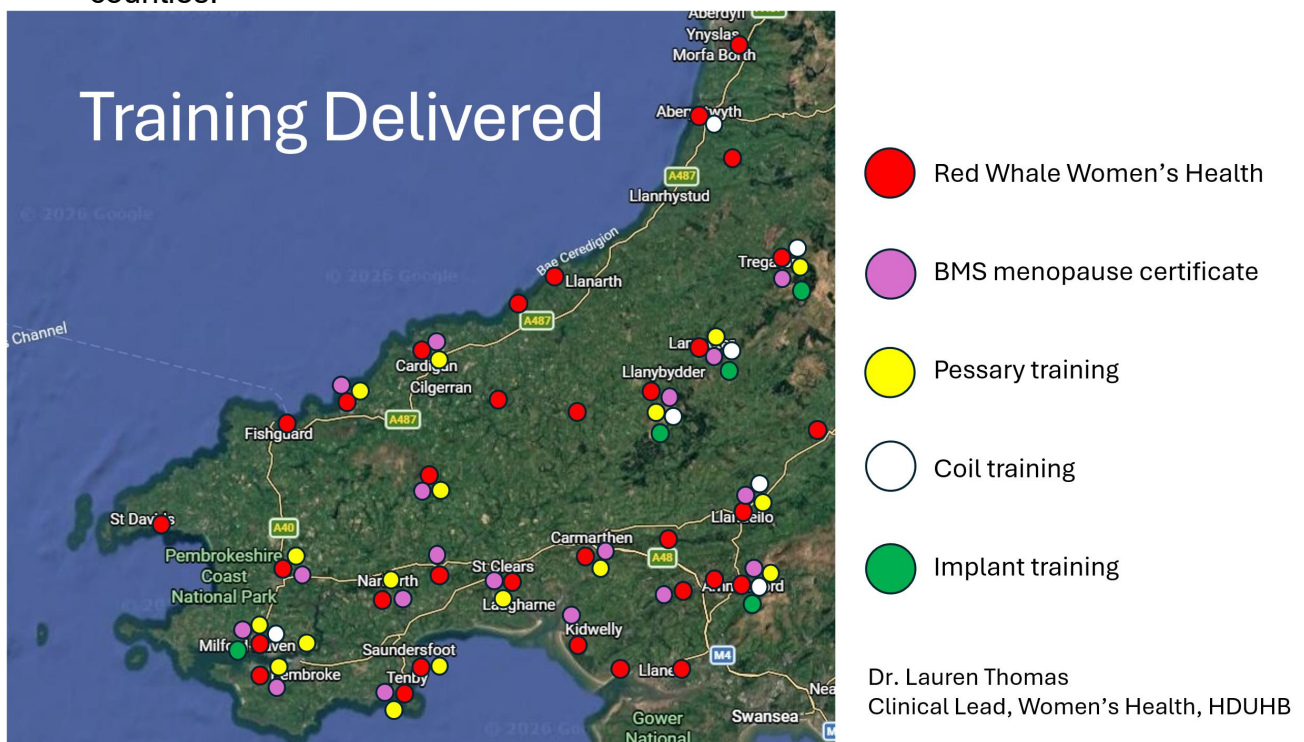
1) Delivery to date (Year 1 progress and achievements)

A five-tier model was utilised ensuring care is delivered at the appropriate level :

- Tier 1: Skilled first contact (primary care)
- Tier 2: Women's Health access service point via Local Enhanced Services Payment in Primary care
- Tier 3: ☆ Women's Health hubs Interface Service (1.5 model)
- Tier 4: Secondary care
- Tier 5: Tertiary care

Hywel Dda has delivered demonstrable progress across workforce capability and pathway redesign & efficiency and reduced escalation. Including:

- 26+ GPs trained in coil and pessary fitting and 30+ clinicians trained in menopause care (including BMS certification), with capability established across all three counties.



- Expansion of community/primary care service provision (including Long Acting Reversible Contraception (LARC), pessary care and menopause care) and development of outpatient hysteroscopy within interface/community settings.
- Emerging outcome data from community gynaecology/interface services indicating:
 - 31–48% discharge at first assessment,
 - up to 55% managed in outpatient settings, and
 - 2–8% requiring escalation to theatre for hysteroscopy,

In relation to quality and safety no adverse safety concerns have been identified; care is being delivered at the appropriate level with improved access and reduced delays.

RAG status:

- Green: workforce readiness, service transformation, activity shift/demand reduction, quality & safety
- Amber: patient experience/outcomes maturity, financial alignment, data/informatics, system integration (1.5 model).

Financial and Resource Position

In year 1 the phased locality-based model is already in delivery and demonstrating early impact. The priority now is to align governance, resource, and financial frameworks to enable sustainable scale and delivery across the Health Board.

In Year 1 progress against the WHP has been delivered within the existing financial envelope. The model is based on:

- Redistribution of existing activity
- Reduction in demand growth
- Avoidance of escalation into high-cost care

Work is ongoing with Finance and Value-Based Healthcare teams to:

- Align financial flows with activity
- Further articulate cost avoidance and value

2) Governance and leadership arrangements (explicit, non-ambiguous assurance)

To meet Welsh Government Year 2 requirements as set out by the CNO at the end of March 2026, the Health Board is required to operate the following leadership and governance structure:

• **Executive Sponsor / SRO (formal accountability):**

The Health Board will designate a single Executive Sponsor who will also be the SRO for the Women's Health Plan, consistent with CNO requirements, with authority to make key decisions and represent Hywel Dda on the Programme Oversight Board. Once agreed by the Executive Team the SRO role will be explicitly confirmed and recorded in programme governance documentation, eliminating ambiguity and ensuring clear Board-to-delivery accountability.

• **Clinical leadership (funded national requirement):**

The Health Board will utilise Welsh Government funding for up to two clinical sessions per week for Women's Health Clinical Lead(s), either as one postholder or split between two leads (e.g., primary/secondary care), with representation at the national Clinical Reference Group and relevant task and finish groups (including hubs).

• **Local accountability and reporting:**

Programme reporting will continue through Health Board governance routes to provide the Quality, Safety and Experience Committee with assurance on safety, quality, experience, equity and delivery, aligned to hub requirements (including data, PREMs/PROMs, access and inclusion).

3) Year 2 onwards – what will change (Welsh Government direction woven into the forward plan)

Welsh Government's stated intent is that 2026/27 will be used to:

- strengthen existing hub models toward the uniform provision described in the Implementation Guide;
- plan and prepare for additional services from April 2027, specifically including: pelvic health, Violence Against Women, Domestic Abuse and Sexual Violence, postnatal health, and healthy ageing.

In line with the Implementation Guide, Hywel Dda's Year 2 programme will focus on strengthening:

- hub "core function" (single point of access / least steps; mechanisms for self-referral and clinical referral; gateway function)
- equity and inclusion focus for underserved communities, and accessible information in multiple formats
- delivery across the Phase 1 clinical priorities (menstrual health, contraception incl. postnatal contraception and abortion care, menopause) and structured expansion for Phase 2
- participation in national impact measures, including PROMs/PREMs and system-level measures, with mechanisms defined centrally

4) Risks and mitigations (assurance framing)

The risks requiring ongoing Committee oversight are:

- Governance and Executive oversight clarity during transition to delivery
- Variation in primary care delivery across clusters/localities (to be mitigated via standardised hub model requirements and reduced unwarranted variation)
- Data limitations / system visibility (to be mitigated through adoption of national measures and minimum datasets aligned to national expectations)
- Financial alignment and flow (work ongoing with Finance and VBHC to align activity and articulate cost avoidance/value)

In year 2, the Women's Health Hub model will be further developed to support a structured, tiered approach to care delivery, aligned with National guidance and local population need.

This model is already in delivery across primary care and interface services and will be scaled to ensure consistency and equity of access across localities

- Tier 1: core women's health provision within primary care, including contraception, menopause management, and first line assessment. Primary care clinicians are now trained and delivering key interventions including coil fitting, LARC provision, and pessary management.
- Tier 1.5 (interface services): Enhanced community-based clinics supporting more complex care, including procedures and diagnostic assessment, delivered by

clinicians with extended skills and supported by multidisciplinary input. This model is already in place through the pilot clinics and is demonstrating increasing activity and demand.

- Tier2: Secondary care services providing specialist and complex interventions where required.
- The development and expansion of the 1.5 interface model is a key component of year 2, enabling care to be delivered at the lowest appropriate level, reducing escalation into secondary care, and improving access for women.
- This tiered approach supports a sustainable shift in activity, reduces unwarranted variation, and aligns with Welsh Government priorities to deliver care closer to home.

Argymhelliad / Recommendation

The Committee is asked to:

- **Take assurance** that Year 1 delivery has achieved measurable progress that the programme is improving access, reducing escalation, and being delivered safely.
- **Take assurance** that Year 2 governance will be compliant with Welsh Government requirements.

Amcanion: (rhaid cwblhau)	
Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.24 Develop a work plan which sets clear priorities for improving quality, safety and experience each year, together with intended outcomes, and monitor delivery throughout the year.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	1. Safe 3. Effective 2. Timely 5. Equitable
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	1. Leadership 1. Leadership Choose an item. Choose an item.
Amcanion Strategol y BIP: UHB Strategic Objectives:	2. Healthier communities All Strategic Objectives are applicable 2. Healthier communities Choose an item.

Amcanion Cynllunio Planning Objectives	6 Clinical services plan 9 Digital plan 6 Clinical services plan Choose an item.
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	2. Develop a skilled and flexible workforce to meet the changing needs of the modern NHS 4. Improve Population Health through prevention and early intervention, supporting people to live happy and healthy lives Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termiau: Glossary of Terms:	WHP: Women's Health Plan LARC: Long Acting Reversible Contraception
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	SOLT, March 2026 CCG February 2026

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	<p>Financial / Service</p> <p>The Women's Health Plan (WHP) represents a system-wide transformation aligned to the Clinical Services Plan "shift left" approach and Healthier West Wales, with a focus on delivering care closer to home through primary, community, and 1.5 interface (hub) models.</p> <p>Elements of the model are already being delivered within existing and supplementary commissioning arrangements, including the provision of coil, pessary and LARC services within primary care, alongside the development of menopause services. This has enabled early progress in shifting activity away from secondary care and improving access.</p> <p>However, the full financial impact of delivering the model at scale has not yet been fully quantified. A comprehensive business case is in development to identify the true cost of the pathway, determine what can be sustained within the current financial envelope, and</p>

	<p>define where targeted investment will be required, including workforce, diagnostics, and hub infrastructure.</p> <p>The programme is underpinned by a spend-to-save approach, with national evidence suggesting significant return on investment through improved outcomes, reduced demand on high-cost services, and increased efficiency. Locally, early benefits are being realised through improved pathway flow, reduced escalation, and increased first-contact resolution.</p> <p>Financial benefits are expected to be realised over the medium to long term (2–5 years), primarily through cost avoidance and demand reduction rather than immediate cash-releasing savings.</p> <p>Failure to progress the model would result in continued pressure on secondary care services, reduced system efficiency, and missed opportunities to deliver high-value care in lower-cost settings.</p>
<p>Ansawdd / Gofal Claf: Quality / Patient Care:</p>	<p>Quality / Patient Care</p> <p>The WHP is expected to have a significant positive impact on patient outcomes and experience, supporting improved access, earlier intervention, and care delivered at the most appropriate level.</p> <p>The model reduces fragmentation by enabling more care to be provided within primary and community settings, supported by the development of Women’s Health hubs to provide integrated, multidisciplinary care at a local level.</p> <p>Early data demonstrates improved pathway efficiency, including high rates of discharge at first assessment and reduced escalation to secondary care and theatre, indicating more appropriate use of resources and improved patient flow.</p> <p>There is a recognised risk of variation in delivery across localities, which could result in inequity or inconsistency in access. This is being actively mitigated through the development of standardised pathways, service specifications, and governance arrangements to ensure equitable access across the Health Board.</p> <p>Failure to deliver the model would increase the risk of delayed care, deterioration in patient conditions, and greater reliance on higher-cost and more complex interventions.</p>

<p>Gweithlu: Workforce:</p>	<p>Workforce</p> <p>The WHP supports a shift in workforce delivery, with increased capability within primary care and community settings through targeted training and upskilling in key areas such as menopause, contraception, and gynaecological care.</p> <p>This approach is intended to reduce pressure on secondary care teams while supporting a more sustainable and flexible workforce model aligned to future demand.</p> <p>Whilst the model is largely deliverable through workforce development, there is potential for short-term reliance on premium staffing during implementation phases, particularly where capacity gaps exist.</p> <p>Effective communication, engagement, and support for staff will be critical to maintaining morale and ensuring successful adoption of the new model. There is a recognised risk of disengagement if change is not well managed, which is being mitigated through phased implementation and workforce involvement in service design.</p>
<p>Risg: Risk:</p>	<p>Risk</p> <p>The principal risks associated with the WHP relate to system integration, workforce capacity, financial alignment, and data maturity.</p> <p>There is also a risk of variation in delivery across primary care clusters, which could impact consistency and equity of access if not effectively managed.</p> <p>These risks are being mitigated through:</p> <ul style="list-style-type: none"> • Development of a comprehensive business case • Strengthened governance and executive oversight • Standardised pathways and service specifications • Workforce development and training • Phased implementation of the 1.5 interface hub model <p>Failure to implement the WHP would result in continued system inefficiencies, increased demand on secondary care, and reduced ability to deliver sustainable, value-based services.</p>

<p>Cyfreithiol: Legal:</p>	<p>Legal</p> <p>The WHP aligns with Welsh Government policy direction, the Clinical Services Plan, and statutory duties under the Health and Social Care (Quality and Engagement) (Wales) Act 2020.</p> <p>There are no significant legal risks identified at this stage. The model is being developed within existing commissioning frameworks, including Local Enhanced Services (LES), and will be subject to appropriate governance and oversight.</p> <p>Failure to implement the model could increase the risk of non-compliance with national policy expectations relating to access, prevention, and service transformation.</p>
<p>Enw Da: Reputational:</p>	<p>Reputational</p> <p>The WHP presents a significant opportunity to enhance the Health Board's reputation by demonstrating delivery against national priorities and improving access to women's health services.</p> <p>There is potential for political and media interest given the strategic importance of women's health and alignment with Welsh Government priorities.</p> <p>Failure to deliver the model, or inconsistency in access across localities, could result in reputational risk, including public concern and increased scrutiny.</p> <p>This is being mitigated through clear communication, phased implementation, and ongoing monitoring of outcomes and experience.</p>
<p>Gyfrinachedd: Privacy:</p>	<p>Privacy</p> <p>No significant privacy risks have been identified at this stage. Any data sharing or service developments will be managed in line with NHS Wales information governance requirements.</p> <p>A Data Protection Impact Assessment (DPIA) will be undertaken where required, in collaboration with the Information Governance team, to ensure compliance with data protection legislation.</p>

**Cydraddoldeb:
Equality:**

Equality

The WHP is expected to have a positive impact on equality, improving access to services closer to home and reducing reliance on secondary care pathways.

The model supports equitable access across the population; however, there is a recognised risk of variation in delivery across localities during implementation.

This is being actively mitigated through standardisation of pathways, development of the hub model, and ongoing monitoring through the Equality Impact Assessment (EqIA), which is currently in progress.