Date	**09/04/2026**
Time	**09:30 - 12:30**
Location	**MS Teams; HDD Picton - Dolau Cothi**

Quality, Safety & Experience Committee

HDD_Quality, Safety & Experience Committee

NHS Wales

Agenda - 9 April 2026

1 Governance

09:30, 10 min

1.1 Welcome and Apologies

Eleanor Marks (Hywel Dda UHB - HDUHB Vice Chair)

1.2 Declarations of Interest

1.3 Minutes from the Previous Meeting and Table of Actions from the meeting held on 12 February 2026

Eleanor Marks (Hywel Dda UHB - HDUHB Vice Chair)

1.4 QSEC Annual Report 2025/26

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

1.5 Chair's Action: QSEC Terms of Reference

Eleanor Marks (Hywel Dda UHB - HDUHB Vice Chair)

2 Risk

20 min

2.1 Assurance and Risk Report- Executive Leads

2.2 Allied Health Professional Risks Deep Dive

Angela Bell (Hywel Dda UHB - Assistant Director Quality, Safety + Patient Experience for Allied Health + Health Sciences)

3 Assurance

1 hr 30 min

3.1 A Path to Safer Beginnings Patient Story and Update Report

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

3.2 **Review of Revised Quality and Safety Governance Arrangements**

Charlotte Wilmshurst (Hywel Dda Health Board - Assistant Director of Assurance and Risk)

3.3 **Quality Assurance Report**

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

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

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

3.5 **Infection Prevention Control Assurance Report**

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

3.6 **Fuller Inquiry Progress of Recommendations**

Craig Baker (Hywel Dda UHB - Cellular Pathology Service Manager), James Severs (Hywel Dda UHB - Executive Director of Allied Health Professions and Health Science)

3.7 **Quality Improvement Framework**

Marilize Preez (Hywel Dda UHB - Improvement and Transformation Lead)

3.8 **First Contact Physiotherapist Update Report**

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

3.9 **Women's Health Hub**

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

3.10 **Targeted Intervention Progress Report**

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

---

4 Clinical Care Group Update Reports

10 min

4.1 Planned and Specialist Care

Paula Goode (Hywel Dda UHB - Service Director for Planned and Specialist Care), Olwen Morgan (Hywel Dda UHB - Assistant Director of Nursing)

5 For Information

5.1 QSEC Work Plan 2026/27

5.2 Reminder: Clinical Audit Programme 2026/27

6 Date of Next Meeting : 11 June 2026

Table of contents

09/04/2026 09:30 - 12:30

1

09:30, 10 Mins

---

1 - Governance

1.1 **09:40,**

1.1 - Welcome and Apologies

Eleanor Marks (Hywel Dda UHB - HDUHB Vice Chair)

1.2

1.2 - Declarations of Interest

hduhb.nhs.wales/about-us/governance-arrangements/register-of-interests-gifts-sponsorship-and-hospit…

1.3

1.3 - Minutes from the Previous Meeting and Table of Actions from the meeting held on 12 February 2026

Eleanor Marks (Hywel Dda UHB - HDUHB Vice Chair)

Attachments

2026-02-12 - Quality, Safety Experience Committee Meeting - Minutes.pdf

Table of Actions QSEC 12 02 2026.pdf

DRAFT MINUTES QUALITY, SAFETY & EXPERIENCE COMMITTEE MEETING

Date of Meeting: **09:30, Thursday 12 February 2026**
Venue: **Microsoft Teams; Picton Terrace Meeting Room**

Present:
Eleanor Marks (Committee Chair)
Rhodri Evans (Vice Chair of the Committee)
Chantal Patel (Independent Board Member)
Michael Imperato (Independent Board Member)
Neil Prior (Independent Board Member)

In Attendance:
Sharon Daniel (Executive Director of Nursing, Quality & Patient Experience)
Andrew Carruthers (Chief Operating Officer)
Caroline Burgin, (Quality and Safety Assurance Team)
Cathie Steele (Interim Assistant Director of Nursing Assurance and Safeguarding)
Charlotte Westacott (Head of Safeguarding)
Danielle Berisha, (Llais Cymru)
Elin Brocke, (Head of Research, Innovation and Improvement)
James Severs (Executive Director of Allied Health Professions and Health Science)
Jo Bradburn (Deputy Director of Allied Health Professions)
Jo McCarthy (Consultant in Public Health)
Louise O'Connor (Assistant Director)
Joanne Wilson (Director of Corporate Governance/Board Secretary)
Mark Henwood (Executive Medical Director)
Simon Chiffi, (Head of Operations)
Katie Lewis (Committee Services Officer)

Minutes Ref.	Item	Action
	Welcome and Apologies Apologies were received from: • Dr Ardiana Gjini, Executive Director of Public Health	
QSEC 26 (01)	**Declarations of Interest** No declarations of interest were noted.	
QSEC 26 (02)	**Minutes from the Previous Meetings on 4 November 2025 and 4 December 2025 and Table of Actions** The minutes from the previous meetings held on 4 November 2025 and 4 December 2025 were reviewed and all actions were noted as completed.	

Decision: The minutes from the previous meetings held on 4 November 2025 and 4 December 2025 were approved.

QSEC 26 (03) **Committee Self-Assessment Report**

Mrs Joanne Wilson presented the Committee Self-Assessment Report. The report was positively received, with a high number of completed actions noted. Areas identified for improvement included the quality and timing of papers and data quality.

Ms Eleanor Marks highlighted the need to streamline the narrative within papers to improve focus and more efficient use of time for both operational staff and Members. She emphasised the importance of providing the Committee with appropriate data to support effective interpretation and reflected on the balance between executive and independent member roles in scrutiny.

Decision: The Committee considered the outputs from the Committee Self-Assessment process and agreed to the actions to be taken to improve its effectiveness.

QSEC 26 (04) **Targeted Intervention Progress Report**

Mrs Sharon Daniel presented the Targeted Intervention Progress Report and highlighted three main areas: hospital-acquired infections, backlog in complaints and incidents, and the need for discipline and accountability in responding to patient and family complaints.

The discussion focused on the recurring spikes in infections and Cllr Rhodri Evans queried the impact of cleaning standards on infection rates, highlighting the high footfall in Emergency Departments. Members were advised that Mr James Severs, Mrs Daniel and Mr Henwood had discussed the interdependencies of infection prevention challenges from a clinical perspective. Mr Severs explained that there has been significant progress has been made within the Facilities Department over the past year to improve practice, with further detail to be provided through the Estates and Facilities Update report later in the meeting.

Referring to the actions arising from inspections that are overdue within the report, Ms Steele noted that service leads often strive to be ambitious and consequently set completion dates that are not always achievable. She explained that timeframes can progress quickly, and setting overly optimistic deadlines can result in actions not being completed on time. She further advised that, before an action can be closed, the Quality and Safety Assurance Team requires evidence demonstrating that the action has been fully completed.

It was noted that open inspection reports are monitored and reported through Clinical Care Group governance meetings. In response to a query from Ms Marks regarding the setting of action dates, Mrs Wilson confirmed that audit and inspection governance training had been delivered to Clinical Care Group

leads. As part of this training, the importance of assigning realistic and achievable timeframes for actions was emphasised.

Ms Steele also advised that, following previous discussions at Committee, the Quality Assurance Report, which provides a focus on a number of the matters highlighted within the TI Report, is currently under review. The revised report is expected to provide greater clarity on trajectories and will include enhanced intelligence to support governance and oversight.

The Committee noted the current position against targeted interventions, the scale and ageing profile of open complaints, and the inspection positions. The need for stronger evidence-based assurance and consideration of corresponding improvements in risk reduction was highlighted.

Decision: The Committee noted:

- The current position against the TI de-escalation criteria within the QSEC remit, triangulated through the 'Our Performance' dashboard for Datix/complaints extracts (PSM; CIM integrated systems), the HIW inspections dashboard, and Beacon dashboard evidence contained within this pack.
- The scale and ageing profile of open complaints and incidents, and that the principal constraint to closure remains timely-awaiting service comments" / response completion.
- The HIW inspections action position and the concentration of overdue actions within a small number of inspections, particularly the ED inspection cohort.

QSEC 26 (05) **QSEC Terms of Reference for Review**

Mrs Wilson presented the Quality, Safety & Experience Committee (QSEC) Terms of Reference. A number of amendments were noted, including changes to membership and the removal of a legacy position.

Mr Neil Prior proposed that the Committee's roles and responsibilities of the Committee be set out more succinctly and clear, emphasising a stronger focus on patient impact, quality, and health outcomes. He also suggested providing a verbal reminder of the Committee's role at the start of each meeting. Subject to these amendments, the Committee approved the Terms of Reference, for submission to the Board. **JW**

Decision: Subject to suggested amendments, the QSEC Terms of Reference were approved for submission to the Board.

QSEC 26 (06) **Unscheduled Emergency Care (UEC) Accelerated Work Programme Update and Patient Story**

Ms Nicola Zroud and Mrs Anna Chiffi joined the meeting to present a patient story and provide an update on the UEC accelerated work programme.

Ms Zroud shared a presentation that illustrated the complexities of caring for vulnerable adults with cognitive impairment, behavioural escalation, safeguarding needs, and significant system pressures impacting flow and staff morale and workload.

The presentation focused on a patient, who presented in the Emergency Department (ED) during June 2025 with increased confusion and was later diagnosed with a urinary tract infection (UTI). The patient's medical history included cognitive impairment, type 2 diabetes, recurrent UTIs, and a recently broken-down care package. While in ED, the patient was cared for in a noisy and busy environment, which exacerbated their confusion and anxiety, and resulted in behavioural disturbances. This made care increasingly challenging for staff and contributed to delays in safeguarding processes, including Deprivation of Liberty Safeguards (DoLS) applications.

The patient was transferred to Ward 12, which was under significant pressure with beds surged beyond capacity. The behavioural issues escalated, requiring intense supervision and intervention. Safeguarding concerns arose at multiple pointsduring the patient's journey, culminating in the submission of a DoLS application. Despite operational pressures, there was strong multidisciplinary co-ordination across nursing, medical therapies, mental health liaison, psychiatry, and safeguarding teams.

The story highlighted several key improvements introduced to address these challenges, including reducing bed surges in Ward 12, reclaiming the activities room to de-escalate behaviours, and proactively identifying patient triggers in partnership with the Reducing Restrictive Practice Team. The presentation underscored the importance of system-wide interdependencies and the impact of challenging environments on patient care and staff workload.

The Committee engaged in a discussion following the presentation, raising questions about the typicality of such cases, data collection, and the broader themes of patient safety risks associated with prolonged stays. The discussion also touched on the impact of treating patients in non-designated spaces, corridor care, and the need for consistent frailty pathways across the Health Board.

There was a consensus on the need for comprehensive governance arrangements to manage and prevent harm, with references to various initiatives such as streaming hubs, expansion of the Same Day Emergency Care (SDEC) pathway, discharge pathways, and boarding risk assessments. The Committee acknowledged the progress made and the strengthened governance and operational controls in place, while

recognising the ongoing challenges and the need for further improvements.

Ms Marks expressed appreciation for the efforts of staff dealing with such complex situations and emphasised the importance of continued focus on improving patient care and staff support.

Decision: The Committee discussed and noted the patient story.

QSEC 26 (07) **Equity Impact Assessment Tool**

Dr Jo McCarthy joined the meeting to present the Equity Impact Assessment Tool, developed as part of the 24-7 model, to ensure that strategic and operational decisions do not impact upon health inequities across the region. The tool focuses on socio-economic factors and aims to support equitable access to services, particularly for people facing transport issues and other barriers.

The toolkit is designed to be user-friendly and has already been utilised in some early decisions within the Clinical Services Plan Programme. Dr McCarthy emphasised the importance of embedding equity considerations in all aspects of service delivery and strategic planning. The Committee discussed the need for an integrated impact assessment process and the formal ratification of the tool kit which Mrs Wilson suggested is appended with the QSEC Update Report to Board for final approval. Members agreed with this approach. **KL**

Mrs Chantal Patel queried how the toolkit would avoid becoming a tick-box exercise, and instead drive meaningful action. Dr McCarthy advised that the identification of equity issues through the toolkit would require the development of specific actions.

The discussion also touched on the broader implications of the toolkit for the Health Board's strategic direction, particularly in relation to the Mid and West Wales Strategy and the shift towards prevention and community-based care. The Committee agreed on the need to combine assessment processes and embedding equity considerations in all decision-making.

Decision: The Committee approved the toolkit and proposed appending it to the QSEC Board Update report for final approval to formalise the toolkit ahead of its integration into the quality impact assessment process.

QSEC 26 (08) **Management of Waiting Lists/DNAS/ Appointments:**

Ms Marilize Preeze joined the meeting and provided a follow-up to the Committee, highlighting the review of communication processes for 109 services and 198 subspecialties. She

emphasised that the review was welcomed by the services and staff involved, with full engagement and no reported resistance.

Three main themes were identified from the review:

- There was a lack of standardised processes across the system. Where guidance existed, staff had different interpretations or were unaware of them. Specific issues included guidance for vulnerable patients, what constitutes a reasonable offer, recording communication, discharge following Did Not Attend (DNA) and Could Not Attend (CAN) appointments, and limited audit processes.
- Positive progress was noted in the hybrid mail rollout, allowing patients to access appointment letters and reminders online. However, multiple access points (e.g., medical secretaries, unmanned answer phones, mobile phone numbers of staff on letters) need streamlining. Additionally, letters sent do not consistently meet accessibility standards.
- Different systems are used for managing waiting lists, with some services still using Excel spreadsheets. The Welsh Patient Access System (WPAS), designed for activity and patient administration, lacks functionality for waiting list management, particularly for identifying vulnerable adults and recording narrative.

Immediate actions recommended establishing a task and finish group and reviewing the governance structures and audit processes.

Cllr Evans raised queries regarding the Referral to Treatment (RTT) guidance, specifically the clock stopping process outlined in the report. Ms Preeze explained that the RTT clock may be stopped when a patient is deemed unfit for treatment and will restart once the patient is fit, with their position on the waiting list restored, as it they had not been removed. However, tracking this manually is challenging. Mr Carruthers added that implementing RTT guidance accurately is complicated, with around 190 users having access to the system, including service managers, medical secretaries, booking clerks, and administration staff. Training is available, but uptake needs improvement.

Mr Neil Prior raised a concern regarding the Health Board failing to undertake basic customer services. In agreement, Mr Henwood emphasised the importance of establishing trust with the population, highlighting the need for robust ownership beyond business cases and task and finish groups. Mr Prior supported this, noting the shift from a paternalistic healthcare system to one focused on customer service and communication.

The Committee agreed on the importance of improving communication and processes, recognising the need for a

permanent focus on these basics. The discussion concluded with an assurance that the Committee is addressing these issues, with plans to update Board in March 2026.

Decision: The Committee noted the findings from the review of Management of Waiting Lists/ DNA's/ Appointments and the recommendations to support improved waiting list management.

QSEC 26 (09) **Quality Assurance Report**

Ms Cathie Steele presented the Quality Assurance Report, noting that the format had been updated based on previous Committee feedback. The reported reduction in complaints, prompted Mrs Marks to question whether reflected a positive improvement or a potential decline in people providing feedback. Acknowledging this valid concern, Mrs Louise O'Connor explained that the decrease is due to re-categorising complaints during an internal exercise, with a number reclassified as inquiries, which are dealt with at the first point of contact. Despite the recent decrease, complaints are starting to increase again.

Ms Steele addressed concerns relating to mandatory infection control training compliance, which stands at 75.36%. Efforts are being made to improve this, including a review of the training offered to ensure it meets staffing needs. The Infection Prevention and Control (IPC) Team is working with the Clinical Care Groups to increase training compliance.

Regarding data sets and safety dashboards, Mrs Steele assured the Committee that the IPC Team provides detailed data through the Infection Prevention Strategic Steering Group. The Clinical Care Groups are being asked to strengthen locality meetings to address improvements.

Cllr Rhodri Evans appreciated the reformatting of the report, which provided comprehensive information.

Decision: The Committee noted the contents of the report and received assurance that processes are in place to review, monitor and improve the quality of services.

QSEC 26 (10) **Safeguarding Update Report**

Ms Charlotte Westacott and Ms Steele presented the Safeguarding Update Report, providing detailed information on compliance with statutory safeguarding requirements. The report included background information on various safeguarding activities, such as the management of People in Position of Trust (PiPOT) cases and collaboration with local authorities.

Ms Westacott explained the concept of restorative supervision developments, which provide emotional and psychological support to staff dealing with complex and traumatic cases. This approach

goes beyond traditional clinical supervision, offering a reflective space for staff.

The Committee discussed the six-month extension requested for the Corporate Safeguarding Policy. Ms Steele assured the Committee that the policy is compliant with statutory requirements, and the extension is to ensure a robust review can be undertaken.

Cllr Evans raised questions about training and compliance, noting the overlap between adult and children's safeguarding training. Ms Steele confirmed that the training meets statutory requirements, however, work is progressing to streamline and improve the training offered.

Mr Severs asked about the impact of granting the extension to the Corporate Safeguarding Policy and sought assurance that internal processes are reviewed alongside external liaison in terms of the PiPOT investigations. Ms Steele and Ms Westacott assured the Committee that strong links exist between safeguarding processes and workforce teams, ensuring timely management of cases.

Decision: The Committee:

- Received assurance on the Health Board's safeguarding arrangements and the current activity, key developments, and actions underway to strengthen compliance with statutory safeguarding requirements.
- Agreed to a six-month extension for the Corporate Safeguarding Policy

QSEC 26 (11) **Assurance and Risk Report- Executive Leads**

Mrs Wilson provided an overview of the Assurance and Risk Report, highlighting the significant increase in operational risks, which have increased from 389 to 467. Of these, 39 risks score over level 20 and are reported to the Committee. The report combines all risks and audits, focusing on principal risks aligned to the Committee. Referring to specific risks, including the sonography and corridor care risks discussed during previous meetings, Cllr Evans queried why these are not covered in this report. Mrs Wilson explained these are managed at operational level by the Clinical Care Groups and reported to the QSEC every other meeting and provided assurance that those specific risks have recently been reviewed by Mr Carruthers and his team. It was highlighted that the risks are significant due to their safety and quality implications. The Committee acknowledged the alignment of these risks with the Clinical Services Plan (CSP) and fragile services.

Mrs Sharon Daniel raised the issue of reviewing the risk around providing care in non-designated clinical areas. This review will be led by the Quality, Safety and Assurance Team, integrating individual risk assessments for each patient cared for in such areas. Mr Carruthers added a general point about the increasing

risks due to the planning process and operational focus. He noted the significant work undertaken in reviewing local operational risk registers, which will inform the high-level risks requiring oversight. An example cited was Risk 1603 concerning *delayed response to referrals for children with selective eating*, identified by a Clinical Care Group as a priority for this year's planning cycle.

Mr Prior inquired about the possibility of deep dives into specific risks on future agendas. It was clarified that deep dives are typically conducted on corporate risks, with recent work undertaken to theme risks to provide clearer insights and this can be discussed further at agenda setting for the next meeting. It was agreed that deep dives into these areas are necessary. Ms Marks emphasised the need to ensure transparency regarding the financial position and its impact on risks, emphasising the importance of making this clear to both the Board and the population served. **JW**

Mr Imperato commented on the high-risk scores and the realism of these assessments, linking them to the planning and financial constraints. Specific risks around diagnostic demands and physiotherapy waiting times were highlighted, with a mention of minor discrepancies in risk scoring that need correction.

The discussion concluded with a consensus on the need to advise the Board about the seriousness of these risks and the potential for deterioration due to financial constraints. The Committee agreed to assure the Board on the process however advise on the specific risks and decisions required. The Committee appreciated the comprehensive nature of the report and took assurance from the detailed risk management processes in place.

Decision: While assurance was provided regarding the robustness of the risk management process, the Committee agreed that further scrutiny of extreme-level risks is required.

QSEC 26 (12) **Epilepsy in Learning Disabilities Update on Public Interest Report**

Mrs Sharon Daniel presented the progress report on epilepsy in learning disabilities. The report provided updates on the task and finish group addressing the Ombudsman's recommendations. External clinical oversight has been secured, although much of the work is still in development and requires continued oversight.

While the pathway for epilepsy care was approved last July it is not yet consistently operational. A mapping exercise revealed gaps that are being addressed through continuous improvement opportunities. The task and finish group remains active, with external clinical assurance and input from Swansea Bay University Health Board. Apology letters have been issued to the affected families. Inaccuracies identified in the letters are being reviewed and addressed.

Systemic risks such as capacity issues persist, with specialist learning disability and epilepsy nursing capacity being considered to meet the needs of patients and carers. The Task and Finish Group has developed a new accountability map to clarify roles across the system, involving various care sectors and advocacy groups.

The Committee expressed assurance that processes are in place to address these complex challenges, with ongoing efforts to support individuals and families involved. The discussion concluded with a consensus that the Board should be assured of the progress and processes in place.

Decision: The Committee:

- Received assurance on the progress made against Recommendations thus far.
- Acknowledged the continued work of the LD Epilepsy Task & Finish Group.
- Agreed to receive a further update at a future meeting for full assurance on equity, access and variation.

QSEC 26 (13) **Estates and Facilities Clinical Care Group**

Mr Simon Chiffi and Ms Elin Brocke joined the meeting to present the report on the Estates and Facilities Clinical Care Group (CCG), highlighting the challenges and progress over the past 12-18 months. The focus has been on strengthening governance and accountability, with revised terms of reference for the Environmental Hygiene Group and completion of actions from the internal audit on standards of cleanliness.

The priority for the coming year is implementing a new model of cleaning provision, with extensive staff engagement. The assessment of cleaning resources aims to shift focus from low-risk to high-risk areas, with proposals put forward for winter resilience workforce. There is an organisational change process underway to strengthen rota arrangements to provide a 7 day a week cleaning service and the team is working closely with Trade Unions to support staff as much as possible.

Mr Chiffi provided an overview of the estate's maintenance and compliance challenges, emphasising the importance of capital investment to address the ageing infrastructure. The CCG has made significant progress in structuring its business, improving governance, and documenting risks comprehensively.

Ms Marks highlighted the importance of strategic capital investment and the challenges of maintaining quality and safety in amid financial constraints. Assurance was provided on the

improvements made and the ongoing efforts to address risks and enhance the estate's quality.

The discussion concluded with recognition of the progress made and the assurance taken from the comprehensive update presented.

Decision: The Committee received assurance on the quality governance arrangements in place within the Estates and Facilities Clinical Care Group in relation to quality, safety and patient experience.

QSEC 26 (14) **Listening and Learning Sub Committee and Terms of Reference for Review**

Mrs O'Connor presented the report from the Listening and Learning Sub Committee, noting no alerts, highlighting the significant work required to implement the Listening to People Regulations. The change impact assessment is pending national-level decisions and will be ready for the next QSEC meeting. The advise matter was accepted. **LOC**

Mrs O'Connor advised that the revised terms of reference have been strengthened in terms of membership and scope, focusing on evidencing how feedback leads to learning and improvement. The Sub Committee aims to demonstrate a reduction in harm and improved experiences through the appreciative inquiry and balanced feedback. Mr Henwood added that medical involvement has been broadened, with assistant medical directors joining the Sub-Committee to ensure widespread distribution of learning.

The Committee expressed appreciation for the positive approach of appreciative inquiry and the strengthened terms of reference.

Decision: The Committee:
• Noted the items the Committee is advising it of
• Received assurance from the items that the Sub Committee provided assurance for.
• Approved the LLSC terms of reference.

QSEC 26 (15) **Safety Alerts Policy**

Burgin. Ms Caroline joined the meeting and explained that the Safety Alerts Policy was due for review within the next 12 months, and it was decided to update it to reflect current practices. The primary change involved the process of managing safety alerts, which would now be uploaded onto the Audit Management and Tracking System (AMAT). This change aims to streamline the allocation of alerts to appropriate individuals and facilitate engagement through the system. Additionally, Ms Burgin referenced aligning the alerts to Committees and Sub Committees for clearer oversight.

Ms Marks expressed appreciation for the updated policy, noting that it made good reading and was beneficial for the organisation. There were no questions from Members, and the policy was approved.

Decision: The Committee approved Policy 429 Management and Distribution of Safety Alerts and Notices.

QSEC 26 (16)

- **QSEC Work Plan 2026-27**
- **Date of Next Meeting: 9 April 2026**

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

TABLE OF ACTIONS FROM
QUALITY, SAFETY & EXPERIENCE COMMITTEE (QSEC) MEETING
HELD ON 12 FEBRUARY 2026

Reference	Item	Responsible	Timescale	Update
QSEC 26 (05)	• **Terms of Reference:** To discuss with Neil Prior suggested amendments to the Roles and Responsibilities for the Committee ahead of submission to Board.	**JW**	**March 2026**	**Complete**
QSEC 26 (07)	• **Health Equity Assessment Toolkit:** To append the tool kit to the Public Board report for final approval for the meeting on 26 March.	**KL**	**March 2026**	**Complete**
QSEC 26 (10)	• **Safeguarding Assurance Report:** To forward plan a review of the Corporate Safeguarding Policy for August 2026.	**KL**	**August 2026**	**Complete**
QSEC 26 (11)	• **Assurance and Risk Report:** To discuss forward planning a deep dive into thematic risk for the April Committee at the QSEC agenda setting meeting.	**EM/ JW**	**March 2026**	**Complete**

JW: Joanne Wilson	KL: Katie Lewis	EM: Eleanor Marks			

1.4

1.4 - QSEC Annual Report 2025/26

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

Attachments

QSEC Annual Review 2526.pdf

QUALITY, SAFETY AND EXPERIENCE COMMITTEE

ANNUAL REVIEW REPORT

2025/2026

1. Introduction and Chair's summary

In line with Standing Orders the Quality, Safety and Experience Committee (QSEC) must submit an Annual Report to the Board through the Chair within 6 weeks of the end of the reporting year setting out its activities during the year and including the review of its performance and that of any Sub-Committees it has established, setting out how the Committee has met its Terms of Reference during the financial year.

The Board uses this annual report to inform:

- The ongoing development of its governance arrangements, including its structures and processes:
- Its Board Development Programme, as part of an overall Organisation Development framework: and

2. Terms of Reference and Workplan

The Terms of Reference (TOR) for the QSEC Committee are reviewed on an annual basis or following any significant changes. The TORs were last reviewed in February 2026.

QSEC Terms of Reference March 2026

The QSEC has a work plan to enable forward planning for the forthcoming year. The workplan is produced to incorporate the duties outlined in the Committee's Terms of Reference and any suggested areas of focus identified during the self-assessment process.

The QSEC Committee workplan covers a range of activities including statutory reporting duties, regular items of business and priority planned pieces of work which support Board and Committee's objectives.

The work plan is regularly updated throughout the year to ensure it remains responsive to emerging issues and risks.

Work Plan 2025/26

3. Sub-Committees

The Listening and Learning Sub-Committee reports into the QSEC with its own terms of reference and workplan for the year. The Sub-Committee's TOR were last reviewed on 12 February 2026.

In line with the Terms of Reference, the Sub-Committee is required to provide a report after each meeting, as well as produce an annual report which are scheduled to be presented to the Committee in June 2026 reporting on activity throughout the year.

4. Table of attendance

Name					Extraordinary meeting		Extraordinary meeting		
Members		**08.04.2025**	**10.06.2025**	**14.08.2025**	**15.09.2025**	**09.10.2025**	**04.11.2025**	**04.12.2025**	**12.02.2026**
Anna Lewis	Independent Member - Committee Chair	✓	✓	✓	✓	✓	**x**	✓	N/A[1]
Eleanor Marks	Independent Member (Committee Vice-Chair)	✓	✓	✓	✓	✓	✓	✓	N/A
Eleanor Marks	Independent Member (Committee Chair)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	✓
Michael Imperato	Independent Member	✓	**x**	✓	✓	✓	✓	✓	✓
Chantal Patel	Independent Member	✓	✓	✓	✓	✓	✓	✓	✓
Sarah Harraway	Independent Member	N/A	**x**	✓	✓	✓	✓	✓	N/A
Rhodri Evans	Independent Member	N/A	N/A	N/A	N/A	N/A	N/A	N/A	✓
Neil Prior	Independent Member	N/A	N/A	N/A	N/A	N/A	N/A	N/A	✓
In Attendance									
Sharon Daniel	Director of Nursing, Quality & Patient Experience	✓	✓	✓	✓	✓	✓	✓	✓
Andrew Carruthers	Chief Operating Officer	✓	✓	✓	✓	✓	✓	**x**	✓
Mark Henwood	Medical Director	✓	**x**	✓	**x**	✓	**x**	✓	✓
Jill Paterson	Director of Primary Care, Community and Long-term Care	✓	✓	✓	**x**	✓	**x**	N/A	N/A
James Severs	Director of Therapies and Health Science	✓	✓	✓	✓	✓	✓	✓	✓
Ardiana Gjini	Executive Director of Public Health	✓	✓	✓	✓	✓	**x**	✓	✓

Louise O'Connor	Assistant Director Legal and Patient Experience	**x**	✓	✓	**x**	✓	**x**	✓	✓
Cathie Steele	Interim Assistant Director of Assurance and Safeguarding	✓	✓	✓	✓	✓	✓	✓	✓
Llais Cymru Representative		✓	**x**	**x**	✓	**x**	**x**	**x**	✓
Meeting quoracy		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

(Not Applicable: due to changes in Membership/ Staff leaving posts)

A quorum shall consist of no less than three of the membership and must include as a minimum the Chair or Vice Chair of the Committee, and two other Independent Members, together with a third of the In Attendance members.

5. Committee Activities – alert, advise and assure.

The Committee is required to report to the Board after each Committee meeting by presenting a report highlighting the key discussion items at the Committee.

Alert – *The following matters were areas where the Committee was unable to take an assurance or had a lack of confidence that the action in place was sufficient to address the issue satisfactorily and/or it was within the scope of the operational team to resolve and were alerting the Board as engagement action or intervention was required.*

- A patient story powerfully illustrated the urgent need for systemic transformation within **Emergency Departments** in June 2025. Key themes included inconsistency in standards of practice for nutrition and hydration processes, poor waiting room conditions, lack of dignity and respect, insufficient patient care due to capacity constraints, and a perceived culture of acceptance amongst staff under pressure. Urgent work was progressing through dedicated accelerated care workstreams, each focusing on specific priority areas.

- Clarification was sought on the approach and frequency with which concerns regarding estate deficiencies and capital investment in June 2025, particularly those affecting infection prevention and control, were raised during discussions with Welsh Government in response to **Targeted Intervention** de-escalation requirements. It was confirmed that such matters, notably ventilation related issues, are regularly addressed during touch point meetings with Welsh Government. A review of the identification of estate deficiencies took place by executive colleagues that reviewed and strengthened how feedback from safety walkarounds was reported and monitored.

Advise – *The following matters were areas of concern where assurance had been taken on actions in place but required close monitoring.*

- The ongoing issues with overcrowding and workforce fragilities at the **Health Board's Urgent and Emergency Care services** were discussed during a Deep Dive report in April 2025, including the outcome of the Getting it Right First Time (GIRFT) review into the Emergency Departments. While a number of positive changes had been implemented to improve the quality and patient experience, which were shared as part of a *patient story*, it was recognised that necessary improvements would not be achievable without systemic transformation.

- A deep dive into quality matters being managed within the **Mental Health and Learning Disabilities** Clinical Care Group was presented in April 2025 including the processes, practices and frameworks. The Committee noted that a revised national Mental Health and Wellbeing Strategy (2025- 2034) would replace the previous ten-year strategy Together for Mental Health which would impact upon local planning. Innovative pilot opportunities were being actively explored by the Clinical Care Group, and the Committee encouraged the Clinical Care Group to be ambitious with its vision for future services.

- It was recognised in April 2025 that there was work required to strengthen reporting, to evidence the Health Board's participation with national clinical audits within the **Targeted Intervention Update Report** in April 2025, which was taking place via the recently established operational governance arrangements and would continue to be monitored via the Audit and Risk Assurance Committee.

- In response to concerns raised regarding culture and high sickness rates in Theatres at Glangwili Hospital via the **Targeted Intervention Progress Report** in June 2025, the Committee requested that an improvement plan is scheduled for the People, Organisational Development and Culture Committee (PODCC). PODCC received an update on 17 February 2026 that an improvement plan co-produced with theatre staff was underway, with Band 7 staff taking ownership of leadership and management roles

- Several key highlights were discussed as part of the routine **Quality Assurance Report** during the June 2025 meeting including staff survey results which indicated that some staff felt uncomfortable reporting incidents. The Clinical Care Groups were asked to emphasise the importance of incident reporting during team meetings, in alignment with the Health Board's ongoing commitment to the Speak up Safely agenda, while PODCC considered themes arising from the survey and other sources of intelligence.

- The serious consequences of stretched services, along with the underlying causes of current shortfalls was discussed in August 2025 as part of the **impact on patient experience and clinical outcomes due to Risk 797: Workforce Pressures in Ultrasound Services** report**.** The need for strategic changes to the workforce model was emphasised, to maximise staffing and resource use, while reducing demand. The vision set out within the report indicated potential service change which would

integrate scanning into the midwife role, reduce sickness rates linked to hand injuries, and provide a more varied role for the midwives. It is anticipated that the review for midwife sonography will strengthen the current fragile system. The service model redesign and workforce plan, which was in development, was shared for Executive and Board approval in March 2026. Further strengthening of 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.

- In December 2025**,** the high-risk issue relating to **Sonography Services (Risk 797**) was reviewed, with concern expressed regarding the timeframes for achieving the target risk score, the potential impact on patient safety, and the effectiveness of current mitigations. It was noted that staff absences and recent retirements had increased service fragility, resulting in the risk score rising from 20 to 25. The initiatives include the development of an integrated midwifery sonography service within one to three years, the extension of insourcing arrangements to address national workforce shortages, and the strengthening of radiography leadership through the introduction of new roles.

- The **Assurance and Risk report** was reviewed by the Committee in August 2025. and the following action was agreed:
  - Concern was raised around risks where internal mitigations had been exhausted, and progress was reliant on external factors, particularly associated with Welsh Government (WG) funding. There was a desire to explore options to make stronger representation to the Board and WG on this issue.

- **Risk 664 - Risk to ophthalmology service delivery due to a national shortage Consultant Ophthalmologists and the inability to recruit**: *S*everal developments within primary care optometry services have mitigated the risks, such as the introduction of Glaucoma filtering and monitoring pathways and the expansion of independent prescribing optometrists. These developments have enabled more services to be delivered within the community, thereby alleviating pressure on the ophthalmology service and supporting more timely diagnosis and treatment.

- **Risk 1708 - increasing fragility in primary care contractor services due to external factors** had been de-escalated. While services remain fragile, the Health Board has a statutory duty to ensure their provision, although the delivery model may change. It was noted that this risk was not solely dependent on the development of the Primary Care Strategy. However, as the service moves closer towards redesign through cluster-based arrangements, additional funding would be required to support this shift. Future Board support would be sought for the implementation of the Primary Care Model for Wales and the local cluster-based service delivery, with further requests to be made for support regarding the Eye Health Plan and the Dental Investment Plan.

- During an extraordinary Committee held during September 2025, a deep dive was provided into **Critical Care services**. The Committee was advised that following a reduction in the number of critical care consultants in Carmarthenshire from 8 to 5, an amended pathway and Standard Operating Procedure (SOP) was developed whereby patients were managed remotely from the Intensive Therapy Unit (ITU) at Glangwili Hospital. However following an incident in December 2024, the level of risk aversion had increased that resulted in all Level 2 and Level 3 Intensive Care Unit patients being transferred from ITU at Prince Philip Hospital (PPH) to Glangwili Hospital. The Committee were advised that an assessment of patients being admitted to ITU at PPH had not been able to determine the rationale for a reduction in the number of patients retained at PPH and that there had been no change to the admission and review process for ITU at Prince Philip Hospital.

- During the meeting in September 2025, the **Stroke Services** deep dive provided the current service provision provided by the Health Board at its four acute hospital sites and advised of the fragility of the service due to workforce limitations, in that there was a vulnerability caused by having services supported by one speciality stroke clinician per acute site in two of the four sites.

- None of the four acute sites or rehabilitation units within the Health Board meet the staffing levels recommended by the Royal College Clinical Guidance for Stroke. Work continues towards the development of a regional strategy for the provision of Hyper-Acute Stroke Units. A Programme Plan to develop Comprehensive Regional Stroke Centres across Wales was being consulted on and modelling work being undertaken. The availability of CT Perfusion Scanning was currently not available within the Health Board due to capacity and workforce constraints within the Radiology service. This provides significant benefit to patients and can lengthen the acute-stroke treatment window from 4.5 hours to 9 hours for thrombolysis, increasing the opportunity for clot retrieval treatment. Proposals were being developed for implementation within the Health Board through the All-Wales Optimal Imaging Pathway.

- At the same meeting, the deep dive of **Emergency General Surgery** service showed that the service was considered fragile due to workforce challenges experienced in managing the Emergency General Surgery rotas for Glangwili Hospital and Withybush Hospital. The recruitment of staff to service-specific recruitment as opposed to site-specific recruitment had been made to make the Health Board more attractive to prospective recruits into general surgery.

- In October 2025, a **Public Interest Report** highlighted the Health Board's failure to provide ongoing specialist care for epilepsy for patients with a learning disability, following the cessation of the dedicated service in June 2021. It detailed the significant impact on patients and carers, noting that, four years later, a clear pathway to specialist care had not been implemented. Following Board consideration in November 2025, an update was provided to the Committee in February 2026 on the progress against the recommendations. The Committee took assurance from the

continued work of the task and finish Group and agreed to receive a further update at a future meeting for full assurance on equity, access and variation.

- While there had been no evident change in the number of referrals to the service since the **temporary service changes for access to the Community Mental Health Service (CMHT) in Ceredigion** during October 2025, a localised increase in hospital admissions had been observed. The Committee asked that this is explored further and also sought assurance that local GPs have been engaged with consultations ahead of the report to Board in November 2025. An update was received through the table of actions in December 2025 confirming planned GP attendance at the north and south collaborative meetings in November 2025, with the purpose of engaging with doctors to gather local feedback.

- Partial assurance was provided on progress with the **Occupational Therapies Paediatric Improvement Action Plan** in October 2025 to develop a sustainable model and reduce waiting times below the 14-week target. A programme of service evaluation, which included a detailed demand and capacity analysis was reported and identified an opportunity to increase productivity by 13 new patients per week across the Paediatric Occupational Therapy service, demonstrating the potential to provide the required capacity to meet demand.

- Despite longstanding national consultant workforce shortages, significant efforts are being made by the team to progress actions to mitigate the challenges in providing a quality **Dermatology Service**, while awaiting the outcome of the Clinical Services Plan. At an extraordinary QSEC meeting held in November 2025 it was reported that steps are being taken to explore regional collaborative opportunities, undertake remote medical appointments and upskill GPs for additional service provision. Concerns remained regarding the impact on the service, if the imminent medical recruitment attempts were not successful.

- Significant concerns were raised regarding prolonged **autism spectrum disorder (ASD) diagnostic waiting times for children and young people (Risk 1032)** in December 2025. The target risk score of 16 remained unchanged due to resource limitations and the need for a strategic response. Patient concerns and the requirement for additional resources to support integrated hubs was discussed. Members highlighted the considerable distress experienced by families and emphasised the need for urgent service improvements. Consequently, the Chief Operating Officer carried out a deep dive meeting to review the risk and undertook to initiate discussions at a regional level on the need to develop a regional needs-led approach, to improve the quality, safety and experience of children and young people, to enable them to have improved access to appropriate support and interventions as opposed to the achievement of performance targets.

- In December 2025**,** the Committee was advised that a comprehensive review of **Waiting List Management** would be undertaken to address identified complexities and inconsistencies in patient communication processes across the Health Board.

The findings would inform a Health Board action plan which would be presented to QSEC in February 2026. In February 2026, the Committee supported the recommendation to form a task and finish group to review governance structures and audit processes related to the management of waiting lists and emphasised the importance of rebuilding trust with the population and improve customer service processes. The Board to receive an update on progress in March 2026.

- In February 2026, a substantial increase in **operational risks** was reported, rising from 389 to 467. Members discussed the likelihood of further deterioration as a result of ongoing financial pressures. While assurance was provided regarding the robustness of the **risk management process**, the Committee agreed that scrutiny of extreme level risks would be required going forward. A thematic deep dive into the Allied Health Professional and Health Science corporate and extreme level operational risks and associated mitigations was scheduled for the next meeting in April 2026, following concerns raised in relation to diagnostic demand and physiotherapy waiting times.

  The risk associated with providing **care in non-designated clinical areas** was reported as currently under review during February 2026 and will be led by the Quality, Safety and Assurance Team and will incorporate individual patient risk assessments for all patients cared for in such environments.

Assure – *The following matters were areas where there was confidence that robust actions are in place and are sufficient to address the issues to operate effectively.*

- In April 2025, it was reported that the rates of **Healthcare Acquired Infections (HCAI)** in the community continue to be examined in partnership with Public Health Wales and Local Authorities. Data was regularly reviewed as part of the Healthcare Associated Infections (HCAI) reporting expectations to Welsh Government for C.Difficile, E.coli, and S.Aureus, and targeted action undertaken, where required.
- In April 2025, the ongoing review of incident data and patient feedback did not suggest a harmful impact on patient care following the temporary closure of the **Minor Injuries Unit at Prince Philip Hospital** overnight service. This was subject to proactive monitoring, and the Committee continued to maintain oversight.
- The activity and successes of the **Improvement Strategic Framework 2023- 2026** was presented to the Committee in April 2025, and it was reported that the planning for Cohort 7 of the **Enabling Quality Improvement in Practice Programme** (EQIiP) would start in June 2025. It was reported that 550 colleagues had been involved with the EQIiP Programme up to April 2025, with 80 projects undertaken and 50 Quality Improvement Coaches across the Health Board.
- An addition had been made to the revised **Fragile Services framework** in June 2025 to include the Fragile Services Register, Improvement Plan and Quality Impact Assessment, to support achievement of the de-escalation criteria actions.

- The key areas of focus which would be prioritised as part of the local cancer transformation programme was shared during a presentation of the **Auditor General Report on Cancer Services** in June 2025.

- The **Duty of Candour Annual Report 2024/25** was presented to the Committee in June 2025 ahead of the Annual General Meeting in September 2025.

- The **Listening and Learning Sub Committee (LLSC) Annual Report 2024/25** was reviewed and approved by the Committee.

- The **Patient Experience Framework** was shared as part of the **LLSC Update Report** in June 2025. This is a tool developed for all NHS services (including commissioned services) to undertake self-evaluation and provide support for the development of improvement plans for improving patient experience.

- A governance review was conducted to evaluate how **Getting it Right First Time** (**GIRFT) reports** and other external reports in June 2025, to strengthen the process, and integrate it within the Health Board's operational and corporate structures. Revised processes are now in place to ensure these are appropriately tracked and implemented within the organisation.

- The Health Board was reported to be meeting its statutory 'duty to calculate' responsibility in respect of the nurse staffing levels in all wards that fall under the inclusion criteria of Section 25B of the **Nurse Staffing Levels (Wales) Act 2016** in June 2025.

- The **Corporate Risk report** was reviewed in June 2025, and the risk (1810) to **delivering effective and timely cancer service due to a high risk that the current Aseptic Unit at Withybush Hospital (WGH) will be forced to close** before the South-West Transforming Access to Medicines hub is operational, was considered. Actions progressing to mitigate the risks include the purchase of isolators. A demountable unit at WGH is also being progressed which would provide increased production and storage of stock for the future.

- A six-month review of actions following the **Committee self-assessment** was undertaken during February 2025 was shared in August 2025, with six out of the 10 actions completed and progressing within agreed timeframes.

- The Committee approved the proposal to revise the operational quality and safety governance arrangements and disestablish the **Quality, Safety and Experience Sub Committee (QSESC)** in August 2025. The 9 reporting Groups that previously reported to QSESC would report to Quality and Safety Intelligence Group (QSIG) which reports to the Integrated Quality, Finance, Performance & Delivery Group (IQFPD). A report will be presented to QSEC in April 2026 to provide an update on the effective implementation of these new operational quality and safety arrangements.

- It was reported in August 2025 that actions underway in response to the second limited assurance audit outcome regarding **cleaning standards** across the organisation were progressing within the specified timescales. A follow up audit was anticipated within the current financial year. In February 2026, the Committee received an update report advising that the **Estates and Facilities Clinical Care Group** had made significant progress in structuring its business, improving governance, and documenting risks comprehensively in the last twelve months. The priority for the coming year would include implementing a new model of cleaning provision, with extensive staff engagement. The assessment of cleaning resources aims to shift focus from low-risk to high-risk areas, with proposals put forward for winter resilience workforce. There was an organisational change process underway to strengthen rota arrangements to provide a 7 day a week cleaning service and the team was working closely with trade unions to support staff as much as possible.

- Several key highlights were discussed as part of the routine **Quality Assurance Report** in August 2025 including:

  - The Quality Assurance team continues to actively promote the significance of incident reporting with staff. An upward trend in incident reporting provided an early indicator of progress.

  - 240 incidents had been closed where the Duty of Candor had been 'triggered', with a discussion on how the learning from these incidents was being implemented across the organisation.

- The Committee received the **Duty of Quality Annual Report 2024/25** in August 2025, ahead of presentation at the Annual General Meeting in September 2025.

- The progress being made to implement a **Women's Health Hub** in line with the NHS Wales Women's Health Plan by 31 March 2026 was reported in August 2025 with an update report scheduled for the meeting on 9 April 2026.

- Assurance was received in August 2025 that due process was being followed in collaboration with key stakeholders for the centralised relocation of the **Section 136** place of safety for people experiencing a mental health crisis to Carmarthen, Carmarthenshire.

- The positive work undertaken in establishing the Frailty Assessment Unit was shared as part of a **Staff Story** in October 2025**,** whereby the Cadog Ward transitioned from a 20-bed frailty ward to a reconfigured model, consisting of a 6-bed assessment unit and 14 short stay frailty beds. This also included the implementation of a pathway to support patients requiring longer-term frailty care. The changes have reduced the need for enhanced patient support, improved outcomes and strengthened patient safety through visible and effective leadership.

- It was reported in October 2025 that appropriate steps were being taken to assess the safety and quality of services in light of the findings from the Independent **Review of Maternity and Neonatal Services** at Swansea Bay University Health Board. A maternity and neonatal assessment report has been scheduled on the QSEC agenda for 9 April 2026.

- Assurance was received in November 2025 during an extraordinary meeting, that significant progress had been achieved in outpatient efficiency, diagnostics and governance within the **Urology Service**. The next steps reported included securing additional theatre sessions, addressing diagnostic bottlenecks and expanding clinical nurse specialist capacity to deliver a sustainable transformation, as part of the Clinical Service Planning process.

- Positive progress was reported in November 2025 in clearing the diagnostic backlog and maintaining high standards of patient experience in **Endoscopy Services as part of the Clinical Services Plan Deep Dives**. Remaining challenges include the prolonged waiting lists, and the potential workforce and financial risks that could impact recovery delivery were noted.

- Mitigations to address **mortuary capacity challenges** (Risk 1552) was reported in December 2025, including short-term measures such as purchasing and renting additional storage units, providing 60 extra spaces to manage winter pressures. Financial support enabled building works at Prince Philip Hospital, adding eight spaces, with further plans to increase freezer capacity by seven. The Committee recognised the risk management efforts.

- The **Listening and Learning Sub Committee** focused on Mental Health and Learning Disabilities during its meeting in December 2025, emphasising person-centred care planning, staff support following adverse incidents, and compliance with HIW recommendations post-discharge. Appreciation was extended to the parents who attended to discuss the loss of their son, for their commitment and determination in helping to drive learning and improvements to mental health services. The Sub Committee reported the progress being made on the implementation of a Health Board wide Listening and Learning from Events Framework.

- The **Clinical Audit Programme 2025/26** was approved which emphasised alignment with organisational priorities through engagement with clinical care groups. Members highlighted the need for a prioritisation process, to be considered by the Executive Team, with suggestions for involving Committee Chairs and incorporating health equity audits. While approving the plan, the Committee expressed interest in greater involvement in audit prioritisation. In March 2026, the Committee were invited to consider what clinical audit projects might be beneficial to the organisation with suggestions to be sent to the Clinical Director for Clinical Audit by the 30 April 2026.

- Deep Dives into **Orthopaedics, Ophthalmology, and Radiology** presented in December 2025 outlined interim measures already in place, and those planned to address current challenges and service fragilities. The actions will remain in place pending the outcome of the Clinical Services Plan and underscore the case for change and the effectiveness of existing mitigations.

- An update report from the **Community Integrated Care and Medicine Clinical Care Group** in December 2025 addressed equitable service access and thematic learning and highlighted both the implementation of audit recommendations and their subsequent impact. Emphasis was placed on the monthly learning panel to embed improvements.

- The updated **guidelines for staff conducting patient-related surveys,** aligned with the new People's Experience Framework and national survey, were approved by the Committee, with assurance that the consultation identified no equality impact.

- A powerful **patient story** presentation during February 2026 illustrated the complexities of caring for vulnerable adults with cognitive impairment, behavioural escalation, safeguarding needs, and significant system pressures impacting flow, staff morale and workload.

- The **Quality Assurance Report** noted a reduction in complaints, leading to questions about whether this reflected genuine improvement or reduced feedback. The decrease had resulted from an internal re-categorisation exercise, with some issues now recorded as enquiries dealt with at first contact, with Committee informed that complaint numbers are beginning to rise again.

- During February 2026, the Committee raised concerns regarding the 75.36% compliance rate for mandatory **infection prevention and control** (IPC) training with actions underway to improve uptake, including reviewing the training offer and collaboration between the IPC Team and Clinical Care Groups. Detailed data continues to be shared through the Infection Prevention Strategic Steering Group, with Clinical Care Groups encouraged to strengthen locality meetings to drive improvements.

- The Committee approved the **Health Equity Impact Assessment toolkit** in February 2026 which was developed as part of the 24-7 model, to ensure that strategic and operational decisions do not impact upon health inequities across the region. This was shared with Board for final approval in March 2026. The tool focuses on socio-economic factors and aims to support equitable access to services, particularly for people facing transport issues and other barriers. The Committee discussed integration of the toolkit into the quality impact assessment process which will be considered by the Executive Team.

- Detailed information on compliance with statutory safeguarding requirements was shared as part of the **Safeguarding Update Report** in February 2026. The report

included background information on various safeguarding activities, such as the management of People in Position of Trust (PiPOT) cases and collaboration with local authorities. In terms of the request for a six month extension to the Corporate Safeguarding Policy, the Committee received assurance that the current policy was compliant with statutory requirements, and the extension was to ensure a robust review can be undertaken with the newly appointed Head of Safeguarding starting in post.

- The significant work underway to implement the Listening to People Regulations was discussed as part of the **LLSC** report in February 2026. The change impact assessment is pending national-level decisions and will be ready to share with the Committee on 9 April 2026. The revised **LLSC Terms of Reference** has been strengthened in terms of membership and scope, focusing on evidencing how feedback leads to learning and improvement. The Committee expressed appreciation for the positive approach to the appreciative inquiry within the Terms of Reference.

6. Committee Effectiveness - Feedback from self-assessment process

As stipulated within Standard Orders, the Board introduced a process of regular and rigorous self-assessment and evaluation of the performance of the QSEC.

This year's self-assessment focused on five core areas of governance and assurance:

- Oversight and Impact on Quality & Safety – how the Committee effectively oversees and influences improvements in the organisation's quality and safety outcomes.
- Data, Indicators, and Assurance - quality of papers including accuracy, timeliness, with relevant data to provide assurance on quality and safety experience, impact and outcomes for patients.
- Culture and Accountability – how the Committee promotes a culture of safety, transparency, and learning across the organisation.
- Risk Recognition and Response – how the Committee effectively identifies and responds to emerging quality and safety risks.
- Continuous Improvement and Committee Effectiveness how the Committee evaluates its own performance and takes steps to improve its effectiveness and strategic influence.

The results from which were fed into an action plan, combining information and Auditor/Regulator feedback.

The process was undertaken during the year and reported to the Committee on 12 February 2026 - Self Assessment Report.

The following themes were provided:

What has gone well:

- Effective chairing and strong Independent Member engagement.
- Effective scrutiny through high support and high challenge to those delivering the services.
- A positive culture of professionalism, openness and transparency.
- Continued oversight of areas requiring improvement.
- The revised approach to writing papers using the Domains of Quality (STEEEP) and enablers as outlined in the Duty of Quality support continuous quality improvement.

What to strengthen going forward:

- Operational reporting by focussing on outcomes and impacts to quality, supported by data, with less focus on performance, to avoid risks being reported after they have materialised.
- Operational governance to minimise ‘surprises’ and being proactive in considering urgent service issues/changes.
- Continue to improve quality of data reported to Committee

The Committee will receive an update on progress at the mid-year point in August 2026.

7. Conclusion

The Committee is satisfied that it continues to operate effectively and in line with the Terms of Reference. Issues have been escalated to Board as appropriate, and the Committee uses feedback from the self-assessment process to evolve and continually improve.

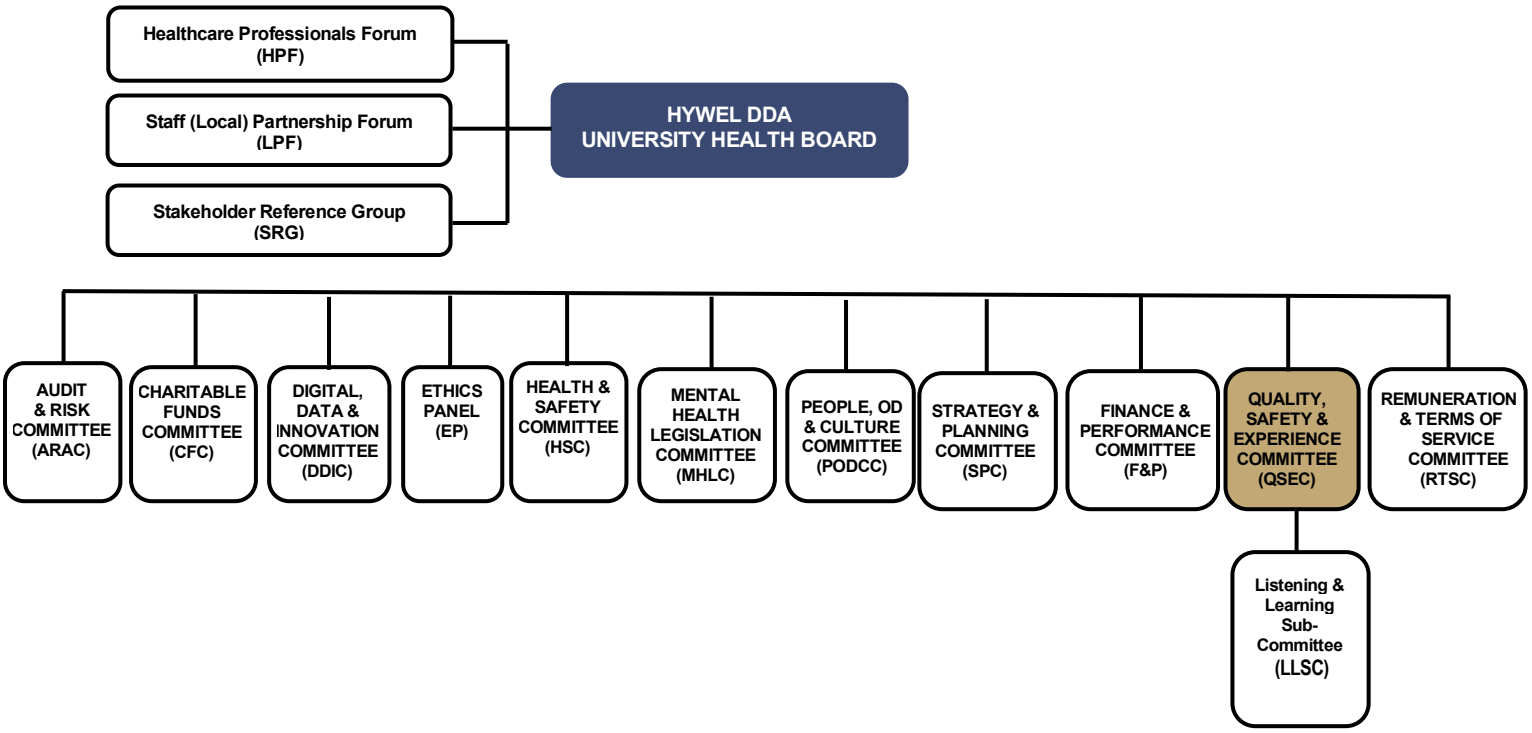
1.5

1.5 - Chair's Action: QSEC Terms of Reference

Eleanor Marks (Hywel Dda UHB - HDUHB Vice Chair)

Attachments

Approved QSEC Terms of Reference 26 March 2026.pdf



TERMS OF REFERENCE

QUALITY, SAFETY & EXPERIENCE COMMITTEE

Version	Issued to:	Date	Comments
V1	Quality Safety & Experience Assurance Committee	16.06.2015	Approved
V2	Hywel Dda University Health Board	30.07.2015	Approved
V3	Hywel Dda University Health Board	26.11.2015	Approved
V4	Quality Safety & Experience Assurance Committee	18.10.2016	Approved
V4	Hywel Dda University Health Board	26.01.2017	Approved
V5	Quality Safety & Experience Assurance Committee	20.02.2018	Approved
V5	Hywel Dda University Health Board	29.03.2018	Approved
V6	Quality Safety & Experience Assurance Committee	05.02.2019	Approved via Chair's Action 20.03.2019
V7	Hywel Dda University Health Board	28.03.2019	Approved

V8	Hywel Dda University Health Board	26.03.2020	Approved
V9	Quality Safety & Experience Assurance Committee	07.04.2020	Approved via Chair's Action on 18.05.2020
V.9	Hywel Dda University Health Board	28.05.2020	Approved
V10	Quality Safety & Experience Assurance Committee	02.02.2021	Approved
V11	Hywel Dda University Health Board	25.03.2021	Approved
V12	Hywel Dda University Health Board	29.07.2021	Approved
V13	Quality Safety & Experience Assurance Committee	22.06.2022	Approved
V13	Public Board	28.07.2022	Approved
V14	Quality, Safety and Experience Committee	13.06.2023	Approved
V14	Hywel Dda University Health Board	27.07.2023	Approved
V15	Quality, Safety and Experience Committee	11.06.2024	Approved
V15	Hywel Dda University Health Board	25.07.2024	Approved
V16	Hywel Dda University Health Board	30.01.2025	Approved (alongside the new governance arrangements)
V17	Quality, Safety and Experience Committee	10.06.2025	Approved
V17	Hywel Dda University Health Board	31.07.2025	Approved
V18	Quality, Safety and Experience Committee	14.08.2025	Alongside the new Quality & Safety Governance Arrangements
V19	Quality, Safety and Experience Committee	12.02.2026	For approval
V19	Hywel Dda University Health Board	26.03.2026	Approved

QUALITY, SAFETY & EXPERIENCE COMMITTEE

1. Constitution

1.1 The Quality & Safety Committee was established as a Committee of the Hywel Dda University Health Board (HDdUHB) and constituted from 1 October 2009.

2. Principal Duties

The purpose of the Quality, Safety & Experience Committee is to:

2.1 Provide the Board with assurance that care across the Health Board is safe, timely, efficient, effective, equitable and person-centred, aligned to the twelve Health and Care Quality Standards and the strengthened statutory Duty of Quality introduced through the Health and Social Care (Quality and Engagement) (Wales) Act 2020.

2.2 Scrutinise performance and patient and population impact and outcomes, and risks, ensuring that the Health Board continually meets its obligations under the Act to consider, monitor, and improve the quality of health services in all decision-making.

2.3 Offer timely, evidence-based advice, and ensure effective and robust governance, strategies and delivery plans are in place to continuously improve the quality and safety of services in line with organisational objectives and the statutory duties of Quality and Candour established by the Act.

3. Key Responsibilities

The Quality, Safety & Experience Committee shall:

3.1 Provide advice to the Board on the adoption of a set of key indicators of quality of care against which the University Health Board's performance will be regularly assessed and reported on.

3.2 Seek assurance on the management of risks within the Corporate Risk Register (CRR) and Operational Risk Registers (including for hosted services and through partnerships and Joint Committees as appropriate) aligned to the Committee and its sub-committees, and report any areas of significant concern e.g. where risk tolerance is exceeded, lack of timely action. Where risks cannot be brought within the Health Board's risk appetite/tolerance, recommend acceptance of risks to the Board.

3.3 Receive assurance through Sub-Committee Update Reports and other management/task & finish group reports that risks relating to their areas are being effectively managed across the whole of the Health Board's activities (including for hosted services and through partnerships and Joint Committees as appropriate).

3.4 Ensure the right enablers are in place to promote a positive culture of quality improvement based on best evidence.

3.5 Oversee the development and implementation of strengthened and more holistic approaches to triangulating intelligence to identify emerging issues and themes that require improvement or further investigation.

3.6 Provide assurance that all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality and safety of care provided, and in particular that sources of internal assurance are reliable, there is the capacity and capability to deliver, and lessons are learned from patient safety incidents, complaints and claims.

3.7 Receive assurance on delivery against the areas of targeted intervention, and the required elements for de-escalation, that are aligned to the Committee.

3.8 Provide assurance to the Board that current and emerging clinical risks are identified and robust management plans are in place and any learning from concerns is applied to these risks as part of this management.

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. Patient Stories, Patient Charter and Board to Floor Walkabouts will feature as a key area for patient experience and lessons learnt.

3.10 Provide assurance to the Board in relation to its responsibilities for the quality and safety of mental health, primary and community care, public health, health promotion, prevention and health protection activities and interventions in line with the Health Board's strategies.

3.11 Ensure that the organisation is meeting the requirements of the Health and Social Care (Quality and Engagement) Act and recommend the Annual Duty of Quality and Duty of Candour Reports to Board for approval as soon as reasonably practicable after the end of each financial year.

3.12 Ensure that the organisation is meeting the requirements of the NHS Concerns, Complaints and Redress Arrangements (Wales) Regulations.

3.13 Approve the required action plans in respect of any concerns investigated by the Ombudsman.

3.14 Agree actions, as required, to improve performance against compliance with incident reporting.

3.15 Provide assurance that the Central Alert Systems process is being effectively managed with timely action where necessary.

3.16 Seek assurance on the delivery of the requirements arising from the Health Board's auditors, inspectorates and regulators, Welsh Government and professional bodies.

3.17 Approve the annual clinical audit plan, ensuring that internally commissioned audits are aligned with strategic priorities.

3.18 Provide assurance that a review process to receive and act upon clinical outcome indicators suggesting harm or unwarranted variation is in place and operating effectively at operational level, with concerns escalated to the Board.

3.19 Consider advice on clinical effectiveness, and where decisions about implementation have wider implications with regard to prioritisation and finances, prepare reports for consideration by the Executive Team who will collectively agree recommendations for consideration through relevant Committee structures.

3.20 Provide assurance in relation to the organisation's arrangements for safeguarding vulnerable people, children and young people.

3.21 Receive decisions made with regard to significant claims against the Health Board, valued in excess of £100,000, or valued under £100,000, but which raise unusual issues or may set a precedent, and ensure that the learning from such cases is considered, with relevant actions agreed as appropriate.

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.

3.23 Assure the Board in relation to its compliance with relevant healthcare standards and duties, national practice, and mandatory guidance.

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.

3.25 Review and approve annual work plans for any Sub-Committees which has delegated responsibility from the Quality, Safety and Experience Committee and oversee delivery and monitor the impact on patients of the Health Board's services and their quality.

3.26 Refer matters which fall within the remit of other Committees.

3.27 Seek assurance on delivery against all Planning Objectives aligned to the Committee, in accordance with the Board approved timescales, as set out in the Health Board's Annual Plan, considering, and scrutinising the plans and programmes that are developed and implemented, supporting and endorsing these as appropriate.

4. Membership

4.1 The membership of the Committee shall comprise:

Member
Independent Member (Chair)
Independent Member (Vice-Chair)
3 x Independent Members (which will include a Member of the Health and Safety Committee and the People, Organisational Development & Culture

Committee)

4.2 The following should attend Committee meetings:

In attendance
Executive Director of Nursing, Quality & Patient Experience (Lead Executive)
Executive Medical Director (Chair of Listening and Learning Sub Committee)
Chief Operating Officer
Executive Director of Allied Health Professions & Health Science
Executive Director of Public Health
Deputy Director of Nursing Quality & Patient Experience
Head of Quality and Governance
Associate Medical Director Quality & Safety
Assistant Director, Legal Services/Patient Experience
Assistant Director of Nursing, Quality and Assurance
Llais Cymru/ Citizens Voice Body Representative (not counted for quoracy purposes)

4.3 Membership of the Committee will be reviewed on an annual basis.

5. Quorum and Attendance

5.1 A quorum shall consist of no less than three of the membership, and must include as a minimum the Chair or Vice Chair of the Committee, and two other Independent Members, together with a third of the In Attendance members.

5.2 The membership of the Committee shall be determined by the Board, based on the recommendation of the UHB Chair, taking into account the balance of skills and expertise necessary to deliver the Committee's remit, and subject to any specific requirements or directions made by the Welsh Government.

5.3 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.

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

5.5 Should any officer member be unavailable to attend, they may nominate a deputy with full voting rights to attend in their place, subject to the agreement of the Chair.

5.6 The Chair of the UHB reserves the right to attend any of the Committee's meetings as an ex officio member.

5.7 The Head of Internal Audit shall have unrestricted and confidential access to the Chair of the Quality Safety & Experience Committee.

5.8 The Committee can arrange to meet with Internal Audit and External Audit (and, as appropriate, nominated representatives of Healthcare Inspectorate Wales), without the presence of officers, as required.

5.9 The Chair of the Quality Safety & Experience Committee shall have reasonable access to Executive Directors and other relevant senior staff.

6. Agenda and Papers

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

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

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

6.4 The agenda and papers 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 Lead Director within **seven** days to check the accuracy, prior to sending to Members (including the Committee Chair) to review within the next seven days.

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

7. In Committee

7.1 The Committee can operate with an In Committee function to receive updates on the management of sensitive and/or confidential information.

8. Frequency of Meetings

8.1 The 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 Committee in discussion with the Lead Executive.

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

9. Accountability, Responsibility and Authority

9.1 Although the Board has delegated authority to the Committee for the exercise of certain functions, as set out in these Terms of Reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens, through the effective governance of the organisation.

9.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

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

9.4 The requirements for the conduct of business as set out in the UHB's Standing Orders are equally applicable to the operation of the Committee.

10. Reporting

10.1 The Committee, through its Chair and Members, shall work closely with the Board's other Committees, including joint and Sub-Committees and groups to provide advice and assurance to the Board through the:
10.1.1 Joint planning and co-ordination of Board and Committee business.
10.1.2 Sharing of information.

10.2 In doing so, the 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.

10.3 The Committee, may, subject to the approval of the Board, establish Sub-Committees or task and finish groups to carry out on its behalf specific aspects of Committee business. The Committee will receive an update following each meeting providing an assurance on business undertaken on its behalf. The Sub-Committees reporting to this Committee are:

10.3.1 Listening & Learning Sub-Committee

10.4 The Committee Chair, supported by the Committee Secretary, shall:

10.4.1 Report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes the submission of a Committee update report, as well as the presentation of an Annual Report within **six** weeks of the financial year.
10.4.2 Bring to the Board's specific attention any significant matter under consideration by the Committee.
10.4.3 Ensure appropriate escalation arrangements are in place to alert the Health Board Chair, Chief Executive or Chairs of other relevant Committees of any

urgent/critical matters that may compromise patient care and affect the operation and/or reputation of the Health Board.

10.5 The 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.

11. Secretarial Support

11.1 The Committee Secretary shall be determined by the Director of Corporate Governance/Board Secretary.

12. Review Date

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.

2

20 Mins

---

2 - Risk

2.1

2.1 - Assurance and Risk Report- Executive Leads

Attachments

QSEC CRR WHC MD Report - Apr 2026 FINAL 25032026.pptx

Appendix 1 - QSEC Corporate Risk Register- Mar26.pdf

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Assurance and Risk Report

Quality, Safety and Experience Committee – 9 April 2026

Situation

This report provides the Quality, Safety and Experience Committee (QSEC) with the status of the corporate risks, Welsh Health Circulars (WHCs), 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 WHCs are being implemented by the Health Board.

Principal risks, operational risks and recommendations from audit and inspections are reported at alternate meetings and will be presented to QSEC at its next meeting in June 2026.

Corporate Risks:
10

Welsh Health Circulars
21

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 allocated 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 (e.g 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.

Corporate Risks assigned to QSEC

HYWEL DDA RISK HEAT MAP					
	LIKELIHOOD →				
IMPACT ↓	RARE 1	UNLIKELY 2	POSSIBLE 3	LIKELY 4	ALMOST CERTAIN 5
CATASTROPHIC 5			1531 1859	1027 1552 1810	797
MAJOR 4				684 1664 2190	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.

Corporate risks have been aligned to the most appropriate Board level Committee.

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 10 corporate risks currently aligned to QSEC (of the 24 that are on the CRR as at 18 March 2026).

The following slides provide a summary of the reportable corporate risks aligned to QSEC. The 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, an expected date to achieve the noted Target Risk Score, and sources of assurance.

Corporate Risks assigned to QSEC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
797 – Risk of adverse patient and workforce outcomes if health board wide ultrasound services are unsustainable	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	**25** ➔ (Reviewed 16/03/2026)	**10**	31/03/2030

Rationale for Current Risk Score (CRS)

This risk was escalated from 20 to 25 due to increased fragility in available workforce due to 2 Whole Time Equivalent (WTE) retirements in January 2026.

Impact score of 5 due to a totally unacceptable level or quality of treatment/service; patients on maternity and cancer pathways are waiting too long for scans required for intervention; gross failure of patient safety if findings not acted on; concerns regarding noncompliance with Welsh Maternity screening targets; gross failure to meet national standards/performance requirements; waiting times non-interventional ultrasound are up to 35 weeks; vascular ultrasound is not available 7 days a week

Probability score of 5/>95% likelihood. The service is no longer able to sustain a safe baseline capacity to provide routine and urgent non obstetric imaging alongside obstetric scanning Monday to Friday, 09:00–17:00 on the Withybush General Hospital (WGH) site (see separate risk 1349 - Risk of being unable to deliver ultrasound services at WGH due to a lack of appropriately trained obstetric staff).

Rationale for the Target Risk Score on next slide

Corporate Risks assigned to QSEC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
797 – Risk of adverse patient and workforce outcomes if health board wide ultrasound services are unsustainable	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	**25** ➔ (Reviewed 16/03/2026)	**10**	31/03/2030

Rationale for Target Risk Score (TRS)
Impact of service failure remains the probability of service failure is the aim of mitigating actions. Probability target of 5-25% (2). In January 2026 the target date was reviewed and extended due to the timeline for Radiology Leadership Organisational Change Process (OCP) and recruitment to bring in the leadership required to mitigate the gaps in controls. Extended timelines required due to pathways changes and training timelines. Annual Planning 2026/27 priorities for Allied Health Professions and Health Sciences Clinical Care Group include further mitigation of this risk via capacity being added of 13WTE. This timeline is due to training timelines it will take at least three years to train a workforce if 2026/27 Annual Planning funding is provided to Radiology.

Corporate Risks assigned to QSEC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Current Risk Score	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	Community & Integrated Medicine	Chief Operating Officer	**20** → (Reviewed 20/02/2026)	**8**	~~31/03/2026~~ 31/10/2028

Rationale for Current Risk Score (CRS)

The most recent available data highlights sustained high operational pressures across all acute sites with increased escalation levels throughout January and early February 2026. Although some key performance metrics show a slight improvement over the last year, all are above Targeted Intervention (TI) targets in January 2026 e.g. the average time to clinical assessment in Emergency Department (ED): 68 mins (TI target: 60 mins); Numbers of >1hr ambulance handovers: 716 (TI target: 680); Pathway of Care Delays (POCDs): 213 (TI target: 174).

Actions to improve flow include implementation of the 7-day Clinical Streaming, Hospital at Home and Optimal Same Day Emergency Care (SDEC) services, as agreed at Public Board in January 2026. Whilst the business case has been approved and additional control measures have been implemented, system pressures remain and TI targets are not consistently being met therefore the current risk score remains at 20 as at February 2026.

Rationale for Target Risk Score (TRS)

The target risk score of 8 reflects delivery of 6 Goals Programme and Accelerated Transformation Programme to address significant issues across the health and care system. TI measures such as ambulance handovers and 12-hour delays in ED will need to improve for a consecutive period of three months to reduce the risk score. The expected date to achieve the TRS has been amended from March 2026 to October 2028 to allow for the implementation and embedding of risk actions. The embedding of 7-day Clinical Streaming and SDEC services will significantly impact on patient flow, however time will be needed for recruitment and embedding of services.

Corporate Risks assigned to QSEC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
1552 – Risk of insufficient mortuary capacity due to current and anticipated future demand	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	**20** → (Reviewed 09/03/2026)	**8**	31/08/2026

Rationale for Current Risk Score (CRS)

Significant risks due to insufficient mortuary capacity across Health Board. Ongoing dependence on temporary body storage and current infrastructure limitations present a challenge maintaining compliance with Human Tissue Authority (HTA), protecting staff wellbeing, ensuring safe manual handling practices, responding to unplanned disruptions, and upholding dignity of deceased. Pressures continue to intensify as future death rates are expected to continue rising. Suboptimal facilities compromise presentation of the deceased, increase emotional distress for families, and pose safety concerns for mortuary staff, especially manual handling. Current control measures, which serve only as temporary contingencies in line with the Human Tissue Authority (HTA) licence are not sufficient to manage the current volume of deaths within the mortuary service, particularly during periods of heightened demand and there is a growing need for enhanced storage capacity throughout the year, not solely during seasonal peaks. Furthermore, the extremely constrained footprint of the mortuary estate significantly restricts opportunities for external expansion or enhancement.

Rationale for Target Risk Score (TRS)

The TRS is based on the outcome of escalating the body storage capacity concerns to Integrated Quality Finance Performance and Delivery (IQFPD) in June 2025. Funding stream discussed with Executive Director of Finance (July 2025) with further meetings and support from planning team to ensure long-term sustainable solution implemented when reasonably possible. TRS and expected date to achieve agreed by Formal Executive Team (November 2025). Assurance provided by the Executive Director of Finance that financial support will be received to enact short-term measures to ensure appropriate capacity available for winter pressure period. Further discussions will be held with finance and planning to discuss a sustainable and future proof plan to ensure TRS achieved and maintained.

Corporate Risks assigned to QSEC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
1032 – Risk to the timely diagnosis and treatment of mental health and learning disabilities clients due to demand and capacity	Mental Health & Learning Disabilities	Chief Operating Officer	**20** ➔ (Reviewed 13/03/2026)	**12**	31/12/2030

Rationale for Current Risk Score (CRS)

Significant waiting times have developed due to exponential demand. Demand outstrips capacity with year-on-year increase in referral rates. Current team capacity can only accommodate 11% of total current demand, compounded by current funding arrangements which are non-recurring, making recruitment and service delivery challenging. Welsh Government (WG) provided funding for Children's Neurodevelopmental (ND) services for 2025/26 to reduce waiting lists (received September 2025). The delay in receipt of funding and the fact that it is non-recurring, along with recruitment delays, has hindered service planning and delivery. However, an improvement plan is in progress which includes stabilising and expanding the workforce, the use of outsourcing and data validation to manage waiting lists and meet ministerial targets, the re-design of our services, and the strengthening of regional partnership working to deliver a whole-system, needs-led approach aligned with ministerial priorities. The demand for diagnostic assessment remains high and in the absence of a regional strategy our focus is currently on meeting the government targets which hinders our ability to develop a needs-led model and reduce the need for diagnostic assessment.

Rationale for the Target Risk Score on next slide

Corporate Risks assigned to QSEC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
1032 – Risk to the timely diagnosis and treatment of mental health and learning disabilities clients due to demand and capacity	Mental Health & Learning Disabilities	Chief Operating Officer	**20** ➔ (Reviewed 13/03/2026)	**12**	31/12/2030

Rationale for Target Risk Score (TRS)

The Clinical Care Group has prioritised implementation of WPAS in Children's Autism Spectrum Disorder (ASD) service which has enabled improved reporting and waiting list management and to determine trajectories of improvement in waiting times. 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 2026.

The achievement of the target risk score is dependent on WG ring-fenced funding being made available on a recurrent basis, service re-design and waiting list initiatives are completed and implemented. Furthermore, the development of a regional, collaborative strategic approach with key stakeholders is imperative to creating whole system, needs-led integrated services. Digital enablers such as artificial intelligence and licenses for digital platforms essential along with access to appropriate clinical venues essential to help reduce target risk score.

Corporate Risks assigned to QSEC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
1810 – Risk to delivering effective and timely cancer service due to Aseptic Unit facilities being non-compliant with Quality Assurance of Aseptic Preparation Services (QAAPS).	Medical Director	Medical Director	**20** ↑ (Reviewed 10/03/2026)	**5**	31/12/2026

Rationale for Current Risk Score (CRS)

WGH Aseptic Unit is the only remaining aseptic unit in the Health Board capable of producing cancer treatments. It is currently non-compliant with regulatory standards. A 2024 audit deemed it a high risk to patient safety and a 2025 follow-up confirmed ongoing staffing issues and insufficient resources to maintain quality standards, putting the unit at risk of forced closure. Temporary control measures have been implemented to reduce microbial contamination and delay closure, but these measures may soon become ineffective due to aging infrastructure. If contamination increases, the unit may be forced to close and there would be no means of obtaining certain cancer therapy for Hywel Dda patients to be administered within the Health Board locality. **The current risk score was increased in March 2026 from 15 to 20** reflecting that the service does not have enough staffing resilience, resulting in insufficient time being dedicated to maintaining the Quality System (a key control to prevent forced closure) and the current lack of resource increases the overall risk.

Rationale for Target Risk Score (TRS)

The TRS is based on the premise that a new demountable aseptic unit will be built at WGH in 2026. The unit would be compliant with regulatory standards and once operational, closure of the unit would be extremely unlikely. A new unit would allow the Health Board to continue safely preparing cancer therapy until the Transforming Access to Medicines (TRAMS) South-West manufacturing hub is operational. It is anticipated that the current risk score could be reduced to 10 once the unit is operational, expected to be September 2026. Achievement of the TRS of 5 is expected once workforce fragilities have been addressed, anticipated to December 2026.

Corporate Risks assigned to QSEC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
1664 – Risk to ophthalmology service delivery due to a national shortage Consultant Ophthalmologists and the inability to recruit	Planned & Specialist Care	Chief Operating Officer	**16** → (Reviewed 17/03/2026)	**8**	31/03/2028

Rationale for Current Risk Score (CRS)

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 Age-related Macular Degeneration (AMD) sessions on weekends, 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 42%. The WG target for R1 delivery is 95%. The current waiting list for new patients is 11,552. The service is currently delivering 0 patients waiting at stage 1 over 52 weeks for March 2026 and this is expected to be maintained through to the end of March 2026. The stage 4 104 weeks, is in a breach of 2 for March 2026 currently with potential solutions being worked through to be 0 by the end of March 2026. 7301 patients have been 100% delayed for their follow up appointment.

The Board decided in February 2026 to progress Clinical Service Plan Option 99 of the Clinical Service Plan and the Aberaeron Integrated Care Centre as a diagnostic hub. The service is currently reviewing the estates and workforce required on each site to deliver Option 99.

Rationale for the Target Risk Score on next slide

Corporate Risks assigned to QSEC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
1664 – Risk to ophthalmology service delivery due to a national shortage Consultant Ophthalmologists and the inability to recruit	Planned & Specialist Care	Chief Operating Officer	**16** → (Reviewed 17/03/2026)	**8**	31/03/2028

Rationale for Target Risk Score (TRS)
The service will be able to reduce the impact score of this risk as whilst the consequences to the patient remains high, recurrent funding has been invested into the service for the delivery of an R1 Eye Care Measures target of 65%. The ministerial Measures target will need to be 0 for 3 months and more and the Follow up delayed will need to be reduced by 12%. The 65% R1 delivery by January 2027 is dependent on all posts being recruited into and all estates needs being met. Further development would be required to reach a 95% R1 delivery score. With the required investment in Glaucoma and IVT and the additional workforce identified in the annual plan 2026/2027 and estates issues being resolved alongside the continued management of the waiting lists, the HB will potentially be able to reduce the score to 8.

Corporate Risks assigned to QSEC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
684 – Risk to the timely investment and replacement of Radiology equipment and supporting infrastructure	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	**16** ➔ (Reviewed 25/02/2026)	**8**	Unknown

Rationale for Current Risk Score (CRS)

Aging equipment continues to break down, disrupting services and affecting Referral to Treatment (RTT) targets, with delays for patient diagnosis and treatment. Replacement of scanners has reduced downtime, but recurrent failures of other key equipment highlights need for further investment. A rolling programme and prioritisation process are in place to manage installations. The Gamma camera at WGH has broken down several times, leading to HIW-reportable Ionising Radiation (Medical Exposure) Regulations (IRMER) incidents and remains a priority for replacement. Due to insufficient physical space and electrical infrastructure, replacement has been delayed, with costs exceeding WG allocations for 2025/26 and the funding window closing, further impacting compliance with Nuclear Medicine specifications. Future plans must be coordinated with Estates to ensure facilities meet current and future nuclear medicine requirements. Like-for-like replacement of equipment is not always cost-effective or compliant with regulatory and warranty requirements, and infrastructure upgrades (e.g. air handling and water chillers) are needed to ensure long-term resilience.

Rationale for Target Risk Score (TRS)

Modern equipment will reduce likelihood of breakdowns, minimise downtime and lessen impact on other hospital sites. Strengthened business continuity planning will further mitigate risks, however, funding is typically released Q3/Q4 of financial year, constraining the scheduling of large installations. The urgency of replacements often forces rapid decisions, resulting in lower-priority equipment being replaced ahead of higher-need installations. Replacement of Nuclear Medicine Single Photon Emission Computed Tomography (SPECT-CT) scanner, the second CT scanner at Glangwili General Hospital (GGH), and DEXA (bone density) scanner at Bronglais General Hospital (BGH) would allow risk to be de-escalated to operational risk register. Completion dependent on WG funding and r o end of 2026/27 financial year due to infrastructure requirements.

Corporate Risks assigned to QSEC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
2190 – Risk of delay in Continuing Healthcare (CHC) direct payments due to short timescale, limited resources & lack of WG policy guidance	Community & Integrated Medicine	Chief Operating Officer	**16** → (Reviewed 20/02/2026)	**12**	31/03/2026

Rationale for Current Risk Score (CRS)

There is a lack of clarity and national guidance regarding the proposed model for the delivery of Direct Payments, and the time available for implementation which has reduced significantly with the date of implementation brought forward from December 2026 to 1 April 2026. There are serious concerns that governance and safety requirements will not be adequately established to meet the revised implementation date, which may increase the risk of inconsistent approaches across Health Boards. The Health Board does not currently have a system in place to manage or deliver Direct Payments to comply with the requirements of the forthcoming policy. Robust governance systems have yet to be developed, and there is a notable absence of dedicated resource, and specialist expertise. Delivery within such tight timescales will require additional resources. Each Health Board will also be expected to put in local arrangements to support delivery at a local level. Without additional resources, staff may be unable to allocate sufficient time to support implementation alongside existing duties. An Implementation Lead is in place and Task and Finish groups established working on policies and processes.

Rationale for Target Risk Score (TRS)

A dedicated local resource is needed to meet legislative requirements by 1 April 2026. Clarity is needed from WG over guidance and implementation plans to enable robust governance and safety requirements. All Health Boards in Wales require a consistent approach to direct payments. Whilst the implementation date is end of March 2026, there is no certainty that this can be achieved without the additional governance and resources.

Corporate Risks assigned to QSEC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
1531 – Risk of being unable to safely support the Consultant on-call rota at WGH & GGH due to workforce pressures	Planned & Specialist Care	Chief Operating Officer	**15** → (Reviewed 18/03/2026)	**5**	01/05/2027

Rationale for Current Risk Score (CRS)

A substantive Upper Gastro-Intestinal (GI) consultant has now been recruited following the exit of the Medacs agency locum consultant in Withybush General Hospital (WGH). A second substantive post is out to advert, with the Advisory Appointments Committee (AAC) planned for April 2026. Successful recruitment will result in 4 substantive consultants on the 1:4 rota at WGH. The Glangwili General Hospital (GGH) rota has one gap, covered by and internal locum at the Health Board card rate. The plan for this rota is to recruit a substantive colorectal consultant to replace the NHS locums. In February 2026, the Health Board made a decision on the Clinical Service Plan (CSP), which would involve the amalgamation of the surgical on-call rotas and Emergency General Surgery being moved from WGH to GGH. The timescale and details of this are not yet confirmed. The service will continue to engage with the CSP programme.

Rationale for Target Risk Score (TRS)

Achievement of the TRS is dependant on the successful appointment of substantive upper GI consultants along with the work currently being undertaken following the outcome of the CSP which would involve the amalgamation of the surgical on-call rotas and Emergency General Surgery being moved from WGH to GGH. The effectiveness of revised rota arrangements depends on several factors including availability of a labour market. There is 1 Upper GI substantive post out to advert and a substantive Lower GI post to be advertised for GGH in April 2026. The rotas at GGH and WGH are currently fully functioning without Medacs locums.
This will be further strengthened by further substantive recruitment and less NHS locum consultants. By May 2026, there should be a balance of upper and lower GI coverage on the rotas, providing recruitment is successful.

Corporate Risks assigned to QSEC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
1859 – Risk of poor patient outcomes and experience due to inability to effectively recognise and manage acute deterioration	Director of Nursing, Quality & Patient Experience	Director Nursing, Quality & Patient Experience	**15** ➔ (Reviewed 17/03/2026)	**10**	~~31/12/2025~~ 30/06/2026

Rationale for Current Risk Score (CRS)

The most recent data (at the end of 2025) shows unplanned admissions into Intensive Treatment Unit (ITU) from ward areas in WGH had reduced by 10%. In GGH the same comparison was unchanged. Cardiac arrests rates for ward areas across all four sites have had varying results:
WGH – Increase of 40% (2024: 16, 2025: 23); all cases have been reviewed by the Resuscitation Team, albeit with less involvement from the Medical Team, which may impact on the opportunity to learn from events.
GGH – Decrease of 30% (2024: 34, 2025: 24); Senior Nurse Managers/Ward Managers/Resus Team & GGH RADAR Lead attend bi-monthly Cardiac Arrest Scrutiny meetings to review all cases; possibly resulting in better decision making, recognition and escalation of deteriorating patients.
BGH – Decrease of 30% (2024: 10, 2025: 7); no theme identified.
PPH – Increase of 70% (2024: 7, 2025: 12); scrutiny meetings established in January 2026. Downgrading of the ITU may have resulted in some patients being managed in ward areas were ITU may have been more appropriate.
It is important to note that in at least 50% of these cases across the Health Board the conclusion from the medical review was that a DNACPR should have been in place, therefore resuscitation should not have started.

Rationale for Target Risk Score (TRS)

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. The TRS date was revised in March 2026 from December 2025 to 30 June 2026 as systems remain under development and have not yet been implemented.

Implementation of Welsh Health Circulars

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

All Welsh Health Circulars (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 status category. The table below outlines the definition of each category, the number of WHCs assigned to each as of March 2026, and the number completed since the previous report.

Status Category	Definition	Number of WHCs
Overdue	The WHC is 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.	4
Unable to Complete	The WHC cannot be implemented due to existing barriers and/or it is no longer relevant/appropriate for the Health Board. Formal sign-off by the CCG/Function Lead is required prior to escalation to the Executive Team for formal approval via operational governance structures.	1
Pending Decision	The WHC is pending a decision in order to implement e.g. outcomes of annual planning process, approval of funding requests, outcome of a QIA panel. Committee updates will detail whether the WHC is overdue or not whilst decision pending.	3
In Progress	The WHC is currently in progress, and within the agreed original timeframe for implementation.	8
Reliant on External Factors	The WHC is considered to be outside the gift of the Health Board to currently implement, e.g. reliant on an external organisation to implement.	2
Complete Pending Formal Approval	The Service / Function have completed the WHC and are currently awaiting formal approval to close.	3
Complete	The WHC has been confirmed as completed by the CCG / Function Lead and formal approval to close has been received.	6

Oversight of the delivery of WHCs has been included in 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 - Overdue

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Name of WHC	Clinical Care Group / Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	Reason for Overdue Status	Impact of non-compliance according to risk assessment	Next Steps
019-22: Non-Specialised Paediatric Orthopaedic Services **Issued June 2022**	Planned & Specialist Care	Chief Operating Officer / CCG Service Director for Planned & Specialist Care	**Original implementation date not met** **Original Completion Date:** 30/04/2025 **Revised Completion Date:** Not Known	No risk identified on Datix.	The Trauma and Orthopaedics Service Leads are in the process of drafting a maturity matrix to address the requirements of this WHC. The maturity matrix will involve multiple CCGs due to the requirements set out in the service specification relating to this WHC. Once the Trauma and Orthopaedics Service Leads have completed their elements of the WHC, the WHC can then be re-assigned to Primary Care as per the action of January 2025 Escalation meeting.
006-24: National Clinical Guideline for Stroke, for the UK and Ireland **Issued March 2024**	Community & Integrated Medicine	Chief Operating Officer / CCG Service Director for Community & Integrated Medicine	**Original implementation date not met** **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	The QIA was presented to the panel in September 2025, however was not accepted by the panel, with further work required from the CCG. The panel agreed that future QIAs should be signed off by the Stroke Strategy Group or CCG, and that the process should ensure proposals are clear and supported by appropriate oversight. At the Extraordinary Board meeting on 19 February 2026, the Board combined alternative options 106 and 210, which were suggested as part of the consultation, as a new idea to be taken forward for further consideration for stroke services. This is a new idea and was not included in the consultation process. It will need further assessment and engagement with staff and communities.

WHCs - Overdue

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Name of WHC	Clinical Care Group / Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	Reason for Overdue Status	Impact of non-compliance according to risk assessment	Next Steps
041-24: Ambulance patient handover guidance **Issued October 2024**	Community & Integrated Medicine	Chief Operating Officer / CCG Service Director for Community & Integrated Medicine	**Original implementation date not met** **Original Completion Date:** 31/12/2025 **Revised Completion Date:** Not Known	No risk identified on Datix.	Patient Flow Unit Plans to extend to a 7-day working model has commenced. A Winter Resilience Executive-led Incident Management Group established to test and support initiatives to enhance system flow. Introduction of the Digital MIYA flow system well received by clinical teams, with work underway to enhance value and functionality. Work underway with Welsh Ambulance Service NHS Trust to understand conveyance rates to our Health Board. Transformation Programme Office currently gathering evidence available to support implementation of the WHC.
051-25: Safety netting discharge leaflets for adults and children **Issued December 2025**	Nursing, Quality & Patient Experience Directorate	Director of Nursing, Quality & Patient Experience	**Awaiting implementation date**	No risk identified on Datix.	This WHC is being jointly led by the Assistant Directors of Nursing to effectively address the needs and compliance requirements for both adult and paediatric populations. A Core Team meeting was held in February 2026 to discuss the need for wider oversight of this WHC and potential realignment to Chief Operating Officer.

WHCs – Unable to Complete

Welsh Health Circular	Clinical Care Group / Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	Reason for Unable to Complete Status	Impact of non-compliance according to risk assessment	Next Steps
026-18: Phase 2 – primary care quality and delivery measures **Issued July 2018**	Primary Care	Chief Operating Officer	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. **Original Completion Date**: 16/07/2018 **Revised Completion Date**: Not Known	No risk identified on Datix.	WHC will be escalated through operational governance structures to obtain relevant approval to close this WHC as the service is unable to implement.

WHCs – Pending Decision

Welsh Health Circular	Clinical Care Group / Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	Reason for Pending Decision 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 & Specialist Care	Chief Operating Officer / CCG Service Director for Planned and Specialist Care	Service unable implement due to funding requirements. WHC requirements and supporting systems have been incorporated into the Annual Planning work stream for 2026/27. **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	Await the outcome of whether the relevant funding has been reallocated to the service as part of the Annual Planning 2026/27 to inform next steps required and revised completion date.
017-19: Living with persistent pain in Wales guidance – **Issued May 2019**	Planned & Specialist Care	Chief Operating Officer / CCG Service Director for Planned and Specialist Care	Service unable implement due to funding requirements. WHC requirements and supporting systems have been incorporated into the Annual Planning work stream for 2026/27. **Original Completion Date:** 31/01/2025 **Revised Completion Date:** Not known	**Risk Ref:** 2120 **Current Risk Score:** 12 **Impacts:** Patients unable to access specialist care in a timely manner, breaches in achieving RTT	Await the outcome of whether the relevant funding has been reallocated to the service as part of the Annual Planning 2026/27 to inform next steps required and revised completion date.

WHCs – Pending Decision

Welsh Health Circular	Clinical Care Group / Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	Reason for Pending Decision Status	Impact of non-compliance according to risk assessment	Next Steps
009-21: School Entry Hearing Screening pathway - **Issued March 2021**	Planned & Specialist Care	Chief Operating Officer / CCG Service Director for Planned & Specialist Care	Service unable implement due to funding requirements. WHC requirements and supporting systems have been incorporated into the Annual Planning work stream for 2025/26. **Original Completion Date**: 31/01/2023 **Revised Completion Date**: Not Known	**Risk Ref:** 1456 **Current Risk Score:** 8 **Impacts:** Detrimental impact on quality, accuracy and consistency of screening services provided	Await the outcome of whether the relevant funding has been reallocated to the service as part of the Annual Planning 2026/27 to inform next steps required and revised completion date.

WHCs - In Progress

Welsh Health Circular	Clinical Care Group/Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	UHB Implementation Date
002-24: Standards for Competency Assurance of Non-Medical Prescribers in Wales **Issued March 2024**	Nursing, Quality & Patient Experience Directorate	Director of Nursing, Quality and Patient Experience	Mar-26
004-25: NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme for 2025/26 **Issued April 2025**	Medical Directorate	Medical Director	Mar-26
006-25: Recording of Mental Health Outcome Measures **Issued May 2025**	Mental Health & Learning Disabilities	Chief Operating Officer / CCG Service Director for Mental Health & Learning Disabilities	Apr-26
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 Directorate	Medical Director	Sep-26
016-24: Healthy Child Wales Programme: for school aged children **Issued April 2024**	Planned & Specialist Care	Chief Operating Officer / CCG Service Director for Planned & Specialist Care	Sep-26
024-25: NHS Wales hearing care: future approach to audiology services **Issued December 2025 (NEW)**	Planned & Specialist Care	Chief Operating Officer / CCG Service Director for Planned & Specialist Care	Jan-31

WHCs - In Progress

Welsh Health Circular	Clinical Care Group/Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	UHB Implementation Date
039-25: AMR and HCAI Improvement Goals for 2025 – 2027 **Issued October 2025**	Nursing, Quality & Patient Experience Directorate	Director of Nursing, Quality & Patient Experience	Mar-27
001-26:Timelines and responsibilities for implementing the patient and family-initiated escalation approach, Call4Concern **Issued January 2026 (NEW*)**	Nursing, Quality & Patient Experience Directorate	Director of Nursing, Quality &Patient Experience	Dec-26

* Upon receipt of a new WHC, responsible leads are contacted by the Assurance and Risk Team and are required to provide an implementation date within 10 working days along with an appropriate response, during which time the WHC is noted as “In Progress”. After 10 working days, if no response is received, the WHC is noted as “Overdue”.

WHCs – Reliant on External Factors

Welsh Health Circular	Clinical Care Group / Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	Reason for External Status	Impact of non-compliance according to risk assessment	UHB Implementation Date
040-23: The NHS Wales: Newborn and Infant Physical Examination Cymru (NIPEC) **Issued November 2023**	Planned & Specialist Care	Chief Operating Officer / CCG Director for Planned & 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.	**Risk Ref:** 2019 **Current Risk Score:** 20 **Impacts:** Decrease in staff morale and a negative impact on service leads.	N/K

WHCs – Reliant on External Factors

Welsh Health Circular	Clinical Care Group / Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	Reason for External Status	Impact of non-compliance according to risk assessment	UHB Implementation Date
033-18: Airborne Isolation Room Requirements **Issued July 2018**	Nursing, Quality & Patient Experience Directorate	Director of Nursing, Quality & Patient Experience	Architectural Projects Team undertook Project Feasibility Report in July 2024 and provided estimate of costs £1,419,946.25 (including contingency fund of £109,416), with project time of 48 weeks from project brief development to completion of works to install negative pressure isolation suite in Clinical Decisions Unit (CDU) GGH. To date, funding not allocated for this project and whilst issue has been raised at 'All Wales High Consequence Infectious Disease Group' hosted by Public Health Wales, there has been no indication of central funding being considered by Welsh Government to support improvement and to move work forward. In the meantime, out turn costs continue to escalate and it is recognised that estimated costs of 2024 may have increased. As of March 2026, Head of Infection confirmed WHC remains unable to be progressed due to funding ('unable to complete'), noting Swansea Bay University Health Board and Aneurin Bevan University Health Board are in a similar position.	**Risk Ref:** 1640 **Current Risk Score:** 15 **Impacts:** Increased risk of transmitting infectious disease	N/K

WHCs – Complete Pending Formal Approval For Closure

Welsh Health Circular	Clinical Care Group/Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	UHB Implementation Date
017-25: Tranexamic Acid use: Recommendation 7a of the Infected Blood Inquiry (IBI) **Issued May 2025**	Planned & Specialist Care	Chief Operating Officer / CCG Service Director for Planned & Specialist Care	Jan-26
037-25: Infected Blood Inquiry: Implementation of Recommendation 7e: Implementing SHOT reports **Issued September 2025**	Operational Allied Health Professions & Health Sciences	Chief Operating Officer & Executive Director of Allied Health Professions & Health Sciences/ CCG Service Director for Operational Allied Health Professions & Health Sciences	Feb-26
007-26: Critical UK-wide Bone Cement Shortage – Immediate National Requirements for NHS Wales (no link currently available) **Issued February 2026 (NEW)**	Planned & Specialist Care	Chief Operating Officer / CCG Service Director for Planned & Specialist Care	Mar-26

WHCs – Complete and Approved

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Welsh Health Circular	Clinical Care Group/Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	UHB Implementation Date
004-22: Guidance for the provision of continence containment products for children and young people: a consensus document **Issued October 2022**	Planned & Specialist Care	Chief Operating Officer / CCG Service Director for Planned & Specialist Care	Feb-26
015-24: People's Experience Framework and People's Experience Survey **Issued April 2025**	Nursing, Quality and Patient Experience	Director of Nursing, Quality & Patient Experience	Jun-25
035-24: Standardising the management of acute deterioration **Issued September 2024**	Nursing, Quality and Patient Experience	Director of Nursing, Quality & Patient Experience	Jan-26
018-25: Tirzepatide (Mounjaro®) for the management of obesity and overweight **Issued May 2025**	Operational Allied Health Professions & Health Sciences	Chief Operating Officer / Executive Director of Operational Allied Health Professions & Health Sciences	Dec-25
027-25: Changes to supply of Gluten Free Foods in Wales; All-Wales Gluten Free Subsidy Card Scheme **Issued July 2025**	Primary Care	Chief Operating Officer	Dec-25
031-25: 3Ps Waiting Well single point of contact (SPOC) activity and outcomes data reporting **Issued September 2025**	Nursing, Quality & Patient Experience	Director of Nursing, Quality & Patient Experience	Nov-25

Implementation of Ministerial Directions

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Ministerial Directives (MDs) are legislative in character as they alter legal rights and duties. MDs are issued by Welsh Ministers and include codes of practice and guidance. In complying with the requirements of various governance codes and the Annual Governance Statement requirements, the Health Board has a duty to provide assurance of compliance with MDs.

The table below shows the number of MDs assigned to each category as at March 2026, summarised over the next slides. Definitions for these categories are included in the table below.

Status Category	Definition	Number of MDs
Overdue	The MD is behind schedule to the timescale provided by the lead officer.	0
Unable to Complete	The MD cannot be implemented due to existing barriers and/or it is no longer relevant/appropriate for the Health Board. Formal sign-off by the CCG/Function Lead is required prior to escalation to the Executive Team for formal approval via operational governance structures.	0
Pending Decision	The MD is pending a decision in order to implement e.g. outcomes of annual planning process, approval of funding requests, outcome of a QIA panel. Committee updates will detail whether the recommendation is overdue or not whilst decision pending.	0
In Progress	The MD is currently in progress, and within the agreed original timeframe for implementation.	0
Reliant on External Factors	The MD is considered to be outside the gift of the Health Board to currently implement, e.g. reliant on an external organisation to implement.	0
Complete Pending Formal Approval	The Service / Function have completed the MD and currently awaiting formal approval to close.	0
Complete	The MD has been confirmed as completed by the CCG / Function Lead and formal approval to close has been received.	1

MDs included within this report are based on the following criteria:

3.1.19 Seek assurances on the requirements arising from the Health Board's regulators, Welsh Government and professional bodies

Progress updates relating to the implementation of MDs are extracted from the AMAT system.

Complete Ministerial Directions

MD	Issued On	Lead CCG / EF	Lead Director	Implementation Date	Progress Update
WG25-72: The Primary Care (Contracted Services: Outpatients Waiting Lists First Appointment Scheme) Directions 2025	14/10/2025	Primary Care	Chief Operating Officer	Dec-25	Forms part of the contracted services and will therefore be actioned in line with the usual commissioning processes.

Recommendations

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

Risk Management

- **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.

Welsh Health Circulars

- **RECEIVE ASSURANCE**, or otherwise, from the lead Executive Director or Supporting Officer on the management of WHCs within their area of responsibility, particularly in respect of understanding when the WHC will be delivered, any barriers to delivery, impacts of non/late delivery and assurance that the risks associated with these are being managed effectively.

Ministerial Directions

- **RECEIVE ASSURANCE** that the Health Board is compliant with the MDs issued by Welsh Government.

DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG

SAFE | SUSTAINABLE | ACCESSIBLE | KIND

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Risk Ref	Risk (for more detail see individual risk entries)	Executive Director	Domain	Previous Risk Score	Risk Score Mar-26	Trend	Target Risk Score (tolerable score)	Expected Date of achieving Target Risk Score	Risk on page no...
797	Risk of adverse patient and workforce outcomes if health board wide ultrasound services are unsustainable	Carruthers, Andrew	Quality/Complaints/Audit	5×5=25	5×5=25	→	2×5=10	3/31/2030	6
1810	Risk to delivering effective and timely cancer service due to Aseptic Unit facilities being non-compliant with QAAPS.	Henwood, Mr Mark	Service/Business interruption/disruption	3×5=15	4×5=20	↑	1×5=5	12/31/2026	11
1552	Risk of insufficient mortuary capacity due to current and anticipated future demand	Carruthers, Andrew	Safety - Patient, Staff or Public	4×5=20	4×5=20	→	2×4=8	8/31/2026	14
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	10/31/2028	19
1032	Risk to the timely diagnosis and treatment of mental health and learning disabilities clients due to demand and capacity	Carruthers, Andrew	Safety - Patient, Staff or Public	5×4=20	5×4=20	→	3×4=12	12/31/2030	24
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	→	2×4=8	3/31/2028	28
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	32
2190	Risk of delay in CHC direct payments due to short timescale, limited resources & lack of WG policy guidance	Carruthers, Andrew	Quality/Complaints/Audit	4×4=16	4×4=16	→	3×4=12	3/31/2026	37
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	5/1/2027	40
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	6/30/2026	45

RISK SCORING MATRIX

Likelihood x Impact = Risk Score					
Likelihood	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Frequency - How often might it/does it happen? (how many times will the adverse consequence being assessed actually be realised?)	**This will probably never happen/recur (except in very exceptional circumstances).**	**Do not expect it to happen/recur but it is possible that it may do so.**	**It might happen or recur occasionally.**	**It might happen or recur occasionally.**	**It will undoubtedly happen/recur, possibly frequently.**
	Not expected to occur for years.*	Expected to occur at least annually.*	Expected to occur at least monthly.*	Expected to occur at least weekly.*	Expected to occur at least daily.*
	* time-framed descriptors of frequency				
Probability - Will it happen or not? (what is the chance the adverse consequence will occur in a given reference period?)	**(0-5%*)**	**(5-25%*)**	**(25-75%*)**	**(75-95%*)**	**(>95%*)**
	*used to assign a probability score for risks related to time-limited or one off projects or business objectives.				
Risk Impact Domains	**Negligible - 1**	**Minor - 2**	**Moderate - 3**	**Major - 4**	**Catastrophic - 5**
Safety of Patients, Staff or Public	**Minimal injury requiring no/minimal intervention or treatment.**	**Minor injury or illness, requiring minor intervention.**	**Moderate injury requiring professional intervention.**	**Major injury leading to long-term incapacity/disability.**	**Incident leading to death.**
	No time off work.	**Requiring time off work for >3 days**	**Requiring time off work for 4-14 days.**	**Requiring time off work for >14 days.**	**Multiple permanent injuries or irreversible health effects.**
		Increase in length of hospital stay by 1-3 days.	**Increase in length of hospital stay by 4-15 days.**	**Increase in length of hospital stay by >15 days.**	**An event which impacts on a large number of patients.**
			Agency reportable incident.	**Mismanagement of patient care with long-term effects.**	
			An event which impacts on a small number of patients.		
Quality, Complaints or Audit	**Peripheral element of treatment or service suboptimal.**	**Overall treatment or service suboptimal.**	**Treatment or service has significantly reduced effectiveness.**	**Non-compliance with national standards with significant risk to patients if unresolved.**	**Totally unacceptable level or quality of treatment/service.**
	Informal complaint/inquiry.	**Formal complaint.**	**Formal complaint -**	**Multiple complaints/ independent review.**	**Gross failure of patient safety if findings not acted on.**
		Local resolution.	**Escalation.**	**Low achievement of performance/delivery requirements.**	**Inquest/ombudsman inquiry.**
		Single failure to meet internal standards.	**Repeated failure to meet internal standards.**	**Critical report.**	**Gross failure to meet national standards/performance requirements.**
		Minor implications for patient safety if unresolved.	**Major patient safety implications if findings are not acted on.**		
		Reduced performance if unresolved.			

Workforce & OD	Short-term low staffing level that temporarily reduces service quality (< 1 day).	Low staffing level that reduces the service quality.	Late delivery of key objective/ service due to lack of staff.	Uncertain delivery of key objective/service due to lack of staff.	Non-delivery of key objective/service due to lack of staff.
			Unsafe staffing level or competence (>1 day).	Unsafe staffing level or competence (>5 days).	Ongoing unsafe staffing levels or competence.
			Low staff morale.	Loss of key staff.	Loss of several key staff.
			Poor staff attendance for mandatory/key training.	Very low staff morale. No staff attending mandatory/ key training.	No staff attending mandatory training /key training on an ongoing basis.
Statutory Duty or Inspections	No or minimal impact or breach of guidance/ statutory duty.	Breach of statutory legislation.	Single breach in statutory duty.	Enforcement action	Multiple breaches in statutory duty.
		Reduced performance levels if unresolved.	Challenging external recommendations/ improvement notice.	Multiple breaches in statutory duty.	Prosecution.
				Improvement notices.	Complete systems change required.
				Low achievement of performance/delivery requirements.	Low achievement of performance/delivery requirements.
				Critical report.	Severely critical report.
Adverse Publicity or Reputation	Rumours.	Local media coverage – short-term reduction in public confidence. Elements of public expectation not being met.	Local media coverage – long-term reduction in public confidence.	National media coverage with <3 days service well below reasonable public expectation.	National media coverage with >3 days service well below reasonable public expectation. AMs concerned (questions in the Assembly).
	Potential for public concern.				Total loss of public confidence.
Business Objectives or Projects	Insignificant cost increase/ schedule slippage.	<5 per cent over project budget. Schedule slippage.	5–10 per cent over project budget. Schedule slippage.	Non-compliance with national 10–25 per cent over project budget. Schedule slippage. Key objectives not met.	Incident leading >25 per cent over project budget. Schedule slippage. Key objectives not met.
Finance including Claims	Small loss.	Loss of 0.1–0.25 per cent of budget.	Loss of 0.25–0.5 per cent of budget.	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget.	Non-delivery of key objective/ Loss of >1 per cent of budget.
	Risk of claim remote.	Claim less than £10,000.	Claim(s) between £10,000 and £100,000.	Claim(s) between £100,000 and £1 million.	Failure to meet specification/ slippage
					Claim(s) >£1 million.
Service or Business interruption or disruption	Loss/interruption of >1 hour. Minor disruption.	Loss/interruption of >8 hours.	Loss/interruption of >1 day.	Loss/interruption of >1 week.	Permanent loss of service or facility.
		Some disruption manageable by altered operational routine.	Disruption to a number of operational areas within a location and possible flow onto other locations.	All operational areas of a location compromised. Other locations may be affected.	Total shutdown of operations.
Environmental	Minimal or no impact on the environment.	Minor impact on environment.	Moderate impact on environment.	Major impact on environment.	Catastrophic/critical impact on environment.
Health Equity	Minimal or no impact on our attempts to improve health equity	Minor impact on our attempts to improve health equity or low level of certainty on the impact we are having on health equity	Moderate impact on our attempts to improve health equity or a lack of sufficient information that would demonstrate this. Indications that we are not having a positive impact on health improvement or health equity	Major impact on our attempts to improve health equity. Validated data suggesting that we are not improving the health of the most disadvantaged in our population whilst clearly supporting the least disadvantaged. Validated data suggesting we are having no impact on health improvement or health equity.	Validated data clearly demonstrating a disproportionate widening of health inequalities or a negative impact on health improvement and/or health equity.

RISK MATRIX

IMPACT ↓	LIKELIHOOD →				
	RARE	UNLIKELY	POSSIBLE	LIKELY	ALMOST CERTAIN
	1	2	3	4	5
CATASTROPHIC 5	5	10	15	20	25
MAJOR 4	4	8	12	16	20
MODERATE 3	3	6	9	12	15
MINOR 2	2	4	6	8	10
NEGLIGIBLE 1	1	2	3	4	5

RISK ASSESSMENT - FREQUENCY OF REVIEW

RISK SCORED	DEFINITION	ACTION REQUIRED (GUIDE ONLY)	MINIMUM REVIEW FREQUENCY
15-25	Extreme	Unacceptable. Immediate action must be taken to manage the risk. Control measures should be put into place which will have an effect of reducing the impact of an event or the likelihood of an event occurring. A number of control measures may be required.	This type of risk is considered extreme and should be reviewed and progress on actions updated, at least monthly.
8-12	High	Very unlikely to be acceptable. Significant resources may have to be allocated to reduce the risk. Urgent action should be taken. A number of control measures may be required.	This type of risk is considered high and should be reviewed and progress on actions updated at least bi-monthly.
4-6	Moderate	Not normally acceptable. Efforts should be made to reduce risk, providing this is not disproportionate. Establish more precisely the likelihood & harm as a basis for determining the need for improved measures.	This type of risk is considered moderate and should be reviewed and progress on actions updated at least every six months.
1-3	Low	Risks at this level may be acceptable. If not acceptable, existing controls should be monitored & reviewed. No further action or additional controls are required.	This type of risk is considered low risk and should be reviewed and progress on actions updated at least annually.

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	
	Detailed review of relevant information
	Medium level review
	Cursory or narrow scope of review

NB Assurance Map will tell you if you have sufficient sources of assurance not what those sources are telling you

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-19		
Strategic Objective:	1. Thriving Teams and 2. Healthier Communities and 3. Great Care and 4. Positive Futures		

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Mar-26
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Apr-26

Risk ID:	**797**	**Corporate Risk Description:**

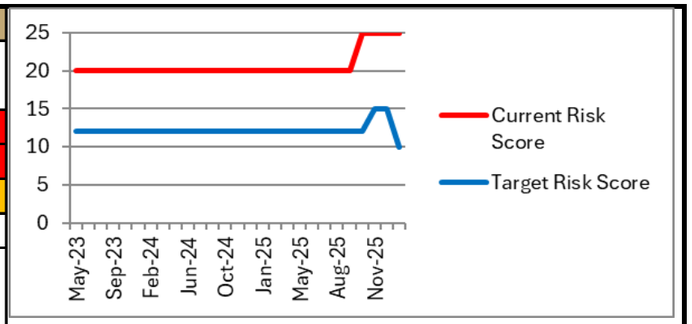
There is a risk that health board wide ultrasound services are unsustainable.

This is caused by - Demand increase across NOUS and Maternity Ultrasound pathways requires 34 148 additional scanning hours.
- Workforce establishment does not match demand.
- Workforce vacancies long standing (national shortage, training pipeline 3 years with large supervision requirement).
- Unable to move staff between sites to cover as all sites unable to meet minimum standards required.
- Occupational Health impact from workloads reducing workforce available (RSI).

This could lead to an impact/affect on - Patient outcomes = delays to scans resulting in delays to treatment or death (cancer and maternity pathways)
- Workforce outcomes = staff harm from RSI resulting in long term injury from too much scanning of similar types (unable to job plan appropriately due to demand and vacancies).
Quality, complaints and audit - (5) Totally unacceptable level or quality of treatment/service. Gross failure of patient safety if findings not acted on. Inquest/ombudsman inquiry. Gross failure to meet national standards / performance requirements.
Safety of patients - (4) Major injury leading to long-term incapacity/disability. Requiring time off work for >14 days. Increase in length of hospital stay by >15 days. Mismanagement of patient care with long-term effects.
Finance including Claims - (5) Claim(s) >£1 million.
Probability = >95%

Does this risk link to any Directorate (operational) risks?	1349 (WGH), 1658 (RSI), 1936 (maternity)

Risk Rating:(Likelihood x Impact)	
Domain:	Quality/Complaints/Audit
Inherent Risk Score (L x I):	5×5=25
Current Risk Score (L x I):	5×5=25
Target Risk Score (L x I):	2×5=10
Expected Date To Achieve TRS:	3/31/2030
Trend:	⟷



Rationale for CURRENT Risk Score:
This risk was escalated from 20 to 25 due to increased fragility in available workforce, due to 2.0WTE retirements in Jan 2026. Impact score of 5 due to: A totally unacceptable level or quality of treatment/service: Patients on maternity and cancer pathways are waiting too long for scans required for intervention Gross failure of patient safety if findings not acted on. Concerns regarding noncompliance with Welsh Maternity screening targets Gross failure to meet national standards / performance requirements. Waiting times non-interventional ultrasound are up to 35 weeks Vascular ultrasound is not available 7 days a week Probability score of 5 / >95% likelihood The service is no longer able to sustain a safe baseline capacity to provide routine and urgent non obstetric imaging alongside obstetric scanning Monday to Friday, 09:00-17:00 on the WGH site (see separate risk 1349).

Rationale for TARGET Risk Score:
Impact of service failure remains the probability of service failure is the aim of mitigating actions. Probability target of 5-25% (2) In Jan 2026 target date was reviewed and extended. Justification for this change is the timeline for Radiology Leadership OCP and recruitment to bring in the leadership required to mitigate the gaps in controls thus requires extended timelines due to pathways changes and training timelines. In addition Annual Planning 2026/27 priorities for AH and HS CCG include further mitigation of this risk via capacity being added of 13WTE (£710 352) therefore likelihood scoring reduces to a 2 (5-25% probability). 2030 target date This timeline is due to training timelines it will take at least three years to train a workforce if 2026/27 Annual Planning funding is provided to Radiology.

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**
Insourcing NOUS undertaking 150 scans per week - funded by WG until 31.3.26. Funding for 26/27 from budget (4.0 vacancies). Locum/Agency capacity - 1.0WTE secured. there are 2.0 agency requests unfilled. Prioritisation of maternity growth scan workload by referring clinician - urgency allocated on referral form by referring clinicians. Training pipeline (supported practice educator) - 5.0WTE in post (end of training Jan 2027), 1.0WTE Midwife sonographer (in preceptorship). MSK and Vascular pathways via AHP extended practice roles (some Physiotherapy and Podiatry pathways in place to support ultrasound workload) Demand vs capacity scanning gap is £710, 352 /13 WTE workforce - Annual Plan 26/27 approved.	Health board wide governance of ultrasound pathways Pathway workforce diversification - Training pipeline does not meet demand or workforce turnover. Training capacity (trainees available but inadequate internal capacity to train) Centralised booking - due to commence June 26 to improve cross site cover. Insourcing/outsourcing/Agency/Locum capacity	Develop and implement a plan to help alleviate pressures through increasing the number of growth scan checks undertaken by midwives.	Llewellyn, Cerian	Completed	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. Jan 26 - midwife sonographer has undertaken course and starting preceptership

Radiology management restructuring as part of stabilisation plan. new posts needed to provide a longer term solution to issue. Not possible with current management structure and stability risk	Procter, Sarah	30/06/2026	Informal consultation received alternative proposal Dec 2025, workshop with stakeholders scheduled early Jan 2026. Informal consultation extended until Feb 2026.Changes made to OCP awaiting exec approval - hoping to start April 26
Training pipeline - 5.0WTE Trainee sonographers scheduled to complete training.	Procter, Sarah	31/01/2027	25/11/2025 - New action.
Training pipeline - 1.0WTE midwife sonographer completed training.	Procter, Sarah	Completed	midwife sonographer has completed the course.
Insourcing/Outsourcing - procurement conversation with current provider of ultrasound capacity relating to adding more scanning capacity for obstetric ultrasound capacity (2000 scans) on top of current contract	Procter, Sarah	Completed	25/11/2025 - new action 29/12/2025 - Chasing of provider who is reporting capacity to meet this demand but is not able to complete the scanning when we have handed over this scanning work. Now a meeting is required to push for this capacity to be released or statement that provider is unable to source the capacity so other options can be sourced.
Agency capacity - throughout 2025/26 2.0WTE out for advert with agency (AG1 (HR form for agency approval) valid until 2027)	Procter, Sarah	31/01/2027	25/11/2025 - AG1 approved for 2.0WTE until Jan 2027, out with Agencies during 2025/26. No interest this year as yet.
Insourcing/Outsourcing - Provider has confirmed capacity but has not been able to pick up scans when allocated. Therefore contract meeting with Deputy HoS (SP) and Director of Performance and Planning (KJ) scheduled (14.01.2026) to understand barrier to release in capacity,	Procter, Sarah	Completed	meeting undertaken - further capacity unlocked

Pathway workforce diversification - Maternity have indicated capacity within Midwifery workforce to complete growth scans. Analysis underway to identify % of scanning and therefore % WTE transfer.	Procter, Sarah	~~28/02/2026~~ 31/04/2026	26/2/26 - SBAR shared with Director of midwifery - awaiting answer. 16/02/2026- meetings with Maternity continue. Paper shared with Director of Midwifery to outline governance around 1.26WTE Sonography capacity moving to Midwifery. Changes made to SBAR and validation by director of delivery's team.
Demand vs Capacity - Submit as a priority for 2026/27 Annual Planning (£710 352 / 13 WTE) additional funding required to meet demand	Quarrie, Sara	Completed	This demand and capacity gap funding was submitted as a priority by the AH and HS CCG in the Annual Planning 2026/27 workshop on the 21.11.2025.
Demand vs Capacity - Clinical validation support from NHS Performance & Improvement (intended outcome is to reduce inappropriate referrals to u/s modality and redirect to alternative and more appropriate modalities).	Procter, Sarah	Completed	Approval given to seek support meeting scheduled SP and NHS Performance and Improvement 16.01.2026 to agree implementation. validation Work started 19.1.26
Demand and Capacity - Skill mix vacancies in u/s to create 1.0WTE 8A - Job description to be sent to job matching	Procter, Sarah	~~28/02/2026~~ 28/03/2026	Action agreed in Dec 2025. delay due to workload - JD in process
Midwife sonographer undertaking preceptorship to be able to work independently - radiology supporting	Procter, Sarah	29/01/2027	new action

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
8 week USC Ante-natal screening Wales	Waiting list monitoring - Live dashboard review by Radiology Leadership (daily) and monthly formal submission of performance * week data to Welsh government (see iPAR).	2nd			IQFPDG 26/11/2025 - SBAR - Ultrasound Fragility - Corporate risk 797					
	Performance monitored at Executive Improving Together Sessions	2nd								

Date Risk Identified:	Feb-24
Strategic Objective:	3. Great Care

Executive Director Owner:	Henwood, Mr Mark	**Date of Review:**	Mar-26
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Apr-26

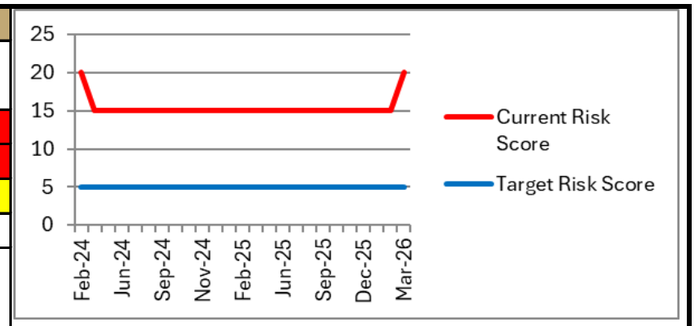
Risk ID:	**1810**	**Corporate Risk Description:**

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 approximate £1m 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):	4×5=20
Target Risk Score (L x I):	1×5=5
Expected Date To Achieve TRS:	12/31/2026
Trend:	



Rationale for CURRENT Risk Score:

Withybush Aseptic Unit is the only remaining aseptic unit in the Health Board capable of producing cancer treatments. However, it is currently non-compliant with regulatory standards. A 2024 audit deemed it a high risk to patient safety, and a 2025 follow-up confirmed ongoing staffing issues and insufficient resources to maintain quality standards, putting the unit at risk of forced closure.

Temporary control measures have been implemented to reduce microbial contamination and delay closure (see control measures), but the aging infrastructure means these measures may soon become ineffective. If contamination increases, the unit may be forced to close. 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 service does not have enough staffing resilience, resulting in insufficient time being dedicated to maintaining the Quality System. Because a robust Quality System is a key control to prevent forced closure, the current lack of resource increases the overall risk.

Rationale for TARGET Risk Score:

The target risk score is based on the premise that a new demountable aseptic unit will be built at Withybush in 2026. 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.

It is anticipated that the current risk score could be reduced to 10 once the unit is operational, expected to be September 2026. Achievement of the Target Risk Score of 5 is expected once workforce fragilities have been addressed, anticipated to December 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. Pharmacists from other areas have been identified to support tasks that do not specifically require aseptics expertise More stringent cleaning and monitoring programmes; this minimises contamination risk and allows early detection of microbial growth. Oversight and steer from Capital Sub-Committee.	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. Availability of additional Pharmacists is limited due to their existing workloads. 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.	More staffing resource is required to support the aseptic unit's quality system, to ensure that all other regulatory standards are adequately met to mitigate the risk of the non-compliant facilities.	Morgan, Cerith	~~30/09/2026~~ 30/12/2026	Internal staffing model has been reviewed to allow the Health Board's lead quality assurance pharmacy technician to provide more support to the quality system. Initial discussions held with other Health Boards to explore whether they have QA resource that could support Hywel Dda through a SLA. Invest to save SBAR developed that would support more staff to work within the aseptic unit through a cost saving opportunity (reducing outsourcing of Azacitidine). QIA has been submitted to the Patient Safety team. Jobs in this paper are being presented to FCSG on 11.03.2026.
		WG have approved funding for a new demountable aseptic unit. Aseptic project team to progress with planning for building the unit and confirm project timelines once finalised.	Morgan, Cerith	31/08/2026	Initial workshops with principal contractor and aseptic unit supplier have been undertaken. Based on current timelines - the new unit will be operational by September 2026.
		Recruit bank pharmacists to take on clinical activities currently being performed by aseptics pharmacists	Morgan, Cerith	30/06/2026	Progress is pending approval from the recruitment team.
		Finalise Memorandum of Understanding with Cwm Taf UHB for quality assurance support	Morgan, Cerith	30/06/2026	New action, with progress to be provided at next risk review

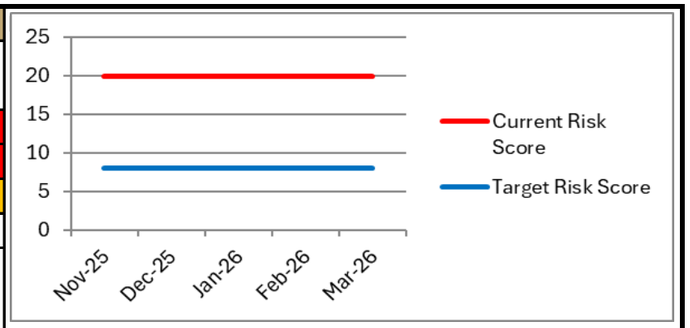
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the 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								
	Monthly Pharmacist Services Governance Meeting .	2nd								

Date Risk Identified:	Feb-22		
Strategic Objective:	3. Great Care		

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Mar-26
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Apr-26

Risk ID:	**1552**	**Corporate Risk Description:**	There is a risk of insufficient mortuary capacity (Fridge & Freezer capacity) Health Board wide to meet the current and future growing demand and provide adequate and appropriate sized storage for ward and community deaths. This is caused by the severe lack of storage capacity across all mortuaries within the Health Board, compounded by the fact that some of the refrigeration spaces are not big enough to accommodate the increasingly larger bodies that are being admitted into our mortuary facilities, and the inability for staff to safely access refrigeration spaces at WGH and BGH. In addition, the increase in economic, social, demographic, regulatory and legislative (Medical Examiner Service - MES) pressures have significantly increased both the quantity of deceased and length of stay within our Mortuary body storage facilities. This could lead to an impact/affect on the dignity, and condition of deceased patients within our care due to the inability to adequately store these patients in a suitable environment. There is also the potential impact of non-compliance with legislative requirements, including Human Tissue Authority, along with reputational damage to the Health Board. There could also lead to emotional distress to the families and friends of the deceased.
Does this risk link to any Directorate (operational) risks?		283, 1554	

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):	4×5=20
Target Risk Score (L x I):	2×4=8
Expected Date To Achieve TRS:	8/31/2026
Trend:	⟷



Rationale for CURRENT Risk Score:

The Health Board is exposed to significant risks resulting from insufficient mortuary capacity across its estate.The ongoing dependence on temporary body storage, particularly during periods of excess deaths, presents challenges in maintaining regulatory compliance, protecting staff wellbeing, ensuring safe manual handling practices,and upholding the dignity of the deceased.The current infrastructure risks non-compliance with HTA standards. According to ONS projections,the death rate is expected to rise, peaking in 2044, further intensifying these pressures.

Suboptimal facilities may lead to compromised presentation of the deceased, increased emotional distress for families, and safety concerns for mortuary staff,especially manual handling.While control measures are in place, they are not sufficient to manage the current volume of deaths within the mortuary service,particularly during periods of heightened demand.These control measures should serve only as temporary contingencies, in line with the HTA licence however,there is a growing need for enhanced storage capacity throughout the year,not solely during seasonal peaks.

Current body storage provisions do not meet operational requirements, and there is limited flexibility to respond to unplanned disruptions, such as those involving MES, HMC, or PM Service interruptions. Furthermore, the extremely constrained footprint of the mortuary estate significantly restricts opportunities for external expansion or enhancement.

Rationale for TARGET Risk Score:

Target score is based on successful outcome from Body Storage Capacity paper being escalated via CCG (03.06.25) to IQFPD (11.06.25). Funding stream discussed with Executive Director of Finance on (21.07.25) along with further meetings and support from the Health Board's finance and planning team to ensure a long-term sustainable solution is implemented as soon as reasonably possible. Assurance has been provided by the Executive Director of Finance that financial support will be received in order to enact the short term measures to ensure appropriate capacity is available for the approaching winter pressure period. Further discussions will be held with finance and planning colleagues to discuss medium and long term mitigating plans. Long term solution need to be sustainable and future proof to ensure the target risk score is achieved and maintained.

TRS and expected date to achieve agreed by Formal Executive Team in November 2025.

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**
1. At times of peak pressure, temporary body storage units are rented 2. Monitoring of numbers of deceased against storage capacity (Health Board wide) 3. Business continuity plans in place (Health Board wide) 4. Contracts with local funeral directors to utilise contingency storage of deceased (Health Board wide) 5. Deceased are relocated to other mortuary sites when needed (Health Board wide) 6. Bariatric blanket available for short-term use across all Health Board sites 7. Additional body refrigeration (Boxcold solution) has been installed into the old PM (Post Mortem) room at WGH site. 8. Participation, engagement and communication with the Health Board's Mortality Group, medical colleagues, Medical Examiner Service and external stakeholders	1. Despite owning 1x 15 BSS unit, we have insufficient storage provision for the upcoming winter pressure period 2. Insufficient suitable space and/or estate within mortuary facilities to increase body storage capacity. 3. Any delay in the death certification process (internal & external stakeholders) significantly impacts on the management of mortuary body storage. As these processes are outside of mortuary control, we frequently invoke contingency plans to accommodate the deceased. Death certification process be noted as a control measure, with the gap being the delays in these processes as a result of sources beyond the Health Board's control (MES, HMC, PM service disruption etc)? 4 & 5. Due to the national shortage of body storage capacity, death	Requirement of additional body storage capacity health board wide. Capital funding needs to be secured.	Baker, Craig	~~31/03/2025~~ 31/03/2026	To be escalated via CCG structure Escalated at IQFPDG June 2025 - meeting to be scheduled with HT re short term capacity and LD for medium/long term capacity for analysis. Body storage capacity paper being submitted via CCG structure. Financial approval from Finance executive to increase temporary storage over winter period (2025 - 2026), this includes funding to cover adding of additional capacity at PPH. In addition, currently reviewing BGH footprint to look at increase of freezer capacity to cover HB. 29/12/25 - Capital funding secured to increase freezer capacity at BGH.

certification processes and current death rates, contingency plans utilising mutual aid are ineffective as all Health Boards are experiencing the same level of body storage capacity pressures and are therefore unable to assist. 6. During the recent Tier 1 National Mass Fatality Pandemic Exercise it was identified that nationally and locally we have insufficient levels of body storage capacity to handle a mass fatality or a period of excess death. Risk areas were identified by the Hywel Dda team that participated in the exercise and these along with suggestions for improvements were feedback to the Local Resilience Forum (LRF) who will escalate this feedback to Welsh Government.	Explore options regarding temporary body storage rental and purchase of body storage capacity.	Brown , Yasmin	Completed	Ongoing Discretionary Capital bid to purchase a 15BSS Nutwell storage unit. 20.08.25 - Currently in discussions with suppliers regarding rental costs. 19.11.25 - The service has been successful in procuring a 15 BSS storage unit via a spend to save scheme. This unit will be delivered towards the end of November/start of December 2025. 19.11.25 - The service has also rented 2x additional 15 BSS nutwell units as contingency storage space as part of our winter preparedness plans and in readiness for the winter increase in death rates.
	Work with estates teams across the Health Board to undertake the minor and major works that are required to allow for the installation of the box cold body storage solutions.	Brown , Yasmin	~~30/12/2025~~ 30/04/2026	Contact has been made with estates managers in WGH, PPH, and GGH. Quotations for minor building works to be undertaken within the PPH and BGH mortuary facilities and are being progressed 19.11.25 - Building works commissioned for PPH with the works scheduled to be completed at the beginning of December 2025 to allow for for the erection of the additional additional body storage capacity (boxcold). 05.01.26 - Building works commissioned for BGH with the works scheduled to be completed March 2026 to allow for for the erection of the additional additional body storage freezer capacity.

Seek external advice on enhancement of mortuary storage capacity within current mortuary estate footprint.	Brown , Yasmin	Completed	Initial site visit has taken place with Wessex refrigeration to determine the art of the possible within the existing GGH mortuary facility footprint. Awaiting receipt of possible plans and quotations. 19.11.25 - Quotations have been received from Wessex refrigeration and engagement is ongoing with estates teams to work these up further.
Develop a business case and explore options in order to secure capital funding to ensure capacity meets both current and future body storage demands.	Baker, Craig	30/11/2026	Initial discussions held with Director of Finance and Director of Strategy and Planning regarding potential options to explore. Some of these options include - Building new estate and facilites - Commissioning body storage from private providers e.g. funeral directors - Working in collaboration with other Health Boards and Local Authority to develop combined regional solutions

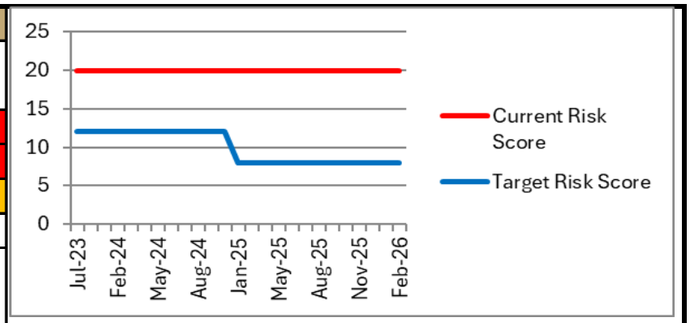
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
	Pathology Strategy Group.	1st			Presentation to IQFPD - June 2025.					
	Hywel Dda HTA Assurance Group.	1st								
	Regional HTA Assurance Group.	2nd								
	Quality & Safety Intelligence Group	2nd								
	AHP & HS CCG reporting up to IQFPD	2nd								
	IQPD	3rd								

Date Risk Identified:	Nov-20		
Strategic Objective:	2. Healthier Communities and 3. Great Care		

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Feb-26
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Mar-26

Risk ID:	**1027**	**Corporate Risk Description:**	There is a risk to the consistent delivery of safe, 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?		1.21075E+57	

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:	10/31/2028
Trend:	⟷



Rationale for CURRENT Risk Score:
The most recent available data highlights sustained high operational pressures across all acute sites with increased escalation levels throughout January and early February 2026. Although some key performance metrics show slight improvement over the last year, all are above Targeted Intervention (TI) targets in January 2026 (e.g. average time to clinical assessment in ED Jan: 68 mins, TI target: 60 mins; Numbers of >1hr ambulance handovers Jan: 716, TI target: 680). POCDs in January were 213 , above the TI target of 174. Actions to improve flow include implementation of the 7-day Clinical Streaming, Hospital at Home and Optimal SDEC services were agreed at Public Board in January 2026. Whilst the Board has approved the business case in January 2026, and additional control measures have been implemented, system pressures remain and TI targets are not consistently being met therefore the current risk score remains at 20 as at February 2026.

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. The expected date to achieve the TRS has been amended from March 2026 to October 2028 to allow for the implementation and embedding of relevant actions, as noted within the risk action plan. The embedding of 7-day Clinical Streaming and SDEC services will significantly impact on patient flow, however time will be needed for recruitment and embedding of services.

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. # MIYA 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 and boarded 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. # Criteria-led discharge guidance and principles continue to be embedded across HB. # 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. SRO in place to lead agreed 6 Goals for UEC programme. # Welsh Ambulance Services NHS Trust involved in all 6 Goals UEC workstreams.	# 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 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	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~~ 30/09/2026	At the public Board Meeting in January 2026, it was agreed to approve the implementation of a seven-day Clinical Streaming Service (CSS), Same Day Emergency Care (SDEC), and Hospital@Home model across Hywel Dda University Health Board. CCG currently progressing with implementation via County Implementation Groups.
		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.
		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	This has been action has been superseded, as the Health Board and Local Authorities now receive monies from Welsh Government (Pathways of Care Transformation Grant) to support development of community teams, being delivered ultimately by Local Authority with support provided by the Health Board, which reports to the National Support in Hospital Discharge Group.

# 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 # 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 Navigator in place. # Direct referral into SDEC in place. # OOH Pilot clinical streaming via GP route. # 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 # Winter Preparedness CELLS governance structure established and meeting weekly. #Trusted Assessor Model in place, ensuring consistent approach to assessment across the region # Patient Flow Unit established, acting as a single point of contact for all flow related matters including ambulance handovers, supported by performance dashboards # ED/MIU Redirection Policy ratified and in place, allowing appropriate clinical staff to redirect patients to alternative appropriate services	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. Public Board January 2026 approved the implementation of a seven-day Clinical Streaming Service (CSS), Same Day Emergency Care (SDEC), and Hospital@Home model across Hywel Dda University Health Board. CCG currently progressing with implementation via County Implementation Groups. # UEC Transformation Acceleration Group (TAG) not currently meeting as of January 2026, awaiting restart date. # Nursing staff and Health Care Support Worker (HCSW) staff shortages across all four sites.	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~~ 30/09/2026	At the public Board Meeting in January 2026, it was agreed to approve the implementation of a seven-day Clinical Streaming Service (CSS), Same Day Emergency Care (SDEC), and Hospital@Home model across Hywel Dda University Health Board. CCG currently progressing with implementation via County Implementation Groups.
		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~~ 31/03/2027	Frailty Lead appointed and developing plan, to be rolled out as part of the 6 Goals Programme during 2026/27.
		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~~ 31/10/2028	At the public Board Meeting in January 2026, it was agreed to approve the implementation of a seven-day Clinical Streaming Service (CSS), Same Day Emergency Care (SDEC), and Hospital@Home model across Hywel Dda University Health Board. CCG currently progressing with implementation via County Implementation Groups. There will be a phased approach to implementation starting with WGH (expected to complete October 2026), BGH (expected to complete October 2027) and GGH (expected to complete October 2028).
		Continued implementation of Optimal Flow Framework including Community sites supported by MIYA digital platform.	Skitt, Peter	31/10/2025	Optimal Flow Framework is being embedded with support from Optimal Flow Coordinators across acute and community sites. MIYA digital platform was rolled out in December 2025 with training schedule ongoing. Revised date noted to reflect this ongoing training.

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	Completed	The Health Board Hospital at Home SOP has been agreed by the Community & Integrated Medicine Clinical Care Group Integrated Governance Group (focus on Quality, Health & Safety) and the Clinical Advisory Group.

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
Ambulance handovers within 15 minutes Ambulance handovers over 1 hour Ambulance handovers over 4 hours 4 & 12 hour waits in A&E Time to triage in A&E Time to see a Doctor in A&E Pathway of care	Medically optimised and ready to transfer patients are reported 3 times daily on situation reports	1st			Seven-Day Business Case for Clinical Streaming Services (CSS), Same Day Emergency Care (SDEC), and Hospital@Home - Public Board January 2026 Unscheduled Emergency Care Accelerated Work Programme Update - Quality, Safety & Experience	None identified.				
	Daily performance data overseen by service management	1st								
	Workstream Delivery Plans overseen by 6 Goals Programme	2nd								
	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								

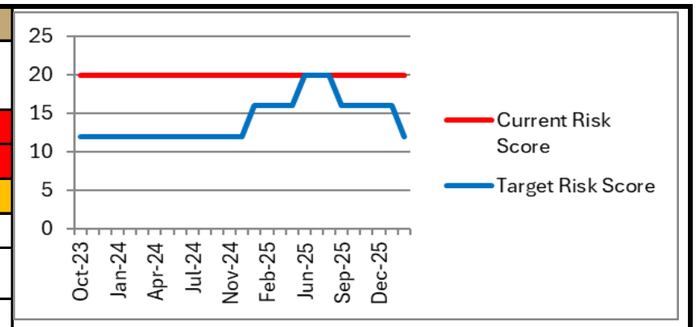
delays	IA review on Transforming Urgent and Emergency Care	3rd			Committee February 2026				
	NHS Executive Same Day Emergency Care (SDEC) Review	3rd							
	NHS Executive ED Review	3rd							
	GIRFT Review on ED	3rd							
	MAG review	3rd							

Date Risk Identified:	Nov-20		
Strategic Objective:	2. Healthier Communities and 3. Great Care and 4. Positive Futures		

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Mar-26
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Apr-26

Risk ID:	**1032**	**Corporate Risk Description:**	There is a risk of delayed access to autism assessment for those on the CYP ASD waiting lists which is in breach of Welsh Government performance standard of 26 weeks. This is caused by an increase in referrals, sustained pressure on service. Internal back log of cases due to previous staffing issues and inefficient internal processes. This could lead to an impact/affect on provision of appropriate care and support. Inability to meet Welsh Government targets. Increase in complaints and adverse publicity as well as 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):	3×4=12
Expected Date To Achieve TRS:	12/31/2030
Trend:	⟷



Rationale for CURRENT Risk Score:

Significant waiting times have developed as a result of exponential demand. Demand outstrips capacity, with year-on-year increase in referral rates. Current team capacity can only accommodate 11% of total current demand, compounded by current funding arrangements which are non-recurring, making recruitment and service delivery challenging.

Welsh Government provided funding for Children's Neurodevelopmental (ND) services for 2025/26 to reduce waiting lists (received September 2025). The delay in receipt of funding and the fact that it is non-recurring, along with recruitment delays, has hindered service planning and delivery. However, an improvement plan is in progress which includes stabilising and expanding the workforce, the use of outsourcing and data validation to manage waiting lists and meet ministerial targets, the re-design of our services, and the strengthening of regional partnership working to deliver a wholeâ€'system, needsâ€'led approach aligned with ministerial priorities. The demand for diagnostic assessment remains high and in the absence of a regional strategy our focus is currently on meeting the government targets which hinders our ability to develop a needs-led model and reduce the need for diagnostic assessment.

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.

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 2026.

The achievement of the target risk score is dependent on Welsh Government ring-fenced funding being made available on a recurrent basis, service re-design and waiting list initiatives are completed and implemented. Furthermore, the development of a regional, collaborative strategic approach with key stakeholders is imperative to creating whole system, needs-led integrated services. Digital enablers such as artificial intelligence and licenses for digital platforms essential along with access to appropriate clinical venues essential to help reduce target risk score.

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 announced - £980,000 allocated to Health Board; funding ring-fenced for CYP service 2025-2026 Weekly Autism Advice Hubs in place for parent carers and CYP Rolling programme of workshops offering advice and support around neuro-diversity for parents of children awaiting diagnostic assessment. ND Service Delivery Manager in place to oversee 3 year performance improvement plan 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. 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. Outsourcing procurement exercise underway to eradicate 3 year waits by March 2026. Contract to the value of £4m to outsource over a 3 year period, commenced in 2025, with the option to increase to 5 years as funding allows Monthly touchpoint meetings with NHS Improvement & Performance to monitor progress against ministerial priorities. SMS text functionality in place for ND to improve attendance and decrease instances of non attendance. Fixed term posts made substantive Early Years pathway and toolkit for Health Visitors in place to encourage a 'watch and wait' approach.	Estates - lack of appropriate dedicated child-centred premises to run clinics Recruitment delays Financial climate and associated cost pressures impacting on acquisition of appropriate IT infrastructure and hard wear that could create more efficiencies Lack of certainty around future funding of ND services. Allocated monies 25/26 are non-recurrent. Uncertainty around RPB infrastructure to help support and deliver regional transformation to needs-led, whole system approaches Lack of capacity within ND services to work strategically to bring about transformational change across the 3 counties. Current capacity within ND services limited due to competing operational responsibility pressures. Lack of a regional partnership strategic action plan to help bring about transformational change across the 3 counties involving all stakeholders.	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	Completed	Psychology posts fully recruited in to within Children's ASD service
		Develop further understanding of drivers for referral with potential for collaboration with partners for needs-based profiling	vaughan, Catherine	~~31/03/2026~~ 31/03/2027	Commenced 1st October 2025 Work progressing with thematic analysis of drivers for referral underway in order to inform re-design of service to needs-led model. Education Strategic meeting with CCC attended to start to agree and develop profiling tool. Work un progress to develop a pilot between Children's ND and CCC Education Psychology service Assistant Psychologist recruited to undertake a thematic review
		Recruit into additional administrative and clinical posts and make existing fixed term posts substantive	vaughan, Catherine	Completed	Recruitment underway in October 2025. Delays gaining financial approval and recruitment delays, recruited into Band 4 Waiting List Coordinator and Band 3 Team Secretary of of 01.02.2026. All posts recruited in except for 1.0wte OT and 0.6wte ND practitioner. Interviews scheduled March 2026 Recruitment nearing completion for all posts
		Outsource a minimum of 585 diagnostic assessments to eradicate >3 year waits	vaughan, Catherine	Completed	Procurement exercise completed. Referrals identified and transferred to contract provider for 585 assessments, to be completed by 31.3.26.
		Develop an all-age regional strategic action plan around neuro-divergence to promote whole system, needs-led services	vaughan, Catherine	~~31/03/2026~~ 31/03/2027	This action has been included in the CCG Annual Plan for 26-27.

Professional consultation introduced across statutory sectors Website developed and in place for all-age ND services. Stakeholder mapping exercise completed and engagement plans in progress to develop needs-led model Looking at a Value Based Healthcare working with partners to develop needs led service.		Introduce an AI scribe across service to reduced administrative burden on clinical staff	vaughan, Catherine	~~31/03/2026~~ 30/06/2026	Use of Magic Notes AI scribe commenced on 6.2.26 as pilot. Outcomes and feedback shared with Digital Director to inform HB procurement of a AI type system.
		Develop and appoint into a strategic Head of Neuro-divergence post, to strengthen existing and further develop strategic partnership working	Temple-Purcell, Rebecca	Completed	This specific action is unrealistic at this present time. Opportunities, roles and responsibilities for the development of strategic partnership working to be undertaken collectively by the CCG leadership team.

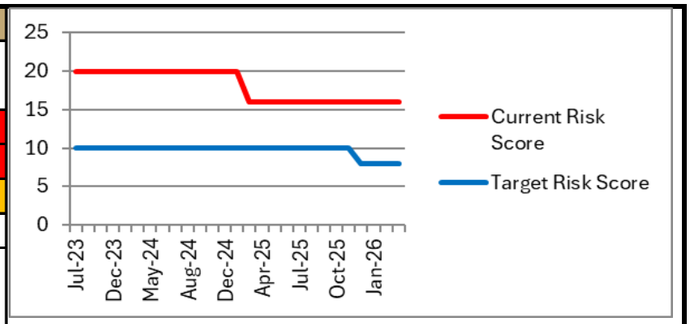
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the 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	System to improve analysis of patient experience				

	Monthly MH&LD Integrated Governance Group (BPPP & QSEG)				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. Papers were presented at Board Seminar in March & September 2025 to provide assurance on current waiting times and control measures.					
	An updated paper was submitted to the September 2025 Board meeting.	2nd								

Date Risk Identified:	May-23	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Mar-26
Strategic Objective:	1. Thriving Teams and 3. Great Care	**Lead Committee:**	Quality, Safety and Experience Committee	**Date of Next Review:**	Apr-26

Risk ID:	**1664**	**Corporate Risk Description:**	There is a risk to service sustainability in Ophthalmology, and the inability to provide timely care to patients with Glaucoma, wet Age Related Macular Degeneration, Vitreoretinal, paediatrics, and Cataract This is caused by a national shortage of Consultant Ophthalmologists and the inability to recruit to vacancies, exacerbated by nursing and medical staffing constraints and reduced service capacity due to lack of physical space. Recruitment difficulties are leading to the Consultant on-call rota being covered by substantive Consultants with 3 gaps in the rota, and Consultants undertaking additional duty hours, with use of agency consultant to fill 2 gaps on the rota. 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). Impacting the ability to provide timely diagnosis and treatment and 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 WG. The service has undertaken successful recruitment of two specialty Doctors who are now onboarding, this will improve capability and capacity in part. The Regional Programme Board continues to support development with 2 Regional substantive Consultant posts (1 post offered) to fill the vacancies within the team.
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):	2×4=8
Expected Date To Achieve TRS:	3/31/2028
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 42%. The WG target for R1 delivery is 95%. The current waiting list for new patients is 11,552. The service is currently delivering 0 patients waiting at stage 1 over 52 weeks for March 2026 and this is expected to be maintained through to the end of March 2026. The stage 4 104 weeks, is in a breach of 2 for March 2026 currently with potential solutions being worked through to be 0 by the end of March 2026. 7301 patients have been 100% delayed for their follow up appointment. The Board has decided to progress Clinical Service Plan Option 99 of the Clinical Service Plan + Aberaeron Integrated Care Centre as a diagnostic hub. The service is currently reviewing the estates and workforce required on each site to deliver Option 99.	The service will be able to reduce the impact score of this risk as whilst the consequences to the patient remains high, recurrent funding has been invested into the service for the delivery of an R1 Eye Care Measures target of 65%. The ministerial Measures target will need to be 0 for 3 months and more and the Follow up delayed will need to be reduced by 12%. The 65% R1 delivery by January 2027 is dependent on all posts being recruited into and all estates needs being met. Further development would be required to reach a 95% R1 delivery score. With the required investment in Glaucoma and IVT and the additional workforce identified in the annual plan 2026/2027 and estates issues being resolved alongside the continued management of the waiting lists, the HB will potentially be able to reduce the score to 8.

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**
The service is included within the Health Board's Clinical Service Plan (CSP). With Option 99 being decided by Public Board as the most suitable option to improve efficiency gains, training and retention of staff. Active recruitment to vacancies through a regional approach, continue grow your own initiatives to secure Substantive Consultants and develop Consultants for the future. 2 Regional Substantive posts have gone out to advert through the Regional programme. 1 post has been offered following interview (Vitreo Retinal) and the other post is going back out to advert (Medical retina)	Vacancies remain high within the service with a high turnover of staff. When recruiting to Clinical posts, delivery is restricted due to the reliance on Medical records and outpatient staff and the introduction of further clinics has been difficult. The SLA with SBUHB for the regional consultant posts needs to be finalised.	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	Application Support Manager started early December, undergoing induction with projects team & IT. Communication established with clinicians to explain Application Support Manager will start shadowing their clinics as soon as possible to determine pathways and support the build up of the system to match clinical activity.

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 funding for the delivery of Wet Age related Macular Degeneration (AMD).IVT outsourcing commenced in February 2025 continues to support the service, whilst service is developed. Additional capacity has been funded for the delivery of Cataract surgery to maintain the 104 week wait for 2025/2026. Wales General Ophthalmic Services (WGOS) for Glaucoma, Diabetic Retinopathy and Medical Retina ongoing. Continued Validation of waiting lists to remove any patients who no longer require treatment. With review of data quality inclusive of Health Risk Factor (HRF) code and clinical codes ongoing to improve data quality. Eye Care Collaborative Group meets quarterly to oversee performance against eye care standards. The second regional ECCG meeting is being held on the 20th March 2026. Highly trained Optometrists working collaboratively with the Secondary Care Eye Service to reduce referrals to secondary care and support the validation process. Ongoing training of Optometrists within secondary care for IPOS, Glaucoma and Medical Retina for continued delivery of WGOS and reduce referrals into secondary care. 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.	The Regional sub-groups are in their infancy with actions being taken to develop sub-specialties. The SAS doctor post for the (AMD) service needs to be recruited into to start additional Injections clinics in NREC. Interviews were held on the 13th march 2026 and posts are onboarding. The required space for the expansion of the service in AVH needs to be secured for 5 days a week. Further meeting to discuss on the 25th March 2026 The regional cataract delivery plan needs to be developed and executed. A WGOS co-ordinator needs to be secured in primary care to support the discharge of patients to the community. The remaining 8 GIRFT recommendations need to be actioned and closed. There still remains areas of the service (e.g. Glaucoma, AMD, Cataract, Paediatrics, Corneal and VR) that require investment. The regional programme board will need to consider further opportunities for a long-term regional model. Central investment in Estates, Infrastructure and Workforce is required to develop a sustainable service. Recovery funding is non-recurring and reviewed annually, which restricts delivery planning.	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~~ 30/09/2026	Recommence the validation of the HCQ patients. Ensure patients start to be discharged to primary care Optometrists when training has been completed. Primary Care still awaiting materials to be finalised and process rolled out.
		Alignment in the Delivery of Eye Care Measures and Ministerial Measures and effective management of Ophthalmology waiting lists.	Coppack, Victoria	31/03/2027	Recruit into 2 regional consultant posts. Deliver actions against regional programme board. AVH OPD to be secured for additional 2 days IVT. Deliver 52 week and 104 week target. Deliver 12% reduction in follow up delayed. Ensure all WGOS patients identified for pathway are discharged to primary care. Complete GIRFT recommendations. Continue with Clinical Services Plan.
		Long-term investment required for IVT and Glaucoma Delivery to recover R1 position	Jones, Keith -	Completed	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	Regional visit to SBUHB completed. Next Regional Eye Care programme Board meeting 20th March 2026
		Orthoptist posts to be recruited into	Coppack, Victoria	~~30/09/2025~~ ~~31/03/2026~~ 30/09/2026	Band 6 1.0 WTE Orthoptist post to be recruited into. Band 8B JD has been signed off by job matching panel. Next steps to identify the funding for this post and authorise through CCG and FCSG.

	There are ongoing concerns in data quality due to referral processes and system use.	Progression of Clinical Services Plan Option 99 + AICC as a diagnostic hub.	Carruthers, Andrew	31/03/2028	The Board has decided to progress Option 99 + AICC as a diagnostic hub. The service is currently reviewing the estates and workforce required on each site to deliver Option 99.

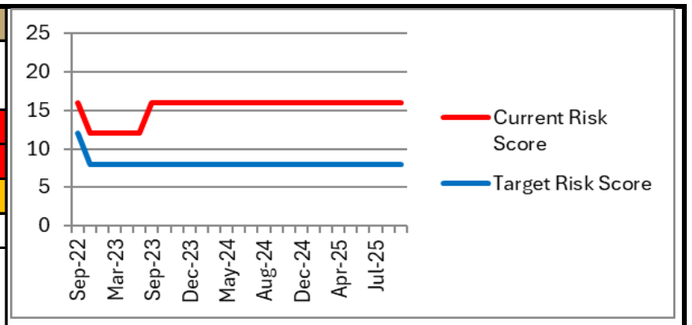
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the 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 GIRFT action plan cataracts GIRFT action plan Glaucoma WPAS, scheduled care performance indicators	1st 1st 1st 1st			SBAR for IVT Service Delivery & SBAR for recovery of R1 position Revised RISK SBAR. Planned Care Annual plan 2026/2027					

Date Risk Identified:	Jan-19		
Strategic Objective:	3. Great Care		

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Feb-26
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Mar-26

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, 1706		

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:	8/30/2050
Trend:	⟷



Rationale for CURRENT Risk Score:

The Health Board's aged imaging equipment continues to break down, disrupting diagnostic services and affecting Referral to Treatment (RTT) targets, with delays in diagnosis and treatment for patients. Replacement of CT and MRI scanners has reduced downtime, but recurrent failures of other key equipment highlight the need for further investment. A rolling programme and prioritisation process are in place to manage installations.

The Gamma camera at WGH, the only unit of its kind in the Health Board, has suffered repeated breakdowns, leading to HIWâ€'reportable IRMER incidents. It remains a priority for replacement as of February 2025. At GGH, a new CT scanner has been installed, but the original unit continues to fail due to outdated technology, undermining resilience at the major trauma site. Likeâ€'forâ€'like replacement is not always costâ€'effective or compliant with regulatory and warranty requirements, and infrastructure upgradesâ€"such as air handling, water chillers, and accommodation adjustmentsâ€"are needed to ensure longâ€'term resilience.

Replacement of the Gamma camera at WGH has been delayed due to insufficient physical space and electrical infrastructure, with costs exceeding Welsh Government allocations for 2025/26. The funding window was closed, further impacting compliance with NRW specifications for Nuclear Medicine. Future plans must be coordinated with Estates to expand electrical capacity and ensure facilities meet current and future Nuclear Medicine requirements.

Rationale for TARGET Risk Score:

Modern equipment will reduce the likelihood of breakdowns, minimize downtime, and lessen the impact on diagnostic services across other hospital sites. Strengthened business continuity planning will further mitigate risks associated with equipment failure. However, funding is typically released in Q3/Q4 of the financial year, constraining the scheduling of large installations. The urgency of replacements often forces rapid decisions, resulting in lowerâ€'priority equipment being replaced ahead of higherâ€'need installations.

The Health Board's top replacement priority is the Nuclear Medicine SPECT scanner, the only unit available which has suffered frequent breakdowns since June 2023. A task and finish group has been convened to plan its replacement in anticipation of Welsh Government funding. The second CT scanner at GGH is the next priority, as it supports outpatient work and serves as a backup; it is increasingly unreliable, with long lead times for parts. Additionally, service variation in DEXA provision has worsened, as the Swansea scanner now performs Trabecular Bone Scoring (TBS), while the BGH scanner cannot. Patients have required repeat scans to obtain TBS results, and the BGH unit also runs on an unsupported Windows version, posing further risk.

Replacement of the Nuclear Medicine SPECTâ€'CT, the second CT scanner at GGH, and the DEXA scanner at BGH would allow risks to be de-escalated to the operational risk register. Completion is dependent on WG funding and may extend to the end of the 2026-27 financial year due to infrastructure requirements.

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~~ 31/03/2026	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. Update Aug 25: Work starting Sept 25
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~~ 31/05/2026	Replacement agreed and funding available for replacement in March 26

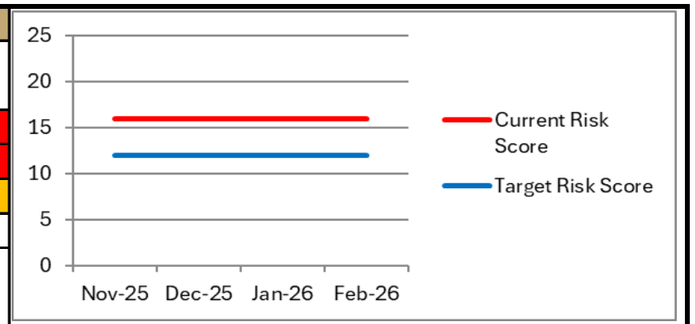
To replace the DEXA scanner at BGH and ensuring suitable accommodation is found to meet regulatory compliance for a larger more modern scanner.	Edwards, David	~~31/03/2024~~ ~~30/09/2024~~ ~~30/09/2025~~ 31/03/2026	Unit is 17 years old, and previously funded via charitable funds This has been added to 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.
Arrange meeting with head of capital planning and head of strategy and planning to discuss long term strategy for equipment replacements.	Procter, Sarah	Completed	meeting undertaken - business case for NM to be developed. Understanding of critical need.
Meeting with head of capital planning to discuss plans for CT and NM replacement in near future.	Procter, Sarah	Completed	meeting has happened 23.1.26 - action develop business case in conjunction with capital planning and estates
Business case to be developed for replacement of Gamma Camera - joint with capital planning team	Procter, Sarah	31/03/2026	new action

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:	Oct-25	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Feb-26
Strategic Objective:	3. Great Care	**Lead Committee:**	Quality, Safety and Experience Committee	**Date of Next Review:**	Mar-26

Risk ID:	**2190**	**Corporate Risk Description:**	There is a risk that the Health Board will be unable to implement Direct Payments for Continuing Healthcare by 1 April 2026. This is caused by the reduced implementation timescale from December 2026 to 1 April 2026, the absence of WG policy guidance (which will not be issued until April 2026) and insufficient resource and capacity to support local implementation within the Health Board. This could lead to an impact/affect on service delivery, with service users not being treated fairly due to a disparate approach resulting from lack of National policy guidance and local governance arrangements. There is potential of increased complaints and Ombudsman queries, and reputational damage to the Health Board in failing to meet national policy. There is also a potential financial impact due to increased costs associated with Direct Payment implementation, and the number of cases that are likely to present in the future.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Quality/Complaints/Audit
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:	3/31/2026
Trend:	⟷



Rationale for CURRENT Risk Score:	**Rationale for TARGET Risk Score:**
There is a lack of clarity and national guidance regarding the proposed model for the delivery of Direct Payments, and the time available for implementation which has reduced significantly with the date of implementation brought forward from December 2026 to 1 April 2026. There are serious concerns that governance and safety requirements will not be adequately established to meet the revised implementation date, which may increase the risk of inconsistent approaches across Health Boards. The Health Board does not currently have a system in place to manage or deliver Direct Payments in order to comply with the requirements of the forthcoming policy. Robust governance systems have yet to be developed, and there is a notable absence of dedicated resource, and specialist expertise. Delivery within such tight timescales will require additional resources. Each Health Board will also be expected to put in local arrangements to support delivery at a local level. Without additional resources, staff may be unable to allocate sufficient time to support implementation alongside existing duties. Implementation Lead in place and Task and Finish groups established working on policies and processes.	A dedicated local resource is needed to meet legislative requirements by 1 April 2026. Clarity is needed from Welsh Government over guidance and implementation plans to enable robust governance and safety requirements. All Health Boards in Wales require a consistent approach to direct payments. Whilst the implementation date is end of March 2026, there is no certainty that this can be achieved without the additional governance and resources.

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**
Local Working Group which includes LTC , MHLD and Children's services as well as finance colleagues which meets monthly. However additional resources have not been identified or clarity on whether a national hub or resources will be available. National CHC leads group meeting already in situ with direct payments regularly discussed. Welsh Government direct payments policy team meeting with Health Boards on a monthly basis. 150k is being held by Powys Health Board and they have appointed the Implementation lead to support Health Boards on implementation. Task and Finish groups set up to review key workstreams: Commissioning Care and Support, DP Eligibility in Care Needs and Safety, DP advice Support& Coordination, Health Board Training staff. Implemented Lead and National Director for Complex Care (Corporate Services) meet regularly with Welsh Government.	No local or national implementation plan in place No development yet of a suite of all Wales protocols and operational guidance. Lack of dedicated resource to implement requirements. No financial protocols designed to support payments.	Hywel Dda input required to support Welsh Government national consultation and development of guidance	McCarthy, Julia	Completed	Health Board to attend Welsh Government policy team monthly meetings. Welsh Government have recently issued the consultation paper regarding the regulation of direct payments for response by 15 October 2025. In addition a further CHC DP draft guidance was given and comments needed by 19th Nov this has been submitted by the Service.
		Identify workforce resources required to action and implement a working plan to deliver direct payments.	McCarthy, Julia	31/03/2026	Director of Finance agreed in Nov 2025 EITS to provide support for potential resources for Direct Payments (DP) being implemented in the Health Board. Local working group established to receive updates from DP workstreams. LTC and MHLD teams have engaged with the three Local Authorities (LA). The LAs are keen to work with the Health Board in supporting implementation of DPs. The Health Board is unclear of the workforce resource required within the Health Board.
		Agreeing the training spec to increase the skills and knowledge base in the Health Board for direct payments and their operation.	McCarthy, Julia	31/03/2026	An All Wales training spec is being developed as part of one of the workstreams for Health Board staff. The draft spec will be circulated end of February 2026 for all Health Boards to agree. In addition we are still waiting the draft policy guidance from Welsh Government.

Implementation lead appointed to lead on Direct payments. Task and Finish groups set up to start to review key workstreams: Commissioning Care and Support, DP Eligibility in Care Needs and Safety, DP advice Support& Coordination, Health Board Training staff.	Devantier, Tracy	Completed	Task and Finish groups have commenced in January 2026 under the leadership of the new Implementation Lead. Long Term Care and MHLD have provided the names of Health Board staff who will participate in the workstreams.
Implement an Electronic DP referral system to support internal Health Board colleagues and LA colleagues. Also to support patients self-referring into the service.	Devantier, Tracy	31/03/2026	Email has been sent to Digital Director to request support for Digital resource to implement an Electronic DP referral.

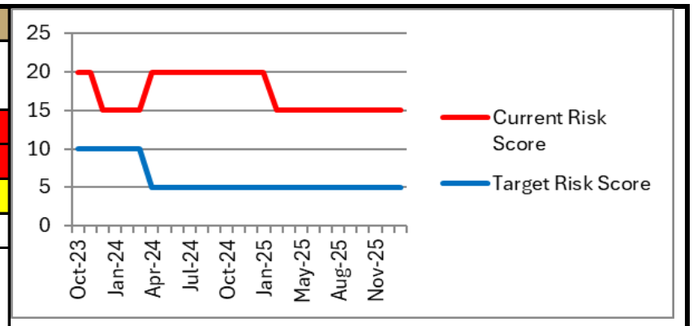
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level		
Reviews completed in line with the national framework. Number of packages and costs reported monthly to local governance forums. Papers are submitted via the CCG IGG. Welsh Government may require reporting but that is yet to be confirmed	There are current finance reporting and review monitoring arrangements in place that could be adapted when direct payments are implemented and would be reported through the CCG and IQFPD. .	1st			
	Recent internal audit of finance procedures received substantial assurance .	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

Date Risk Identified:	Nov-22	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Mar-26
Strategic Objective:	1. Thriving Teams and 3. Great Care	**Lead Committee:**	Quality, Safety and Experience Committee	**Date of Next Review:**	Apr-26

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 are also affected and there is an increased expenditure on agency locum consultants and internal locum rates at 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?		2067	

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:	5/1/2027
Trend:	



Rationale for CURRENT Risk Score:

A substantive Upper GI consultant has now been recruited following the exit of the Medacs agency locum consultant in Withybush General Hospital. A second substantive post is out to advert, and the Advisory Appointments Committee (AAC) is planned for April 2026. Successful recruitment will result in 4 substantive consultants on the 1:4 rota at WGH. The GGH rota has only 1 gap which is being covered by internal locum at the HB card rate. The plan for this rota is to recruit a substantive colorectal consultant to replace 1 of the NHS locums. On 19/02/2026, The Health Board made a decision on the Clinical Service Plan (CSP), which would involve the amalgamation of the surgical on-call rotas and Emergency General Surgery being moved from WGH to GGH. The timescale and details of this are not yet confirmed, but the service will continue to engage with the CSP programme.

Rationale for TARGET Risk Score:

Achievement of the target risk score is dependant on the successful appointment of substantive upper GI consultants along with the work currently being undertaken following the outcome of the Clinical Services Plan which would involve the amalgamation of the surgical on-call rotas and Emergency General Surgery being moved from WGH to GGH. The effectiveness of revised rota arrangements will depend on several factors including availability of a labour market.

A substantive Upper GI (UGI) consultant has now been recruited following the exit of the Medacs agency locum consultant in Withybush General Hospital. There is 1 UGI substantive post out to advert and a substantive LGI post to be advertised for GGH in April 2026. The rotas at GGH and WGH are currently fully functioning with no Medacs locums. This will be further strengthened by further substantive recruitment and less NHS locum consultants. By May 2026, there should be a balance of upper and lower GI coverage on the rotas, providing recruitment is successful.

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. The WGH rota is a 1:4 frequency with 3 substantive consultants and 1 NHS locum consultant. The GGH rota is a 1:8 frequency with 1 gap on the on-call rota, due to health reasons. This gap is being covered by internal locum at the HB card rate. The rota consists of 4 substantive consultants and 3 NHS locum consultants. There is a plan to replace one of the NHS locum colorectal consultants with a substantive consultant. This will be going out to advert in April 2026. A substantive upper GI consultant post is currently out to advert, which will replace the NHS locum. The AAC is planned for April 2026. These are dual location posts between GGH and WGH, and they participate in the on-call rota at WGH. Â Â When there is sickness or unexpected leave, due to emergency circumstances, the following process is followed by the management team to cover the on-call: 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. Â Proactive sickness management Escalation to clinical leads 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 the CSP programme. A decision has been made through the CSP programme, but there is currently no timescale confirmed for this.	All posts are yet to be filled substantively. It is unknown whether the service will be able to successfully appoint to the second substantive upper GI post, due to previous withdrawals of applicants. The Consultants at GGH also provide the support to the junior and SAS level doctors at PPH for the elective pathway. There is a part time rota co-ordinator in WGH covering maternity leave. This post is shared between surgery and T&O. The rest of the work is being undertaken by the service team which has had a detrimental impact on their workload. 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.	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.
		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 2nd September. 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.
Successfully recruit 2 x substantive upper GI consultants.	Lewis, David	~~30/09/2025~~ 01/05/2026	1 consultant started in post on 27th January 2026. There was an AAC planned for the second consultant in February 2026, but both candidates withdrew. The post is now back out to advert with the AAC anticipated for April 2026.

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, Sep 24, Oct 24) SBAR to Executive Team and OPDP to agree 1:3 rota (Mar23)	Assurance to Board on communication and repatriation arrangements				

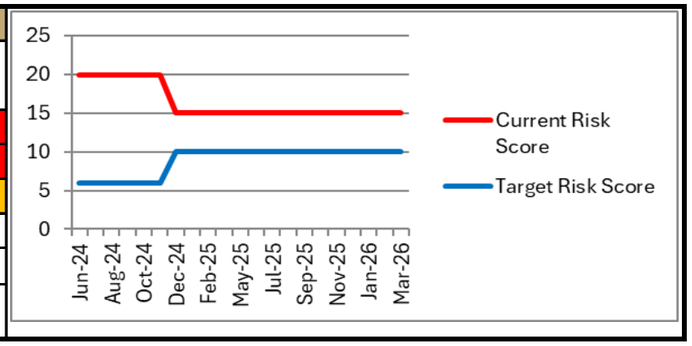
	Reported to monthly General Surgery Business Meetings on each site (BGH/GGH/WGH)	2nd			General Surgery Report to Board (Mar23) Management team to present updated SBAR to Acute Leadership Group (Oct23 & Nov23) Management team to present updated SBAR to Corporate Directorate Group (Apr24) Upper GI service SBAR presented at ALG (Sep24) Upper GI service SBAR presented at Quality, Safety and Experience committee Meeting (Oct24) Updated SBAR to Executive Team (Nov24) Options Appraisal via CSP to Board (Nov 24)				
	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							

	GIRFT report on General Surgery which raised the sustainability of general surgery across 3 sites in Hywel Dda - final report awaited				Upper GI service SBAR presented at scheduled care directorate QSEAC (Jan25) CSP Public Board (18/02/2026)				

Date Risk Identified:	May-24	**Executive Director Owner:**	Daniel, Sharon	**Date of Review:**	Mar-26
Strategic Objective:	1. Thriving Teams and 3. Great Care	**Lead Committee:**	Quality, Safety and Experience Committee	**Date of Next Review:**	Apr-26

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:	6/30/2026
Trend:	⟷



Rationale for CURRENT Risk Score:

At the end of 2025 Unplanned Admissions into ITU (from Ward areas) in WGH had reduced by 10%. In GGH the same comparison was unchanged.
Cardiac arrests rates for Ward Areas across all 4 sites have had varying results:
WGH - Increase of 40% (2024: 16, 2025: 23); unfortunately although all cases have been reviewed by the Resuscitation Team there has been less involvement from the Medical Team in WGH in undertaking reviews, possibly leading to less scrutiny and less opportunity to learn from events.
GGH - Decrease of 30% (2024: 34, 2025: 24); significant amount of work has been undertaken by the SNMs/Ward Managers/Resus Team & GGH RADAR lead to undertake monthly/bi-monthly Scrutiny meetings to review all cardiac arrest cases. It is possible that this added scrutiny and feedback and lead to better decision making, recognition & escalation of deteriorating patients.
BGH - Decrease of 30% (2024: 10, 2025: 7); no theme identified
PPH - Increase of 70% (2024: 7, 2025: 12); Scrutiny meetings only established in Jan 2026. Difficult to fully attribute but has the down grading of the ITU resulted in sicker patients being managed in ward areas were ITU may have been more appropriate.

In at least 50% of these cases across the HB the conclusion from the medical review was that a DNACPR should have been in place, therefore resuscitation should not have started.

Rationale for TARGET Risk Score:

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.

As at March 2026, TRS date has been revised from 31/12/2025 to 30/06/2026 as systems remain under development and have not yet been implemented.

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**
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. RADAR directly reports to Quality and Safety Intelligence Group (QSIG) Local RADAR groups (across all sites, counties, MHLD and Paediatrics) which report to Health Board wide RADAR group. 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. WAST have remained with the patient and allowed the HB to utilise their pre	Treatment escalation plans not in place but continued to be discussed at WGH and GGH Call for Concern only for inpatient adult patients only and at the moment is only across 2 sites. 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	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 -	Completed	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, with risk actions to be updated accordingly. RADAR next scheduled to meet on 7th October 2025.
	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.	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~~ 30/04/2026	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.

hospital mechanical CPR device equipment within the hospital setting. Networks in place across the wider Health Board, including support from QIST (Quality Improvement Service Transformation) Team 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 and Specialist Care Clinical Care Group (i.e not fully linked to Acute Deterioration resource) 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 in place at GGH and WGH for inpatient adult patients only. Process for implementation in Paediatrics, Mental Health and remaining sites under review. Cascade Trainers in place across the Health Board (community and acute)	Training requirement to meet recommended Resus Council Standards greater than current allocate Resuscitation Team resource 60 - 70& attendance of courses, even if fully booked. Current resource not being used to full potential with financial implications. Inconsistent and irregular site RADAR meetings which report in to HB-wide RADAR Group, with lack of medical leadership Whilst there is a dedicated Resuscitation Team in place, the HB does not have a Mechanical CPR Device in any of its Acute Sites. The Resuscitation Council Guidelines for Resuscitation state thatÂ a LUCAS is a good alternative for situations where it may be difficult or to maintain continuous high-quality compressions, or when it may be too strenuous on the medic to do so. There have been occasions when WAST have remained with the patient and allowed the HB to utilise their pre hospital mechanical device equipment within the hospital setting. However, this is not routinely or officially suitable practice.	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~~ ~~31/12/2025~~ 31/03/2026	Supporting metrics for the dashboard identified: 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. 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. Data being supplied however further work required to align to the new operational CCG structures on the dashboards.
		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~~ ~~31/03/2026~~ 31/12/2026	Task and Finish Group is in place, chaired by Mandy Davies. Call for Concern has been implemented in Adult Inpatient areas in GGH and WGH due to these sites having outreach services. Discussions are underway with PPH and BGH on how this programme can be implemented. Paediatric Services have set up a group to review how this could be worked in their area. The National Group have a timeline of March 2027 for full implementation.

Put in place All Wales Policy for treatment escalation plans to enable safe and effective care management when patient deteriorating.	Edmunds, Dr Eiry	Completed	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 September 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. To discuss at RADAR meeting scheduled for October 2025. Palliative Care Consultant has been appointed as the TEP Lead for the Health Board.
To feedback the audit to clinical leads so that they can implement improvements on the use of sepsis bundles at the bedside.	Wastell, David	~~31/12/2025~~ ~~31/03/2026~~ 31/12/2026	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. Implemented in July 2025, and audits have commenced to monitor compliance. Scrutiny of compliance is underway to ensure improvements are embedded, in consideration of an electronic system being launched early 2026.

Improve compliance with DNACPR National Guidance	Steele, Cathie	Completed	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	Completed	Senior nurse for acute deterioration is working with Interim ADN for Quality and Safety to develop SharePoint page. Refinement of the Sharepoint site underway to finalise and launch as of September 2025.
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~~ ~~30/09/2025~~ ~~31/12/2025~~ ~~31/03/2026~~ 30/09/2026	Acute Deterioration Nursing Leads from across Wales are in the process of reviewing. Awaiting the National decision.

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 -	Completed	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. This phase completed.
Following assessment and interpretation of the All Wales Direction, the Health Board is engaging in National work, namely roll out of Call for Concern.	Wastell, David	30/09/2026	National Guidance now issued - Call for Concern has to be implemented by December 2026. This has to be implemented in all adult inpatient areas including Maternity Services, Paediatrics, Neonates and Mental Health. Task and Finish Group has been established. Mark Henwood is the Executive sponsor and work continues.
Capital Bid to be submitted for 3-4 LUCAS machines (mechanical CPR machines).	Wastell, David	Completed	4 machines now delivered and training on each site is planned March/April 2026. Action complete.

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	EWS (Early Warning Scores)/NEWS2 Audits undertaken by RESUS Team on AMAT and action plans for Ward Managers are requested where necessary	1st			RADAR Group Update presented to QSIG, 13th November 2025. RADAR Group update presented to QSIG, 15th January 2026.	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~~ ~~31/12/2025~~ 31/03/2026	Progress to be provided once dashboards in place and functional for reporting to future RADAR meetings. Awaiting feedback from Performance Team.
	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								
	DNAR/CPR group chaired by Deputy Medical Director - group needs to be re-established (as of January 2026).	2nd								

2.2

2.2 - Allied Health Professional Risks Deep Dive

Angela Bell (Hywel Dda UHB - Assistant Director Quality, Safety + Patient Experience for Allied Health + Health Sciences)

Attachments

QSEC OAHP Deep Dive.pptx

Coporate Risks for OAHP_HS Deep Dive - March 2026.pdf

Operational Risk Register for AHP_HS Deep Dive - Mar 26.pdf

Risk Deep Dive: Operational Allied Health Professions and Health Science

9 April 2026

Overview

The purpose of the deep dive on risks owned by Operational Allied Health Professions and Health Sciences (OAHP&HS) Clinical Care Group (CCG) is to assure Quality, Safety and Experience Committee (QSEC) on the:

- management of risks within the CCG
- services are safe and sustainable,
- appropriate actions are in place to further manage and mitigate the risk, addressing any gaps in control and assurances.

This slide deck details the 2 corporate risks and the 2 operational risks which are scoring 25 owned by the OAHP&HS CCG, that are aligned to QSEC based on data as of 17 March 2026.

This slides provide rationale for the current risk scores, mitigating controls in place and their effectiveness to manage the risk and provides assurance that the planned actions are credible and deliverable, as well as provide assurance on the risk management arrangements in place.

Corporate Risk 797

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference and Title	Inherent Risk Score (Impact x Likelihood)	Current Risk Score (Impact x Likelihood)	Target Risk Score (Impact x Likelihood)	Expected Date to Achieve Target Risk Score
797 - Risk of adverse patient and workforce outcomes if health board wide ultrasound services are unsustainable (Radiology) **Risk Domain:** Quality / Complaints / Audit **Risk Identified:** November 2019	**5x5 = 25**	**5x5 = 25**	**5x2 = 10**	31 March 2030

Effectiveness of risk controls	The risk controls are effective, and include operational short-term actions, short to medium term workforce stabilisation solutions and a long-term training plan to establish baseline substantive workforce **Key Controls** • Cross site cover and clinical prioritisation of maternity growth scan workload by referring clinician • Insourcing Non-Obstetric Ultrasound (NOUS) funded by WG until 31.3.26, thereafter funded from budget (4.0 WTE vacancies). • NOUS workload directed to alternative pathways where in place (MSK and Vascular – AHP extended practice roles) **Gaps in control and actions** • Pathway diversification – working with maternity to identify which growth scans which can be undertaken by a midwife sonographer. Once mapping of demand and identification of maternity workforce is completed, the pathway will be re-designed. Governance capacity will need to be provided from Radiology • Ultrasound Service (USS) governance - Radiology leadership structure is not sufficient to meet governance demands within and outside of the radiology service. USS leadership role and U/S validator role are required • National shortage of locum/agency sonographers. The service is exploring ways to increase the number of sonographers they can offer agency posts to. • Training pipeline does not meet demand or workforce turnover – 3-year plan is required to baseline substantive workforce

Corporate Risk 797 - continued

Justification for the current risk score (CRS)	This risk was escalated from 20 to 25 due to increased fragility in available workforce, due to 2.0WTE retirements in Jan 2026. **Impact score** of 5 due to: • A totally unacceptable level or quality of treatment/service: Patients on maternity and cancer pathways are waiting too long for scans required for intervention • Gross failure of patient safety if findings not acted on: Concerns regarding capacity to achieve Welsh Maternity screening targets • Gross failure to meet national standards / performance requirements: Waiting times non-interventional ultrasound are up to 35 weeks and Vascular ultrasound is not available 7 days a week **Probability score** of 5 / >95% likelihood due to: The service is no longer able to sustain a baseline capacity to provide routine and urgent non obstetric imaging alongside obstetric scanning Monday to Friday, 09:00–17:00 on the WGH site (see separate risk 1349).
Effectiveness of risk action plan	Completion of risk actions will achieve TRS. Target date of 2030 is required to complete the workforce the training pipeline Maternity have indicated capacity within Midwifery workforce to complete growth scans, which will support pathway diversification. SBAR in final stages - funding is available via annual plan allocation for 26/27. Workforce – an opportunity to utilise Australian and New Zealand Sonography workforce is being explored (with additional governance and checks to assure quality without registration). Success would enable appointment to locum positions to support the service capacity and allow substantive workforce to increase their training capacity. This would be funded form 26/27 Annual Plan allocation if approval is gained. Radiology management restructuring as part of stabilisation plan. The OCP is planned for formally commence in April 26, additional governance capacity recruitment on schedule for Q2, 26-27.
Risk assurances	This risk is being monitored and escalated via service risk review meetings and CCG Integrated Governance Meetings.

Corporate Risk 1552

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference and Title	Inherent Risk Score (Impact x Likelihood)	Current Risk Score (Impact x Likelihood)	Target Risk Score (Impact x Likelihood)	Expected Date to Achieve Target Risk Score
1552 - Risk of insufficient mortuary capacity due to current and anticipated future demand (Pathology) **Risk Domain:** Safety – Patient, Staff or Public **Risk Identified:** December 2022	**5x4 = 20**	**5x4 = 20**	**4x2 = 8**	31 August 2026

Effectiveness of risk controls	Pressure on mortuary capacity driven by a combination of operational monitoring, contingency arrangements and additional storage solutions. Business continuity plans are in place and include: • renting temporary storage during peak demand. • redistributing deceased individuals across sites. • using contracted funeral directors for overflow capacity. Additional refrigeration units and bariatric equipment provide further flexibility, and ongoing engagement with Mortality Group members, medical colleagues, the Medical Examiner Service, and external stakeholders ensures continuous communication and oversight.
Justification for the current risk score (CRS)	The current risk score of 20 is due to demand regularly exceeding permanent storage and requiring reliance on temporary units, contingency arrangements and cross-site redistribution. While existing controls help manage immediate pressures, they do not prevent recurrence, and the consequences of insufficient capacity within Health Board remain severe, including risks to regulatory compliance, staff safety, dignity of the deceased, and service resilience. **Impact score** of 5 due to: • Potential failure to meet national standards (HTA) • Reputational damage, including potential national media coverage if insufficient storage **Probability score** of 4 / 75-95% likelihood due to: • regularly exceeding permanent storage and requiring reliance on temporary units

Corporate Risk 1552

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference and Title	Inherent Risk Score (Impact x Likelihood)	Current Risk Score (Impact x Likelihood)	Target Risk Score (Impact x Likelihood)	Expected Date to Achieve Target Risk Score
1552 - Risk of insufficient mortuary capacity due to current and anticipated future demand (Pathology) **Risk Domain:** Safety – Patient, Staff or Public **Risk Identified:** December 2022	**5x4 = 20**	**5x4 = 20**	**4x2 = 8**	31 August 2026

Effectiveness of risk action plan	The risk action plan includes minor works at both Prince Philip Hospital H and Bronglais Hospital BGH to increase fridge and freezer capacity, which is expected to slightly reduce the likelihood score once completed in March 2026. A longer-term business case is also being developed locally and regionally to fully address and mitigate the risk.
Risk assurances	Risk is monitored in the Human Tissue Authority (HTA) assurance group and QSIG, Service risk review meetings and CCG Integrated Governance Meetings

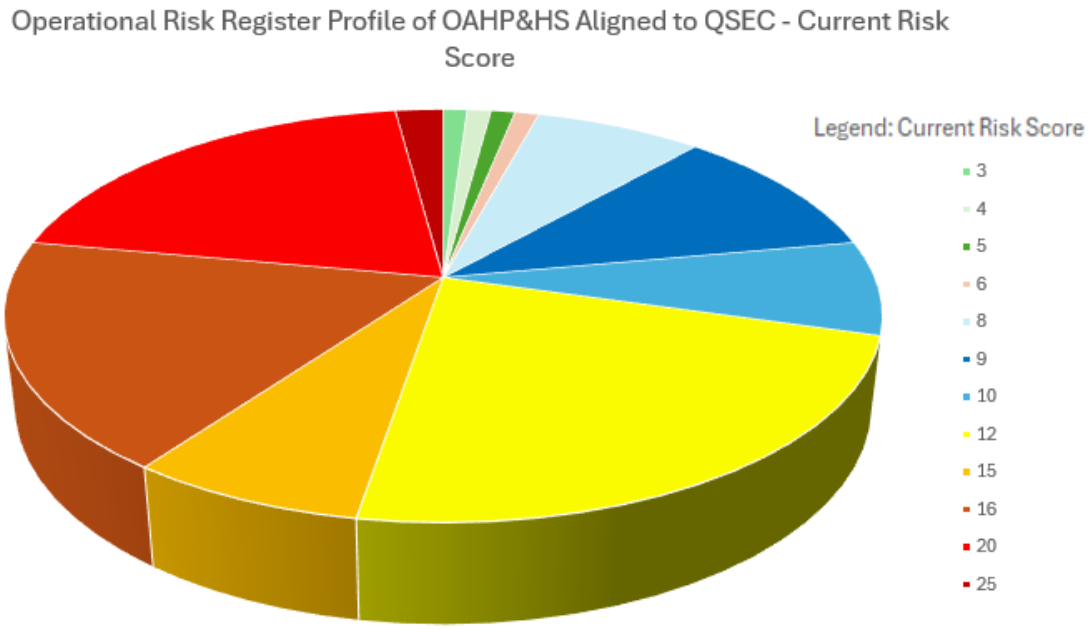
Overview of Extreme Operational Risks (i.e Current Risk Score (CRS) 15 and above)

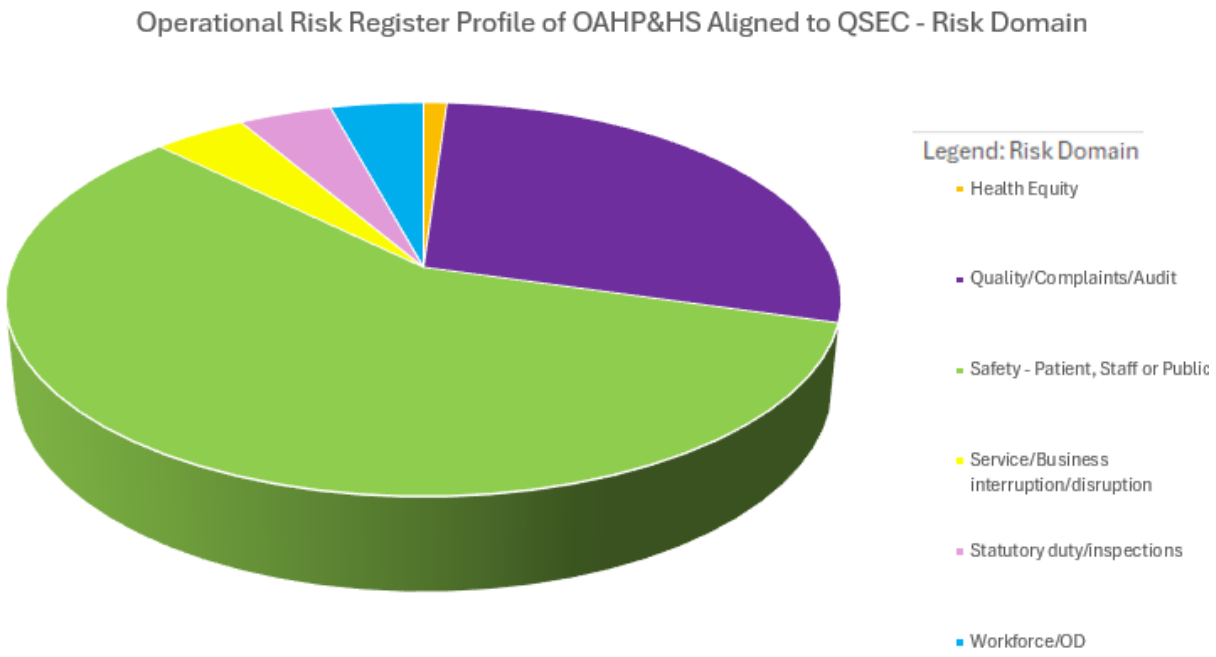
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Of the 618 operational risks on Datix (as of 17 March 2026) 18.7% (n=116) are aligned to the OAHP&HS CCG.
Of these:

- 50.8% (n=59) are scored as “extreme” (i.e with a CRS of 15 or more), 48 are aligned to QSEC
- 62 are aligned to the risk domain of “Safety – Patient, Staff or Public” (28 of which are Extreme scoring)
- 5 have CRS which exceed the TRS and have surpassed their expected date to achieve the target risk score, all of which are aligned to QSEC.

The following slides provide detail on the 2 operational risks aligned to QSEC which have a Current Risk Score of 25.





Operational Risk 1349

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference and Title	Inherent Risk Score (Impact x Likelihood)	Current Risk Score (Impact x Likelihood)	Target Risk Score (Impact x Likelihood)	Expected Date to Achieve Target Risk Score
1349 - Risk of being unable to deliver ultrasound services at WGH due to a lack of appropriately trained obstetric staff (Radiology) **Risk Domain:** Safety – Patient, Staff or Public **Risk Identified:** March 2022	**5x5=25**	**5x5=25**	**5x2=10**	31 March 2030

Effectiveness of risk controls	The key controls and steps to address the gaps are those described in risk 797 (slide 3) . They include operational short-term actions, short to medium term workforce stabilisation solutions and a long-term training plan to establish baseline substantive workforce The insourcing is targeted to obstetric workload at WGH, as this is the most fragile site, alongside the flexing of workforce from other sites when peak staff shortages are experienced at WGH
Justification for the current risk score (CRS)	Justification is described in corporate risk 797 (slide 3 and 4)
Effectiveness of risk action plan	Credible medium- and long-term action plan is described in corporate risk 797 (slide 3 and 4)
Risk assurances	This risk is being monitored and escalated via service risk review meetings and CCG Integrated Governance Meetings.

Operational Risk 834

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference and Title	Inherent Risk Score (Impact x Likelihood)	Current Risk Score (Impact x Likelihood)	Target Risk Score (Impact x Likelihood)	Expected Date to Achieve Target Risk Score
834 - Risk of clinical deterioration due to reduced service resilience within the Clinical Haematology sub-specialty (Pathology) **Risk Domain:** Workforce / OD **Risk Identified:** March 2022	**5x5 = 25**	**5x5 = 25**	**4x1 = 4**	31 December 2028

Effectiveness of risk controls	Current controls provide short-term mitigation but do not yet deliver sustainable service resilience. Full-time above-price-cap agency locum cover maintains Clinical Haematology services at GGH and WGH, with a bank consultant supporting PPH to stabilise rotas and protect patient safety. Clinical Nurse Specialists (CNS) support the caseload within their scope of competence, helping to maintain pathways and reduce pressure on medical staff. Workforce redesign, including recruitment of 3 WTE CNS posts to replace a retired associate specialist, represents progress toward a more resilient multidisciplinary model.
Justification for the current risk score (CRS)	These controls are heavily reliant on temporary workforce solutions, are financially unsustainable, and remain vulnerable to workforce change. CNS capacity is at maximum, there is an agreed exit plan to reduce agency reliance (4 WTE as of March 2026), however this will take time to come into fruition. The retirement of a consultant at BGH in April 2026 without middle-grade support represents a significant gap. As a result, the controls have not yet reduced the likelihood or impact of the risk, and the CRS remains unchanged. **Impact score** of 5 due to: ongoing unsafe staffing levels – reliance on 4WTE agency to maintain safe service **Probability score** of 5 / >95% likelihood due to: Loss of Consultant at BGH will increase the likelihood above 95%.
Effectiveness of risk action plan	The action plan is phased and credible, focusing initially on stabilising medical cover by reducing high-cost agency reliance, strengthening rotas and progressing Specialist Doctors and international recruits. Medium- and long-term actions reinvest funding to expand multidisciplinary capacity, deliver consultant succession planning and restrict agency use to exceptional circumstances. Full delivery will stabilise staffing, reduce impact to 1 and likelihood to 4, achieving the target risk score of 4 within risk appetite.
Risk assurances	This risk is being monitored and escalated via service risk review meetings and CCG Integrated Governance Meetings.

Recommendation

The Committee are asked to take assurance:

- that the management of risks within the CCG are safe and sustainable,
- appropriate actions are in place to further manage and mitigate the risk, addressing any gaps in control and assurances.

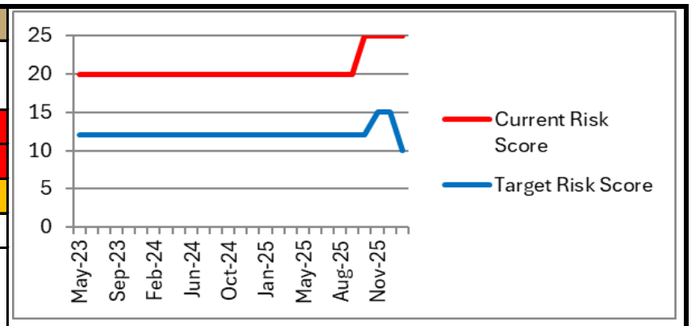
Date Risk Identified:	Nov-19
Strategic Objective:	1. Thriving Teams and 2. Healthier Communities and 3. Great Care and 4. Positive Futures

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Mar-26
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Apr-26

Risk ID:	**797**	**Corporate Risk Description:**	There is a risk that health board wide ultrasound services are unsustainable. This is caused by - Demand increase across NOUS and Maternity Ultrasound pathways requires 34 148 additional scanning hours. - Workforce establishment does not match demand. - Workforce vacancies long standing (national shortage, training pipeline 3 years with large supervision requirement). - Unable to move staff between sites to cover as all sites unable to meet minimum standards required. - Occupational Health impact from workloads reducing workforce available (RSI). This could lead to an impact/affect on - Patient outcomes = delays to scans resulting in delays to treatment or death (cancer and maternity pathways) - Workforce outcomes = staff harm from RSI resulting in long term injury from too much scanning of similar types (unable to job plan appropriately due to demand and vacancies). Quality, complaints and audit - (5) Totally unacceptable level or quality of treatment/service. Gross failure of patient safety if findings not acted on. Inquest/ombudsman inquiry. Gross failure to meet national standards / performance requirements. Safety of patients - (4) Major injury leading to long-term incapacity/disability. Requiring time off work for >14 days. Increase in length of hospital stay by >15 days. Mismanagement of patient care with long-term effects. Finance including Claims - (5) Claim(s) >£1 million. Probability = >95%

Does this risk link to any Directorate (operational) risks?	1349 (WGH), 1658 (RSI), 1936 (maternity)

Risk Rating:(Likelihood x Impact)	
Domain:	Quality/Complaints/Audit
Inherent Risk Score (L x I):	5×5=25
Current Risk Score (L x I):	5×5=25
Target Risk Score (L x I):	2×5=10
Expected Date To Achieve TRS:	3/31/2030



Trend: ⟷

Rationale for CURRENT Risk Score:
This risk was escalated from 20 to 25 due to increased fragility in available workforce, due to 2.0WTE retirements in Jan 2026. Impact score of 5 due to: A totally unacceptable level or quality of treatment/service: Patients on maternity and cancer pathways are waiting too long for scans required for intervention Gross failure of patient safety if findings not acted on. Concerns regarding noncompliance with Welsh Maternity screening targets Gross failure to meet national standards / performance requirements. Waiting times non-interventional ultrasound are up to 35 weeks Vascular ultrasound is not available 7 days a week Probability score of 5 / >95% likelihood The service is no longer able to sustain a safe baseline capacity to provide routine and urgent non obstetric imaging alongside obstetric scanning Monday to Friday, 09:00-17:00 on the WGH site (see separate risk 1349).

Rationale for TARGET Risk Score:
Impact of service failure remains the probability of service failure is the aim of mitigating actions. Probability target of 5-25% (2) In Jan 2026 target date was reviewed and extended. Justification for this change is the timeline for Radiology Leadership OCP and recruitment to bring in the leadership required to mitigate the gaps in controls thus requires extended timelines due to pathways changes and training timelines. In addition Annual Planning 2026/27 priorities for AH and HS CCG include further mitigation of this risk via capacity being added of 13WTE (£710 352) therefore likelihood scoring reduces to a 2 (5-25% probability). 2030 target date This timeline is due to training timelines it will take at least three years to train a workforce if 2026/27 Annual Planning funding is provided to Radiology.

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**
Insourcing NOUS undertaking 150 scans per week - funded by WG until 31.3.26. Funding for 26/27 from budget (4.0 vacancies). Locum/Agency capacity - 1.0WTE secured. there are 2.0 agency requests unfilled. Prioritisation of maternity growth scan workload by referring clinician - urgency allocated on referral form by referring clinicians. Training pipeline (supported practice educator) - 5.0WTE in post (end of training Jan 2027), 1.0WTE Midwife sonographer (in preceptorship). MSK and Vascular pathways via AHP extended practice roles (some Physiotherapy and Podiatry pathways in place to support ultrasound workload) Demand vs capacity scanning gap is £710, 352 /13 WTE workforce - Annual Plan 26/27 approved.	Health board wide governance of ultrasound pathways Pathway workforce diversification - Training pipeline does not meet demand or workforce turnover. Training capacity (trainees available but inadequate internal capacity to train) Centralised booking - due to commence June 26 to improve cross site cover. Insourcing/outsourcing/Agency/Locum capacity	Develop and implement a plan to help alleviate pressures through increasing the number of growth scan checks undertaken by midwives.	Llewellyn, Cerian	Completed	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. Jan 26 - midwife sonographer has undertaken course and starting preceptership
		Radiology management restructuring as part of stabilisation plan. new posts needed to provide a longer term solution to issue. Not possible with current management structure and stability risk	Procter, Sarah	30/06/2026	Informal consultation received alternative proposal Dec 2025, workshop with stakeholders scheduled early Jan 2026. Informal consultation extended until Feb 2026.Changes made to OCP awaiting exec approval - hoping to start April 26
		Training pipeline - 5.0WTE Trainee sonographers scheduled to complete training.	Procter, Sarah	31/01/2027	25/11/2025 - New action.
		Training pipeline - 1.0WTE midwife sonographer completed training.	Procter, Sarah	Completed	midwife sonographer has completed the course.

Insourcing/Outsourcing - procurement conversation with current provider of ultrasound capacity relating to adding more scanning capacity for obstetric ultrasound capacity (2000 scans) on top of current contract	Procter, Sarah	Completed	25/11/2025 - new action 29/12/2025 - Chasing of provider who is reporting capacity to meet this demand but is not able to complete the scanning when we have handed over this scanning work. Now a meeting is required to push for this capacity to be released or statement that provider is unable to source the capacity so other options can be sourced.
Agency capacity - throughout 2025/26 2.0WTE out for advert with agency (AG1 (HR form for agency approval) valid until 2027)	Procter, Sarah	31/01/2027	25/11/2025 - AG1 approved for 2.0WTE until Jan 2027, out with Agencies during 2025/26. No interest this year as yet.
Insourcing/Outsourcing - Provider has confirmed capacity but has not been able to pick up scans when allocated. Therefore contract meeting with Deputy HoS (SP) and Director of Performance and Planning (KJ) scheduled (14.01.2026) to understand barrier to release in capacity,	Procter, Sarah	Completed	meeting undertaken - further capacity unlocked
Pathway workforce diversification - Maternity have indicated capacity within Midwifery workforce to complete growth scans. Analysis underway to identify % of scanning and therefore % WTE transfer.	Procter, Sarah	~~28/02/2026~~ 31/04/2026	26/2/26 - SBAR shared with Director of midwifery - awaiting answer. 16/02/2026- meetings with Maternity continue. Paper shared with Director of Midwifery to outline governance around 1.26WTE Sonography capacity moving to Midwifery. Changes made to SBAR and validation by director of delivery's team.
Demand vs Capacity - Submit as a priority for 2026/27 Annual Planning (£710 352 / 13 WTE) additional funding required to meet demand	Quarrie, Sara	Completed	This demand and capacity gap funding was submitted as a priority by the AH and HS CCG in the Annual Planning 2026/27 workshop on the 21.11.2025.
Demand vs Capacity - Clinical validation support from NHS Performance & Improvement (intended outcome is to reduce inappropriate referrals to u/s modality and redirect to alternative and more appropriate modalities).	Procter, Sarah	Completed	Approval given to seek support meeting scheduled SP and NHS Performance and Improvement 16.01.2026 to agree implementation. validation Work started 19.1.26

Demand and Capacity - Skill mix vacancies in u/s to create 1.0WTE 8A - Job description to be sent to job matching	Procter, Sarah	~~28/02/2026~~ 28/03/2026	Action agreed in Dec 2025. delay due to workload - JD in process
Midwife sonographer undertaking preceptorship to be able to work independently - radiology supporting	Procter, Sarah	29/01/2027	new action

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
8 week USC Ante-natal screening Wales	Waiting list monitoring - Live dashboard review by Radiology Leadership (daily) and monthly formal submission of performance * week data to Welsh government (see iPAR).	2nd			IQFPDG 26/11/2025 - SBAR - Ultrasound Fragility - Corporate risk 797					
	Performance monitored at Executive Improving Together Sessions	2nd								

Date Risk Identified:	Feb-22
Strategic Objective:	3. Great Care

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Mar-26
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Apr-26

Risk ID:	**1552**	**Corporate Risk Description:**

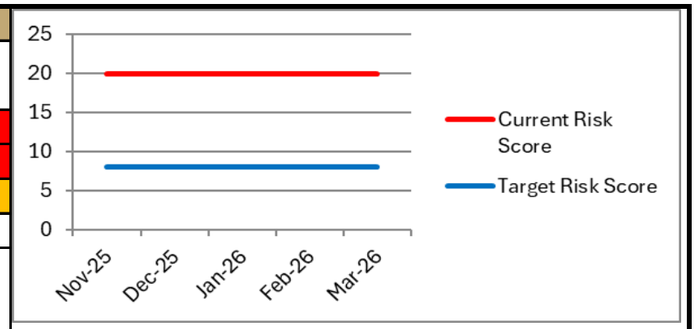
There is a risk of insufficient mortuary capacity (Fridge & Freezer capacity) Health Board wide to meet the current and future growing demand and provide adequate and appropriate sized storage for ward and community deaths.

This is caused by the severe lack of storage capacity across all mortuaries within the Health Board, compounded by the fact that some of the refrigeration spaces are not big enough to accommodate the increasingly larger bodies that are being admitted into our mortuary facilities, and the inability for staff to safely access refrigeration spaces at WGH and BGH. In addition, the increase in economic, social, demographic, regulatory and legislative (Medical Examiner Service - MES) pressures have significantly increased both the quantity of deceased and length of stay within our Mortuary body storage facilities.

This could lead to an impact/affect on the dignity, and condition of deceased patients within our care due to the inability to adequately store these patients in a suitable environment. There is also the potential impact of non-compliance with legislative requirements, including Human Tissue Authority, along with reputational damage to the Health Board. There could also lead to emotional distress to the families and friends of the deceased.

Does this risk link to any Directorate (operational) risks?	283, 1554

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):	4×5=20
Target Risk Score (L x I):	2×4=8
Expected Date To Achieve TRS:	8/31/2026
Trend:	⟷



Rationale for CURRENT Risk Score:
The Health Board is exposed to significant risks resulting from insufficient mortuary capacity across its estate.The ongoing dependence on temporary body storage, particularly during periods of excess deaths, presents challenges in maintaining regulatory compliance, protecting staff wellbeing, ensuring safe manual handling practices,and upholding the dignity of the deceased.The current infrastructure risks non-compliance with HTA standards. According to ONS projections,the death rate is expected to rise, peaking in 2044, further intensifying these pressures. Suboptimal facilities may lead to compromised presentation of the deceased, increased emotional distress for families, and safety concerns for mortuary staff,especially manual handling.While control measures are in place, they are not sufficient to manage the current volume of deaths within the mortuary service,particularly during periods of heightened demand.These control measures should serve only as temporary contingencies, in line with the HTA licence however,there is a growing need for enhanced storage capacity throughout the year,not solely during seasonal peaks. Current body storage provisions do not meet operational requirements, and there is limited flexibility to respond to unplanned disruptions, such as those involving MES, HMC, or PM Service interruptions. Furthermore, the extremely constrained footprint of the mortuary estate significantly restricts opportunities for external expansion or

Rationale for TARGET Risk Score:
Target score is based on successful outcome from Body Storage Capacity paper being escalated via CCG (03.06.25) to IQFPD (11.06.25). Funding stream discussed with Executive Director of Finance on (21.07.25) along with further meetings and support from the Health Board's finance and planning team to ensure a long-term sustainable solution is implemented as soon as reasonably possible. Assurance has been provided by the Executive Director of Finance that financial support will be received in order to enact the short term measures to ensure appropriate capacity is available for the approaching winter pressure period. Further discussions will be held with finance and planning colleagues to discuss medium and long term mitigating plans. Long term solution need to be sustainable and future proof to ensure the target risk score is achieved and maintained. TRS and expected date to achieve agreed by Formal Executive Team in November 2025.

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**
1. At times of peak pressure, temporary body storage units are rented 2. Monitoring of numbers of deceased against storage capacity (Health Board wide) 3. Business continuity plans in place (Health Board wide) 4. Contracts with local funeral directors to utilise contingency storage of deceased (Health Board wide) 5. Deceased are relocated to other mortuary sites when needed (Health Board wide) 6. Bariatric blanket available for short-term use across all Health Board sites 7. Additional body refrigeration (Boxcold solution) has been installed into the old PM (Post Mortem) room at WGH site. 8. Participation, engagement and communication with the Health Board's Mortality Group, medical colleagues, Medical Examiner Service and external stakeholders	1. Despite owning 1x 15 BSS unit, we have insufficient storage provision for the upcoming winter pressure period 2. Insufficient suitable space and/or estate within mortuary facilities to increase body storage capacity. 3. Any delay in the death certification process (internal & external stakeholders) significantly impacts on the management of mortuary body storage. As these processes are outside of mortuary control, we frequently invoke contingency plans to accommodate the deceased. Death certification process be noted as a control measure, with the gap being the delays in these processes as a result of sources beyond the Health Board's control (MES, HMC, PM service disruption etc)?	Requirement of additional body storage capacity health board wide. Capital funding needs to be secured.	Baker, Craig	~~31/03/2025~~ 31/03/2026	To be escalated via CCG structure Escalated at IQFPDG June 2025 - meeting to be scheduled with HT re short term capacity and LD for medium/long term capacity for analysis. Body storage capacity paper being submitted via CCG structure. Financial approval from Finance executive to increase temporary storage over winter period (2025 - 2026), this includes funding to cover adding of additional capacity at PPH. In addition, currently reviewing BGH footprint to look at increase of freezer capacity to cover HB. 29/12/25 - Capital funding secured to increase freezer capacity at BGH.

4 & 5. Due to the national shortage of body storage capacity, death certification processes and current death rates, contingency plans utilising mutual aid are ineffective as all Health Boards are experiencing the same level of body storage capacity pressures and are therefore unable to assist. 6. During the recent Tier 1 National Mass Fatality Pandemic Exercise it was identified that nationally and locally we have insufficient levels of body storage capacity to handle a mass fatality or a period of excess death. Risk areas were identified by the Hywel Dda team that participated in the exercise and these along with suggestions for improvements were feedback to the Local Resilience Forum (LRF) who will escalate this feedback to Welsh Government.	Explore options regarding temporary body storage rental and purchase of body storage capacity.	Brown , Yasmin	Completed	Ongoing Discretionary Capital bid to purchase a 15BSS Nutwell storage unit. 20.08.25 - Currently in discussions with suppliers regarding rental costs. 19.11.25 - The service has been successful in procuring a 15 BSS storage unit via a spend to save scheme. This unit will be delivered towards the end of November/start of December 2025. 19.11.25 - The service has also rented 2x additional 15 BSS nutwell units as contingency storage space as part of our winter preparedness plans and in readiness for the winter increase in death rates.
	Work with estates teams across the Health Board to undertake the minor and major works that are required to allow for the installation of the box cold body storage solutions.	Brown , Yasmin	~~30/12/2025~~ 30/04/2026	Contact has been made with estates managers in WGH, PPH, and GGH. Quotations for minor building works to be undertaken within the PPH and BGH mortuary facilities and are being progressed 19.11.25 - Building works commissioned for PPH with the works scheduled to be completed at the beginning of December 2025 to allow for for the erection of the additional additional body storage capacity (boxcold). 05.01.26 - Building works commissioned for BGH with the works scheduled to be completed March 2026 to allow for for the erection of the additional additional body storage freezer capacity.

Seek external advice on enhancement of mortuary storage capacity within current mortuary estate footprint.	Brown , Yasmin	Completed	Initial site visit has taken place with Wessex refrigeration to determine the art of the possible within the existing GGH mortuary facility footprint. Awaiting receipt of possible plans and quotations. 19.11.25 - Quotations have been received from Wessex refrigeration and engagement is ongoing with estates teams to work these up further.
Develop a business case and explore options in order to secure capital funding to ensure capacity meets both current and future body storage demands.	Baker, Craig	30/11/2026	Initial discussions held with Director of Finance and Director of Strategy and Planning regarding potential options to explore. Some of these options include - Building new estate and facilites - Commissioning body storage from private providers e.g. funeral directors - Working in collaboration with other Health Boards and Local Authority to develop combined regional solutions

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
	Pathology Strategy Group.	1st			Presentation to IQFPD - June 2025.					
	Hywel Dda HTA Assurance Group.	1st								
	Regional HTA Assurance Group.	2nd								
	Quality & Safety Intelligence Group	2nd								
	AHP & HS CCG reporting up to IQFPD	2nd								
	IQPD	3rd								

Risk Ref	Clinical Care Group / Executive Function	Clinical Service Group / Executive Function Service	Clinical Service Sub-Group / Executive Function Service	Executive Director	Clinical Care Group Director / Executive Function Lead	Clinical Service Group Lead / Executive Function Service Lead	Clinical Service Sub-Group Lead / Executive Function Service Lead	Date risk Identified	Risk Statement	Existing Control Measures Currently in Place	Domain	Current Likelihood	Current Impact	Current Risk Score	Rationale for Current Risk Score	Additional Risk Action Required	By Whom	By When	Progress Update on Risk Actions	Lead Committee	Target Likelihood	Target Impact	Target Risk Score	Rationale for Target Risk Score	Detailed Risk Decision	Review date
834	Operational Allied Health Professions & Health Sciences	AHP&HS: Pathology	AHP&HS: Clinical Haematology	Carruthers, Andrew	Quarrie, Sara	Jones*, Dylan	Beard, Nick	6-Feb-20	There is a risk of severe workforce fragility in clinical haematology This is caused by vacancies within the small Consultant Haematologist teams covering all sites and reliance on expensive high cost agency locums. Reliance on staff who have retired and returned to cover BGH. Consultants working single handed and finding it difficult to take annual and study leave. This will lead to an impact/affect on ability to achieve safe staffing levels across whole health board. This will lead to patients having poorer outcomes from the delays in commencement of treatment, reliance on locums, increased complaints and claims and increased scrutiny from Welsh Government. Also the impact on the health and wellbeing of the remaining staff. Risk location, Bronglais General Hospital, Glangwili General Hospital, Prince Philip Hospital, Withybush General Hospital.	02/03/26 - Full time above price cap agency locum supporting GGH and WGH service. Bank consultant supporting PPH. Clinical Nurse Specialists in Haematology support the caseload within their scope of competency. Workforce redesign recruitment of 3 WTE CNS to replace retired associate specialist Dr.	Workforce/OD	5	5	25	02/03/26 - Reviewed risk and changed domain from patient safety to workforce as it aligns with risk. The likelihood remains at 5 as there are a number of vacant posts across In Hywel Dda and across Wales within this specialty. Difficulty in recruitment of Consultant Grade staff. Currently there are 5.5 WTE vacancies out of an establishment 7.5. These are being covered by temporary workforce solutions (Agency and Fixed term staffing) Changed impact from 4 to 5 as workforce gaps will result in non delivery of service at BGH as a result of retirement of consultant and lack of middle grade in medical rota.	Recruit to the 1.0 WTE vacant post based at GGH	Jones*, Dylan	Completed	Locum currently in place for 6 months and one has been recruited (awaiting visa and relevant training).	Quality, Safety and Experience Committee	4	1	4	The plan prioritises quickly replacing highâ€'cost agency locums with an NHS locum, formalising three Specialist Doctors, strengthening the onâ€'call rota, and accelerating development for international recruits. Mediumâ€'term actions include using the Â£270k drug underspend to fund CNS, pharmacist and admin posts, creating subspecialty teams, and establishing a consistent crossâ€'site nursing model. Longâ€'term goals focus on Consultant succession planning, developing Specialist Doctors into future Consultants, expanding international recruitment, and reducing agency use to exceptional circumstances only. Once long term plan achieved the target risk will reach 4. Staffing levels to stabilise once exit plan to reduce agency is realised that would result in an impact score of 1. The likelihood will reduce to 4 as there will be occasions when there are gaps in substantive workforce (score of 4).	Treat	2-Mar-26
																Secure charitable fund resource to purchase MGUS DAWN software package to enable CNS staff to manage / monitor MGUS patients, which will help support the Consultant caseload.	Stiens, Andrea	Completed	There is a significant amount of Charitable Funds within the Haematology fund to support the purchase but not the on going revenue element. 09/02/2022 - Approval received in 2020 for Charitable funds, however waiting on further costings on IT support requirements. Potential delay with the project in obtaining an interface as HDdUHB is the only HB in Wales requiring this. Action to be closed, with new action to be raised for a potential new project.							
																Complete SBAR to identify the benefits of a revenue investment in relation to procurement of MGUS DAWN software.	Stiens, Andrea	Completed	Total revenue required for the project is being collated. Presented to Charitable Funds Committee, action closed.							
																Review service provision post Covid to identify if any service changes introduced during the pandemic can be continued e.g. virtual/telephone consultations/ clinics.	Stiens, Andrea	Completed	Discussed in haematology management Meeting, and escalated to relevant management.							
																Application to Charitable funds to seek support for Clinical Haematology nurse specialist post at BGH as succession planning for existing staff member, following withdrawal of Macmillan funding.	Stiens, Andrea	Completed	Application submitted							
																Creating haemotology software package so the CNS can manage patients more efficiently	Jones*, Dylan	Completed	As at September 2022, Signatory Fund transferred to Dylan Jones, with work ongoing.							

Risk Ref	Clinical Care Group / Executive Function	Clinical Service Group / Executive Function Service	Clinical Service Sub-Group / Executive Function Service	Executive Director	Clinical Care Group Director / Executive Function Lead	Clinical Service Group Lead / Executive Function Service Lead	Clinical Service Sub-Group Lead / Executive Function Service Lead	Date risk Identified	Risk Statement	Existing Control Measures Currently in Place	Domain	Current Likelihood	Current Impact	Current Risk Score	Rationale for Current Risk Score	Additional Risk Action Required	By Whom	By When	Progress Update on Risk Actions	Lead Committee	Target Likelihood	Target Impact	Target Risk Score	Rationale for Target Risk Score	Detailed Risk Decision	Review date
																Service review to be undertaken, with support from the Transformation Team	Jones*, Dylan	**Completed**	Short term review has been undertaken and have recruited into current vacancies. Next steps to look at long term service provision to make the service more sustainable in the future.							
																SBAR to be prepared on succession planning.	Jones*, Dylan	**Completed**	Now complete. To bring to next escalation meeting.							
																Recruit into clinical haematology SDM role to support service development/resilience.	Jones*, Dylan	~~30/09/2024~~ ~~31/03/2025~~ ~~31/08/2025~~ ~~30/09/2025~~ 31/05/2026	Position has been rejected in the Financial Control Group. An SDM JD has been created for Haem Onc. The plan is for this service to be reassigned to another CCG. Meeting with Peter SKitt is planned to discuss potentially moving to C&IM.							
																Recruit into vacant Consultants posts (2x Consultant, WGH and GGH)	Jones*, Dylan	~~31/12/2024~~ ~~31/03/2025~~ ~~31/08/2025~~ ~~31/10/2025~~ ~~31/01/2026~~ 31/07/2026	All Wales international recruitment took place in November 2024. Currently unable to recruit into substantive posts. International haematologists have joined HB however these are not consultants, therefore we still need to recruit (adverts unsuccessful to date). Revised date extended to account for new round of recruitment.							
																Recruit Clinical Lead for Clinical Haematology.	Jones*, Dylan	~~30/09/2025~~ 31/03/2026	Revised JD in draft (currently in engagement phase)							
																Create SBAR reviewing which directorate Clinical Haematology should sit in the future. Changes to organisation structure and Regional Pathology will drive this discussion	Jones*, Dylan	**Completed**	SBAR completed. Agreement now being sought.							

Operational Risk Register

Date: March 2026

Risk Ref	Clinical Care Group / Executive Function	Clinical Service Group / Executive Function Service	Clinical Service Sub-Group / Executive Function Service	Executive Director	Clinical Care Group Director / Executive Function Lead	Clinical Service Group Lead / Executive Function Service Lead	Clinical Service Sub-Group Lead / Executive Function Service Lead	Date risk Identified	Risk Statement	Existing Control Measures Currently in Place	Domain	Current Likelihood	Current Impact	Current Risk Score	Rationale for Current Risk Score	Additional Risk Action Required	By Whom	By When	Progress Update on Risk Actions	Lead Committee	Target Likelihood	Target Impact	Target Risk Score	Rationale for Target Risk Score	Detailed Risk Decision	Review date
																Escalate SBAR reflecting the change in BGH service as a result of consultant retirement at BGH.	Beard, Nick	31/07/2026	New action							
																Create SBAR for escalation to convert drugs underspend from non pay budget into establishment in the Pay budget to help stabilise workforce.	Jones*, Dylan	31/03/2026	New action							

Risk Ref	Clinical Care Group / Executive Function	Clinical Service Group / Executive Function Service	Clinical Service Sub-Group / Executive Function Service	Executive Director	Clinical Care Group Director / Executive Function Lead	Clinical Service Group Lead / Executive Function Service Lead	Clinical Service Sub-Group Lead / Executive Function Service Lead	Date risk Identified	Risk Statement	Existing Control Measures Currently in Place	Domain	Current Likelihood	Current Impact	Current Risk Score	Rationale for Current Risk Score	Additional Risk Action Required	By Whom	By When	Progress Update on Risk Actions	Lead Committee	Target Likelihood	Target Impact	Target Risk Score	Rationale for Target Risk Score	Detailed Risk Decision	Review date
1349	Operational Allied Health Professions & Health Sciences	AHP&HS: Radiology	AHP&HS: Radiology	Carruthers, Andrew	Quarrie, Sara	Roberts-Davies, Gail	Roberts-Davies, Gail	28-Feb-22	There is a risk of of failing to deliver the ultrasound service at WGH. This is caused by a lack of appropriately trained obstetric staff due to: Retirements and long term sickness. National shortage of sonographers. Increased obstetric demand for growth scans Lack of agency/locum sonographers. Difficulty in training due to low levels of trained staff and the length of the sonography course (2 years) This will lead to an impact/affect on increasing routine ultrasound waiting lists. adverse peri-natal outcomes. failure to provide obstetric scans within the time required. non-adherence to RCOG and NICE guidelines. increased risk of staff developing Repetitive Strain Injury (RSI) failure to provide same-day diagnostics. Risk location, Withybush General Hospital.	Continual recruitment campaigns and improved adverts. Ability to request assistance from other sites when peak staff shortages experienced at WGH Outpatient referrals are being sent to other sites where possible. Continued ultrasound insourcing to reduce NOUS waits in line with funding Insourcing to cover vacancy particularly targeted with obstetric workload at WGH which is fragile. Insourcing on non obstetric to release substantive to train and undertake obstetric workload. Demand vs capacity scanning gap is £710, 352 /13 WTE workforce - Annual Plan 26/27 approved. Prioritisation of maternity growth scan workload by referring clinician - urgency allocated on referral form by referring clinicians.	Quality/Complaints/Audit	5	5	25	This risk was escalated from 20 to 25 due to increased fragility in available workforce, due to 2.0WTE retirements in Jan 2026. Impact score of 5 due to: A totally unacceptable level or quality of treatment/service: Patients on maternity and cancer pathways are waiting too long for scans required for intervention Gross failure of patient safety if findings not acted on. Concerns regarding noncompliance with Welsh Maternity screening targets Gross failure to meet national standards / performance requirements. Waiting times non-interventional ultrasound are up to 35 weeks Vascular ultrasound is not available 7 days a week Probability score of 5 / >95% likelihood The service is no longer able to sustain a safe baseline capacity to provide routine and urgent non obstetric imaging alongside obstetric scanning Monday to Friday, 09:00â€“17:00.	Convert existing sonographer vacancy to backfill the release of radiographer to train in ultrasound from Jan23	Lingwood, Gill	**Completed**	Post is at vacancy approval stage on Trac. However it takes a year to complete sonography training.	Quality, Safety and Experience Committee	2	5	10	Once the training plan, the pathway diversification and additional leadership are appointed and imbedded into service. The timeline reflects the lead time to achieve a reduction of likelihood from 5 to 2	Treat	16-Mar-26
																An update paper to written for OPDP to inform of the plan to sustain services in the short to medium term.	Roberts-Davies, Gail	**Completed**	Updates to OPDP are ongoing. Initial update paper presented to OPDP on 11th May 2022. Verbal update to be given at OPDP on 25th May and ongoing. Discussion with Head of Radiology confirmed that the initial action has been completed, and ongoing discussions now a control for the risk as it's an ongoing process.							
																Developing a mini competition document to test the market for insourcing ultrasound company for at least 12 months	Roberts-Davies, Gail	**Completed**	The mini-competition doc was approved and advertised. The closing date for submissions was 12:00 on 25/05/2022. Unfortunately no companies on the Welsh framework responded. One company on the Crown framework has been engaged via a direct award. A rolling three month programme for insourcing has been approved as at July 2022 and commenced Aug 2022. This is progressing well and early indications are promising. As document has been developed- action closed and added to controls for the risk.							
																Seek support to undertake a demand and capacity (D&C) review and detailed establishment review of the radiology service.	Roberts-Davies, Gail	**Completed**	New action							

Risk Ref	Clinical Care Group / Executive Function	Clinical Service Group / Executive Function Service	Clinical Service Sub-Group / Executive Function Service	Executive Director	Clinical Care Group Director / Executive Function Lead	Clinical Service Group Lead / Executive Function Service Lead	Clinical Service Sub-Group Lead / Executive Function Service Lead	Date risk Identified	Risk Statement	Existing Control Measures Currently in Place	Domain	Current Likelihood	Current Impact	Current Risk Score	Rationale for Current Risk Score	Additional Risk Action Required	By Whom	By When	Progress Update on Risk Actions	Lead Committee	Target Likelihood	Target Impact	Target Risk Score	Rationale for Target Risk Score	Detailed Risk Decision	Review date
																Approach PHW about the possibility of the Health Board failing to provide an obstetric screening service	Lingwood, Gill	Completed	Discussions with obstetrics service have taken place to agree that they will have this discussion with PHW.							
																Explore the possibility of sending obstetric patients to other sites.	Lingwood, Gill	Completed	Radiology Staffing Task and Finish Group met on 31/03/22 and it was established that it is not currently practical to send obstetric patients to other sites. In addition to the Site Lead Superintendent Radiographer, sonographers from other sites providing cover, a locum for 2 months has been granted, however the service is still fragile due to sickness and annual leave. Update- Locum will end her contact with us on 31/05/22 due to uncertainty of continued employment as she has to take a six month break due to previously being an employee within the HB. This locum will therefore take her 6 month break from this point which has placed additional pressures on the service							
																Train Radiographers & midwives to be able to scan obstetrics	Roberts-Davies, Gail	Completed	7.11.24 advert for 2x annex 21 posts live							
																Create Annexe 21 job description and advertise vacancies as training posts. 25.9.24 - Annex 21 JD not required. Explore funding options via HEIW or WGH budget. Assessment to be submitted to annex 21 team. Trac advert to be developed.	Whitecross, Faith	Completed	New action - interviews to take place 21.11.24. Successful candidate to enrol on US course in UWE by 9.12.24 for January 2025 start							

Risk Ref	Clinical Care Group / Executive Function	Clinical Service Group / Executive Function Service	Clinical Service Sub-Group / Executive Function Service	Executive Director	Clinical Care Group Director / Executive Function Lead	Clinical Service Group Lead / Executive Function Service Lead	Clinical Service Sub-Group Lead / Executive Function Service Lead	Date risk Identified	Risk Statement	Existing Control Measures Currently in Place	Domain	Current Likelihood	Current Impact	Current Risk Score	Rationale for Current Risk Score	Additional Risk Action Required	By Whom	By When	Progress Update on Risk Actions	Lead Committee	Target Likelihood	Target Impact	Target Risk Score	Rationale for Target Risk Score	Detailed Risk Decision	Review date
																Update required on current WTE and impact on current service due impending reduction in hours from current substantive and regular bank staff.	Whitecross, Faith	Completed	New action com-pleted							
																Include ultrasound staffing requirement in 2025-2026 Radiology Annual Plan, based upon capacity and demand work which has been completed.	Roberts-Davies, Gail	Completed	Update 10/4/25, over 8 week list reduced from 2236 to 1264 between january and april.							
																Ultrasound insourcing to be introduced to WGH to reduce 8 week wait for NOUS.	Whitecross, Faith	Completed	Update 10/4/25, over 8 week list reduced from 2236 to 1264 between January and April 2025. This will continue into the 24/25 financial year							
																Await outcome of Annual Plan and Radiology investment request	Roberts-Davies, Gail	Completed	Update 10/4/25, over 8 week list reduced from 2236 to 1264 between january and april.							
																Option to use insourcing for obstetric patients to be explored.	Procter, Sarah	Completed	Contract extension to include obstetric has been prepared and being signed for nov 25							
																A joint workshop to take place between Radiology & Women and Children's services to build a joint understanding of the UHB provision and position on obs & gynae u/s	Roberts-Davies, Gail	Completed	This has been unable to process due to the management fragility.							
																Recruitment of Ultrasound Principal and Ultrasound Governance Lead.	Procter, Sarah	~~30/04/2026~~ 31/05/2026	OCP delayed starting awaiting sign off after revisions. plan to start in April 26 if signed by exec team.							
																SBAR to be submitted to CCG meeting - alert of increase of risk score	Procter, Sarah	Completed	SBAr has been written and presented to CCG 18.11.25 and escalation to IQPFD							

Risk Ref	Clinical Care Group / Executive Function	Clinical Service Group / Executive Function Service	Clinical Service Sub-Group / Executive Function Service	Executive Director	Clinical Care Group Director / Executive Function Lead	Clinical Service Group Lead / Executive Function Service Lead	Clinical Service Sub-Group Lead / Executive Function Service Lead	Date risk Identified	Risk Statement	Existing Control Measures Currently in Place	Domain	Current Likelihood	Current Impact	Current Risk Score	Rationale for Current Risk Score	Additional Risk Action Required	By Whom	By When	Progress Update on Risk Actions	Lead Committee	Target Likelihood	Target Impact	Target Risk Score	Rationale for Target Risk Score	Detailed Risk Decision	Review date
																Workforce - Explore opportunity to utilise Australian and New Zealand Sonography workforce (with additional governance and checks to assure without HCPC registration). Success would enable appointment to locum positions to support the service capacity and allow substantive workforce to increase their training capacity.	Procter, Sarah	05/01/2026	SBAR with Deputy Director of Health Science							
																A Skill mix of vacancies in ultrasound will create a 0.63 WTE 8a Clinical Validator role- the post will provide ringfenced capacity to validate the u/s waiting list and ensure compliance to National pathways;	Procter, Sarah	30/04/2026	JD being devised Advert out in April							
																Pathway workforce diversification - Maternity have indicated capacity within Midwifery workforce to complete growth scans.	Procter, Sarah	31/05/2026	SBAR in final stages.							

3

90 Mins

3 - Assurance

3.1

3.1 - A Path to Safer Beginnings Patient Story and Update Report

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

Attachments

The Path to Safer Beginnings.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:	09 April 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Perinatal benchmark to National Maternity and Neonatal assessment: The Path to Safer Beginnings
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	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 report is presented to the Quality, Safety and Experience Committee to provide assurance on the quality and safety of maternity and neonatal services within Hywel Dda University Health Board (HDdUHB).

The report explicitly presents the Health Board's position benchmarked against the All-Wales Assurance Assessment: The Path to Safer Beginnings in Wales (2026) outlining areas of strength, key risks, and the strategic response in place.

Cefndir / Background

The Welsh Government commissioned the national assurance assessment The Path to Safer Beginnings in Wales (2026) to evaluate the safety, quality, and experience of maternity and neonatal services across Wales. The assessment identified both strengths and significant system-wide challenges, particularly in relation to workforce, postnatal care, equity, governance consistency, and neonatal service configuration.

HDdUHB has undertaken a structured benchmarking exercise against the national findings. This demonstrates that the Health Board is performing above the Welsh average in several key domains, particularly in governance, safety culture, and selected clinical outcomes.

The national report highlights that many of the challenges identified are system-wide across Wales and the wider UK, rather than isolated to individual organisations.

In response to both national findings and local intelligence, HDdUHB has developed a 5-year Perinatal "One Team" Strategy, aligned to the national perinatal workforce strategy and embedded within the IMTP, providing a structured and sustainable framework for improvement.

Asesiad / Assessment

Current Position

Benchmarking against the national assurance assessment demonstrates that HDdUHB is a high-performing maternity and neonatal service, with particular strengths in:

- Governance and safety culture, including high levels of incident reporting and multidisciplinary learning
- Psychological safety, with an open, transparent culture and strong staff engagement
- Clinical outcomes, including stillbirth rates below the Welsh average
- Structured service user engagement, including Birth Afterthoughts and thematic feedback review

These strengths position HDdUHB ahead of the national baseline, where governance inconsistency, delays in learning, and workforce pressures are more pronounced.

Risk Assessment (RAG Rating)

The following risks reflect system pressures identified both locally and nationally, and are being actively managed:

		Risk Description	Mitigation / Controls
Governance & Safety	🟢 High	Strong governance framework, embedded MDT learning, high reporting culture	Sustained governance oversight, real-time dashboard monitoring
Psychological Safety & Culture	🟢 High	Open, transparent culture with strong staff engagement and Just Culture principles	Leadership visibility, supervision, reflective practice
Workforce Sustainability	🟠 Moderate	Increasing acuity and complexity placing pressure on workforce model	Updated Birthrate+, workforce pipeline, rotational staffing model
Postnatal Care Quality	🟠 Moderate	Capacity pressures impacting consistency of postnatal experience	Strengthened postnatal model, targeted improvements via strategy
Equity & Data Maturity	🟡 Developing	Need to strengthen data visibility on inequalities and outcomes	Equity dashboard, embedding Perinatal Engagement Measures
System Learning & Externality	🟡 Developing	Opportunity to strengthen external peer review	Exploration of peer review models, continued MDT learning
Rising Intervention Rates	🟡 Moderate	Increasing caesarean rates consistent with national trends	Pathway optimisation, prevention focus
Digital/Data Assurance	🟢 Low	Temporary data assurance considerations during digital transition	Informatics leadership, validation processes

Overall Risk Position

The overall risk profile is assessed as MODERATE within a high-performing, well-governed, and psychologically safe service.

Strategic Response

HDdUHB has developed a 5-year Perinatal "One Team" Strategy, aligned to the national perinatal workforce strategy and operationalised through the IMTP.

This strategy directly responds to national and local risks by:

- Strengthening workforce sustainability
- Improving postnatal care and experience
- Enhancing equity and inclusion
- Supporting a unified perinatal service model
- Strengthening governance and system learning

This provides assurance that risks are clearly understood, planned for, and actively managed within a deliverable framework.

Evidence Base

This report is informed by:

- The All-Wales Assurance Assessment (The Path to Safer Beginnings in Wales, 2026)
- HDdUHB benchmarking against national findings
- HDdUHB self-assessment and governance data

Argymhelliad / Recommendation

The Committee is asked to:

- Take assurance from the quality and safety of maternity and neonatal services within HDdUHB
- Note the Health Board's strong performance relative to national benchmarking
- Acknowledge the identified risks, which are consistent with national system pressures
- Support the continued delivery of the 5-year Perinatal Strategy through the IMTP

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.4 Ensure the right enablers are in place to promote a positive culture of quality improvement based on best evidence.
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)	3. Effective 1. Safe 3. Effective

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	9 Digital plan 1 Workforce Stabilisation
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	8. Transform our communities through collaboration with people, communities and partners

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Risk Assessments
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:	Women's and Children's CCG Governance meeting February 2026 Planned Care CCG Business Planning February 2025

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No immediate additional financial impact identified. Actions are aligned to existing resources within the IMTP. Workforce and service developments are incorporated within planned financial frameworks.
Ansawdd / Gofal Claf: Quality / Patient Care:	Positive impact through strong governance, high safety culture, and good clinical outcomes. Risks identified to postnatal care experience and increasing acuity, with mitigation plans in place through the perinatal strategy.

Gweithlu: **Workforce:**	Workforce pressures remain due to increasing acuity and demand. Mitigation includes Birthrate+ review, workforce planning and delivery of the 5-year Perinatal strategy.
Risg: **Risk:**	Overall risk profile assessed as moderate within a high-performing service. Key risks relate to workforce sustainability, postnatal care, and equity, with clear mitigation plans in place.
Cyfreithiol: **Legal:**	No immediate legal implications identified. Ongoing compliance with national standards, professional regulation, and governance requirements.
Enw Da: **Reputational:**	Positive reputational position as a high-performing service relative to national benchmarking. Risk remains if national system pressures are not met effectively managed
Gyfrinachedd: **Privacy:**	No adverse impact identified. All data handled in accordance with information governance and data protection requirements.
Cydraddoldeb: **Equality:**	EqIA screening Yes Full EqIA not required at this stage

3.2

3.2 - Review of Revised Quality and Safety Governance Arrangements

Charlotte Wilmshurst (Hywel Dda Health Board - Assistant Director of Assurance and Risk)

Attachments

QSEC SBAR QS Governance SBAR 020426.pdf

Appendix 1 Detailed Review Against the QS Governance ToRs 020426 .pdf

Appendix 2 Action Plan QS Review 020426.pdf

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:**	Outcome from the 6 Month Review of the Revised Quality & Safety Governance Arrangements Introduced in September 2025
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Joanne Wilson, Director of Corporate Governance/Board Secretary
SWYDDOG ADRODD: **REPORTING OFFICER:**	Charlotte Wilmshurst, Assistant Director of Assurance & Risk Alison Gittins, Head of Special Projects, Corporate Governance

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 share the outcome from the 6 month review of the revised quality and safety governance arrangements introduced across both the operational and the assurance arm of the Health Board in September 2025, for consideration by the Quality, Safety and Experience Committee (QSEC).

Cefndir / Background

In the 'Proposed Quality & Safety Governance Arrangements Report' to QSEC in August 2025, it was agreed that for further assurance, a report would be presented to QSEC 6 months post the introduction of the revised arrangements, to provide an update on their effective implementation.

Terms of Reference for this review were crafted and shared with those whose views it was agreed would be sought to inform the review.

The purpose of the review was:

1.1 *To undertake a comprehensive review of the revised quality & safety governance arrangements introduced within HDdUHB in September 2025 to establish their effectiveness in terms of leading to improvements in quality and safety, and to prepare a report on the outcome for consideration by the Quality, Safety & Experience Committee in April 2026.*

1.1.1 To establish whether the revised Quality & Safety Intelligence Group arrangements are providing Clinical Executive Directors with an improved level of oversight of quality & safety across the Health Board enabling actions to be directed to address issues related to quality performance in key areas.

1.1.2 To establish whether discussion on quality intelligence at Integrated Quality, Finance & Performance Delivery Group is leading to appropriate actions and

responses from relevant Clinical Care Groups (CCGs) to address concerns or issues related to quality performance.

1.1.3 To confirm whether the Quality, Safety & Experience Committee is receiving the assurance it requires from the revised quality & safety governance arrangements in place since September 2025, leading to better patient outcomes.

A Project Plan was initiated to undertake the review comprising two distinct components:

- A desktop review of the agendas, papers and workplan of the Quality & Safety Intelligence Group (QSIG), the Integrated Quality, Finance & Performance Delivery Group (IQFPDG), and the Quality & Safety Committee (QSEC) itself.
- Interviews with the Interim Assistant Director of Nursing Assurance and Safeguarding, the Clinical Executive Directors of the Health Board, and the Chair of QSEC.

The Assessment section below sets out the high-level findings under each element of the review together with their recommendations, with the detailed work that has been undertaken against the terms of reference set for the review captured in Appendix 1.

The actions proposed in support of these recommendations are set out in the accompanying Action Plan (see Appendix 2).

Asesiad / Assessment

Quality & Safety Intelligence Group (QSIG) Arrangements

The first element of the Quality & Safety Governance review sought to establish whether the revised Quality & Safety Intelligence Group (QSIG) arrangements provided Clinical Executive Directors with an improved level of oversight of quality & safety across the Health Board, enabling actions to be directed to address issues related to quality performance in key areas.

Through the desktop review of QSIG's agenda, papers and workplan, and through interviews with Clinical Executive Directors, the key findings and recommendations are as follows (with the full findings and recommendations set out in Appendix 1).

Agendas

QSIG held its inaugural meeting under the revised and more formal arrangements on 11 September 2025 and has held regular, monthly meetings since. Its agendas are in line with the standard template agreed in terms of the 'governance' items, with the exception of QSIG's Action Tracker which was only presented to the January 2026 QSIG meeting. It is recommended that consideration is given to adopting a Table of Action discipline where actions are reviewed and closed at each meeting, rather than placing reliance on a Live Action Tracker where the onus is on members to pro-actively seek out their actions and complete them.

Other QSIG agenda items comply with the standard template proposed and include the Our Safety Dashboard; Concerns Management Groups and other concerns for escalation; Nationally Reportable Incidents; Healthcare Associated Infections; HIW and other regulatory matters; Mortality; Deep Dives (as appropriate); Fragile Services; and Reporting Group Updates.

Reporting Groups Terms of Reference and Reporting Cycle

9 operational groups previously reported into Operational Quality, Safety & Experience Sub-Committee (OQSESC):

- Effective Clinical Practice Advisory Panel
- Medicines Management Operational Group

- Human Tissue Authority Assurance Group
- Mental Capacity Act & Consent Group
- Nutrition & Hydration Group
- Recognition of Acute Deterioration and Resuscitation Group
- Medical Devices Group
- Infection Prevention Strategic Steering Group
- Strategic Safeguarding Group

These have all become reporting groups of QSIG, together with QSIG's existing Fragile Services Oversight Group, the Medical Exposures Group as confirmed by the Clinical Executive Directors as a further reporting group of QSIG, and the Quality Impact Assessment Panel which was identified as an additional reporting group following QSIG's inaugural meeting, making 12 reporting groups of QSIG in total.

Chairs of each reporting group were added to QSIG's membership and invited to QSIG's inaugural meeting to better understand QSIG's expectations going forward. Each Chair was asked to review their reporting group's Terms of Reference to align reporting and assurance in line with the new quality and safety governance arrangements, update the membership as appropriate, and bring back revised Terms of Reference to QSIG for approval when they were next scheduled to report.

To date however, only 4 out of the 12 reporting groups have revised their Terms of Reference and presented these to QSIG for approval over the past 6 months. Therefore the majority of the reporting groups have still not clarified their objectives or outputs, leading to a lack of clarity regarding their roles and effectiveness.

It is therefore recommended to finalise the Terms of Reference for all reporting groups by their next reporting period in order to clarify their aims, standards, responsibilities and escalation reports, and to ensure their reporting groups work plans align to expected standards.

In order to manage the additional workload involved for QSIG, and to subsequently manage IQFPDG's agenda, it had been agreed that the reporting groups would maintain their current meeting rhythm and report into QSIG on rotation i.e. 3 groups every 4 months.

Currently however, the reporting groups report to QSIG following each of their meetings which led to QSIG receiving 5 reporting group update reports in September 2025, 4 in October 2025, 5 in November 2025, 4 in December 2025, 4 in January 2026 and 4 in February 2026.

This has resulted in an over-reporting from certain reporting groups, particularly those with a more frequent meeting rhythm, and gaps in reporting from others.

A reinforcement of the agreed 4 monthly cycle is therefore required to allow the reporting groups to develop their work plans, collaborate with CCGs and other Corporate functions, and provide more focused, actionable updates to QSIG to ensure manageable agendas and to accommodate groups with less frequent meetings avoid gaps in reporting and oversight.

Whilst updates from reporting groups are regularly received at QSIG, the review noted that the current 3As (Alert, Advise and Assure) template does not lend itself to meeting the requirement of the responsibility within QSIG's Terms of Reference to '*indicate 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.'*

While the current 3As reports are useful, they often flag issues that reporting groups should be able to resolve themselves; a clearer definition of what should be escalated to QSIG is therefore required which could be addressed through specific additional wording in reporting groups Terms of Reference.

There is also little evidence of reporting groups undertaking baseline assessments and ensuring these are incorporated into their reporting cycle to QSIG to enable the Health Board's position against the required legislation or standards to be measured and understood, nor to identify how any gaps in achieving compliance will be addressed.

The creation of a new standard reporting template for reporting groups is therefore recommended to ensure that these key elements are consistently included and considered in discussions.

QSIG Quoracy

In terms of QSIG's meeting practice, the review noted the challenge of achieving quoracy with only 3 out of the 6 monthly QSIG meetings having the required two Clinical Executive Directors present. Planning meetings a year in advance and coordinating with administrative staff to ensure alignment of QSIG meetings with other key meetings, such as QSEC and the Board will be key to ensuring the required number of Clinical Executive Directors are available.

Our Safety Dashboard/Triangulation of Data

In terms of QSIG's responsibilities, the review established that all operational responsibilities as set out in QSIG's Terms of Reference had been met with the exception of *'Making 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.*

Whilst the Our Safety Dashboard presented to QSIG makes use of key performance indicators and metrics, it is recognised that these are not necessarily triangulated with patient feedback, surveys and patient stories. Data use needs to be expanded beyond performance metrics into patient experience, recognising that this is currently a gap.

Whilst improvement actions in terms of the minimum requirements to reduce escalation levels are included within the routine Our Safety Dashboard presented to QSIG, also included within its Terms of Reference was that QSIG would continue to issue 'outcome letters' from discussions at each of its meetings to the CCG Service Directors or Corporate functions in order to follow up on any action required within their respective services; it is understood that this is no longer the case. It is recommended that consideration be given to reinstating outcome letters or action summaries to CCGs and Corporate functions, particularly around escalation.

Deep Dives

In terms of deep dives, whilst over the review's 6 month reference period, a total of 9 deep dives have featured at QSIG's meetings, consideration could be given to developing a more structured approach to planning deep dives throughout the year, ensuring that topics are aligned to QSEC agenda items, and identified and scheduled in advance where possible while retaining flexibility for emerging issues from reporting groups and other areas as and when these arise.

Administrative Support

The significant administrative workload involved in supporting QSIG and those of its reporting groups was recognised by the review, noting that capacity constraints and limited administrative support remain challenging.

It is recommended that clarity is sought on the administrative resourcing required to sustain operational governance functions, through discussion at Executive Team.

Integrated Quality, Finance & Performance Delivery Group (IQFPDG) Arrangements

The second element of the Quality & Safety Governance review sought to establish whether discussion on quality intelligence at IQFPDG is leading to appropriate actions and responses from relevant CCGs and Corporate functions to address concerns or issues related to quality performance.

Through the desktop review of IQFPDG's agenda, papers and workplan, and through interviews with the Chair of IQFPDG (Quality, Health & Safety agenda), the key findings are as follows (with the full findings and recommendations set out in Appendix 1).

<u>QSIG Reporting to IQFPDG</u>
A composite 'intelligence' report is routinely presented to IQFPDG at each of its meetings, based on the Our 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 and for them to operationalise any responses required.

This Quality and Safety Report also provides the Alert, Advise and Assure items from each QSIG meeting for IQFPDG's consideration, and to agree any actions for CCGs and Corporate functions to undertake.

The review noted that the detail within the Quality & Safety Report correlates with the issues raised within the CCG 3As update reports.

However, this Quality & Safety Report is placed on the agenda following the individual CCG and Corporate functions 3As reports and it is suggested that by placing it in front of these reports would provide for the necessary context.

Since IQFPDG was temporarily stood down in January 2026 due to winter pressures, it was agreed to share the Quality and Safety Report directly with Formal Executive Team in the absence of IQFPDG meetings taking place. However, no evidence could be found of this in Formal Executive Team agenda or minutes and it is recommended that the Quality & Safety Report is shared with Formal Executive Team directly in the absence of IQFPDG meetings or appended to the IQFPDG Update Report to Formal Executive Team when IQFPDG meetings are taking place.

<u>Cross-Organisational Learning</u>
One of the purposes behind establishing IQFPDG had been to facilitate cross-organisational learning across CCGs and other Corporate functions, and to provide a forum for CCG Service Directors and Assistant Directors of Nursing, Quality and Experience/Assistant Director of Quality, Safety and Experience present at IQFPDG meetings to be directly informed of the quality & safety issues within their specific areas in order that the service could then operationalise any responses that may be required, and to hold shared discussions and cross-pollination of insights and ideas with the aim of avoiding siloed solutions.

It is recognised that the role of IQFPDG is currently under review, however the absence of a forum where CCG Service Directors and Assistant Directors of Nursing, Quality and Experience/Assistant Director of Quality, Safety and Experience are present could re-create

silos, reduce cross-group information and risk pertinent information bypassing the Chief Operating Officer and other Executive Directors present at IQFPDG.

Quality, Safety & Experience Committee (QSEC) Arrangements

The third element of the Quality & Safety governance review sought to confirm whether QSEC is receiving the assurance it requires from the revised quality & safety governance arrangements in place since September 2025, leading to better patient outcomes.

Through the desktop review of QSEC's agenda, papers and workplan, and through interviews with the Chair of QSEC, the key findings are as follows (with the full findings and recommendations set out in Appendix 1).

Quality & Safety Assurance Report

It had been agreed that a Quality & Safety Assurance Report would be submitted to each QSEC meeting drawing out the key issues from the intelligence provided for the reporting groups (3 times per year) and any alert and advise items from the CCGs and Corporate functions 3As reports with the agreed plan of action to address these.

Whilst a Quality & Safety Assurance Report was submitted to each of QSEC's meetings, it did not include the key issues from the intelligence provided for QSIG's reporting groups nor any alert and advise items from the CCG and Corporate functions 3As reports with the agreed plan of action to address these as discussed at IQFPDG. It is therefore recommended that this is included going forward.

The review also noted that the Quality & Safety Assurance Report is often placed towards the end of QSEC's meeting agenda, leading to the potential for it to be overlooked. The importance of effective agenda setting to ensure that sufficient time is allocated to key topics and to ensure that meetings do not run out of time for important items placed at the end of the agenda is therefore recommended.

CCG and Public Health Assurance Reports

It had also been agreed that QSEC would receive a six-monthly assurance report from each CCG, and Public Health, on their quality governance arrangements to enable QSEC to gain direct assurance.

Three out of these six assurance reports were presented to QSEC at its meeting on 4 December 2025, and one to its meeting on 13 February 2026, the remaining two having been deferred from the February meeting during agenda setting due to operational pressures at the time.

From QSEC's 2026/27 Annual Workplan, CCG assurance reports have been plotted three times a year rather than the proposed 6 monthly frequency, and it is recommended that the previously agreed frequency is adopted.

It was also noted that CCG assurance reports can be of variable quality, with some lacking clarity and insight and not always providing the necessary information on outcomes and impacts, while others can be more reassuring. Overall, this indicates an inconsistency in reporting maturity across the organisation leading to the Committee not being fully assured by reporting groups' outputs/reports.

It is therefore recommended that the Committee would benefit from a more prominent and clearer action summary within the reports presented.

Safeguarding and Infection Prevention & Control Assurance Reports

It had also been agreed that routine 6 monthly assurance reports would be received at QSEC in respect of safeguarding and infection prevention & control. Whilst Safeguarding and Infection Prevention & Control Assurance Reports were both due to be received at QSEC's meeting in February 2026, only the Safeguarding Assurance Report was received as it was agreed to stagger these two assurance reports given both were to be written by the same reporting author.

Both assurance reports have been plotted on QSEC's 2026/27 workplan three times a year i.e. at every other QSEC meeting, rather than the proposed 6 monthly frequency, and it is recommended that the previously agreed frequency is adopted.

Gaps Identified in Reporting to QSEC

Overall, whilst the review found that the new arrangements are judged to be working more effectively, enabling the Committee to remain more strategic and avoid it becoming drawn into operational detail at too early a stage which had been the case previously with the former Sub-Committee structure, gaps particularly in terms of the capturing of walkabout intelligence and assurance flow back to QSEC were observed. It is therefore recommended that consideration be given to improving walkabout intelligence capture without the attendant creation of additional bureaucracy

Summary

In summary, the 6 monthly review of the revised quality & safety governance arrangements introduced in September 2025, has demonstrated the following against the review's purpose:

- **To establish whether the revised Quality & Safety Intelligence Group arrangements are providing Clinical Executive Directors with an improved level of oversight of quality & safety across the Health Board enabling actions to be directed to address issues related to quality performance in key areas.**

  Whilst the review has established that the revised QSIG arrangements are providing Clinical Executive Directors with an improved level of oversight of quality & safety across the Health Board, the following recommendations are made to enable any outstanding actions to be directed to address issues related to quality performance in key areas.

- Adopt a Table of Action discipline at QSIG where actions are reviewed and closed at each meeting, rather than placing a reliance on the current Live Action Tracker.
- Ensure all reporting groups review and re-submit by their next reporting period their revised Terms of Reference to QSIG for approval.
- Reinforce the previously agreed 4 monthly reporting cycle discipline for QSIG's reporting groups to avoid over and under reporting.
- Develop structured reporting group specific templates incorporating baseline assessments against which the Health Board's position against the required legislation or standards can be measured, identifying how any gaps in achieving compliance can be met, together with the actions being taken forward, by whom and by when.
- Ensure QSIG meetings are scheduled sufficiently in advance and aligned with Clinical Executive Director availability at mutually appropriate/agreeable times to enable quoracy at QSIG to be maintained.

- Ensure use of key performance indicators is triangulated with patient feedback, surveys and patient stories by expanding data use beyond performance metrics into patient experience within Our Safety Dashboard.
- Reinstate outcome letters or action summaries to CCGs and Corporate functions, following QSIG meetings, particularly around escalation.
- Develop a more structured approach to planning deep dives on QSIG's agenda throughout the year, ensuring that topics are identified and scheduled in advance where possible, while retaining flexibility for emerging issues, as and when they arise.
- Introduce a clearer definition of what should be escalated to QSIG from reporting groups within their respective Terms of Reference.
- Acknowledging that capacity to sustain operational governance functions is an issue, discussion to be held at Executive Team on how support can be provided.

- **To establish whether discussion on quality intelligence at Integrated Quality, Finance & Performance Delivery Group is leading to appropriate actions and responses from relevant Clinical Care Groups (CCGs) to address concerns or issues related to quality performance.**

  Whilst the review has established there is discussion on quality intelligence at IQFPDG meetings, the following recommendations are made to ensure that these are leading to appropriate actions from CCGs and Corporate functions to address concerns or issues related to quality performance.

- Ensure the Quality & Safety Report is placed on IQFPDG's agenda in front of the individual CCG and Corporate functions 3As reports to provide for the necessary context.
- To reinstate the sharing of the Quality & Safety Report with Formal Executive Team directly in the absence of IQFPDG meetings, or append to the IQFPDG Update Report to Formal Executive Team when IQFPDG meetings are taking place.
- Dependent upon the outcome of the review of IQFPDG, consideration to be given to how the necessary cross-group information will be addressed in any new governance arrangements proposed.

- **To confirm whether the Quality, Safety & Experience Committee is receiving the assurance it requires from the revised quality & safety governance arrangements in place since September 2025, leading to better patient outcomes.**

  Whilst the review has confirmed that the revised quality & safety governance arrangements are an improvement over those previously in place, offering more structure and direction both for the Committee and the Board and prompting Committee members to consider more carefully those actions or responses that are required through the QSEC 3As Report submitted to Board, the following recommendations are made to further improve the arrangements in place.

- Include within the Quality & Safety Assurance Report to QSEC the key issues from the intelligence provided for QSIG's reporting groups and any alert and advise items from the CCG and Corporate functions 3As reports with the agreed plan of action to address these as discussed at IQFPDG.
- Place the Quality and Safety Assurance Report nearer the beginning of QSEC's meeting agenda to avoid late-meeting fatigue and to ensure sufficient time is allocated to its discussion.

- Reinforce the previously agreed 6 monthly reporting cycle discipline for CCG and Public Health assurance reports on QSEC's agenda.
- Address concerns regarding the variability and content of CCG and Public Health assurance reports by introducing a more prominent and clearer action summary within these reports to QSEC.
- Reinforce the previously agreed 6 monthly reporting cycle discipline for Safeguarding and Infection Prevention and Control assurance reports on QSEC's agenda.
- Explore a light-touch mechanism for capturing and feeding walkabout insights into QSEC when formal note-taking is unavailable.

For QSEC's assurance, all recommendations from this review have been captured in an action plan to address the issues identified and to support continuous improvement within quality & safety arrangements across the organisation (see Appendix 2).

Argymhelliad / Recommendation

QSEC is requested to:

- Receive assurance that while the revised quality and safety governance arrangements introduced in September 2025 represent an improvement over the arrangements formerly in place, there is further work to do to fully implement and embed the previously agreed actions which will be addressed through the Action Plan set out in Appendix 2.

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 10.5 The 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)	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	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	QSEC Terms of Reference QSIG Terms of Reference Proposed Quality & Safety Governance Arrangements Report to QSEC in August 2025
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 Clinical Executive Directors HDdUHB Vice-Chair (Chair of QSEC)

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No direct impact
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 impact
Risg: Risk:	No direct impact

Cyfreithiol: **Legal:**	No direct impact
Enw Da: **Reputational:**	No direct impact
Gyfrinachedd: **Privacy:**	No direct impact
Cydraddoldeb: **Equality:**	No direct impact

REVIEW OF THE EFFECTIVE IMPLEMENTATION OF THE REVISED QUALITY & SAFETY GOVERNANCE ARRANGEMENTS INTRODUCED SEPTEMBER 2025

TERMS OF REFERENCE

1. PURPOSE

1.1 To undertake a comprehensive review of the revised quality & safety governance arrangements introduced within HDdUHB in September 2025 to establish their effectiveness in terms of leading to improvements in quality and safety, and to prepare a report on the outcome for consideration by the Quality, Safety & Experience Committee in April 2026.

1.1.1 To establish whether the revised Quality & Safety Intelligence Group arrangements are providing Clinical Executive Directors with an improved level of oversight of quality & safety across the Health Board enabling actions to be directed to address issues related to quality performance in key areas.

1.1.2 To establish whether discussion on quality intelligence at Integrated Quality, Finance & Performance Delivery Group is leading to appropriate actions and responses from relevant CCGS to address concerns or issues related to quality performance.

1.1.3 To confirm whether the Quality, Safety & Experience Committee is receiving the assurance it requires from the revised quality & safety governance arrangements in place since September 2025, leading to better patient outcomes.

2. PROJECT PLAN

2.1 Quality & Safety Intelligence Group (QSIG)
Desktop Review (through the sourcing of QSIG's agenda, papers and workplan)

2.1.1 Review QSIG agendas and papers against the QSIG standard agenda template and work plan.

Through a desktop exercise undertaken of QSIG's agendas, papers and annual workplan the review sought to establish whether the following revised arrangements as articulated in the 'Proposed Quality & Safety Governance Arrangements Report' to QSEC in August 2025, had been effectively implemented:

'Quality & Safety Intelligence Group (QSIG), previously an advisory group reporting into Executive Team comprising HDdUHB's Clinical Executive Directors together with Deputy and Associate Directors, to move to becoming an intelligence–led group reporting into IQFPDG, adopting 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 Our 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. 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.'

The desktop review confirmed that QSIG held its inaugural meeting under the revised and more formal arrangements on 11 September 2025 and has held regular, monthly meetings since.

Current QSIG's agendas appear to be broadly in line with the standard template proposed. In terms of the 'governance' items submitted, while QSIG minutes from previous meetings are always presented to subsequent meetings, a QSIG Table of Actions is not routinely submitted; only at the January 2026 QSIG meeting was the QSIG Live Action Tracker presented. It is therefore recommended that consideration is given to adopting a Table of Action discipline where actions are reviewed and closed at each meeting, rather than placing reliance on a Live Action Tracker where the onus is on members to pro-actively seek out their actions and complete them. QSIG's Annual Workplan is always presented to each meeting and follows the standard format prescribed.

Other current QSIG agenda items comply with the standard template proposed and include the Our Safety Dashboard; Concerns Management Groups and other concerns for escalation; Nationally Reportable Incidents; Healthcare Associated Infections; HIW and other regulatory matters; Mortality; Deep Dives (as appropriate); Fragile Services; and Reporting Group Updates.

2.1.2 Verify that QSIG's reporting groups have maintained their meeting rhythm and report into QSIG, on rotation (3 groups every 4 months). Establish the type of information and the improvement actions being reported to QSIG through their 3As Reports, ensuring these are consistently covering off the CCG and Health Board quality & safety performance, detailing the outcomes and any actions required (Consider whether a standardised template is required).

Through the desktop exercise, the review sought to establish whether the following revised arrangements as articulated in the 'Proposed Quality & Safety Governance Arrangements Report' to QSEC in August 2025 had been effectively implemented:

'The 9 operational groups previously reporting into QSESC to report into QSIG alongside QSIG's existing reporting group, the Fragile Services Oversight Group, requiring a change to the reporting arrangements within

these 9 operational groups' Terms of Reference, approval of these Terms of Reference at QSIG, and a conversation with their Chairs on QSIG's expectations of how these reporting groups would operate going forward. This would also require changes 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 previously by the Clinical Executive Directors. To manage the additional workload involved for QSIG, and to manage IQFPDG's agenda, the reporting groups in total would maintain their current 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.'

The following 9 operational groups previously reported into Operational Quality, Safety & Experience Sub-Committee (OQSESC):

- Effective Clinical Practice Advisory Panel
- Medicines Management Operational Group
- Human Tissue Authority Assurance Group
- Mental Capacity Act & Consent Group
- Nutrition & Hydration Group
- Recognition of Acute Deterioration and Resuscitation Group
- Medical Devices Group
- Infection Prevention Strategic Steering Group
- Strategic Safeguarding Group

These have all become reporting groups of QSIG necessitating an increase in support to manage the additional workload involved, together with QSIG's existing Fragile Services Oversight Group, the Medical Exposures Group as confirmed by the Clinical Executive Directors as a further reporting group of QSIG, and the Quality Impact Assessment Panel which was identified as an additional reporting group following QSIG's inaugural meeting, making 12 reporting groups of QSIG in total.

The Chairs of each reporting group were added to QSIG's membership and invited to QSIG's inaugural meeting to better understand QSIG's expectations of their reporting groups going forward. An undertaking was made at that meeting by each Chair to review their reporting group's Terms of Reference to align reporting and assurance in line with the new quality and safety governance arrangements, update the membership as appropriate, and to bring back revised Terms of Reference to QSIG for approval when they were next scheduled to report.

However, from the findings of the desktop review, only 4 out of the 12 reporting groups have revised their Terms of Reference and presented these to QSIG for approval over the past 6 months; these are Effective Clinical Practice Advisory Panel; the Mental Capacity Act & Consent Group; the Medicines Management Oversight Group and the Medical Exposure Group. Aside from the Effective Clinical Practice Advisory Panel, it has not been clear from their report or the subsequent QSIG minutes that these Terms of Reference were presented for approval, or that they were approved.

It had been agreed that in order to manage the additional workload involved for QSIG, and to subsequently manage IQFPDG's agenda, the reporting groups would maintain their current meeting rhythm and report in to QSIG on rotation i.e. 3 groups every 4 months, with 3 of the reporting groups' data reported to IQFPDG through the Quality & Safety Report submitted once every 4 months.

However, from the findings of the desktop review, it appears that the reporting groups report to QSIG following each of their meetings, some of which are held bi-monthly, some quarterly. This meant QSIG receiving 5 reporting group update reports in September 2025, 4 reports in October 2025, 5 reports in November 2025, 4 reports in December 2025, 4 reports in January 2026 and 4 reports in February 2026.

Despite the high number of reporting group update reports received, not all QSIG groups were equally represented as identified below:

- HTA reported to 4 out of 6 QSIG meetings (11 September 2025, 13 November 2025, January 2026, 13 February 2026)
- The Effective Clinical Advisory Panel reported to 3 out of 6 QSIG meetings (11 September 2025, 13 November 2025 and 15 January 2026);
- MEG reported to 3 out of 6 QSIG meetings (10 October 2025, 12 December 2025, 13 February 2026)
- MCA reported to 2 out of 6 QSIG meetings (10 October 2025, 12 December 2025)
- MMOG reported to 2 out of 6 QSIG meetings (11 September 2025, 15 January 2026)
- RADAR reported to 2 out of 6 QSIG meetings (11 September 2025, 13 November 2025
- QIA reported to 2 out of 6 QSIG meetings (11 September 2025, 15 January 2026)
- IPSSG reported to 2 out of 6 QSIG meetings (10 October 2025, 12 December 2025)
- SSG reported to 2 out of 6 QSIG meetings (10 October 2025, 12 December 2025)
- MDG reported to 2 out of 6 QSIG meetings (13 November 2025, 13 February 2026)
- NHG reported to 1 out of 6 QSIG meetings (13 November 2025)

The Fragile Services Oversight Group did not report to QSIG at all during the 6 month reference period.

2.1.3 Review QSIG meeting practice against its Terms of Reference in terms of its responsibilities, membership, meeting frequency, quoracy

At the 11 September 2025 inaugural meeting, QSIG's Terms of Reference were reviewed and agreed with minor amendments to group titles and roles for

accuracy. The membership, meeting frequency, quoracy and secretariat arrangements were also clarified and it was agreed to review the Terms of Reference in January 2026.

Whilst these were scheduled for review in January 2026 and placed on the agenda, subsequent discussion only identified that *'it was noted that no specific concerns had been raised, but was confirmed that the Terms of Reference would be reviewed alongside wider governance arrangements.'*

Quoracy has however been challenging, with only 3 out of the 6 monthly QSIG meetings having two Clinical Executive Directors present. QSIG's quoracy requirements are as follows:

> *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).*

In terms of QSIG's responsibilities, the following have been extracted from its Terms of Reference, with the desktop review identifying how far each have been met:

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

  The Our Safety Dashboard, presented to each QSIG meeting, is focused on the delivery of quality and safe services within the NHS Wales Performance Framework.

- *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.*

  QSIG oversees and agrees the escalation levels for CCGs and other Corporate functions for the Quality domain, and as well as providing the reasons for escalation within the routine Our Safety Dashboard presented to QSIG, it also includes the minimum requirements to reduce escalation levels, together with annotated notes from the Assessor.

  - *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.*

    Whilst the Our Safety Dashboard presented to QSIG makes use of key performance indicators and metrics, it is recognised that these are not

necessarily triangulated with patient feedback, surveys and patient stories. Data use needs to be expanded beyond performance metrics into patient experience, and it is recognised that this is currently a gap.

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

  There is evidence in QSIG's minutes of discussions regarding the process to be adopted for recommending deep dives, noting that these should be driven by outputs from governance processes such as IQFPDG and EITS, and also through a review of the minutes from QSEC and IQFPDG to identify any areas or items that need to be the subject of deep dives, which should be structured, balanced, and aligned to quality and safety.

  QSIG agreed to keep considering new areas for deep dives and encouraged members to bring forward suggestions, with no objections raised to the deep dive topics proposed.

  The following deep dives were received at QSIG meetings during the 6 month reference period:

  - <u>QSIG Meeting 10 October 2025:</u>
    - Assessment and Care of 'Medical' Issues Arising in In-patients within MH&LD Settings
    - Public Health Operational Issues – Scabies

  - <u>QSIG Meeting 12 December 2025</u>
    - Transition of Care for Young People with ADHD and ASD

  - <u>QSIG Meeting 15 January 2026</u>
    - Mortality following Trauma and Orthopaedic Surgery
    - Medical Devices Update

  - <u>QSIG Meeting 13 February 2026</u>
    - Veno-Thrombo Embolism and Healthcare Acquired Thrombosis
    - Deconditioning
    - Incidents Occurring in Non-Designated Clinical Areas
    - Nursing Provision at Ysgol Heol Goffa

  Consideration could be given to developing a more structured approach to planning deep dives throughout the year, ensuring that topics are aligned to QSEC agenda items, identified and scheduled in advance where possible, while retaining flexibility for emerging issues from reporting groups and other areas, as and when they arise.

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

  Improvement actions in terms of the minimum requirements to reduce escalation levels are included within the routine Our Safety Dashboard presented to QSIG.

  However, it was also agreed that QSIG would continue to issue 'outcome letters' following on from discussions at each of its meetings, to the CCG Service Directors or Corporate functions in order to follow up on any action required within their respective services; it is understood that this is no longer the case. It is recommended that *c*onsideration be given to reinstating outcome letters or action summaries to CCGs and Corporate functions, particularly around escalation.

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

  The Our Safety Dashboard which is routinely presented to QSIG, is the central tool for highlighting themes and identifying issues such as mortality, incidents, thrombectomy and cardiac arrests, and used to select topics for deep dives and to monitor trends across reporting groups.

  Artificial intelligence, such as Copilot, is beginning to be used to interrogate systems and identify themes and trends that are not easily visible through standard reporting.

- *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.*

  A Quality and Safety Report, based on the Our Safety Dashboard Analysis is provided to IQFPDG, setting out the improvement actions required in terms of reducing escalation levels.

- *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.*

  Whilst updates from reporting groups are received, the current 3As (Alert, Advise and Assure) template does not lend itself to meeting the requirements of this responsibility. There is little evidence of reporting groups undertaking baseline assessments and ensuring these are incorporated into their reporting cycle to QSIG to enable the Health Board's position against the required legislation or standards to be measured and understood, nor to identify how any gaps in achieving

compliance will be addressed. The creation of a new standard reporting template for reporting groups is therefore recommended to ensure that these key elements are consistently included and considered in discussions.

- *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.*

  No evidence of items relating to horizon scanning, nor feedback from national groups, could be found within QSIG's agendas over the review's 6 month reference period.

Through interviews conducted individually with Clinical Executive Directors, the following questions were posed in regard to QSIG:

- **Are the revised QSIG arrangements providing an improved level of oversight of the quality & safety processes and systems across the Health Board to enable actions to be directed to where there are issues related to quality performance and for improvements to be driven in key areas**

  The current effectiveness of QSIG arrangements, the structure and discipline of reporting groups, and the operational challenges in maintaining oversight and timely reporting of quality & safety within the Health Board were discussed with individual Clinical Executive Directors, focusing on reviewing the effectiveness, maturity, and future direction of the QSIG governance structure, its reporting groups, operational arrangements, meeting frequency, and alignment with wider governance forums such as IQFPDG, QSIG, and CCGs Integrated Governance Group meetings.

  It was reported that the revised arrangements in place represent a *'massive step forward'*, improving oversight and influence over quality and safety issues, with improved visibility of quality and safety issues compared to the previous arrangements.

  These new governance arrangements have enabled more direct and regular discussions about quality and safety issues among key stakeholders including the 3 Clinical Executive Directors, with reporting groups now providing more actionable information. This new structure is seen as a significant improvement over the previous arrangements, where issues were not as visible. There is a need however to ensure QSIG remains focused on quality & safety and not drift into purely performance-based discussions.

  It was agreed that moving away from the previous Sub-Committee structure has avoided a number of issues being escalated to QSEC which has prevented unnecessary burden for the Committee, and led to more open and relevant discussions, although the bar for assurance remains high and there

is still confusion regarding the distinction between assurance and reassurance.

Discussions were held on the evolution of the governance structure, highlighting improved oversight provided by QSIG, the need for reporting group maturity, and the importance of structured feedback loops between reporting groups, CCGs, and other forums such as QSEC and IQFPDG.

One Clinical Executive Director expressed the view that Clinical Executive Directors are currently too involved in operational details rather than providing strategic leadership, suggesting that as leadership structures mature, Clinical Executive Directors should step back and focus on oversight and assurance.

Reflections were made on the ongoing need for continuous improvement in governance processes, and the importance of not making disruptive changes while the current system is maturing. Ongoing review and incremental improvement of QSIG processes were advocated, rather than radical changes, to ensure the system continues to mature and deliver better outcomes.

- **Are the revised QSIG arrangements working in terms of identifying the risks, gaps and controls required to improve quality and safety**

  Through individual discussions with the Clinical Executive Directors, it was acknowledged that reporting groups are still maturing, with a tendency currently to be reactive rather than proactive. The aim would be for these reporting groups to be more aligned to their core remit, focusing on their core business, use data to identify compliance gaps, and interact more effectively with CCGs and other Corporate functions to resolve issues before escalating these to the next level. It was recognised that the shift from the previous assurance focus of the OQSESC to an operational focus of the new arrangements had been intended to foster more direct problem-solving and reduce unnecessary escalation.

  Discussions were held on the importance of closing the feedback loop by ensuring that issues raised by reporting groups are addressed at the appropriate level, with clear communication back to the groups about actions taken or required. It was agreed that the revised arrangements allow for better influence and more structured reporting to IQFPDG, Executive Teams and QSEC.

  With regard to the quality of reporting, the effectiveness of the current 3As reporting templates was evaluated, to consider whether this format provides sufficient detail and actionable intelligence for the Health Board's needs. It was recognised that the 3As template may not always capture the necessary detail for effective operational oversight, especially compared to the templates used by other groups. The need for clearer, more structured reporting from reporting groups beyond reactive *'alerts'* was identified. While the current 3As reports are useful, they often flag issues that reporting groups

should be able to resolve themselves; a clearer definition of what should be escalated to QSIG is therefore required which could be addressed through specific additional wording in reporting groups Terms of Reference. It was also suggested that a more tailored approach, potentially with group-specific templates, could improve the quality of information provided.

The importance of including baseline assessments, and compliance with legislation/standards in reports was emphasised, particularly for areas such as safeguarding. Reports should provide clear intelligence on the actions that are required, where gaps exist, and what the Health Board is required to do about these. The need for reports to also cover other elements such as training, workforce development, and public interface was also emphasised to ensure comprehensive oversight.

The creation of a new standard reporting template for reporting groups was proposed, which would ensure that key elements are consistently included and considered in discussions.

- **Has the QSIG adopted a more formal approach in terms of a maintenance of its monthly meeting rhythms and associated operating arrangements**

Through individual discussions with the Clinical Executive Directors, the structure of QSIG meetings was reviewed, and it was agreed that the current monthly schedule for QSIG meetings is appropriate as reducing the frequency could hinder oversight, whilst increasing it would be unmanageable.

In terms of QSIG's associated operating arrangements with regard to quoracy, challenges with Clinical Executive Director attendance were noted. In 3 out of the 6 reviewed QSIG meetings, the number of Clinical Executive Directors required for quoracy i.e. 2 were not present. Whilst it was agreed that the level of quoracy is set appropriately, issues such as holidays, illness and the variable scheduling of meetings attributed to the challenges.

To address attendance issues at QSIG, planning meetings a year in advance and coordinating with administrative staff to ensure alignment of QSIG meetings with other key meetings, such as QSEC and the Board would be key to ensuring the required number of Clinical Executive Directors are available.

The importance of having Deputies and Associate Medical Directors attend when Clinical Executive Directors are unavailable was discussed, as was the need to ensure the right combination of participants, including the Chairs of reporting groups and Corporate function leads, to maintain effective oversight and decision-making.

In terms of QSIG's associated operating arrangements in regard to reporting groups terms of reference, concerns were raised that for the majority of the reporting groups, terms of reference remain outdated or unclear; after six

months, many reporting groups have still not clarified their objectives or outputs, leading to a lack of clarity about their roles and effectiveness.

There is a need therefore to finalise the terms of reference for reporting groups to clarify their aims, standards, responsibilities and escalation reports, and to ensure work plans align to expected standards.

In terms of QSIG's associated operating arrangements in regard to reporting groups reporting frequencies, it was agreed that the current 'ad hoc' reporting arrangement is overwhelming for groups and does not allow for sufficient time for progress to be made between meetings. It is also burdensome in terms of the excessive agenda items it leads to at QSIG, and leads to an increased administrative burden without a corresponding improvement in outcomes. It also means reporting group Chairs need to attend QSIG meetings more often if they are obliged to bring papers each time. A shift back to the agreed 4 monthly cycle, regardless of each reporting groups meeting rhythm, to allow the reporting groups to develop their work plans, collaborate with CCGs and other Corporate functions, and provide more focused, actionable updates to QSIG was therefore advocated, to ensure manageable agendas and to accommodate groups with less frequent meetings avoid gaps in reporting and oversight.

- **Is the overall flow of information improved**

  It was noted that combining certain reporting groups that previously provided separate update reports has improved the flow of information and enabled more targeted actions.

- **Has the pace of work/discussion/deliberations increased or been slowed down**

  Other than the need to introduce a more regular rhythm for reporting group update reports to QSIG, the review found no evidence to suggest that the pace of work or discussions and deliberations at QSIG have been slowed down since the introduction of the new arrangements.

- **Is there a disproportionate administrative burden compared to the added value**

  Through individual discussions with Clinical Executive Directors, the significant administrative workload involved in supporting QSIG and its related governance activities was recognised, noting that capacity constraints and limited administrative support remain challenging.

  It was further recognised that the administrative support for QSIG's reporting groups has shifted, with the administrative burden increased due to changes in team responsibilities, leading to less experienced staff supporting the reporting groups and managing the processes involved, which can result in missed updates where reporting group meetings are cancelled or rescheduled.

The need for balance between effective governance and a duty to not overburden staff was recognised, especially as some roles are now add-ons to existing responsibilities.

It is recommended that clarity is sought on the administrative resourcing required to sustain operational governance functions, through discussion at Executive Team.

Recommendations in Relation to QSIG:

- Adopt a Table of Action discipline at QSIG where actions are reviewed and closed at each meeting, rather than placing a reliance on the current Live Action Tracker
- Reinstate outcome letters or action summaries to CCGs and Corporate functions, following QSIG meetings, particularly around escalation.
- Reinforce the previously agreed 4 monthly reporting cycle discipline for QSIG's reporting groups to avoid over and under reporting.
- Introduce a clearer definition of what should be escalated to QSIG from reporting groups within their respective Terms of Reference.
- Develop structured reporting group specific templates incorporating baseline assessments against which the Health Board's position against the required legislation or standards can be measured, identifying how any gaps in achieving compliance can be met, together with the actions being taken forward, by whom and by when.
- Ensure QSIG meetings are scheduled sufficiently in advance and aligned with Clinical Executive Director availability at mutually appropriate/agreeable times to enable quoracy at QSIG to be maintained.
- Ensure all reporting groups review and re-submit by their next reporting period, their revised Terms of Reference to QSIG for approval.
- Ensure use of key performance indicators is triangulated with patient feedback, surveys and patient stories by expanding data use beyond performance metrics into patient experience within Our Safety Dashboard.
- Develop a more structured approach to planning deep dives on QSIG's agenda throughout the year, ensuring that topics are identified and scheduled in advance where possible, while retaining flexibility for emerging issues, as and when these arise.
- Acknowledging that capacity to sustain operational governance functions is an issue, discussion to be held at Executive Team on how support can be provided.

2.2 Integrated Quality, Finance & Performance Delivery Group (IQFPDG) Desktop Review (through the sourcing of IQFPDG's agendas, papers and workplan)

2.2.1 Establish whether a composite 'intelligence' report is presented routinely to IQFPDG, based on the Our 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 and for them to operationalise any responses required.

Through a desktop exercise undertaken of IQFPDG's agendas, papers and annual workplan, the review sought to establish whether the 'intelligence' from QSIG has been presented to IQFPDG on a monthly basis, providing the context for its quality, health & safety focused meetings, through a Quality and Safety Report.

It was confirmed that this has been the case, with the Quality and Safety Report providing the monthly escalation levels for CCGs and Corporate functions for the Quality domain, and the minimum requirements to reduce escalation levels, as well as the Alert, Advise and Assure items from the most recent QSIG meeting. The only exception to this being the Quality and Safety Report from QSIG to IQFPDG on 22 October 2025 where no Alert, Advise or Assure items were included from QSIG's meeting on 10 October due to unexpected leave; a verbal update was instead provided.

Since IQFPDG was temporarily stood down in January 2026 due to winter pressures, it was agreed to share the Quality and Safety Report directly with Formal Executive Team in the absence of IQFPDG meetings taking place.

2.2.2 Establish whether issues from QSIG's reporting groups and the proposed actions required for IQFPDG to agree for the Clinical Care Groups are incorporated into the composite intelligence report to IQFPDG (3 of the reporting groups' data reported to IQFPDG once every 4 months).

The Quality and Safety Report submitted to IQFPDG sets out the monthly escalation levels for functions for the Quality domain with the de-escalation criteria for CCGs and other Corporate functions and also identifies a summary of matters considered at the previous QSIG meeting.

These matters are set out in a 3As format and reproduce the discussion at the previous QSIG meeting for IQFPDG's consideration, and to agree any actions for CCGs and Corporate functions to undertake.

2.2.3 Establish whether a summary report of the Quality & Safety intelligence is appended to the routine IQFPDG report and presented to Executive Team, to provide an overview of any issues

that needed actions agreed through IQFPDG for Clinical Care Groups to take forward.

A summary report of the Quality & Safety intelligence has routinely been appended to the IQFPDG Update Report to Executive Team, providing an overview of any issues that needed actions agreed through IQFPDG for CCGs to take forward, up until IQFPDG meetings were stood down in January 2026. Since this time, it had been agreed that the Quality & Safety Report would be shared directly with Executive Team in the absence of IQFPDG meetings taking place, however no evidence could be found of this in Formal Executive Team agenda or minutes.

Through interviews conducted with the Chair of IQFPDG (Quality, Health & Safety meetings) the following questions were posed:

- **Is there an appropriate level of discussion at IQFPDG on the Quality & Safety Intelligence Report (i.e. is there sufficient time allocated on IQFPDG's agenda for this item, is the depth of discussion commensurate with the issues involved)**

The review noted that whilst the detail within the Quality & Safety Report correlates with the issues raised within the CCG 3As update reports, the Quality & Safety Report is placed on the agenda following the individual CCG and Corporate functions 3As reports and it is suggested that by placing it in front of these reports would provide for the necessary context.

- **How does the data/intelligence from the Quality & Safety Intelligence Report triangulate with the 3As Assurance Reports from the CCGs IGG (QHS) meetings**

As above, much of what is contained within the Quality & Safety Report has also been raised by the CCGs in their 3As update reports to IQFPFDG.

- **Is there evidence to confirm that the responses required to address concerns or issues related to quality performance are appropriately being addressed by CCGs i.e. is there buy in from the CCGs**

One of the purposes behind establishing IQFPDG was to facilitate cross-organisational learning across CCGs and other Corporate functions, and to provide a forum for shared discussions and cross-pollination of insights and ideas with the aim of avoiding siloed solutions.

The CCG Service Directors and Assistant Directors of Nursing, Quality and Experience/Assistant Director of Quality, Safety and Experience present at IQFPDG meetings should be directly informed of the quality & safety issues within their specific areas in order that the service could then operationalise any responses that may be required.

The role of IQFPDG is currently under review, however the absence of a forum where CCG Service Directors and Assistant Directors of Nursing, Quality and Experience/Assistant Director of Quality, Safety and Experience are present could re-create silos, reduce cross-group information and risk pertinent information bypassing the Chief Operating Officer and other Executive Directors present at IQFPDG.

IQFPDG plays an important role in ensuring quality and safety issues do not reach Executive Directors without sufficient operational input, or indeed QSEC, as 'surprises'.

- **Are the indicators showing an improving position – too soon to tell or to attribute to the new governance arrangements**

  Whilst some improvement trajectories have been observed, it is recognised that seasonal/winter pressures have served to impact consistency. It is therefore too early to tell whether these improvements can be attributed to the new arrangements in place.

- **Is there any subsequent discussion at Formal Executive Team on the Quality & Safety Intelligence Report appended to the IQFPDG Update Report**

  Whilst a summary report of the Quality & Safety intelligence had been agreed to be appended to the IQFPDG Update Report to Executive Team, no evidence could be found of this, or any discussion, in Executive Team's agenda or minutes.

Recommendations in Relation to IQFPDG:

- Ensure the Quality & Safety Report is placed on IQFPDG's agenda in front of the individual CCG and Corporate functions 3As reports to provide for the necessary context.
- To reinstate the sharing of the Quality & Safety Report with Formal Executive Team directly in the absence of IQFPDG meetings, or append to the IQFPDG Update Report to Formal Executive Team when IQFPDG meetings are taking place.
- Dependent upon the outcome of the review of IQFPDG, consideration to be given to how the necessary cross-group information will be addressed in any new governance arrangements proposed.

2.3 Quality, Safety & Experience Committee (QSEC)

Desktop Review (through sourcing of QSEC's agendas, papers and workplan)

2.3.1 Establish whether the 6 CCG (and Public Health) Quality Reports are being received in appropriate rotation and at appropriate intervals at QSEC.

Through a desktop exercise undertaken of QSEC's agendas, papers and annual workplan the review sought to establish whether the following revised

arrangements as articulated in the 'Proposed Quality & Safety Governance Arrangements Report' to QSEC in August 2025, had been effectively implemented:

> *In addition to the Quality Assurance report, QSEC are to receive a six monthly assurance report from each CCG, and Public Health, on their quality governance arrangements to enable QSEC to gain assurance direct from each CCG.*

From the desktop review undertaken, the following 3 CCG assurance reports were presented to QSEC at its meeting on 4 December 2025:

- Community & Integrated Medicine CCG
- Allied Health Professions & Health Science CCG, and
- Planned & Specialist Care CCG

Only one CCG assurance report was presented to QSEC at its meeting on 13 February 2026, from Estates & Facilities. Both the Mental Health & Learning Disabilities CCG and Public Health had been plotted onto QSEC's 2025/26 Workplan for 13 February 2026, however it was agreed to defer these during agenda setting as the February QSEC agenda was considered too full.

From QSEC's 2026/27 Workplan, CCG assurance reports have been plotted three times a year rather than the proposed 6 monthly as follows:

- Mental Health & Learning Disabilities; Estates & Facilities; Public Health – 11 June 2026, 9 October 2026 and 9 February 2027 QSEC meetings.
- Community & Integrated Medicine, Allied Health Professions & Health Science, Planned & Specialist Care - 9 April 2025, 11 August 2025 and 3 December 2025.

2.3.2 Establish whether a quality assurance report is reported routinely to QSEC, drawing out the key issues from the intelligence provided for the reporting groups (3 times per year) and any alert and advise items from the Clinical Care Group 3As reports with the agreed plan of action to address these.

From the desktop review undertaken, a Quality & Safety Assurance Report has been submitted to QSEC at each of its three meetings held on 9 October 2025, 4 December 2025 and 4 February 2026, where QSEC was asked to take assurance that processes are in place to review, monitor and improve the quality of the Health Board's services through Patient Safety Incidents, Nationally Reported Patient Safety Incidents, Duty of Candour, Patient Experience, Complaints Management, Public Services Ombudsman for Wales Annual Letter, Infection Prevention and Control, Inspections and Peer Reviews including the activity of Healthcare Inspectorate Wales (HIW).

However, the report does not include the key issues from the intelligence provided for QSIG's reporting groups nor any alert and advise items from the Clinical Care Group and Corporate functions 3As reports with the agreed plan of action to address these.

Following the presentation of, and discussion on, the key highlights from each report, QSEC received assurance at each of its three meetings that processes are in place to review, monitor and improve the quality of Health Board services through the various mechanisms outlined within the Quality Assurance Report, with the exception of the key issues from the intelligence provided for QSIG's reporting groups and any alert and advise items from the Clinical Care Group and Corporate functions 3As reports with the agreed plan of action to address these.

Areas requiring immediate assurance i.e. areas that were flagged in the most recent report to IQFPDG (and to the Senior Nurse Management Team) from CCGs and QSIG's reporting groups, were included within the Quality & Safety Assurance Report to QSEC.

2.3.3 Establish whether this Quality Assurance Report also provides 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.

As above, the Quality Assurance Report does not include the key issues from the intelligence provided for QSIG's reporting groups (including the QIA Panel) nor any alert and advise items from the Clinical Care Group 3As reports with the plan of action to address these as agreed at IQFPDG.

2.3.4 Establish whether routine 6 monthly assurance reports are received at QSEC in respect of safeguarding and infection prevention & control.

From the desktop review undertaken, Safeguarding and Infection Prevention & Control assurance reports were both due to be received at QSEC's meeting in February 2026, however only the Safeguarding Assurance Report was received; it was agreed to stagger these two assurance reports given both were to be written by the same reporting author and it was agreed it would be too much to cover. With the Chair's agreement, the Infection Prevention & Control assurance report was deferred until QSEC's meeting in April 2026.

From the Safeguarding Report received at QSEC in February 2026, the Committee was provided with detailed information on compliance with statutory safeguarding requirements and asked to receive an assurance on the Health Board's safeguarding arrangements and the current activity, key developments, and actions underway to strengthen compliance with statutory safeguarding requirements.

Both assurance reports have been plotted on QSEC's 2026/27 workplan three times a year rather than the proposed 6 monthly i.e. at every other QSEC meeting, as follows:

- Infection Prevention & Control in April 2026 August 2026 and December 2026
- Safeguarding in June 2026, October 2026 and February 2027

Through interviews conducted with the QSEC Chair, the following questions were posed:

- **Are the revised quality & safety governance arrangements in place since September 2025 working better than the arrangements previously in place**

  Through discussion with the Chair of QSEC, it was confirmed that the new arrangements are an improvement over those previously in place whilst acknowledging that some areas still require improvement, offering more structure and direction for the Committee and Board, and prompting Committee members to consider more carefully those actions or responses that are required through the QSEC 3As Report submitted to Board.

  It was recognised that the intention behind the revised arrangements had been to help the Board understand what is important and to provide direction back to the Committee, which it was agreed has been achieved to a greater extent than previously.

- **Are the new arrangements reducing the number of 'surprises' reported to the Committee**

  Through discussion with the QSEC Chair, it was acknowledged that the previous arrangements often led the Committee into operational detail at too early a stage, however the revised arrangements in place have reduced the need for unnecessary alerts and have served to improve clarity.

- **Are the new arrangements focusing on reporting impacts and outcomes**

  Through discussion with the QSEC Chair, there was a general confidence in the Committee's ability to receive assurance regarding compliance with standards and the effectiveness of reporting from subgroups, however areas were highlighted where reporting could be strengthened, especially regarding outcomes and impacts where it was noted that the information provided can be variable and not always proactively driven. It was suggested that the Committee could benefit from a more prominent or clearer action summary within the reports presented.

  Additionally, it was noted that the Quality and Safety Assurance Report is often placed towards the end of QSEC's meeting agenda, leading to the potential for it to be skimmed over/overlooked. The importance of effective agenda setting to ensure that sufficient time is allocated to key topics and to ensure that meetings do not run out of time for important items placed at the end of the agenda is therefore recommended.

In terms of CCG assurance reports, concerns were raised that reports can be of variable quality; some are defensive or lack clarity or necessary insight, and do not always provide the necessary information on outcomes and impacts and need improving in order to better assure the Committee. Others however are more reassuring, however overall this indicates an inconsistency in reporting maturity across the organisation and therefore the Committee cannot be fully assured by the reporting groups' outputs.

- **Is the Committee's oversight of quality & safety improved**

  Through discussion with the QSEC Chair, it was agreed that the revised arrangements lend themselves to the Committee remaining more strategic and avoid it becoming drawn into operational detail which had been the case previously with the former Sub-Committee structure. However, in order to maintain strategic focus, there will be a need to continue emphasising strategic oversight to avoid the Committee being drawn into operational detail.

  It was noted that the 3As framework has helped less experienced Independent Members understand the difference between being assured i.e. with evidence, and being reassured i.e. by statements, which has improved the quality of oversight.

  The value of deep dive sessions for the Committee, including extraordinary deep dive sessions, was also discussed with the QSEC Chair, with it agreed that these are particularly effective for gaining a thorough understanding of issues as they allow for more detailed discussion than is possible in regular meetings, however the time required for these sessions can be a challenge for Independent Members given their other commitments.

- **Is there sufficient first, second and third line assurance from the reports received at QSEC**

  Through discussion with the QSEC Chair, it was agreed that the Committee generally receives assurance regarding compliance with legislation, regulation, etc, with the Director of Nursing, Quality & Patient Experience credited for maintaining a strong grip on quality and standards.

  Application of the 3As template in Committee reporting was discussed, and while the Chair acknowledged its usefulness, the need for nuancing in terms of distinguishing between assurance of process and assurance of outcome was recognised. It was acknowledged that the Committee can sometimes be assured by the process although not necessarily by the outcome, and that while the 3As framework allows for this distinction, it can make reporting more complex.

- **Is there any duplication in the papers received at QSEC**

  Through discussion with the QSEC Chair, it was noted that while duplication within QSEC papers is no longer a significant issue, having reduced due to

the revised arrangements in place, similar papers are often submitted to different Committees. Going forward it would be important to draw out from these papers the specific relevance for each Committee and to tailor these in order to avoid unnecessary repetition.

- **Are there any perceived gaps**

  Through discussion with the QSEC Chair, it was understood that while the new arrangements are working more effectively, there are still gaps, particularly in terms of walkabout intelligence and assurance flow. Whilst walkabouts provide useful context, there is uncertainty about whether all walkabout observations and intelligence is consistently captured and fed back to QSEC.

  Ways could also be explored to provide relevant briefing information to non-QSEC members prior to quality and safety walkabouts, especially regarding specific concerns or service changes.

Recommendations in Relation to QSEC:

- Reinforce the previously agreed 6 monthly reporting cycle discipline for CCG and Public Health assurance reports on QSEC's agenda.
- Include within the Quality & Safety Assurance Report to QSEC the key issues from the intelligence provided for QSIG's reporting groups and any alert and advise items from the CCG and Corporate functions 3As reports with the agreed plan of action to address these as discussed at IQFPDG.
- Reinforce the previously agreed 6 monthly reporting cycle discipline for Safeguarding and Infection Prevention and Control assurance reports on QSEC's agenda.
- Address concerns regarding the variability and content of CCG and Public Health assurance reports by introducing a more prominent and clearer action summary within these reports to QSEC.
- Place the Quality and Safety Assurance Report nearer the beginning of QSEC's meeting agenda to avoid late-meeting fatigue and to ensure sufficient time is allocated to its discussion.
- Explore a light-touch mechanism for capturing and feeding walkabout insights when formal note-taking is unavailable.

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

REVIEW OF THE EFFECTIVE IMPLEMENTATION OF THE REVISED QUALITY & SAFETY GOVERNANCE ARRANGEMENTS INTRODUCED SEPTEMBER 2025 – ACTION PLAN

RECOMMENDATION QSIG	ACTION	LEAD	TIMESCALE	PROGRESS
Adopt a Table of Action discipline at QSIG where actions are reviewed and closed at each meeting, rather than placing a reliance on the current Live Action Tracker.	Introduce the QSIG Live Action Tracker as a standard agenda item on QSIG's agenda.	CS	April 2026	
Ensure all reporting groups review and re-submit by their next reporting period their revised Terms of Reference to QSIG for approval.	Ensure that all Reporting Group Chairs review their Terms of Reference for QSIG at their next reporting period for approval.	CS	April 2026	
Reinforce the previously agreed 4 monthly reporting cycle discipline for QSIG's reporting groups to avoid over and under reporting.	Plot on QSIG's Annual Workplan QSIG Reporting Group Update Reports at 4 monthly intervals	CS	April 2026	
Develop structured reporting group specific templates incorporating baseline assessments against which the Health Board's position against the required legislation or standards can be measured, identifying how any gaps in	Develop a bespoke reporting group template to QSIG incorporating baseline assessments against which the Health Board's position can be measured, to identify any gaps in compliance and the actions required to address these.	CS	May 2026	

RECOMMENDATION QSIG	ACTION	LEAD	TIMESCALE	PROGRESS
achieving compliance can be met, together with the actions being taken forward, by whom and by when.				
Ensure QSIG meetings are scheduled sufficiently in advance and aligned with Clinical Executive Director availability at mutually appropriate/agreeable times to enable quoracy at QSIG to be maintained.	Liaise with Clinical Executive Director PAs to ensure alignment of QSIG meetings with availability and other key meetings such as QSEC and the Board.	CS	April 2026	
Ensure use of key performance indicators is triangulated with patient feedback, surveys and patient stories by expanding data use beyond performance metrics into patient experience within the Our Safety Dashboard.	Triangulate the key performance indicators and metrics within the Our Safety Dashboard with patient feedback, surveys and patient stories in order to expand data use beyond performance metrics.	CS	May 2026	
Reinstate outcome letters or action summaries to CCGs and Corporate functions, following QSIG meetings, particularly around escalation.	Re-introduce ‘outcome letters’ to CCGs and Corporate functions following discussion at QSIG to follow up on any action required within their respective services.	CS	April 2026	
Develop a more structured approach to planning deep dives on QSIG’s agenda throughout the year, ensuring that topics are identified and scheduled in advance where possible, while	Plot on QSIG’s Annual Workplan topics for deep dives throughout the year which are structured, balanced, and aligned to the quality and safety agenda.	SD/CS	May 2026	

RECOMMENDATION QSIG	ACTION	LEAD	TIMESCALE	PROGRESS
retaining flexibility for emerging issues, as and when they arise.				
Introduce a clearer definition of what should be escalated to QSIG from reporting groups within their respective Terms of Reference.	Revise the QSIG Reporting Group Terms of Reference template to include a clear definition of what should be escalated to QSIG.	CG Team	April 2026	
Acknowledging that capacity to sustain operational governance functions is an issue, discussion to be held at Executive Team on how support can be provided.	Discuss how the administrative resource required to sustain operational governance functions can be provided.	Exec Team	May 2026	

RECOMMENDATION IQFPDG	ACTION	LEAD	TIMESCALE	PROGRESS
Ensure the Quality & Safety Report is placed on IQFPDG's agenda in front of the individual CCG and Corporate functions 3As reports to provide for the necessary context.	Introduce the Quality & Safety Report ahead of the individual CCG and Corporate functions 3As reports on IQFPDG's agenda.	HM	April 2026	
To reinstate the sharing of the Quality & Safety Report with Formal Executive Team directly in the absence of IQFPDG meetings, or append to the IQFPDG Update Report to Formal Executive Team when IQFPDG meetings are taking place.	Share the Quality & Safety Report to IQFPDG with Formal Executive Team	HM/JJ	April 2026	
Dependent upon the outcome of the review of IQFPDG, consideration to be given to how the necessary cross-group information will be addressed in any new governance arrangements proposed.	Address cross-group information within any new governance arrangements proposed to avoid silo working.	Exec Team	May 2026	

RECOMMENDATION QSEC	ACTION	LEAD	TIMESCALE	PROGRESS
Include within the Quality & Safety Assurance Report to QSEC the key issues from the intelligence provided for QSIG's reporting groups and any alert and advise items from the CCG and Corporate functions 3As reports with the agreed plan of action to address these as discussed at IQFPDG.	Add the key issues from the intelligence provided for QSIG's reporting groups and any alert and advise items from the CCG and Corporate functions 3As reports with the agreed plan of action to address these as discussed at IQFPDG into the Quality & Safety Assurance Report to QSEC.	CS	June 2026	
Place the Quality & Safety Assurance Report nearer the beginning of QSEC's meeting agenda to avoid late-meeting fatigue and to ensure sufficient time is allocated to its discussion.	Introduce the Quality & Safety Assurance Report earlier onto QSEC's agenda.	KL	June 2026	
Reinforce the previously agreed 6 monthly reporting cycle discipline for CCG and Public Health assurance reports on QSEC's agenda.	Plot on QSEC's Annual Workplan CCG and Public Health Assurance Reports at 6 monthly intervals.	KL	April 2026	
Address concerns regarding the variability and content of CCG and Public Health assurance reports by introducing a more prominent and clearer action summary within these reports to QSEC.	Include within the CCG and Public Health Assurance Reports template a more prominent and clear action summary.	CS	June 2026	

RECOMMENDATION QSEC	ACTION	LEAD	TIMESCALE	PROGRESS
Reinforce the previously agreed 6 monthly reporting cycle discipline for Safeguarding and Infection Prevention and Control assurance reports on QSEC's agenda.	Plot on QSEC's Annual Workplan Safeguarding and Infection Prevention and Control Assurance Reports at 6 monthly intervals	KL	April 2026	
Explore a light-touch mechanism for capturing and feeding walkabout insights into QSEC when formal note-taking is unavailable.	Implement a mechanism to enable feedback submission from those involved with walkabouts to ensure consistent reporting to QSEC.	SD	June 2026	

Key

CS	Cathie Steele	SD	Sharon Daniel	CG Team	Corporate Governance Team
AC	Andrew Carruthers	HM	Helen Mitchell	JJ	John Jenkins
KL	Katie Lewis				

3.3

3.3 - Quality Assurance Report

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

Attachments

3.1 QS Assurance Report Apr2026 v1.0.pdf

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

Quality and Safety Assurance Report

Quality, Safety and Experience Committee

April 2026

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
- Never Events
- Duty of Candour
- Patient Experience
- Complaints management
- Inquests and Regulation 28
- Infection prevention and control
- Inspections and peer reviews including activity of Healthcare Inspectorate Wales (HIW)

This report also includes information regarding the HIW: Strategic Plan for 2026-2030 and the NHS Wales Performance and Improvement: National Patient Safety Plan for NHS Wales for 2026-2031

Patient Safety Incidents

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

There were 15,204 incidents reported on Datix Cymru in Hywel Dda UHB between 1 January and 31 December 2025. Of these, 12,139 were Patient Safety Incidents.

Of the 12,139 patient safety incidents reported, 9,462 have been closed. 68 (0.7%) were closed as moderate, severe or catastrophic harm.

The top 3 incident classifications (patient safety incidents reported between 01/11/2024 and 31/10/2025 and closed as moderate, severe or catastrophic harm) were pressure damage (20); accident or injury (14); 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	16
Slip, trip or fall	13
Treatment or procedure issues	8

These themes have been shared with:

- Clinical Care Groups (CCG) for discussion, consideration and improvement action
- The learning library and Viva Engage

A review, using the support of AI, identified the main themes, within the lessons learned of patient safety incidents reported between 01/01/2025 and 31/12/2025 and closed, were:

1) Clinical Assessment & Decision-Making
Many incidents involve incomplete assessment, failure to recognise deterioration, missed injuries, and delayed escalation to senior clinicians.
Recommendations to the CCGs :
Strengthen use of structured assessment tools (ABCDE, trauma pathways, Advanced Trauma Life Support (ATLS) principles).
Ensure timely senior or specialist review when presentation is complex.
Reinforce need for comprehensive documentation of clinical findings and rationale.
Mandate re-assessment if symptoms persist, worsen, or do not align with initial diagnosis.

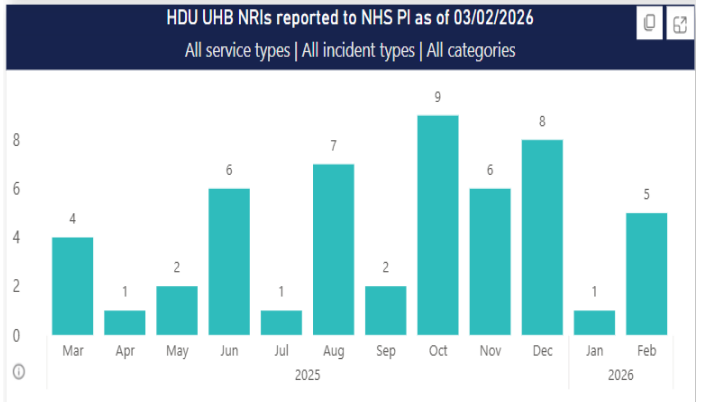
2) Escalation & Communication
Escalation often happened late, was incomplete, or relied on assumptions. Communication between teams, patients and families is critical.
Recommendations to the CCGs :
Escalate immediately when deterioration is identified or when safeguarding factors arise.
Improve communication handover processes (nursing ↔ medical, ward ↔ community).
Ensure Next of Kin is informed promptly following incidents.
Apply Duty of Candour processes consistently, including documentation and letters.

3) Risk Assessment & Documentation
Many incidents highlight missing or incomplete risk tools, care plans, body maps, or inconsistent records.
Recommendations to the CCGs:
Complete Purpose-T, Waterlow score, and Falls assessments at admission AND after changes.
Keep documentation aligned: risk tools must match care plans and repositioning schedules.
Ensure body maps are completed before discharge and co-signed.
Improve accuracy a of updates to Welsh Nursing Care Record (WNCR) and wound charts.

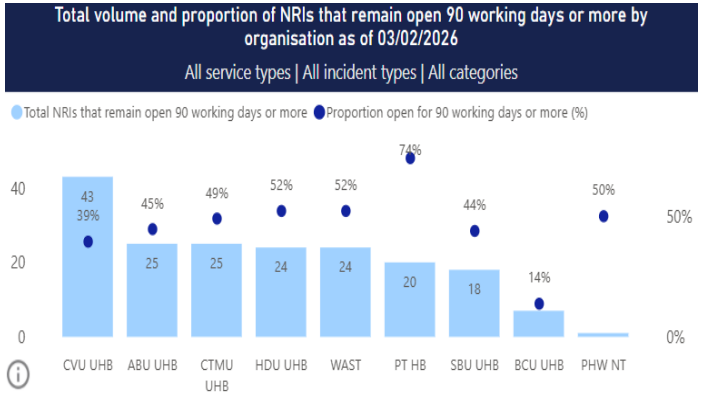
Diogel Safe

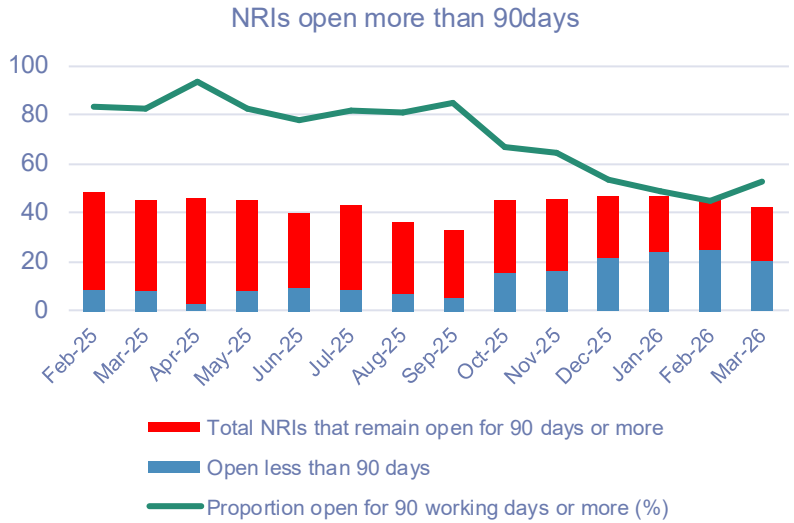
Nationally Reportable Incidents

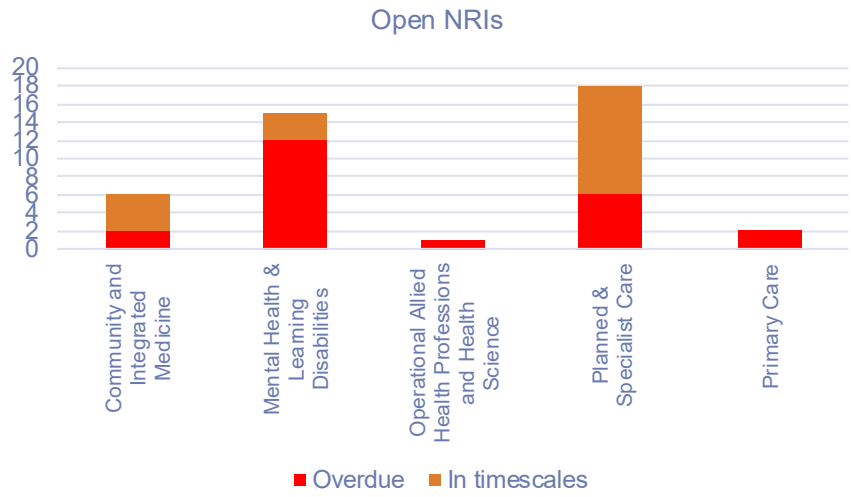
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board



Source: Beacon Dashboard
06/03/2026







Number of days since reporting to NHS Wales Performance and Improvement

	0-60days	61-90days	91-120days	121-180days	>180days	Total
Community and Integrated Medicine	4		1	1		6
Mental Health & Learning Disabilities	3			1	11	15
Operational Allied Health Professions and Health Science		1				1
Planned & Specialist Care	7	4	2	3	2	18
Primary Care	1			1		2
Totals	15	5	3	6	13	42

Never Events

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

HDU UHB Never Events occuring (by incident date, Mar-25 to Feb-26) as of 03/02/2026												
Year	2025										2026	
Never Event	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Retained foreign object post procedure	0	0	0	0	0	0	0	0	1	0	0	0
Total Never Events	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**

Source: Beacon Dashboard 06/03/2026

HDD79894 (NRI-4672)

Date reported 19/02/2026. Outcome form due for submission by 19/05/2026.

Patient was discharged with a newly inserted nasogastric (NG) tube without confirmation of correct placement, contrary to Health Board policy and national safety guidance

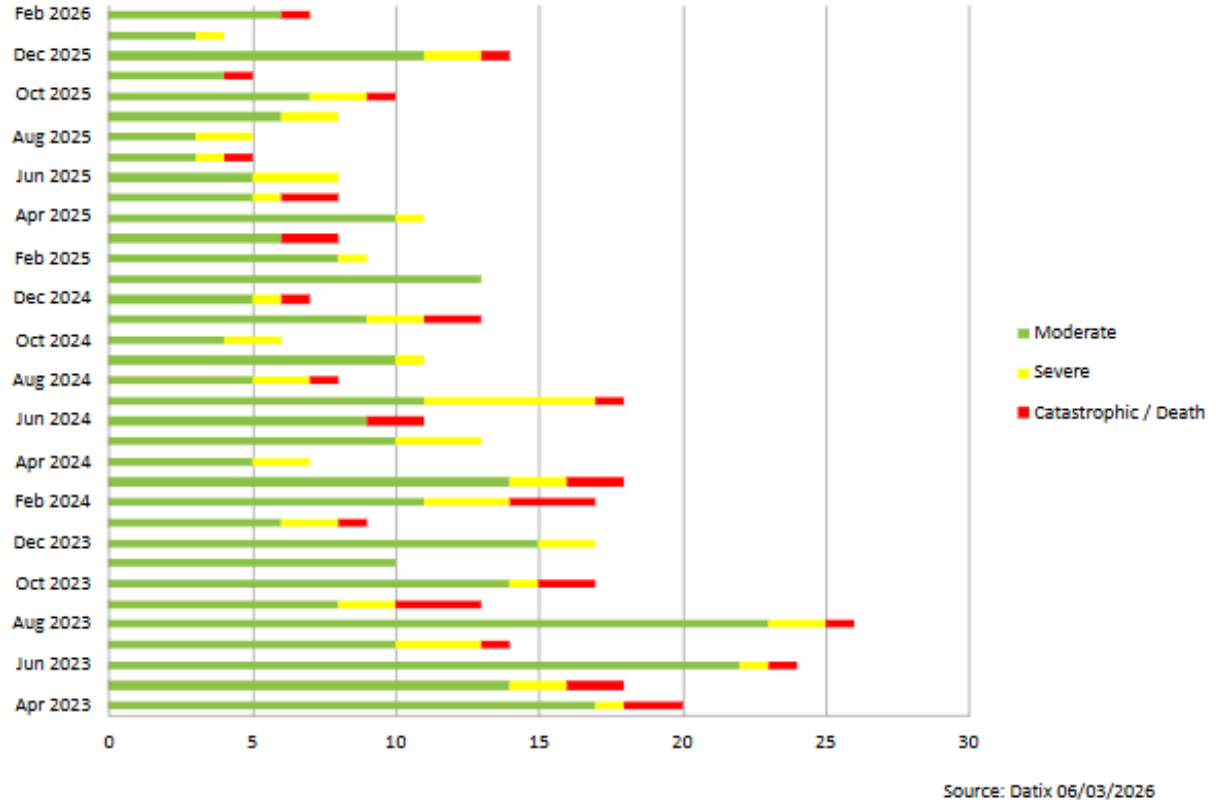
Immediate actions included:

- Notifying departmental leads, reinforcing Health Board policy on NG tube safety (including potential of hydrogen (pH) testing, radiographic confirmation, and guidewire removal), and directing staff to nasogastric insertion training to prevent recurrence
- A 7-minute briefing on Never Event reporting has been drafted and will be circulated to all staff.
- Just Culture tool to be completed in relation to individual who placed the NG tube and if appropriate workforce policy to be followed whilst incident investigation relating to system issues continues.
- Nutrition and Hydration Group to consider other immediate actions to be taken to ensure awareness and knowledge of correct procedures for insertion

Health Board Overview – Duty of Candour

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Incidents by Incident date (Month and year) and Manager's interim harm assessment



Source: Datix 06/03/2026

284 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	54	164	3	1	296
	Severe	1	9	5	14	3	32
	Catastrophic / Death	3	5	1	2	5	16
	Total	18	68	170	19	9	284

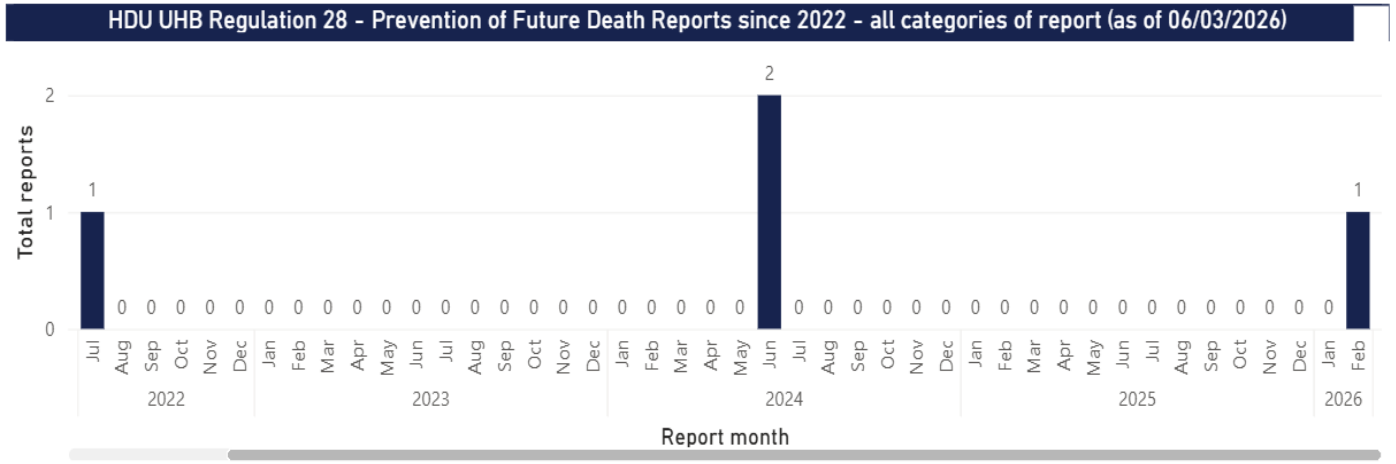
Top 3 incident classifications

Incidents occurring after 01/04/2023 where duty of candour has triggered and investigation has closed and harm post investigation is moderate or above

Pressure Damage, Moisture Damage	**39**
Pressure ulcer developed or worsened during care in this clinical care area/caseload	34
Pressure ulcer present before admission to this clinical care area/caseload	1
Pressure from medical device present before admission to this clinical care area/caseload	1
Pressure from medical device developed or worsened in this clinical care area/caseload	3
Accident, Injury	**46**
Contact with object or animal	0
Slip, trip or fall	44
Patient injury	2
Maternity adverse occurrence	**25**
Maternal	12
Neonate	13

Diogel Safe | Amserol Timely | Effeithiol Effective | Person ganolog Person centred

Inquests and Regulation 28



Source: Beacon Dashboard 06/03/2026

The Coroner has a legal power and duty to write a report following an inquest if it appears there is a risk of other deaths occurring in similar circumstances. This is known as a "Regulation 28 Report" or "Prevention of Future Death Report'

The report is sent to the people or organisations who are in a position to take action to reduce this risk. They then must reply within 56 days to say what action they plan to take. A Regulation 28 report was issued to all LHBs by Pontypridd Coroner following death of 4-year-old in Prince Charles Hospital in March 2024. His Majesty's (HM) Coroner recommended that:

"Paediatric crash trolleys are necessarily different to adult crash trolleys, but there was consensus in evidence that it would be safer if there was a single standardised version of each type across every hospital setting in which junior doctors rotate, to minimise confusion at a time critical moment."

Arrest trollies in the Health Board comply with the minimum equipment list recommended by the Resuscitation Council for arrest trolleys (Paediatrics and Adults)

- One for all paediatric wards and Accident and Emergency (A&E) Departments in the Health Board
- One for the paediatric emergency equipment cupboard in Glangwili General Hospital (GGH) A&E
- One for Outpatient Departments onsite
- One for Outpatient Departments offsite

The Health Board has:

- Shared this Regulation 28 with the Recognition of Deterioration and Acute Resuscitation (RADAR) Group for further discussion and consideration of additional actions
- Shared the Regulation 28 with the Welsh Resus Forum.
- Received the Regulation 28 at the Quality and Safety Intelligence Group who considered and agreed the proposed actions.

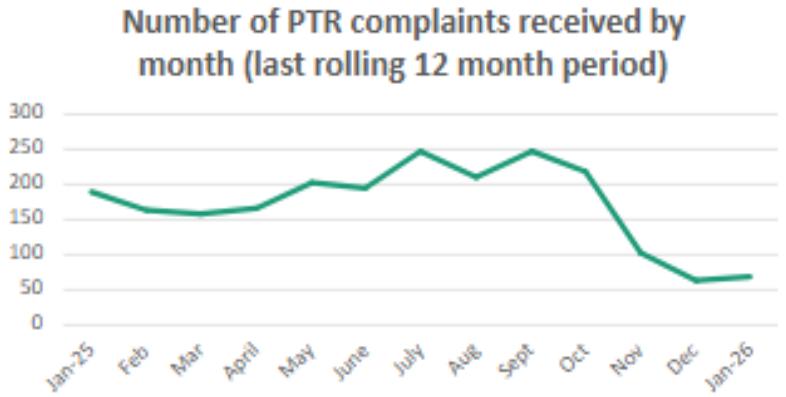
NHS Wales Performance and Improvement Team has confirmed that they have also received the Regulation 28 report.

Further action to be undertaken includes:

- Respond to HM Coroner regarding the trolleys in our organisation – response due 27/06/2026

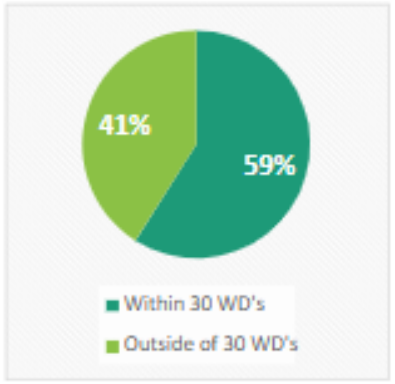
Health Board Overview: Complaints Management

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

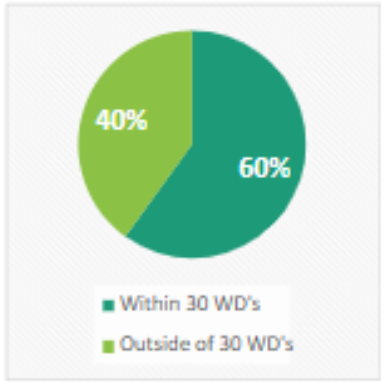


Proportion of complaints closed within 30 working days

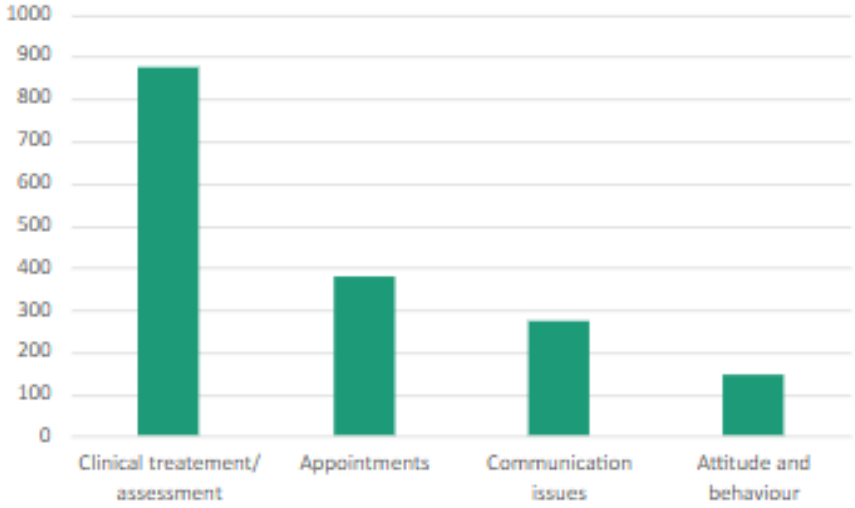
Q1 2025/ 26



Q2 25/26



The above charts show that, based on NHS Wales data, the performance in Q3 25/26 is consistent with Q2, although remains below target set by Welsh Government (75% within 30 WD's). Q3 data is not yet available.



Main themes giving rise to complaints remain consistent month on month; Emergency Departments, Ophthalmology, Gynaecology and Urology receiving higher numbers of complaints in these categories.

At least quarter of all complaints about appointments and waiting times are linked to Ophthalmology services. Urology, Rheumatology, Dermatology and Orthopaedics also receive higher numbers in this theme As usually seen, complaints about communication, attitude and behaviour are spread across Health Board services.

The reduction in new complaints received in November, December 25 and January 26 reflects the trial of a triage and navigation process to direct general and waiting time enquiries to more appropriate teams in the first instance, before they are handled as formal complaints, if necessary.

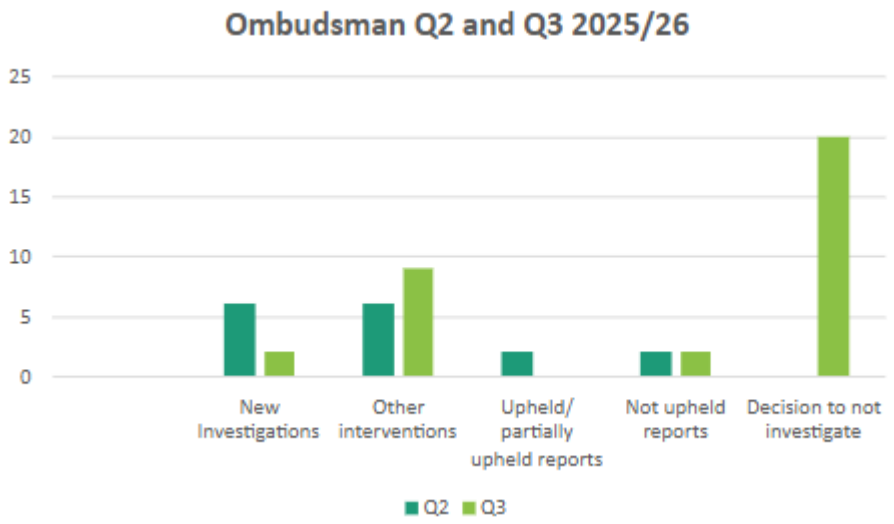
Health Board Overview: Outcomes and Closure Trajectory

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Since the start of the financial year, 45 complaints have identified a breach of duty of care which have not led to harm.

Between April 2025 – February 2026, 56 cases have been escalated to Redress (comparable period last year = 51) because failings have, or may have, caused harm to patients. These have mostly occurred at our general hospital sites (other sites include Tregaron and South Pembrokeshire Community Hospitals, as well as Primary Care.

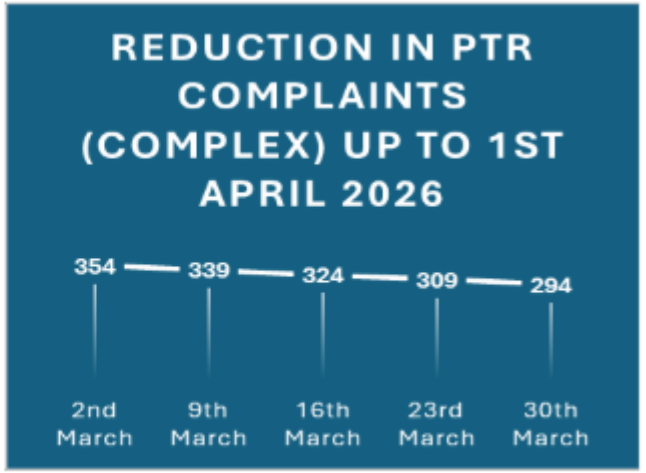
Learning from events reports will be produced following these incidents.

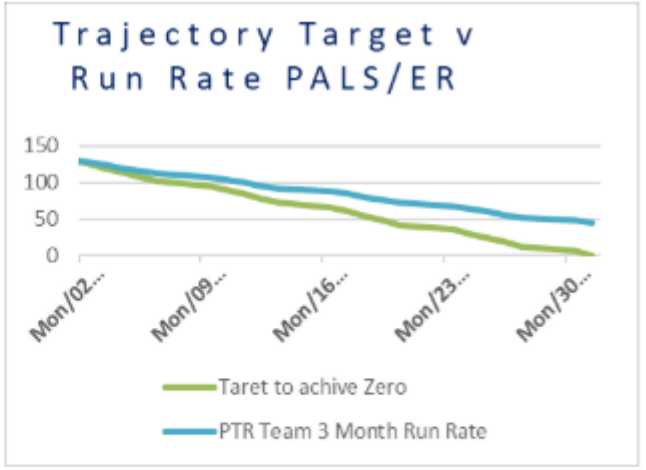


Backlog reduction (2–31 March):

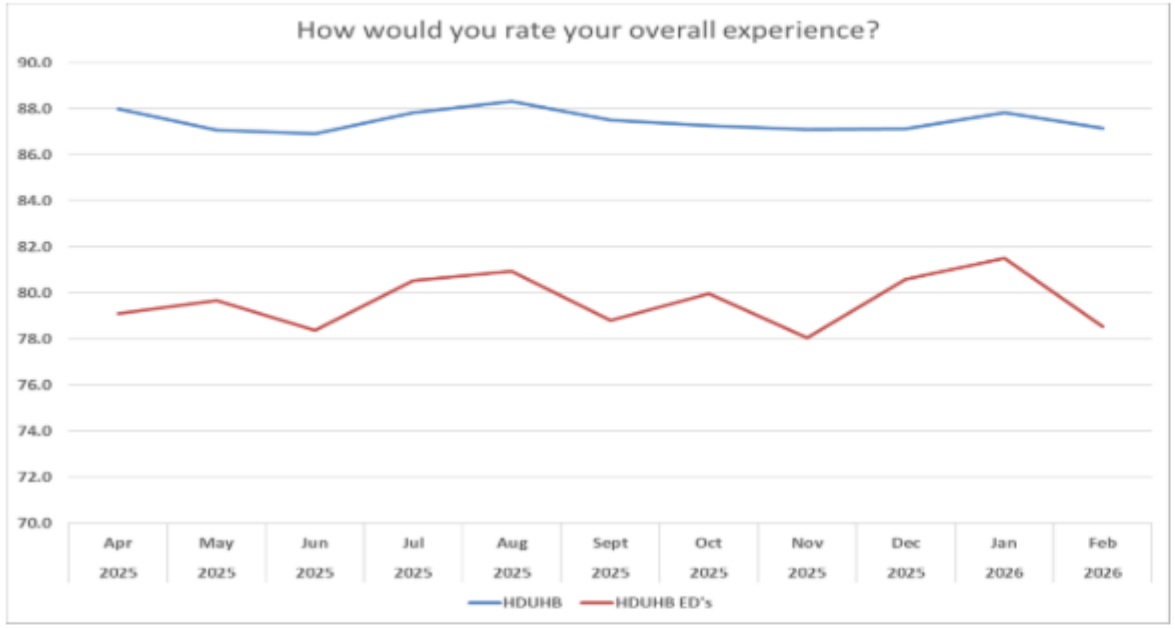
- From 1st April 2025, the Complaints Team should aim to close approximately 12 complaints per week consistently thorough Q1 and Q2, meaning that all complaints over 10 months will be closed by 1st April.
- Of the 61 cases we would aim to close in the next 4 weeks (until 1st April), almost 75% of these are either waiting for outstanding comments of waiting for approval by managers.

- Remaining PTR complaints will be closed (latest) by end Q2 – it is anticipated that these will be closed prior to this.
- PALS: cleared (0) by 1st April
- Service low grade PTR: ≤25-40 open at 1st April.
- Enquiries: no appointment/waiting-time queries in the complaints stream.
- LtP-ready: listening discussions embedded; 10-day early-resolution in use; proportionate investigations; learning demonstrably captured and shared.
- Complaint team resource has been divided into PTR (backlog and current open) and LTP (early resolution, listening meeting, proportionate responses).





Patient Experience



Measure name	Feb-26 Actual %
I am treated with dignity and respect	89.90%
Things were explained to me in a way I could understand	90.10%
I was able to communicate in my preferred language	95.60%

ED experience is volatile and fragile; non-ED experience is predictable and resilient

- Across Emergency Departments and Minor Injury Units, patient experience is highly polarised:
- Significant volumes of "Very good" sit alongside a persistent tail of "Poor / Very poor".
- Clinical staff (especially nurses, triage staff and MIU clinicians) are consistently praised
- Waiting times, communication and environment are the dominant drivers of poor experience
- Negative ratings are strongly associated with long waits, lack of beds, environment, and communication failures rather than clinical care quality
- Minor Injury Units are acting as a pressure-release valve and are viewed far more positively than A&E
- Responses to "Were you able to communicate in your preferred language?" Is consistently above 95% in all areas including the ED's
- Non ED areas ratings are much more stable.
- Majority responses are "Very good" or "Good", with fewer extreme negatives.
- Poor ratings tend to relate to delays, parking, cancellations, or communication, not unsafe care.

Infection Prevention and Control (IP&C): Strategic Overview

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Quality Planning

- Organisation Annual Plan
- Annual IP&C work plan
- Infection Prevention Strategic Steering Group Work Plan
- Welsh Health Circular (WHC) Antimicrobial Resistance (AMR) & Health Care Acquired Infection (HCAI) Improvement Goals 2025-2027
- Collaboration with Public Health Team
- Engagement with primary care and community services to reduce infection in high-risk populations
- Quality Statement – Infection Prevention and Control
- NHS Wales National Standards of Healthcare Cleanliness 2025

Quality Control

- Standardisation of assurance/ scrutiny groups in progress
- Reports to and from Clinical Care Groups (CCGs) / Subgroups of Infection Prevention Strategic Steering Group (IPSSG)
- Review of Health Board IPC policies
- Self-assessment against C.diff Framework for Wales and attendance at Wales C. diff Focus Forum Meeting.
- Review of data sets against TI reduction expectations- disseminated to all services and use of safety dashboards
- Review by Antimicrobial Group (AMG) and antibiotic pharmacists of compliance with SSTF for each acute site
- IPC policy review ongoing. The 2026/2027 workplan focuses on the adoption of national All Wales policy linked to the National Infection Prevention and Control Manual (NIPCM) and review of upcoming changes to transmission-based precautions

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 reinstated 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
- HPV in use in 4 acute sites
- For the 2026/2027 work plan- an IPC training review has been conducted. Staff will be directed to E-Learning for Level 2 IPC training rather than face to face. The IPC Team will deliver targeted/ opportunistic training at ward/ unit level to address emerging themes or lessons learnt within the Health Board. Enhancing knowledge and building competence within the workforce
- Engagement in the C diff Learning Collaborative - Co Design Event. IV [illegible] project to be revisited in Spring with CCG engagement and ownership

IP&C continued

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Quality Assurance

Performance de-escalation summary

Latest position key

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

	Measure	De-escalation criteria	Baseline	Baseline	Goal	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Infections	Number of laboratory confirmed C.difficile cases with hospital onset	25% reduction, maintained for 3 months	8	Baseline	6	5	11	8	8	2	7
	Number of laboratory confirmed S.aureus bacteramia cases with hospital onset	33% reduction, maintained for 3 months	3	Baseline	2	4	3	4	6	2	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	9	10	7	8	2	5

All CCGs to review progress against the HB Safety Dashboard

Review of monthly data from Hospital Antibiotic Review Programme (HARP) with internal HB analysis and scrutiny

Aseptic Non-Touch Technique (ANTT) training 85.02% compliance

Level 2 mandatory training at 73.77%.

Hydrogen Peroxide Vapour (HPV) enhanced cleaning now available at 4 acute sites

IP&C Overall Trend

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Table 1. Current FY rate per 1,000 hospital admissions of specimens by HB, Apr - Feb 26

Additional filters for Table 1.

Select month or FY: Current FY

Select organism group: All organisms

< than same period last FY
= same period last FY
> than same period last FY

	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Aneurin Bevan UHB	2.17	0.07	1.27	3.36	1.07	0.3
Betsi Cadwaladr UHB	3.24	0.08	1.82	4.8	1.36	0.34
Cardiff and Vale UHB	2.92	0.24	1.89	4.1	1.83	0.41
Cwm Taf Morgannwg UHB	2.49	0.12	1.73	5.8	2.22	0.24
Hywel Dda UHB	2.87	0.26	1.9	6.31	2.13	0.35
Powys THB	17.47	0	0.73	0.73	0	0
Swansea Bay UHB	3.16	0.13	1.77	4.08	1.73	0.43
Velindre NHST	1.23	0	1.23	4.3	0.61	0.61
Wales	**2.81**	**0.13**	**1.68**	**4.56**	**1.6**	**0.34**

Table 1. Current FY count of hospital onset (HO)* specimens by HB, Apr - Feb 26

Additional filters for Table 1.

Select month or FY: Current FY

Select organism group: All organisms

< than same period last FY
= same period last FY
> than same period last FY

	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Aneurin Bevan UHB	83	3	52	90	30	9
Betsi Cadwaladr UHB	165	4	47	107	41	8
Cardiff and Vale UHB	67	8	45	60	53	12
Cwm Taf Morgannwg UHB	51	6	32	55	34	5
Hywel Dda UHB	81	8	33	75	27	3
Powys THB	4	0	0	1	0	0
Swansea Bay UHB	100	3	42	62	49	16
Velindre NHST	1	0	0	4	0	0
Wales	**552**	**0**	**251**	**454**	**234**	**53**

IP&C Outbreaks / Incidents

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Feb/March 2026

Site	Area	Pathogen	Commenced	Impact	Opened
BGH	Enlli	Norovirus	16/02/26	3 patients and 4 staff	23/02/26 but unable to clean until 25/02/26
WGH	Ward 1	Norovirus	25/02/26	5 patients and 3 staff	Cleaning and opening 06/03/26
GGH	Cadog/ FAU	Norovirus and Covid	05/03/26	9 patients.	11/03/26

Incidents

Water concerns (ongoing)

Stenotrophomonas Maltophilia colonisation on ITU Glangwili Hospital (GGH) - ongoing action plan linked to environment and practice

Verona Integron-encoded Metallo-β-lactamase (VIM)-positive *P. aeruginosa* (VIM-PA) on Derwen Ward GGH - ongoing action plan linked to environment and practice

Tuberculosis (TB) in healthcare worker. Contact tracing in place

IP&C C. difficile infection

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Improvement Goal: To reduce the overall burden of C. diff infection by at least 25% against the 2024-25 counts

Table 2. Monthly count and rate of C. difficile in Hywel Dda UHB, 2025/26

Additional filters for Table 2.

Select FY: 2025/26

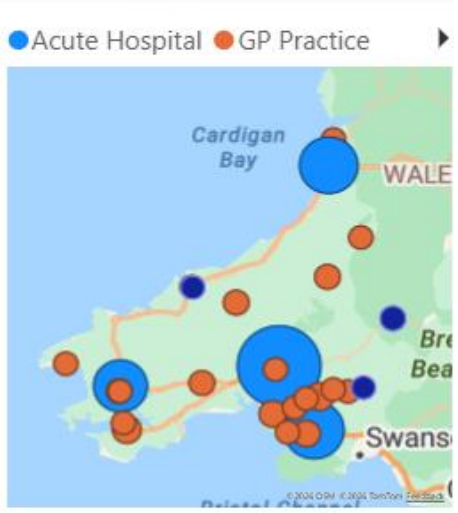
*Community onset (CO) - specimen taken in a community location or less than 3 days into a hospital inpatient stay

**Hospital onset (HO) - specimen taken more than 2 days into a hospital inpatient stay

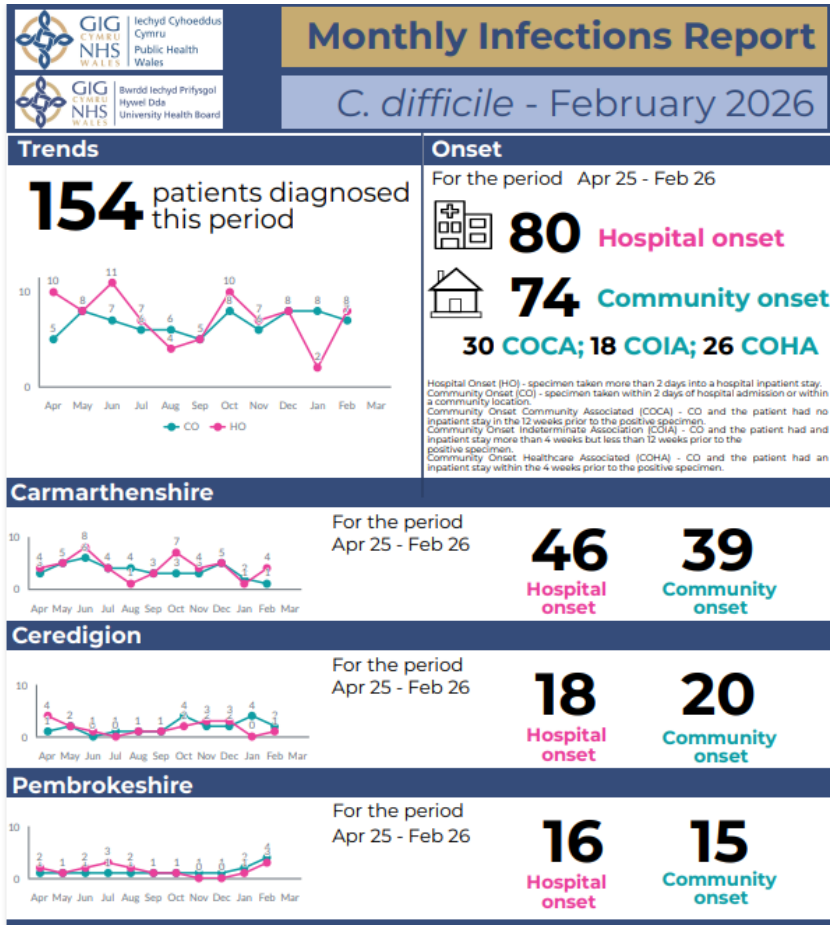
N.B. a hospital inpatient stay includes transfers with the same HB

***(HO count/Total count)*100

	Total count	CO* count	HO** count	% HO***	Total rate per 1,000 hospital admissions	Total rate per 100,000 population
2025/26	154	73	81	53%	2.87	43.36
April 2025	15	5	10	67%	3.19	47.02
May 2025	16	8	8	50%	3.43	48.54
June 2025	18	7	11	61%	3.74	56.42
July 2025	13	6	7	54%	2.62	39.44
August 2025	10	6	4	40%	2.23	30.33
September 2025	10	5	5	50%	2.07	31.35
October 2025	18	7	11	61%	3.45	54.60
November 2025	13	5	8	62%	2.61	40.75
December 2025	16	8	8	50%	3.22	48.54
January 2026	10	8	2	20%	2.01	30.33
February 2026	15	8	7	47%	3.02	50.38



For Hospital Onset (HO) cases, ≤5 patients have had 2 positive samples accounting for 8 HO cases during 25/26. For Community Onset (CO) cases 8 patient have 2 positive samples, and ≤5 patients have had 3 positive samples during 25/26 accounting for 22 CO results.



IP&C C. difficile infection

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Learning identified and actions

Learning Identified	Actions Required
Mattress cleaning: Ensure consistent, documented cleaning and decontamination	• Monthly mattress audits for wards/ departments • Mattress checking on discharge reinforced in line with decontamination and mattress cleaning policy
Hydrogen Peroxide Vapour (HPV) deep cleaning: Ensure HPV is used for all required deep cleans regardless of patient flow pressures.	• Trigger HPV decontamination in all required scenarios, even during operational pressures. • Non-compliance to be recorded • Training sessions for ward staff booked with Inivos in May for each acute site linked to new targeted IPC training
Review of historic Proton Pump Inhibitor (PPI) medication: Identify and review	• Share key themes and findings with clinical teams and discuss at Healthcare Associated Infection (HCAI) Assurance meetings/ C.diff infection (CDI) Improvement Group
IV to Oral switch project linked to C.diff Collaborative and WHC for AMR and HCAI 2025-2027 to recommence	• To link with CCGs to identify ward areas for pilot • To be monitored through CDI Improvement Group • Start Smart Then Focus audits to be presented to CCGs for ownership nd action plans

IP&C E. coli bacteraemia

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Improvement Goal: A reduction of at least 10% in cases of hospital onset E. coli blood stream infection (BSI) is expected vs the cases in 2024-2025.

Table 2. Monthly count and rate of E. coli bacteraemia in Hywel Dda UHB, 2025/26

Additional filters for Table 2.

Select FY: 2025/26

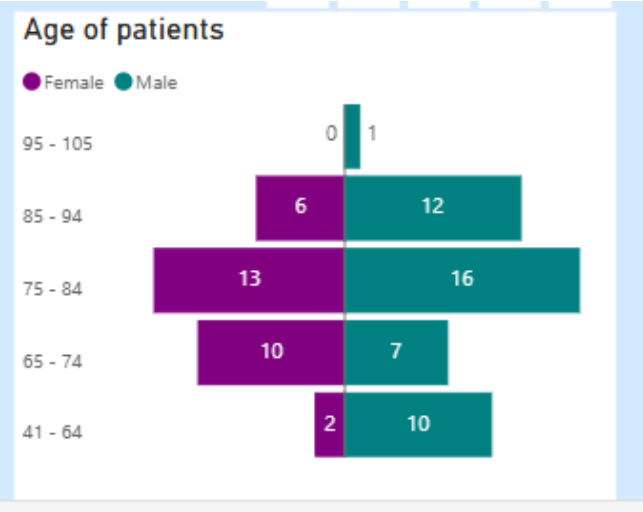
*Community onset (CO) - specimen taken in a community location or less than 3 days into a hospital inpatient stay

**Hospital onset (HO) - specimen taken more than 2 days into a hospital inpatient stay

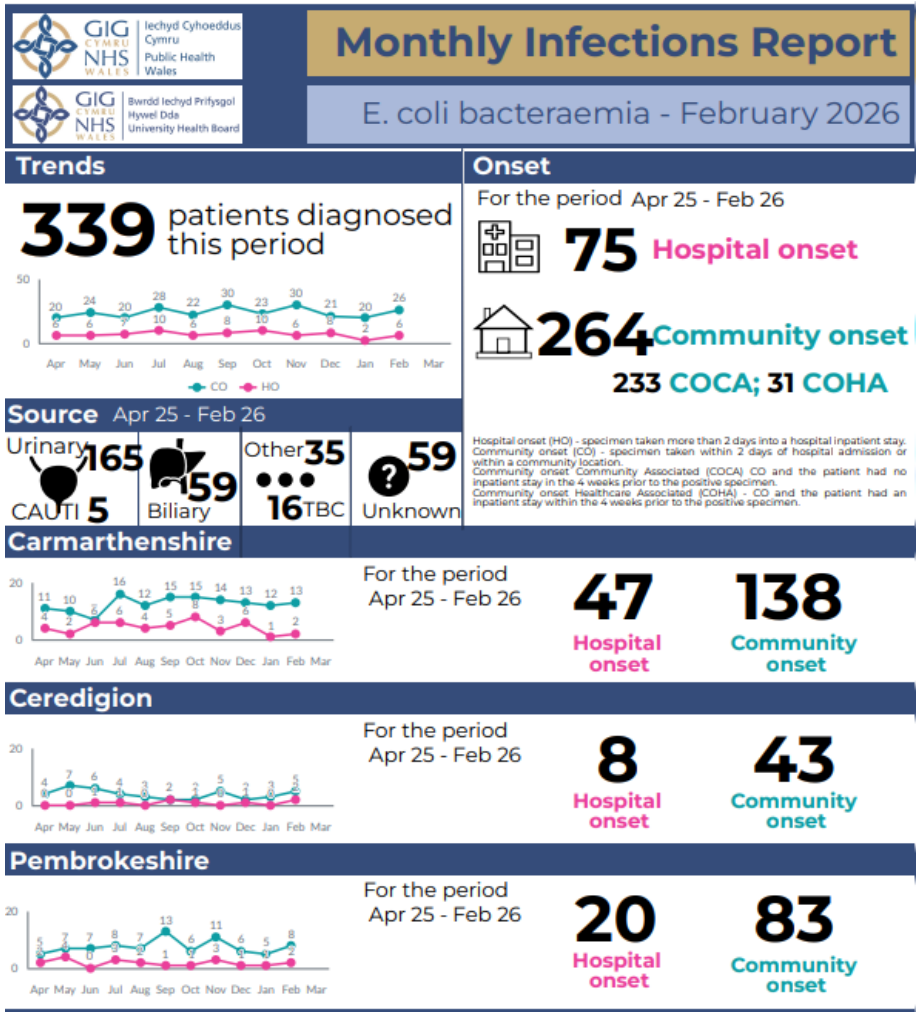
N.B. a hospital inpatient stay includes transfers with the same HB

***(HO count/Total count)*100

	Total count	CO* count	HO** count	% HO***	Total rate per 1,000 hospital admissions	Total rate per 100,000 population
2025/26	338	263	75	22%	6.31	95.16
April 2025	26	20	6	23%	5.53	81.50
May 2025	30	25	5	17%	6.43	91.00
June 2025	27	20	7	26%	5.60	84.63
July 2025	38	28	10	26%	7.65	115.27
August 2025	28	22	6	21%	6.23	84.94
September 2025	38	29	9	24%	7.86	119.12
October 2025	33	23	10	30%	6.33	100.11
November 2025	36	29	7	19%	7.23	112.85
December 2025	29	21	8	28%	5.84	87.97
January 2026	22	20	2	9%	4.43	66.74
February 2026	31	26	5	16%	6.24	104.11



For HO 25/26 5 patients have returned 2 positive results. These have been linked to repeat blood cultures and urological issues.



Learning identified and actions

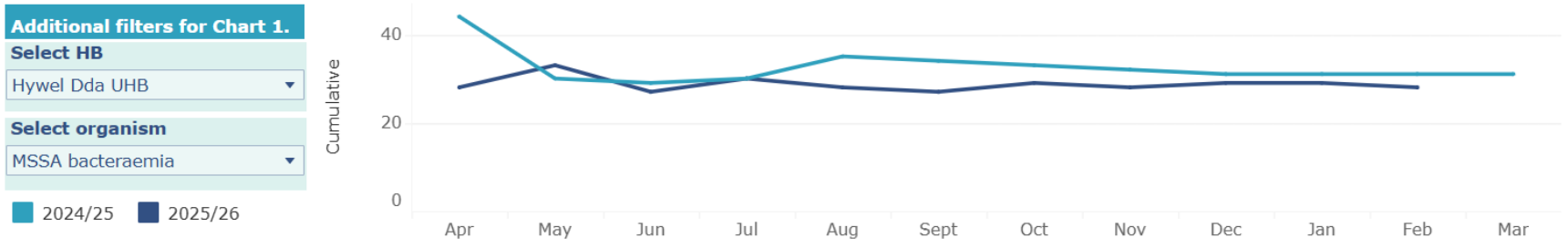
Learning Identified	Actions Required
Adherence to catheter bundles is lacking: Gaps in completion	• Compliance to be monitored through Infection Prevention Improvement Audits (IPIA) (formally QIAs) • Asceptic Non Touch Technique (ANTT) compliance review
Many cases related to complex pre-existing conditions requiring microbiology input: Complexity	• Ensure early MDT involvement for high-risk patients (microbiology, pharmacy, urology as needed). • Introduce proactive review of patients with recurrent UTIs or urological conditions.
Patient hand hygiene needs reinforcing: Poor patient hand hygiene can increase infection risk	• Compliance to be monitored through IPIAs • Reiterate the mealtime coordinator role in supporting patient hand hygiene

IP&C S.aureus bacteraemia

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

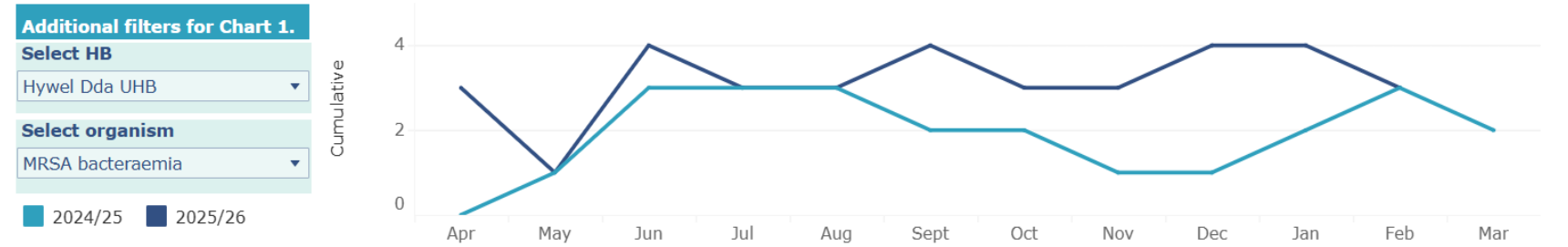
MSSA Improvement Goal: A decrease of at least 20% compared to the 2024/25 baseline counts for all Health Boards.
MRSA Improvement Goal: All Health Boards should have fewer MRSA BSI cases in 2025/26 than in 2024/25.

Chart 1. Cumulative monthly rate per 100,000 population of MSSA bacteraemia in Hywel Dda UHB, 2025/26 compared to previous FY

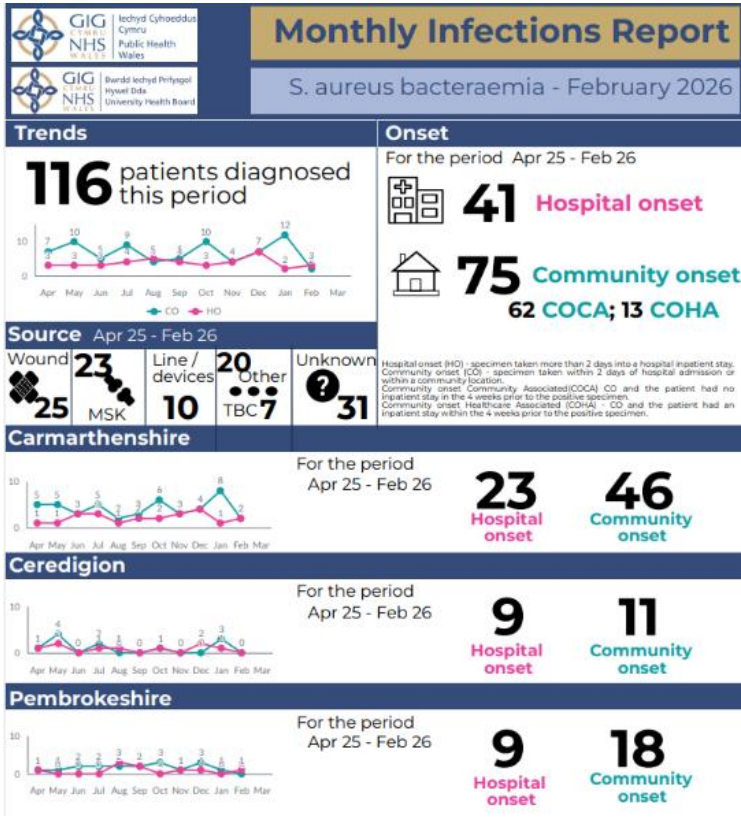


The rate of MSSA bacteraemia in Hywel Dda UHB is 28.72 per 100,000 population for Apr 25 - Feb 26. This is 10% lower than the equivalent period in 2024/25.

Chart 1. Cumulative monthly rate per 100,000 population of MRSA bacteraemia in Hywel Dda UHB, 2025/26 compared to previous FY



The rate of MRSA bacteraemia in Hywel Dda UHB is 3.94 per 100,000 population for Apr 25 - Feb 26. This is 27% higher than the equivalent period in 2024/25.



Learning identified and actions

Learning Identified	Actions Required
PVC bundle not completed: Gaps in peripheral vascular catheter (PVC) bundle compliance increase risk of infection	• Compliance to be monitored through IPIAs • Ensure use of PVC bundles as best practice and ensure documentation • IV to oral switch project to be progressed to reduce to number of PVCs and other lines required, reducing risk
Cases appearing across all ward areas: Distribution suggests system-wide issues rather than isolated ward-specific practice gaps. Burden remains in the community.	• Conduct thematic analysis across all affected ward areas to identify common contributory factors • Increase oversight through ward/ board rounds focused on invasive device care.
ANTT compliance needs improvement: Variation in compliance levels, assurance around practical assessment required from CCGs	• Reinforce ANTT training and competency assessments across all clinical teams. • Share good practice examples/ accreditation

HIW / CIW / HTA inspection activity:

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Date of letter	HIW ref	Matter
25/02/2026	16228	GGH Palliative patient Added a bed to a 2 bed side room Felt lack of care & self-discharge
27/01/2026	15863	PPH ward 4 Personal care for a patient during a 6 day length of stay on ward 4 Governance and oversight in place on the ward
22/01/2026	15877	GGH Inside isolation room environment hygiene Ward environment IPC Shared spaces hygiene Wheelchair storage areas hygiene Cleaning supervision concerns hygiene
24/11/2025	15323	Theatres GGH Staff training and experience Staffing levels, burnout and turnover Patient safety risks and incident reports Staff wellbeing and morale Senior management and culture concerns
23/10/2025	15014	A&E GGH poor hygiene and infection control practice, lack of response to concerns raised about hygiene and safety, personal safety risks and insufficient staff training, inadequate incident follow up general concerns relating to staff training not being addressed
08/10/2025	13391	Update on CSP consultation for Critical Care

Inspections

All inspection reports in the last 6-12 month have now been published.

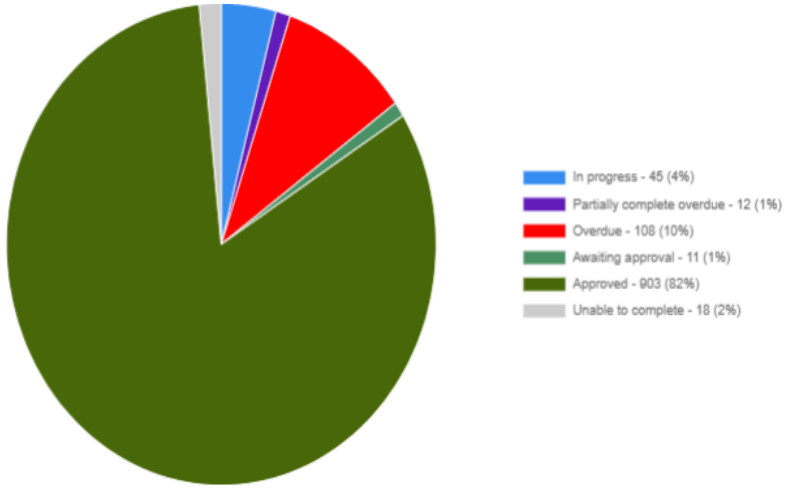
The Health Board have has received the following letters from HIW requesting assurance during 2025 (those in grey type have been previously reported to QSEC

Date of letterv	HIW ref	Matter
16/01/2025	12474	Emergency Department staffing, GGH
30/01/2025	12589	Ceredig Ward, BGH – care of patient
14/02/2025	12702	Cwm Seren – care of patient
14/02/2025	12734	Staff behaviour in Radiology, GGH
25/02/2025	12858	Theatre Department staffing, GGH
18/03/2025	12994	PPH Bryngolau – care of patient
20/03/2025	12997	Ward 12 staffing, WGH
11/04/2025	13271	Paediatric Medical Workforce
12/04/2025	13272	Mental health services provision in north Ceredigion
12/04/2025	13274	Member of staff St Nons Ward, Bro Cerwyn
30/04/2025	13391	Critical care provision in Carmarthenshire
02/05/2025	13274	Member of staff St Nons Ward, Bro Cerwyn - additional query
20/05/2025	13271 13272 13274	Paediatric Medical Workforce – request for update regarding recruitment progress Mental health services provision in north Ceredigion – request for further information St Non's Ward – request for update
06/06/2025	13747	Withybush General Hospital – care of patient
11/06/2025	13391	Critical care provision in Carmarthenshire - status and timescales CSP consultation
11/06/2025	13274	St Non's Ward – request for update
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

HIW Quality Checks/Inspections: Reviews and inspections

Improvement Actions relating to HIW reviews

Source: AMaT 03/03/2026



	Overdue	Partially complete (overdue)
Community and Integrated Medicine	78	6
Estates and Facilities	0	0
Mental Health and Learning Disabilities	5	0
Nursing, Quality and Patient Experience	0	0
Operational Allied Health and Health Science	18	3
Planned and Specialist Care	2	1

	Position as at 21/01//2026	Position as at 03/03/2026
Overdue	69	108
Partially complete (overdue)	12	12
Partially complete	2	0
In progress	56	45
Rejected (to be resubmitted)	2	0

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
14	144/267 (54%)	1/1 (100%)	0	0	45	0	12	108	10	12	0	320

Note for each open inspection, an action is created for the QAS Team to confirm with HIW closure of the inspection actions (this is not included within the HIW inspection report). Therefore. if actions are overdue, the action for QAST will also be overdue.

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
30	306/306 (100%)	18/18 (100%)	0	0	0	0	0	0	7	0	0	583

HIW Quality Checks/Inspections: Open reviews and inspections

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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)/2025/716	HIW Cwm Seren LSU & PICU	2/15 (13%)	0	0	0	15	0	0	0	0	0	0	5
Healthcare Inspectorate Wales (HIW)/2025/628	HIW Derwen Ward 04054	24/32 (75%)	0	0	0	2	1	0	6	0	2	0	114
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	11/13 (85%)	0	0	0	2	0	0	0	0	0	0	21
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)	18/40 (45%)	0	0	0	0	0	0	3	4	0	0	26
Healthcare Inspectorate Wales (HIW)/2025/750	HIW Improvement plan – Community Learning Disability Team	0/6 (0%)	0	0	0	8	0	0	0	0	0	0	1
Healthcare Inspectorate Wales (HIW)/2025/668	HIW Inspection BGH Emergency Department	20/29 (69%)	0	0	0	1	0	2	7	3	0	4	56
Healthcare Inspectorate Wales (HIW)/2024/86	HIW IRMER Diagnostic Imaging x-ray department Withybush Hospital January 2024	6/9 (67%)	0	0	0	0	0	2	1	1	0	0	10
Healthcare Inspectorate Wales (HIW)/2023/69	HIW St Non, St Caradog, Canolfan Bro Cerwyn WGH	12/18 (67%)	1/1 (100%)	0	0	0	0	0	2	0	0	0	23
Healthcare Inspectorate Wales (HIW)/2024/498	IRMER Regulations	7/9 (78%)	0	0	0	0	0	0	3	0	0	0	7
Healthcare Inspectorate Wales (HIW)/2025/587	Joint Inspection of Child Protection Arrangements (Pembrokeshire)	14/21 (67%)	0	0	0	3	0	2	7	0	0	0	22
Healthcare Inspectorate Wales (HIW)/2025/595	Mynydd Mawr Ward, Prince Philip HospitaL 03921	20/24 (83%)	0	0	0	1	0	3	1	2	0	0	51
Healthcare Inspectorate Wales (HIW)/2025/596	Nuclear Medicine IRMER WGH 03909	16/26 (62%)	0	0	0	10	0	3	0	0	0	0	29

HIW Strategic Direction 2026 - 2030

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

HIW has published their Strategic Plan for 2026 to 2030 on 1 April 2026. They have identified four strategic priorities, detailed as follows:

- Putting People First
- Learning and Working Together
- Investing in our People
- Taking Action that Matters

Each strategic goal has a number of aims.

The purpose of HIW identified as “To check that healthcare services are provided in a way that maximises the health and wellbeing of people.”

The link to the report is here: Our Strategy and Operational Plan | Healthcare Inspectorate Wales

there is a short video covering the strategic plan and a PDF report of the plan, plus an easy read version.

National Patient Safety Plan for NHS Wales:2026-2031

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

NHS Wales Performance and Improvement published, on the National Patient Safety Plan for NHS Wales for 2026-2031 on 30tMarch 2026.

The Plan is described as “a critical step in strengthening our healthcare system. The aim is: Listening, leading and learning for safer care in Wales.”

The national clinical safety priorities in the plan are:

- Acute physical deterioration
- Deconditioning in the community
- Health care associated infections
- Improving safety in secondary care mental health services
- People with a learning disability and neurodivergence
- Maternity and neonatal services

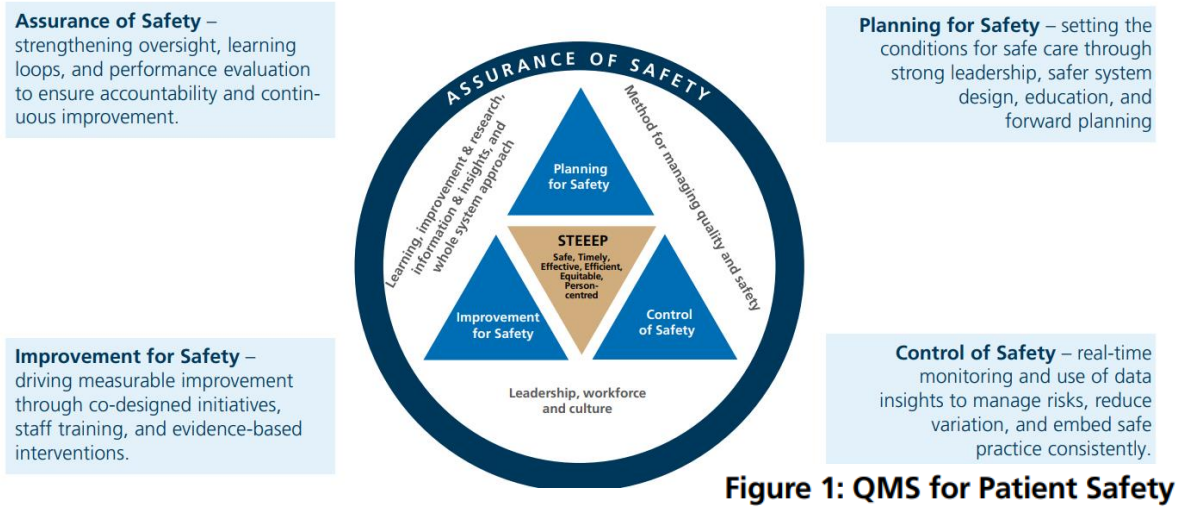


Figure 1: QMS for Patient Safety

The plan also states medicines safety is a development area.

The actions outlined in the plan and to be taken between 2026-2031 relate to NHS Wales Performance and Improvement.

At the time of writing this paper, the plan was newly published. This plan will be shared with the Quality and Safety Intelligence Group for further consideration and discussion of local actions to support the work outlined in the plan.

Recommendations

The QSEC 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
- Complaints management
- Inquests and Regulation 28
- Infection prevention and control
- Inspections and peer reviews including activity of Healthcare Inspectorate Wales (HIW)

QSEC is asked to note the publication of the HIW: Strategic Plan for 2026-2030 and the NHS Wales Performance and Improvement: National Patient Safety Plan for NHS Wales for 2026-2031

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 – Louise O'Connor, Assistant Director for Legal Services and Patient Experience
5. Complaints Management – Louise O'Connor, Assistant Director for Legal Services and Patient Experience
6. Inquests and Regulation 28 - Cathie Steele, Interim Assistant Director of Nursing, Assurance and Safeguarding
7. Infection Prevention and Control – Rebecca Richards, Head of Infection Prevention and Control
8. Healthcare Inspectorate – Caroline Burgin, Patient Safety and Assurance

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

The Duty of **Candour**

Openness and honesty should be at the heart of every relationship between those providing treatment and care and those experiencing it.

DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG

SAFE | SUSTAINABLE | ACCESSIBLE | KIND

3.4

3.4 - Listening and Learning Sub Committee Update Report

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

Attachments

Listening and Learning Update Report March 2026.pdf

ADRODDIAD DIWEDDARU'R PWYLLGOR/

SUB-COMMITTEE UPDATE REPORT

LISTENING AND LEARNING SUB-COMMITTEE

Date of last meeting/ Dyddiad y cyfarfod diwethaf: 26 March 2026

Quoracy/ Cworwm: The meeting was quorate

Report by/ Adroddiad gan: Eiry Edmunds, Vice Chair

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 wishes to **alert** the Quality, Safety and Experience Committee that:

- A detailed update on **Ophthalmology services** highlighted insights from patient experience feedback, complaints, redress cases and external scrutiny. With 793 responses to the patient experience survey, engagement levels were strong. The data showed that while patients were generally very satisfied with the care they received once seen, many experienced considerable anxiety, distress and safety concerns due to long waits,particularly those at risk of losing their sight.

  Complaints data reflected similar themes. Since January 2024, the service received 565 complaints, most of which related to delays in appointments, follow-up, and access to timely care. These delays have affected patient wellbeing and eroded confidence in the service. Complaints tended to fall into two main categories: difficulties in getting patients into the system in the first place, and issues arising during treatment such as pathway pressures and documentation quality. Members were informed that many of these concerns relate to historic issues and that most cases have been managed through Redress rather than litigation, with only a small number of successful claims. The recurring themes emphasise the need for strengthened governance, improved consistency and improve learning across the service.

  The Sub Committee noted that these challenges are occurring in the context of long-standing operational pressures, limited workforce capacity and the vulnerability of a multi-site service model, all areas that have been recognised within the organisation's Clinical Services Plan. The Sub Committee wished to draw particular attention to the significant risks associated with the Ophthalmology waiting list. Nearly 18,000 patients are currently categorised as R1—the highest clinical priority, which without prompt intervention has the

[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.*

potential for permanent sight loss. Despite active prioritisation and escalation measures, capacity constraints continue to present risk of harm to high-risk patients , posing a significant ongoing patient safety and experience concern.

Two additional clinic days per week are technically available to provide **clinical capacity at Amman Valley Hospital**, with a room and equipment in place however, the space is currently being utilised by other clinics, limiting Ophthalmology's ability to expand delivery. As a result, the availability of physical space does not address the risk associated with the current volume of R1 patients, nor the heightened patient experience impact of continued delays. The Sub-Committee agreed that the inability to fully utilise available infrastructure represents a material constraint on risk reduction.

Advise

The Listening and Learning Sub-Committee wishes to **advise** the Quality, Safety and Experience Committee that:

- A Public Interest Report was issued by the Public Services Ombudsman for Wales following serious failings in the Ophthalmology care of a patient whose right-eye cataract was not reviewed for a prolonged period, despite specialist advice from another health board. When the patient was eventually seen, the review was inadequate: essential tests were not performed, clinical records were incomplete, communication with the patient's GP was poor, and several appointments were cancelled. These failures led to the patient becoming significantly sight-impaired in the affected eye. Given the seriousness of the case, the Ombudsman required a formal apology, financial redress (£4,500 for the lasting impact and £300 for time and trouble), and service-wide reminders to clinicians about reviewing previous correspondence, ensuring timely referrals, and improving clinical documentation. The service has accepted and implemented these recommendations and is awaiting the Ombudsman's formal sign-off.

  Members discussed whether similar risks could affect other patients. While steps have been taken to strengthen documentation, communication and clinical review processes, the Sub Committee was not assured that risks have been fully mitigated, particularly given current service pressures and historically complex pathways. The forthcoming implementation of the Open Eyes electronic patient record system was recognised as an important mitigation, however it is recognised that some residual risk remains.

  Ongoing close monitoring of risk stratification and prioritisation processes for Ophthalmology patients is required. Robust clinical risk-stratification arrangements are in place, with optometrists playing a key role in validating pathways and identifying patients who need urgent escalation. Patients showing signs of deterioration are moved into emergency or expedited pathways to ensure timely intervention.

An update on **Learning from Events and Redress (LFER), Reimbursement from Welsh Risk Pool** was presented, including assurance risks associated with the quality and timeliness of learning submissions to the Welsh Risk Pool. Members noted increasing expectations from the Welsh Risk Pool for clearer evidence of learning, standardisation and impact, and the potential financial and indemnity implications where assurance is insufficient. Concerns were raised about delays in presenting learning, variable quality of documentation across care groups, and the risk of repeated themes not being adequately addressed. The Sub-Committee agreed on the need for a more structured and consistent approach to LFER, including improved governance, clearer panels or oversight arrangements, and stronger evidence that learning is embedded and monitored, to mitigate both patient safety and organisational risk.

Assure[2] (to note)/ Sicrhau (i nodi)

The Listening and Learning Sub-Committee wishes to **assure** the Quality, Safety and Experience Committee that:

The following actions are being taken by the service to mitigate the risks identified above and improve the patient experience for **Ophthalmology Services**:

- Active reduction of the stage one waiting list, alongside targeted work to increase clinic delivery and throughput where possible, with a focus on patients at highest clinical risk.
- Robust clinical risk stratification, supported by optometrists validating referrals and identifying patients requiring urgent escalation, including use of emergency eye care pathways where deterioration is identified.
- Stabilisation of the clinical rota, recognising workforce shortages and the need to maximise available specialist capacity across sites.
- Expansion and scoping of additional laser clinics, aimed at increasing treatment capacity and reducing delays for time-critical interventions.
- Investment in additional staff and equipment, to support clinic delivery, improve patient flow and enhance overall patient experience.
- Implementation of the Open Eyes electronic patient record system, identified as a key improvement to strengthen clinical documentation, communication, continuity of care and oversight across pathways.
- Review and strengthening of governance arrangements for outsourced Ophthalmology care, including clearer consent processes, improved patient information, and assurance of clinical standards following earlier patient experience and complaint issues.
- Ongoing reduction in the stage one waiting list and improvements in intravitreal injection delivery, with evidence of progress reported through service metrics.

Review of Risks/ Adolygiad o Risgiau

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

The Sub-Committee recognises the extensive work underway within **Ophthalmology** to manage risk, respond to patient feedback and implement learning from complaints and external scrutiny. However, the scale of the R1 waiting list, constrained clinic capacity (including at Amman Valley Hospital), and the findings of the Ombudsman's public interest report mean this remains an area of heightened risk requiring continued escalation, monitoring and organisational support.

Recommendation/ Argymhelliad

The Committee is asked to:

- **Respond** to the items the Sub Committee is alerting them to
- **Note** the items the Sub Committee is advising them of
- **Take assurance** from the items that the Sub Committee is providing assurance on

Date of next meeting/ Dyddiad y cyfarfod nesaf: 14 May 2026

3.5

3.5 - Infection Prevention Control Assurance Report

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

Attachments

IPC Report to QSEC Apr 2026.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	09 April 2026
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Infection Prevention and Control Update: Arrangements with the Health Board to Prevent and Control Infection
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Sharon Daniel, Executive Director of Nursing, Quality and Patient Experience
SWYDDOG ADRODD: **REPORTING OFFICER:**	Cathie Steele, Interim Assistant Director of Nursing Assurance and Safeguarding Rebecca Richards, Head of Infection Prevention

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to provide the Quality, Safety and Experience Committee (QSEC) with assurance on the Health Board's current infection prevention and control (IP&C) arrangements, governance structures and improvement activity, and highlights key areas of focus to support ongoing compliance with national standards and the delivery of safe, high quality care for the population served.

Cefndir / Background

Infection prevention and control (IP&C) is a fundamental component of safe, effective and high quality healthcare and is a core statutory responsibility of Health Boards in Wales. Robust IP&C arrangements are essential to protect patients, staff and visitors from Healthcare Associated Infections (HCAIs), reduce avoidable harm, and support the delivery of safe and sustainable services across all care settings.

Health Boards in Wales are required to have effective systems in place to prevent, identify and manage infection risks in accordance with national legislation, standards and guidance, including the Public Health (Wales) Act 2017, the Health and Social Care (Quality and Engagement) (Wales) Act 2020, and Welsh Government policies relating to healthcare associated infection and antimicrobial resistance. These duties are reinforced through national infection prevention and control manuals, surveillance requirements, and professional standards, which collectively set expectations for governance, assurance and continuous improvement.

Effective IP&C relies on strong leadership, clear accountability, skilled specialist teams, and consistent application of evidence based practice across clinical and nonclinical environments. Health Boards must ensure that staff are appropriately trained and supported, that infection risks are identified and mitigated promptly, and that learning from incidents, outbreaks and surveillance data is used to drive improvement and strengthen organisational resilience.

Within this context, IP &C Teams play a critical role in providing expert advice, oversight and assurance, supporting services to meet statutory requirements, respond to emerging risks, and

embed a culture of safety and quality. This includes close collaboration with clinical services, estates and facilities, occupational health, public health partners and external agencies to ensure a coordinated and proportionate response to infection risks.

Asesiad / Assessment

Quality Assurance

The Infection Prevention Strategic Steering Group (IPSSG) meets monthly. The terms of reference have been reviewed and approved by the Quality and Safety Intelligence Group (QSIG) in September 2025. The Executive Director of Nursing, Quality and Patient Experience is the Chair of IPSSG. IPSSG seeks to:

- Ensure that the organisational direction (the strategic direction) for the prevention, detection and rectification of irregularities or deficiencies in infection prevention and control is agreed and is in line with national standards and best practice
- Ensure that improvement and assurance arrangements are in place to promote best practice and make improvements in infection prevention and control with staff and patient protection being a fundamental principle of its business
- Promote inter-discipline working in the prevention and control of infection through effective communication and multi-disciplinary working.

With the introduction of the new Clinical Care Groups (CCG) and the integrated governance arrangements established, work is underway to review and improve operational ownership of the Infection Prevention Locality meetings. Each CCG is required to report on infection prevention and control matters to the IPSSG.

Targeted Intervention and Reporting

In January 2024, Hywel Dda University Health Board was subject to Level 4 escalation with Welsh Government in relation to quality of care concerns associated with HCAIs. Progress against agreed improvement actions, including those relating to infection prevention and control, is monitored through established internal governance arrangements, with routine oversight and escalation through Welsh Government's Integrated Quality and Performance Delivery Group (IQPDG). This provides a structured and coordinated forum for reviewing delivery against improvement trajectories, managing risks- and ensuring executive oversight. Assurance on infection prevention and control performance, key risks and mitigating actions was provided to QSEC through the regular Quality Assurance report, enabling ongoing scrutiny, transparency and assurance in line with Welsh Government expectations and statutory quality duties.

In January 2026, Welsh Government confirmed that the Health Board would remain in level 4 escalation for quality of care related to HCAIs with a continued requirement to demonstrate:

- how we are delivering sustainable services through stabilisation of the increased trajectory of cases of HCAI and evidence of continuous improvement accompanied by a strong Quality Improvement (QI) approach and plan that has oversight and monitoring by QSEC and Board.
- appropriate governance and leadership through:
    - a clear improvement plan based on a root cause analysis to address the issue of hospital onset HCAIs.
    - having clear and effective response mechanisms in place to respond to outbreaks reporting directly to Board.

The de-escalation criteria set by Welsh Government focus on reducing the number of hospital onset (HO) infections. In response, reporting to QSEC has been strengthened

through the Quality Assurance report to provide enhanced oversight and assurance. The April 2026 Quality Assurance report includes detail on identified- areas for improvement, actions agreed to address the issues raised, and progress against these actions. Information relating to outbreaks has also been incorporated to support transparency, learning and ongoing scrutiny.

Quality Control (and Quality Planning)

Quality Statement: infection prevention and control

In February 2026, Welsh Government published the quality statement for infection prevention and control. The Health Board is required to undertake a review of their status in relation to each of the 54 quality attributes described in the quality statement. This will act as a baseline and contribute to the development of, or alignment to, existing local improvement plans and will be used to assess delivery, experience and assurance according to national expectations.

Work, led by the I IP &C Team with input from the CCGs, is planned to establish the current position against each attribute and improvement actions required to meet the quality statement. The position assessment and improvement plan will be reported through IPSSG to the QSIG. Regular updates will also be provided to the QSEC through the Quality Assurance report.

NHS Wales National Standards of Healthcare Cleanliness

In March 2026, Welsh Government published the NHS Wales National Standards of Healthcare Cleanliness. The revised Standards set out a national approach to the provision and maintenance of safe, clean healthcare environments across health boards and trusts. The Standards have been developed by the HCAI: Antimicrobial Resistance & Prescribing (HARP) Team in Public Health Wales, under the leadership of the HCAI Delivery Group alongside engagement with the wider service. They set clear expectations on what good looks like and are accompanied by a range of supporting actions to ensure compliance.

Health Boards and NHS Wales Trusts have been asked by Welsh Government to undertake a detailed baseline assessment and quantify both the resource requirements of implementing the standards and the expected benefits and savings where relevant. The quality and financial impact assessments were to be submitted to Welsh Government by 20 March 2026 for their consideration on successful implementation of the Standards. The standards will be shared when available in the public domain.

An update will be provided to the next IPSSG on the Health Board's assessment and plan for implementation of the standards.

Antimicrobial resistance and healthcare associated infection improvement goals: 2025 to 2027 (WHC/2025/039)

In October 2025, Welsh Government published the Antimicrobial resistance and health care associated infection improvement goals: 2025 to 2027. This Welsh health circular reaffirmed the improvement goals previously set out in WHC/2024/038 reflecting on the data from the previous year and the updated targets set out in the new AMR National Action Plan. To note: there is an overlap between the Quality Statement for infection prevention and control, the National Standards of Healthcare Cleanliness, the requirements for de-escalation under targeted intervention and this WHC.

The Antimicrobial Stewardship Group has been asked to consider the WHC and report through the IPSSG on the delivery of the actions set out in the WHC.

Quality Improvement

Clostridioides difficile (C. difficile) Collaborative Improvement Work

As part of the Health Board's response to (HCAI) improvement requirements, an improvement opportunity was identified through the C. difficile collaborative, focusing on the timely switch from intravenous (IV) to oral antimicrobial therapy where clinically appropriate. This intervention aligns with national antimicrobial stewardship principles and aims to reduce infection risk, improve patient experience and support safer, more effective care pathways.

Whilst the IV-to-oral switch was identified as the agreed Quality Improvement (QI) project, progress has not been advanced during this reporting period. It has been agreed that further development, delivery and monitoring of this work will be managed through the C. Difficile Improvement Group, ensuring appropriate clinical ownership, multidisciplinary input and alignment with antimicrobial stewardship arrangements. The IP&C Team will continue to support this work through governance oversight and reporting via established structures.

Review of IPC Level 2 Training

A review of IPC Level 2 training compliance has been undertaken, with compliance figures routinely reported to CCGs through existing assurance mechanisms. Attendance at face-to-face training sessions has been consistently low, despite face-to-face delivery being recommended every three years, with annual IPC updates required for all staff.

Competence Name	Assignment Count	Required	Achieved	Compliance %
NHS|CSTF|Infection Prevention and Control - Level 2 - 1 Year|	9531	9531	7031	73.77%
NHS|MAND|Aseptic Non Touch Technique - 3 Years|	7018	7018	5967	85.02%

To note: level 1 training compliance is currently 88.4%

In response, a revised approach to training delivery has been agreed. Staff will be directed to IPC Elearning to support improved accessibility and compliance, whilst the IP&C Team will deliver targeted, opportunistic facetoface training based on identified themes informed by lessons learned from Hospital Acquired Infection (HAI) assurance meetings, risks and areas of concern. This will enable training activity to be aligned with surveillance data, incident learning and emerging infection risks, supporting focused improvement activity where it will have the greatest impact.

This blended approach is intended to strengthen assurance, improve compliance with mandatory training requirements and support sustained improvement in infection prevention practice across clinical areas.

Argymhelliad / Recommendation

The Quality, Safety and Experience Committee is asked to take an assurance on the Health Board's current infection prevention and control arrangements, governance structures and improvement activity, and highlights key areas of focus to support ongoing compliance with national standards and the delivery of safe, high-quality care for the population served.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.23 Assure the Board in relation to its compliance with relevant healthcare standards and duties, national practice, and mandatory guidance.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:	Not applicable

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:	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	4. Improve Population Health through prevention and early intervention, supporting people to live happy and healthy lives 8. Transform our communities through collaboration with people, communities and partners

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Quality statement for infection prevention and control NHS Wales National Standards of Healthcare Cleanliness Antimicrobial resistance and health care associated infection improvement goals: 2025 to 2027.
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:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	The arrangements and improvement activity outlined in this report are being delivered largely within existing resources and established governance structures, with no immediate additional recurrent financial requirement arising directly from this paper. Infection prevention and

	control activity is embedded within core clinical, nursing, estates and facilities functions. However, there are potential service and resource implications associated with national requirements, particularly the *NHS Wales National Standards of Healthcare Cleanliness*, for which a baseline assessment has been completed and submitted to Welsh Government. Any future workforce, operational or financial impacts will be subject to national decisions and local prioritisation. Service impacts are focused on strengthening assurance, improving compliance with mandatory IPC training and supporting sustained improvement in infection prevention practice, managed through revised training delivery, targeted quality improvement activity and strengthened reporting to minimise service disruption while improving safety and quality outcomes.
Ansawdd / Gofal Claf: **Quality / Patient Care:**	The arrangements and improvement activity described in this report are intended to have a positive impact on patient safety and quality of care by strengthening infection prevention and control governance, assurance and improvement arrangements across the Health Board. Effective IP&C systems reduce the risk of healthcare-associated infections, prevent avoidable harm to patients, staff and visitors, and support the delivery of safe, effective and high-quality care. The paper highlights enhanced oversight through strengthened reporting to the QSEC, targeted quality improvement activity, improved use of surveillance and incident learning, and revised approaches to mandatory IPC training. Collectively, these measures support earlier identification and mitigation of infection risks, improved compliance with national standards, greater consistency in infection prevention practice and improved patient outcomes, particularly in the context of targeted intervention and ongoing scrutiny of hospital-onset infections.
Gweithlu: **Workforce:**	The arrangements and improvement activity outlined in this report are being delivered largely within existing workforce structures, with infection prevention and control responsibilities embedded across clinical, nursing, estates and facilities teams. Workforce impacts are primarily associated with the requirement to strengthen compliance with mandatory IPC training, including IPC Level 1 and Level 2 training, and to support consistent application of evidence-based infection prevention practice across services. In response to low attendance at face-to-face training, a revised blended training approach has been agreed, combining increased use of e-learning with targeted, opportunistic face-to-face sessions informed by surveillance data, incident learning and identified risk areas. This approach is intended to improve accessibility

	and compliance while minimising disruption to service delivery and supporting staff capability, confidence and safety in line with national standards and targeted intervention requirements.
Risg: **Risk:**	The principal risks identified within this paper relate to the ongoing risk of healthcare-associated infections, particularly hospital-onset infections, and the associated potential for patient harm, regulatory scrutiny and reputational impact if sustained improvement is not achieved. These risks are heightened in the context of Welsh Government targeted intervention and the requirement to demonstrate effective delivery against agreed improvement trajectories. The paper outlines mitigating actions through strengthened infection prevention and control governance, enhanced surveillance and incident learning, targeted quality improvement activity, improved compliance with mandatory IPC training and strengthened reporting to the QSEC and Board. Collectively, these measures are intended to reduce infection risk, support early identification and escalation of concerns, and provide assurance that risks are being actively managed in line with national standards and statutory quality duties.
Cyfreithiol: **Legal:**	The arrangements described in this report support the Health Board's compliance with its statutory duties relating to infection prevention and control, including responsibilities under the *Public Health (Wales) Act 2017* and the *Health and Social Care (Quality and Engagement) (Wales) Act 2020*. Failure to maintain effective infection prevention and control systems could increase the risk of regulatory non-compliance, enforcement action, legal challenge, or claims arising from avoidable patient harm associated with healthcare-associated infections. The paper outlines mitigating actions through strengthened governance, assurance and reporting arrangements, improved surveillance and incident learning, and targeted quality improvement activity, which collectively support legal compliance, reduce exposure to litigation risk and provide assurance that statutory quality and safety obligations are being actively managed, particularly in the context of Welsh Government targeted intervention.
Enw Da: **Reputational:**	The principal reputational risks identified within this paper relate to the ongoing scrutiny of healthcare-associated infections, particularly hospital-onset infections, and the Health Board's status within Welsh Government targeted intervention arrangements. Failure to demonstrate sustained improvement, effective governance and robust assurance could result in increased regulatory, political or media interest and potential loss of public confidence. The paper outlines mitigating actions through strengthened infection prevention and control governance, enhanced

	surveillance and reporting, targeted quality improvement activity and regular assurance to the QSEC and Board. Collectively, these measures support transparency, accountability and learning, and are intended to protect and strengthen the Health Board's reputation by demonstrating proactive management of infection risks and compliance with national standards and statutory quality duties.
Gyfrinachedd: **Privacy:**	No specific privacy impacts have been identified within this paper. The IP&C arrangements and improvement activity described are delivered through existing governance, surveillance and assurance processes that operate in line with established information governance requirements. Any use of patient or staff information for surveillance, incident review or reporting purposes is managed within current data protection frameworks, ensuring confidentiality and compliance with relevant legislation and organisational policies.
Cydraddoldeb: **Equality:**	No specific negative equality impacts have been identified within this paper. The infection prevention and control arrangements and improvement activity described apply across all services and care settings and are intended to support safe, high-quality care for all patients, staff and visitors. The actions outlined are focused on strengthening governance, assurance, training and compliance with national standards, which are expected to have a positive and equitable impact by reducing the risk of healthcare-associated infections for all population groups.

3.6

3.6 - Fuller Inquiry Progress of Recommendations

Craig Baker (Hywel Dda UHB - Cellular Pathology Service Manager), James Severs (Hywel Dda UHB - Executive Director of Allied Health Professions and Health Science)

Attachments

Quality, Safety Experience Committee SBAR- David Fuller Phase 2 - V5 - 31~.pdf

Appendix 1 - HDUHB - Fuller Phase 2 Gap analysis - March 2026 - V7.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:	09 April 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	David Fuller Independent Inquiry – Phase 2 Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	James Severs – Executive Director of Allied Health Professionals & Health Sciences, Hywel Dda University Health Bord
SWYDDOG ADRODD: REPORTING OFFICER:	Craig Baker – Cellular Pathology & Mortuary Service Manager

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

On 15 July 2025, The Independent Inquiry into the issues raised by the David Fuller case published its concluding (Phase 2) report and articulated that current arrangements for safeguarding the security and dignity of the deceased across all sectors in England are insufficient to prevent abuse and or neglect.

The report makes a total of 75 recommendations which cover sectors such as NHS Hospitals, independent hospitals, medical education and training, hospices, Ambulance services, local authorities, care homes, faith organisations and the funeral sector. While these recommendations target the NHS in England, on 3 October 2025, the Welsh Government Chief Medical Officer (CMO) sent a letter to all NHS Wales Chief Executives requesting action.

"We *request that HTA Corporate License Holders work with your Designated Individuals to consider the recommendations of the Inquiry that relate to NHS provided services, and deliver a report to their executive board on the findings, setting out any risks to dignity of the deceased caused by non-concordance of local arrangements with the relevant recommendations set out in the report, reflecting any appropriate risks in your corporate risk register*"

Welsh Government will seek assurance on the Board's review of recommendations at the Integrated Quality, Planning and Delivery meeting in September 2026.

The Mortuary Management Team has focused on evaluating its services according to relevant recommendations contained in Chapter 1 – NHS Hospitals. This approach was reported to Quality and Safety Intelligence Group (QSIG) on 13 November 2025, and Strategic Safeguarding Steering Group (SSSG) on 20 November 2025.

A number of recommendations relate to organisational areas sitting outside of the mortuary service, these have not been assessed within the remit of this work. However, meetings were

held on the 27 March 2026 to gain insight and information from colleagues in other care groups in order to address these recommendations.

Cefndir / Background

The Independent Inquiry into the issues raised by the David Fuller case was established to investigate how David Fuller was able to carry out unlawful actions in the mortuaries at Maidstone and Tunbridge Wells NHS Trust and why they went undetected.

Phase 1 of the inquiry, concluded in November 2023.

After receiving the Phase 1 report, the Hywel Dda University Health Board (HDdUHB) Mortuary Management Team promptly implemented all recommendations to achieve full compliance.

Phase 2 of the Inquiry expanded to assess national procedures across sectors handling deceased individuals, also reviewing relevant regulators and legislative frameworks.

Based on the Phase 2 report, a gap analysis was conducted focusing on recommendations related to HDdUHB's mortuary and an action plan developed to address identified gaps.

Asesiad / Assessment

After the Phase 1 report, the HDdUHB Mortuary Management Team completed actions that already meet the mortuary recommendations found in the Phase 2 report.

Examples of implemented actions include:

- Strengthened assurance through both internal and regionally aligned Human Tissue Authority (HTA) governance and reporting structures – providing clear lines of accountability and reporting
- Enhanced mortuary security access control systems including complete review, audit and restriction of mortuary access
- Implementation of routine mortuary security (security access systems & Close Circuit Television (CCTV) audits at all mortuary sites
- Enhanced Mortuary CCTV coverage implemented providing comprehensive monitoring of all key areas involved with the management of deceased patients
- Revised swipe card access protocols – mortuary management control and oversight
- Review of contractor access arrangements and policies
- Regional HTA Designated Individual appointed
- Technically trained Regional Mortuary Manager appointed
- Two Regional Lead Anatomical Pathology Technologists appointed
- Ongoing regular review of mortuary risks and mitigation measures
- Reinforced principle of deceased to be treated with same respect and care as living patients – standardisation of procedures across all sites with implementation of equitable porter training at all unlicenced sites.

The gap analysis of mortuary recommendations identified that one recommendation has not achieved full compliance: "*All NHS trusts should consider the installation of 'swipe to exit' for mortuary facilities. This would allow trusts to monitor and audit entry and exit, as well as time spent in the mortuary."*

While HDdUHB's four mortuary sites have swipe-to-enter security systems, swipe-to-exit has not been installed, as it was not required for the HTA licence. Quotations for installing swipe-to-

exit devices have been obtained and a risk assessment conducted, yielding a low-risk score of 3 (Risk id: RAMOR611), due to current controls like personalised access cards, porter log-in books, CCTV, and regular audits.

Due to the low-risk score, mortuary services advise no further action required currently. Further steps depend on guidance from the Welsh Government regarding acceptance of the Phase 2 report recommendations. To date there has been no update from Welsh Government regarding their position on the 75 recommendations outlined in the phase 2 report.

Subject to Welsh Government acceptance and mandate of the recommendation, the service will seek funding to install swipe-to-exit devices across all HDdUHB mortuaries.

The mortuary service gap analysis has identified several recommendations relevant to NHS organisations that extend beyond the scope of the mortuary service. Assurance of actions in relation to these is required from nursing, medical and corporate colleagues, to inform the report to Board that the CMO has requested.

For example, NHS trust boards should ensure that safeguarding training and policies explicitly address the security and dignity of deceased people,, and that clear executive accountability is established for safeguarding the security and dignity of deceased people within NHS mortuaries and body stores. Further details are contained within Appendix 1.

Argymhelliad / Recommendation

The Quality, Safety and Experience Committee are asked to receive assurance that Hywel Dda University Health Board has proactively addressed recommendations from both Phase 1 and 2 reports.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.23 Assure the Board in relation to its compliance with relevant healthcare standards and duties, national practice, and mandatory guidance.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	NA
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	1. Safe 6. Person-Centred 3. Effective 4. Efficient
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	1. Leadership 4. Learning, improvement and research 5. Whole systems persepctive
Amcanion Strategol y BIP: UHB Strategic Objectives:	1. Striving teams 3. Great care 4. Positive futures

Amcanion Cynllunio Planning Objectives	4 Planned care, diagnostics and cancer Recovery
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:	Contained within Appendix 1
Rhestr Termau: Glossary of Terms:	Contained 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:	Quality and Safety, Intelligence Group (QSIG) Formal Executive Team (FET) HTA Assurance Group

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:	Not Applicable
Risg: Risk:	Contained within the report
Cyfreithiol: Legal:	Not Applicable
Enw Da: Reputational:	Contained within the report
Gyfrinachedd: Privacy:	Contained within the report
Cydraddoldeb: Equality:	Not Applicable

ACTION PLAN / DEVELOPMENT OF MANAGEMENT RESPONSES

Process

Within one month of receipt of report, please complete the table below to confirm:

1) If the recommendation is accepted or not (justification must be documented if not accepted);
2) A management response to the accepted recommendations detailing:
   a) how it will be implemented, i.e., the actions that will be undertaken to fully implement the recommendation. Consideration must be given to what is within the means and capacity of the service in order to deliver, with any barriers to its implementation, or additional resource requirements clearly documented
   b) who will own this recommendation (if the recommendation owner sits outside of your service, you **must** consult with them to agree the management response)?
3) A realistic and achievable completion date, taking into account your capacity and resource availability;
4) The evidence/documentation that will demonstrate the recommendation has been fully implemented as this will need to be uploaded to AMAT before it will be fully approved as complete by the relevant authoriser (e.g., Internal Audit, QAST, Assurance and Risk Team); and
5) Any recommendation that cannot be fully implemented **must be escalated through the relevant management structure** and action plans must be signed off by the relevant Clinical Care Group.
6) Management responses to recommendations in these reports should be **SMART (Specific, Measurable, Achievable, Realistic/Relevant and Time-Bound).**

S	Specific	What is the recommendation – is it achievable? Your response should be clear and well defined to ensure that you able to achieve the outcome set out in the recommendation.
M	Measurable	What documentation can you provide to evidence that the recommendation has been completed to a satisfactory standard? Do you need to create/amend policies, processes etc?
A	Achievable	Can we as a Health Board achieve the outcome needed – are there any factors (internal and external) that need to be taken into account to be able to achieve the outcome i.e., financial implications, workforce capacity, specific equipment etc?

R	Realistic/Relevant	Are you able to complete the action - Do you have the correct resources? Do you have enough workforce capacity to complete the action?
T	Time-bound	Ensure that you set yourself realistic and achievable completion dates. Give yourselves enough time to be able to complete the action – and maybe add some extra time such as a month or so on top of that in case of any unforeseen circumstances which may cause delays.

After sign off by Clinical Care Group/Director, action plans must be reviewed by IQFPDG prior to onward submission to Formal Executive Team for approval should there be any recommendations which are not accepted, unable to be implemented, or require additional resources.

Once approved, action plans should be sent to the Head of Assurance and Risk for initial upload to AMaT.

The report and action plans will then be presented to the relevant Board level Committee at its next meeting to provide assurance that the management response are addressing the areas of concern/improvement detailed in the report, and progressing in line with expected timescales.

Progress against recommendations must be regularly provided on AMaT by the relevant recommendation owners, with monitoring of their delivery undertaken by the relevant Clinical Service Group, with oversight from the Clinical Care Group. Any exceptions to the implementation of recommendations are required to be reported to IQFPD.

Non-compliance of implementing recommendations within agreed timescales is one of the criteria considered within the Governance domain within the Health Board's Improving Together Framework.

Report: Fuller Inquiry - Phase 2 Report

Issued On: 3rd October 2025

Lead CCG / Officer: Operational Allied Health Professions and Health Sciences CCG / Cellular Pathology & Mortuary Service Manager

Suggested Overseeing Committee: QSEC

Recommendation	Management Response	Recommendation Owner (name, job title and CCG)	Completion Date - Please enter a specific implementation date for your action. For recommendations that are reliant on factors external to the Health Board, please note as "External"	Expected Evidence of Implementation
Chapter 1: NHS Hospitals				
R1. All NHS trusts with mortuaries and/or body stores should commission a specialist strategic review of the systems in place to protect deceased people, which should include a detailed risk assessment of the potential breaches of security that could occur. The review should include an assessment of: • the systems in place to identify any unauthorised access to the facility; • the strength and effectiveness of barriers to prevent unauthorised access to the facilities; • the systems in place to identify any access to deceased people for unauthorised purposes; and • how CCTV is used, including its monitoring and any audits undertaken.	**GGH (HTA Licenced):** 1. CCTV – Standalone PC to allow review via Hikvision software. 2. Dual/layered entry system in place should breach of primary entrance occur. 3. Monthly Security audits incorporating: • Authorised user review • Access card entries • Sign in sheet review • Access denied scrutiny 4. CCTV Monitoring – Randomised audits of access entries (x5 pcm) 5. Installation of SALTO security access system – controlled and managed via mortuary management **BGH:** 1. Networked CCTV 2. Monthly Security audits • Authorised user review	Cellular Pathology & Mortuary Service Manager Regional Mortuary Manager AHP & HCS CCG	01/01/2026	**AUD7788 – GGH** **AUD7787 – BGH** **AUD7790 – WGH** **AUD7789 – PPH**

	• Access card entries • Sign in sheet review • Access denied scrutiny 3. CCTV Monitoring – selected audits of access entries aligned with audit findings (x5 pcm) 4. SALTO security access system – controlled and managed via mortuary management **WGH:** 1. Networked CCTV in place 2. Installation of SALTO security access system – controlled and managed via mortuary management **PPH:** 1. Networked CCTV in place 2. Dual/layered entry system in place should breach of primary entrance occur. 3. Installation of SALTO security access system – controlled and managed via mortuary management			
R2. All NHS trusts should install CCTV inside the mortuary, with cameras facing all doors and access points, the reception area and the doors of body fridges, while maintaining the security and dignity of deceased people by implementing the appropriate safeguards. Where double-ended fridges also open into the post-mortem room, NHS trusts should install CCTV cameras inside	**GGH (HTA Licenced):** CCTV upgraded to include PM Room fridge doors. **BGH:** Networked CCTV in place **WGH:** Security upgrades installed. Salto security access system and additional networked CCTV cameras. **PPH:** Security upgrades installed.	Cellular Pathology & Mortuary Service Manager Regional Mortuary Manager AHP & HCS CCG	01/01/2026	

the post-mortem room that focus on the doors to the fridges	Salto security access system and additional networked CCTV cameras.			
R3. All NHS trusts should routinely audit the access data of all facilities used to store deceased people.	**GGH (HTA Licenced):** 1. CCTV – Standalone PC to allow review via Hikvision software. 2. Dual/layered entry system in place should breach of primary entrance occur. 3. Monthly Security audits incorporating: • Authorised user review • Access card entries • Sign in sheet review • Access denied scrutiny 4. CCTV Monitoring – Randomised audits of access entries (x5 pcm) 5. Installation of SALTO security access system – controlled and managed via mortuary management **BGH:** 1. Networked CCTV 2. Monthly Security audits • Authorised user review • Access card entries • Sign in sheet review • Access denied scrutiny 3. CCTV Monitoring – selected audits of access entries aligned with audit findings (x5 pcm) 4. SALTO security access system – controlled and managed via mortuary management	Cellular Pathology & Mortuary Service Manager Regional Mortuary Manager AHP & HCS CCG	01/01/2026	**AUD7788 – GGH** **AUD7787 – BGH** **AUD7790 – WGH** **AUD7789 – PPH**

	WGH: 1. Networked CCTV 2. Monthly Security audits • Authorised user review • Access card entries • Sign in sheet review • Access denied scrutiny 3. CCTV Monitoring – selected audits of access entries aligned with audit findings (x5 pcm) 4. SALTO security access system – controlled and managed via mortuary management **PPH:** 1. Networked CCTV 2. Monthly Security audits • Authorised user review • Access card entries • Sign in sheet review • Access denied scrutiny 3. CCTV Monitoring – selected audits of access entries aligned with audit findings (x5 pcm) 4. SALTO security access system – controlled and managed via mortuary management			
R4. The practice of using shared electronic swipe cards for specific staff groups should cease immediately.	**GGH (HTA Licenced):** Individual staff access cards issued to Health Board staff who require access to Mortuary. **BGH:** Individual staff access cards issued to Health Board staff who require access to Mortuary.	Cellular Pathology & Mortuary Service Manager Regional Mortuary Manager	01/01/2026	

	WGH: Individual staff access cards issued to Health Board staff who require access to Mortuary. **PPH:** Individual staff access cards issued to Health Board staff who require access to Mortuary.	AHP & HCS CCG		
R5. All NHS trusts should consider putting in place systemic operational barriers that prevent the security and dignity of deceased people being compromised. An example of this would be implementation of a rule that prevents electronic devices such as phones or cameras being taken into a mortuary, other than for approved reasons.	Signage present in all Mortuary Body Stores and Family viewing areas prohibiting the use of cameras/mobile phones. Additional Health Board Action • Care After Death Manager to review and update Care after Death Policy to ensure it includes guidance regarding the management, security and dignity of deceased (adults, Paediatric and neonatal) resting outside of mortuary.	Cellular Pathology & Mortuary Service Manager Regional Mortuary Manager AHP & HCS CCG Care After Death Manager	29/05/2026	
R6. All NHS trusts should take every breach of security in a mortuary or body store extremely seriously. Each security incident should be reviewed by a security expert who is able to identify any systemic security issues associated with the incident. A detailed action plan should be developed for each security breach, no matter how minor trusts regard such breaches to be. All security breaches occurring in mortuaries	Health Board wide Security Advisor in Place DATIX Incident reporting system in place Security access system audits to assess for identification of possible anomalies. CCTV review of all potential security anomalies/unusual activity.	Cellular Pathology & Mortuary Service Manager Regional Mortuary Manager AHP & HCS CCG	01/01/2026	

should be incorporated into security reports provided to trust boards or relevant subcommittees, in line with security breaches in other vulnerable areas.	Any anomalies are reported via internal HTA Governance Structures and corporate governance structures.			
R7. The NHS should ensure that the security standards required for body stores are the same as those required for facilities licensed by the Human Tissue Authority.	At request of Welsh Government - HTA Advisory inspections undertaken at all unlicenced HB sites April 2024. All findings uploaded to AMAT. Updates: • Alignment of Security access systems and CCTV across all sites. • Alignment of Porter Training across all sites. • Alignment of Deceased patient transfer procedures across all sites.	Cellular Pathology & Mortuary Service Manager Regional Mortuary Manager AHP & HCS CCG	01/01/2026	• LPMOR615 - Security & CCTV Compliance • MFMOR610 CCTV Compliance - Equipment on Mortuary site • MFMOR611 CCTV Compliance – Annual service Checklist • MFMOR612 Access log of security camera records • MFMOR609 CCTV Compliance – Site Incident Log • MFMOR606 Detailed

				Security Checklist • MFMOR614 Mortuary Security Access List for Staff • MFMOR608 CCTV compliance - General site information on the site CCTV • MFMOR613 Active Fob List for the Mortuary Security Alarm System • EXMOR725 HIK Vision Network Digital Video Recorder Manual
R8. All NHS trusts should consider the installation of 'swipe to exit' for mortuary facilities. This would allow trusts to monitor and audit entry and exit, as well as time spent in the mortuary.	As part of security upgrades at each site, additional quotations received from Greens Security Property Services – under review by Service Manager. **GGH (HTA Licenced):** No 'swipe to exit' in situ	Cellular Pathology & Mortuary Service Manager Regional Mortuary Manager	Click or tap to enter a date.	

	WGH: No 'swipe to exit' in situ **BGH:** No 'swipe to exit' in situ **PPH:** No 'swipe to exit' in situ Having no swipe out system at this moment in time has been risk assessed, with a low-risk score identified. Action will to be await further guidance from Welsh Government as to whether this recommendation will be mandated.	AHP & HCS CCG		
R9. All NHS trusts should monitor the number of staff with access to the mortuary or body store and keep this under routine review	All security access systems are controlled by Mortuary Management. **GGH (HTA Licenced) PPH, WGH & BGH:** 1. Monthly Security audits incorporating: • Authorised user review • Access card entries • Sign in sheet review • Access denied scrutiny	Cellular Pathology & Mortuary Service Manager Regional Mortuary Manager AHP & HCS CCG	01/01/2026	
R10. NHS trusts should ensure that Designated Individuals have enough time and resource to fulfil their responsibilities, including time for learning and development.	Regional HTA Designated Individual for HDUHB & SBUHB – Part of Consultant Pathologist (DI) job plan which is reviewed. Currently the DI has two sessions assigned per week.	Cellular Pathology & Mortuary Service Manager Regional Mortuary Manager AHP & HCS CCG	01/01/2026	
R11. NHS trusts should ensure that senior managers, including the Chief Executive, have a clear understanding of the role of the Designated Individual, their lines of	Document created articulating to roles and responsibilities of the Designated Individual (DI), Corporate Licence Holder (CLH) and Persons Designate (PD) relating	Cellular Pathology & Mortuary Service Manager	01/01/2026	

accountability, and the individual legal responsibility associated with being a Designated Individual.	to the HTA/ legal standards is to be added as an appendix to the HTA Operational Group and HTA Assurance Group Terms of Reference. This will be reviewed in line with the annual review of TORs.	Regional Mortuary Manager AHP & HCS CCG		
R12. NHS trusts should ensure that Designated Individuals attend the correct governance forums. This would allow them to escalate issues and risks, as well as reporting upwards when required.	Mortuary HTA Governance Structure in place: (HTA DI will attend all below) • Regional HTA DI Meeting • HTA Operational Group • HTA Assurance Group • Regional HTA Assurance Group	Cellular Pathology & Mortuary Service Manager Regional Mortuary Manager AHP & HCS CCG	01/01/2026	
R13. A professional background in the field of mortuary services should be made a prerequisite for the post of Mortuary Manager	1x Regional Mortuary Manager in place who is an APT by profession. 2x Regional Lead APT's in place	Cellular Pathology & Mortuary Service Manager Regional Mortuary Manager AHP & HCS CCG	01/01/2026	
R14. NHS trusts should assure themselves that the Mortuary Manager has adequate resources and support to perform their role effectively, including meeting any reporting requirements.	Mortuary Manager provided with adequate resources and support to perform role; however, additional administrative support would be beneficial.	Cellular Pathology & Mortuary Service Manager Regional Mortuary Manager AHP & HCS CCG	01/01/2026	
R15. All NHS trusts should establish a routine reporting system for matters relating to mortuaries and body stores. This reporting	Mortuary HTA Governance Structure in place:-	Cellular Pathology & Mortuary Service Manager	01/01/2026	

system should include the presentation of a formal report, by the accountable executive director, to the trust board on a routine basis. The accountable executive director should prepare and present to the trust board a formal annual report, similar to the annual safeguarding report. The report should include: • staffing matters; • security incidents; • all serious incidents; • Human Tissue Authority reports (where applicable); and • all security audits, including audits of access and any access breaches.	• Regional HTA DI Meeting • HTA Operational Group • HTA Assurance Group • Regional HTA Assurance Group • Relevant committee (QSIG, QSEC, IQFPD, FET, Board)	Regional Mortuary Manager AHP & HCS CCG		
R16. Trust boards should assure themselves that the recommendations in this Report have been implemented	Gap analysis undertaken, paper presented at CCG (Q&S), FET, QSEC (February 2026) Board level oversight of recommendations and progress through Public Board via QSEC on date 9th April 2026	Cellular Pathology & Mortuary Service Manager Regional Mortuary Manager AHP & HCS CCG	Click or tap to enter a date.	
R17. Trust boards should ensure that these recommendations and governance arrangements are applied to any temporary facilities used by trusts for the storage and care of deceased people	No temporary body storage facilities exist within Hywel Dda UHB that are situated externally to the acute hospital mortuaries and body stores.	Cellular Pathology & Mortuary Service Manager Regional Mortuary Manager AHP & HCS CCG	01/01/2026	

R18. Trust boards should take note of the fact that mortuary services are subject to statutory regulation and should be treated with equivalent regard to other regulated activities within trust governance arrangements.	There are governance arrangements in place to ensure oversight of licenced activities within the Health Board, from mortuary service to Board.	Cellular Pathology & Mortuary Service Manager Regional Mortuary Manager AHP & HCS CCG	01/01/2026	
R19. NHS trust boards should ensure that the security and dignity of deceased people are included in safeguarding training, policies and assurance.	Charlotte Westacott (Head of Safeguarding) – reviewing safeguarding training and its provision. If not already included the safeguarding of deceased needs to be included as part of the review.	Cellular Pathology & Mortuary Service Manager Regional Mortuary Manager AHP & HCS CCG Head of Safeguarding	29/05/2026	
R20. The remit of the Chief Nurse in NHS trusts should explicitly include executive responsibility for safeguarding the security and dignity of deceased people in NHS mortuaries and body stores	Executive Director of Nursing Quality Safety and Patient Experience is responsible for overall safeguarding of dignity of people. Executive Director of Allied Health Professions and Health Science is responsible for safeguarding of dignity of deceased people inside of mortuary facilities.	Cellular Pathology & Mortuary Service Manager Regional Mortuary Manager AHP & HCS CCG	01/01/2026	

R21. NHS England should formally incorporate the safeguarding of deceased people into its safeguarding framework for NHS trusts.	There is a Welsh Government All Wales safeguarding procedure and policy in place. However, we will further consider this via internal health board Care After Death policy.	Cellular Pathology & Mortuary Service Manager Regional Mortuary Manager AHP & HCS CCG Care After Death Manager	01/01/2026	
Chapter 2: Independent hospitals				
R22. Independent sector healthcare providers should ensure that there are Standard Operating Procedures and policies in place to protect the security and dignity of any patients that die under their care. Wherever possible, deceased patients' rooms should be kept locked. Providers should also ensure that staff are aware of the need to protect the security and dignity of deceased patients and are able to assess and mitigate risks to this.			Click or tap to enter a date.	
R23. Independent sector healthcare providers should ensure that only people who have a legitimate reason to access a room that contains a deceased patient do so, even if they are staff members, and that they are always accompanied.			Click or tap to enter a date.	
Chapter 3: Medical education and training				
R24. All organisations providing anatomical education and training using donors should make sure that policies and procedures are	Not applicable – Anatomy Schools, etc.		Click or tap to enter a date.	

in place to ensure the security and dignity of donors. These should include: • security and access policies and the auditing of security and access measures such as swipe card access, CCTV and access to the locations where donors are kept; • governance arrangements to ensure effective oversight of and accountability for the security and dignity of donors; • a review of contracts or agreements with external organisations for the transfer of donors to or between facilities; and • policies and processes on incident reporting, both within the organisation and to the Human Tissue Authority, that are clear and accessible to all students and staff.				
R25. Postgraduate training providers using donors should ensure clarity in their governance and information-sharing, in particular where the providers are linked to both university and NHS settings. This clarity should include formal agreements, where relevant, including management, governance and Human Tissue Authority licensing arrangements for the organisations involved	Not applicable		Click or tap to enter a date.	
R26. The Human Tissue Authority should change its guidance to require that relevant adverse incidents in the anatomy sector are	Not applicable – External Governance – Human Tissue Authority		Click or tap to enter a date.	

formally reported as Human Tissue Authority Reportable Incidents (HTARIs).				
Chapter 4: Hospices				
R27. Hospices that care for deceased people on their premises should: • introduce auditable access control of the area where deceased people are kept; • have Standard Operating Procedures regarding the care of deceased people, including security of and access to the areas where deceased people are kept; and • minimise unaccompanied access to areas where deceased people are cared for, wherever possible.			Click or tap to enter a date.	
R28. To avoid confusion over its remit, the Care Quality Commission should issue clear guidance to inspectors (and others) that hospice inspections should not include areas where deceased people are kept, other than to focus on the needs of bereaved relatives.			Click or tap to enter a date.	
R29. Hospices should be considered in scope for the regulatory measures recommended in Chapter 11.			Click or tap to enter a date.	
Chapter 5: Ambulance services				
R30. Data on how often deceased patients are conveyed in ambulances, and the	Not applicable- Ambulance Service		Click or tap to enter a date.	

reasons for this, should be routinely collected and reported to NHS England, and monitored to assess risk.				
R31. Every NHS ambulance service should have a policy setting out where ambulance crew members should sit when conveying deceased patients. This should include reference to the risk of abuse of deceased patients, as well as training requirements.	Not applicable- Ambulance Service		Click or tap to enter a date.	
R32. NHS ambulance services should also have policies regarding the security and dignity of the deceased, including when the deceased should be covered and/or secured. NHS England should monitor that such policies are in place.	Not applicable- Ambulance Service		Click or tap to enter a date.	
R33. Every NHS ambulance service must put policies in place regarding taking photographs of deceased patients, including any circumstances in which this may be required, and ensure that ambulance staff are aware of these and comply with them.	Not applicable- Ambulance Service		Click or tap to enter a date.	
R34. The Inquiry has focused its investigations into ambulance services on NHS ambulance services. However, the Inquiry considers that these recommendations could also be applied to independent ambulance services, including private ambulances.	Not applicable- Ambulance Service		Click or tap to enter a date.	
Chapter 6: Local authorities				

R35. There should be a process to routinely review who is permitted to access the mortuary unsupervised.	Not applicable – Local Authority		Click or tap to enter a date.	
R36. Where unsupervised access is permitted for a legitimate and unavoidable purpose, there should be individualised electronic access controls to enter the mortuary and restrict access to specific areas of the mortuary, such as the post-mortem room. There should be a requirement to 'swipe to exit' to ensure that all activity is auditable. There should be no shared electronic access controls.	Not applicable – Local Authority		Click or tap to enter a date.	
R37. Where people other than mortuary staff are visiting the mortuary during working hours, for example contractors, cleaners and other visitors: • Access must be limited to specific areas required for the purposes of their work or visit. • They must be supervised when working in areas where there is access to deceased people, for example in the fridge or post-mortem rooms. • Their attendance must be recorded and audited.	Despite this recommendation being under the Local Authority chapter, this also is applicable to NHS Mortuaries and has been implemented as per HTA licencing standards. • Restricted access in place. • Supervision in place by Mortuary staff. • Cleaning during working hours only • All Porter/External contractors advised to attend in pairs. • Attendance recorded on visitor sign-in sheets – No out of hours access permitted with exception of Porter Staff undertaking transfers/admissions.		01/01/2026	
R38. Where mortuary staff are permitted to work alone in the mortuary, there should be	**GGH (HTA Licenced):**		01/01/2026	**AUD7788 – GGH**

a review of lone working policies, including consideration of activities involving direct handling of the deceased, alongside mitigations that can be put in place to safeguard the security and dignity of the deceased, such as CCTV.	1. CCTV – Standalone PC to allow review via Hikvision software. 2. Dual/layered entry system in place should breach of primary entrance occur. 3. Monthly Security audits incorporating: • Authorised user review • Access card entries • Sign in sheet review • Access denied scrutiny 4. CCTV Monitoring – Randomised audits of access entries (x5 pcm) 5. Installation of SALTO security access system – controlled and managed via mortuary management **BGH:** 1. Networked CCTV 2. Monthly Security audits • Authorised user review • Access card entries • Sign in sheet review • Access denied scrutiny 3. CCTV Monitoring – selected audits of access entries aligned with audit findings (x5 pcm) 4. SALTO security access system – controlled and managed via mortuary management **WGH:** 1. Networked CCTV 2. Monthly Security audits • Authorised user review			**AUD7787 – BGH** **AUD7790 – WGH** **AUD7789 – PPH**

	• Access card entries • Sign in sheet review • Access denied scrutiny 3. CCTV Monitoring – selected audits of access entries aligned with audit findings (x5 pcm) 4. SALTO security access system – controlled and managed via mortuary management **PPH:** 1. Networked CCTV 2. Monthly Security audits • Authorised user review • Access card entries • Sign in sheet review • Access denied scrutiny 3. CCTV Monitoring – selected audits of access entries aligned with audit findings (x5 pcm) 4. SALTO security access system – controlled and managed via mortuary management			
R39. Routine and regular audits of security must be conducted, encompassing both access to and exit from the mortuary and movement within it, including the post-mortem room. Access data must be reconciled against CCTV footage. Audits must be reported to the Designated Individual and head of service or equivalent.	Not applicable – Local Authority This recommendation is covered in Chapter 1: NHS Hospitals		01/01/2026	
R40. Immediate steps must be taken to commission a specialist strategic review of	Not applicable – Local Authority		01/01/2026	

the systems in place to protect the deceased, which should include a detailed risk assessment of the potential breaches of security that could occur. The review should include an assessment of: • the systems in place to identify unauthorised access to the facility; • the strength and effectiveness of barriers to prevent unauthorised access to the facility; • the systems in place to identify any inappropriate access to the deceased; and • how CCTV is used, including its monitoring and any audits undertaken.	This recommendation is covered in Chapter 1: NHS Hospitals			
R41. There must be no reliance on keys and keypad codes alone to secure access to the mortuary.	Not applicable – Local Authority This recommendation is covered in Chapter 1: NHS Hospitals		01/01/2026	
R42. Fridges and freezers containing deceased people must be locked at all times, with appropriate key security in place.	Not applicable – Local Authority All fridges and freezers are located within a locked and secure access facility strictly controlled by Mortuary Management. There is the ability to secure individual fridges if required.		01/01/2026	
R43. CCTV must be installed inside the mortuary facing all doors and access points, the reception area and the doors of all	Not applicable – Local Authority		01/01/2026	

fridges containing deceased people, including where these are accessible from within the post-mortem room. Local authorities must put appropriate safeguards in place to maintain the security and dignity of the deceased in relation to the monitoring of CCTV. CCTV footage should be regularly reviewed. This should be done by mortuary staff where it is of a sensitive nature.	This recommendation is covered in Chapter 1: NHS Hospitals			
R44. Arrangements for responding to incidents of unauthorised access must be reviewed and incorporated into Standard Operating Procedures.	Not applicable – Local Authority This recommendation is covered in Chapter 1: NHS Hospitals		01/01/2026	
R45. All policies and procedures in relation to the security of the mortuary must be accurately and comprehensively reflected in a single security Standard Operating Procedure.	Not applicable – Local Authority Mortuary Security & CCTV Compliance Policy in place as per Recommendation 7. This recommendation is covered in Chapter 1: NHS Hospitals		01/01/2026	• LPMOR615 - Security & CCTV Compliance • MFMOR610 CCTV Compliance - Equipment on Mortuary site • MFMOR611 CCTV Compliance – Annual service Checklist

				• MFMOR612 Access log of security camera records • MFMOR609 CCTV Compliance – Site Incident Log • MFMOR606 Detailed Security Checklist • MFMOR614 Mortuary Security Access List for Staff • MFMOR608 CCTV compliance - General site information on the site CCTV • MFMOR613 Active Fob List for the Mortuary Security Alarm System

				• EXMOR725 HIK Vision Network Digital Video Recorder Manual
R46. There must be a process to ensure that, where there is a requirement for funding to strengthen mortuary security, it is expedited and considered at the highest levels within the local authority.	Not applicable – Local Authority Despite this recommendation referring to Local Authority Mortuaries, there has been significant capital investment into the security of all four acute mortuary sites within Hywel Dda UHB. If capital investment is required, risk assessments are undertaken and both risk assessment and capitals bids are escalated up through Corporate Governance structure.		01/01/2026	
R47. There must be an investigation into the root cause of each security breach. Each incident, the investigation and action plan must be reported to director level within the local authority as a minimum. Serious security breaches must also be reported to the relevant cabinet member and/or committee of elected members.	Not applicable – Local Authority This recommendation is covered in Chapter 1: NHS Hospitals		01/01/2026	
R48. There must be audits of the mortuary Standard Operating Procedures and compliance with Human Tissue Authority requirements, undertaken annually as a minimum, with a clear record of	Not applicable – Local Authority This recommendation is covered in Chapter 1: NHS Hospitals		01/01/2026	

authorisation by the Designated Individual, head of service or equivalent. Audits of staff compliance with the Standard Operating Procedures must be undertaken at least annually, with the results of the audits reported to the Designated Individual and head of service or equivalent.				
R49. There must be a review of the management and oversight arrangements for the mortuary service, taking into consideration who is appointed as the Designated Individual, their direct contact with the mortuary, level of influence within the local authority, and attendance at governance forums. In particular: • Local authorities must ensure that the Designated Individual has enough time and resource to fulfil their statutory responsibilities, including time for learning and development. • The Designated Individual must have access to director-level officers in the local authority. The Designated Individual must also be able to directly raise issues in relation to the mortuary at the highest level within the local authority if they deem it is necessary. • Where the Designated Individual is non-technically trained, a senior anatomical pathology technologist must fulfil the Mortuary Manager	Not applicable – Local Authority This recommendation is covered in Chapter 1: NHS Hospitals		01/01/2026	

role to ensure that there is sufficient technical experience within the mortuary. • The Designated Individual must attend regular, documented meetings at mortuary level. The Designated Individual must also attend governance forums where the mortuary is discussed and scrutinised. • In line with Human Tissue Authority guidance, the named Licence Holder must be at a more senior level than the Designated Individual (e.g. director level or higher) and have a clear understanding of the Human Tissue Authority's statutory requirements and the role of the Designated Individual.				
R50. The mortuary service must be treated in the same way as other regulatory services within local authority reporting structures: • The mortuary must be visible to scrutiny at the relevant statutory committee, with regular reporting. • Key performance indicators must be identified and must include the results of audits of compliance with Human Tissue Authority requirements. • Inspections by the Human Tissue Authority and Human Tissue Authority Reportable Incidents	Not applicable – Local Authority This recommendation is covered in Chapter 1: NHS Hospitals		01/01/2026	

(HTARIs) must be reported to the relevant statutory committee, and actions to achieve compliance monitored.				
R51. The mortuary service must be reviewed by professional auditors at least biennially, with the results of the audit reported to a formal committee regardless of the level of assurance. Local authorities must arrange a peer review of the mortuary service at least every three years.	Not applicable – Local Authority		Click or tap to enter a date.	
R52. All relevant reports and incidents concerning the mortuary must be made known to the lead local authority manager for the coroner service (and the Senior Coroner if they wish to see these reports). Local authorities that are not the lead authority for the coroner service must also share these reports and incidents with the coroner service lead in that coroner area.	Not applicable – Local Authority All relevant reports concerning the mortuary are reported via DATIX and HTA Incident reporting pathways (HTARI). These are also reported internally via HTA Governance structures.		01/01/2026	
R53. The implementation of these recommendations must be reported to the relevant statutory committee.	Not applicable – Local Authority This recommendation is covered in Chapter 1: NHS Hospitals		01/01/2026	
R54. Local authorities providing a coroner service must review plans for the provision and operation of contingent body storage, in collaboration with local organisations providing mortuary services.	Not applicable – Local Authority		Click or tap to enter a date.	
R55. Local authorities providing an unlicensed body store must be prepared to comply with the Human Tissue Authority's	Not applicable – Local Authority		01/01/2026	

standards and guidance where applicable, in the event that a Human Tissue Authority licence is required to enable activities outside Human Tissue Authority licensing exemptions.	This recommendation is covered in Chapter 1: NHS Hospitals			
R56. Where local authorities provide an unlicensed body store, they should do so in line with this Report's recommendations to local authority providers of licensed mortuaries.	Not applicable – Local Authority		Click or tap to enter a date.	
R57. Local authorities must review all contractual arrangements and agreements with third-party providers of services that care for and transport the deceased. This must include consideration of assurance mechanisms, such as key performance indicators, regular reporting, formal contract review meetings, site visits and stakeholder feedback.	Not applicable – Local Authority This recommendation is covered in Chapter 1: NHS Hospitals		01/01/2026	
R58. There must be a contractual requirement to formally notify the contract manager and senior local authority officers of any incidents involving the deceased, as well as the outcome of inspections or other action by the Human Tissue Authority or others with an oversight role, such as the Health and Safety Executive.	Not applicable – Local Authority		Click or tap to enter a date.	
R59. Local authorities must ensure that the providers they contract or enter into agreements with have robust governance processes in place to oversee the services they provide. This should include Standard Operating Procedures that protect the	Not applicable – Local Authority This recommendation is covered in Chapter 1: NHS Hospitals		01/01/2026	

security and dignity of the deceased and audits to ensure staff compliance with them, as well as the reporting of incidents.				
Chapter 7: Care homes				
R60. The regulatory measures recommended in Chapter 11 should apply to care homes in England. Regulation should cover both systems and professionals where staff are providing care to deceased people in care homes	Not applicable – Care Homes		Click or tap to enter a date.	
Chapter 8: Funeral sector				
R61. The UK government should establish an independent statutory regulatory regime for funeral directors in England as a matter of urgency in order to safeguard the security and dignity of the deceased. This regime should include a licensing scheme, mandatory standards against which funeral directors should be inspected regularly, and enforcement powers.	Not applicable – Funeral Sector		Click or tap to enter a date.	
R62. These regulations and standards should be considered within the overall care and journey of the deceased rather than applying in isolation to funeral directors.	Not applicable – Funeral Sector		Click or tap to enter a date.	
R63. The standards should include details of mandatory information to be given to customers by funeral directors to provide transparency about the care of the deceased, including information on measures to protect their security and dignity, and what should be expected of funeral directors' services.	Not applicable – Funeral Sector		Click or tap to enter a date.	

R64. Direct cremation businesses should also be considered in this context, and mandatory standards to protect the security and dignity of the deceased should be applied to these businesses and to any emerging new models of delivery of care for the deceased.	Not applicable – Funeral Sector		Click or tap to enter a date.	
R65. While the introduction of a proportionate statutory regulation and inspection regime may require significant adjustment by funeral director organisations, it is the view of the Inquiry that the benefit to customers and the need for public confidence outweigh the difficulties that may be experienced by some businesses.	Not applicable – Funeral Sector		Click or tap to enter a date.	
R66. The funeral sector in England should be considered in scope for the broader regulatory measures recommended in Chapter 11.	Not applicable – Funeral Sector		Click or tap to enter a date.	
Chapter 9: Faith organisations				
R67. All faith organisations should consider how to support their members to deliver high standards of care for the deceased, with a focus on the security and dignity of the deceased – for example, by sharing guidance	Not applicable – Faith Organisations		Click or tap to enter a date.	
R68. Where deceased people are in a religious building overnight, measures should be taken to ensure that the building is secure, including, for example, CCTV and secure access control for the area in which they are kept.	Not applicable – Faith/Funeral Sector		Click or tap to enter a date.	
Chapter 10: Locality visits				

R69. Where organisations work together to care for people after death, the arrangements should be formalised through contracts or service level agreements. This should include joint Standard Operating Procedures. The parties to the contracts or service level agreements should ensure that the contracts or agreements are managed effectively, and that they seek assurance that the arrangements protect the security and dignity of people after death	Formal contracts in place via Procurement Visits to Contracted Funeral Directors: - Co-operative Funeral Care – 23.07.2025 Arthur Cambrey, Llanelli – 04.11.2025 F.G. Rees, Haverfordwest - TBA D.G. Evans, Aberystwyth - TBA		Click or tap to enter a date.	
Chapter 11: Regulation and oversight				
R70. The Chief Coroner should review the difference in practice between coronial areas as soon as possible to ensure that: • All coroners are informed of the findings of this Inquiry. • All coroners are aware of the prevalence of offending by David Fuller against deceased people who were formally under the control of the coroner. • All coroners understand the importance of a consistent approach to ensuring the security and dignity of deceased people who are under their control. This is likely to require guidance from the Chief Coroner to ensure that there is a consistent approach nationally, and it should be considered an area for further training for all coroners and their staff.	Not applicable – External Governance – HM Coroner		Click or tap to enter a date.	

R71. The UK government should establish an independent statutory regulatory regime, headed by a Chief Inspector, for those who store and care for deceased people. The purpose of the regulatory regime should be to ensure that the security and dignity of deceased people are protected, in whichever institutions or locations they are cared for, examined or stored. The government should ensure that this role is adequately resourced to discharge its responsibilities and should provide it with powers to require information and enter premises and to take appropriate enforcement action (including against office holders in any organisation). Either the Human Tissue Authority should be required to work under the auspices of this new regime, or its remit should be formally expanded to comply with the statutory regime's requirements.	Not applicable – External Governance – UK Government		Click or tap to enter a date.	
R72. In the interim, the government should immediately appoint a Commissioner for the Dignity of the Deceased who should immediately issue universal guidance that applies to all those who store and care for deceased people. This guidance should set out expectations for the security and dignity of deceased people	Not applicable – External Governance – UK Government		Click or tap to enter a date.	
R73. The government should amend the Human Tissue Act 2004 so that the organisation holding the licence has primary legal responsibility to ensure that:	Not applicable – External Governance – UK Government		Click or tap to enter a date.	

• There is a suitable Designated Individual in place at their establishment. • Suitable premises are provided and maintained • Suitable individuals are employed • All relevant legal and regulatory duties pertaining to the licence are met.				
R74. The Human Tissue Authority, and/or the new Inspectorate, should require the organisations it licenses to ensure that any individual who provides care to deceased people is suitably qualified, experienced and supervised. The regulatory regime should set minimum standards on the qualifications likely to be considered sufficient to demonstrate 'suitability' for particular roles or levels of responsibility. Failure to ensure that suitable individuals are employed would be subject to regulatory enforcement.	Not applicable – External Governance – Human Tissue Authority/New Inspectorate		Click or tap to enter a date.	
Chapter 12: Chair's conclusions and recommendations				
R75. The government should take responsibility for the implementation of all the recommendations we make in this Report, regardless of the primary organisation they are directed at, and make arrangements to monitor the progress of their implementation	Not applicable – External Governance – UK Government then devolved.		Click or tap to enter a date.	

Prepared By: ……

Prepared On: ……

Approved By: ……

Approved On: ……

3.7

3.7 - Quality Improvement Framework

Marilize Preez (Hywel Dda UHB - Improvement and Transformation Lead)

For approval

Attachments

Quality Improvement Framework.pdf

Quality Improvement Strategic Framework_v7.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:	09 April 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Draft Quality Improvement Strategic Framework 2026-29
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Sharon Daniel, Executive Director of Nursing, Quality and Patient Experience
SWYDDOG ADRODD: REPORTING OFFICER:	Marilize du Preez, Improvement and Transformation Lead

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 existing Quality Improvement Strategic Framework (QISF) 2023-2026 has been revised to continue to strengthen and develop Hywel Dda University Health Board's strategic and systematic approach to Quality Improvement (QI) for the next three years.

The framework forms a crucial component of the Health Board's Quality Management System and outlines our ambition not simply to undertake more improvement activity but to ensure QI consistently delivers measurable impact. The framework also outlines how we will focus on the spread and scale of high quality, high impact QI projects along with continuing to build QI capability and capacity to deliver and sustain highquality, safe, effective, and customer-focused care.

Approval from the Quality, Safety and Experience Committee is sought to progress the Framework to final design and publication, ahead of its submission to the Board.

Cefndir / Background

The development of the QISF has taken place over the past several months through an iterative engagement process. This has included:

- Engagement with senior leaders to ensure alignment with strategic objectives and service priorities.
- Review of evidence-based improvement methodologies, including the Health Board's Quality Management System, ValueBased Healthcare principles, and the IHI Model for Improvement.
- Refinement through feedback including the QIST team and senior leaders.

The draft framework also reflects how the QISF will support the delivery of the Health Board's wider priorities, including prevention, value-based healthcare, improving outcomes,

strengthening patient and carer experience, and supporting staff to embed quality as part of everyday practice.

Asesiad / Assessment

The QISF provides:

- A clear strategic direction for QI aligned with the Health Board's Strategic Objectives and priorities.
- A central ambition to move beyond building capability alone to delivering measurable, demonstrable impact at scale. Over recent years, considerable progress has been made in equipping staff with QI knowledge and skills; the next phase focuses on ensuring that this capability consistently translates into improved outcomes, reduced harm, better experience, greater value, and strengthened prevention across services.
- A focus on system-wide improvement supported by robust methods, tools, and data.
- An ambition to develop a structured approach to spread and scale of high quality, high impact improvement projects.
- A strengthened approach to capability and capacity building, including the continued delivery of EQIiP and the development of a Community of Practice.
- A structured approach to governance, monitoring, and providing assurance to QSEC and the Board.
- A commitment to national alignment, including Improvement in Practice standards, national frameworks (QMS) and integration with the Duty of Quality.

The draft document outlines the QISF strategic intent and priorities over the next three years with identified outcomes and benefits, and the mechanisms needed to successfully deliver the QISF. Once agreed the document will be formatted for board submission.

Argymhelliad / Recommendation

The Quality, Safety and Experience Committee is asked to:
1. Approve the proposed QISF strategic intent for 2026-29.
2. Approve the QISF priority areas and proposed outcome and benefit metrics.
3. Approve the QISF delivery approach.
2. Approve the draft Quality Improvement Strategic Framework for finalisation.
3. Support its subsequent submission to the Board for final approval.
4. Endorse the governance and reporting arrangements described in the framework.

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. Patient Stories, Patient Charter and Board to Floor Walkabouts will feature as a key area for patient experience and lessons learnt.
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:	
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:	Not applicable
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:	Not applicable

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not Applicable
Ansawdd / Gofal Claf: Quality / Patient Care:	Intended to promote the quality of patient care
Gweithlu: Workforce:	Intended to develop workforce
Risg: Risk:	Not Applicable
Cyfreithiol: Legal:	Not Applicable

Enw Da: **Reputational:**	Not Applicable
Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	Not Applicable

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

QUALITY IMPROVEMENT STRATEGIC FRAMEWORK (QISF) 2026– 2029

Contents

1. Introduction

The Quality Improvement Strategic Framework (QISF) sets out how we aim to engage, empower, and equip our entire workforce to continually improve the quality of our services and deliver value and impact. As an organisation, we are committed to delivering a healthcare system of the highest quality, achieving excellent outcomes for our patients and wider population.

This document outlines the continued Quality Improvement (QI) journey that Hywel Dda University Health Board (HDUHB) has undertaken and sets out the whole system strategic approach to QI that the Health Board will adopt over the next three years.

The framework aligns to the HDUHB Strategic Objectives and sets out the Quality Goals that will drive QI priorities focused on improving patient outcomes, reducing harm, strengthening prevention, and enhancing overall customer experience. We want staff at every level and in every role to feel confident, empowered and supported to identify opportunities for improvement and to lead changes that enhance experiences and outcomes of care.

By promoting, encouraging, and supporting continuous improvement – and making quality everyone's responsibility – we will sustain high quality services, strengthen our prevention-focused approach, and ensure HDUHB is an attractive, rewarding and valued place to work and deliver compassionate and customer-focussed care.

2. Our Health Board

Our Strategic Objectives

The QISF will support and enable the delivery of the health board's four strategic objectives, and our move towards achieving our aspiration of Healthier Lives, Well Lived.

HDUHB Strategic Objectives

Starting with building ***thriving teams*** which are orientated towards supporting ***healthier communities***, embedding our 20four7 prevention model, emphasising a social model for health and wellbeing and enhancing primary care and community provision. When required patients deserve to receive ***great care***, with timely access to safe, high-quality services delivering improved health outcomes. Finally, we should be building ***positive futures*** where people are born healthy, live and age well, and die with dignity; and the NHS maximises its contribution to building a strong and sustainable society.

Our Quality Management System (QMS)

The Duty of Quality sets out the expectation that every person should receive high-quality, safe and effective healthcare. QI is an integral part of the Health Board's QMS Strategic Framework which aims to provide a system-wide approach to achieving quality of care in a way that drives continuous improvement.

Our Quality Management System Strategic Framework

The QMS ensures that services reliably meet the needs of the population by integrating four core components- quality planning, quality improvement, quality control, and quality assurance. The QI approach outlined within this framework will support the Health Board in bringing together a single quality system to meet its goals and improve overall customer care.

Embedding a culture of continuous improvement across organisation supports our Quality Management System (QMS), alongside the nationally and locally adopted Institute for Healthcare Improvement (IHI) Model for Improvement. Together, these provide a consistent, evidence-based approach to improvement practice. This integrated, whole-system approach strengthens the organisation's ability to deliver high-quality, sustainable care and fosters a shared culture of quality at every level.

Our Approach to Research and Innovation

QISF is closely aligned with the Health Board's Research and Innovation strategy, as both aim to strengthen our ability to deliver better outcomes, earlier diagnosis, more effective treatments and improved models of care. QI provides the practical methodology for turning research evidence and innovative ideas into measurable, reproducible improvements in real-world clinical settings. While research and innovation generate new knowledge, technologies and understanding of what works, QI ensures this learning is systematically tested, adapted and embedded into routine practice.

Together, they enhance patient and carer experience, improve workforce satisfaction, reduce mortality, and support prudent, value-based use of resources. By linking innovation with continual learning and operational improvement, QI acts as a bridge that helps translate discovery into better health outcomes and quality of life for the population.

Understanding the outcomes of each intervention or treatment—what they mean for patients, their families, and communities, as well as the associated cost—is central to delivering and sustaining value-based healthcare. This approach ensures that we focus not only on clinical results but also on customer experience, overall wellbeing, and the wider impact on people's lives.

3. Quality Improvement in Hywel Dda

Quality is integral to everything we do in Health and Social Care. Quality improvement (QI) can be defined as "a systematic continuous approach that aims to solve problems in healthcare, improve service provision, and ultimately provide better outcomes for patients" (Backhouse & Ogunlayi, 2020). The Health Foundation (2021) highlights the importance of considering all dimensions of quality when setting priorities for improvement. Within healthcare**, the six recognised domains of quality** provide a comprehensive framework for understanding what "good" looks like.

- **Safe**: Avoiding harm to patients
- **Timely**: Reducing waits and harmful delays
- **Effective**: Providing evidence-based care
- **Efficient**: Avoiding waste of resources
- **Equitable**: Ensuring consistent high-quality care for all
- **Patient-centred**: Respectful, responsive and preventative care aligned with customer (patient) needs.

As an organisation we take all six domains into account when identifying and prioritising improvement activity, as they are often interconnected and mutually reinforcing. By recognising how these dimensions complement each other, we can design improvement work that delivers value and impact across all domains of quality.

Our Quality Improvement Strategic Intent for 2026-2029

Between 2026 and 2029, Hywel Dda University Health Board will use Quality Improvement (QI) as a primary driver for safer care, better outcomes, improved experience, and greater value for our population.

Our aim is not to simply undertake more improvement activity, but to ensure that quality improvement consistently delivers measurable impact where it matters most to patients, service users, carers, communities, and our workforce.

Quality Improvement will be the mechanism through which the organisation:

- reduces avoidable harm and unwarranted variation,
- improves reliability, timeliness, and patient experience,
- supports a shift towards prevention and a social model of care,
- strengthens staff engagement, capability, and wellbeing, and
- maximises value from finite resources in line with prudent healthcare principles.

Moving from capability to impact

Over recent years, Hywel Dda has invested significantly in building QI capability, infrastructure, and a strong improvement culture. The strategic focus for the next three-year period is to continue to build QI capacity but crucially move decisively to delivering impact at scale.

This means:

- prioritising improvement activity where there is the greatest risk, harm or inequity
- aligning QI effort tightly to the Health Board's Strategic Objectives, Quality Goals and principal risks
- using QI deliberately to support delivery of annual plans, transformation programmes and system change
- embedding improvement as part of everyday practice rather than as an additional activity.

- QI will therefore function as a core organisational discipline, supporting delivery across operational, clinical and corporate portfolios.

To achieve this ambition, the Quality Improvement Strategic Framework will:

- provide clear direction for where and how QI effort is focused;
- enable consistent governance, oversight and assurance;
- support the development and deployment of improvement capability where it adds greatest value; and
- ensure that improvement activity contributes directly to safer, more effective, more equitable and sustainable services.

Quality Improvement will remain everyone's responsibility, but strategic QI deployment will be deliberate, focused and outcome driven.

Key QISF deliverables- what would good look like in 2029:

- Demonstrable improvement in safety and outcomes, including sustained reduction in avoidable harm and unwarranted variation across priority pathways.
- Improved patient and carer experience, with improvement activity increasingly driven by what matters to people who use our services.
- Stronger use of data for learning and improvement, with teams confident in measurement, testing change and understanding impact.
- A confident and engaged workforce, where staff at all levels feel empowered and supported to identify, lead and sustain improvement.
- More consistent delivery of value-based, prudent care, reducing waste and duplication while strengthening prevention and community-based approaches.
- Clear Board level assurance that QI activity is aligned, prioritised and delivering measurable benefits.

4. Our Strategic QI Focus Areas for 2026–2029

To deliver our strategic ambition, Quality Improvement activity across Hywel Dda will be focused, prioritised and aligned to the following six system level focus areas. These represent where most QI effort will deliberately be directed to over the next three years, and will support the delivery of our four strategic objectives.

Focus area 1: Reducing Avoidable Harm and Improving Reliability of Care

Quality Improvement will be prioritised to:

- reduce avoidable harm and high severity patient safety incidents;
- improve the reliability of core clinical and care processes;
- strengthen early identification, escalation and prevention of deterioration;
- embed a culture of continuous learning and prevention.

Improvement activity will be informed by harms data, learning from incidents and complaints, and national safety priorities, with a particular focus on areas of persistent risk or unwarranted variation.

Key outcomes and benefits:

- Sustained reduction in:
  - severe patient harm incidents
  - avoidable mortality measures
- Improvement in:
  - reliability of key safety processes (e.g. medication, deterioration, infection prevention)
  - learning loop closure following incidents and complaints
- Evidence that:
  - High risk and fragile services are actively using QI methods to address safety risks
  - staff report increased confidence in speaking up and improving safety

Focus area 2: Improving Flow, Timeliness and Access Across Pathways

Quality Improvement will be used as a key enabler of:

- improving patient flow across acute, community and primary care pathways;
- reducing waits and delays that negatively impact experience, safety and outcomes; and
- supporting redesign of pathways to deliver the right care, in the right place, at the right time.

This focus will directly support service sustainability, workforce wellbeing, and improved customer experience.

Key outcomes and benefits:

- Reduction in:

  - avoidable waits and delays within priority pathways
  - demand related harm (e.g. deterioration linked to delays)

- Improvement in:
  - patient reported experience of access and timeliness of care
  - flow measures across acute, community and primary care interfaces

- Evidence of:
  - Pathway level improvement work rather than isolated team-based changes
  - multidisciplinary ownership of improvement outcomes

Focus area 3: Strengthening Value, Productivity and Prudent Use of Resources

Quality Improvement will support a shift from activity-based improvement to value-based improvement, with a focus on:

- reducing waste, duplication and low value activity;
- addressing unwarranted variation using evidence based best practice; and
- improving outcomes that matter to patients relative to the resources used.

This will align improvement activity with prudent healthcare principles and Value Based Health Care, supporting responsible stewardship of public resources.

Key outcomes and benefits:

- Reduction in:
  - unwarranted clinical and operational variation
  - low value or duplicated activity

- Improvement in:
  - alignment between QI activity and Value Based Healthcare measures
  - demonstrable benefits realised from improvement initiatives

- Evidence that:
  - improvement work considers outcomes, experience and resource use together
  - services can articulate the value added by QI interventions

Focus area 4: Enhancing Patient, Carer and Community Experience Through Coproduction

Quality Improvement activities will increasingly be driven by:

- what matters most to patients, carers and communities;
- learning from feedback, complaints and lived experience; and
- meaningful coproduction in the design and testing of improvements.

This focus ensures improvement activity consistently reflects person-centred care, equity and inclusion, and supports trust and transparency with the population we serve by actively moving from “doing to” toward coproduced solutions shaped by lived experience and community need.

Key outcomes and benefits:

- Increased use of:
    - patient, carer and community insight in improvement design
- Improvement in:
    - patient reported experience measures (PREMs)
    - themes arising from feedback and complaints
- Evidence that:
    - coproduction is embedded in priority improvement programmes
    - services can demonstrate how feedback has directly shaped change

Focus area 5: Supporting Prevention and a Social Model of Health and Care

Quality Improvement will contribute directly to:

- prevention focused approaches that reduce avoidable demand on acute services;
- improvement of care models that support people to stay well for longer; and
- addressing wider determinants of health through integrated, system wide improvement.

Improvement activity in this area will increasingly span organisational and agency boundaries, supporting whole system working.

Key outcomes and benefits:

- Increase in:
    - improvement projects focused on prevention and early intervention
    - cross organisational or multiagency improvement initiatives
- Improvement in:
    - outcomes linked to keeping people well and independent
- Evidence that:
    - QI is supporting pathway redesign beyond hospital based care
    - community based services are enabled and supported to lead improvement

Focus area 6: Building Sustainable Improvement Capability Where It Delivers Greatest Impact

While improvement capability remains important, the strategic focus will be on:

- deploying QI expertise where it adds the greatest value;
- embedding improvement skills within operational services and teams; and
- supporting leaders to use QI as a core management and decision-making tool.

Capability building will therefore be purposeful and targeted, rather than uniform, ensuring improvement effort translates into measurable impact.

Key outcomes and benefits:

- Evidence of:
    - improvement capability embedded within operational services
    - leaders using QI routinely in planning, decision making and risk management
- Improvement in:
    - staff confidence and engagement in improvement
    - spread and sustainability of successful improvement work
- Assurance that:
    - QI investment is targeted, proportionate and aligned to strategic risk

These strategic focus areas will:

- guide prioritisation of QI projects and programmes, including our Enabling Quality Improvement in Practice (EQIiP) programme;
- inform annual improvement planning and resource deployment;
- shape conversations between Executives, services and clinical leaders; and
- support Board level assurance that improvement effort is aligned with organisational risk, priorities and outcomes.

These focus areas, although clear, are complex and apply across all our services, spanning clinical care, preventive care, population health, and broader determinants of wellbeing. Progress will require meaningful engagement from staff at every level, using recognised and evidence-based Quality Improvement tools and methodologies.

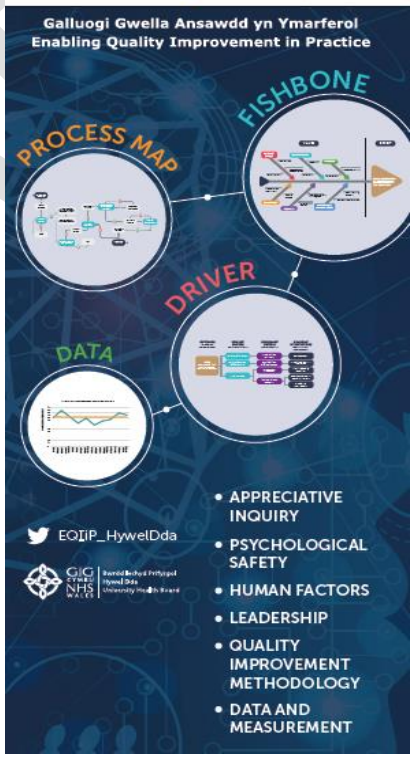
5. Delivering Our Quality Improvement Strategic Framework

The delivery of our QISF will be achieved through several mechanisms:

- The EQIiP programme
- Ongoing QI coach development
- Targeted Quality Improvement and Service Transformation (QIST) team deployment and engaging with national QI resources and collaboratives
- Building capacity and capability
- QI SharePoint
- QI Community of Practice
- Developing a collaborative health board approach to Spread and Scale

Enabling Quality Improvement in Practice (EQIiP) Programme

Our collaborative EQIiP programme will remain one of our primary enablers for the delivery of our QISF and is a central mechanism for supporting and strengthening our QMS.



The Breakthrough Collaborative model on which EQIiP is based is a well-established, evidence-based approach to improvement, workforce development and enabling change (Nadeem et al., 2013; Hulscher et al., 2013). The EQIiP programme applies this model to support frontline staff and leaders. EQIiP has been running since 2019 and has had seven cohorts of 102 teams with 808 participants completing the programme.

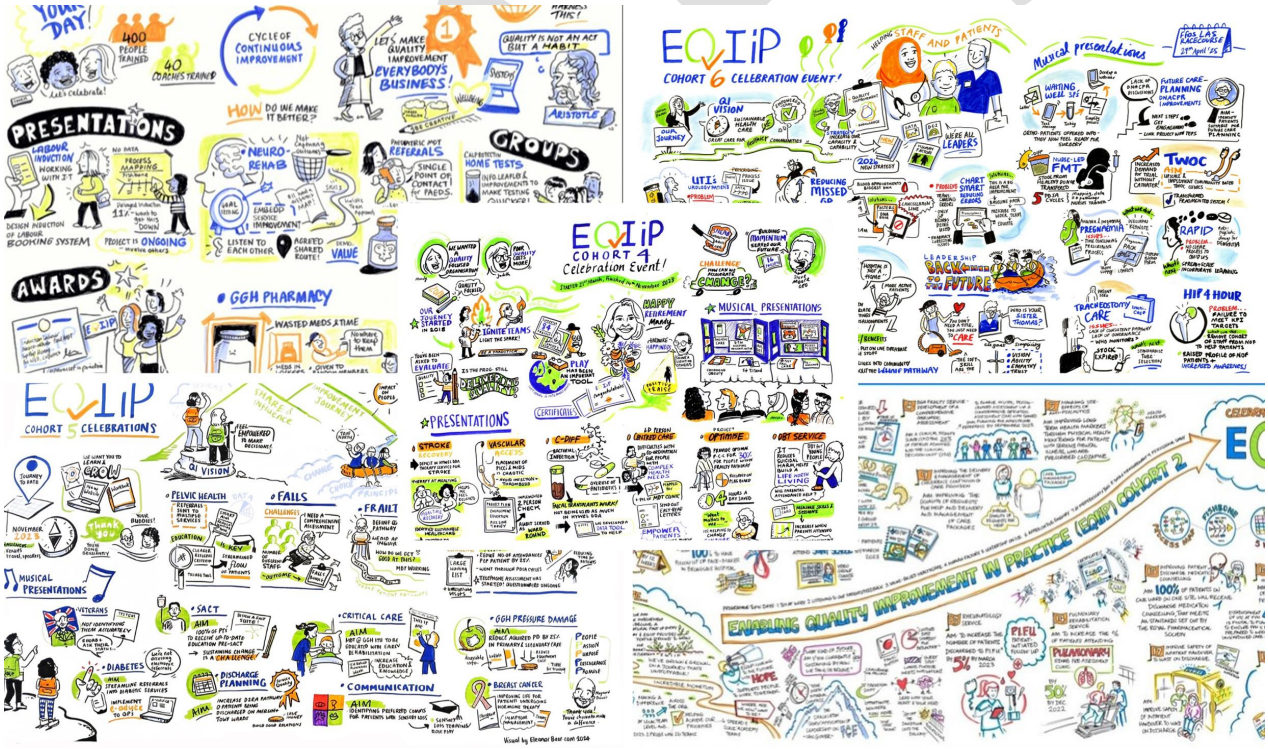
The 9- month programme is designed to bring together multidisciplinary teams from across services and organisations to work on a defined improvement project aligned to our Strategic Objectives and Quality priorities. These projects focus on delivering better value, enhancing customer (patient and carer) experience, and strengthening preventative approaches within clinical pathways.

Teams participate in a series of structured learning events delivered by internal and external subject matter experts, complemented by support from health board improvement coaches. Dedicated time for skills development, supported activities, and peer learning enables staff to learn from each other as well as from national and local experts in improvement science.

EQIiP has progressively been refined through systematic evaluations of each cohort, including detailed participant feedback from every educational session. After the first two cohorts a formal and independent evaluation was undertaken (Williams et al., 2022), and the programme's design is continually being refined through successive Plan-Do-Study-Act cycles. Each cycle contributes evidence and insights that guide improvements, ensuring the programme remains relevant, impactful, and aligned with organisational priorities, customer needs, and preventative approaches to health and wellbeing.

Through EQIiP multidisciplinary teams are supported to develop their QI skills using evidence-based methodologies and tools/techniques to continuously improve service delivery. Working on a 'live' improvement project they have to opportunity to directly contribute to and design the improvement activities and interventions within their areas. Throughout the programme, teams continue to receive tailored support from experts in improvement methodology, ensuring effective delivery, measurable impact, and long-term sustainability of their projects. Each team is supported by one of the health board's dedicated QI coaches.

Visual minutes from EQIiP Cohort Celebration Events



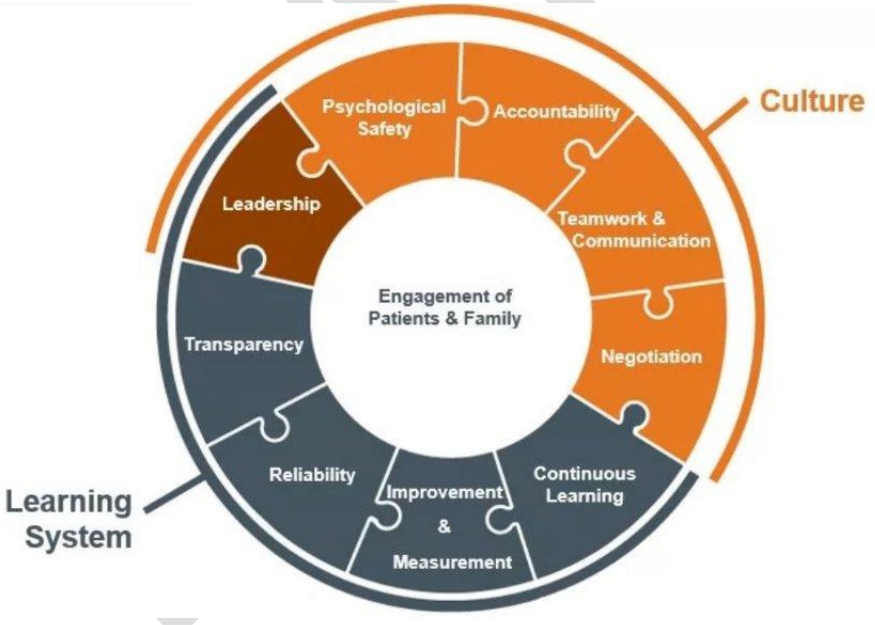
As the programme has developed the scope of the QI projects has increased from team membership being solely from the health board to extend to include other key stakeholders and agencies and therefore impacting on the entire healthcare system.

EQIiP Programme Content

The educational content of EQIiP has been developed in line with the priorities of the organisation and advancement of the published research in improvement science/quality improvement as outlined below. Delivery of educational sessions are now largely covered by members of the Quality Improvement and Service Transformation (QIST) Team and other experts within the Health Board and external stakeholders such as Academi Wales.

EQIiP programme content:

- Appreciative Inquiry
- Behavioural science
- Benefit realisation
- Clinical Audit
- Coproduction
- Data and measurement
- Duty of Quality/Duty of Candour
- Equality, Diversity and Inclusion
- Framework for Safe Effective Reliable Care (SERC)
- Human Factors
- Leadership
- Listening to patients/feedback
- Psychological Safety
- Publishing QI work/accreditation
- QI methodology and tools
- Spread and scale
- Sustainability
- Team building
- Value based healthcare



IHI Framework for Safe, Reliable, Effective Care

The Institute of Healthcare Improvement (IHI) framework for safe, reliable and effective care (SREC) is integral to the EQIiP programme. It is used to assess, benchmark and guide QI activity and support within project teams.

An example of how the IHI SREC framework is used to identify appropriate support in practice.

The national Quality, Safety and Improvement team within NHS Performance and Improvement has supported the development of a mechanism enabling all EQIiP participants to achieve the Improvement in Practice (IiP) accreditation, consistent with the national framework for Quality Improvement Training. Teams that demonstrate successful, scalable improvements—particularly those enhancing quality, patient experience, value, and prevention—are supported to attend the Spread and Scale Academy programme to extend their impact across the systems.

To support the delivery of the QISF we will continue to deliver EQIiP over the next three years with projects aligned to our QI focus areas and strategic objectives. This will enable us to support approximately 42 QI priority projects over the next 3 years through EQIiP and develop additional QI capacity and capability in over 300 members of staff.

QI Coach Development and Network

Identifying and developing more QI coaches will be key to the successful delivery of the QISF. Although QI coaches are essential to the delivery of the EQIiP programme, our long-term vision is to have a coach in every operational and clinical team to support QI at the point of care delivery.

Since 2019 when EQIiP was first introduced over 58 QI coaches have been developed within the organisation. Currently there are 40 active coaches/buddy coaches that support the EQIiP programme. This network of Improvement Coaches includes members of the Quality Improvement and Service Transformation (QIST)

team and the wider EQIiP alumni community. The Improvement Coach Development Programme encourages both current and former EQIiP participants to join this network, where they receive additional training in Human Factors, Appreciative Inquiry, LEAN methodology, ergonomics, behavioural science, and advanced Quality Improvement methodology.

We will continuously review the content and offer a rolling development programme to all our new and existing buddy coaches/coaches along with developing a competency framework to support the transition from buddy coach to coach. This network will enable coaches to share good practice and promote peer-learning and support.

All Improvement Coaches will hold Improvement in Practice (IiP) accreditation and will benefit from this additional specialist training. After each EQIiP cohort, participants who demonstrate enthusiasm and capability for supporting others are invited to become Improvement Coaches and enter the development programme strengthening the network and the opportunity to embed quality improvement across all services.

Expanding the network beyond the QIST team creates significant value: it enables improvement activity to be supported directly within services by coaches who understand local pathways, customer needs, and opportunities for prevention. This distributed model strengthens capacity, embeds improvement as part of everyday practice, and enhances the quality and experience of care within teams.

Targeted deployment of Quality Improvement and Service Transformation (QIST) team resources and engaging with national QI resources and collaboratives

All Quality Improvement and Service Transformation resources are coordinated under the leadership and direction of the Director of Nursing, Quality & Patient Experience, who serves as the Executive Lead for Quality across all services and disciplines within HDUHB. Responsibility for championing, supporting, and promoting Quality Improvement activity is shared across the Executive Team, with each Executive Director expected to drive improvement within their own portfolio.

The QIST team comprises of 20 core members, including nine Improvement Advisors. The team and advisors bring specialist expertise gained through recognised advanced QI training and Improvement Advisor programmes, equipping them to design, measure, and apply advanced improvement methodologies that enhance value, strengthen prevention, and improve customer (patient and carer) experience. The QIST team also operates a model where some QIST staff are embedded directly within operational teams. This model ensures that services have direct access to QI expertise while maintaining strong professional leadership, governance, and support for staff working in these roles. The QIST team also offers ongoing support to services, teams, and individuals seeking improvement guidance, subject to capacity and demand.

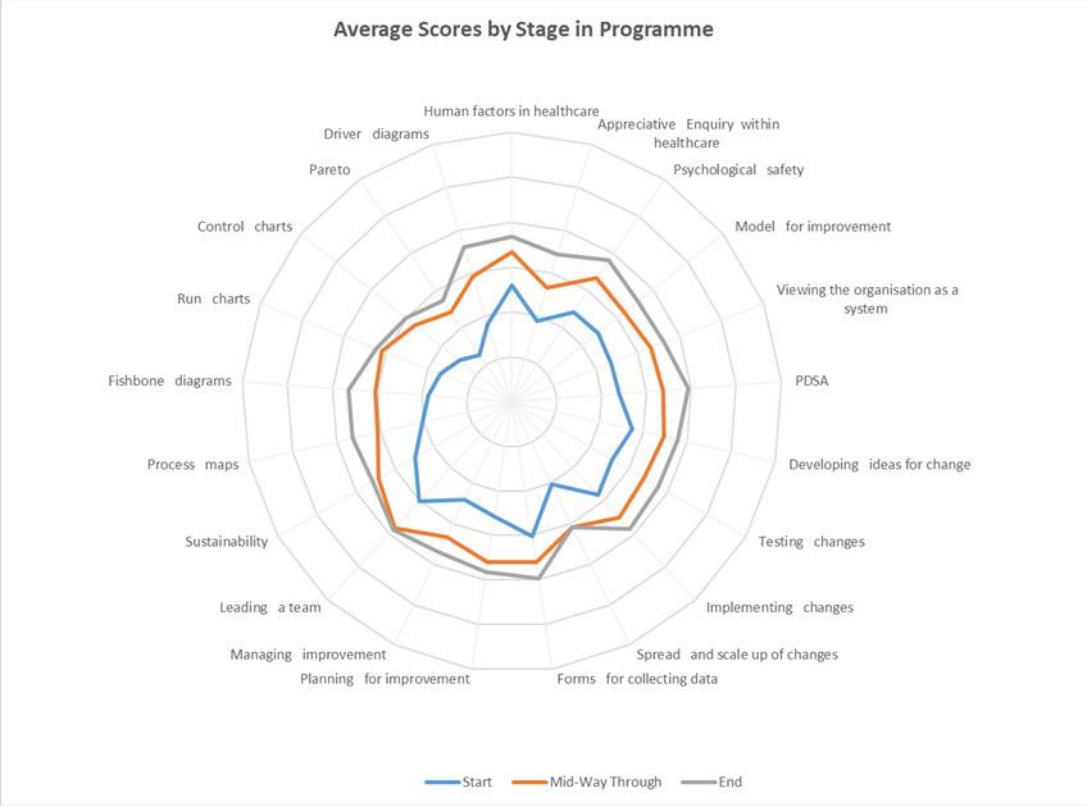
We will also continue to make best use of national QI resources and expertise available through NHS Wales Performance and Improvement and the Welsh Value in Health Centre, and engage with national QI collaboratives. These partnerships support the spread of evidence-based practice, alignment with national standards, and delivery of improvements that offer better outcomes, improved experience, and preventative benefits for our population.

Over the next 3 years the QIST team will continue to be strategically deployed to support targeted QI initiatives in focus areas across the organisation.

Building QI capacity and capability

HDUHB will continue to uphold its commitment to national standards for Quality Improvement training. All staff will be expected to complete IQT (Improving Quality Together) Bronze level training, or an equivalent accredited programme, as a foundation for developing improvement capability. This introductory training acts as a catalyst, helping staff recognise opportunities to enhance value, strengthen prevention, and improve customer (patient and carer) experience within their areas of practice.

Through EQIiP we will build additional QI capacity and capability. To assess the development of EQIiP participants' QI skills, a self-assessment tool is administered at three stages of the EQIiP programme: at the start, midpoint, and end, shown in the figure below. Each team receives a summary of their results, highlighting areas of progress as well as aspects requiring further development.



Spider diagram – self assessment QI tool used in EQIiP

The self-assessment is an important element of the EQIiP programme as it enables participants to actively track their growth in quality improvement (QI) capability over time. By completing the tool at the start, midpoint, and end of the programme, individuals and teams gain insight into how their knowledge, confidence, and practical skills are developing. This structured reflection promotes greater self-awareness, supports goal-setting, and encourages participants to take ownership of their learning.

At a team level, the aggregated results highlight areas of collective strength as well as capability gaps that may need further support. This enables the QIST team to tailor coaching, resources, and teaching to real needs—ensuring each cohort receives relevant and timely guidance. The data also acts as a feedback loop for programme improvement, helping the EQIiP team understand what is working well and where refinements may enhance impact.

Ultimately, the self-assessment strengthens the programme's ability to build sustainable QI capacity and capability by supporting reflective practice, reinforcing learning, and ensuring a responsive, learner-centred approach.

In additional, to ensure continued capability development and QI succession planning we aim for three members of the QIST team to attend an Improvement Advisor programme each year.

Quality Improvement SharePoint

Over the past three years, we have established and expanded a dedicated SharePoint site that hosts a range of supportive QI tools that are accessible to all staff. Our intention is to continue developing this platform so it can provide ongoing support to project teams, while also acting as a space to capture, share, and disseminate project outcomes—including conference posters, presentations, and professional or academic publications. It also serves as a central repository for the QI projects completed as part of the EQIiP cohorts.

Community of Practice

To continue to support and develop participants that have completed EQIiP a community of practice (CoP) will be established. The CoP will offer a supportive, collaborative environment where staff can share learning, test ideas, and continue to build improvement capability over time. The purpose of the CoP will be to strengthen and sustain organisational QI capability and capacity, spread best practice and support strategic priorities.

The CoP will blend structured elements (such as learning sessions, facilitated discussions) with informal peer-to-peer exchange that enables participants to learn from real-world examples. As the community develops, iterative feedback, reflective learning, and small tests of change will help refine the model, ensuring that the community remains responsive to staff needs, organisational goals, and the broader

shift toward prevention and value-based, person-centred care. Ultimately, the CoP will offer a sustainable mechanism for shared learning, collective problem-solving, and embedding improvement into everyday practice.

Developing a collaborative health board approach to Spread and Scale

EQIiP teams that have demonstrated successful, scalable improvements—particularly those enhancing quality, patient experience, value, and prevention—have been supported to attend the Spread and Scale Academy hosted by the Dragons Heart Institute to try and extend their impact across the system. However, the impact of this approach to Spread and Scale has been variable.

To support our ambition to delivering impact at scale it is the intention to develop a robust internal spread and scale approach to ensure that high quality, high impact projects emerging from EQIiP or other QI initiatives can achieve wider and more sustainable outcomes and influence across the organisation. This approach will create a structured method for proven improvements to be adopted consistently across teams, services and systems. It will include clear criteria for project readiness, how to demonstrate benefits and value, and practical tools and guidance to support wider adoption and spread.

This will require a strong coordinated effort across the system to develop an approach that is achievable and will maintain momentum to provide the support needed for successful implementation. By embedding leadership, sponsorship, aligning with strategic priorities, and building capability within frontline teams, this spread and scale approach will help ensure that QI projects not only sustain their improvements but deliver measurable benefits at scale.

6. Quality Improvement Governance Arrangements

Oversight and assurance for quality, safety, and experience are delivered through the Quality, Safety and Experience Committee (QSEC) structure. QSEC will receive regular reports on the implementation, progress, and outcomes of this strategy, or more frequently if requested.

Feedback from our staff survey is routinely monitored and reported through the Board Assurance Framework, the Integrated Performance Assurance Report, and the bi-monthly Workforce Update submitted to the People, Organisational Development and Culture Committee. Insights from staff feedback directly inform strategic discussions and decisions, which are subsequently reported to the Board. This ensures that actions taken respond meaningfully to staff experience, which in turn supports improved customer (patient and carer) experience and strengthens the organisation's ability to deliver preventative, safe, and compassionate care.

HDUHB will develop an Annual Plan that this framework will support and enable. The Harms Dashboard will play a key role in shaping and prioritising this plan, providing real-time insight into safety, experience, and areas where preventative action is needed most. These data-driven insights, combined with the "Improving Together" conversations at directorate and service levels, ensure that improvement activity is

aligned not only to national priorities but also—critically—to the needs and priorities of our local population.

References

- Backhouse, A. & Ogunlayi, F. (2020), Quality improvement in practice, BMJ, 368:1
- Hulscher, ME, Schouten, LM, Grol, RP, & Buchan, H. (2013). Determinants of success of quality improvement collaboratives: what does the literature show? BMJ Quality & Safety. 22(1):19–31.
- Langley, G. Moen, R. Nolan, K. Nolan, T. Norman, C. & Provost, L. (2009). The Improvement Guide: A practical approach to enhancing organisational performance. Jossey Bass, San Francisco.
- Nadeem, E, Olin, SS, Hill, LC, Hoagwood KE, & Horwitz, SM. (2013) Understanding the components of quality improvement collaboratives: a systematic literature review. Milbank Quarterly. 91(2):354–94.
- The Health Foundation (2021) Quality improvement made simple, Health Foundation, London.
- Frankel A, Haraden C, Federico F, Lenoci-Edwards J. A Framework for Safe, Reliable, and Effective Care. White Paper. Cambridge, MA: Institute for Healthcare Improvement and Safe & Reliable Healthcare; 2017. (Available on ihi.org)
- Williams, SJ. Caley, L. Davies, M. Bird, D. Hopkins, S. & Willson, A. (2022), "Evaluating a quality improvement collaborative: a hybrid approach". Journal of Health Organisation and Management, 36(8):987–1008, doi: https://doi.org/10.1108/JHOM-11-2021-0397

3.8

3.8 - First Contact Physiotherapist Update Report

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

Attachments

First Contact Physiotherapy Report.pdf

Appendix 1, 2 and 3.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:	09 April 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	First Contact Practitioner (FCP) Physiotherapist Investigation Outcome Report (HDD49221)
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Sharon Daniel, Executive Director of Nursing, Quality, Safety and Experience
SWYDDOG ADRODD: REPORTING OFFICER:	Jo Bradburn, Deputy Director of Allied Health Professions

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 details of the conclusion to the patient safety review following identification of record keeping concerns relating to a First Contact Practitioner (FCP) Physiotherapist. The report provides assurance to the Quality, Safety and Experience Committee on the process followed to investigate the incident, identify learning from this incident, the immediate actions taken and further actions required to mitigate recurrence.

Cefndir / Background

In April 2023, a patient raised a concern that a First Contact Practitioner (FCP) Physiotherapist had not acted on clinical decisions to arrange radiological investigations and onward referrals to therapy specialties. A local investigation took place to establish the nature of this concern. During the local investigation, further concerns were identified relating to the practice and record keeping of the same FCP Physiotherapist. There was evidence to suggest this practice extended beyond the original scope of the initial concern.

The Head of Physiotherapy escalated these concerns to the Clinical Director of Therapies, prompting escalation to the Executive Director of Allied Health Professions and Health Science in November 2023.

It was considered appropriate to review all patient consultations (including assessment and treatment) which had been undertaken by the FCP Physiotherapist from the date of their three-year employment as a FCP Physiotherapist from 2020 to 2023. Due to the potential number of patients impacted by this practice, an executive led investigation process was commissioned by the Executive Team to investigate the breadth and scale of these concerns.

Initial assessment indicated the number of patients potentially affected was in the region of 4000 patients aligned to 6 General Practice (GP) surgeries within Carmarthenshire and Pembrokeshire. The actual number of patient records reviewed during the process was 3965. The number of patient records reviewed by GP surgery is detailed below:

GP Surgery	Number of Patient Records Reviewed
Argyle	1115
Morfa Lane	672
Nantgaredig	122
Neyland	770
Narberth	733
Furnace House	553
Total	3965

In February 2024, the Executive Team approved the *Framework for the Review of Harm Following Identification of Record Keeping Not in Line with Professional and Organisational Standards.* This included Terms of Reference for an Incident Control Group to oversee the review.

Asesiad / Assessment

Governance and Oversight of the Investigation Process

Incident Control Group

The Executive Team established an Incident Control Group to oversee this investigation. The Control Group met monthly with weekly progress updates provided to the Executive Director of Nursing, Quality and Patient Experience and the Executive Director of Allied Health Professions and Health Science.

The Control Group initially established two reporting sub-groups: a Scrutiny Panel and a Redress Panel. The function of these two sub-groups was reviewed, and it was determined more valuable to merge the group function, forming one 'Scrutiny and Redress Panel'. A further two sub-groups were established: a Communication Task and Finish Group and a Learning from Events Group.

Scrutiny and Redress Panel

The multiprofessional panel was composed of health care professionals with relevant knowledge, skills and experience to review specific cases of potential or actual harm, thus ensuring appropriate and timely remedial action could be taken.

The panel developed an 'Assessment of HarmTool' to enable the identification of potential or actual harm for each case (Appendix 1). The tool was consistently applied to the review of each case by Patient Safety Officers within the Quality, Assurance and Safety Team.

In cases where harm was identified, a member of the Quality, Safey and Assurance Team and Scrutiny & Redress Panel contacted each individual patient to inform them of the situation. Each individual patient was invited to a meeting to discuss the situation and what this meant for their individual circumstances. Depending on the specific needs of each patient, an individualised treatment plan was developed to ensure timely remedial action, in line with Duty of Candour.

The Scrutiny and Redress Panel categorised patients into one of four categories outlined in the table below:

Category 1	Patients who have suffered pain, suffering or loss of amenity as a direct result of the breach; patients who have a requirement for additional treatment as a result of the breach or whose outcome is affected, patients who have opted for private treatment when otherwise they would have received this treatment within the NHS, and patients where treatment timeframes have now exceeded as a result.
Category 2	Patients who have been identified and placed onto waiting lists for further treatment where they would have been had the action been carried out by the FCP service in 'real time'.
Category 3	Patients who opted for private treatment sooner than the wait within the current NHS wait times.
Category 4	Patients where no harm has been identified.

Each individual patient case was presented to the Scrutiny and Redress Panel following the screening process, except for patient cases identified in category 4.

Communication Task and Finish Group

The Communication Task and Finish Group supported the Scrutiny and Redress Panel to ensure the situation was communicated in a sensitive and timely manner to patients impacted by this situation. The methodology is outlined in the table below:

Category 1	Patients will be prioritised to those requiring urgent care and remedial treatment and receive meeting with Assistant Director of Legal Services and Patient Experience and Consultant Clinical Lead for Trauma and Orthopaedics.
Category 2	Patients will be contacted by the Waiting List Support Service and reassured that they are on the waiting list, where they should be with usual support via the Waiting List Support Service.
Category 3	No further action for these patients as patients chose to opt for treatment sooner than the NHS would provide.
Category 4	No direct communication planned.

The Communication Task and Finish Group provided guidance to staff working within primary care and the FCP physiotherapy service to ensure consistent communication with affected patients who continued to receive care and treatment by the FCP physiotherapy service. Similarly, guidance was provided to the Waiting List Support Service to ensure consistent and clear communication with all affected patients.

In January 2025, the Task and Finish Group engaged with senior leaders from the 6 GP surgeries to seek their feedback from the process, and to understand the impact of this incident on their patients and staff. It was considered important to ensure the learning and experience identified within the GP surgeries was included for wider system learning in the short and longer term.

Learning from Events Group

In December 2024, a Learning from Events Group was established to identify opportunities for learning and mitigate the risk of recurrence which is covered within the main body of this report.

Patient Impact

The total number of patient records reviewed was 3965. From these reviews a small number of patients were identified as requiring escalation of clinical treatment plans and <5 of these remain within the NHS redress scheme.

The number of patients that fall into each category is detailed below:

Patient group	Number of affected patients
Category 1	20
Category 2	31
Category 3	5
Category 4	3899

For those patients in Category 1, an individual incident record has been created on Datix Cymru and Duty of Candour instigated. This ensures that due process has been followed and any outcomes have been formally recorded.

The Assistant Director of Legal Services and Patient Experience and Consultant Clinical Lead for Trauma and Orthopaedics continue to meet with the category 1 patients and will be contacting the remaining patients more recently identified following scrutiny review during April/early May (<10). For patients where urgent treatment is required, these cases are prioritised and arranged via a mix of outsourcing to a private provider or internal provision, depending on the needs and wishes of the patients. All ongoing communication is being managed appropriately via duty of candour and the NHS redress scheme.

Learning From the Events

In December 2024, a Learning from Events Group was established to identify opportunities for learning and mitigate the risk of recurrence. On reflection, the membership of the group did not reflect the experience and learning from staff impacted through this incident and process. To capture the richness and value of their contribution, specific one to one meetings and focus groups were led by the Deputy Director of Allied Health Professions.
Using the information obtained through the investigation and the stakeholder engagement outlined above, key themes were identified to inform opportunity for future learning from this incident. There were 7 key themes identified including clinical, operational, governance, professional, digital, investigation and leadership across the Health Board. These 7 key themes have been outlined within this paper as recommendations 1 to 7 outlined below:

Recommendation 1: Embed clinical governance and assurance

Rationale:

- There was no service level or directorate level governance structure in place to monitor compliance with policy and audit.
- There was no service level or directorate level governance process in place to scrutinise patient safety incidents and the learning from these incidents.
- There was no process or precedent for how to upscale an investigation involving such a significant number patients, at pace.

Recommendation 2: Strengthen supervision and accountability

Rationale:

- There was no supervision policy or procedure in place which determined the standards of supervision for Allied Health Professionals.
- The GP surgeries with the strongest models of clinical supervision in place reported less patient harm.
- There was no national framework for enhanced, advanced and consultant level practice at the time of the incident. There was a Health Board developed EAGLE framework to support advanced practice roles but this was not consistently applied across all professional groups.
- There was variable knowledge and understanding of professional accountability which restricted physiotherapy professional lead access to primary care digital record keeping system and delayed the investigation process.
- There was no formal tool to ensure robust caseload management within the service.
- There were variable induction processes for FCP physiotherapists working in primary care which impacted on knowledge and understanding of the local operating model.

Recommendation 3: Optimise clinical pathways and service design

Rationale:

- There was a variation in the service delivery model of FCP physiotherapy in primary care, for example, the triage process was not consistent across all GP surgeries, leading to duplication of work by General Practitioners and FCP Physiotherapists.

Recommendation 4: Strengthen record keeping policies and processes

Rationale:

- Clinical record keeping audits not routinely undertaken within all the Allied Health Professions.

- Clinical audits that were undertaken did not consider the quality or content of the record and whether actions had been completed.
- Routine clinical audits would have identified this incident earlier.
- The availability and use of an electronic patient record keeping system in primary care was identified as being instrumental to patient safety and aided the efficacy of the investigation. However, the availability of an electronic patient record keeping system is not consistently available across a number of Allied Health Professions which needs to be risk assessed across the Health Board.
- There were examples of excellent record keeping with clear decision making that could be used as exemplars across the Health Board.

Recommendation 5: Establish professional governance and promote professionalism

Rationale:

- There was a need to ensure a standard approach to incident management which relates to the clinical workforce (registered and non-registered), particularly when concerning patient safety incidents across the directorate, that aligned to Health Board process.
- There was a need to improve the process of review of job planning across the service.

Recommendation 6: Strengthen leadership culture

Rationale:

- There was variable understanding and application of incident reporting and management processes, including application of the duty of candour within the directorate.
- There were missed opportunities to address workforce concerns at the time.
- There is a need to promote and embed mechanisms for staff to raise concerns such as the 'Speak Up' framework across the directorate.
- There is a need to ensure appropriate support is available for staff when dealing with an incident of this scale and complexity, in addition to their day-to-day role.

Recommendation 7: Improve communication both internally and externally

Rationale:

- There is a need to ensure timely sharing of patient information as routine practice between primary care, community services and secondary care to uphold continuity of patient care and safety.

It is imperative that action is taken to reduce the risk of incidents of a similar nature occurring within the Health Board. There are examples of learning which must be undertaken to mitigate this risk which range from individuals to wider system learning.

Actions to Mitigate Recurrence

Following the identification of this incident some immediate actions were taken by the physiotherapy service to prevent recurrence. These are outlined below and highlight the immediate impacts of these actions.

Immediate Actions Undertaken	Impact of Action
Refresh of physiotherapy record	Audit tool amended to reflect need to identify missing clinical records and timeliness of actions

keeping audit tool and process	Compliance percentage increased (>90% no areas of concern, 75-90% compliance showed moderate concern, <75% compliance significant concerns)
Review of record keeping audits on annual cycle and in line with record keeping policy	Service wide audits undertaken on an annual basis since 2024 Findings reported to Physiotherapy Quality, Safety and Risk Group Further actions identified as a result of learning from audits e.g. The need to refine guidance re: us of abbreviations Individual action plans developed where concerns raised about individual registrants Early identification of concerns about record keeping with immediate and timely support provided
Monthly physiotherapy governance meeting established which review incidents and identify learning.	Established governance meetings within Physiotherapy service held monthly Physiotherapy governance meeting reports into Clinical Care Group Integrated Governance Meeting Evidence of improved incident management with no open incidents in service over 60 days and an improving trend of incident management between 2023 and 2026 Increased reporting of incidents across physiotherapy service reflecting increased awareness of incident management process Physiotherapy service in Level 1 escalation for management of incidents
Reinforce the importance of incident reporting to include suspected missing records across physiotherapy service	Physiotherapy staff report increased confidence in understanding importance of reporting record keeping incidents >85% of physiotherapists have confirmed they understand the importance of this when surveyed Physiotherapy service has seen further incidents related to record keeping reported as a result of improved governance and awareness raising across the department
Learning shared with Therapies Directorate (prior to introduction of Clinical Care Groups structures).	Services within the Therapies Directorate have all reviewed clinical record keeping audit processes because of this incident. This has resulted in identification of other record keeping incidents and allowed for themes to be identified which have further supported identification of learning/actions related to this incident and reinforced the need for system wide approach to the sharing of learning
Individualised support to directly impacted staff.	Support tailored to individual needs has been provided by Senior Leadership in Physiotherapy, Workforce Teams and Wellbeing Services available across the Health Board.
Culture review undertaken within Physiotherapy Service with accompanying action plan.	Workforce and Organisation Development Team have supported Senior Leadership in Physiotherapy to develop an action plan Impact to be evaluated alongside analysis of staff survey results for 2025
Development of 'Accountability Arrangements for Registered Allied Health Professions' Policy	Accountability Arrangements for Allied Health Professions Policy has been published following wide engagement with professional and operational stakeholders. This clarifies the minimum standards required to provide assurance to the organisation that accountability arrangements are clear. This policy underpins the development of other procedures and processes for the Allied Health Professions including supervision, management of professional concerns and job planning.

Implementation of 'Accountability Arrangements for Registered Allied Health Professions' Policy.	The implementation of the Accountability Arrangements for Allied Health Professions Policy is underway with additional procedures to be established to ensure the full impact of the policy can be evaluated and monitored

A 'Management of Professional Concerns Process for Allied Health Professions' has been drafted and is currently with workforce and trade unions for consideration before going out for wider consultation. This will ensure equity when managing professional concerns and ensure that patient safety is considered as part of this process.

A 'Supervision Framework for Allied Health Professions' has been developed which will outline minimum standards of professional, clinical and line management supervision for the Allied Health Professions (registrant and non-registrant) workforce.

The Incident Learning Action Plan (Appendix 2) has been developed which outlines the actions necessary to mitigate the risk of similar incidents.

A 'Learning from Experience – Good Practice/ Self-Assessment' (Appendix 3) has been developed to further mitigate the risk of similar incidents across the wider Health Board.
The Incident Control Group was stood down on 13th November 2025.

On 19th November 2025 the Executive Team received and endorsed the incident closure report which includes the learning from this incident and the associated action plan to mitigate the risk of recurrence across the Health Board.

Following a further detailed review, the original action plan has been refined to strengthen clarity, proportionality and assurance, resulting in the removal or consolidation of 22 proposed actions. This refinement does not reduce accountability or learning from the incident; rather, it ensures the action set is tightly aligned to the investigation findings and addresses both immediate causes and underlying system factors through high-impact, sustainable actions.

Actions were removed only where they duplicated existing controls, were more appropriately delivered through Health Board-wide policies or governance arrangements or were not directly causally linked to the incident. All investigation findings have been explicitly mapped to retained actions or strengthened organisational processes, providing assurance that learning has been fully captured and embedded in line with Duty of Quality and Duty of Candour expectations. A fuller narrative and findings-to-actions mapping are provided in 'Incident Learning Action Plan' (Appendix 2).

Next Steps

The report and associated action plan to be considered by the Quality, Safety and Experience Committee on 09 April 2026 for assurance of the process and learning from the incident. Recommendation for Quality, Safety and Experience Committee to delegate oversight of the action plan to the relevant executive lead to ensure compliance and completion of the action plan, ensuring Health Board wide learning in line with the report recommendations.

Argymhelliad / Recommendation

The Quality, Safety and Experience Committee are requested to:

- **DISCUSS** the contents of the paper.
- Receive **ASSURANCE** about the process followed to investigate this incident.
- Receive **ASSURANCE** that the action plan responds to the learning identified in the report.
- **ENDORSE** the recommendation that the oversight of the action plan is delegated to the relevant Executive lead
- **DELEGATE** oversight of the completion of the action plan to Listening and Learning Sub-Committee for formal reporting to the Sub-Committee in six months time

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.18 Provide assurance that a review process to receive and act upon clinical outcome indicators suggesting harm or unwarranted variation is in place and operating effectively at operational level, with concerns escalated to the Board.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	1. Safe 6. Person-Centred
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	5. Whole systems persepctive
Amcanion Strategol y BIP: UHB Strategic Objectives:	
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:	AHP – Allied Health Professions FCP – First Contact Practitioner GP – General Practitioner
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	Formal Executive Team – 13/11/25 Executive Director of Nursing, Quality and Patient Experience Executive Director of Allied Health Professions and Health Science Interim Assistant Director of Nursing, Assurance and Safeguarding Service Director for Allied Health Professions and Health Science First Contact Practitioner Incident Control Group

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:**	Contained within the report
Enw Da: **Reputational:**	Contained within the report

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

Appendix 1: Assessment of Harm Tool

First Contact Practitioner (FCP) Physiotherapy Incident Investigation Form			
Patient name:		Date of Birth:	
EMIS Number:		NHS number:	
Date of initial MSK FCP Consultation:		GP Practice	
Where there further MSK FCP consultations?		If yes, what dates	
Reason for referral to MSK FCP			
Timeline of FCP and Other Consultations			
Other relevant medical history			
Details of MSK FCP Consultation			
Were notes completed in a timely manner and on the GP record for the FCP consultation?		If yes, what date were the notes made?	
In the electronic record, were notes made retrospectively?		If yes, what date were the notes made?	
Were the electronic notes satisfactory		If not, why were the notes deemed not satisfactory?	
Are there handwritten notes for the FCP consultation?		If yes, what date were the notes made?	
If notes of the FCP consultation are available, was there a plan for further investigation or onwards referral or FCP review?		If yes, was this completed ?	
Reviewers comments			
Further contact following MSK FCP Consultation			
Has the patient been seen by a GP for the same problem (since the MSK FCP contact)?		If yes, what was the date of the consultation?	
If yes, did the GP request further investigation or make an onward referral?			
Has the patient been seen elsewhere (not including the GP practice) since the MSK FCP consultation for the same or related issue?		If yes, please provide further detail	
Other notes			
Conclusion			
In your opinion, what is the level of harm to the patient?		Do you consider further investigation to be required?	
Administration			
Investigation undertaken by:		Date:	

Screening for Scrutiny Panel			
Does the incident meet the requirements to present to Scrutiny Panel		Additional notes	
Incident for this patient reported through Datix Cymru		If yes, what is the incident reference number	
Date screening for panel undertaken		Name and designation of person making decision	
Scrutiny Panel			
Is further investigation required?		If yes, please provide further detail	
Is involvement / advice from Legal Services required?		If yes, please provide further detail	
What was the panel's decision regarding level of harm?		Notes of discussion at Scrutiny Panel	
Outcome of panel		Date of Scrutiny Panel:	

Appendix 2: Incident Learning Action Plan

Purpose of this Action Plan

This action plan has been developed in response to the findings of a Control Group–led investigation. Its purpose is to ensure that learning from the incident is fully captured and translated into meaningful, proportionate, and sustainable improvement actions that reduce the risk of recurrence and strengthen patient safety, quality, and experience.

Approach to Action Development and Refinement

The original action plan deliberately adopted a wide and exploratory scope, identifying actions across governance, supervision, accountability, induction, record keeping, incident management, and organisational culture. This breadth was intentionally used to ensure that no potential area of learning was overlooked at the outset.

Following further review with service leads, professional leadership, and quality governance colleagues, the action plan has been refined and rationalised. This refinement has resulted in the removal or consolidation of 22 proposed actions. This decision was taken to improve clarity, deliverability, and assurance, not to reduce learning or diminish the seriousness of the incident.

Rationale for Removal or Consolidation of Actions

Actions were removed or merged only where one or more of the following criteria were met:

1. *Duplication of Assurance*

Several actions addressed the same underlying risk through different mechanisms (e.g. multiple actions focused on promotion of existing policies or reiteration of existing governance processes). In these cases, actions were consolidated into single, stronger system-level actions supported by audit, monitoring, and reporting through established governance structures.

2. *Learning Already Embedded via System-Level Actions*

Where learning from the incident is more effectively addressed through Health Board–wide policy, governance, or process improvement, service-specific actions were removed to avoid fragmentation. Examples include supervision policy development, large-scale incident management processes, and record-keeping oversight mechanisms, which are now addressed at organisational rather than service level.

3. *Actions Not Causally Linked to Investigation Findings*

Some actions were identified as general areas for service improvement but were not directly linked to the investigation’s causative or contributory factors. While acknowledged as legitimate improvement opportunities, inclusion in this action plan would risk diluting focus on the specific safety learning arising from the incident.

4. *Existing Controls Requiring Strengthening Rather Than Replication*

Actions proposing the re-creation of guidance, standards, or training already in place were removed where the issue was identified as compliance, assurance, or oversight, rather than absence or where the remaining action set focuses instead on audit, governance scrutiny, accountability, and learning loops to ensure existing controls are effective in practice.

5. *Deliverability and Proportionality*

Actions that could not be made SMART, were dependent on significant national or long-term system changes or would not deliver timely risk reduction were removed. This ensures the final plan is achievable, risk-focused, and capable of being assured within agreed timescales.

Assurance That Learning Has Not Been Lost

Importantly, the removal of actions does not equate to removal of learning. All investigation findings have been mapped explicitly to retained actions and addressed either through service-level improvement actions or organisation wide policy, process and governance changes. The retained actions address both active failures (documentation quality, missed escalation, delayed identification) and latent system issues (governance visibility, audit effectiveness, supervision standards, incident management processes). Additionally, actions strengthen multiple layers of defence, including policy, practice, oversight, and culture and align with Duty of Candour and Duty of Quality principles.

Transparency and Ongoing Oversight

To support transparency and assurance a clear mapping of investigation findings to retained actions has been maintained and is available for scrutiny. Progress against actions will be monitored through established governance routes and reported to the appropriate committees. The effectiveness of the reduced action set will be reviewed after implementation to confirm that learning has been fully embedded and risks mitigated. Further actions will be introduced if evidence suggests residual or emerging risk.

Conclusion

The refinement of this action plan represents a maturation rather than a dilution of learning. By focusing on high-impact, system-level, and auditable actions, the organisation is better positioned to demonstrate that it has learned from the incident, acted proportionately, and strengthened assurance in a way that meaningfully improves patient safety and quality.

Ref	Action	By When?	Executive Lead	Status	Recommendations Action Addresses (1=yes, 0=no)						
					1 - Embed clinical governance and assurance	2 - Strengthen supervision and accountability	3 - Optimise clinical pathways and service design	4 - Strengthen record keeping policies and processes	5 - Establish professional governance and promote professionalism	6 - Strengthen leadership culture	7 - Improve communication both internally and externally
1	Review existing SLAs to include process for the escalation of concerns inc. professional, clinical and defines responsibilities of physiotherapy service. Must also include how feedback provided to commissioner and access arrangements to digital systems	31/3/27	Executive Director of Strategy and Planning	On track	1	1	1	1	1	1	1
2	Write a supervision policy for Allied Health Professions that includes standards for frequency of supervision, defines clinical, professional, and line management supervision, sets standards for clinical and professionals supervision, determines the frequency with which caseload review needs to be undertaken for registrants working independently ensuring there is an audit process to evaluate the effectiveness of the policy	30/9/26	Executive Director of Allied Health Professions and Health Science	On track	0	1	0	0	0	0	0
3	Establish a governance structure and process for the employment of enhanced, advanced and consultant practice which must include governance arrangements, use of job descriptions, scope of practice documents and guidance, design of roles, monitoring and maintenance of skills and competencies	30/6/26	Executive Director of Allied Health Professions and Health Science/ Executive Director of Nursing, Quality, and Patient Experience	On track	0	1	0	0	0	0	0
4	Develop policy for the Accountability Arrangements for Allied Health Professions (including physiotherapy) that clearly outlines professional responsibilities, responsibilities of operational managers and demonstrate it has been approved through the appropriate governance structures.	31/3/26	Executive Director of Allied Health Professions and Health Science	Complete	0	1	0	0	0	0	0
5	Establish an Allied Health Professions (including physiotherapy), Health Sciences, Medicines, Nursing Governance process to monitor professional concerns and monitor and manage compliance with professional standards	30/6/26	Executive Director of Allied Health Professions and Health Science/ Executive Director of Nursing, Quality, and Patient Experience/ Executive Medical Director / Executive Director of Workforce and Organisation Development	On track	0	1	0	0	0	0	0
6	Promote, encourage and embed the physiotherapy staff's understanding of the HCPC code of conduct and professional standards and their roles and responsibilities in relation to this	31/3/26	Executive Director of Allied Health Professions and Health Science	Complete	0	1	0	0	0	0	0
7	Embed and communicate Accountability Arrangements Policy for AHP within physiotherapy	30/9/26	Chief Operating Officer	On track	0	1	0	0	0	0	0
8	Develop induction checklist that is local to physiotherapy services that includes specific requirements for those working in primary care, documentation standards, records of policies read and reviewed during induction, supervision arrangements, key contacts for day-to-day management, professional accountability, role specific training, timetable for induction period	30/6/26	Chief Operating Officer	On track	0	1	0	0	0	0	0
9	Embed and implement the Supervision Policy for Allied Health Professions across the Health Board	31/12/26	Chief Operating Officer	Dependent on action 2	0	1	0	0	0	0	0
10	Develop and implement procedure for supporting staff affected by large scale investigation which includes availability of general wellbeing, clinical, professional support as well as more specialised support as required	31/12/25	Executive Director of Nursing, Quality, and Patient Experience	Complete	1	0	0	0	1	1	0
11	Ensure a process is in place to respond to large scale incidents	31/12/25	Executive Director of Nursing, Quality, and Patient Experience	Complete	1	0	0	0	1	1	0

Ref	Action	By When?	Executive Lead	Status	Recommendations Action Addresses (1=yes, 0=no)						
					1 - Embed clinical governance and assurance	2 - Strengthen supervision and accountability	3 - Optimise clinical pathways and service design	4 - Strengthen record keeping policies and processes	5 - Establish professional governance and promote professionalism	6 - Strengthen leadership culture	7 - Improve communication both internally and externally
12	Primary care services to ensure that governance meetings include the monitoring of incidents and lessons learned from incidents	1/3/25	Chief Operating Officer	Complete	1	0	0	0	0	0	0
13	Contribute to the review Health Board Clinical Record Keeping Policy to ensure that it incorporates the learning from this incident, specifically there is a mechanism to ensure the quality of clinical records	20/4/26	Executive Director of Allied Health Professions and Health Science / Executive Director of Nursing, Quality, and Patient Experience / Executive Medical Director	On track	1	0	0	1	0	0	0
14	Review and develop physiotherapy governance and assurance frameworks that demonstrates how quality, safety and experience are monitored and managed, how workforce processes are monitored and managed, how learning is shared across services and clinical care groups, how actions are developed and implemented from the learning identified	1/3/25	Chief Operating Officer	Complete	1	0	0	0	0	0	0
15	Develop and embed an audit tool to audit the effectiveness of local physiotherapy induction process	31/3/27	Chief Operating Officer	Dependent on action 8	1	0	0	0	0	0	0
16	Physiotherapy staff to achieve >85% compliance with duty of candour training	30/6/26	Chief Operating Officer	On track	1	0	0	0	1	1	0
17	Undertake a cultural review of the physiotherapy service	1/3/25	Chief Operating Officer	Complete	0	0	0	0	0	1	0
18	Develop and deliver a bespoke programme of organisational and leadership development for the physiotherapy leadership team	30/6/26	Executive Director of Workforce and Organisation Development / Chief Operating Officer	On track	0	0	0	0	0	1	0
19	Develop an action plan for the physiotherapy service based on the culture review which is to be monitored through the care group governance structures	30/6/25	Executive Director of Workforce and Organisation Development / Chief Operating Officer	Complete	0	0	0	0	0	1	0
20	Primary Care Clinical Care Group to include record keeping audits and relevant findings as standard agenda items within governance meetings to ensure that services are undertaking audits of compliance with clinical record keeping, discussing the findings and identifying areas of improvement	31/12/26	Chief Operating Officer	On track	0	0	0	1	0	0	0
21	Review and amend policy and best practice guidance for the delivery of commissioned services across the HB that outlines best practice when developing service level agreements that ensures inclusion of key deliverables, monitoring arrangements and escalation of concerns and the governance arrangements required for approving the delivery of commissioned services	31/3/27	Executive Director of Strategy and Planning	Interdependency with action 1	0	0	1	0	0	0	1
22	Assess the opportunities for integrated patient records across primary care and Allied Health Professions	30/12/25	Executive Director of Allied Health Professions and Health Science / Executive Director of Finance	Complete	0	0	0	1	0	0	0
23	Develop policy for the development, implementation and monitoring of job plans for Allied Health Professions (including physiotherapy), Health Sciences, Nursing (especially advanced practice) and Pharmacy which must include how job plans are developed equitably and realistically, how job plans are reviewed for effectiveness and compliance and escalation where there is drift from a job plan	31/12/26	Executive Director of Allied Health Professions and Health Science / Executive Director of Nursing, Quality, and Patient Experience	Interdependency with actions 2,3,4	0	0	0	0	1	0	0
24	Commission the National MSK Network to undertake a review of all MSK physiotherapy services including CMATs, FCP and MSK outpatients in order to provide an independent, comprehensive peer review of the MSK Physiotherapy Services delivered by Hywel Dda University Health Board. The review must evaluate clinical effectiveness, accessibility, patient outcomes, compliance with clinical guidelines and alignment with best practice, local and national strategic objectives and inform the service development, quality improvement and strategic planning for MSK services.	31/8/25	Executive Director of Allied Health Professions and Health Science	Complete	0	0	1	0	0	0	0
		31/3/27		Dependent on action 23	0	0	0	0	1	0	0

Ref	Action	By When?	Executive Lead	Status	Recommendations Action Addresses (1=yes, 0=no)						
					1 - Embed clinical governance and assurance	2 - Strengthen supervision and accountability	3 - Optimise clinical pathways and service design	4 - Strengthen record keeping policies and processes	5 - Establish professional governance and promote professionalism	6 - Strengthen leadership culture	7 - Improve communication both internally and externally
25	Embed and communicate process for development of job plans for AHPs within physiotherapy service		Chief Operating Officer								
26	Promote, encourage and embed physiotherapy staff's understanding of the duty of candour and their roles and responsibilities in relation to this	30/9/25	Chief Operating Officer	Complete	0	0	0	0	0	1	0
27	Ensure mechanism to share speaking up safely framework are promoted across professional and operational groups at intervals appropriate to the framework.	30/9/25	Executive Director of Workforce and Organisation Development	Complete	0	0	0	0	0	1	0
28	Promote, encourage and embed the non-punitive and learning focused culture of incident reporting and management process as set out in the Incident, Near Miss and Hazard Reporting and Management Procedure across Clinical Care Groups.	30/6/25	Chief Operating Officer	Complete	0	0	0	0	1	1	0
29	Develop a physio specific audit tool of clinical records that must consider: • Time of written record (in working hours and contemporaneous) • Time of patient communication • Whether action plans have been completed • Whether action plan was completed in clinically appropriate timescale • Adherence to standards as defined by HCPC and/or relevant professional body	1/4/24	Chief Operating Officer	Complete	0	0	0	1	0	0	0
30	Develop and implement a schedule for clinical record keeping in line with best practice standards to be reported via local physiotherapy governance	1/4/24	Chief Operating Officer	Complete	0	0	0	1	0	0	0
31	Commission bespoke support for the affected FCP therapy team to facilitate professional reflection and recovery from the incident based on feedback from FCP team	31/12/25	Chief Operating Officer	Complete	0	0	0	0	0	1	1
32	Facilitate all leaders, registrants and support workers affected by this incident to reflect on this incident to inform personal development plans	30/6/26	Chief Operating Officer / Executive Director of Allied Health Professions and Health Science / Executive Director of Nursing, Quality, and Patient Experience	On track	0	0	0	0	0	1	0

Appendix 3: Learning from Experience Good Practice/ Self-Assessment

Operational – LfE Good Practice/ Self-Assessment	Yes	No	Partially	N/A	Actions Needed
Does your service have a local induction checklist that includes specific requirements for the setting, documentation standards, records of policies read and reviewed during induction, supervision arrangements, key contacts for day-to-day management, professional accountability, role specific training, timetable for induction period?					
Does you service have a tool to evaluate the effectiveness of local induction process?					
Does your service have annually reviewed organisation charts that clearly identifies operational and professional accountability?					
Do all job descriptions used within your service specify operational and professional accountability?					
Does your service have job plans in place?					
Does your service have a process to review and monitor job plans?					

Does your service have a service specification that defines the standards of care for the provision of your service and includes aims, objectives, scope of service, clinical standards, qualifications and competencies, referral criteria and pathways, service delivery (inc. location, scheduling, communication with patients), outcome measures, mechanisms for quality assurance, patient experience?					
Does your service have a schedule for clinical record keeping audits?					
Are clinical records in your service area audited?					
Do you monitor compliance with the Clinical Record Keeping audit?					
Do you have report templates for your service area to communicate to the referrer and/or GP/senior clinician of the outcome of intervention?					
Does your service include the following into service governance meetings: monitoring of incidents (including learning), demonstration of compliance with mandatory training and action plans where compliance is less than 85%?					
Do your teams know how to raise concerns via the Speaking Up Safely platform?					

Do your teams know how and when to raise incidents via Datix/Civica?					

Professional LfE Good Practice/ Self-Assessment	Yes	No	Partially	N/A	Actions Needed
Do you have a process in place to monitor and manage concerns raised about a registrant health care professional?					
Are there clearly defined and documented accountability arrangements in place for registrants within your professional group that clearly outlines professional responsibilities, responsibilities of operational managers and demonstrate it has been approved through the appropriate governance structures?					
Are the accountability arrangements understood and embedded across your professional group?					
Is there a process for the development, implementation and monitoring of job plans for your professional group which include how job plans are developed equitably and realistically, how job plans are reviewed for effectiveness and compliance and escalation where there is drift from a job plan?					
Are job plans embedded within your professional group?					

Do you have a documented process in place to monitor the compliance of your professional group in line with both the Clinical Record Keeping Policy and the Clinical Audit Policy?					
Do you have a supervision policy for your professional group that includes standards for frequency of supervision, defines clinical, professional, and line management supervision, sets standards for clinical and professionals' supervision, determines the frequency with which caseload review needs to be undertaken for registrants, particularly those working independently?					
Is there a process in place for communicating with other professionals (particularly those in primary care) following an intervention for your professional group?					
Does your professional group have a governance structure and process for the employment of enhanced, advanced and consultant practice which must include governance arrangements, use of job descriptions, scope of practice documents and guidance, design of roles, monitoring and maintenance of skills and competencies?					
Do advanced practitioners within your profession have scope of practice documents in place?					

Do you have a process in place to monitor your professions compliance against professional standards?					
Is there a culture of professional curiosity and reflective practice across your professional group as evidence through a professional forum, peer review process and clinical audit cycle?					
Do you have an audit tool for the audit of supervision across your professional group?					
Does your professional group have a documented Professional Governance process to monitor professional concerns and monitor and manage compliance with professional standards?					

3.9

3.9 - Women's Health Hub

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

Attachments

Womens Health Hub Progress.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:	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 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 Year 2 programme will strengthen hub delivery towards uniform provision and align with national standards and measures, as set out within the NHS Wales Women's Health Hub Clinical Implementation Guide and associated national performance framework

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 Chief Nursing Officer 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

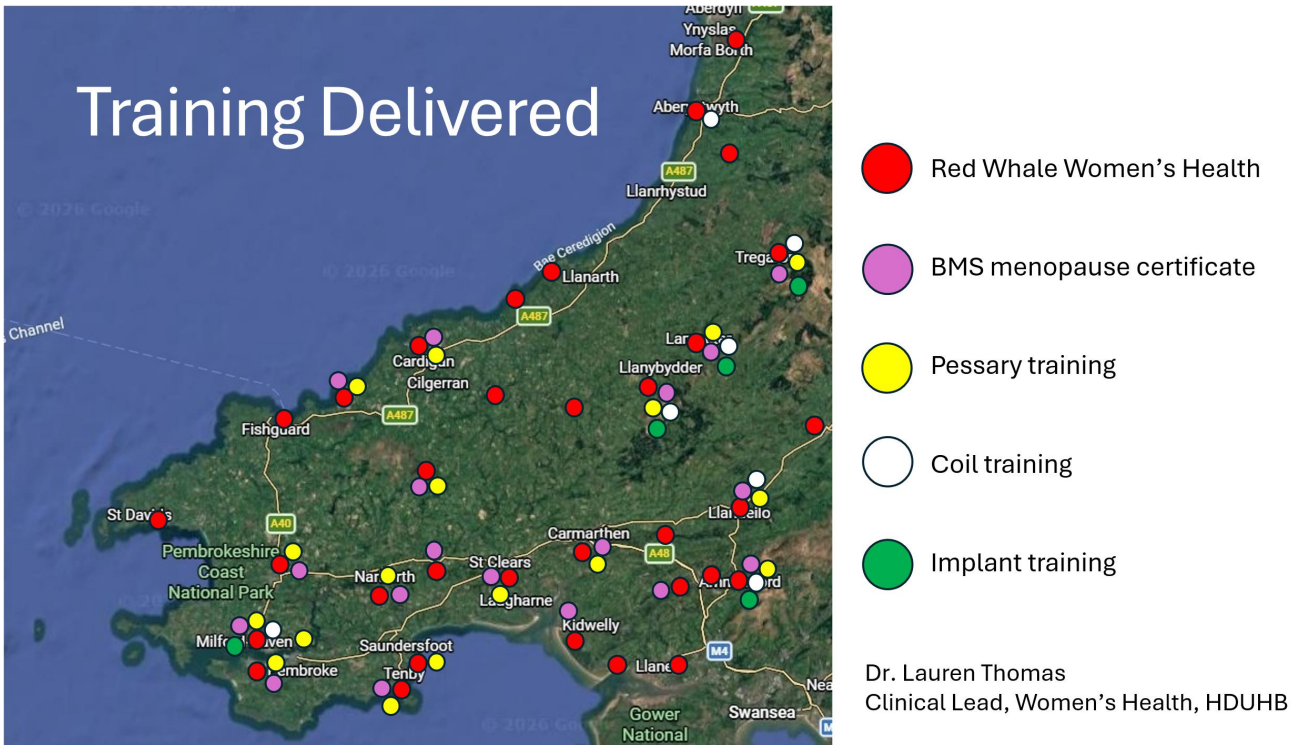
1) Delivery to date (Year 1 progress and achievements)

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 LES 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 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

Initial pump-priming funding has supported early implementation of the Women's Health Plan, Including workforce development, clinic training, and establishment of a pilot interface services. This investment has enabled rapid mobilisation of community-based delivery and early demonstration of the impact, providing a foundation for the phased locality based model now in delivery & demonstrating early impact. The priority now is to align governance, resource, and financial frameworks to enable sustainable scale and delivery across the Health Board.

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 Senior Responsible Officer (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 QSEC 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, VAWDASV, 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.
- Tier 2: 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 Termau: Glossary of Terms:	WHP: Women's Health Plan LARC: Long Acting Reversible Contraception
Partïon / 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:	**Financial / Service** 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. 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. 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

	define where targeted investment will be required, including workforce, diagnostics, and hub infrastructure. 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. 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. 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.
Ansawdd / Gofal Claf: Quality / Patient Care:	**Quality / Patient Care** 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. 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. 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. 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. 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.

Gweithlu: **Workforce:**	**Workforce** 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. This approach is intended to reduce pressure on secondary care teams while supporting a more sustainable and flexible workforce model aligned to future demand. 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. 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.
Risg: **Risk:**	**Risk** The principal risks associated with the WHP relate to system integration, workforce capacity, financial alignment, and data maturity. 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. These risks are being mitigated through: • 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 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.

Cyfreithiol: **Legal:**	**Legal** 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. 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. Failure to implement the model could increase the risk of non-compliance with national policy expectations relating to access, prevention, and service transformation.
Enw Da: **Reputational:**	**Reputational** 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. There is potential for political and media interest given the strategic importance of women's health and alignment with Welsh Government priorities. Failure to deliver the model, or inconsistency in access across localities, could result in reputational risk, including public concern and increased scrutiny. This is being mitigated through clear communication, phased implementation, and ongoing monitoring of outcomes and experience.
Gyfrinachedd: **Privacy:**	**Privacy** 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. 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.

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.

3.10

3.10 - Targeted Intervention Progress Report

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

Attachments

QSEC Escalation Update - April 2026 .pptx

Targeted intervention escalation update

April 2026

Lead executive: Mrs Sharon Daniel

Report author: Mr Shaun Ayres

Purpose and Scope

Purpose

This report provides the Quality, Safety and Experience Committee (QSEC) with a final escalation update against the original targeted intervention (TI) criteria for the quality, safety and experience domain. It draws on quantitative data from our incident, complaints and infection dashboards alongside qualitative intelligence from the Beacon national dashboard and the Audit, Management and Tracking System (AMaT) inspections dashboard.

Revised escalation framework - February 2026

Welsh Government issued a revised escalation framework on 20 February 2026. Under the revised framework, the original numbered TI criteria (10-40) no longer exist as standalone de-escalation criteria. The topics they covered - complaints, incidents, patient experience, Health Inspectorate Wales (HIW) responsiveness and patient feedback - have been absorbed into the broader domain action requirements for Unscheduled and Emergency Care (UEC) (level 4), HCAIs (level 4), planned care (level 3) and clinical services (level 4).

The only de-escalation criteria that remain under the revised framework are quantitative targets: the three Health Care Acquired Infections (HCAI) organism-specific thresholds (C. difficile, S. aureus, E. coli), UEC performance metrics (ambulance handovers, 12-hour waits, clinical decision times, delayed pathways) and planned care waiting time targets.

This is therefore the last report in this format. Future reporting to QSEC will align to the revised framework structure. The Committee can take assurance that the actions and expectations covered by the former criteria continue to be discharged through our existing governance arrangements.

Escalation Status Overview

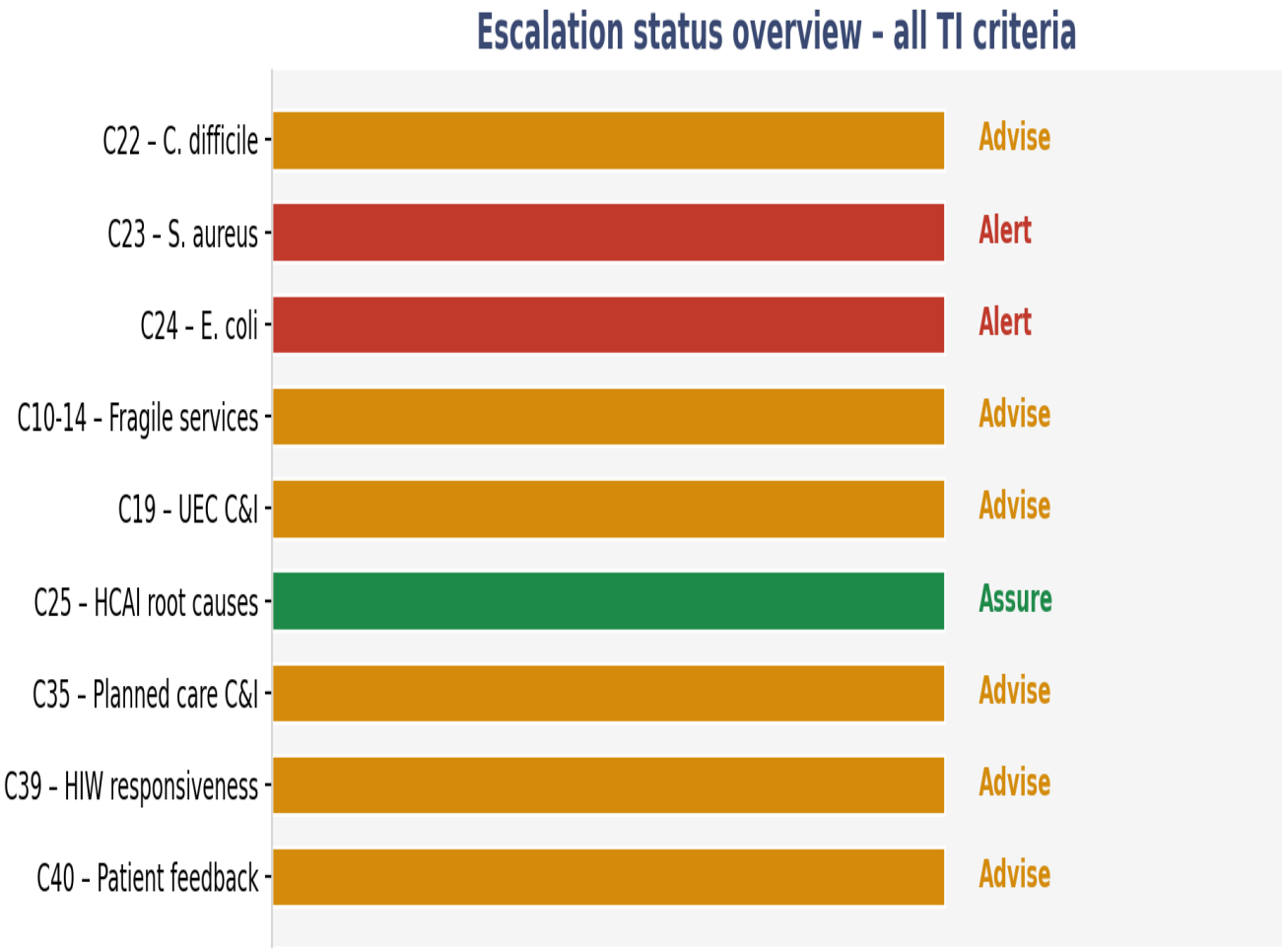
Final assessment against original TI criteria

Assure (1):
HCAI root causes (former C25)

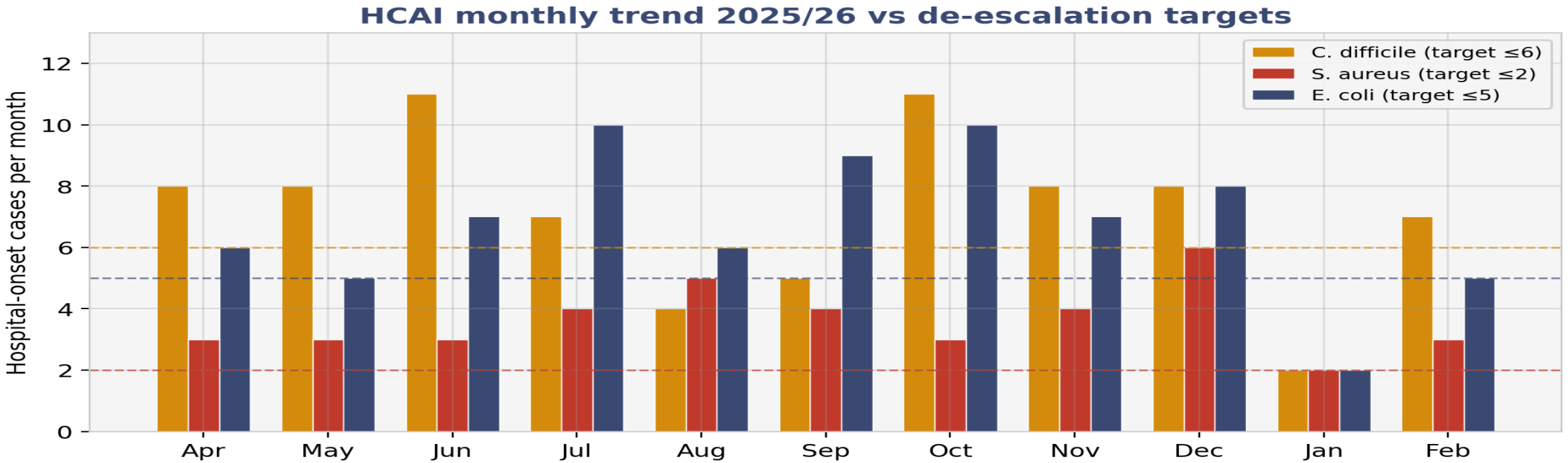
Advise (6):
C. difficile (C22), UEC C&I (C19), planned care C&I (C35), HIW (C39), patient feedback (C40), fragile services (C10-14)

Alert (2):
S. aureus (C23), E. coli (C24)

Under the revised framework, only the three HCAI targets carry forward as de-escalation criteria. The remaining topics are now embedded within domain action requirements.



HCAI: Monthly Trend Comparison 2025/26

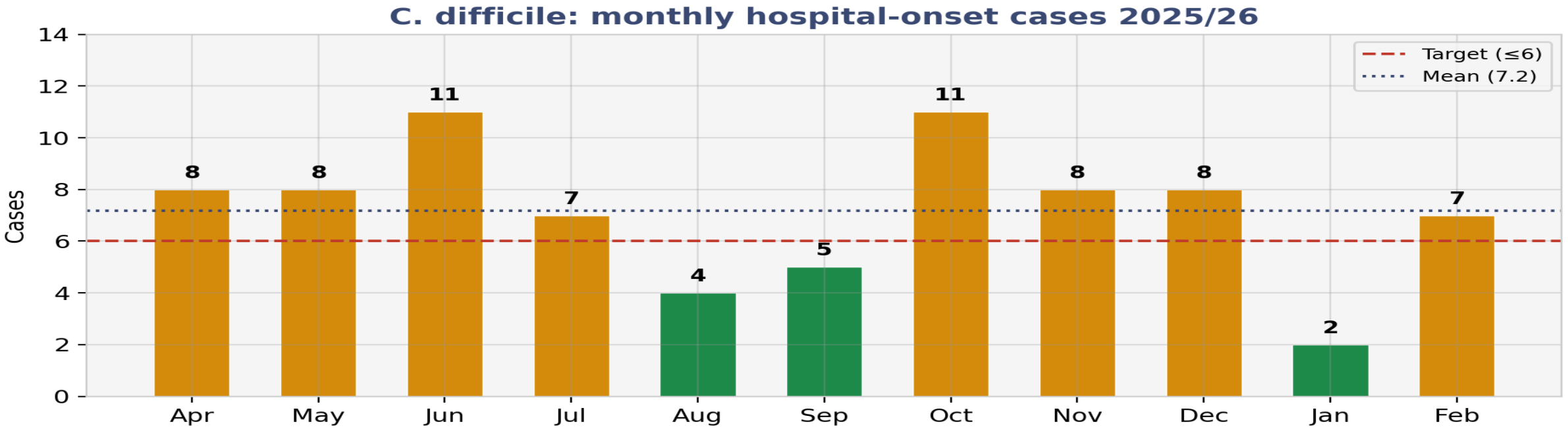


These three targets remain as de-escalation criteria under the revised framework.

No organism has achieved the sustained 3-month target. C. difficile is closest (2 consecutive months in Aug-Sep). S. aureus and E. coli remain persistently above threshold.

- C. difficile: mean 7.2/month (target ≤6). 3 months met threshold individually.
- S. aureus: mean 3.6/month (target ≤2). Only January 2026 met threshold.
- E. coli: mean 6.8/month (target ≤5). 3 months met but no consecutive run.

C. Difficile - Advise (De-Escalation Criterion)

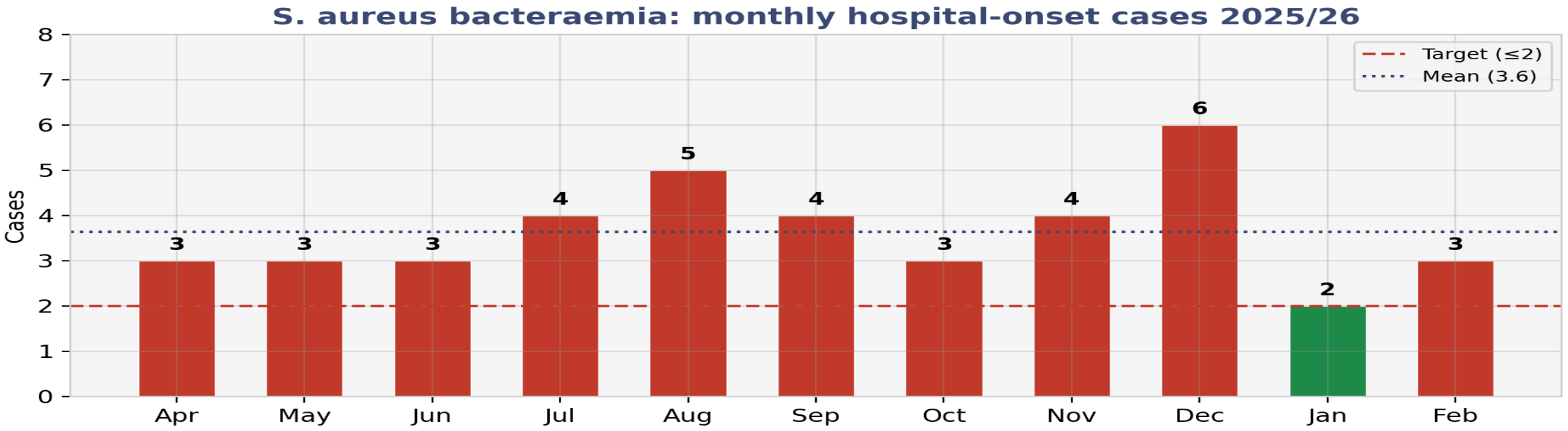


Target: reduce hospital-onset C. difficile by 25% to ≤6/month, sustained for 3 consecutive months. Mean 2025/26 = 7.2 cases/month.

- HPV enhanced cleaning operational at 3 acute sites. C. difficile Improvement Group active with national learning collaborative participation.
- IPC level 2 training at 75.56% (below standard). Carmarthenshire carries highest burden (47 cases in 2024/25).

Assessment: target achievable in individual months but not yet sustained. Continued antimicrobial stewardship essential.

S. Aureus Bacteraemia - Alert (De-Escalation Criterion)

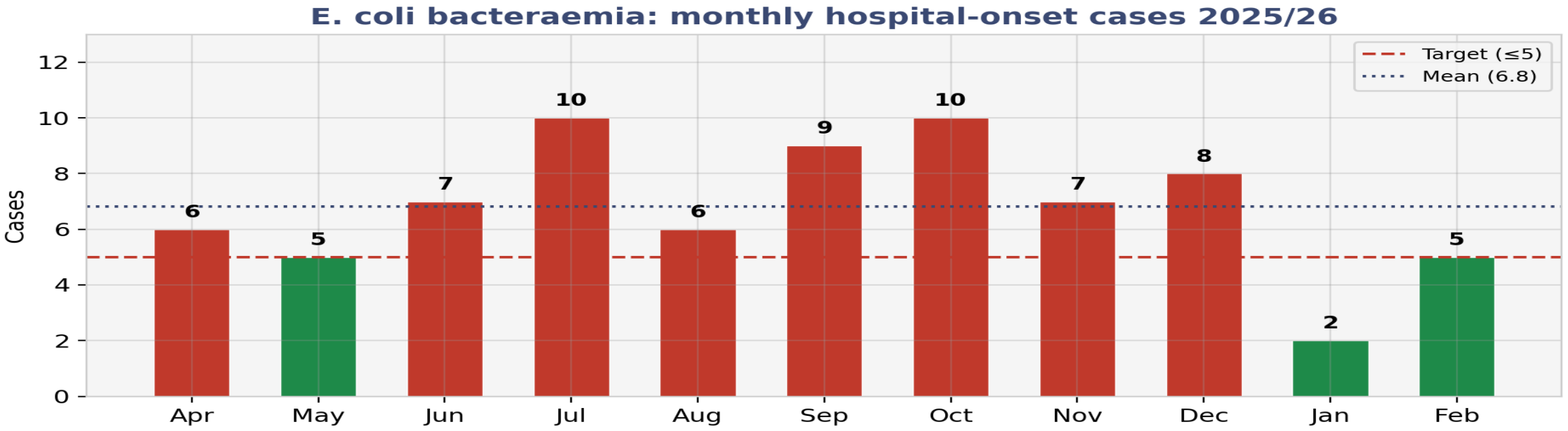


Target: reduce hospital-onset S. aureus by 33% to ≤2/month, sustained for 3 consecutive months. Mean 2025/26 = 3.6 cases/month.

- Threshold met only once (Jan 2026 = 2). December peaked at 6 cases. Device-related (10), wound (16) and MSK (23) infections are predominant sources.
- ANTT compliance at 82.58% (target 95%). ANTT being made mandatory on ESR.

Assessment: persistent upward trajectory and device-related drivers require urgent focused intervention.

E. Coli Bacteraemia - Alert (De-Escalation Criterion)



Target: reduce hospital-onset E. coli by 25% to ≤5/month, sustained for 3 consecutive months. Mean 2025/26 = 6.8 cases/month.

- High volatility: range 2-10. Urinary Tract Infection (UTIs) (186 cases) and biliary sources (72) predominate. Community-onset (321) far exceeds hospital-onset (59).
- Carmarthenshire carries highest regional burden (33 hospital-onset in 2024/25). Cross-sector prevention initiative commenced.

Assessment: sustained performance not achieved. UTI prevention and catheter management must intensify.

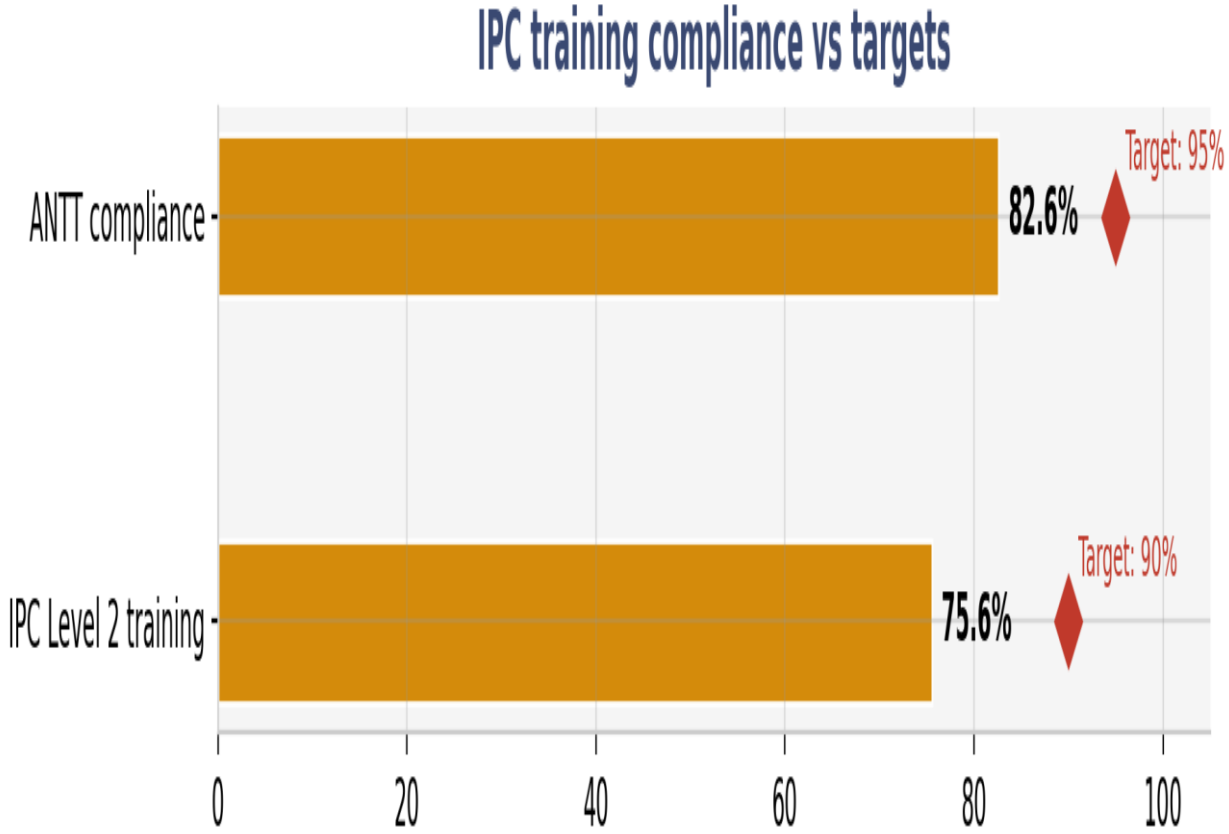
HCAI: Infection Prevention Control (IPC) Infrastructure and Compliance

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

The revised framework requires a clear improvement plan based on root cause analysis and effective response mechanisms with outbreaks reporting directly to board. Former criteria 25 (HCAI root causes) is now embedded within these domain requirements.

- HPV enhanced cleaning operational at 3 acute sites. Environmental and observational audit programmes in place.
- Hand hygiene audits monitored via AMaT; validation audits conducted as indicated.
- Beacon dashboard: HCAI rates per 100,000 population show mixed national trends.

The infrastructure is robust but training compliance gaps (ANTT 82.58%, IPC Level 2 75.56%) limit the broader programme impact and must be resolved.



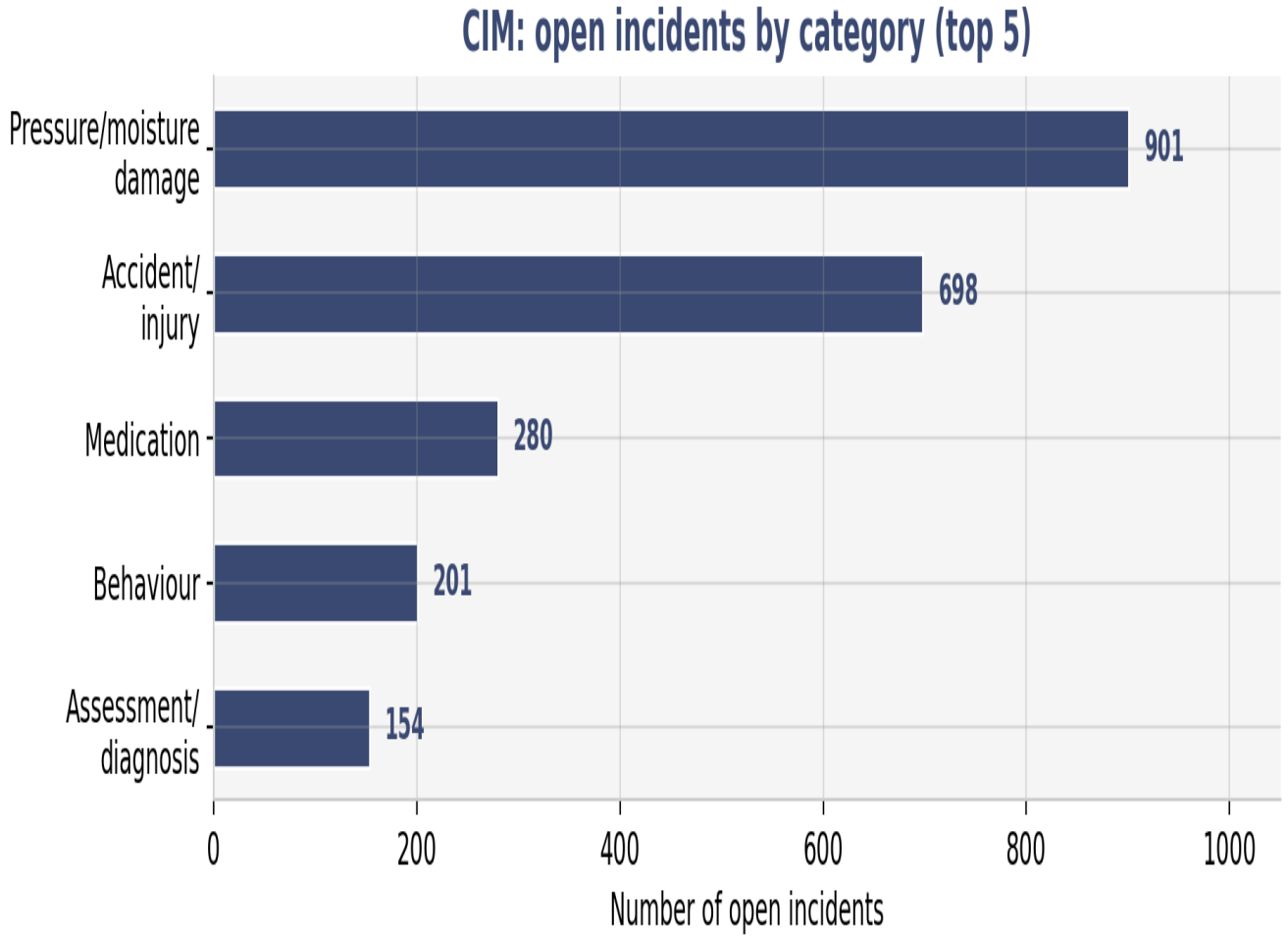
UEC Complaints and Incidents (Former Criteria 19)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

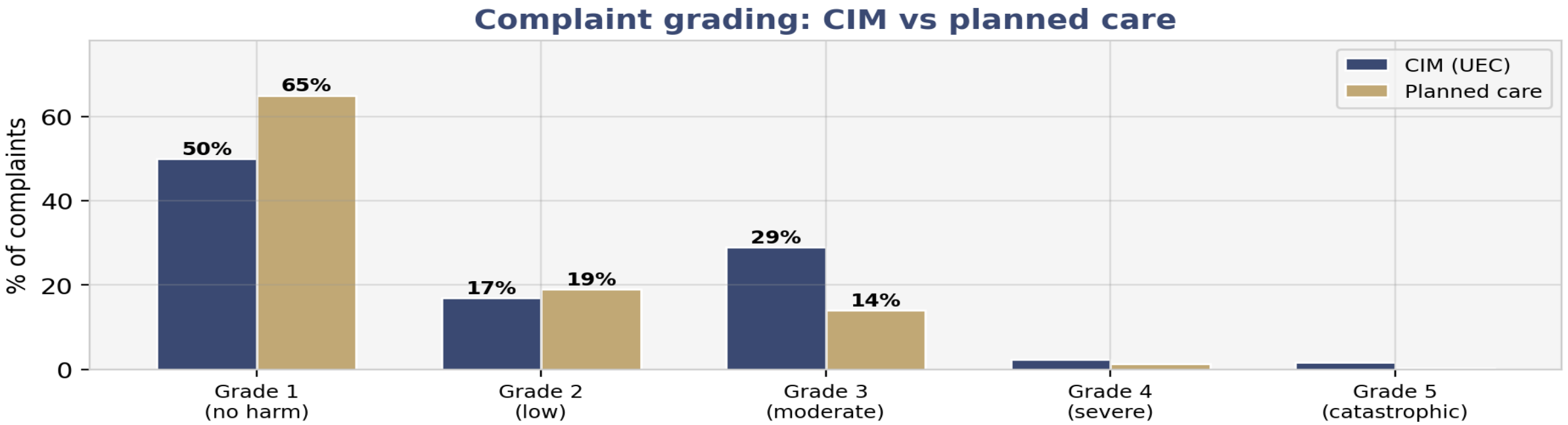
Under the revised framework, UEC complaints and patient experience are no longer a standalone de-escalation criterion. They are now embedded within the UEC domain action requirements. This is the final report against the original criteria.

- 2,997 open incidents. Oldest open 1,552 days. Monthly reporting reduced from ~1,000 (2022/23) to 556-683 (2025/26).
- 257 open complaints. 50% grade 1, 29% grade 3. Only 40.55% resolved within 30 days (target 75%).

Assurance: these actions continue to be monitored through existing governance arrangements within the Community and Integrated Medicine (CIM) Clinical Care Group.



Complaint Grading: CIM vs Planned Care



- CIM: 50% grade 1 (no harm), 17% grade 2, 29% grade 3 (moderate), 2.4% grade 4, 1.7% grade 5.
- Planned care: 65% grade 1, 19% grade 2, 14% grade 3, 1.3% grade 4, 0.3% grade 5.

CIM shows a notably higher proportion of moderate-to-catastrophic grading (33%) compared to planned care (15.6%), reflecting the acuity and complexity of UEC presentations.

CIM top subjects: clinical treatment (1,214), communication (326), discharge (305). Planned care: clinical treatment (1,549), appointments (1,382).

Planned Care Complaints and Incidents (Former Criteria 35)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Under the revised framework, planned care complaints and patient experience are no longer a standalone de-escalation criterion. They are embedded within the planned care domain action requirements, including responding to concerns at quarterly escalation meetings. This is the final report against the original criteria.

Incidents

- 690 open incidents. Top types: maternity adverse occurrence (136), treatment/procedure (85), assessment/diagnosis (82). Oldest: HDD41353 = 967 days. Monthly peak July 2025 (231), returning to 118-154 in Jan-Feb 2026.

Complaints

- 202 open complaints. Only 38.15% resolved within 30 days. Top subjects: clinical treatment (1,549), appointments (1,382), communication (403).

Assurance: operational recovery continues (zero cataract pathway breaches since Q1 2025; 18% reduction in diagnostic waits; Statistical Proces Control (SPC) P above 60%). Complaints and incidents will continue to be monitored through the Planned and Specialist Care Clinical Care Group governance structure.

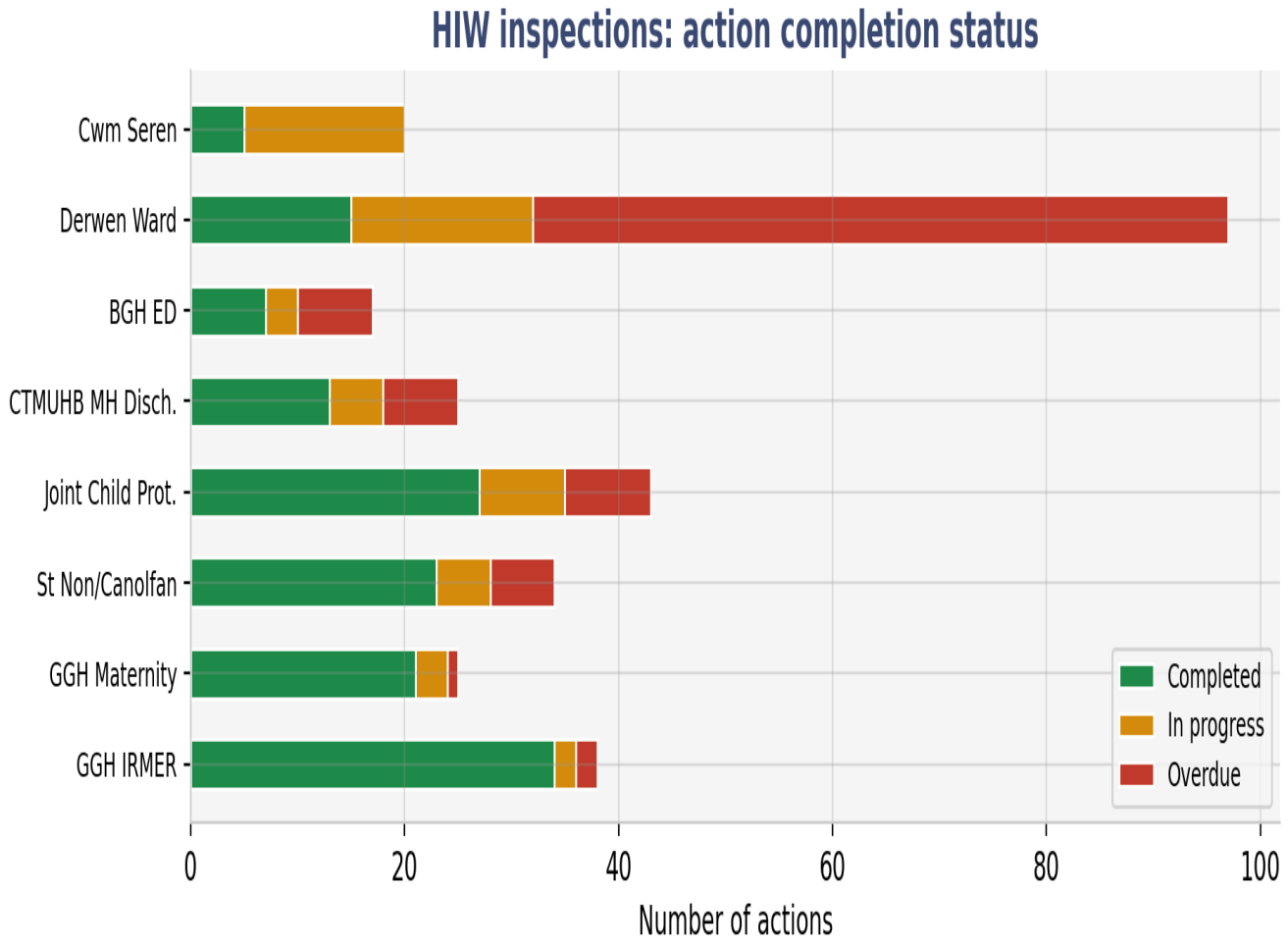
HIW Inspection Responsiveness (Former Criteria 39)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Under the revised framework, HIW responsiveness is no longer a standalone de-escalation criterion. It is embedded within UEC and planned care domain requirements to respond to external reviews. This is the final report against the original criteria.

- AMaT (20 March 2026): 13 inspections, 502 actions. 335 completed (67%), 45 in progress, 90 overdue.
- Must-do: 151/263 (57%). Concern: Derwen Ward (25% MD, 65 overdue), Cwm Seren (13% MD).

Assurance: HIW actions continue to be tracked through AMaT and monitored through the quality governance structure.



Fragile Services and Patient Feedback (Former Criteria 10-14, 40)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Under the revised framework, fragile services criteria are now listed under the clinical services domain with updated wording. Patient feedback is embedded within the planned care communications and engagement requirements. This is the final report against the original criteria.

Fragile services

- A fragile services framework with heat-map assessments is in place. Early pilots with diabetes and ultrasound services. Fragile Services Oversight Group established. External recommendations tracked through AMaT (overdue actions reduced from 51 to 22, a 57% reduction, prior to the latest inspection wave).
- Consolidated board-level view of fragile-service scores not yet routinely reported. Clinical leads not yet formally identified for all fragile services.

Patient and family feedback

- Only 38-41% of complaints resolved within 30 days (target 75%). Longest open complaints range 438-499 days. People's Experience Framework and Enabling Quality Improvement in Practice (EQIiP) projects demonstrate meaningful patient involvement.

Assurance: fragile services will continue to be reported under the clinical services domain. Patient feedback actions are monitored through the quality governance structure and the People's Experience Framework.

Transition to Revised Framework

The revised escalation framework (February 2026) restructures reporting around four domains. The de-escalation criteria that will be reported to QSEC going forward are:

Quality of care related to HCAIs (level 4)

- C. difficile: ≤6 hospital-onset cases/month, sustained for 3 months
- S. aureus: ≤2 hospital-onset cases/month, sustained for 3 months
- E. coli: ≤5 hospital-onset cases/month, sustained for 3 months

Clinical services (level 4)

- Fragile services de-escalation criteria including data triangulation, clinical leadership, external recommendations, board oversight, and 65% R1 ophthalmology pathways within or no longer than 25% of target date, maintained for 3 months.

The Committee should note that the UEC and planned care domains also carry specific quantitative de-escalation criteria (ambulance handovers, 12-hour waits, waiting time targets) which will be reported through the relevant committee structures.

Key risks and next steps

Key risks

- S. aureus trajectory remains persistently above threshold. December 2025 peaked at 6 cases. Device-related infection links require urgent targeted action on insertion and maintenance protocols.
- E. coli monthly counts volatile (range 2-10). Sustained 3-month requirement unlikely without step-change in UTI prevention and catheter management.
- IPC training compliance (75.56% level 2; 82.58% Aseptic Non Touch Technique (ANTT) below required standards, limiting broader IPC programme impact.
- Complaint timeliness across CIM and planned care (38-41% within 30 days vs 75% target) remains a concern, now monitored within domain governance.

Next steps

- Intensify device-care interventions for S. aureus with targeted improvement on cannula insertion and maintenance protocols across all acute sites.
- Drive ANTT compliance to 95% and IPC level 2 training to 90% through mandatory Electronic Staffing Record (ESR) requirements and protected time.
- Strengthen catheter management and hydration protocols for E. coli, with enhanced community-onset prevention.
- Align future escalation reporting to the revised framework structure for the next committee cycle.

Recommendation

The Committee is asked to:

- Note this is the final report against the original targeted intervention criteria for this domain, following the revised escalation framework issued by Welsh Government on 20 February 2026.
- Note the alert ratings for S. aureus bacteraemia and E. coli bacteraemia and the advise rating for C. difficile, recognising that sustained 3-month performance below the respective thresholds has not yet been achieved. These three targets carry forward as de-escalation criteria under the revised framework.
- Take assurance that the actions and expectations formerly covered by standalone criteria (UEC and planned care complaints/incidents, HIW responsiveness, patient feedback and HCAI root causes) continue to be discharged through existing governance arrangements and are now embedded within the revised framework domain requirements.
- Support the proposed next steps and note that future reporting will align to the revised escalation framework structure.

4

10 Mins

4 - Clinical Care Group Update Reports

4.1

4.1 - Planned and Specialist Care

Paula Goode (Hywel Dda UHB - Service Director for Planned and Specialist Care), Olwen Morgan (Hywel Dda UHB - Assistant Director of Nursing)

Attachments

Planned Care Specialist Services CCG Report (Final) to QSEC 09.04.2026 (1).pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	09 April 2026
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Planned Care & Specialist Services Care Group Quality Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Andrew Carruthers, Chief Operating Officer
SWYDDOG ADRODD: **REPORTING OFFICER:**	Paula Goode, Director Planned Care & Specialist Services Olwen Morgan, Assistant Director of Nursing, 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

This report details the quality governance arrangements within the Planned Care and 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 Clinical Care Group (CCG) in order to promote collaboration, trust, innovation and personal growth.

Meeting the Duty of Quality is the highest priority for the CCG 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

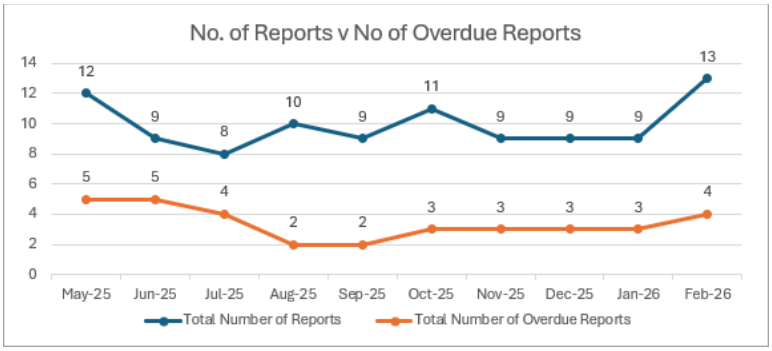
The CCG Quality Governance meetings are planned every month, and are well represented by nursing, managerial staff across all Service Groups, as well as other multi-disciplinary colleagues from across the Health Board, all of which take an active part in the meetings and shape the overall agenda. Consistent medical engagement remains a challenge. Each Service Group holds monthly Quality and Safety meetings, reporting to the CCG Quality Governance meeting.

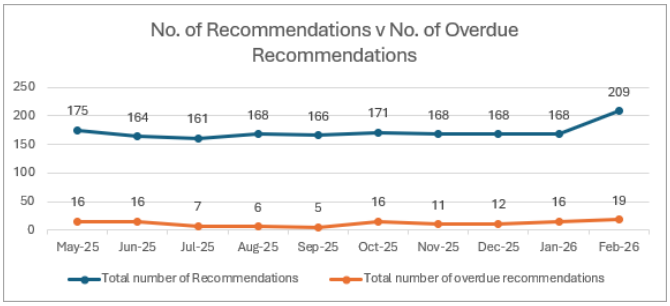
Safe Care

Current internal escalation status for Governance Level 2
Areas of Focus
Risks & Risk Actions
18% (21 out of 117) risks were overdue for review. 17% (31 out of 186) risk actions are overdue for review
Audits & Inspections Reports
9% (19 out of 209) recommendations are overdue for review
Welsh Health Circulars
9 WHCs assigned to Planned and Specialist Care 11% (1 out of 9) are overdue 33% (3 out of 9) are Pending Decision 33% (3 out of 9) are In Progress 11% (1 out of 9) is Reliant on External Factors 11% (1 out of 9) is Complete Pending Formal Approval

Overview of Audit & Inspection Recommendations

In February 2026, the CCG had a total of 13 Reports with 4 being overdue equating to 31%. Of the 209 recommendations, 19 (9%) were overdue.





Focused work progressing to address any overdue reports and actions.

<u>The CCG has a number of patient safety incidents subject to investigation through Incident Management Group (IMG):</u>

- Dermatology – Melanoma
- Breast – Bronglais Hospital (BGH)
- Ophthalmology – North Road
- Critical Care – Glangwili Hospital (GGH)

These cases are being managed and progressing through IMG

<u>Infection Prevention & Control</u>

Infection Prevention and Control (IPC) findings within the Critical Care Unit at GGH highlighted several significant concerns requiring urgent action and enhanced oversight. Poor compliance with 'standard' IP&C environmental audits noted, with all domains amber and red. With the support and guidance of the IP&C Team, immediate action was taken by the Senior Nurse Management (SNM) and Senior Sisters within the Unit. Formal action plan developed and monitored through the service group Quality, Safety & Governance Meeting. Follow up audits have demonstrated significant and sustained improvement. Additional spot check audits are being undertaken across all critical care units.

Stenotrophomonas: Stenotrophomonas has been detected in 26 critical care drains within the GGH Unit, with new associated patient cases identified.
Immediate actions:

- Ultra Violet (UV) environmental cleaning.
- Trial of probiotic drain treatments considered
- Audits of sink usage and compliance
- A risk has been added to the Risk Register.

On-going monitoring in place.

A dedicated CCG Infection Prevention & Control Meeting is being established to strengthen performance, monitoring and governance. The Terms of Reference are in development.

Theatre Services:

Theatre Estate, Safety and Operational Risks Across GGH

A significant risk has been identified across the theatre estate at GGH, culminating in the enforced suspension of all general anaesthetic activity in Theatre 6 and the Day Surgery Unit (DSU) following a Fire Risk Assessment completed on 23 February 2026. The assessment confirmed that current fire evacuation arrangements are unsafe for non-ambulant or anaesthetised patients, and that activity cannot resume until completion of Phase 2 fire safety works. The strategic resolution, installation of a fire evacuation lift is not expected until 2027, creating a prolonged period of operational constraint.

Impact

The loss of 14 elective General Anaesthesia (GA) sessions per week, significantly impacting Gynaecology, Paediatrics, Urology and Ear, Nose and Throat (ENT) pathways. Without mitigation, this equates to a loss of up to 200 paediatric cases and 840 gynaecology Unscheduled Care (USC)/ Referral to Treatment (RTT) procedures per annum.

In February 2026, the situation deteriorated further due to failure of the air-handling unit serving theatre 6, resulting in both Theatre 6 and DSU being non-operational for an estimated four-week period - timeline for completion of work 23 April 2026.

A comprehensive set of service reconfigurations across GGH and Prince Philip Hospital (PPH) has recovered 13 of the 14 lost sessions, leaving a residual gap equivalent to approximately 150 orthopaedic cases per year, which presents a continued RTT risk;particularly for arthroplasty patients.

Despite mitigations, system resilience remains extremely limited. There is no available decant theatre and estate reliability remains poor across all sites, creating sustained operational instability.

Due to planning assumptions for 2026/2027 our best assumption is as a minimum requirement, 1 additional inpatient theatre either at GGH or PPH (requires inpatient facilities).

Key Risks

- Fire safety non-compliance in Block 32 with prolonged inability to safely deliver General Anaesthesia (GA) activity. now mitigated with reconfigurations
- Ongoing estate fragility across the theatre environment, including ventilation and equipment issues.
- Material impact on elective recovery and sustained RTT and USC pressures across Urology, Colorectal and Orthopaedics.
- High risk of further disruption due to absence of decant capacity.

Recommendations

1. Explore acceleration of fire safety works, particularly the evacuation lift programme scheduled for 2027.
2. Consider procuring a mobile theatre to support elective throughput and protect urgent and cancer pathways.
3. Agreement to progress with recruitment of a locum in Trauma and Orthopaedics to operate in Neath Port Talbot (NPT) to secure theatres lists at NPT.

4. Consider the new build of sustainable new theatre at PPH versus high cost repair works for building not fit for purpose.
5. Drive forward improved productivity and efficiency through the newly appointed Service Group Leadership.
6. Consider build to connect DSU to main building increasing theatre capacity and allowing DSU to take overnight stays (major project).

Timely, Effective, Evidence based, Equitable, Person Centred

Cancer.

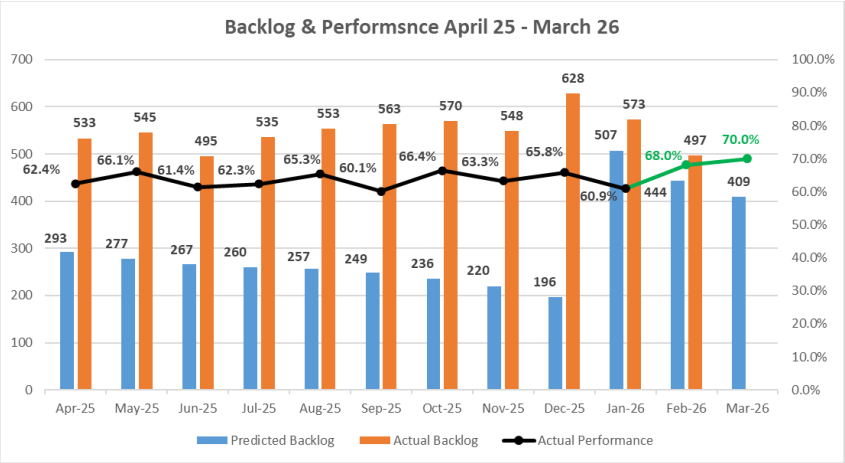
Cancer care remains underperforming against national minimum waiting time standards of 70%. The Planned and Specialist CCG have prioritised the achievement of 28-day diagnosis, which is the most complex and challenged part of the pathway as this relies on timely access to cancer diagnostics. The following table shows the 28-day diagnostic position for the Health Board in January 2026:

	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
All referrals	50%	75%	60%	47%	44%	55%	56%	59%	53%	56%	56%	58%	57%
Head and neck	70%	91%	94%	72%	72%	75%	72%	69%	71%	77%	75%	73%	72%
Upper GI	57%	83%	86%	72%	64%	65%	76%	70%	66%	78%	70%	71%	68%
Lower GI	19%	32%	79%	15%	18%	27%	35%	28%	22%	27%	28%	40%	45%
Lung	25%	50%	26%	30%	22%	35%	39%	23%	21%	35%	41%	34%	32%
Sarcoma	0%	0%	33%	0%	0%	0%	38%	43%	17%	29%	25%	25%	50%
Skin (exc BCC)	72%	85%	4%	88%	80%	87%	84%	78%	86%	85%	84%	85%	85%
Brain/CNS	78%	100%	40%	50%	67%	78%	38%	80%	60%	44%	75%	60%	33%
Breast	81%	91%	23%	71%	75%	78%	72%	79%	75%	78%	81%	82%	72%
Gynaecological	57%	81%	86%	40%	44%	51%	57%	57%	49%	53%	54%	57%	46%
Urological	35%	54%	71%	25%	26%	35%	41%	41%	36%	38%	43%	39%	31%
Haematological (exc acute leukaemia)	42%	80%	9%	26%	10%	32%	25%	31%	17%	25%	22%	17%	24%
Acute leukaemia	100%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Children's	100%	0%	0%	0%	67%	67%	100%	25%	75%	50%	60%	100%	50%
Other	58%	93%	88%	86%	70%	59%	81%	58%	60%	69%	64%	59%	45%

The Dermatology performance is maintaining the overall performance above 60%. The CCG is focused on specific improvements:

Gynaecology: GA Hysteroscopy waiting times and Pre-Operative Assessment, pathology waiting times. Pathway innovation – sedation procedures.
Urology: Optimal pathway delivery waiting times, 28-day diagnosis, access to theatre for treatment backlogs. Pathway Innovation: Galeas Bladder urine testing, outsourcing of Magnetic Resonance Imaging (MRI's), One Stop outsourcing under discussion. Pathology waiting times.
Lower Gastrointestinal (GI): Computed Tomography (CT) scan waiting times, pathology, access to theatres.

The 62-day backlog can be seen below and relates mostly to Urology backlog, by far the largest service, with high demand, high conversion rates circa 14%. Hence the focus on backlog clearance is intensely focused on supporting the Urology service. There are concerns regarding the tail of the waiting list, which is often not visible.



Tertiary delays, particularly waits of up to six months for robotic prostatectomy at Swansea Bay University Health Board (SBUHB), remain a major risk and require urgent regional escalation. In parallel, we are now exploring procurement of robotic prostatectomy capacity outside of Wales to protect patients from prolonged delays and to ensure equitable access to timely definitive treatment. This is exacerbated by longer waiting times prior to referral. A summary of urology is included for context:

MRI Outsourcing – Diagnostics Now Returning in 7-10 Days
The introduction of MRI outsourcing has delivered a major step-change in prostate cancer diagnostics:

- **MRI reports now returned within 1 week**, compared with historic waits of **5–6 weeks**.
- This improvement has been the **single largest enabler** of Faster Diagnosis Standard (28-day) recovery.
- It directly addresses the MRI bottlenecks
- Improved MRI throughput has accelerated Local Anaesthetic Transperineal (LATP) biopsy scheduling, MDT preparation, and treatment planning.

Introduction of the Galeas Bladder Urine Genomic Test (March 2026)

In March 2026, the service implemented the **Galeas Bladder** genomic urine test as part of an early-diagnosis innovation pilot.

- 60 patients referred within the first 3 weeks.
- This test enables improved stratification of haematuria/bladder cancer risk.
- Expected to reduce reliance on cystoscopy and GA diagnostic theatre time, supporting sustainability of the bladder pathway.

Hywel Dda have been the earliest adopter of this technology in Wales.

3. February–March 2026 Recovery Programme
To reduce the number of patients waiting more than 62 days for treatment, the service implemented an intensive 2-month recovery plan. This was essential given the diagnostic fragility, MRI delays, and capacity pressures

Activity Delivered

Component	Activity	Cost

Outpatient Clinics (OPA)	60 patients across 3 clinics	£5,500
LATP Biopsy Sessions	48 biopsies across 6 sessions	£48,000
Flexi Cystoscopy Sessions	43 patients	£16,000
Additional MDTs	3 full MDTs	£10,000
GA Diagnostic Theatre Lists	46 cases over 9 days	£72,000

Impact of Recovery Work on 62-Day Breaches
The recovery plan delivered a substantial improvement in treatment timeliness.

- **January 2026:** 290 patients breaching 62 days
- **End of March 2026: ~200 patients** breaching
- **Net reduction: ~90 patients**

This brings the Urology service closer to the intended recovery trajectory for 2026/27.

Proposal: Strengthening Prostate Pathway Coordination

Despite recent improvements in imaging and biopsy capacity, diagnostic gains cannot be fully converted into treatment performance without dedicated pathway coordination.

To address this gap, the service is recruiting a **Band 7 Prostate Clinical Nurse Specialist (CNS)** and a **Band 4 Prostate Pathway Coordinator**.

Local Theatre Capacity

The service continues to face **insufficient GA diagnostic theatre capacity** and a specific challenge around **nephrectomy capacity**, particularly affecting the bladder cancer pathway. However, two important mitigations will take effect from April:

a. Additional Fortnightly Nephrectomy List (From April 2026)
b. From April, 2026 Urology will have access to an additional dedicated nephrectomy list every two weeks.

This will:
- Increase surgical capacity for major cancer cases
- Improve patient flow post-diagnostics
- Reduce dependency on ad hoc scheduling
- Support recovery of the 62-day treatment standard

This represents the first meaningful uplift in nephrectomy capacity in more than 18 months.

c. Trial of Two Nephrectomy Cases per List (16 April 2026)

On **16 April 2026**, the service will trial undertaking **two nephrectomies on one list**, where clinically appropriate.
This model aims to:

- Test the feasibility of increasing list productivity

- Maximise consultant and anaesthetic efficiency
- Potentially double throughput on selected lists

If successful, this model will be considered for further adoption.

d. Remaining Risks
- Baseline nephrectomy demand still exceeds routine theatre allocation
- Case complexity may limit how often two-case lists can be delivered
- Anaesthetic cover and postoperative bed availability remain constraints

Nonetheless, these actions provide a clear pathway to reducing long waits and stabilising the bladder cancer treatment pathway.

Key Outstanding Issues – Tertiary Delays Impacting Treatment
Delays for Bone and PET Scans
- Extended tertiary imaging waits continue to delay staging and MDT decision-making.
- These delays create unavoidable breaches in the 62-day pathway despite strong local diagnostic performance.

Severe Delays for Robotic Prostatectomy – SBUHB
A critical external dependency impacting Hywel Dda patients is the prolonged wait for robotic prostatectomy at SBUHB.

Current Position
- **7 patients** currently waiting for robotic prostatectomy.
- Longest wait: **Referral on 22 December 2025 — still without a treatment date**. **Longest pathway wait is 254 days** where the patient was referred for Bone and Positron Emission Tomography (PET) scans in October 2025 and following extended waits, now awaits a date for a prostatectomy in SBUHB
- Typical referral volume: **~3 patients per month**.

Impact
- These waits result in guaranteed breaches of the 62-day standard and the maximum wait of 104 weeks for safer care.
- Patient anxiety is rising as waits approach **six months**.
- This capacity gap cannot be mitigated locally.

There are significant challenges across all parts of the Urology cancer pathway, the service is diligently working through finding solutions to all aspects, and the CCG is now exploring the option of outsourcing robotic prostatectomy as there is a national waiting time of up to 4 months after the point of referral. This is resulting in waits of well over 250 days on a 62-day maximum pathway. Internally there are concerns relating to diagnostic waiting times for cancer patients overall with waits well exceeding the optimal waiting times of 7 days. The following table relates to CT backlog clearance funded by Planned Care and Specialist, Mobile CT at Withybush Hospital:

CTs	
Month performed	Average days from performed to reported
Oct-25	6.9
Nov-25	5.9
Dec-25	7.2

Jan-26	6.3
Feb-26	3.1

	CT to be dated on PTL	CTs dated on PTL	CT to be reported on PTL
30/11/2025	79	175	38
28/02/2026	30	82	21

The current waiting time for a CT scan at Hywel Dda University Health Board (HDdUHB) from request to report is 3-4 weeks, prior to the CT initiative it was 5-6 weeks. Planned Care and Specialist CCG is working with radiology and pathology colleagues to find solutions to reducing waiting times down to the optimal wait of 7 days, pathology turnaround times for cancer patients should be 7 days in line with national standards.

Ophthalmology Services:
Significant concerns regarding the current operational pressures within the Ophthalmology service. These include:

- Increased workload and performance demands, resulting in reduced capacity to meet required activity levels.
- Rising incident numbers and challenges in maintaining timely responses and governance oversight. Publication of the Public Interest Ombudsman Report relating to patient harm will have an impact on service user confidence and potential reputational damage to the Health Board. This is also having a detrimental impact of staff within the service, increasing stress and anxiety.
- Service Delivery Manager resignation, creating a gap in operational leadership.
- Long-term sickness absence across both the service management team and the Senior Nurse, further impacting service resilience.
- Ongoing requirements related to insourcing and outsourcing arrangements, adding complexity to coordination and oversight.
- The challenge of managing day-to-day operational activity across multiple sites, placing additional strain on the remaining leadership and administrative teams.
- On-going challenges with accessing capacity in Amman Valley Hospital (AVH). Discussions on-going with Community & Integrated Medicine to resolve.

Despite the considerable challenges within the service, patient feedback from CIVICA is largely positive.

<u>Positive Patient Satisfaction</u>
Most feedback responses are rated Very Good or Good, showing high patient satisfaction levels.
Strong Patient Engagement
A total of 793 responses indicate strong patient engagement and willingness to share experiences.
Quality Care and Clinical Excellence
Positive ratings reflect clinical excellence and staff commitment to quality ophthalmology care.
Comprehensive Feedback Insights
The high response rate captures diverse patient perspectives, aiding service improvement.

<u>Summary of Experience Feedback</u>

Positive Patient Feedback

The majority of ophthalmology patients rate their care as very good or good, reflecting trust in staff professionalism and compassion.

Ophthalmology has a high response volume within the Health Board the data shows 793 ophthalmology responses, one of the largest specialties, indicating strong patient engagement

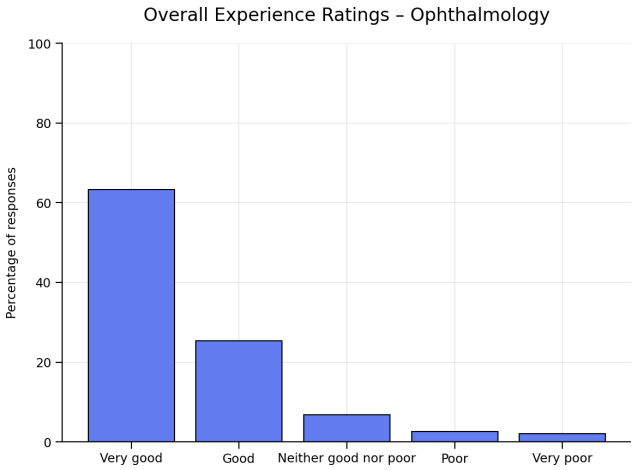
Alignment with Health Values

Patient experience strongly aligns with Health Board values of dignity, respect and kindness in care delivery.

Concerns of High Impact
Concerns, though fewer, involve delays and uncertainty in care, requiring Board's focused attention due to their high impact.

Risk Understanding

Distinction between frequency and consequence is vital for understanding risks associated with ophthalmology patient experience.



What Patients Value

Staff Attitude and Professionalism
Patients value courteous and caring staff who demonstrate professionalism throughout their care experience.

Clear Communication
Patients appreciate clear explanations of tests and results that help them understand their care pathway.

Clinic Efficiency
Efficient clinics minimize waiting times and ensure appointments run smoothly for a better patient experience.

Appointment Organisation

Good organisation and timely reminders reduce patient anxiety and prepare them for visits effectively.

Recurring Issues

Long Wait Times
Extended waiting periods for clinics, follow-ups, and surgeries cause frustration and anxiety among patients.

Communication Gaps
Insufficient communication about preparation and next steps leaves patients uncertain and unsupported.

Rushed Consultations
Limited consultation time may reduce interaction quality, affecting patient understanding and satisfaction.

Environmental and Accessibility Challenges
Parking difficulties, travel distance, and crowded waiting areas increase patient anxiety.

Impact of Delays

Patient Perception of Delays
Delays in ophthalmology are linked to worsening vision and increased anxiety for patients, creating a unique negative perception. Patients in ophthalmology express stronger emotional language and highlight links between delays and potential harm.

Consequences of Visual Deterioration
Visual decline from delayed care impacts quality of life and daily functioning significantly.

Need for Timely Access
Timely access to ophthalmology services and clear communication about waiting times are crucial to reduce patient distress.

Supportive Interventions
Prioritization and targeted interventions can help minimize delays and support patients through treatment.

Comparisons with other services.

Severity of Delays
Delays in ophthalmology can lead to irreversible vision loss, unlike some other specialties where delays are less critical.

Impact on Patient Well-being
Vision loss affects patient independence and mental health, emphasizing the high stakes in ophthalmology care.

Importance of Communication
Clear communication is essential for patients to manage their condition and make informed decisions.

Need for Specialised Strategies
Ophthalmology requires tailored approaches to ensure timely, transparent, and compassionate patient care.

Argymhelliad / Recommendation

The Quality, Safety and Experience Committee is asked to take an assurance on the quality governance arrangements in place within the Planned Services and Specialist Care 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 Provide the Board with assurance that care across the Health Board is safe, timely, efficient, effective, equitable and person-centred, aligned to the twelve Health and Care Quality Standards and the strengthened statutory Duty of Quality introduced through the Health and Social Care (Quality and Engagement) (Wales) Act 2020.
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:	2. Working together to be the best we can be 3. Striving to deliver and develop excellent services 5. Safe sustainable, accessible and kind care 6. Sustainable use of resources
Amcanion Cynllunio Planning Objectives	4 Planned care, diagnostics and cancer Recovery
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	2. Develop a skilled and flexible workforce to meet the changing needs of the modern NHS

Gwybodaeth Ychwanegol: **Further Information:**

Ar sail tystiolaeth: Evidence Base:	Contained within the report
Rhestr Termau: Glossary of Terms:	Contained 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:	Planned Services and Specialist Care Clinical Care Group meetings

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

5

5 - For Information

5.1

5.1 - QSEC Work Plan 2026/27

Attachments

Draft QSEC Work Programme 2026 27.pdf

QUALITY SAFETY & EXPERIENCE COMMITTEE WORK SCHEDULE APRIL 2026– MARCH 2027

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 2026 – March 2027.

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2026	11 June 2026	11 August 2026	9 October 2026	3 December 2026	9 February 2027
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 and Risk 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 2026	11 June 2026	11 August 2026	9 October 2026	3 December 2026	9 February 2027
Self-Assessment - Six month review of actions August 2026	**Chair**	**JW**			✓ update on actions			✓outcome report
Patient/Staff Story	**SD**	**LOC/ Service Leads**	✓	✓	✓	✓	✓	✓
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**	**LOC**		✓				
A report on the impact of revised governance arrangements	**SD/ AC/ JS/ MH**		✓					
Clinical Audit Programme for Approval	**MH**	**IB**		✓ outcome from reviews				

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2026	11 June 2026	11 August 2026	9 October 2026	3 December 2026	9 February 2027
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) • WHC's overview *(every other meeting) (TI 52)*	**SD**	**CS**	✓	✓	✓	✓	✓	✓
Safeguarding Assurance Report	**SD**	**CW**			✓			✓
Infection Prevention Control Report	**SD**	**RR**	✓			✓		
Duty of Candour Annual Report 2025/26	**SD**	**CS**		✓				

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2026	11 June 2026	11 August 2026	9 October 2026	3 December 2026	9 February 2027
Duty of Quality Annual Report 2025/26	**SD**	**CS**			✓			
Nurse Staffing Levels (Wales) Act: Assurance Reports (as required) –Annual Report and Spring Calculation Cycle	**SD**	**HH**		✓				
Cleanliness Standards Audit report and Action Plan	**JS**	**SC/ EB**			✓			
Fuller Inquiry assurance of progress of recommendations	**JS**	**CB**	✓					
First Contact Physiotherapist Report	**JS**	**JB**	✓					
Epilepsy in Learning Disabilities Update	**AC**	**DS**			✓			
Ceredigion Community Mental Health Referral Pathway	**AC**	**LC**			✓			
Quality Assurance Report for Commissioned Services	**LD**	**AS**		✓				
Clinical Care Group Updates								
Mental Health and Learning Disabilities	**AC**	**RTP**		✓		✓		✓
Community and Integrated Medicine	**AC**	**ACh**		✓	✓		✓	
Allied Health Services	**AC**	**SQ**			✓		✓	
Planned and Specialist Care	**AC**	**PG**	✓		✓		✓	

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2026	11 June 2026	11 August 2026	9 October 2026	3 December 2026	9 February 2027
Estates and Facilities	**JS**	**EB/ SC**		✓		✓		✓
Public Health	**AG**	**BL**		✓		✓		✓
Listening and Learning Sub Committee Update Report	**MH**	**LOC**	✓	✓	✓	✓	✓	✓ TOR for review
POLICIES			**EXPIRY DATE**					
1133 Service User Access Policy - Psychological Therapies	**AC**	**Andrew Homfray**	5-Mar-26 Extended whilst full review is finalised					
429 Management and Distribution of Safety Alerts and Notices Policy	**SD**	**Cathie Steele**	13-Jun-26					
004 Claims Management Policy	**SD**	**Louise O'Connor**	5-Oct-26					
894 Putting Things Right Management and Resolution of Concerns Policy (Incidents, Complaints and Claims)	**SD**	**Louise O'Connor**	5-Oct-26					
63 Use of Patient and Carers Stories Guideline	**SD**	**Louise O'Connor**	13-Feb-27					
307 Production of Patient and Carer Information Policy	**SD**	**Louise O'Connor**	21-Mar-27					
892 Incidents Near Miss and Hazard Reporting procedure	**SD**	**Cathie Steele**	31-Jul-27					
18 Inquest guidance	**SD**	**Louise O'Connor**	15-Aug-27					
309 - Continuing NHS Healthcare Operational Policy to Support Framework for Implementation	**AC**	**Tracy Devantier**	15-Aug-27					
568 Production and Use of Surveys	**SD**	**Louise O'Connor**	4-Dec-28					

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2026	11 June 2026	11 August 2026	9 October 2026	3 December 2026	9 February 2027
Guideline								
1097 Corporate Safeguarding Policy	**SD**	**Charlotte Westacott**	11-Aug-26					
Listening and Learning Sub Committee Update Report	✓	✓	✓	✓	✓	✓	✓	✓ TOR for review
For Information								
HIW Annual Report	**N/A**	**N/A**					✓	
JCC Quality Safety Outcomes Sub Committee	**N/A**	**N/A**	✓	✓	✓	✓	✓	✓
Work plan 2026/27	**N/A**	**N/A**	✓	✓	✓	✓	✓	✓
Patient Experience Report	**N/A**	**N/A**	✓	✓	✓	✓	✓	✓
Agenda setting meeting with Chair and Exec Lead to include discussion on deep dives on new risks (at least 6 weeks before the meeting)	**CSO**	**CSO**	✓	✓	✓	✓	✓	✓
Draft agenda to go to Executive Team prior to being issued.	**CSO**	**CSO**	✓	✓	✓	✓	✓	✓
Call for papers (at least 4 weeks before the meeting to receive papers at least 14 days before the meeting)	**CSO**	**CSO**	✓	✓	✓	✓	✓	✓
Disseminate agenda and papers 7 days prior to the meeting	**CSO**	**CSO**	✓	✓	✓	✓	✓	✓
Type up minutes and TOA within 7 days of the meeting	**CSO**	**CSO**	✓	✓	✓	✓	✓	✓
Circulate minutes and TOA to	**CSO**	**CSO**	✓	✓	✓	✓	✓	✓

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2026	11 June 2026	11 August 2026	9 October 2026	3 December 2026	9 February 2027
Committee for comments, points of accuracy and matters arising within 10 days of the meeting								
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 Board	**CSO**	**CSO**	✓	✓	✓	✓	✓	✓
Prepare schedule of meetings	**CSO**	**CSO**					✓	
QSEC Annual Work Programme	**CSO**	**CSO**	✓	✓	✓	✓	✓	✓

Initials

SD- Sharon Daniel	CSO-Katie Lewis	MP- Marilize Preez	LOC- Louise O'Connor	MH- Mark Henwood
AC- Andrew Carruthers	BL- Bethan Lewis	CS- Cathie Steele	AG- Ardiana Gjini	JS- James Severs
HH- Helen Humphreys	SA- Shaun Ayres	MD- Mandy Davies	RW- Rachel Williams	IB- Ian Bebb
RTP- Rebecca Temple Purcell	ACh- Anna Chiffi	SC- Simon Chiffi	AS- Ann Simpson	LD- Lee Davies
EB- Elin Brocke				

5.2

5.2 - Reminder: Clinical Audit Programme 2026/27

Attachments

2a. Exec Clinical Audit Programme Letter 2026-2027.pdf

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

MEMORANDWM / MEMORANDUM

I / To: Distribution list – see below

Oddiwrth / From: Mr Stefan Bajada
Clinical Director for Clinical Audit
Chair of the Clinical Audit Scrutiny Panel

Dyddiad / Date: 26.02.2026

Dear Colleagues,

The Clinical Audit Department will be collating a Health Board wide Clinical Audit Programme. This Programme will be a summary of planned clinical audit activity regularly updated and prioritised in accordance with Health Board strategy and policy.

We would like to invite you to consider what clinical audit projects might be beneficial to the organisation. As members of a Senior Organisational Committee, you will have a unique and overarching view of priorities and can support the alignment of clinical audits with organisational objectives.

Projects proposed for the programme are intended to be pre-defined, planned clinical audits that will be carried out within the next 6 months. As a committee, you may not be able to suggest something so specific and may wish to suggest “topics” or areas of concern instead. Discussing these projects/topics with the relevant operational team will be the most effective way of seeing these projects being implemented. The Clinical Audit Department can support this process by highlighting these projects to operational teams as a priority audit topic.

We would ask you to:

- Consider audit topics/projects for inclusion within the programme
- Notify the relevant Operational Team that you have highlighted this topic for inclusion
- Notify the Clinical Audit Department of this project/topic

Please note that all projects on the programme will still be required to go through the Health Board clinical audit proposal/approval process. When the audit is ready to be undertaken it will need to be registered on the AMAT system at that time.

To include proposed projects in the audit programme we will need to receive all responses by the 30th April 2026. Any project proposals submitted after this date will be required to go through additional processes for inclusion in the programme as existing audits will have been allocated a priority.

We look forward to hearing from you. In the meantime, if you have any questions, please contact the Clinical Audit Manager or Director for Clinical Audit. Additional information and contact details can be found below.

Yours Sincerely

S Bajada

Mr Stefan Bajada
Consultant Trauma & Orthopaedics

I J Bebb

Ian Bebb
Clinical Audit Manager

Clinical Director for Clinical Audit ian.bebb@wales.nhs.uk
Chair, Clinical Audit Scrutiny Panel
Stefan.Bajada2@wales.nhs.uk

Hywel Dda University Health Board Clinical Audit Programme 2026/27 (Apr – Sept)

Name of person completing submission: .....***E-mail:***.....
Name of committee or group this submission originates from: .....

Specialty	Audit Topic	Project Lead	Proposed Location	Reasons for Inclusion* *(please see below)*

**Reasons for inclusion - Please provide details of the following:*

- *Details of the key objective, risk register reference etc. that the project is linked to*
- *Reference to the high priority nature of this project and other relevant details including consideration of why this project should be chosen over other audits*

Projects that do not meet the criteria for inclusion cannot be added to the forward programme

Prince Philip
carol.williams10@wales.nhs.uk
☎ 01554 783699

Glangwilli
Liz.evans2@wales.nhs.uk
☎ 01267 229635

Bronglais
chloe.robertson-brock@wales.nhs.uk
☎ 01970 635617

Withybush
George.Ruloff@wales.nhs.uk
☎ 01437 773717

Additional Information

How we can support you
All clinical audit projects will be assigned a priority level based on the clinical audit proposal and supplementary information that we receive regarding the audit. The Clinical Audit Department aims to support clinical audit projects on the Health Board Wide programme. Support will be allocated based on priority and availability of Department resources.

The finalised programme will be available to view on the intranet, allowing all staff to view current/planned audit activity within the Health Board. All clinical audit activity is also viewable using the AMAT system and can be accessed by any AMAT user.

Why we are doing this
The Health Board needs to support effective clinical audit that leads to improvements in the quality of care that we provide. Audit projects should contribute to the achievement of Health Board priorities and be clear about how patient care will be improved. There is a need to adhere to all external mandatory priorities whilst continuing to support quality local audit activity related to Health Board priorities. With finite resources for audit activity there is a limited number of projects which can be supported by the Clinical Audit Department and the wider Health Board, therefore, it is vital that we have a robust system to prioritise, approve, and monitor audits.

It will be an annual programme broken down into two 6 monthly periods with reports produced each financial year.

Functions of the programme
The programme will fulfil several functions and allows us to:

- Meet the requirements for external priorities
- Monitor progress made in completing the programme
- Monitor the quality of clinical audit activity
- Monitor the impact of the programme
- Focus audit activity on quality improvement
- Identify specialties/departments with low levels of clinical audit activity

Priorities for inclusion in the programme

- National Clinical Audit and Outcome Review Plan - automatically included on the programme (***see below***)
- Patient Safety Issues
- NICE guidance
- Welsh Risk Pool required audits
- Audits associated with the risk register
- Complaints/Incidents/Litigation that require clinical audit
- Important local audit priorities

Re-audit, in order to identify the impact of change, will be a core part of the programme.

Mandatory National Clinical Audits
Update for 2026

- **Acute**
  - National Joint Registry

- National Laparotomy Audit (NELA)
- Case Mix Programme (ICNARC)
- National Major Trauma Registry

- **Long Term Conditions**
  - National Core Diabetes Audit (Primary Care)
  - National Diabetes Footcare
  - National Diabetes Inpatient Safety Audit
  - National Gestational Diabetes Audit
  - National Pregnancy in Diabetes
  - National Paediatric Diabetes Audit
  - National Diabetes Prevention Programme Audit
  - National Diabetes Integrated Specialist Survey Audit
  - Transition (Adolescents and Young Adults) and Young Type 2 Audit
  - National Chronic Obstructive Pulmonary Disease (COPD)
  - National Pulmonary Rehabilitation
  - National Adult Asthma Audit
  - Wales Primary Care Audit (Asthma & COPD)
  - National Early Inflammatory Arthritis
  - All Wales Audiology Audit

- **Older People**
  - SSNAP (Stroke)
  - National Audit of Inpatient Falls
  - National Hip Fracture Database
  - Fracture Liaison Service Database
  - National Audit of Dementia

- **End of Life**
  - National Audit of Care at the End of Life (NACEL)

- **Heart**
  - National Heart Failure
  - Cardiac Rhythm Management
  - Myocardial Ischaemia National Audit Project (MINAP)
  - Cardiac Rehabilitation

- **Cancer**
  - National Lung Cancer
  - National Prostate Cancer
  - National Oesophago-Gastric Cancer Audit
  - National Audit of Metastatic Breast Cancer
  - National Audit of Primary Breast Cancer
  - National Bowel Cancer Audit
  - National Ovarian Cancer Audit
  - National Pancreatic Cancer Audit
  - National Non-Hodgkin Lymphoma Audit
  - National Kidney Cancer Audit

- **Women's and Children's Health**
  - National Neonatal Audit Programme
  - National Maternity and Perinatal
  - National Children and young people's asthma

- National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)

- **Mental Health**
  - National Clinical Audit of Psychosis

N.B. All projects listed above have the potential to run in the 2026/27 year, however most, but not all of them will do so.

6

6 - Date of Next Meeting : 11 June 2026