Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	09 October 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Unscheduled Care Programme Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Andrew Carruthers, Chief Operating Officer
SWYDDOG ADRODD: REPORTING OFFICER:	Peter Skitt, Clinical Care Group Service Director - Community and Integrated Medicine

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 for the Six Goals Urgent and Emergency Care (UEC) and Accelerated Transformation Programme in relation to quality, safety and patient experience. It sets out achievements, progress and planned actions to meet the Duty of Quality, and is presented to the Quality, Safety and Experience Sub Committee to provide assurance on the arrangements in place.

Cefndir / Background

The aim of the Six Goals Urgent and Emergency Care (UEC) and Accelerated Transformation Programmes are in summary to:

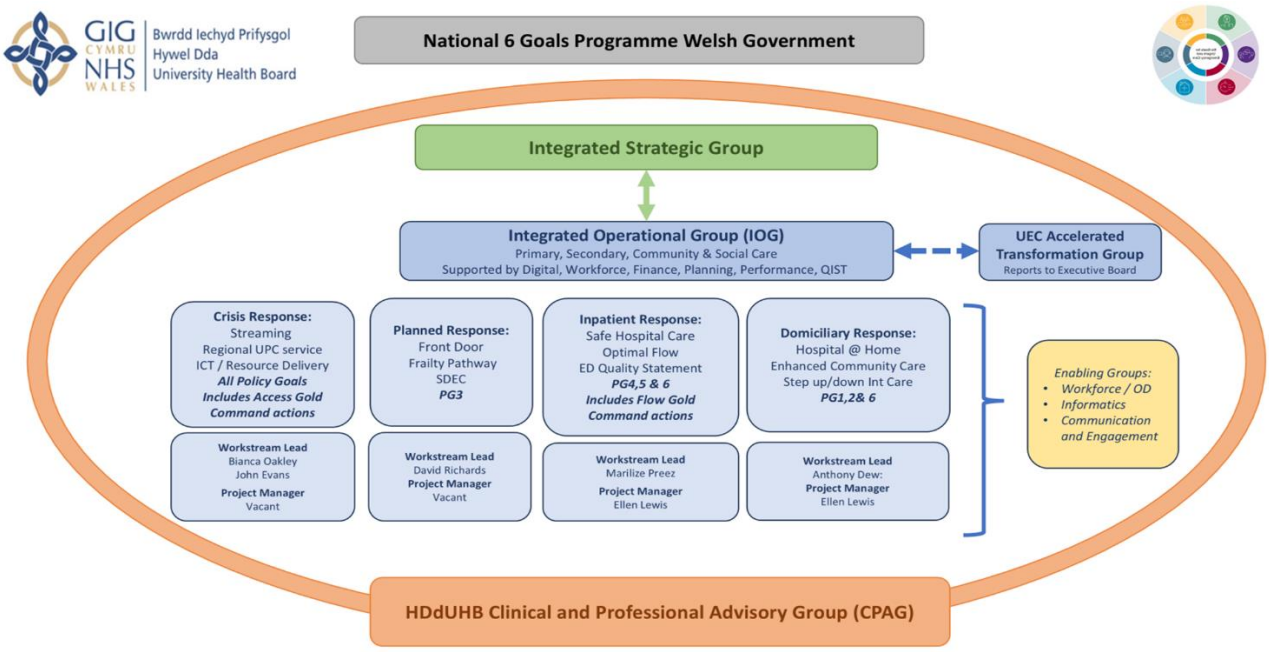
- Ensure there is a process in place to continually monitor and review its risk register, acting to mitigate quality and safety risks on an ongoing basis;
- Maintain an open culture of improving quality, safety and patient experience across all teams and all staff;
- Promote a positive culture of staff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

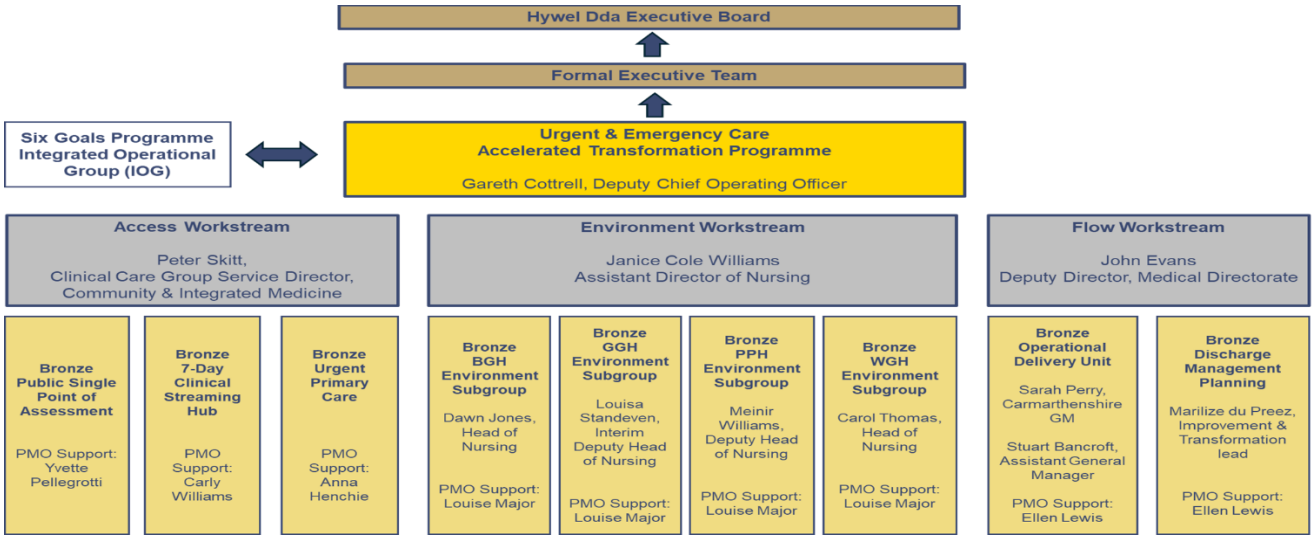
Meeting the Duty of Quality is the highest priority for the Programmes and its governance structures and oversight has developed significantly. The Senior Responsible Officers, Workstream Leads and Clinical lead head the agenda which is aligned to the six domains of quality as defined by the Duty of Quality Statutory Guidance 2023. This report is set out under each of these domains.

Asesiad / Assessment

Quality Assurance

There are established monthly and weekly Programme meetings, with approved Terms of Reference, Risk Registers, Programme/Project Plans and governance frameworks. The meetings are are well represented by medical, nursing and managerial staff across all Service Groups, as well as other multi-disciplinary colleagues from across the Health Board, all of which take an active part in the meetings and shape the overall agenda. Terms of reference are reviewed annually and governance structures, which outline supporting groups, can be seen below:



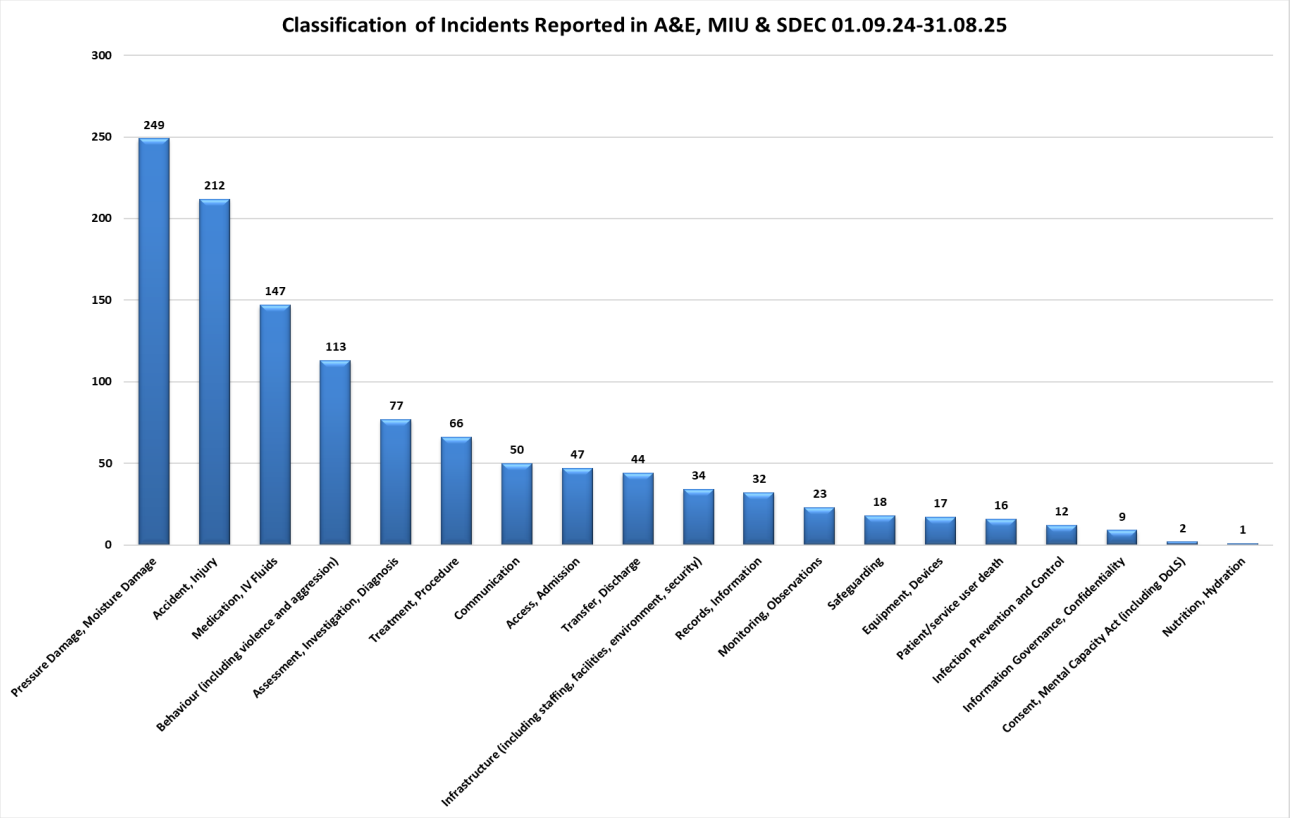


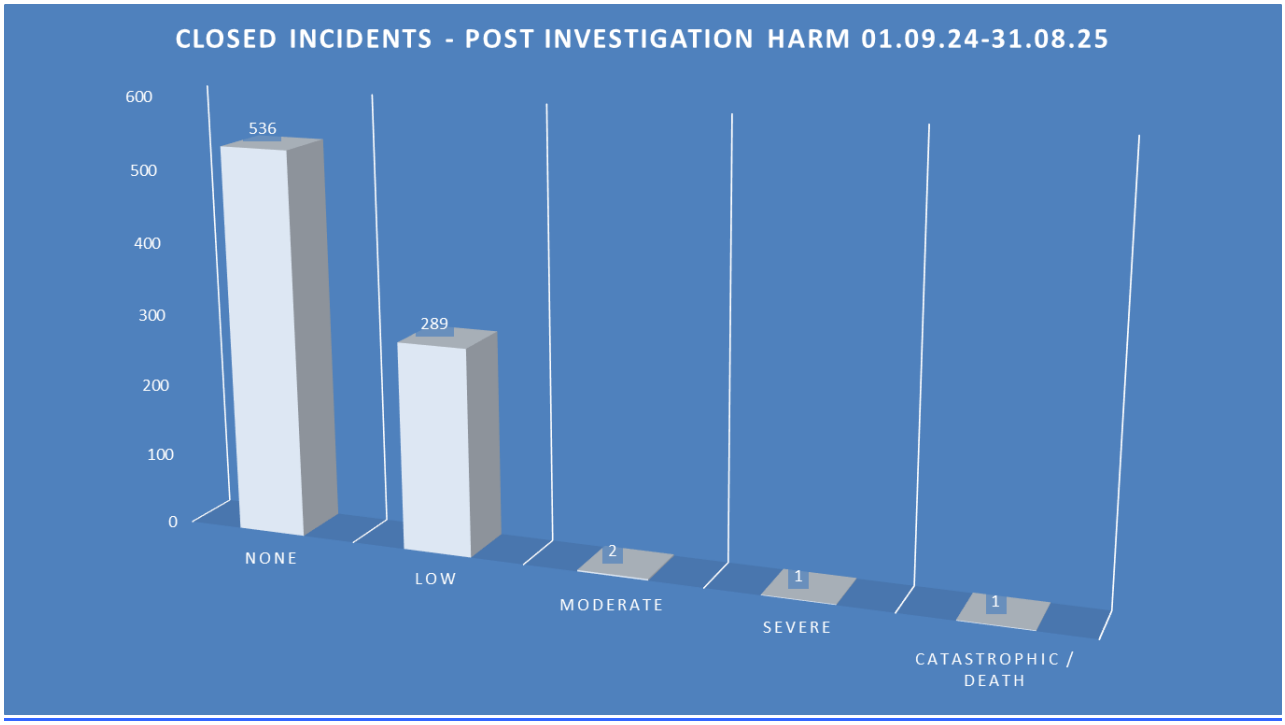
Both Programmes report to the Improving Quality and Performance and Delivery Group (Welsh Government) and the Improving Quality, Finance, Performance Delivery Group on a monthly basis. Furthermore, the Accelerating Transformation Programme reports to Formal Executive Team meetings on a fortnightly basis (please refer to attached Terms of Reference).

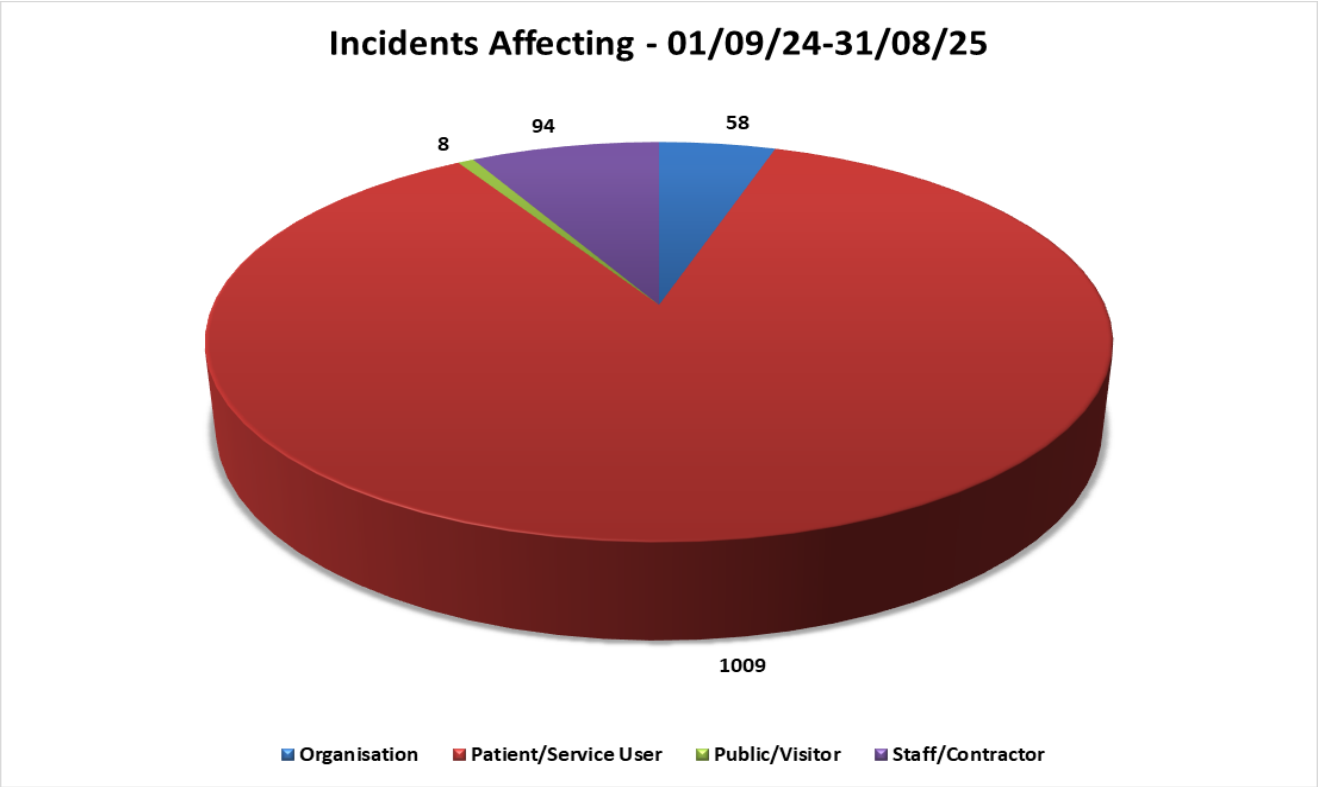
Safe Care

Incident reporting

Includes: Unscheduled Care Bronglais, Unscheduled Care Glangwili, Unscheduled Care Prince Philip, Unscheduled Care Withybush, or Urgent Emergency Care Med Mgnt)


Classification of Incidents Reported in A&E, MIU & SDEC 01.09.24-31.08.25
300
250
200
150
100
50
0
249
212
147
113
77
66
50
47
44
34
32
23
18
17
16
12
9
2
1
Pressure Damage, Moisture Damage
Accident, Injury
Medication, IV Fluids
Behaviour (including violence and aggression)
Assessment, Investigation, Diagnosis
Treatment, Procedure
Communication
Access, Admission
Transfer, Discharge
Infrastructure (including staffing, facilities, environment, security)
Records, Information
Monitoring, Observations
Safeguarding
Equipment, Devices
Patient/service user death
Infection Prevention and Control
Information Governance, Confidentiality
Consent, Mental Capacity Act (including DoLS)
Nutrition, Hydration


CLOSED INCIDENTS - POST INVESTIGATION HARM 01.09.24-31.08.25
600
500
400
300
200
100
0
536
289
2
1
1
NONE
LOW
MODERATE
SEVERE
CATASTROPHIC / DEATH



On further review of incidents presented above the following was noted:

• Of the 212 Accident, Injury incidents reported 175 are attributed to a slip, trip or fall and 172 of those falls was a patient, 1 a visitor and 2 a staff member
• Of the 249 Pressure Damage, Moisture Damage incidents 65 developed or worsened during the patients care in the admitting area. 97 were moisture damage and 87 were pressure damage already present when the patient was admitted.

Emergency Department Environments

As part of the Environment Workstream work under the Accelerated Transformation Programme, Outcome and Process Measures for Environmental considerations for Emergency Departments have now been identified and formally agreed. The measures focus on key themes including:

- Nutrition and Hydration
- Customer Care, Professionalism and Communication
- Privacy, Dignity and Confidentiality
- Cleanliness
- Staff Culture

Weekly data collection commenced across the four acute sites during the week beginning 15th September 2025. At the time of reporting the data had not been inputted for review.

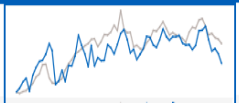
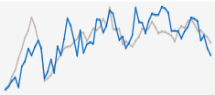
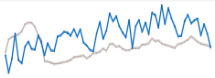
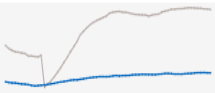
Summary Emergency Department Indicator Table (SEDIT) July 2025 Data/Get It Right First Time (GIRFT) Data:

SEDIT Data is used to inform and develop the GIRFT audit and recommendations (please see Clinical Audit section for further GIRFT data)

Bronglais Hospital (BGH)

Demand | Capacity | Flow | > Outcomes

Click on a metric below to view further analysis.

Metric Name	Site Value		Mean	LQ	Median	UQ	Dotted lines indicate 5th and 95th percentiles. RAG rating based on quartiles	Site value per month against the mean	Previous Month		Change
All ED patients spending > 12 hours in department	%	6.1	%	9.5	3.3	8.2	14.0		%	7.7	▼21.7%
APBR-12 (admitted patient breach rate > 12 hours)	%	20.2	%	26.5	10.3	24.2	42.7		%	23.6	▼14.4%
APD-12 (admitted patient delay > 12 hours)	hrs	11.0	hrs	11.2	4.7	6.8	11.1		hrs	14.4	▼23.1%
ED-DRH (estimate of annual number of ED patients with delay-related harm)		34.9		141.3	87.1	135.5	192.1			35.1	▼0.6%
Litigation liability per ED attendance	£	9.7	£	8.6	6.7	8.9	9.7		£	9.7	0.0%
NHS Staff Survey: Happy with standard of care for a relative/friend	%	51.1	%	50.2	54.9	62.7	67.7		%	51.1	0.0%
NHS Staff Survey: Recommend as a place to work	%	53.4	%	52.6	54.2	59.2	63.6		%	53.4	0.0%

Glangwili Hospital (GGH)

Click on a metric below to view further analysis.

Metric Name	Site Value		Mean	LQ	Median	UQ	Dotted lines indicate 5th and 95th percentiles. RAG rating based on quartiles	Site value per month against the mean	Previous Month		Change
All ED patients spending > 12 hours in department	%	13.8	%	9.5	3.3	8.2	14.0			%	15.5	▼11.3%
APBR-12 (admitted patient breach rate > 12 hours)	%	33.2	%	26.5	10.3	24.2	42.7			%	38.4	▼13.5%
APD-12 (admitted patient delay > 12 hours)	hrs	20.6	hrs	11.2	4.7	6.8	11.1			hrs	20.3	▲1.6%
ED-DRH (estimate of annual number of ED patients with delay-related harm)		87.8		141.3	87.1	135.5	192.1				88.7	▼0.9%
Litigation liability per ED attendance	£	9.7	£	8.6	6.7	8.9	9.7			£	9.7	0.0%
NHS Staff Survey: Happy with standard of care for a relative/friend	%	51.1	%	50.2	54.9	62.7	67.7			%	51.1	0.0%
NHS Staff Survey: Recommend as a place to work	%	53.4	%	52.6	54.2	59.2	63.6			%	53.4	0.0%

Withybush

Infection Prevention and Control (IPC)

HDUHB continues to be under TI for rates of C. difficile, E.coli and S. aureus infections. Hospital onset cases reduced in July; it is suspected that increased testing in May and June due to norovirus outbreaks led to increase findings on C.difficile infections/ dual infection in patients, accounting for this month's reduction. No outbreaks in August however a scabies outbreak on Steffan Ward GGH with a full Multi-Disciplinary Team response was reported.
Two risks currently on the risk register for IPC under corporate nursing-
1640- Risk of harm to patients due to a lack of recommended Airborne Isolation Suites at GGH and WGH

1490- Risk of increased harm to patients due to escalating rates of Clostridioides Difficile Infection (CDI)

The Health Board is consistently above the de-escalation criteria for infections and a multidisciplinary response is required and has been sought through the monthly Healthcare Acquired Infection assurance meetings. These meetings provide scrutiny on Hospital Onset Infections and the shared learning will be presented in monthly CCG meetings and IPSSG. Our safety dashboard will be reviewed to include more IPC metrics and the locality meetings will be reviewed to align to the Clinical Care Group.

Mortality reviews

The mortality review figures continue to demonstrate a significant number of unresolved investigations across the three systems. These date back to 2021 and are broken down into areas as follows.

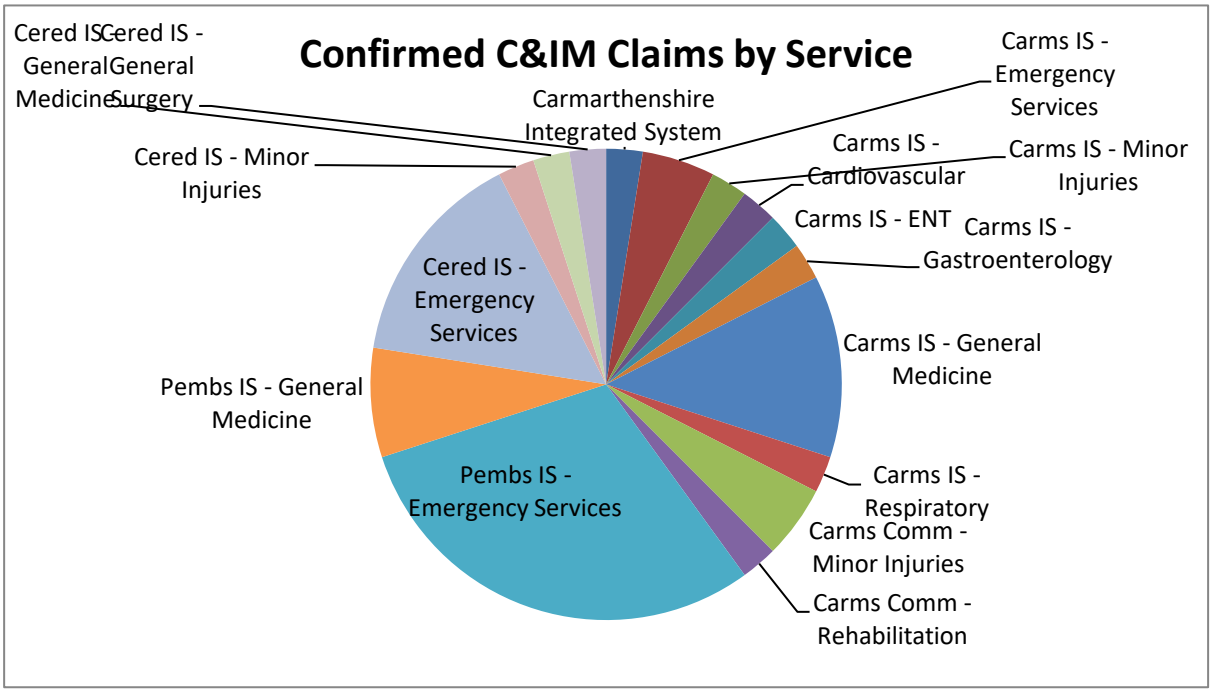
- Glangwilli General Hospital – 61
- Prince Philip Hospital – 11
- Carmarthenshire Community - 1
- Bronglais General Hospital – 43
- Ceredigion Community - 1
- Withybush General Hospital – 11
- Pembrokeshire Community – 6

It is felt that due to the complexity and level of investigation that is required to thoroughly undertake these reviews, there is currently not sufficient capacity to complete in a timely manner. The Clinical Care Group have agreed to explore whether there is opportunity to review the current practice and support with additional resource to clear the backlog of cases. Themes from the mortality reviews will be brought to our care group learning forums from next month.

The risk is that we are missing key learning opportunities for sharing across the Health Board, there is potential for impact on future patient experience and care.

Claims and Redress

There are currently 40 Confirmed Clinical negligence Claims open in Community & Integrated Medicine with a Total of Estimated Damages at £9.7m and Estimated Costs at £2.3m.



Two Clinical Negligence Claims are with the services for completion:

- Pembs A&E - HD/MN/RL/680 due by 04/12/2025

- Pembs Ward 11 and Community Nursing - HD/MN/RL/992 due by 21/11/2025

Two Personal Injury Claims LFEs are with the services for completion:

- Carms GGH ASU – HD/PI/RL/557 due by 10/10/25
- Pembs Community Nursing – HD/PI/RL/1359 due by 27/10/2025

The Pembrokeshire and Carmarthenshire systems have been asked to review and respond accordingly to meet the deadlines set.

The most recent Care Group quality and safety meeting a discussion was held in relation to how we monitor and regulate claims for specific areas. The care group has been asked to review and update revised content for the claims and redress report from a governance perspective. A bespoke dashboard will be created to support thematic review and understanding across the CCG.

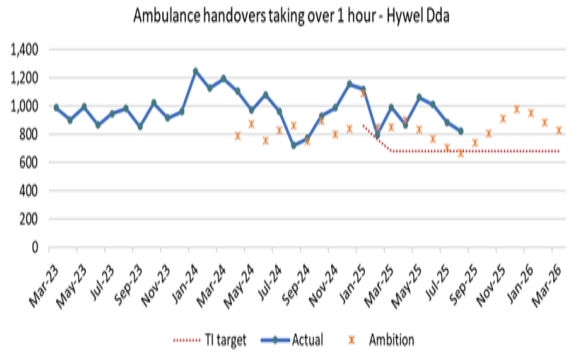
Urgent and Emergency Care Risk

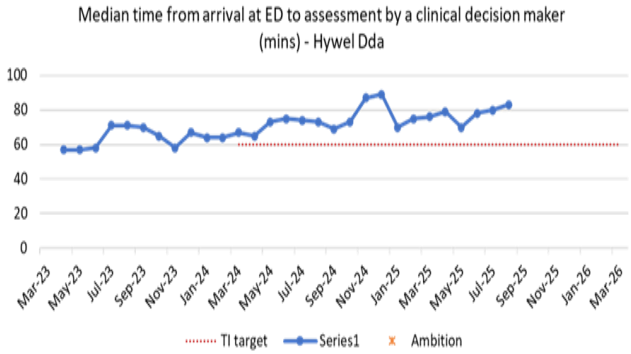
Date Identified	Risk Area	Risk Title	Risk Statement	Risk Owner	Risk Assigned	Severity	Likelihood	Risk Score	Mitigation Plan	Mitigated Severity	Mitigated Likelihood	Mitigated Risk Score
14/01/2025	Programme	Corporate	There is a risk to the consistent delivery of timely and high quality urgent and emergency care. This is caused by significant fragility across the urgent and emergency care (UEC) system (acute, primary care (including out of hours), community and social care services), related to workforce compromise and increasing levels of demand and acuity. This could lead to an impact/effect 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.	Andrew Carruthers	Peter Skitt	5	4	20	Six Goals Programme. Is on Corporate Risk Register for Health Board and reviewed on a regular basis through ARAC system	3	5	15

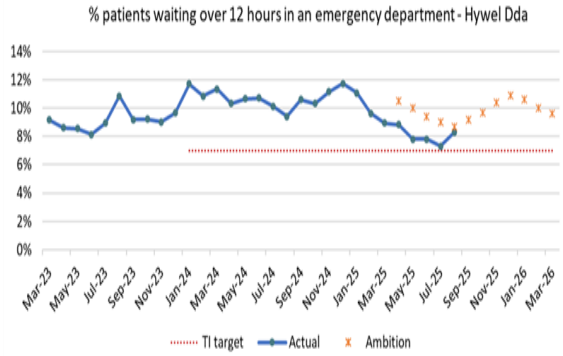
Risks are scrutinised on a monthly basis at both individual system and care group wide level. This ensures mitigations are updated and reviewed appropriately and on a regular basis. This also acts as a consistency check for the revised risk level, reported on a monthly basis.

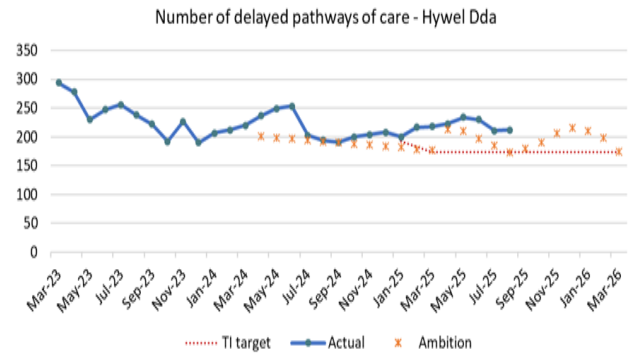
Timely

(please note the UEC escalation data is updated on the fifth working day of the month and therefore September's data was not available at the time of writing this report)









Targeted Intervention targets are not met for August 2025 across Hywel Dda (please note Sept. 2025 data not available at time of writing).

- Health Board >1hr ambulance delays have shown month on month improvement since May 25 but are at 821, which is still above the Targeted Intervention (TI) target of 680. WGH seems to be the most challenged site in this metric and although there has been a slight decrease on last month's performance, >1hr is at 291 which is above TI target of 188. GGH has shown improvement since June 25, and in August is at 325 >1hr handovers, below the local TI target of 326.
- HDdUHB has increased in median time to assessment over the last few months. For remains the median time was 83 mins, TI target 60 mins. The poorest performing site for this metric is BGH, with a median time of 90 mins.
- % of patients waiting >12 hours have increased since last month and is at 8.3%, above TI target of 6%. All sites seem to have increased over the last month across this metric with WGH as the poorest performing site at 15.9%.
- POCD has shown improvement since April 2025 but remains above TI target of 174 at 212.

Effective

Quality improvement

Quality improvement around the programmes of work centre on the following goals:

1. Access

Goal: Transform how patients access urgent and emergency care, aiming for a 50% reduction in ED attendances and 75% of emergency activity to be scheduled, shifting care into the community.

Key Actions & Progress:

- 24/7 Contact First Model: Joint work with WAST, 111, and GP Out of Hours. Regional workshops are ongoing, but public-facing Single Point of Access (SPOA) will not be achieved by 2025.
- 7/7 Clinical Streaming Hub: Pilot completed; business case and evaluation presented to the Board. Phased implementation planned, with mentorship and educational programmes funded and scheduled.
- Integrated Community Teams: Rapid response teams across primary care, mental health, social care, and voluntary sectors. Financial and digital challenges identified; options for cost-neutral and business-case approaches are being developed.

2. Environment
Goal: Create a culture of customer service excellence and pride in urgent and emergency care environments.

Key Actions & Progress:

- Cleanliness: Standards reviewed and SBARs (Situation, Background, Assessment, Recommendation) developed for domestic/facilities coverage.
- Welcoming Front of House: Environmental audits completed; site-specific action plans in progress.
- Nutrition & Hydration: Standards set and audits completed; site plans in place.
- Privacy & Dignity: Environmental reconfigurations and digital solutions (e.g., self-registration, e-triage) are being explored.
- Communication: Consistent patient messaging and wayfinding solutions (including a robot pilot) are being developed. Customer service training for reception staff is scheduled.

3. Flow
Goal: Implement a coordinated, data-driven approach to patient flow, eliminating ambulance handover and ED delays, and enabling timely discharge.
Key Actions & Progress:

- Operational Command Centre: Weekly project meetings, data mapping, and integration with digital systems (e.g., Alcidion, E-Flow, E-Obs) are ongoing.
- 7/7 Operational Delivery Unit (ODU): Soft-launched in September 2025; recruitment and training are underway.
- Discharge Management: New policies, toolkits, and professional standards have been launched. Internal secondments for discharge practitioner posts are being recruited, and training videos are planned.

Key Themes and Risks
There is a strong emphasis on collaboration across health, social care, and voluntary sectors.
Ongoing digital and workforce challenges, especially around data integration and recruitment.
Financial constraints and the need for executive decisions/support in several areas.

In order to minimise risks/issues there is a commitment to continuous improvement, with regular audits, stakeholder engagement, and learning from other Health Boards.

Enabling Quality Improvement in Practice (EQIiP) Projects

1: BGH re-conditioning - patients who have optimised for discharge are not always maintained at that level and can decondition to prevent discharge. The team are currently looking at the reasons for this and the aim will be to reduce it on a particular ward, most likely Y Bwa. Aims not yet confirmed and baseline data still being collected.

2. Improving communication to patients in ED waiting room, GGH. This project will likely reduce complaints and improve patient safety within the ED department.

3. The Multi-Model Rehab team is made of 3 specialist service provisions: Pulmonary Rehab, Long Covid & Neuro. The teams are concerned that their existing systems and processes do not meets the needs of each service provision. Through EQIiP, the team are looking to streamline their data recording requirements to aid good quality reporting mechanisms. This in turn will contribute to service development as the data will:

- Better illustrate the needs of the services,
- Highlight areas where demand is not being met
- Showcase the strengths of what each programme delivers through better recorded outcomes for the service as well as the patient.
- Triangulate the data with other systems to demonstrate if prevention techniques are having a positive impact on the wider system in terms of admission avoidance.

4.Deteriorating patients' safety is compromised due to healthcare professionals failing to recognise and escalate clinical deterioration promptly.
Project Aim : 100 % of patients on Ward 7 (WGH) and Preseli Ward (GGH) are escalated correctly when clinically appropriate by March 2026.

5: Preventing deconditioning in PPH Acute Medical Assessment Unit (AMAU). AMAU is the main entry point for patients at the front door in PPH. When patients arrive there is often minimal information to support their needs & capabilities around deconditioning. The project seeks to ensure patients at the front door level are supported to not decondition at the beginning of their journey so that when they are transferred to other wards, or discharged, the LOS will be reduced and there will be better patient outcomes. Ensuring overall deconditioning at the front door will support overall hospital flow. Aim: To reduce deconditioning in Acute Medical Assessment Unit, PPH by 20% by January 2026

6: Preventing deconditioning from a nutrition and hydration perspective for WGH

Clinical Audit

Get It Right First Time and Ministerial Advisory Groups have audited our Emergency Departments and hospital departments and we are monitored on progress against recommendations through the IQFPD (Local) and IQPD (National) Groups. Recommendations, owners and timescales against each action are logged on the Health Board AMAT system. Please see below for a summary position against all:

GIRFT Audit: Key Recommendations

- Reduce unwarranted variation in clinical practice and outcomes.
- Improve patient flow and reduce ED delays and ambulance handover times.
- Enhance workforce planning and address staffing gaps, especially in EDs.
- Adopt best practice pathways for specialties (e.g., stroke, ophthalmology, general surgery, emergency medicine).
- Increase elective surgery as day case and separate elective from unscheduled work.
- Utilise data-driven approaches for benchmarking and improvement.
- Implement robust audit and assurance processes for continuous improvement.

Actions Taken

- Action Plans Developed: Each GIRFT report triggers a formal action plan, reviewed and signed off by management leads, with progress tracked in the Audit Management and Tracking System (AMaT).
- Monthly Monitoring: Progress against recommendations is reported via monthly escalation frameworks and committees (e.g., IQFPD, ARAC).
- ED Improvements: Boarding protocols, surge capacity management, and flow improvements implemented at sites like Withybush and Glangwili Hospitals
- Staffing: Increased registered nurse allocation, recruitment of advanced practitioners, and review of medical staffing models
- Pathway Redesign: Mapping and implementation of optimal imaging and rehabilitation pathways (e.g., stroke, cataract surgery)
- Audit Compliance: Real-time data recording and regular review meetings for assurance (e.g., SSNAP data for stroke
- Specialty Reviews: Ophthalmology, general surgery, and urology recommendations tracked, with most actions completed or on track
- Environment & Experience: Environmental audits, improvement of facilities, and patient experience initiatives (e.g., seating, hygiene, privacy)

Ministerial Action Group (MAG) Audit, Key Recommendations:

- Improve performance and productivity in urgent and emergency care, planned care, diagnostics, and cancer services.
- Standardise clinical pathways and reduce unwarranted variation.
- Strengthen clinical leadership and accountability.
- Use data more effectively for monitoring and improvement.
- Accelerate implementation of best practice models (e.g., surgical hubs, streaming hubs).
- Address ambulance handover delays and optimise patient flow.

Actions Taken

- MAG recommendations are assigned to service leads and tracked in AMaT, with regular updates to ARAC and IQFPD
- Surgical Hubs: Use GIRFT documents to guide setup, staffing, and running of hubs; national standards for cases per list adopted.
- Theatre Productivity: Theatre utilization targets set at 85%, with ongoing monitoring and regional collaboration.
- Frailty & SDEC Expansion: Acute frailty units and same day emergency care models expanded, with barriers (e.g., staffing, diagnostics) addressed through targeted interventions

- Ambulance Handover: Elasticity of ED used to eliminate handover delays, not to accommodate excess patients; boarding protocols and escalation policies in place.
- Cancer Pathways: FIT testing standardized, with recommendations for improved traceability and inclusion in referrals
- Continuous Flow Models: Exploration of continuous flow models to improve patient movement and reduce delays.

Evidence based

Aligned to National Guidance/Priorities:

- **National Six Goals Programme for Urgent and Emergency Care**
- **Emergency Department Quality Statement**

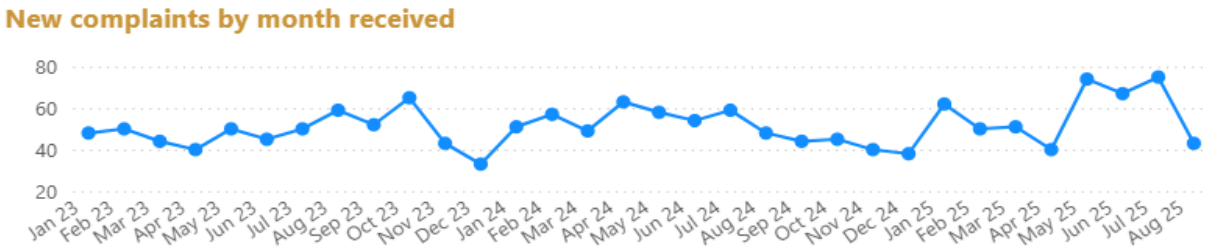
- **Ministerial Priorities for UEC**
    - UEC1: Implement effective Community Based Falls Response Services. To enhance outcomes and experience for those who fall by improving initial response times, reducing the risk of long lies and ensuring service users access community falls pathways when appropriate
    - UEC2: Implement a robust 'Single Point of Access' (SPOA) for UEC. Create in each health board area that simplifies access to services by offering clinicians advice and guidance to support onward referral, ensuring patients get the right care for their needs quickly and safely, to improve patient outcomes regardless of where they present
    - UEC3: Implement an Acute Front Door Frailty Service at all acute hospitals. Integrated with community frailty services - that ensure that older people with frailty are diverted to the most appropriate services within the hospital as quickly as possible and, where possible, discharged home on the same day
    - UEC4: Implement the Welsh Health Circular - Ambulance Patient Handover Guidance. To ensure timely transfer of patients from ambulance crews to emergency department staff
    - UEC5: Implement actions described in the Optimal Hospital Flow Framework. To ensure people who possess a clinical need for admission to hospital are discharged home when clinically ready, with the right support and without delay. This should support a reduction in pathways of care delays.

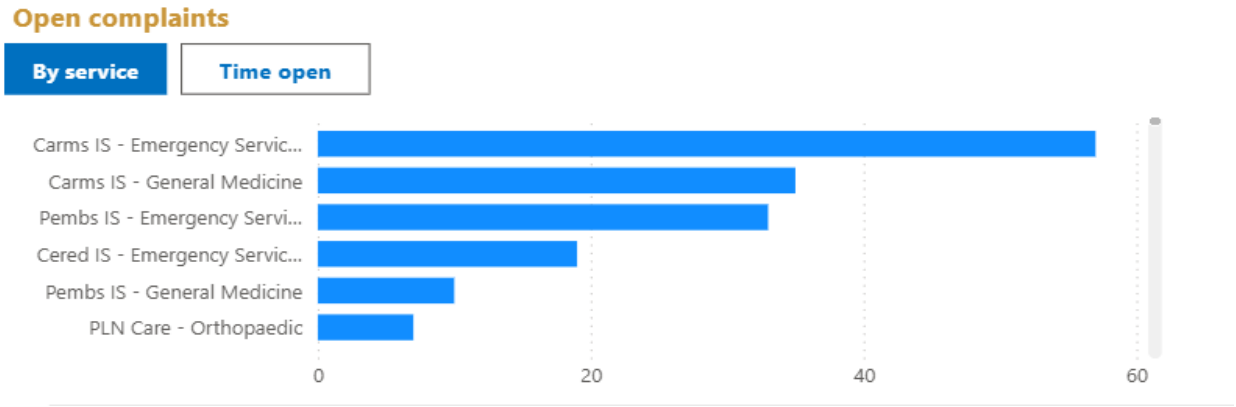
Equitable

Work from both the Accelerated Transformation and Six Goals Programmes are in evidence pan Hywel Dda. It is the governing groups for the Programmes, as well as the Community and Integrated Medicine Clinical Care Group's responsibility, to ensure patient outcomes/pathways are equitable.

Person Centred

Complaints are collected centrally through our Patient Support Service, please see below graphs detailing complaints by month and number of open complaints (Health Board wide):





Public Services Ombudsman for Wales (PSOW), A&E, Same Day Emergency Care (SDEC) and Minor Injuries Unit (MIU)

Please see below for a summary of findings over the last year:

- The PSOW upheld findings in respect of pain management, this included shortcomings in measuring a patient's pain, a lack of adequate documentation in respect of pain relief and the justification for the approach taken regarding fluid management. This meant that it was not possible to definitively conclude that patients had been effectively managed.

- In one case the patient had a long delay outside ED in an ambulance. The PSOW asked the Health Board to consider any learning from the case, given the national problem of patients having prolonged waits in ambulances outside of ED before being transferred. As part of quality assurance, the PSOW asked that their final investigation report be shared with the Quality and Patient Safety Committee.

- Other recommendations included a review of the use of pain charts, rounding, amber care documentation/last days of life pathways to definitively address the appropriateness of individual symptom control and improve patient experience. Also to remind the medical teams of the need to ensure clear documentation to explain and justify why a specific approach has been taken in relation to a patient's care.

- All PSOW recommendations are recorded on AMAT and are raised and monitored through relevant governance meetings.

<u>Healthcare Inspectorate Wales (HIW) Report</u>

Derwen Ward, Glangwili Hospital
Date of inspection: 2nd and 3rd September 2025

HIW identified a number of areas that required immediate assurance and action;

1. The health board must ensure that checks of the drug refrigerator in the clinical room are monitored and recorded daily.
2. The health board must ensure that daily checks of the emergency resuscitation trolley are completed and documented daily.
3. The health board must ensure that sufficient domestic staff are available to clean the ward to maintain appropriate infection prevention and control (IPC)
4. The health board must ensure that multi patient use items such as BP cuffs, are appropriately decontaminated between use and that clean equipment is correctly labelled.
5. The health board must ensure that oxygen tubing and face masks are easily accessible for all bed areas on the ward.
6. The health board must ensure wall suction units are fully operational
7. The health board must ensure that patient records are stored securely at all times
8. The health board must ensure that all staff have received training and complete patient risk assessments appropriately and take the relevant action in line with local or national guidance, and document this in patient records. This includes:
    - Taking appropriate action when NEWS scores are 3 or above
    - Completing and documenting Sepsis Screening for those at risk of sepsis, such as a NEWS score of 5 or above
    - Completing and documenting VTE risk assessments on admission and thereafter in line with local and national guidance.
9. The health board must ensure that all the findings in this immediate improvement plan are not systemic across all other wards within the hospital and the wider health board.

Immediate improvement plan submitted to HIW to provide the necessary assurance. Local audits ongoing across all other clinical areas within the health board alongside our quality improvement team specific to these findings to ensure learning is taken and embedded. Evidence to be submitted to HIW in due course.

The CCG is on trajectory to meet the identified actions within the timeframes given. Currently awaiting the full report which will then be updated on AmAT for governance purposes

Argymhelliad / Recommendation

The Quality, Safety and Experience Committee is asked to take an assurance on the quality governance arrangements in place within the Six Goals and Accelerated Transformation Programme in relation to quality, safety and patient experience.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	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.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	1027 – details of risk within paper
Parthau Ansawdd: Domains of Quality	1. Safe 2. Timely

Quality and Engagement Act (sharepoint.com)	3. Effective 4. Efficient
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply Enablers of Quality Enablers of Quality Choose an item.
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable Choose an item. Choose an item. Choose an item.
Amcanion Cynllunio Planning Objectives	3 Transforming Urgent and Emergency Care programme Choose an item. Choose an item. Choose an item.
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	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:	Contained in report, GIRFT, MAG etc.
Rhestr Termau: Glossary of Terms:	Contained in report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	CIM CCG

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not Applicable (N/A)
Ansawdd / Gofal Claf: Quality / Patient Care:	Contained in Report
Gweithlu: Workforce:	N/A
Risg: Risk:	Contained in Report

Cyfreithiol: **Legal:**	N/A
Enw Da: **Reputational:**	N/A
Gyfrinachedd: **Privacy:**	N/A
Cydraddoldeb: **Equality:**	N/A