Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Date	**09/10/2025**
Time	**09:30 - 12:30**
Location	**Microsoft Teams Meeting/ Ystwyth Boardroom**

Quality, Safety & Experience Committee Meeting

HDD_Quality, Safety & Experience Committee

NHS Wales

Agenda - 9 October 2025

1 Governance

09:30, 40 min

1.1 Declarations of Interest

Anna Lewis (Hywel Dda UHB - Independent Board Member)

1.2 Minutes from the Previous Meeting and Table of Actions

Anna Lewis (Hywel Dda UHB - Independent Board Member)

1.3 Targeted Intervention Progress Report

1.4 Assurance and Risk Report- Executive Leads

1.5 Cadog Ward Frailty Unit Nurse Staffing Presentation- Verbal

Donna Major (Hywel Dda UHB - Junior Sister)

2 Nurse Staffing Levels (Wales) Act Report and Impact of Reduction of Agency and Bank Staff on quality, safety and patient experience- To Follow

10 min
Helen Humphreys (Hywel Dda UHB - Head of Nursing for Professional Standards and Regulation), Janice Cole-Williams (Hywel Dda UHB - Assistant Director of Nursing)

3 Clinical Care Group Reports

3.1 Planned and Specialist Care Group

DEFERRED

4 Risk

30 min

4.1 Unscheduled Care Deep Dive

Peter Skitt (Hywel Dda UHB - Clinical Care Group Service Director - Community & Integrated Medicine), Gareth Cottrell (Hywel Dda UHB - Deputy Chief Operating Officer)

4.2 Public Interest Report- Verbal

Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Sharon Daniel (Hywel Dda UHB - Executive Director of Nursing, Quality & Patient Experience), Louise O'Connor (Hywel Dda Health Board - Assistant Director), Olwen Morgan (Hywel Dda UHB - Assistant Director of Nursing)

5 Assurance

1 hr

5.1 Quality Assurance Report

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

5.2 Criteria 2 Quality Impact Assessment Related Planning- To Follow

Cathie Steele (Hywel Dda UHB - Interim Assistant Director of Nursing Assurance and Safeguarding), Sian Jenkins (Hywel Dda UHB - Deputy Director of Finance), Sharon Daniel (Hywel Dda UHB - Executive Director of Nursing, Quality & Patient Experience)

5.3 Temporary Service Changes in Ceredigion Community Mental Health Team

Amanda Davies (Hywel Dda UHB - Head of Service, Adult Mental Health)

5.4 Occupational Therapies Paediatric Improvement Action Plan

Sara Quarrie (Hywel Dda UHB - Service Director for Allied Health Professions and Health Sciences)

5.5 Maternity and Neonatal Assessment

Cerian Llewellyn (Hywel Dda UHB - Interim Head of Midwifery)

5.6 Listening and Learning Sub Committee Update Report

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

6 For Information

6.1	QSEC Work Plan 2024-25	

7 Date of Next Meeting : 4 December 2025

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1.3 - Targeted Intervention Progress Report

Attachments

1.3 De-escalation Criteria Progress Update October 25 V2

1.4 - Assurance and Risk Report- Executive Leads

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Appendix 1 - Principal Risks

1.5 - Cadog Ward Frailty Unit Nurse Staffing Presentation- Verbal

2 - Nurse Staffing Levels (Wales) Act Report and Impact of Reduction of Agency and Bank Staff on quality, safety and patient experience- To Follow

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2 Quality Safety Experience Committee impact of reduction in agency bank~

3 - Clinical Care Group Reports

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DEFERRED

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6.1 - QSEC Work Plan 2024-25

Attachments

Draft QSEC Work Programme 2025 26 (3)

- Date of Next Meeting : 4 December 2025

1

09:30, 40 Mins

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1 - Governance

1.1 **10:10,**

1.1 - Declarations of Interest

Anna Lewis (Hywel Dda UHB - Independent Board Member)

1.2

1.2 - Minutes from the Previous Meeting and Table of Actions

Anna Lewis (Hywel Dda UHB - Independent Board Member)

Attachments

2025-08-14 - Quality, Safety _ Experience Committee Meeting - Minutes.pdf

Draft Minutes from the Quality, Safety & Experience Committee Meeting

Date of Meeting:	**09:30, Thursday 14 August 2025**
Venue:	**Microsoft Teams Meeting/ Ystwyth Boardroom**

Present:
Anna Lewis (Chair of the Committee)
Chantal Patel (Independent Board Member)
Eleanor Marks (Committee Vice Chair)
Michael Imperato (Independent Board Member)
Sarah Harraway (Independent Board Member)

In Attendance:
Sharon Daniel (Executive Director of Nursing, Quality & Patient Experience and Lead Executive for the Committee)
Andrew Carruthers (Chief Operating Officer)
Bethan Lewis (Assistant Director of Public Health Strategic Business and Operations) deputising for Dr Ardiana Gjini, Executive Director of Public Health
Caroline Burgin (Patient Safety and Assurance Manager)
Cathie Steele (Interim Assistant Director of Nursing Assurance and Safeguarding)
Charlotte Wilmshurst (Assistant Director of Assurance and Risk)
Dana Scott (Director of Midwifery & Professional Governance for Women & Children)
Elin Brock (Head of Research, Innovation & Improvement)
James Severs (Executive Director of Allied Health Professions and Health Science)
Jill Paterson (Director of Primary Care, Community and Long Term Care)
Katie Lewis (Committee Services Officer)
Kay Isaacs (Assistant Service Director- MHLD Clinical Care Group)
Liz Carroll (Service Director MH&LD Clinical Care Group)
Louise O'Connor (Assistant Director of Legal and Patient Experience)
Mark Henwood (Executive Medical Director)
Mwape Burke (Aspiring Board Member)
Olwen Morgan (Assistant Director of Nursing)

Apologies were noted from:

- Ardiana Gjini, Director of Public Health
- Joanne Wilson, Director of Corporate Services (Charlotte Wilmshurst is deputising)
- Vanessa Davies, Health Inspectorate Wales
- Amanda Glanville, Assistant Director of Workforce
- Subhamay Ghosh, Associate Medical Director for Quality and Safety

Minutes Ref.	Item	Action
	The Chair of the Committee, Mrs Anna Lewis, extended a warm welcome to all and introductions were made.	

QSEC 25 (36) Declarations of Interest

Ms Eleanor Marks declared an interest as a Member of the Professional Standards Authority.

QSEC 25 (37) Minutes from the Previous Meeting and Table of Actions

Referring to action reference QSEC (25)17: To share with the Committee a plan for the development of a 'patient communication strategy' across planned care services which represents a critical requirement for multiple de- escalation criteria, Mrs. Lewis queried the timelines for the development of the project scope. In response, Mrs. Sharon Daniel advised that the team are currently mapping out the requirements through a quality improvement lens and in collaboration with Communication Hub. Mrs Daniel undertook to request that a report is presented to the October QSEC meeting. **SD/ MD**

Decision: The minutes from the meeting on 10 June 2025 were approved as an accurate record.

QSEC 25 (38) Self-Assessment - Six month Review of Actions

The six month review of actions following the Committees self-assessment undertaken in February 2025 was shared, with six out of the 10 actions completed and progressing within agreed timeframes. The final report will be shared in February 2026.

Decision: The Committee received assurance from the progress made against the actions being undertaken to improve its effectiveness.

QSEC 25 (39) Assurance on Governance Arrangements Report - Executive Leads

The Committee received a revised reporting format for the Corporate Risk Report, which now includes internal and external audit reports, monitoring of Ministerial Directions and Welsh Health Circulars (WHCs). Mrs Lewis commented that the revised format is helpful in providing focus for the Committee.

Mrs Chantal Patel expressed concern over the extended timelines for achieving target risk scores, highlighting Risk 664 - *Risk to ophthalmology service delivery due to a national shortage Consultant Ophthalmologists and the inability to* recruit as an example, with its target score not expected to be met until 31 March 2027.

Miss Paterson clarified that the Ophthalmology Risk is not solely dependent on the recruitment of a Consultant Ophthalmologist. She noted several developments within Primary Care Optometry 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.

In response to Mrs. Patels' observation regarding long-standing risks, Mrs. Lewis noted that some risks are deeply embedded in the system, or subject to wider strategic developments, such as the Clinical Service Plan. As a result, the associated timelines may no longer be appropriate or reflective of current circumstances. Ms. Wilmshurst provided assurance to the Committee that the Executive Team is currently reviewing the Annual Planning Process to adopt a risk-based approach. This will involve executive oversight to determine which risks will be tolerated and incorporated into the Clinical Care Groups (CCG's) annual plans.

Building on Ms. Wilmshurst's point, Mr. Carruthers noted that several long-standing risks continue by default unless refreshed through an annual review process. He confirmed that discussions are underway with operational teams to review how the risk register is being utilised to inform the planning process. He also acknowledged that strategic developments can influence the timescales associated with these risks.

Mrs. Lewis highlighted that the target score for Risk 1032 - *Risk of timely diagnosis and treatment of Mental Health and Learning Disabilities* clients *due to demand and capacity* is the same as the current risk score and requested that this is clarified ahead of the next meeting. **LC**

In terms of Risk 1859 - *poor patient outcomes and experience due to the inability to effectively recognise and manage acute deterioration*, Ms. Marks understands that this relates to patients who are under the care of the Health Board, and in light of the significant implications, queried what is being done to manage the risks. In response, Mrs. Daniel highlighted the focus on enhancing education and training opportunities aimed at increasing awareness, ensuring that all staff who undertake clinical observations can identify the signs of deterioration in a timely manner. However, she acknowledged that the current position falls short of the desired standard.

In response to a further query from Ms. Marks regarding how this risk was identified, Mrs. Daniel explained that it emerged during discussions within the Quality and Safety Improvement Group. The concern was flagged following an increase in cardiac arrests, where delayed medical intervention was highlighted as a recurring theme. Ms. Marks expressed reassurance that this demonstrated the effectiveness of the organisation's governance processes for escalating risks.

AC

Mrs. Lewis commented that there is currently no confirmed date for achieving the target risk score for *Risk 684 - timely investment and replacement of Radiology equipment and supporting infrastructure.* However, she had been informed there is a plan in

progress. Acknowledging the need to revise the wording of the risk, Mr. Carruthers confirmed that a plan is indeed in place. Nevertheless , he clarified that the required capital funding from Welsh Government has not been secured to support its implementation.

The Committee discussed concerns around risks where internal mitigations have been exhausted and progress is reliant on external factors, particularly Welsh Government funding. Mrs. Lewis questioned whether stronger representation should be made to Welsh Government or the Board. Ms. Marks requested clarity on how these risks are being escalated to WG and committed to raising the issue at the Vice Chairs' meeting. Mrs. Lewis expressed a desire to explore further actions the Committee could take. **LD/HT** **EM**

In terms of Risk 1708 - *increasing fragility in primary care contractor services due to external factors*, Mrs. Lewis asked Miss Paterson to provide a brief overview from the service and explain what support is needed from the organisation to accelerate progress on the Primary Care Strategy. Miss Paterson updated the Committee that this risk has recently been de-escalated. While services remain fragile, the Health Board has a statutory duty to ensure their provision, although, the delivery model may change.

Miss Paterson clarified that Risk 1708 is 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 is required to support this shift.

Miss Paterson advised that future Board support will be sought for the implementation of the Primary Care Model for Wales and the local cluster-based service delivery. She also highlighted further requests for support regarding the Eye Health Plan and the Dental Investment Plan.

Mrs Lewis proposed that the Board be formally advised of this risk, emphasising its critical role in enabling progress, which is closely linked to the approval of the Primary Care Strategy.

Decision: The Committee received 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.

QSEC 25 (40) Targeted Intervention Progress Report

Mrs. Lewis thanked Mr. Shaun Ayres for preparing the insightful report and was pleased to note a number of positive developments and improvements, whilst acknowledging the further work required such as the number of Healthcare Inspectorate Wales (HIW) recommendations that remain unaddressed. In agreement, Mrs. Daniel advised that the Interim Assistant Director of Nursing, Quality Assurance and

Safeguarding has requested that a risk assessment is undertaken for these actions, as over half are aligned with national action plans or with other Health Boards to address. For assurance, the risk assessments will be reported to the Directorate Improving Together sessions (DITs). Work is underway to strengthen the Health Board's relationship with the HIW through monthly touchpoint meetings, in response to an increasing number of letters of concern received from HIW.

Mrs. Daniel highlighted that Healthcare Acquired Infections (HCAI) remain as an alert for the Committee, with the Health Board reporting 7.3 cases per month of C-Diff which is 1.3 cases above the target.

Reported cases of Staphylococcus aureus bacteraemia are averaging 3.2 per month with the target to de-escalate being 2. The position continues to be monitored through active surveillance and strengthened ownership from CCG leads for HCAI.

Commending the report, which sets out the position clearly for the Committee, Mrs Lewis highlighted that while the report articulates the actions needed to make progress or improvements, the ownership and timelines of the recommended actions are not included. Noting Mrs. Lewis's observation, Mrs. Daniel assured the Committee that the actions form part of the internal escalation process and DITs, which are monitored appropriately. Mrs. Lewis added it would be helpful to articulate the actions underway and timelines in future reports. **SA**

Ms Harraway noted a recurring theme among the areas in escalation raised concerns regarding the lack of project management support articulated within the report. With significant organisational change being proposed, it is concerning that there is a shortage of the necessary support to drive these initiatives forward. Mr. Henwood acknowledged the benefits, however explained that there are financial constraints.

Ms. Harraway further questioned how project support is being aligned with the organisations strategic objectives. and shared her positive experience with a centralised transformation team. Mrs. Daniel explained that the Deputy Chief Executive is developing a proposal for a centralised support unit combining quality improvement and transformation expertise.

Decision: The Committee acknowledged the measurable progress demonstrated across several Targeted Intervention criteria, and noted that whilst positive trajectories are evident, six criteria remain at ‘Alert’ status requiring focused intervention.

QSEC 25 (41) Quality and Safety Governance Arrangements

Mrs. Daniel presented the proposals to revise the operational quality and safety governance arrangements and disestablish the

Quality, Safety and Experience Sub Committee (QSESC). The 9 reporting Groups that previously reported to QSESC will report to Quality and Safety Intelligence Group (QSIG) and the Chairs of the groups will be Members, with QSIG reporting to the Integrated Quality, Finance, Performance & Delivery Group (IQFPD). The new arrangements aim to address the long-standing challenges whereby operational matters were being reported to the Board's assurance function. As an intelligence group QSIG, will require CCG Leads to present performance data using dashboard metrics and monitoring tools such as incidents and complaints trends.

Due to statutory requirements, the Safeguarding Steering Group and Infection Prevention Control Group will report every 6 months via the Quality Assurance Report. Mrs. Daniel advised that a gap analysis has been shared as an appendix with the report to provide assurance that there are no gaps in the transition to the new arrangements.

Mrs. Daniel advised that, subject to the Committee's approval of the disestablishment of QSESC, a follow-up report will be scheduled in six months' time to evaluate the impact of the revised governance arrangements and assess improvements made across the organisation. **CS**

In response to Committee queries, Mr Henwood clarified that QSIG will serve as a central forum for Clinical Executives to monitor quality, safety and experience across the organisation, supporting effective Board assurance. All CCG's will participate, with learning shared through the Alert, Advise and Assure reports. The structure will provide direct visibility of operational challenges, with clear delegation of actions, ownership and timelines.

Decision: The Committee received assurance that QSESC's previous functions have been mapped to the new proposed approach, with due consideration given to its governance requirements and accountabilities, with enhanced reporting arrangements to QSEC in place and approved the dis-establishment of QSESC; The Committee noted that, for further assurance, a report will be presented in 6 months' time to provide an update on the effective implementation of these new operational quality and safety arrangements.

QSEC 25 (42) Patient Story- Verbal

Mr Daniel Jones shared a patient story from the All-Wales library which provided a focus on how small acts of kindness and compassion can positively influence a patient's journey, even under significant pressures. The story also highlighted other services integral to a patient's wellbeing, in this case the chaplaincy services. Mrs. Louise O'Connor emphasised the importance and impact positive communication can have on a patients health and wellbeing.

The Committee, moved by the patient story, extended a heartfelt thanks to the individual for sharing their experience and

expressed admiration for their resilience and positive outlook, despite the life altering nature of their journey.

QSEC 25 (43) Cleanliness Standards Audit report and Action Plan

Mr James Severs presented the Cleanliness Standards Audit Report to update to the Committee providing an update on the actions underway in response to the second limited assurance audit outcome regarding cleaning standards across the organisation. He provided assurance that these actions are progressing within the specified timescales. Noting that the report has also recently been presented at Audit and Risk Assurance Committee, Mr. Severs was conscious that it does not provide a focus on the quality and patient experience impacts, however a more robust assessment will be shared in readiness for an upcoming Board Seminar whereby the future direction of Estates and Facilities function will be discussed.

For the benefit of new Committee members, Mrs. Anna Lewis provided the background that cleanliness standards at hospitals have been a long-standing concern across the organisation and unfortunately tangible improvements made between the first and second internal audit was limited. The Committee had previously received the initial audit and requested clarity on the necessary step change required to address the identified challenges, following the limited assurance outcome of the follow up audit. Ms Charlotte Wilmshurst advised that a further follow up audit is scheduled for March 2026.

Mrs. Lewis highlighted that the concerns primarily relate to the systems, processes and structures in place, rather than individual staff members. Based on her own observations, staff have been working diligently under challenging circumstances.

Mrs. Patel acknowledged Mr. Severs' informative report and raised concerns about leadership within the report. She enquired whether the Committee can expect to see tangible improvements resulting from the ongoing work. In response, Mr. Severs confirmed that leadership structures are being strengthened, as current supervisory arrangements are not fit for purpose. A key strategic focus includes the imminent recruitment of a Facilities Manager for each acute site.

Ms. Lewis thanked Mr. Severs for the update and stressed the importance of avoiding a repeat of the current situation, requesting an update on tangible progress ahead of the third audit. She asked whether an internal shadow audit was planned. Mr. Severs responded that a re-audit is not currently intended, he wanted the Committee to be cited on the progress in revising governance arrangements. He also proposed providing updates through the Infection, Prevention and Control Steering Group, given the close link between cleaning standards and infection prevention. Mrs. Lewis agreed to take direction from Executive

Leads on how best to keep the Committee sighted on progress and improvements and suggested a follow-up discussion with Mrs Daniel and Mr Severs outside of the meeting to determine whether to forward plan a future agenda item or provide a verbal update in October 2025, followed by a more detailed report ahead of the March 2026 audit. **SD/JS**

Decision: The Committee received assurance that progress is being made to implement the actions arising from the internal audit report 2024/25 on Standards of Cleanliness

QSEC 25 (44) **Sonography - The impact on patient experience and clinical outcomes due to Risk 787: Workforce Pressures in Ultrasound Services**

Ms Dana Scott presented a report providing an overview of the clinical impact on patients due to work force challenges in Ultrasound Sonography Services. The serious consequences of stretched services, along with the underlying causes of current shortfalls. The need for strategic changes to the workforce model was emphasised, aiming to maximise staffing and resource use, while reducing footfall. Members acknowledged that despite a global decline in birth rates, the complexity of cases and specialist skills required to support mothers and babies has increased.

Mrs Lewis expressed her appreciation to Ms Scott for framing the clinical risks within the context of workforce challenges, noting that it was valuable to gain insight into the future vision for the service model.

Reflecting upon concerns raised by Mrs Lewis following the Safety WalkRound during which staff openly explained the clinical impact of the workforce challenges in sonography, Mrs Patel asked whether the actions articulated in the report address those concerns. In response, Mrs. Lewis noted she lacked the expertise to fully address the challenges, however confirmed the actions addressed the concerns raised during her visit. She also expressed discomfort over the potentially serious, possibly preventable outcomes described in the report.

The vision within the report, as explained by Ms Scott, proposes service change which would integrate scanning into the midwife role, aiming to 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 a currently fragile system.

Mrs. Daniel emphasised the importance of effective communication with service users, particularly if demand and capacity challenges affect where pre-natal care is delivered. Mrs. Daniel questioned whether there is a wider piece of work to be considered by Public Health on the rationale for the increase in complexities for pre-natal care. Ms. Scott responded that factors including diet, lifestyle and age contribute to this trend.

BL

Providing an update on the recently HIW published report relating to the unannounced visit to Glangwili Hospital's maternity ward, Mrs. Daniel confirmed that the press release has been issued and noted that whilst there are recommendations to be addressed, the overall findings in the report are very positive. Mrs Daniel expressed thanks to Ms. Scott and colleagues for their continued dedication and hard work in driving improvements. She also reminded the Committee of the All Wales Maternity and Neonatal (Mat Neo) Review which will take place in due course.

Mrs. Lewis reflected positively on her visit to the maternity unit, expressing enthusiasm with the team including expert clinicians. She was pleased to note that the findings of the HIW report aligned with her own impressions. In terms of the service model redesign and workforce plan scheduled for Executive approval in March 2026, Mrs. Lewis asked timelines for Board approval are factored in.

Decision: The Committee received assurance from the review and progress to mitigate the challenges in the Obstetric Ultrasound Service (Risk 797), supported the internal review process within Radiology and supported the strategic workforce plan to train more midwife sonographers.

QSEC 25 (45) Quality Assurance Report

Ms. Caroline Burgin presented the Quality Assurance Report, drawing attention to a recent positive development following concerns previously raised at the Committee relating to an apparent decline in incident reporting. She noted that there has been a recent encouraging upward trend, which serves as an early indicator of progress. The Quality Assurance Team continue to actively promote the significance of incident reporting with staff.

Mrs. Patel queried the varied feedback from ethnic groups highlighted within the patient experience demographic slides and wondered whether this is being explored further to understand the differences from the other groups. In response, Mrs. Louise O'Connor advised that they are at the start of this analytical process and currently embedding the new systems to receive patient feedback via the survey according to demographics; therefore data is limited at the moment in terms of quality feedback to support the information presented. As the survey expands this will allow a deeper analysis which can be presented to a future meeting. Mrs. Lewis noted that it would be beneficial for the Committee to receive once the data becomes available. **LOC**

Ms. Eleanor Mark highlighted the significant learning identified from the 240 incidents closed where Duty of Candor has been triggered and queried how the learning is being implemented across the organisation. In response, Ms Burgin explained that incident outcomes are fed back through team meetings and disseminated across the organisation through the QAST Team.

Additionally a learning library has been established via SharePoint for cross organisation learning. Mrs. Lewis suggested forward planning an update on the impact of the Learning Framework that has been developed. Mrs Patel commented it will be helpful during this update to provide clarity on how these learning opportunities are shared with the Education Team, highlighting that while lessons learned are discussed regularly within the report, there is a lack of clarity on the mechanisms for sharing the learning for quality improvements. **LOC**

In response to Mrs. Patels' query regarding the link with education, Ms. Steele advised that she is a member of a multidisciplinary education group which reviews learning from incidents and other themes to develop action plans. The consideration of themes has recently progressed with support from artificial intelligence (AI) function. Newsletters are also being developed and shared via the CCG's. This process also improves the link with the Enabling Quality Improvement in Practice (EQIiP) programme to target specific areas. Mrs. O'Connor added that the membership of the Listening and Learning Sub Committee is in the process of being updated to include Workforce and Education colleagues to ensure learning is shared across the organisation.

Highlighting an increase in pressure damage incidents reported during inpatient care, which indicates a shift from previous trends, Miss. Paterson enquired whether the underlying causes, such as training gaps or staff turnover, are understood and whether this is being investigated. In response, Ms. Steele clarified that reporting pressure damage present on admission has remained consistent particularly for patients admitted from a care home or a nursing home. Whilst these incidents occur outside of healthcare settings, it is important to report them to ensure ongoing monitoring and safeguarding referrals where necessary.

The Committee requested a further investigation into the increase in pressure damage in hospital settings and the agreed that the findings would be included in the Quality Assurance Report at the October meeting. **CS**

Drawing attention to the Speaking up Safely slides, and noting that a more detailed discussion from a staff perspective will take place at the forthcoming People, Organisational Development and Culture Committee, Mrs. Lewis reflected upon the narrative within the report expressing concern that it appeared overly optimistic in comparison to the data presented which indicates modest improvements. Mrs. Lewis suggested that going forward a trend analysis is included to indicate the difference the Speaking up Safely agenda is making across the organisation. **RB/CS**

In terms of national benchmarking, Mrs Lewis commented this exercise holds limited value unless it is undertaken against consistently high standards of performance, which she noted are not currently being met on a national level. In agreement, Ms Marks expressed encouragement regarding the

work being undertaken, although shared concern about the current Health Board position within this area.

On the same matter, Mrs Patel expressed concern about a disconnect between what is being presented to Committee and the realities at ward level, sharing feedback from a recent medical conference whereby some doctors indicated that they were unaware of the Speaking up Safely agenda. Additionally, Mrs Patel noted a lack of clarity around how this work aligned with the education framework, highlighting that the link with education is not evident within a number of reports presented today.

RB

Acknowledging the feedback, Mrs Daniel proposed a follow-up discussion with the reporting team to review the narrative in the report and ensure that the statistical significance of the data is reported in an objective and balanced manner.

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

QSEC 25 (46) Duty of Quality Annual Report 2024/25

Ms. Caroline Burgin presented the Duty of Quality Annual Report and informed the Committee that stories continue to be collated. Thanking Ms Cathie Steele for preparing the report, Mrs Lewis highlighted the omission of 'Efficient' for the STEEEP acronym within the report.

CS

Decision: The Committee received the Duty of Quality Annual Report 2024/25 Report and supported the proposed next steps.

QSEC 25 (47) Quality, Safety and Experience Sub Committee (QSESC) and Terms of Reference for Annual Review

Mr Mark Henwood shared the QSESC update report and advised that the terms of reference would no longer require ratification as the proposals to dis-establish the Sub Committee had been approved by the Committee.

Decision: The Committee noted the Quality, Safety and Experience Sub Committee Update Report.

QSEC 25 (48) Listening and Learning Sub Committee Update Report

Mr Mark Henwood provided the key highlights from the Listening and Learning Sub Committee report, which took place on 11 August 2025, and apologised to the Committee for the late circulation of the paper. The meeting focused on the theme of communication, encompassing patient experience, complaints, Ombudsman cases, incidents, redress cases, and inquests. Communication has been issued following a recurrent concern across different feedback mechanisms. The Board recognised this trend and had tasked both the Listening and Learning Sub-Committee and the Quality, Safety and Experience Committee with analysing the underlying themes to inform targeted

improvement initiatives aimed at enhancing communication, care quality, and patient experience. Mr Henwood recognised that this is a significant piece of work that will require embedding across the system. He emphasised the need for careful planning in determining the membership of the working group that will take this initiative forward.

Mr Henwood highlighted the need for improved resources and training for staff to support education and motivate better patient care. He also referred to ongoing concerns raised by patients regarding multiple points of contact and inconsistencies in correspondence, identifying this as an area which requires focus.

The Committee received a request to extend Guideline 568 until 31 October 2025, following update made to align the guidance with revised national requirements. The extension was approved.

Decision: The Committee noted the contents of Listening and Learning Sub Committee Update Report and approved the extension of Guideline 568 until 31 October 2025

QSEC 25 (49) Epilepsy Service in Mental Health and Learning Disabilities

Mrs. Olwen Morgan presented an update on the actions and recommendations arising from the 2023 external review of epilepsy services for individuals with learning disabilities. She also gave a brief overview of the role of the Task and Finish Group that has been established to address the ongoing challenges and co-produce a revised patient pathway. The work will be progressed at pace to improve access to services for patients.

Members noted that most actions from the external review have been completed, including recruitment into clinical posts. Mrs. Morgan highlighted that the main challenge for this service is timely patient access to Neurology Services, with the consultant commissioned via Swansea Bay University Health Board (SBUHB). Mr. Carruthers noted the existing national challenges affecting the epilepsy service pathway and confirmed that SBUHB currently lacks capacity to provide additional support in this service.

Mrs. Lewis stressed the importance of ensuring that individuals with a learning disability are not disadvantaged in accessing physical health services, noting that this may require the Health Board to implement reasonable adjustments. She also highlighting that the Committee have been discussing these concerns for over two years, and queried whether more could be done to accelerate progress. In response, Mrs. Morgan provided assurance that the Task and Finish Group are working at pace to address the challenges and confirmed that delays will be escalated promptly for resolution.

Members were pleased to note the co-production is taking place with service users and families and that the Clinical Executives met with families of those affected periodically to provide updates on progress.

Thanking Mrs. Morgan and Ms. Carroll for the update, Mrs. Lewis suggested this is reported to Board as an 'assure' item and the Committee will track progress in due course.

Decision: The Committee received assurance from the plan to review and improve the pathway for individuals with Learning Disabilities and Epilepsy.

QSEC 25 (50) Women's Health

Ms Dana Scott presented an update on the plan to implement the Women's Health Hub (WHH) in line with the national plan by 31 March 2026. Ms Scott shared an overview of staff feedback and data from referrals and discharges to ascertain what is needed, including the need to upskill staff educationally within a number of areas.

Members noted that Health Education and Improvement Wales (HEIW) is developing a women's health specific training package. A clinical lead has been appointed and co-production arrangements are in place. The proposed model involves county-based primary care led hubs supported by a travelling practitioner with extended roles, delivering weekly clinics in local surgeries equipped for gynecological assessments. These clinics will be led by General Practitioner (GP) with oversight from Secondary Care Consultant to provide clinical support, upskilling and training of primary care teams. Business cases are currently being developed in line with the final funding cycle, with a submission deadline of 29 August 2025.

Mrs. Lewis welcomed the progress being made and on behalf of the Committee looked forward to reviewing the impact of the WHH on quality, safety and patient experience for the Hywel Dda population.

Ms. Marks was fully supportive of the developments and queried how guidance will be disseminated to patients on whether to access GP or WHH, noting that this will increase complexity for the different pathways. Ms Scott provided assurance that the website and sign posting will be key to this and highlighted that women will be able to self-refer to the WHH. Mr. Carruthers added that the NHS App will be a useful tool to support patients in self-referring.

Ms Paterson welcomed the opportunity to work with Ms Scott to strengthen engagement with Primary Care and to ensure there are no gaps in the services when the changes are implemented.

Decision: The Committee received assurance from the progress to implement a Women's Health Hub in line with the NHS Wales Women's Health Plan by 31 March 2026.

QSEC 25 (51) Section 136 Suite- Mental Health and Learning Disabilities

Ms Kay Isaacs presented the key points on the proposals to centralise the Section 136 Place of Safety suite to Carmarthen, which will be presented to Board for approval in due course.

Ms Isaacs provided the background to Section 136 of the Mental Health Act (1983), which applies to individuals experiencing a mental health crisis who need to be transported to a safe place for assessment. She noted that the Health Board has historically, experienced ongoing challenges in resourcing this provision consistently across each county. A working group, including representatives from Health, Local Authority and Dyfed Powys Police has conducted an options appraisal and recommended the centralisation of the service to Carmarthen. A Quality Impact Assessment has been undertaken and approved by the Executive Team.

Ms Marks believed that Carmarthen would be the most appropriate place due to its central location across the Health Board. Mrs Lewis was pleased to note that the place of safety will be hospital based.

Decision: The Committee received assurance that due process has been followed in collaboration with key stakeholders for the centralised relocation of the S136 place of safety to Carmarthen, Carmarthenshire.

QSEC 25 (52) Policy for Approval: 1133 Service User Access Policy Psychological Therapies

A request for the extension to review the Service User Access Policy for six months was presented for approval.

Decision: The Committee approved an extension of the review of the current Access to Psychological Therapies (1133) policy by a further 6 months (to March 2026)

QSEC 25 (53) For Information

- JCC Quality, Safety and Outcomes Sub-Committee Highlight Report
- Patient Experience Report
- Work Plan 2025/26

- Date of Next Meeting : 9:30am 2pm 15 September 2025

1.3

1.3 - Targeted Intervention Progress Report

Attachments

1.3 De-escalation Criteria Progress Update October 25 V2.pdf



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Quality, Safety and Experience Committee
Escalation De-escalation Criteria Progress Update
09 October 2025

Introduction

Reference	Criterion	Description	Status	Lead Executive
TI-2025/547/MD1/3	9	Evidence that the health board has the appropriate mechanism to understand the drivers behind a fragile service through triangulation of key data points	Advise	Mr Lee Davies
TI-2025/547/MD2/1	10	Fragile services are supported by strong clinical leadership, have an effective integrated improvement plan, project management structure and effective transformation support	Advise	Ms Sharon Daniel
TI-2025/547/MD3/1	12	Evidence that all recommendations from Royal Colleges, HIW and other reviews are discharged and either verified or delivered or scheduled for delivery	Advise	Ms Sharon Daniel
TI-2025/547/MD4/1	13	Evidence that the Board is sighted on fragile services and has a robust response to these issues	Advise	Mr Lee Davies
TI-2025/547/MD5/3	19	Assessment of health board response and handling of concerns, complaints, incidents and patient experience feedback related to UEC	Advise	Ms Sharon Daniel
TI-2025/547/MD6/1	22	C. difficile: reduce hospital onset infections by 25% and maintain for 3 months (target: ≤6 per month)	Advise	Ms Sharon Daniel
TI-2025/547/MD7/1	23	S. aureus: reduce hospital onset infections by 33% and maintain for 3 months (target: ≤2 per month)	Alert	Ms Sharon Daniel
TI-2025/547/MD8/1	24	E. coli: reduce hospital onset infections by 25% and maintain for 3 months (target: ≤5 per month)	Alert	Ms Sharon Daniel
TI-2025/547/MD9/1	25	Addressing the root cause of HCAIs and having effective response mechanisms	Alert	Ms Sharon Daniel
TI-2025/547/MD10/1	N/A	Planned care: concerns, complaints, incidents and patient feedback	Advise	Ms Sharon Daniel

- **Scope and sources** - This update covers performance to August 2025 drawing on the Quality & Safety Assurance Report, Infection Prevention & Control (IP&C) dashboards, AMaT external-recommendations tracker, and complaints/incidents dashboards. Where relevant, targets require three consecutive months at/under threshold to evidence sustainability.

- **How classifications are applied** - Advise is used where core controls and improvement actions are in place and there is evidence of progress, but sustained delivery against the defined threshold is not yet demonstrated; Alert where material risk persists and/or performance is deteriorating against the threshold. (Applied across HCAI targets and experience measures in this report.)

- **Data presentation** - The Committee should note minor presentational nuances between Improving Together and Beacon dashboards (e.g., calendar vs working days) when interpreting trends.

Introduction

Focus of Today's Update

This report focuses on providing the Committee with a comprehensive overview of progress across all 10 criteria. We have prioritised detailed reporting on:

- **Healthcare-associated infections** - where quantitative targets provide clear metrics for measuring sustained improvement over the required three-month periods
- **Management of concerns, complaints and incidents** - where timeliness of response and resolution directly impacts patient experience
- **External regulatory compliance** - where demonstrating systematic closure of recommendations evidences our quality assurance processes

These areas have been selected because they represent key measurable indicators of our quality and safety systems, allow the Committee to assess both current performance and sustainability of improvements, and demonstrate our responsiveness to external scrutiny and internal learning.

TI-2025/547/MD3/1 – Discharging external recommendations

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

TI-2025/547/MD3/1 – Discharging External Recommendations
Lead Executive - Ms Sharon Daniel

Issue
Royal College reviews, Healthcare Inspectorate Wales (HIW) inspections and other external reviews have generated multiple recommendations that need to be closed or planned into the Health Board's longer-term improvement programme.

Current Status
The Health Board has established comprehensive tracking systems through the Audit Management and Tracking system (AMaT), which provides direct access for leads to update progress and upload evidence. During the reporting period 22nd August 2025 to 30th September 2025, the Health Board received five inspections - Maternity Glangwili (13th-14th May), WGH Radiology Nuclear Medicine (17th-18th June), EUCC Bronglais (28th July), Mynnyd Mawr at Prince Philip Hospital (5th August) and Derwyn ward at Glangwili (2nd September). Feedback has been generally positive, though EUCC, Mynnyd Mawr and Derwyn ward raised immediate actions which have been addressed within the timeline provided. The Maternity Glangwili report was published on 14th August 2025 and the WGH Radiology Nuclear Medicine report on 18th September 2025. Draft reports are awaited for EUCC Bronglais, Mynnyd Mawr and Derwyn ward.

The Health Board has maintained enhanced dialogue with HIW following the May 2025 correspondence regarding collective concerns about quality governance arrangements. Between 20th May and 12th September 2025, the Health Board received 17 letters from HIW requesting assurance on matters including paediatric medical workforce, mental health provision (North Ceredigion and Bro Cerwyn), radiology staffing concerns, ward assurance issues, and service user concerns. All responses have been provided within the requested timescales, with multiple touchpoints maintained throughout the period.

TI-2025/547/MD3/1 – Discharging external recommendations

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Rationale – Advise

- **Controls and system in place -** AMaT provides a live register for recommendations with evidence upload and lead access, underpinning systematic tracking and closure.

- **Regulatory throughput and responsiveness** - Five inspections in-period (Maternity GGH; WGH Radiology Nuclear Medicine; EUCC Bronglais; Mynnyd Mawr PPH; Derwyn Ward GGH) with immediate actions raised at three sites and addressed within the required timelines; 17 HIW assurance letters responded to within timescales, demonstrating timely engagement.

- **Direction of travel on external actions** - Overdue HIW actions reduced 57% (51→22) and actions in progress reduced 79% (119→25), evidencing traction in closure.

- **Why not "Assure" yet** - Draft reports remain outstanding for several inspections; while immediate actions have been completed, the Health Board must evidence verified closure of all recommendations (within the agreed timescales) and benefits realisation across services to demonstrate sustained compliance. However, there has clearly been a significant level of progress within the criterion

TI-2025/547/MD5/3 – Handling Unscheduled Emergency Care (UEC) concerns, complaints and incidents

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TI-2025/547/MD5/3 – Handling UEC concerns, complaints and incidents
Lead executive - Ms Sharon Daniel

Issue

Urgent and Emergency Care (UEC) remains a high risk on the corporate risk register, and the Health Board must demonstrate that it responds effectively to incidents, complaints and concerns.

Current Status

Incidents - Analysis of the **Our Performance Dashboard** for the Community and Integrated Medicine function (August 2025 data) reveals -

- Open incidents - 1,059 incidents remain open for over 120 days; 1,495 incidents have been open for over 60 days
- Incident trends - Reported incidents by month have stabilised between 120-200 since 2023, demonstrating consistent reporting patterns
- Closure rates - Almost all directorates now close over 94% of incidents, showing improved incident management processes
- Longest open incidents - Several incidents remain open for over 600 days (HDD7679 at 1,444 days, HDD14727 at 1,299 days, HDD19101 at 1,208 days), indicating significant delays in investigation and learning
- Top incident categories - Pressure damage/moisture damage (767 cases), accident/injury (527 cases), and medication/IV fluids (258 cases) represent the most common incident types

TI-2025/547/MD5/3 – Handling UEC concerns, complaints and incidents

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Complaints

The complaints dashboard shows -

- 30-day performance - Only 40.55% of complaints have been resolved within 30 days for the Community and Integrated Medicine function
- Open complaints - The longest open complaint has been outstanding for 681 days
- Volume trends - New complaints fluctuate between 40-80 per month, with ongoing challenges in timely resolution

Healthcare Inspectorate Wales (HIW) Progress

- Monthly meetings with HIW now established
- Overdue HIW actions reduced from 51 (February 2024) to 22 (August 2025) – a 57% reduction
- Actions in progress reduced from 119 to 25 – a 79% reduction

Rationale - Advise

Timely closure of incidents is improving, with over 94% closure rates across most directorates demonstrating that effective processes are in place. The significant reduction in overdue HIW actions (57%) and actions in progress (79%) demonstrates sustained focus on regulatory compliance.

However, the following concerns remain:

- Volume of aged incidents - 1,059 incidents open over 120 days suggests learning from events is not consistently timely
- Very long-standing incidents - Cases open for 1,200+ days indicate systematic investigation delays
- Poor complaint performance - Only 40.55% resolution within 30 days (against a 75% target) demonstrates ineffective complaint management
- Longest open complaint - 681 days significantly exceeds a[33]meframes

TI-2025/547/MD6/1 – Reducing Clostridioides difficile infections

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TI-2025/547/MD6/1 – Reducing Clostridioides difficile infections
Lead executive - Ms Sharon Daniel

Issue - The TI de-escalation criterion requires a 25% reduction from the Q3 2023 baseline of eight C. difficile cases with hospital onset to a maximum of six cases per month, sustained for three months.

Current status - Between April and August 2025, the Health Board reported monthly hospital-onset C. difficile counts of 8, 8, 11, 7 and 4 cases respectively. August 2025 achieved 4 cases, meeting the target threshold for the first time in the reporting period and representing a significant reduction from both the July figure of 7 cases and the June peak of 11 cases. The infection prevention report states there were 31 hospital-onset cases and 30 community-onset cases during the period from 1 April to 31 July 2025. During the April to July period, four patients had two positive samples and one patient had three positive samples. These patients will be reviewed for suitability for Faecal Microbiota Transplantation (FMT). Carmarthenshire accounted for 22 hospital-onset cases between April and August 2025. The C. difficile Infection (CDI) Improvement Group has discussed the C. difficile collaborative, and many staff have taken part in interviews and focus groups relating to potential projects. HPV enhanced cleaning is now available at three acute sites. Mandatory Level 2 training stands at 75.56%. No new outbreaks have been reported since the last update.

Rationale - Advise - August 2025 represents a positive development with 4 cases, the lowest monthly count in the reporting period and below the target threshold of six cases. However, the de-escalation criterion requires this level of performance to be sustained for three consecutive months, which has not yet been achieved. The June figure of 11 cases represents the highest monthly count in the reporting period. Continued focus on the improvement initiatives currently underway will be essential to demonstrate sustained performance at or below the target threshold

TI-2025/547/MD7/1 – Reducing Staphylococcus aureus bacteraemia

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TI-2025/547/MD7/1 – Reducing Staphylococcus aureus bacteraemia
Lead executive - Ms Sharon Daniel

Issue -The target is a 33% reduction in hospital-onset Staphylococcus aureus bacteraemia from a baseline of three cases per month to no more than two cases per month, sustained for three months.

Current Status - Between April and August 2025, the Health Board reported monthly hospital-onset S. aureus cases of 3, 3, 3, 4 and 5 respectively. The Quality and Safety Assurance Report states that during April to August 2025, 53 patients were diagnosed with S. aureus bacteraemia across the region, of whom 18 were hospital-onset. The IP&C section notes that "MRSA rates in August increased" and that "early cases review indicates that these cases are linked to cannulas/invasive devices." Most sources related to wounds, musculoskeletal sites or lines/devices, with some sources still to be confirmed following further review. Antiseptic Non-Touch Technique (ANTT) compliance is 82.58% for critical care and other inpatient areas seeking accreditation. ANTT is to be made mandatory on ESR for the Health Board. Hand hygiene audits encompassing bare below the elbow are profiled, with validation audits conducted as indicated. Ward manager and senior nurse hand hygiene audits are now on AMaT and monitored. Line-care audits are ongoing.

Rationale - Alert - The target of two cases per month has not been achieved in any month during the April to August 2025 period. Cases increased from 3 in June to 4 in July and 5 in August, representing an upward trajectory (albeit marginal). MRSA rates in August increased with early case reviews linking infections to cannulas and invasive devices; potential improvement through enhanced device care and ANTT compliance.

TI-2025/547/MD8/1 – Reducing Escherichia coli bacteraemia

TI-2025/547/MD8/1 – Reducing Escherichia coli bacteraemia
Lead executive - Ms Sharon Daniel

Issue - A 25% reduction from the baseline of 6.7 cases per month means hospital-onset E. coli bacteraemia should not exceed five cases per month, sustained for three months.

Current status - Between April and August 2025, the Health Board reported monthly hospital-onset E. coli cases of 6, 5, 7, 10 and 6 respectively. May 2025 achieved the target of five cases per month. August showed improvement, reducing from the July peak of 10 cases to 6 cases. The Quality and Safety Assurance Report states that during April to August 2025, 150 patients were diagnosed with E. coli bacteraemia across the region, of whom 35 were hospital-onset whilst 115 were community-onset. The IP&C section notes that "E. coli bacteraemia rates remain high" and that urinary tract infections were the predominant source, followed by biliary tract infections and catheter-associated urinary tract infection (CAUTI). Age-profile analysis shows the burden falls predominantly in the 80-89 age bracket. Aseptic Non-Touch Technique (ANTT) compliance stands at 82.58%. Hand hygiene audits encompassing bare below the elbow are profiled, with validation audits conducted as indicated. Ward manager and senior nurse hand hygiene audits are now on Audit and Management Tracking System (AMaT) and monitored. The burden for both E. coli and S. aureus infections remains in the community, with proactive prevention work ongoing with public health.

Rationale - Alert - The quality report explicitly states that "E. coli bacteraemia rates remain high." Whilst May 2025 achieved the target threshold of five cases and August demonstrated improvement from the July peak, sustained performance at or below target has not been achieved. The target requires five or fewer cases sustained for three consecutive months. The July figure of 10 cases represents the highest monthly count in the reporting period, though the subsequent reduction to 6 cases in August indicates an improvement.

TI-2025/547/MD9/1 – Addressing root causes of HCAIs

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TI-2025/547/MD9/1 – Addressing root causes of HCAIs
Lead executive - Ms Sharon Daniel

Issue - Beyond meeting numerical targets, the Health Board must demonstrate that it understands and addresses the underlying drivers of hospital-acquired infections (HCAIs).

Current status - The Infection Prevention Strategic Steering Group (IPSSG) oversees a comprehensive programme. Quality-planning measures include an annual IP&C work plan, compliance with Welsh Health Circulars on antimicrobial resistance and HCAI improvement and working with public health and community services to prevent infection in high-risk populations and community settings. Quality-control efforts involve standardising assurance and scrutiny meetings across clinical care groups, reviewing Health Board IPC policies, self-assessment against the C. difficile Framework for Wales and attendance at the Wales C. difficile Focus Forum Meeting. Quality-improvement activities include assurance and scrutiny meetings where all hospital-onset HCAIs are discussed with learning obtained and action plans implemented, with themes derived and a move to learning panels; working with managed practices presenting infographics for infections, sources and learning; environmental audit programme and observational audits programme in place with improvement action plans produced; HPV in use in three acute sites; HCID/infectious disease pathway training completed for GGH and BGH with dates in September and October for PPH and WGH; and engagement in the National C. difficile Learning Collaborative. Mandatory Level 2 training stands at 75.56%. ANTT compliance is 82.58%. HPV enhanced cleaning is now available at three acute sites. IPC environmental audits focus on very high-risk and high-risk areas, with theatres, ITUs, maternity and oncology completed. HCAI and IP&C are included within all CCG Escalation Improving Together Sessions. The IP&C section states "There is a mixed trend for HDUHB, with some infections improving and others being more challenging." August 2025 showed significant improvement for C. difficile (4 cases, the lowest in the reporting period) and improvement for E. coli (reducing from 10 to 6 cases), though S. aureus cases increased from 4 to 5.

TI-2025/547/MD9/1 – Addressing root causes of HCAIs

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Rationale - Alert - the Quality and Safety Assurance Report explicitly states that "E. coli bacteraemia rates remain high" and that "MRSA rates in August increased." The IP&C section notes "There is a mixed trend for HDUHB, with some infections improving and others being more challenging." Whilst August demonstrated significant improvement for C. difficile (achieving the lowest count in the reporting period at 4 cases) and improvement for E. coli following the July peak, sustained performance below target thresholds has not been achieved for any of the three organisms. S. aureus showed an upward trajectory during the period. The comprehensive quality improvement infrastructure is in place, and the marked month-on-month improvements in August for C. difficile indicate that improvement activities are having impact, though this requires consolidation and sustained delivery across all three organisms.

TI-2025/547/MD10/1 – Planned care - concerns, complaints, incidents and patient feedback

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TI-2025/547/MD10/1 – Planned care - concerns, complaints, incidents and patient feedback
Lead executive - Ms Sharon Daniel

Issue - Planned care services, including outpatient clinics and theatres, must manage incidents and complaints effectively whilst implementing recovery plans for lengthy waiting lists.

Current status - Quality dashboards for planned and specialist care show that incidents by month have fluctuated between 120 and 200 since 2023. Top open-incident categories include maternity adverse occurrences (147 cases), assessment/diagnosis (145) and access/admission issues (114). The longest open incidents have been outstanding for over 600–900 days, indicating delays in closure. Complaint dashboards reveal that new complaints received each month oscillate between 60 and 100, with peaks in June and October 2024. Ophthalmology, orthopaedics and gynaecology carry the highest numbers of open complaints, and some cases have been open for more than 350 days. Improvement actions taken during 2025 include insourcing and training posts for ultrasound, investment to support ophthalmology recovery, and planned replacement of ageing radiology equipment and a new aseptic unit to open in February 2026. On the positive side, there have been zero cataract pathway breaches since Q1 2025, diagnostic waits have reduced by 18% and Single Cancer Pathway performance has improved above 60%. However, only 38.15% of complaints in 2025/26 were closed within 30 days, demonstrating slow complaint resolution.

Rationale: Advise - recovery plans are delivering improvements in waiting times and diagnostic performance (which is a theme within complaints and patient feedback), but the volume and duration of open incidents and complaints highlight weaknesses in implementation of the agreed management process and patient-experience management. Strengthening complaint-handling processes, improving communication with patients and increasing timely investigation of incidents should be priorities before assurance can be given.

Conclusion

NOTE:

- Significant progress in regulatory compliance with overdue HIW actions reduced by 57% (51 to 22) and actions in progress reduced by 79% (119 to 25), with all responses to 17 HIW assurance requests provided within timescales

- C. difficile achieved 4 cases in August 2025 - the lowest monthly count in the reporting period and first achievement below the target threshold of 6 cases

- Comprehensive governance infrastructure now established including AMaT tracking system, Infection Prevention Strategic Steering Group, and standardised Clinical Care Group assurance meetings

- The Health Board is using Improving Together dashboards for reporting, and whilst data aligns with Beacon Dashboard, there can be nuances in data presentation between the two systems (calendar days vs working days)

RECOGNISE:

- No infection target has achieved the required sustained performance of three consecutive months at or below threshold, with S. aureus showing deteriorating performance (3 – 4 - 5 cases) and E. coli remaining volatile with rates described as "remaining high“

- Unscheduled care complaint resolution at 40.55% and planned care at 38.15% fall significantly short of the 75% target, with the longest open complaint at 681 days

Conclusion

- In unscheduled care (Community and Integrated Medicine function), 1,059 incidents remain open over 120 days with several exceeding 600 days (longest at 1,444 days), indicating systematic delays in learning from incidents

- Planned care also shows longest open incidents at 600-900 days

ACKNOWLEDGE:

- The Health Board has built the foundational infrastructure and improvement programmes required for sustained improvement, with early indicators (particularly August C. difficile performance) suggesting interventions are beginning to have impact

- The critical challenge is now translating this infrastructure into consistent, sustained performance over the required timeframes for de-escalation

- Almost all directorates now close over 94% of incidents, demonstrating that effective processes are in place, though aged incidents require accelerated resolution



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1.4

1.4 - Assurance and Risk Report- Executive Leads

- Corporate Risks
- Operational Risks
- Internal and External Audit Reports
- Monitoring of Ministerial Directions
- Monitoring of Welsh Health Circulars (WHCs)

Attachments

QSEC PRR ORR AI Report - Oct 2025 FINAL cleanv3.pdf

Appendix 1 - Principal Risks.pdf



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Assurance and Risk Report

Quality, Safety & Experience Committee – 9 October 2025

Situation

This report provides the Quality, Safety & Experience Committee (QSEC) with the status of the Principal risks, Operational Risks, and Audit and Inspections recommendations within its remit (the latter being the first time the items are being presented to the Committee).

The Committee is asked to seek assurance from the Lead Executive Directors that risks are being managed effectively, and that recommendations from Audits and Inspections are being implemented by the Health Board.

Corporate risks, Welsh Health Circulars and Ministerial Directions are reported at alternate meetings, and due to be presented to QSEC at its next meeting in December 2025.

Principal Risks:
4

Operational Risks
389

Audit and Inspection Reports
27

Risk Management - Overview

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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.

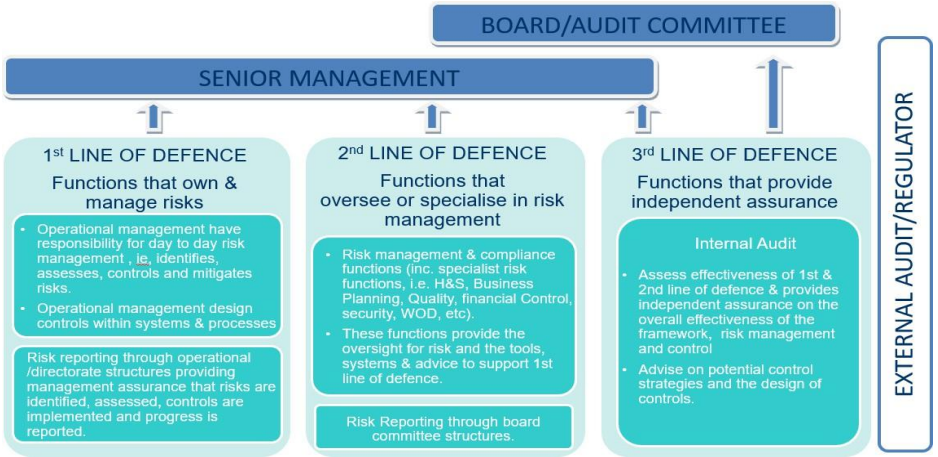
The Health Board operates within the widely accepted "Three Lines of Defence" model to ensure the appropriate responsibility is allocate for the management, reporting and escalation of risk.

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 (eg 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.

A revised approach to risk tolerance was agreed by the Board at its meeting in March 2025 to reflect the organisation's readiness to bear the risk after risk treatment, in order to achieve its objectives. Risk leads are required to provide a rationale for the target risk score (TRS), and an expected date when the TRS will be achieved. These are mandatory fields on Datix as of 1 July 2025, and therefore where risks do not currently have this detail, risk leads will be asked to provide by the next report to QSEC.



Principal Risks assigned to QSEC

HYWEL DDA RISK HEAT MAP					
	LIKELIHOOD →				
IMPACT ↓	RARE 1	UNLIKELY 2	POSSIBLE 3	LIKELY 4	ALMOST CERTAIN 5
CATASTROPHIC 5					
MAJOR 4		1184	1191		
MODERATE 3			1195, 1189		
MINOR 2					
NEGLIGIBLE 1					

Each risk on the Principal Risk Register (PRR) has been mapped to a Board level Committee to ensure that risks on the PRR 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.

Principal risks have been identified by the Executive Team via a top down and bottom-up approach and are associated with the delivery of the Health Board's strategic (long-term) objectives.

There are 4 risks currently aligned to QSEC (out of the 15 that are on the PRR as of 8 September 2025).

The following slides provides a summary of the reportable principal risks aligned to QSEC. The PRR 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, and sources of assurance.

Principal risks will be reviewed as part of the strategy refresh that is currently underway.

Principal Risks assigned to QSEC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
1191 - Underestimation of excellence	Medical Director	**12 → (Reviewed 09/09/25)**	**6**	To be reviewed as part of the strategy refresh

Rationale for Current Risk Score

The risk score has remained at 12 since May 2024 when it was reduced to reflect achievements made in Value Based Healthcare, Research and Innovation and Clinical Effectiveness. Further work proposed around job planning to enable protected Supporting Professional Activities (SPA) time for medics and a multi-professional workshop was established in October 2024 to strengthen continuous improvement, talent management and progression of clinical teams across the Health Board.

Rationale for Target Risk Score (TRS)

A review of clinical leadership at all levels/capacity and capability/multi-professional working/empowerment of more junior staff identifying change champions and empower local leadership models will be completed as part of the Health Board's response to Targeted Intervention and will facilitate the Health Board to develop and deliver excellent services.

Risk Reference & Title	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
1195 - Comprehensive early indicators of shortfalls in safety	Director of Nursing, Quality and Patient Experience	**9 → (Reviewed 01/10/25)**	**6**	To be reviewed as part of the strategy refresh

Rationale for Current Risk Score

Systems are not yet established to enable easy triangulation of data and there are still some gaps in information collection. Since 1 April 2023, the introduction of the Quality and Engagement Act has refreshed the focus on quality and safety through the 6 domains and internal metrics developments. These developments have facilitated discussions at the appropriate forums such as Board, Committees and local governance arrangements. There has been improvement in interrogation and reporting of data within RL Datix Incident Reporting system.

Rationale for Target Risk Score

The target risk score is based on implementing a system to enable the capture of data across the breadth of our services with timely escalation reporting arrangements in place.

Principal Risks assigned to QSEC (continued)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
1189 - Timely and sufficient learning, innovation and improvement	Director of Nursing, Quality and Patient Experience	**6 ↓ (Reviewed 01/10/25)**	**3**	To be reviewed as part of the strategy refresh

Rationale for Current Risk Score

The current risk score reflects the fact that the organisation has existing processes in place to value and embed learning and improvement but that it is not comprehensive. This means we may miss opportunities to enhance the care we provide and create a supportive environment for staff to develop and grow. There is increasing evidence that the mindset of the organisation is focussed on learning, the skillset is developing quickly, particularly in areas such as EQIiP, Improving Together and Research, Innovation and Development, however further work is required to strengthen our toolset. Operational pressures are also likely to be causing challenges for people to enact change or improvement in their areas however Improving Together sessions with Directorates have facilitated and helped to embed learning and improvement. The new internal

Escalation Framework is helping to improve learning and drive improvements in areas where performance issues are identified. There has been progress in more timely responses to ability to address our audit, inspectorate and regulatory requirements at pace, through CCG ownership and use of AMAT. The new Health and care quality standards have been embedded within reporting requirements and quality impact assessment. The use of the IPAR, Our Performance, Our Safety dashboard has improved the way data is used at operational and strategic levels. Data is available.

Rationale for Target Risk Score (TRS)

3 of our 4 strategic objectives are people-focussed and are aimed at making the Health Board a great place to work and receive care. The Board will be focussing on this for the long term which would result in an organisation which has learning, innovation and improvement threaded through everything it does.

The risk has been reviewed by the Executive Director of Nursing and Interim Assistant Director of Nursing for Assurance and Safeguarding in October 2025. Target likelihood reviewed. The risk needs a full review and consideration of whether the risk remains and what new mitigations are in place.

Principal Risks assigned to QSEC (continued)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
1184 – Measuring how we improve patient and workforce experience	Director of Nursing, Quality and Patient Experience	**6 ↓ (Reviewed 01/10/25)**	4	To be reviewed as part of the strategy refresh

Rationale for Current Risk Score

The current risk score reflects the current maturity level of formal mechanisms to triangulate different sources of engagement and feedback from public, patients and staff across Hywel Dda. The information being used in Improving Together, Escalation and QSIG sessions/meetings which requires further development of dashboards requires further embedding, however this is facilitating a conversation regarding the utilisation of various metrics better. Value opportunities framework is embedded with EQIIP, and embedded into all service change and transformation activity.

Rationale for Target Risk Score (TRS)

Target score is predicated on developing the mechanisms to support the triangulation of various pieces feedback and quality and safety metrics.

Operational Risks assigned to QSEC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Following the dis-establishment of Quality, Safety & Experience Sub Committee (QSESC) agreed by QSEC at its meeting in August 2025), operational risks previously aligned to the sub-committee have been realigned for reporting to QSEC. Of the 389 operational risks aligned to QSEC, 338 have been identified as reportable based on the following criteria:

- QSEC has been selected by the risk lead as the 'Assuring Committee' on Datix;
- Risks have been identified at operational level on Datix risk module;
- The current risk score is 'extreme' or 'high'; and
- The current risk score is either equal to or exceeds the target risk score.

Following identification and assessment of risks, all operational risks are aligned to a specific Health Board committee or sub-committee. 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. Operational risks must be managed within Clinical Care Groups and Executive Functions (collectively referred to as Functions) under the ownership and leadership of individual Executive Directors, who must establish local arrangements for the review of their Risk Registers, which includes the validation of the information and risk scores, and the prioritisation and identification of solutions to their risks. Each Clinical Care Group Integrated Goverance Group (CCG IGG) is provided with an Assurance and Risk Report, with any issues escalated to the Integrated Quality, Finance and Performance Delivery Group via the 3As Report following each CCG IGG meeting.

In addition to established local arrangements, Hywel Dda University Health Board has implemented formal monitoring and scrutiny mechanisms to provide assurance to the Board regarding the effective management of risks. A monthly assessment is made for each Clinical Care Group/Executive Function (hereto referred to as Functions) on their risk management which informs their overall level within the 'Governance' domain as part of the Health Board's internal escalation framework. One key metric in the Health Board's internal escalation process under the Governance domain is how Functions are managing risks in terms of the scale, significance, timeliness and quality, with measures extended from April 2025 to inform levels to be awarded. The criteria is noted on the next slide.

The Assurance and Risk Team provide focussed support for those Functions at levels 3 and 4 to aid their de-escalation/recovery, and to prevent those awarded level 2 status being escalated. Detail is provided within each report provided and presented at Function governance meetings the reasons behind their escalation status, and suggested actions in order to de-escalate (where appropriate).

Operational Risks assigned to QSEC

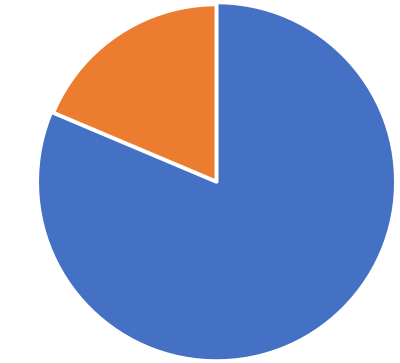
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Measures to assess against the Governance Domain (risks)

Level	Criteria
Level 4 – no assurance and insufficient actions / engagement	No plan in place and no engagement, (eg no risk action plans, no expected date to achieve Target Risk Score). No evidence that risks are escalated via CCG management structures where necessary, no engagement and the ability for leadership to make informed decisions on prioritisation of resources
Level 3 – no assurance	Lack of evidence that risks are being managed and mitigated within expected timescales. Evidence where known risks are not articulated on the function's risk register. **Less than 80% compliance** of risks and risk actions being updated within required timescales Limited evidence that risks are escalated via CCG management structures where necessary, therefore not demonstrating good engagement and the ability for leadership to make informed decisions on prioritisation of resources
Level 2 – Limited assurance	Relevant risks articulated on risk registers with action plans in place, but lack of evidence that risks are being managed and mitigated within expected timescales. *(eg risk action plans not being implemented within original action dates, limited evidence of reduction in current risk score).* **Between 80% - 89% compliance** of risks and risk actions being updated within required timescales Some evidence that risks are escalated via CCG management structures where necessary, demonstrating engagement and the ability for leadership to make informed decisions on prioritisation of resources
Level 1 – Reasonable assurance	Relevant risks articulated on risk registers with action plans in place, and evidence that the function is delivering against these (eg specific and measurable risk action plans, current risk score and target risk score clearly articulated, achieving expected target risk dates) **Over 90% compliance** of risks and risk actions being updated within required timescales Evidence that risks are escalated via CCG management structures where necessary, demonstrating good engagement and the ability for leadership to make informed decisions on prioritisation of resources

Operational Risks assigned to QSEC

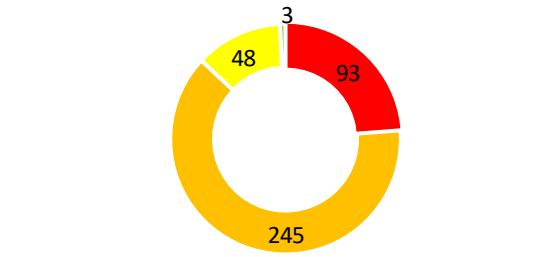
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

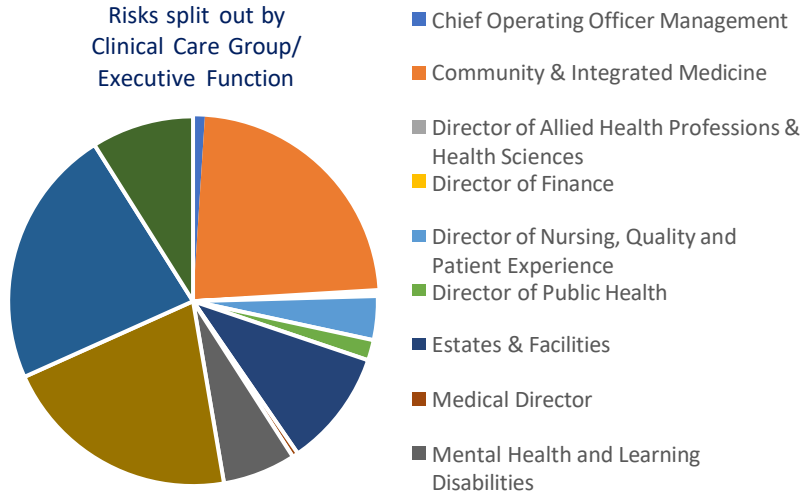


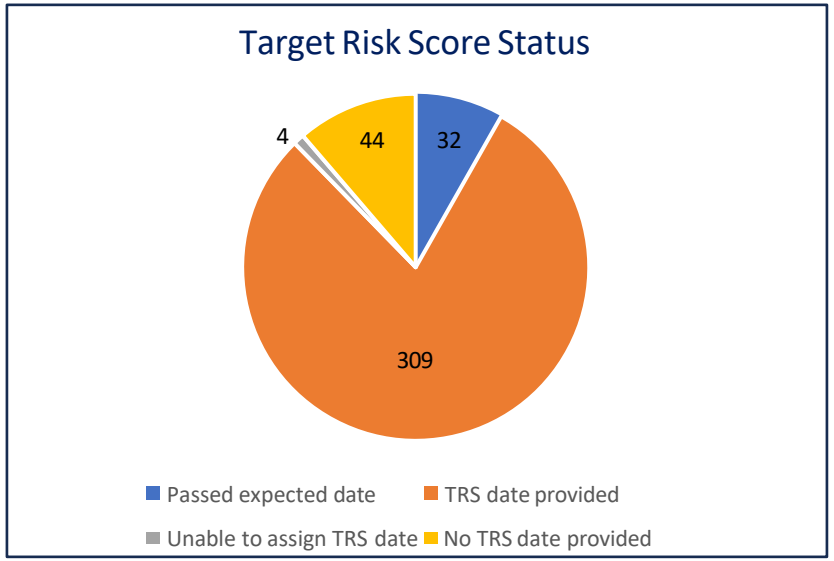
A summary of the 32 operational risks assigned to QSEC with a current risk score of 20 is provided over the next slides.

Details related to target risk scores (TRS) became mandatory fields on Datix as of 1 July 2025, and therefore for the 44 risks which do not currently have this detail, risk leads will be asked to provide by the next report to QSEC.

Where expected dates to achieve the TRS have lapsed (denoted in red on the following slides), the Assurance and Risk Team will remind risk leads to ensure the appropriate actions and updates are taken on Datis (eg has this risk now been fully managed and mitigated, or if TRS has not been met, what further actions are required and a revised TRS date provided and updated rationale).







Extreme Level Operational Risks Reportable to QSEC (1 of 5)

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

Risk Reference & Title	Overseeing Clinical Care Group / Executive Function	Lead Director	Current Risk Score*	Target Risk Score	Expected Date to Achieve Target Risk Score	Date of last risk review
1290 - Risk of increased Adult ADHD waiting list due to referrals exceeding service capacity.	Mental Health and Learning Disabilities	Chief Operating Officer	20	16	30/04/2026	15/09/2025
1287 - Risk of clients not being provided with timely interventions due to waiting lists for assessment & diagnosis of ASD.	Mental Health and Learning Disabilities	Chief Operating Officer	20	16	30/04/2026	15/09/2025
2109 - Risk that we are not able to provide safe and robust clinical leadership to the Paediatric Occupational Therapy Service	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	15	**29/08/2025**	08/09/2025
2118 - Risk of harm to Physiotherapy patients due to inadequate Medical service capacity at GGH	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	12	31/03/2026	11/09/2025
2113 - Risk of patient harm in Emergency department Withybush hospital due to demand exceeding capacity,	Community & Integrated Medicine	Chief Operating Officer	20	12	30/04/2026	29/08/2025
1517 - Risk of poor outcome and poor experience due to breaches of routine Physiotherapy waiting times	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	12	31/12/2026	14/08/2025
1115 - Risk of increased time in A&E due to lack of inpatient beds, GGH	Community & Integrated Medicine	Chief Operating Officer	20	12	31/10/2025	29/08/2025

Extreme Level Operational Risks Reportable to QSEC (2 of 5)

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

Risk Reference & Title	Overseeing Clinical Care Group / Executive Function	Lead Director	Current Risk Score*	Target Risk Score	Expected Date to Achieve Target Risk Score	Date of last risk review
2134 - Risk of harm to Occupational Therapy patients due to inadequate medical team cover	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	10	31/10/2025	04/09/2025
1309 - Risk to meeting demands for diagnostic reporting due to shortfall in Consultant Cellular Pathologist workforce	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	10	31/08/2028	28/08/2025
2151 - Risk of service users unable to access timely medical /prescribing interventions leading to poorer outcomes	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	9	31/08/2026	18/08/2025
1996 - Risk of reduced workforce recruitments and developments due to lack of funding	Planned & Specialist Care	Chief Operating Officer	20	8	31/07/2026	18/08/2025
1894 - Risk of stroke patients not receiving the therapy rehabilitation they need due to lack of staffing	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	8	31/03/2026	10/09/2025
1869 - Risk of NHS Dental Services not achieving Patient Charge Revenue Income targets due to lower activity/income at practices	Primary Care, Community Strategy & Long Term Care	Chief Operating Officer	20	8	31/03/2026	29/08/2025
1820 - Risk of patient harm due to the withdrawal of funding for the Diabetes Remission service	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	8	31/03/2026	11/09/2025

Extreme Level Operational Risks Reportable to QSEC (3 of 5)

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

Risk Reference & Title	Overseeing Clinical Care Group / Executive Function	Lead Director	Current Risk Score*	Target Risk Score	Expected Date to Achieve Target Risk Score	Date of last risk review
1820 - Risk of patient harm due to the withdrawal of funding for the Diabetes Remission service	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	8	31/03/2026	11/09/2025
1552 - Risk of inadequate body storage capacity across Health Board mortuaries	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	8	**31/08/2025**	10/09/2025
1547 - There is a risk to timely and safe radiology provision as capacity does not match demand	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	8	30/03/2029	07/08/2025
834 - Risk of clinical deterioration due to reduced service resilience within the Clinical Haematology sub specialty	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	8	30/09/2026	12/09/2025
2145 - Risk of harm to patients due to insufficient capacity to meet rehabilitation demand in acute hospitals	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	6	14/08/2026	14/08/2025
2090 - Risk to patient care in the Ceredigion area due to workforce capacity	Mental Health and Learning Disabilities	Chief Operating Officer	20	6	03/08/2026	15/08/2025
2028 - Harm to Patients/Staff due to extreme theatre workforce shortages at GGH affecting ability to provide safe/essential care	Planned & Specialist Care	Chief Operating Officer	20	6	30/06/2026	19/08/2025

Extreme Level Operational Risks Reportable to QSEC (4 of 5)

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

Risk Reference & Title	Overseeing Clinical Care Group / Executive Function	Lead Director	Current Risk Score*	Target Risk Score	Expected Date to Achieve Target Risk Score	Date of last risk review
1930 - Risk of harm to mortuary staff and porters when manual handling due to failure of hoist (Whisper 200)	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	6	Not yet assigned	10/09/2025
1717 - Risk of harm to children and young people living with obesity due to no weight management service provision	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	6	31/03/2027	11/09/2025
2141 - Risk of harm to patients, staff and public due to insufficient physical security measures in place at BGH	Community & Integrated Medicine	Chief Operating Officer	20	5	09/08/2028	13/08/2025
2136 - Risk of being unable to provide a haematology and blood transfusion service due to insufficient staffing	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	5	31/08/2025	01/09/2025
2156 - Risk of patient harm within the bone health service due to lack of clinical capacity across the Hywel dda University HB	Community & Integrated Medicine	Chief Operating Officer	20	4	31/03/2026	29/08/2025
2049 - Risk of being unable to support paediatric patients in acute respiratory distress due to ageing equipment	Planned & Specialist Care	Chief Operating Officer	20	4	31/03/2026	28/08/2025
1992 - Risk to patient safety due to insufficient Medical staffing to volume of medical patients severe & inpatient acuity	Community & Integrated Medicine	Chief Operating Officer	20	4	31/10/2025	31/07/2025

Extreme Level Operational Risks Reportable to QSEC (5 of 5)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Overseeing Clinical Care Group / Executive Function	Lead Director	Current Risk Score*	Target Risk Score	Expected Date to Achieve Target Risk Score	Date of last risk review
1349 - Risk of being unable to deliver ultrasound services at WGH due to a lack of appropriately trained obstetric staff	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	4	31/03/2028	26/08/2025
1256 - Risk to safety and management of hip fracture patients due to lack of Orthogeriatric service at GGH	Planned & Specialist Care	Chief Operating Officer	20	4	31/03/2026	04/09/2025
104 - Risk of avoidable infection from contaminated waste due to failed autoclave at WGH	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	1	31/03/2026	01/09/2025
1706 - Risk of loss of Nuclear Medicine Service due to decline in condition of equipment and failure to comply with NRW compliance.	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	1	30/07/2027	26/08/2025

*Movement in current risk score since previously reported to Committee will be denoted at the next report to QSEC in January 2026.

Risk Themes (1 of 2)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk owners can assign 'themes' to risks on Datix, allowing risk information to be shared on specific areas with relevant subject matter experts within the Health Board. They in turn can offer specific support and guidance to risk owners in the management of risk and identify trends and areas of concern. Each risk theme is aligned to a specific and relevant committee or sub-committee to provide assurance that processes are in place to deliver a holistic approach to risk management. Theme owners are provided with a thematic risk register on a bi-monthly basis to identify trends, or risk clusters, and to consider whether there are gaps in controls in the Health Board's control framework, and to determine whether further action is required to prevent risks from materialising.

The following themes are currently aligned to QSEC as of September 2025:

Risk Theme	Definition	Number of risks
Business continuity /service disruption	A risk that threatens to disrupt the functioning of the organisation, typically caused by an untoward incident or disaster that has a negative impact on operations.	139
Consent and Mental Capacity	Risks relating to consent to examination or treatment e.g. missing, illegible, incorrect consent form; failure to obtain consent; mismatch between consent form and list etc. Risks relating to people who may lack mental capacity e.g. failure or concerns relating to assessment of decision-making capacity; acting in the person's best interests; consulting with those close to the person etc.	0
Deprivation of Liberty Safeguards (DoLS)	Risks relating to a failure to submit DoLS referral when needed, a person being deprived of their liberty when they have capacity to consent to be in hospital, a lack of awareness of what actions can and cannot be taken when a DoLS authorisation is in place (e.g. you can stop someone from absconding), DoLS doesn't give authority for care and treatment decisions, a patient with a DoLS authorisation can be discharged).	1
Fragile Services	A fragile service is one where there is a risk of a diminished service being delivered, or a service being unable to be delivered	189
Infection Control	An incident that may compromise the effectiveness of infection prevention and control measures, leading to staff and/ or patients being exposed to a confirmed or suspected pathogen increasing the likelihood of a transmission event and a healthcare acquired infection (HAI) or outbreak	25

Risk Themes (2 of 2)

Risk Theme	Definition	Number of risks
Medical Devices	A risk related to a medical device or devices, including any instrument (other than a medicine) that is used to diagnose, monitor, treat or manage a medical condition. The definition covers a wide range of products including syringes, dressings, surgical tools, scanners, software, apparatus, machines and some medical apps.	35
Medication	A risk that involves the prescribing, dispensing or supply, administration or monitoring of medicines.	19
NICE / National Guidance	Risks related to the Health Board's ability to comply with evidence-based guidance for health and care.	33
Safeguarding	Safeguarding in its wider context is everyone's responsibility and we have duty of care to support children and adults. It is expected that services and professionals "own" their concerns and take responsibility for the work that needs to be done to keep individuals safe. This includes taking action before, during and after a safeguarding referral has been made. Should risks arise whereby children and adults may be put at risk due to gaps in service provision, or training compliance for example, then a safeguarding theme may be assigned to the risk.	28

The Assurance and Risk Team are working with the Interim Assistant Director of Nursing, Assurance and Safeguarding to review existing risk themes to re-align them to the revised quality and safety operational governance structure which underpins the newly established Quality and Safety Intelligence Group (QSIG). It is anticipated that risk themes will be agreed, and operational risks aligned to these on Datix during Q3 of 2025/26.

It will be the responsibility going forward of the relevant QSIG sub-group to review those operational risks aligned to them to oversee and monitor (second line of defence) to help ensure that operational leads (first line of defence) are effectively managing risks.

A thematic analysis will be provided to QSEC in February 2026, when operational risks are next due to be reported to the Committee.

Audits and Inspections - Overview

The Health Board remains in Targeted Intervention (TI) (Level 4) status with Welsh Government (WG) as a result of challenges relating to financial sustainability, strategy and planning, service delivery and organisational performance. Whilst the Health Board has been de-escalated for 'Governance' from TI (Level 4) to Enhanced Monitoring (Level 3), the Health Board must meet the revised criteria:

- Evidence that all recommendations from the Royal Colleges / Health Inspectorate Wales (HIW) and other reviews specific to Hywel Dda UHB are discharged and either verified or delivered or scheduled for delivery within the Health Board's longer-term improvement plan;
- Demonstrate a prompt response to any HIW inspections, concerns, incidents, never-events, coroners requests and regulation 28s; and
- The Board acts on, and addresses appropriately, concerns raised through NHS regulators such as HIW.

All reports from audits, inspections and reviews undertaken across the Health Board are logged and tracked on AMaT (Audit Management and Tracking), with progress updated by relevant service leads against each recommendation, with evidence required to be uploaded to demonstrating progress and implementation.

AMaT enables services to directly update progress against all recommendations via one central system, promoting a consistent approach with regards to processes and reporting, improvement in transparency and accountability, supporting services with their governance arrangements, and improvement in information flow. Progress is monitored via the utilisation of a traffic light system based on performance against original completion dates.

Status	Explanation
Green	Recommendation has been confirmed as completed by the service / directorate lead (*AMAT Status: Complete and awaiting approval / Fully Complete*)
Amber	Recommendation is currently in progress, and within the agreed **original** timeframe for implementation (*AMAT Status: Partially Complete / In Progress*)
Red	Recommendation is in progress, but has exceeded its agreed **original** timeframe for implementation (i.e. overdue) (*AMAT Status: Overdue / Partially Complete (Overdue)*)
External	Recommendations considered to be outside the gift of the Health Board to currently implement, e.g. reliant on an external organisation. Due to current system limitations, the action title has been amended to include the phrase "external" to denote this status.

Audits and Inspection reports assigned to QSEC (1 of 4)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

There are currently 27 reports assigned to QSEC to enable them to undertake the following responsibility set out in their Terms of Reference:

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

HIW inspection activity is monitored by the Quality & Safety Team (QAST) and further detail is presented to QSEC via item 4.1 on the agenda (Quality Assurance Report).

Date of report	Report issued by	Report Title	Clinical Care Group/ Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommendations in original report	Red (behind schedule)	Amber (on schedule)	Green (complete)	External Recs	Any Barriers to Completion Noted?
Oct-19*	Delivery Unit	Review of Dermatology Services in Wales Hywel Dda University Health Board	Planned and Specialist Care	Chief Operating Officer	Sep-25	Sep-25	5	0	5	0	0	No barriers noted
Dec-22	Public Health Wales	Llwynhendy Tuberculosis Outbreak External Review	Medical Director	Medical Director	Jul-23	N/K	7	0	0	2	5	Access to funding in an outbreak and awaiting completion of actions by PHW.
Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 November (Publication date 16 February 2023)	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	Sep-23	N/K	19	1	0	18	0	Recurrent and non-recurrent finance required
Apr-23	Peer Review	Out of Hours Peer Review	Primary Care, Community Strategy & Long Term Care	Chief Operating Officer	Dec-23	Dec-25	17	5	0	12	0	Lack of Urgent Primary Care Centre in HB.
May-23	HIW	Mental Health Discharge Review	Mental Health and Learning Disabilities	Chief Operating Officer	Mar-24	Oct-25	40	5	0	32	3	Awaiting publication of national standards

* Report was added to AMAT in August 2025 after its presentation to IQFPD by Planned and Specialist Care leads.

Audits and Inspection reports assigned to QSEC (2 of 4)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Date of report	Report issued by	Report Title	Clinical Care Group/ Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommendations in original report	Red (behind schedule)	Amber (on schedule)	Green (complete)	External Recs	Any Barriers to Completion Noted?
Jun-23	Peer Review	Follow Up: Congenital Heart Defect Provider, Assessment Return,	Planned and Specialist Care	Chief Operating Officer	Nov-22	N/K	10	0	0	9	1	No barriers noted
Sep-23	NHS Exec	Children and Young Person's Neurodevelopmental Services All Wales Review	Planned and Specialist Care	Chief Operating Officer	Nov-24	Oct-25	9	1	0	8	0	No barriers noted
Sep-23	HIW	Review of Psychology & Psychological Interventions for Children and Young People	Planned and Specialist Care	Chief Operating Officer	Dec-24	N/K	9	2	0	7	0	Consensus on the proposed pathway is still being finalised.
Oct-23	HIW	St Non, St Caradog, Canolfan Bro Cerwyn WGH	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Oct-24	Oct-25	19	2	0	17	0	Fragility of current medical workforce capacity.
Oct-23	Peer Review	Cervical Screening Wales Quality Assurance Visit Report	Planned and Specialist Care	Chief Operating Officer	N/K	N/K	58	15	0	43	0	No barriers noted
Jan-24	HIW IRMER	Diagnostic Imaging x-ray department Withybush Hospital January 2024	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	Apr-26	Apr-26	9	2	0	7	0	No barriers noted
Feb-24	HIW	Children and Young People Mental Health Review	Mental Health and Learning Disabilities	Chief Operating Officer	Feb-26	Feb-26	9	3	3	3	0	No barriers noted
Jun-24	Welsh Risk Pool	Welsh Risk Pool Concerns Assessment (December 2024)	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	Mar-25	N/K	11	7	0	4	0	No barriers noted

Audits and Inspection reports assigned to QSEC (3 of 4)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Date of report	Report issued by	Report Title	Clinical Care Group/ Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommendations in original report	Red (behind schedule)	Amber (on schedule)	Green (complete)	External Recs	Any Barriers to Completion Noted?
Jul-24	HIW	Glangwili Hospital – Morlais Ward	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Mar-25	N/K	9	1	0	8	0	No barriers noted
Sep-24	Internal Audit	Bryngolau Ward, Prince Philip Hospital September 2024	Mental Health and Learning Disabilities	Chief Operating Officer	Aug-25	Sep-25	40	1	0	39	0	Lack of capacity to release workforce for training
Oct-24	Internal Audit	Falls Management Final Internal Audit Report October 2024	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	May-25	Dec-25	6	2	0	4	0	No barriers noted
Oct-24	HIW IRMER	IRMER Regulations	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	Jul-25	N/K	9	2	0	7	0	No barriers noted
Jan-25	Internal Audit	Reinforced Autoclaved Aerated Concrete – Withybush General Hospital Final Report 2024/25	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Mar-26	Mar-26	6	0	1	5	0	No barriers noted
Jan-25	Internal Audit	Learning Lessons Final Internal Audit Report 2024/25	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	May-25	N/K	4	2	0	2	0	No barriers noted
Jan-25	Internal Audit	Mortuary Services Final Internal Audit Report 2024/25 Swansea Bay University Health Board Hywel Dda University Health Board	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	Mar-25	Mar-26	1	1	0	7	1	No barriers noted

Audits and Inspection reports assigned to QSEC (4 of 4)

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

Date of report	Report issued by	Report Title	Clinical Care Group/ Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommendations in original report	Red (behind schedule)	Amber (on schedule)	Green (complete)	External Recs	Any Barriers to Completion Noted?
Mar-25	HIW	Joint Inspection of Child Protection Arrangements (Pembrokeshire)	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	Mar-26	Mar-26	21	1	19	1	0	No barriers noted
May-25	HIW	HIW GGH Maternity Services	Planned and Specialist Care	Chief Operating Officer	Sep-26	Sep-26	13	4	6	3	0	No barriers noted
May-25	Internal Audit	Standards of Cleanliness Final Internal Audit Report 2024/25	Estates & Facilities	Director of Allied Health Professions and Health Sciences	Oct-25	Oct-25	6	0	2	4	0	No barriers noted
Jun-25	HIW	Nuclear Medicine IRMER WGH	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	Apr-27	Apr-27	26	2	23	1	0	No barriers noted
Jun-25	Internal Audit	Discharge Management (Follow Up) Final Internal Audit Report 2024/25	Community & Integrated Medicine	Chief Operating Officer	Mar-25	N/K	1	1	0	0	0	No barriers noted
Jul-25	Internal Audit	Nursing Management Final Internal Audit Report 2025/26	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	Sep-25	Sep-25	3	0	3	0	0	No barriers noted
Aug-25	HIW	Mynydd Mawr Ward, Prince Philip Hospital	Community & Integrated Medicine	Chief Operating Officer	Oct-25	Oct-25	3	2	1	0	0	No barriers noted

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; and
- **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.

Audits, Inspections and Regulatory Reports

- **RECEIVE ASSURANCE** from the lead Executive Director or Supporting Officer on the management of recommendations raised in audit, inspection and regulatory reports within their area of responsibility, particularly in respect of confirming the full implementation of recommendations with any barriers to delivery noted.



DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG

SAFE | SUSTAINABLE | ACCESSIBLE | KIND

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

APPENDIX 1 - QSEC PRINICPAL RISKS

Risk Ref	Risk (for more detail see individual risk entries)	Executive Director	Domain	Previous Risk Score	Risk Score Oct-25	Trend	Target Risk Score (tolerable score)
1191	Underestimation of Excellence	Henwood, Mr Mark	Business objectives/projects	3×4=12	3×4=12	→	2×3=6
1195	Comprehensive early indicators of shortfalls in safety	Daniel, Sharon	Quality/Complaints/Audit	3×3=9	3×3=9	→	2×4=8
1189	Timely and sufficient learning, innovation and improvement	Daniel, Sharon	Business objectives/projects	3×3=9	2×3=6	↓	1×3=3
1184	Measuring how we improve patient and workforce experience	Daniel, Sharon	Finance inc. claims	2×4=8	3x2=6	↓	2×2=4

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.			

APPENDIX 1 - QSEC PRINICPAL RISKS

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 slip.	<5 per cent over project budget. Schedule slip.	5–10 per cent over project budget. Schedule slip.	Non-compliance with national 10–25 per cent over project budget. Schedule slip. Key objectives not met.	Incident leading >25 per cent over project budget. Schedule slip. 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/ slip
					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

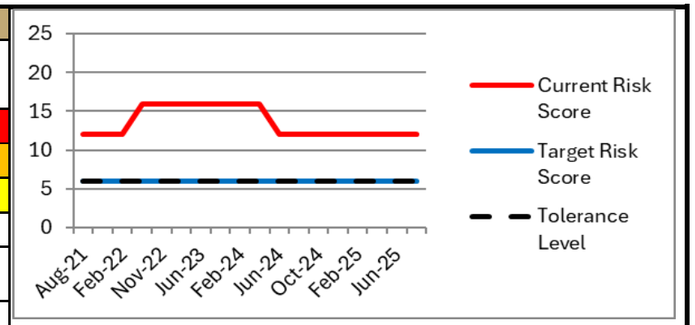
NB Assurance Map will tell you if you have sufficient sources of assurance not what those sources are telling you

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:	May-21	**Executive Director Owner:**	Henwood, Mr Mark	**Date of Review:**	Sep-25
Strategic Objective:	3. Great Care	**Lead Committee:**	Quality, Safety and Experience Committee	**Date of Next Review:**	Dec-25

Risk ID:	**1191**	**Principal Risk Description:**	There is a risk that the Health Board has suboptimal ambition for our services. This is caused by an underestimation of excellence by the Health Board. This could lead to an impact/affect on our ability to recognise opportunities for improvement or relative deterioration in the quality of our services in the future, inability to improve recruitment and retention of the workforce, staff morale, poor patient experience or harm, poorer value healthcare and reduction of confidence from our stakeholders.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Business objectives/projects
Inherent Risk Score (L x I):	4×4=16
Current Risk Score (L x I):	3×4=12
Target Risk Score (L x I):	2×3=6
Expected Date To Achieve TRS:	
Trend:	⟷



Rationale for CURRENT Risk Score:

Striving for Excellence is a continuous process where the HB will always be looking to strengthen and maximise its clinical effectiveness systems and processes The risk score has been reduced to reflect that the achievements that have been made in Value Based Healthcare, Research and Innovation and Clinical Effectiveness. Further work is required to embed this through job planning to enable protected SPA (Supporting Professional Activities) time for medics.

A multi professional workshop has been established, with initial meeting held in October 2024 to strengthen continuous improvement, talent management and progression of clinical teams across the Health Board.

Rationale for TARGET Risk Score:

As part of the current escalation framework (level 4 Targeted Intervention) there are key areas to address specifically to clinical engagement and leadership specifically to ensure that that clinical leadership is visible and effective; there is leadership development support in place and the consultant body as a whole is actively engaged in driving forward service improvement. A review of clinical leadership at all levels/capacity and capability/multi-professional working/empowerment of more junior staff identifying change champions and empower local leadership models will be completed as part of the Health Board's response to Targeted Intervention and will facilitate the Health Board to develop and deliver excellent services.

Assurance & Risk Officer has entered placeholder TRS date whilst undertaking housekeeping on this risk. Risk lead to input 'Expected date to achieve Target Risk Score' at next review.

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**
# Quality Assurance System including Clinical effectiveness # Process re NICE and professional guidance. # National & Local Clinical Audits Programme # Peer Reviews # Healthcare standards # Major cause of harm # National Quality setting. # AMAT system in place to monitor NICE compliance # TSG to learn from best in World. # Advisory Board. # Clinical Director for Clinical Effectiveness - role to secure clinical engagement. # Monitoring system in place for NICE guidance. # QSEC Approved Research & Development (RDI) Strategy with Implementation Plan # Research & Innovation Sub Committee with strengthened membership for improved scrutiny # Strengthened RDI Management Team # Partnership and collaborative working initiatives - some joint funded posts and research and innovation projects in place. # University partnership arrangements in place. # Strategic Enabling Groups # Value Based Health Care Sponsoring Group # Value Based Health Care Programme Team # National Value Based Health Care Community of Practice # Improving Together Programme # Regular attendance at Directorate/ County Quality and Governance Groups to improve engagement on clinical effectiveness # Establishment of the Clinical Standards and Guidelines Group as a forum to support better engagement with service areas and promote excellence through a focus on clinical effectiveness standards and guidelines and	Being cognisant of patients' perception of excellence Clinical engagement across the Health Board is growing but it still needs to be strengthened in some areas to ensure that clinical effectiveness systems and processes are fully embedded and used to their maximum potential. Staffing fragility within the RDI Team Over-reliance on external funding for RDI and insufficient recurrent internal financial investment, or resource alignment (e.g. time for research) to support ambition within RDI strategy Inadequate facilities to undertake research activities. Resources within the wider HB to deploy to servicing the university partnership arrangements. Focused patient input into the use of Value Based Health Care intelligence in providing higher value services Explicit Nursing input into the programmatic implementation of Value	To achieve workforce sustainability through the delivery of workforce planning, recruitment, retention, and development, and effectiveness initiatives. 1. Develop a Workforce Plan which sets out actions to achieve a balance between workforce demand and supply, supporting workforce stabilisation. 2. Delivery of a targeted Recruitment Plan which will reduce reliance on high-cost agency staff through substantive recruitment (supply-side) supporting the Workforce Plan. 3. Delivery of a Retention Plan to support the supply-side elements of the Workforce Plan and underpin workforce stabilisation. 4. Delivery of a Workforce Education and Development Plan which supports the pipeline (supply-side) for staff progression. (PO 1)	Gostling, Lisa	31/03/2025	On track as per highlight report presented to PODCC in May 2025.
		To provide a set of plans for key clinical services to address critical sustainability risks up to the future hospital network. (PO 6)	Davies, Lee	31/03/2025	On track as per highlight report presented to SPC in June 2025.
		Progress against Business Case process for Implementation of A Healthier Mid and West Wales Strategy & Estates Rationalisation - Modernisation and rationalisation scheme year 1-4 implementation (PO 8)	Davies, Lee	31/03/2025	Behind schedule as per highlight report presented to SPC in June 2025.

support from teams across the quality system to identify gaps and improve services. # Multi-Professional Clinical Workshop, led by Clinical Executives	Based Health Care across the Health Board Development of governance arrangements to encompass the Value Based Health Care work being undertaken as part of the Mid Wales Health Collaborative Clinical services configuration and current resource constraints	Implement the Digital Strategic Plan A. To appoint a Commercial Transformation Partner arrangement to support with the implementation of large-scale digital transformation projects across the Health Board and the region B. To work with WG to secure funding for the roll-out of ePMA, and a patient flow and e-observation system. C. To implement the following key system developments: 1. Welsh Intensive Care Information System, 2. PROMs and PREMs system & 3. Hybrid print and post. D. To ensure that future planning is progressed for the following key system developments: 1. Re-procurement of the Laboratory Information Management System, 2. The Integrated Eye Care Electronic Health Record, 3. Development of a Community Information System & 4. E. Development of Maternity and Paediatric record systems. (PO 9)	Thomas, Huw -	31/03/2025	Complete as per highlight report presented to DDIC in April 2025.
		Review of the Medical Leadership Forum (MLF) to adopt the form of a 'working MLF' to reset, refocus and reignite the MLF to encourage continued engagement and generate an enthusiasm that is taken back into clinical teams.	Henwood, Mr Mark	~~31/03/2025~~ ~~30/09/2025~~ 30/11/2025	The review of Medical Leadership within Clinical Care Groups, aligned with the Chief Operating Officer's OCP process, is progressing. Associate Medical Directors (AMDs) have now been appointed, with recruitment for Clinical Directors and subsequently Clinical Leads to follow. Upon completion of the recruitment process, successful candidates will be co-opted onto the Medical Leadership Forum to support strategic clinical leadership. Due to the ongoing nature of the OCP, the September meeting of the Medical Leadership Forum has been stood down and will be rescheduled for November.

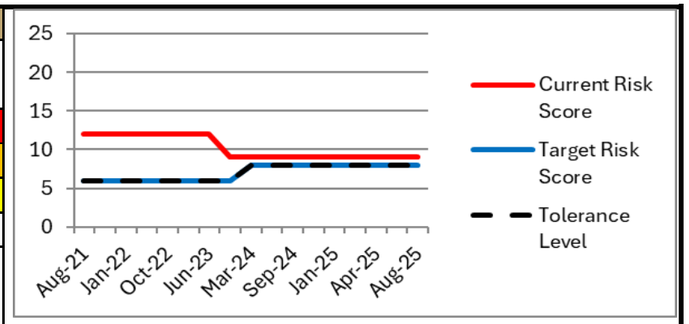
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
See Our Outcomes section on the BAF Dashboard	# Participation in the NICE Welsh Health Network where specific guidelines are proposed for review on a national basis - to provide benchmark information	1st			Update ECPAP Reports to QSEC (Oct23) Effective Clinical Practice Strategic Plan for ratification to ECPAP (Sep22) Effective Clinical Practice Delivery Plan to ECPAP (Dec22)	Due to gaps in the historic system, it is not always possible to provide assurance to DCMO re: specific guidelines				
	# Senior management Team meeting monitor delivery of RDI activities and RDI Strategy/Plan	1st								
	# VBHC Programme Plan for rollout of PROM/PREM collection and capture of resource utilisation	1st								
	# Medical Leadership Forum	2nd								
	# VBHC facilitated Service Review Meetings with operational and clinical staff followed by presentation to Executive colleagues for action	2nd								
	# Reporting through the Effective Clinical Practice Advisory Panel and Clinical Standards and Guidelines Group	2nd								
	# Alignment with Health Board Quality and Governance Groups	2nd								
	# Responses to letters from Welsh Government (DCMO) relating to specific guidelines	2nd								
	# RDI Sub Committee & HCRW monitor delivery of RDI Strategy/Plan	2nd								

# Board Committees & Executive Team (through its reporting groups) oversee delivery of Planning Objectives	2nd										
# Annual Performance Review by WG/HCRW	3rd										
# RDI Activity overseen by UK RD - Peer Review to review arrangements in place for research activities	3rd										
# IA on NICE Guidelines Follow-up (Reasonable Assurance)	3rd										
IA on Job Planning - May24 (Limited Assurance)	3rd										
# HCRW Annual Review of R&D (awaiting final report - positive verbal feedback to date)	3rd										

Date Risk Identified:	May-21	**Executive Director Owner:**	Daniel, Sharon	**Date of Review:**	Sep-25
Strategic Objective:	3. Great Care	**Lead Committee:**	Quality, Safety and Experience Committee	**Date of Next Review:**	Dec-25

Risk ID:	**1195**	**Principal Risk Description:**	There is a risk that the Health Board is not yet consistently recognising and reporting early indications of shortfalls in quality and safety across all services within the Health Board as required by the Quality and Engagement Act (which came in to force on 1st April 2023) This is caused by no comprehensive and consistent way of measuring safety aligned to the standards adopted by the Health Board for all the services we provide and commission on behalf of people requiring health care interventions. This could lead to an impact/affect on public and patient confidence, organisational reputation, positive patient reported outcomes.
Does this risk link to any Directorate (operational) risks?		1184	

Risk Rating:(Likelihood x Impact)	
Domain:	Quality/Complaints/Audit
Inherent Risk Score (L x I):	4×4=16
Current Risk Score (L x I):	3×3=9
Target Risk Score (L x I):	2*3=6
Expected Date To Achieve TRS:	
Trend:	⟷



Rationale for CURRENT Risk Score:
Systems are not yet established to enable easy triangulation of data and there are still some gaps in information collection. Since 1st April 2023, the introduction of the Quality and Engagement Act has refreshed the focus on quality and safety through the 6 domains and internal metrics developments. These developments have facilitated discussions at the appropriate forums such as Board, Committees and local governance arrangements. There has been improvement in interrogation and reporting of data within RL Datix Incident Reporting system.

Rationale for TARGET Risk Score:
The target risk score is based on implementing a system to enable capture data across the breadth of our services with timely escalation reporting arrangements in place.

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**
Range of performance measures/metrics in place Updated Datix Incident reporting system Standardised approach through a standard agenda in Quality Governance meetings CIVICA system is available and being rolled out to gain feedback to let us know issues in services Range of different mechanisms to capture feedback from service users and staff Speak Up Arrangements are in place, however further developing required in light of the Speak Up Framework as issued by Welsh Government in October 2023 Listening and Learning Sub-Committee Quality, Safety and Experience Committee Clinical Audit Programme Quality Safety Intelligence Group External reports (HIW, HSE, MWWFRS, Peer Reviews, etc) Mortality Reviews and Medical Examiners Service National Accreditation Standards for service specifications 6 Domains as noted in the Duty of Quality Act (STEEEP) PROMS and PREMs in identified services	There is no standardised way of joining existing systems in place Ability to triangulate sources of data and provide meaningful thematic qualitative analysis Not all services have clear pathways and variance trackers in place to enable consistent monitoring and interpretation to enable rationale for variance. Not yet consistently using the information from PROMs, PREMs and FROMs as part of triangulation process	Urgent and Emergency Care / 6 Goals Programme - UEC / Implement the Six Goals To develop and implement a plan to by March 2025 to deliver Ministerial priorities by 2026 1. Delivery and Implementation of a 24/7 Urgent Care Service, accessible via 111 Wales, to support improved access and GMS sustainability. 2. Implementation of Same Day Emergency Care services /direct access pathways. 3. Improving patient flow through the acute sites. 4. Develop a strategy for our Alternative Care Provision to support care closer to home. 5. Minimise delays in hospital discharge due to assessment-related issues within Pathways of Care. 6. Improve the effectiveness and efficiency of community services, with an emphasis on avoiding unnecessary hospital admissions and facilitating timely discharges (PO 3)	Carruthers, Andrew	31/03/2025	On track as per highlight report presented to FPC in June 2025.
		Improve Planned Care and Cancer performance, with a focus on reducing the longest waits, and reduce the 8 week wait for diagnostics. (PO4)	Carruthers, Andrew	31/03/2025	Behind schedule as per highlight report presented to FPC in June 2025.
		Mental Health and Learning Disabilities service improvement though: 1. Mental Health Recovery Programme Optimisation 2. Section 136 3. Redesign the End-to-End Inpatient and Community Pathway (PO 5)	Carruthers, Andrew	31/03/2025	On track as per highlight report presented to FPC in June 2025.

Directorate and Service Quality Governance Meetings established Directorate Improving Together Sessions Increased quality element of commissioned services from external organisations Harms Dashboard and our Performance Dashboard in place to facilitate triangulation of data with other intelligence, eg weekly hot and happening meetings. Quality Impact Assessments process now in place Quality Management System now in place Increased use of AMAT across the Health Board to track the implementation of recommendations raised.	To provide a set of plans for key clinical services to address critical sustainability risks up to the future hospital network. (PO 6)	Davies, Lee	31/03/2025	On track as per highlight report presented to SPC in June 2025.

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
See Our Outcomes section of the BAF Dashboard	Quality and Safety Intelligence Group	2nd			Patient Experience Report - every Board (May24) Healthcare Contracting Update - SRC (Aug22) QIA - QSEC (Oct 23) Quality and Commissioning Update - QSEC (Oct 23)	Assurance on triangulation of data				
	Directorate Quality Governance Meetings in place	2nd								
	Patient and staff feedback	2nd								
	Harms Dashboard is reported monthly to Formal Executive team with Our Performance and other intelligence for triangulation of data	2nd								
	Improving Together performance sessions with clinical and corporate directorates aligned to the Internal Escalation Framework	2nd								
	Performance reports through power BI and Committee reports	2nd								

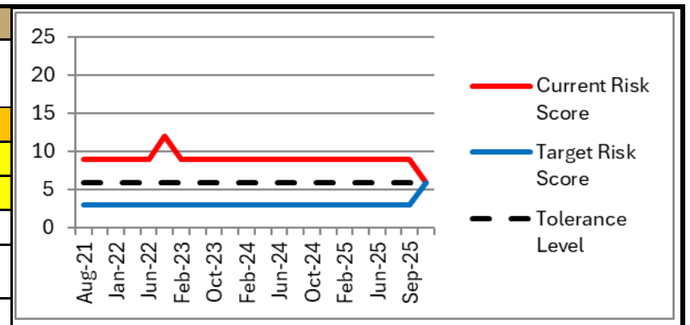
PTHB/HDUHB LTA/CQPR Meeting and Hywel Dda & SBU (SLA & LTA) Meetings to review quality aspects from commissioning arrangements	2nd									
Commissioning arrangements overseen by Sustainable Resources Committee (SRC)	2nd									
GIRFT Reports reported to QSEC	2nd									
Quality Impact Assessments and Panel	2nd									
HIW patient complaints	3rd									
Quality Governance Follow up Report (Oct21)	3rd									
Annual Structured Assessments by Audit Wales	3rd									
Internal audit on Safety Indicators (Reasonable Assurance	3rd									
Internal Audit plans which include reviewing Quality Governance	3rd									

Date Risk Identified:	May-21
Strategic Objective:	3. Great Care

Executive Director Owner:	Daniel, Sharon	**Date of Review:**	Oct-25
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Dec-25

Risk ID:	**1189**	**Principal Risk Description:**	There is a risk that services fail to learn, innovate and improve to a sufficient level in a timely manner. This is caused by a culture that does not facilitate learning (mindset); that skills are not developed across the organisation to implement the approach (skillset) and that the systems required to support the rollout are not implemented (toolset). This could lead to an impact/affect on services failing to see evidence of continuous improvement.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Business objectives/projects
Inherent Risk Score (L x I):	3×4=12
Current Risk Score (L x I):	2×3=6
Target Risk Score (L x I):	2×3=6
Expected Date To Achieve TRS:	01/01/1900
Trend:	⟷



Rationale for CURRENT Risk Score:

The current risk score reflects the fact that the organisation has existing processes in place to value and embed learning and improvement but that it is not comprehensive. This means we may miss opportunities to enhance the care we provide and create a supportive environment for staff to develop and grow. There is increasing evidence that the mindset of the organisation is focussed on learning, the skillset is developing quickly, particularly in areas such as EQIiP, Improving Together and Research, Innovation and Development, however further work is required to strengthen our toolset. Operational pressures are also likely to be causing challenges for people to enact change or improvement in their areas however Improving Together sessions with Directorates have facilitated and helped to embed learning and improvement which has enabled an overall score of 9 to be maintained.
The new internal Escalation Framework is helping to improve learning and drive improvements in areas where performance issues are identified.
There has been progress in more timely responses to ability to address our audit, inspectorate and regulatory requirements at pace, through CCG ownership and use of AMAT.
The new Health and care quality standards have been embedded within reporting requirements and quality impact assessment.
The use of the IPAR, Our Performance, Our Safety dashboard has improved the way data is used at operational and strategic levels. Data is available.

Rationale for TARGET Risk Score:

3 of our 6 strategic objectives are people-focussed and are aimed at making the Health Board a great place to work and receive care. The Board will be focussing on this for the long term which would result in an organisation which has learning, innovation and improvement threaded through everything it does.

Assurance & Risk Officer has entered placeholder TRS date whilst undertaking housekeeping on this risk. Risk lead to input 'Expected date to achieve Target Risk Score' at next review.

01/10/2025 Risk reviewed by EDON and IADON, Assurance and Safeguarding. Target likelihood reviewed.
This risk needs a full review and consideration of whether the risk remains and what new mitigations are in place

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**
Risk Management Framework and Board Assurance Framework (BAF) Established governance structures Established Assurance Trackers for audits, inspectorates & regulators, Welsh Health Circulars, Ministerial Directions Healthcare Standards (HCS) 6 Domains of Quality embedded within governance framework to improve clinical quality and patient experience Research, Development and Innovation Strategy approved by QSEC The Improving Together programme which aims to shift the organisation from one that manages performance to one that manages quality and embeds an improvement culture into all of its working arrangements Quality framework, with the Enabling Quality Improvement in Practice (EQIiP) programme, improvement coach development programme and access to supporting resources/ teams (QIST/ VBHC/ TPO/ PMO/ OD/ workforce/ R&D etc) Effective clinical practice (Clinical Audit, Clinical Standards and Guidance, Clinical Written Control Documents, Mortality Reviews etc) OD Cultural Plans A comprehensive range of Leadership Development pathways in place to create cohorts of leaders (includes Medical Leadership Programme, Clinical Leads Forum, Consultant Programme, HEIW Clinical Leadership Programme, LEAP, CLIMB and increased coaching capacity) Quality Impact Assessment process and panel and Quality Safety Intelligence Group	Staff not being clear of the expectation of their contribution to the delivery of the strategic objectives/planning objectives Having an effective process to find new opportunities to improve what the HB does and how it does it through new POs and enablers Alignment of BAF to strategic objectives Having ambitious comprehensive RDI programme Having an effective process to collate and disseminate learning across the organisation Cohesive engagement and capacity of operational teams to engage in programmes listed in the 'key controls'.	Improve Planned Care and Cancer performance, with a focus on reducing the longest waits, and reduce the 8 week wait for diagnostics. (PO4)	Carruthers, Andrew	31/03/2025	Behind schedule as per highlight report presented to FPC in June 2025.
		To provide a set of plans for key clinical services to address critical sustainability risks up to the future hospital network. (PO 6)	Davies, Lee	31/03/2025	On track as per highlight report presented to SPC in June 2025.
		Implement the Digital Strategic Plan. A. To appoint a Commercial Transformation Partner arrangement to support with the implementation of large-scale digital transformation projects across the Health Board and the region B. To work with WG to secure funding for the roll-out of ePMA, and a patient flow and e-observation system. C. To implement the following key system developments: 1. Welsh Intensive Care Information System, 2. PROMs and PREMs system & 3. Hybrid print and post. D. To ensure that future planning is progressed for the following key system developments: 1. Re-procurement of the Laboratory Information Management System, 2. The Integrated Eye Care Electronic Health Record, 3. Development of a Community Information System & 4. E. Development of Maternity and Paediatric record systems. (PO 9)	Thomas, Huw -	31/03/2025	Complete as per highlight report presented to DDIC in April 2025.

Urgent and Emergency Care (UEC) / 6 Goals Programme - Implement the Six Goals To develop and implement a plan to by March 2025 to deliver Ministerial priorities by 2026 1. Delivery and Implementation of a 24/7 Urgent Care Service, accessible via 111 Wales, to support improved access and GMS sustainability. 2. Implementation of Same Day Emergency Care services /direct access pathways. 3. Improving patient flow through the acute sites. 4. Develop a strategy for our Alternative Care Provision to support care closer to home. 5. Minimise delays in hospital discharge due to assessment-related issues within Pathways of Care. 6. Improve the effectiveness and efficiency of community services, with an emphasis on avoiding unnecessary hospital admissions and facilitating timely discharges (PO 3)	Carruthers, Andrew	31/03/2025	On track as per highlight report presented to FPC in June 2025.

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
See Our Outcomes section of BAF Dashboard	Tracker Performance reports issued to Lead Directors on bi-monthly basis	1st			Tracker Report - every ARAC Strategic Business intelligence - Board (Aug21)	Assurance arrangements for overseeing development and delivery of BI and modelling				
	Committee oversight of delivery of WHCs and MDs	2nd								
	ARAC oversight of Audit Tracker	2nd								
	RD&I Sub Committee overseeing delivery and success of RDI Strategy	2nd								

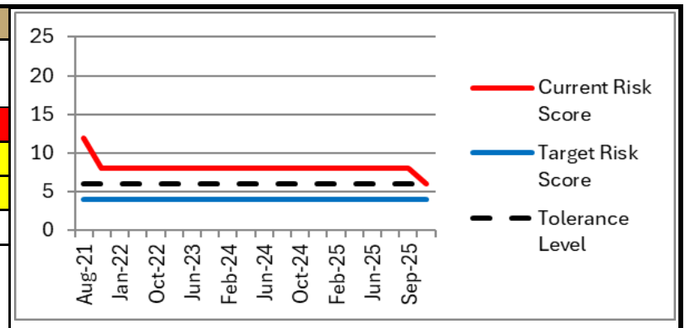
	IQPFD overseeing quality performance	2nd								
	Quality Impact Assessment Panel reporting to QSEC	2nd								
	Quality and Safety Intelligence Group	2nd								
	Internal Quality & Engagement Act Implementation Group	2nd								
	Directorate Improving Together Sessions aligned to the internal Escalation Framework (Bi-monthly)	2nd								
	IA Health and Care Standards to review adequate procedures in place to ensure, and monitor, effective utilisation of the standards to improve clinical quality and patient experience -Reasonable Assurance (Feb21)	3rd								
	AW & IA Plan includes annual review of risk management arrangements & BAF	3rd								

Date Risk Identified:	Apr-21
Strategic Objective:	3. Great Care

Executive Director Owner:	Daniel, Sharon	**Date of Review:**	Oct-25
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Dec-25

Risk ID:	**1184**	**Principal Risk Description:**	There is a risk that the Health Board will not be able to measure whether the transformational changes it is investing in are improving the experience for our workforce and the delivery of care, and will enable it to meet or exceed patient and families expectations. This is caused by the lack of an effective, systematic way to continuously engage with and capture feedback from our workforce, patients and public across the breadth of our services. This could lead to an impact/affect on poor patient experience, poor staff experience, lack of public confidence, missed opportunities and the inability to offer patients and staff a great experience.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Finance inc. claims
Inherent Risk Score (L x I):	4×4=16
Current Risk Score (L x I):	2×3=6
Target Risk Score (L x I):	2×2=4
Expected Date To Achieve TRS:	01/01/1900
Trend:	⟷



Rationale for CURRENT Risk Score:
The current risk score reflects the current maturity level of formal mechanisms to triangulate different sources of engagement and feedback from public, patients and staff across Hywel Dda. The information being used in Improving Together, Escalation and QSIG sessions/meetings which requires further development of dashboards requires further embedding, however this is facilitating a conversation regarding the utilisation of various metrics better. Value opportunities framework is embedded with EQIIP, and embedded into all service change and transformation activity.

Rationale for TARGET Risk Score:
Target score is predicated on developing the mechanisms to support the triangulation of various pieces feedback and quality and safety metrics. Assurance & Risk Officer has entered placeholder TRS date whilst undertaking housekeeping on this risk. Risk lead to input 'Expected date to achieve Target Risk Score' at next review.

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**
Central Communication Hub in place with workstreams established supporting 27 operational teams in communicating with patients Central Communication Hub lead appointed Civica system capturing feedback from patients implemented, with signficant roll out across services Change mechanisms established through improvement and transformation programmes with direct impact on how clinical services are structured liked to CSP Organisational Development Relationship Managers to influence the culture change journey and support the creation of transformational and compassionate culture within the Health Board, and actively work with services Methodology to manage change with services to facilitate clinical engagement and pace of delivery (Engagement Team, Quality Improvement Team and Transformation Team) underpinned by the Safe Care Collaborative and 6 Goals Urgent and Emergency Care programme of work Waiting List Support Programme (WLSP) Plan with workstreams established to support continued engagement with clinical staff and services following the National 3 Ps policy and directly supporting patients on waiting lists	Communications Hub and WLSP in place but further consideration needed to identify other areas that will benefit. Routine periodic reporting during and after service change to reflect on the impact /improvement to patients, staff and performance remains in its infancy. No agreed method of aligning PROMs, PREMs and other measures to service change or development Whilst there have been developments in the collection of data, work remains in order to strengthen the triangulation of qualitative data collected.	To achieve workforce sustainability through the delivery of workforce planning, recruitment, retention, and development, and effectiveness initiatives. 1. Develop a Workforce Plan which sets out actions to achieve a balance between workforce demand and supply, supporting workforce stabilisation. 2. Delivery of a targeted Recruitment Plan which will reduce reliance on high cost agency staff through substantive recruitment (supply-side) supporting the Workforce Plan. 3. Delivery of a Retention Plan to support the supply side elements of the Workforce Plan and underpin workforce stabilisation. 4.Delivery of a Workforce Education and Development Plan which supports the pipeline (supplyside) for staff progression. (PO 1)	Gostling, Lisa	31/03/2025	On track as per highlight report presented to PODCC in May 2025.
		To provide a set of plans for key clinical services to address critical sustainability risks up to the future hospital network. (PO 6)	Davies, Lee	31/03/2025	On track as per highlight report presented to SPC in June 2025.

	Transforming Urgent and Emergency Care (TUEC) Programme - TUEC / Implement the Six Goals To develop and implement a plan to by March 2024 to deliver Ministerial priorities by 2026 1. Delivery and Implementation of a 24/7 Urgent Care Service, accessible via 111 Wales, to support improved access and GMS sustainability. 2. Implementation of Same Day Emergency Care services /direct access pathways. 3. Improving patient flow through the acute sites. 4. Develop a strategy for our Alternative Care Provision to support care closer to home. 5. Minimise delays in hospital discharge due to assessment-related issues within Pathways of Care. 6. Improve the effectiveness and efficiency of community services, with an emphasis on avoiding unnecessary hospital admissions and facilitating timely discharges (PO 3)	Carruthers, Andrew	31/03/2025	On track as per highlight report presented to FPC in June 2025.
	Implement the Digital Strategic Plan A. To appoint a Commercial Transformation Partner arrangement to support with the implementation of large-scale digital transformation projects across the Health Board and the region. B. To work with WG to secure funding for the roll-out of ePMA, and a patient flow and e-observation system. C. To implement the following key system developments: 1. Welsh Intensive Care Information System, 2. PROMs and PREMs system & 3. Hybrid print and post. D. To ensure that future planning is progressed for the following key system developments: 1. Re-procurement of the Laboratory Information Management System, 2. The Integrated Eye Care Electronic Health Record, 3. Development of a Community Information System & 4. Development of Maternity and Paediatric record systems. (PO 9)	Thomas, Huw -	31/03/2025	Complete as per highlight report presented to DDIC in April 2025.

WLSP Phased Iterative Implementation Plan which is regularly reviewed

Ongoing evaluation of WLSP now in place following initial evaluation to inform programme development

Power BI Performance dashboards on IRIS

Engagement in place with Llais Cymru (formal and informal arrangements in place)

Staff Partnership Forum (UHB and County Partnership Forums)

Mechanism in place to ensure charitable funding applications demonstrate impact through agreed evaluation and metrics

Engagement Team facilitate stakeholder events to capture population feedback on consultations and key workstreams

Harms Dashboard and our Performance Dashboard in place to facilitate triangulation of data with other intelligence, eg weekly quality intelligence / surveillance meetings

Health Board wide Improving Together Sessions in place, which utilise dashboards

Staff Surveys and Pulse Surveys undertaken regularly to evaluate staff experience, and reported to People, Organisational Development and Culture Committee

Quality Impact Assessments introduced and reported to Quality, Safety and Experience Committee.

A system has been developed to support triangulation of data d. Performance Team are actively working on mechanism to facilitate easier triangulation.

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
See Our Outcomes section of BAF Dashboard	Pulse surveys sampling 1000 employees each month, selecting different staff each month	1st			Single Point of Contact Report - Board (Mar21) Patient Experience Report - every Board (May24) Periodic update reports to Executive Team on the impact of the Communication Hub and WLSP Staff Feedback Reports - PODCC QIA reported to QSEC (Sep23)	Routine reporting of triangulated performance metrics				
	Communication Hub and WLSP Steering Group overseeing delivery of the plan and the workstreams	2nd								
	Improving Together performance sessions with clinical and corporate directorates aligned to the Internal Escalation Framework	2nd								
	Formal Executive Team review and triangulate data from the Harms Dashboard, Our Performance Dashboards and other intelligence	2nd								
	Communication Hub Steering Group	2nd								
	Executive Team, through its reporting groups, oversee delivery of Planning Objectives	2nd								
	Board Committee oversight of Planning Objectives	2nd								
	Patient Experience Report to every Board	2nd								

	Listening and Learning Sub Committee oversight of patient experience	2nd							
	Periodic reporting of engagement index survey results to People, OD and Culture Committee and Board (from Nov21)	2nd							
	Public Service Ombudsman for Wales Reports	3rd							
	HIW Inspection Reports and Complaints, including implementation of recommendations	3rd							

1.5

1.5 - Cadog Ward Frailty Unit Nurse Staffing Presentation- Verbal

Donna Major (Hywel Dda UHB - Junior Sister)

2

10 Mins

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2 - Nurse Staffing Levels (Wales) Act Report and Impact of Reduction of Agency and Bank Staff on quality, safety and patient experience- To Follow

Helen Humphreys (Hywel Dda UHB - Head of Nursing for Professional Standards and Regulation), Janice Cole-Williams (Hywel Dda UHB - Assistant Director of Nursing)

Attachments

2 Quality Safety Experience Committee impact of reduction in agency bank~.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 October 2025
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Nurse Staffing Levels: Impact of Reduction of Agency and Bank Staff on quality, safety, and patient experience
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Sharon Daniel, Interim Executive Director of Nursing, Quality & Patient Experience
SWYDDOG ADRODD: **REPORTING OFFICER:**	Janice Cole-Williams, Assistant Director of Nursing Helen Humphreys, Head of Nursing, Professional Standards and Regulation Catrin Jones, Nurse Staffing Programme Lead

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 Quality, Safety and Experience Committee with an updated on the impact of reduction of agency and bank staff on quality, safety, and patient experience.

Cefndir / Background

Reviewing the impact of reduction of agency and bank staff on quality, safety and patient experience originated from an action from the People, Organisational Development & Culture Committee (PODCC) on 9th April 2024. An update on the stabilisation work programme, the recruitment of internationally educated nurses included a discussion on whether there had been any impact of these changes on clinical outcomes. A subsequent action from the meeting was to "examine the triangulation between clinical outcomes and reduction of agency and bank staff, and report back to Committee."

This update was provided to People, Organisational Development & Culture Committee (PODCC) on the 29th of October 2024 hduhb.nhs.wales/about-us/governance-arrangements/board-committees/people-organisational-development-and-culture-committee-podcc/podcc-29-october-2024/2-3-workforce-efficiency-update/. The Committee received assurance from the report, but the update highlighted the need for further review of any impact these changes may be having on the quality, safety, and experience of patients and that subsequent updates would be provided to the Quality, Safety and Experience Committee.

An SBAR was presented to the Quality, Safety and Experience Committee on 13th February 2025. hduhb.nhs.wales/about-us/governance-arrangements/board-committees/quality-safety-and-experience-committee-qsec/qsec-13-february-2025/2-1-nurse-staffing-levels-impact-of-reduction-of-agency-and-bank-staff-interim-report/, and the committee received assurance from the report.

Work currently being undertaken is in line with requirements set out in the Nurse Staffing Levels (Wales) Act 2016 (the 'Act') and includes:

- The health board's responsibilities to provide "sufficient nurses to allow the nurses time to care for patients sensitively" in all settings (Section 25a).
- The responsibilities of the designated person for calculating and maintaining the nurse staffing levels for those areas were S25b (3) applies (Section 25b and Section 25c).
- The Welsh Government's responsibilities to develop statutory guidance (Section 25d); and
- The Health Board's reporting responsibilities (Section 25e). The statutory guidance (2021) published to support the application of the 'Act' defines nurse 2 of 11 staffing levels as the number of Registered Nurses (RN) and others who undertake nursing duties under the supervision of RN which is "appropriate to provide care to patients that meets all reasonable requirements" (Welsh Government, 2016; p. 3)

Asesiad / Assessment

The data for Community and Integrated Medicine, Planned and Specialist Care and Mental Health and Learning Disabilities Clinical Care Groups shows that:

- As of July 2025, the Band 5 vacancy position was 131wte. When compared to the vacancy position in May 2023 (277wte), this is a 52% reduction.

RN Band 5 vacancies:		
July 2025	Sept 2024	May 2023
131wte	166wte	277wte

  The vacancy position is expected to reduce further once the September 2025 newly registered nurses commence their employment with us.
- The monthly Whole Time Equivalent (wte) usage of temporary nursing workforce reported through Allocate shows that Registered Nurse (RN) agency usage has seen a reduction and is currently 63.06wte as of August 2025 (although slightly up on the July 2025 position). This compares to 105.36wte for December 2024 (and 341.25wte in January 2023), an overall reduction of 81.5% since January 2023 and a 40.15% on the December 2024 position. Vacancy and short-term sickness are the main reasons for RN agency requests. Agency usage is expected to reduce further over the coming months due to the placement of newly registered nurses starting with us as of September 2025.
- The 12-month rolling sickness for Registered Nurses for August 2025 was 6.7%. The 12-month rolling sickness has been consistent since April 2023 - with a low of 6.4% in December 2024 and a high of 7% in April 2023.

Incident reporting: a downward trend in reporting has been seen across the HB when comparing the number of incidents reported during 2024/2025 when compared to previous years. An exploration of the top classification and categories has been undertaken by the Quality, Safety and Assurance Team which shows that the reduction is in the number of pressure and moisture damage incidents being reported. The reduction in these types of incidents being report is due to targeted work to remove duplicate incidents and improved understanding about reporting of pressure damage identified on admission.

The Quality metrics reviewed for the purpose of this report are as follows:

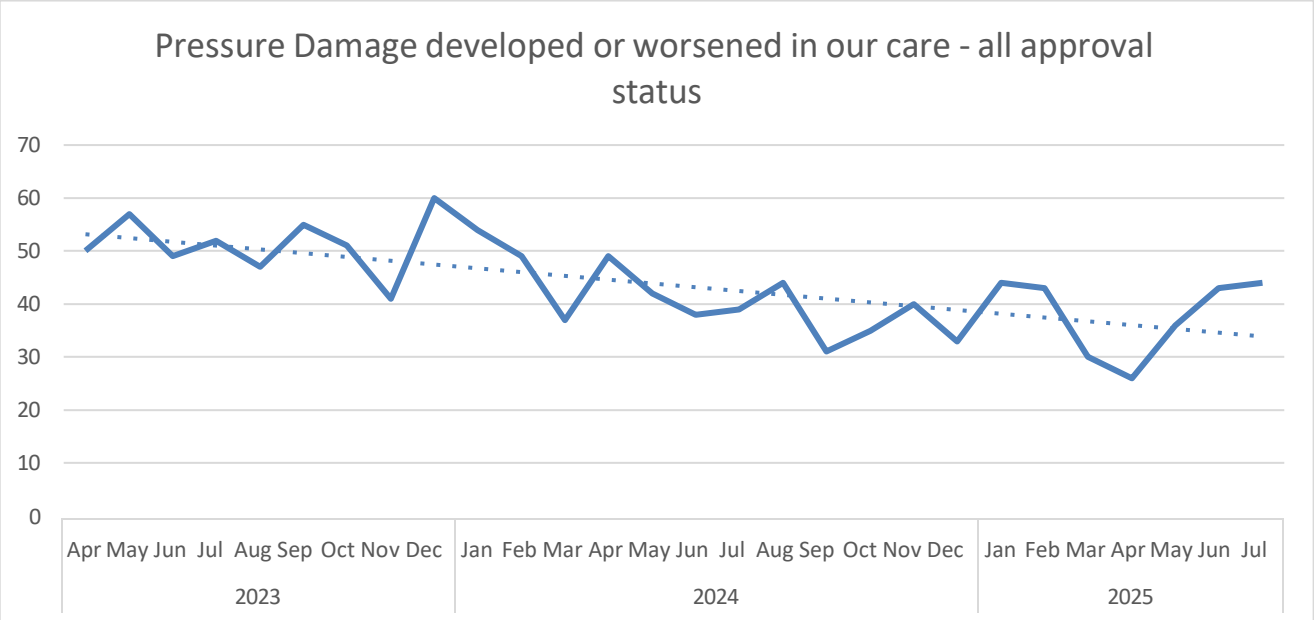
Patient safety incidents: There was a total of 31,671 Patient Safety Incidents reported across all services within Hywel Dda UHB between 1st April 2023– 31st July 2025 (data from Datix Cymru).

he incidents referenced below are for the Community and Integrated Medicine, Planned and Specialist Care and Mental Health and Learning Disabilities Clinical Care Groups and is for those areas where bank and/or agency staff are predominantly utilised. The incident data in this SBAR may therefore be different from the incident data referenced in other reports.

Pressure Damage which developed or worsened in our care (including pressure damage from medical device which developed or worsened in our care)

All our services (Community and Integrated Medicine, Planned and Specialist Care and Mental Health and Learning Disabilities Clinical Care Groups)**:** There continues to be a downward trend in the number of pressure damage which developed or worsened in our care since 1st April 2023. Some of the reduction in these types of incidents is due to targeted work to remove duplicate incidents and improved understanding about reporting of pressure damage identified on admission (since November 2023) mentioned previously.

Time period	Average number of incidents reported per month
April-December 2023	51.3 incidents (range a high of 60 in December 2023 to a low of 51 in November 2023)
January-December 2024	40.9 incidents (range a high of 54 in January 2024 to a low of 26 in April 2024)
January-July 2025	38 incidents (range a high of 44 in January and July 2025 to a low of 26 in April 2025)



- **Avoidable harm:** The number of incidents of avoidable harms across these services has also decreased.

Time period	Average number of incidents reported per month
April-December 2023	18.8 incidents (range a high of 24 in Sept 2023 to a low of14 in May 2023)
January-December 2024	17 incidents (range a high of 25 in February 2024 to a low of 11 in December 2024)
January-July 2025	13.4 incidents (range a high of 18 in January 2025 to a low of 9 in April 2025)

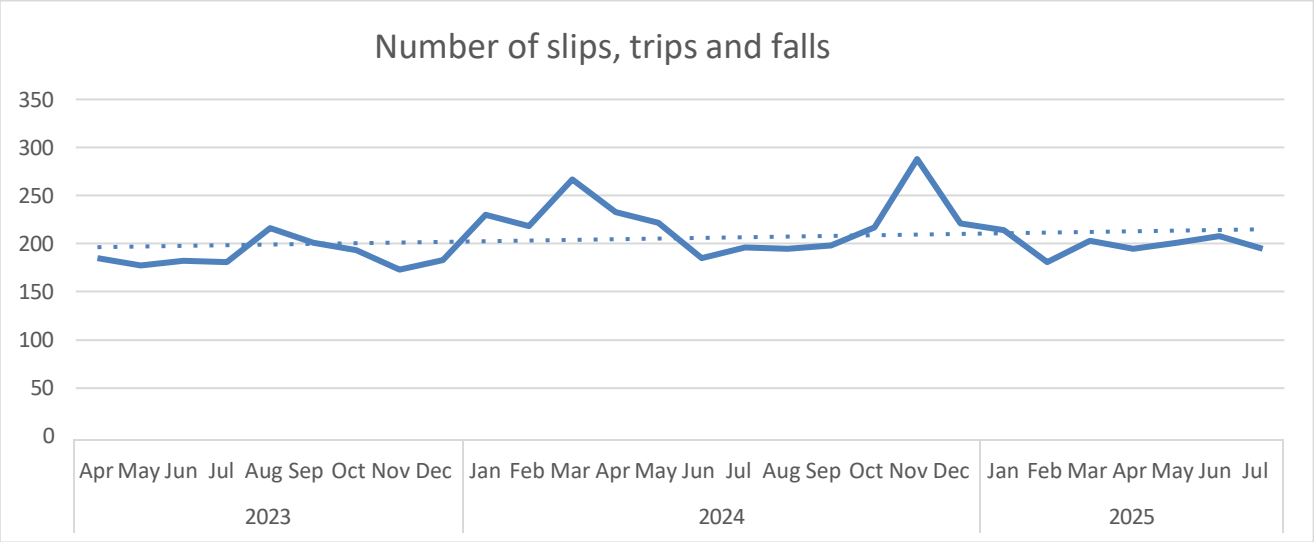
- **Temporary worker:** The number of pressure damage incidents which developed or worsened in our care where a temporary worker was involved (across all our services) has also seen a decrease from an average of 7.2 incidents per month during 2023 to an average of 5.08 per month for 2024, and to 2.2 per month for the period Jan-July 2025.

Adult Wards where S25B applies: The number of pressure damage cases which developed or worsened in our care on the adult wards where section 25B of the Nurse Staffing Levels (Wales) Act (the 'Act') applies i.e. adult acute medical and surgical inpatient wards, has reduced from an average of 25.44 per month in 2023 to an average of 22.25 per month in 2024 and an average of 16.7 per month for the period January to July 2025.

- **Avoidable harm:** The number of incidents of avoidable harms across our S25B adult wards has also decreased. An average of 8.1 per month in 2023, 7.8 per month in 2024 and an average of 6.1 incidents per month the period January to July 2025.
- **Temporary worker:** The number of pressure damage incidents which developed or worsened in our care where a temporary worker was involved (across S25B adult wards) has also seen a decrease from an average of 1.7 incidents per month during 2023 to an average of 0.66 per month for 2024, and to 0.1 per month for the period Jan-July 2025.

Falls

Across all our services (Community and Integrated Medicine, Planned and Specialist Care and Mental Health and Learning Disabilities Clinical Care Groups) **-** There was an increase in the total number of falls being reported across these services between 2023 and 2024 (from an average of 118.7 falls per month in 2023 to an average of 222.5 incidents of falls in 2024) but a decrease between 2024 and 2025 with an average of 199.57 falls per month for January to July 2025.



- **Level of Harm:** for those incidents that have been investigated and closed the number of falls resulting in no or low harm (post investigation harm assessment) increased between 2023 and 2024 (an average of 184 per month in 2023 and an average of 216.66 per month in 2024) but has decreased between 2024 and 2025 with an average of 171.14 per month for January to July 2025. There is also a downward trend in those incidents that have been investigated and closed that have resulted in resulting in moderate, severe or catastrophic harm (post investigation harm assessment) (an

average of 3.3 per month in 2023, an average of 1.9 per month in 2024 and an average of 0.42 per month for January to July 2025).

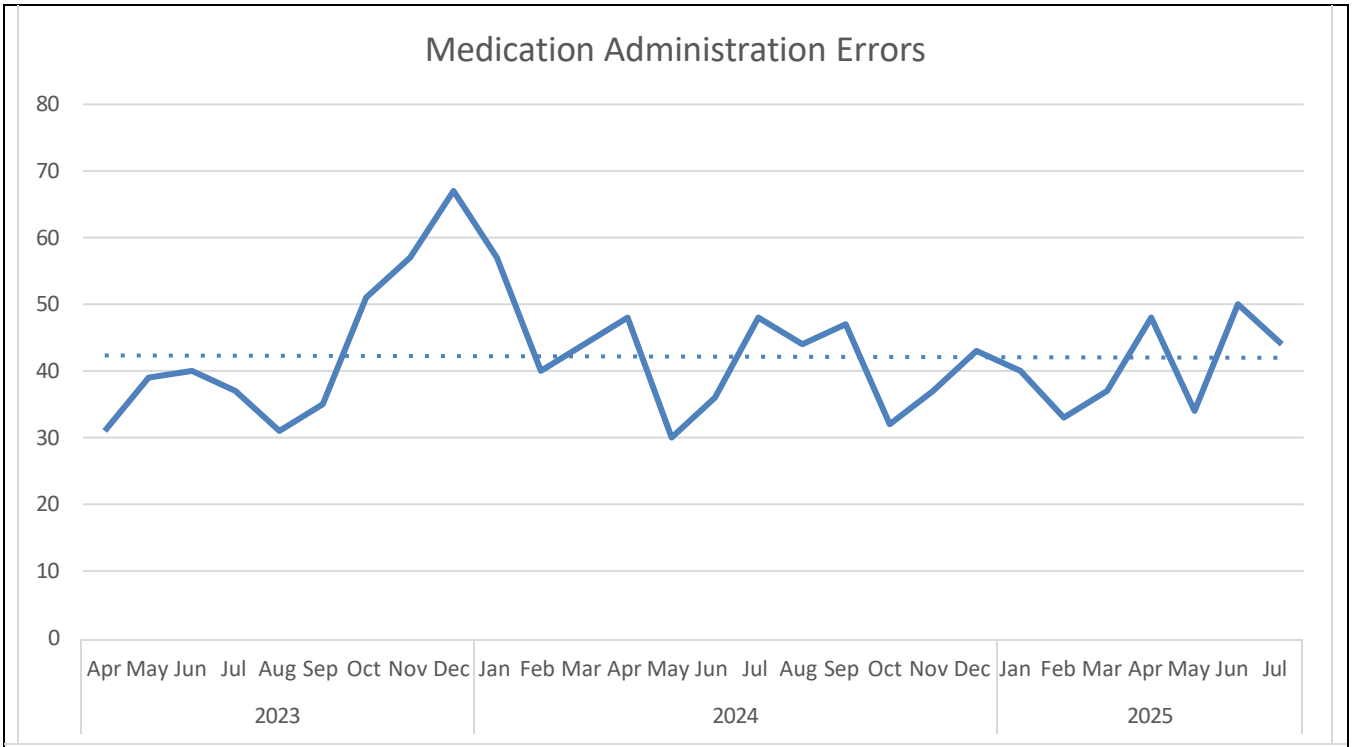
- **Temporary worker**: The number of falls where a temporary worker was involved (across all our services) increased between 2023 and 2024 from an average of 28.55 incidents per month during 2023 to an average of 29.25 per month for 2024. The number of falls where a temporary worker was involved has decreased to an average of 5.85 incidents per month for the period Jan-July 2025.

Adult Wards where S25B applies: The number of falls reported across the wards where S25B applies increase between 2023 and 2024 (an average of 103.22 per month in 2023 to 111.16 per month in 2024) but has decreased between 2024 to 2025 with an average of 108.57 per month for the period January to July 2025.

- **Level of harm:** For those incidents that have been investigated and closed there was increase in the number of falls resulting in no or low harm (post investigation harm assessment) between 2023 and 2024 (an average of 101.66 per month in 2023, an average of 106.91 per month in 2024) but there has been a decrease between 2024 and 2025 with an average of 97.28 per month for January to July 2025.
- For those incidents that have been investigated and closed that have resulted in moderate, severe, or catastrophic harm (post investigation harm assessment) there was an average of 1.44 per month in 2023, and an average of 1.16 per month in 2024. There are no closed incidents of falls resulting in moderate, severe, or catastrophic harm for 2025 but there are three open incidents for 2025 which are currently being investigated.
- **Temporary worker**: The number of falls where a temporary worker was involved (across S25B wards) has decreased from an average of 16.5 incidents per month during 2023 to an average of 12.75 per month for 2024 and 3.2 per month for the period January to July 2025.

Medication Administration Errors

Across all our services (Community and Integrated Medicine, Planned and Specialist Care and Mental Health and Learning Disabilities Clinical Care Groups): The number of medication administration errors affecting patients (closed and open incidents) is reported as seeing a small decrease from an average of 43 incidents per month during 2023 to an average of 42 incidents per month for 2024 and an average of 41 incidents per month for January to July 2025.



- **Temporary worker -** The number involving temporary staffing has seen a decrease from an average of 12.6 incidents per month in 2023 to an average of 13.5 incidents per month in 2024 to an average of seven incidents per month for the period January to July 2025. In 2024, a robust monitoring process was introduced to support temporary staff to orientate to new areas.

Adult Wards where S25B applies • The number of medication administration errors affecting patients has seen a decrease with an average of fourteen incidents per month reported in 2023 compared to 12.5 incidents in 2024 and 12.4 incidents for January to July 2025.

- Temporary worker - The number involving a temporary worker has seen a decrease from 5.55 incidents per month in 2023 to an average of 3.9 incidents per month in 2024 and an average of 2.85 incidents per month for January to July 2025.

The HB will be shortly rolling out an Electronic Prescribing and Medicines Administration (EPMA) system. It is anticipated that the roll out of EPMA will reduce medication errors linked to illegibility, multiple or missing drug charts and incorrect dosing or frequency. However, EPMA will not reduce errors linked to human factors, communication breakdowns or adverse drug reactions. Medication-Related Incidents and the Potential Impact of EPMA Systems (2024)

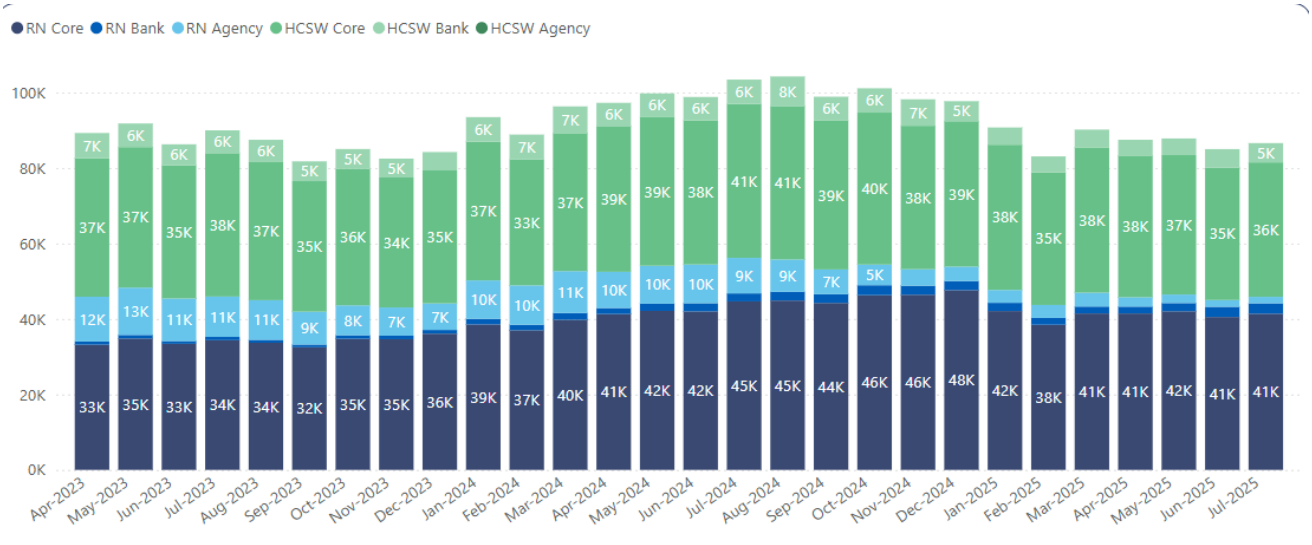
Number of RN and Health Care Support Worker (HCSW) staffing Hours on S25B wards - this data is captured via safecare for those areas where section 25B of the Act applies. The data sets out the number of hours worked by:

- RN core (substantive staff)
- RN bank
- RN agency
- HCSW core (substantive staff)
- HCSW bank
- HCSW agency (if appliable)

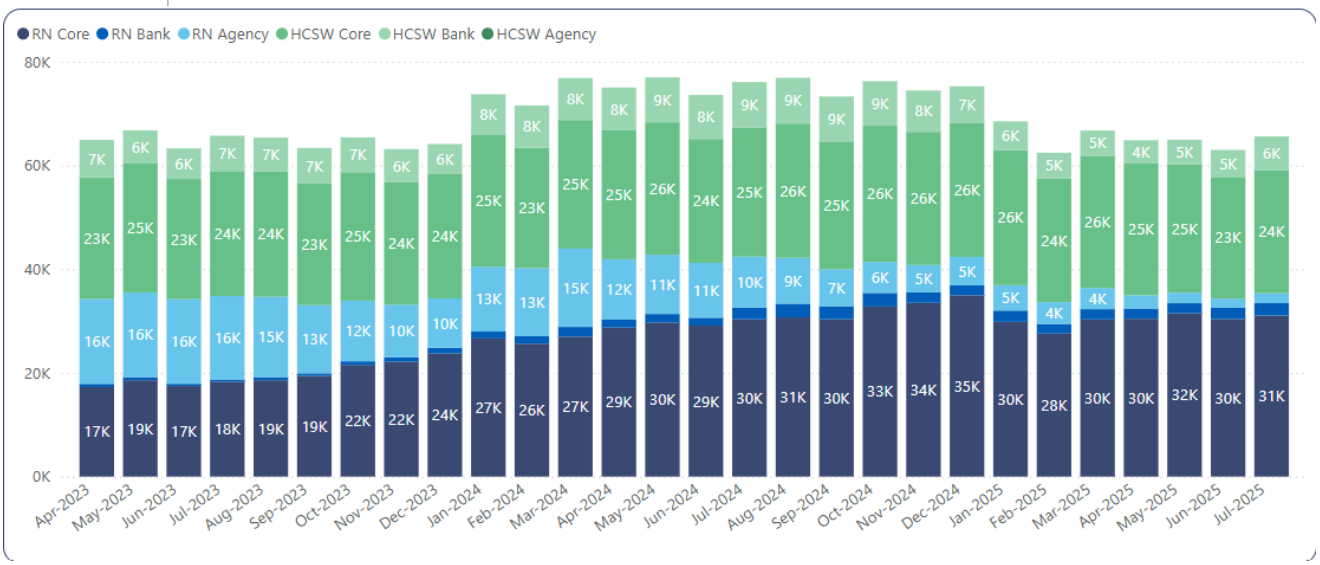
For the adult S25B wards, the data shows that although agency staff were being deployed on both day and night shifts, most of the agency usage was at night (most agency staff indicated

that they would prefer to work night duty rather than day duty). The data does show the decrease in agency usage since April 2023, which is particularly noticeable on the graph for the night shifts (the lighter blue in the two graphs). the data also shows the corresponding increase in RN core hours (the darker blue in the two graphs).

Day - Number of RN and HCSW staffing Hours.



Night - Number of RN and HCSW staffing Hours.



Falls – the times of the incidents of falls have been reviewed and where the time of the incident is record, the average numbers of falls that occurred between 730pm and 730am for 2023 was 99.66 per month. This increased to an average of 107.16 per month for 2024 but has decreased to 94.28 per month for the period January-July 2025.

Risk and Limitations for this paper:

- it is recognised that the data for 2023 and 2025 is part year data (9 months and 7 months respectively) whereas the data for 2024 is for the full 12 months and this may impact on some of the analysis.
- As more substantive staff are recruited, the number of nursing and midwifery vacancies decreases, however, it is recognised that in several of our clinical areas we have inexperienced, newly registered nurses and nurses who are new to the UK Health

Service (particularly in BGH) who will need time and support to become established in their registered nurse role.

Conclusion:
The data does suggest that there have been positive changes in terms of patient outcomes since April 2023 and whilst some of this is down to the reduction of bank and agency usage, it is unlikely that the reduction in the use of bank and agency workers is the only factor that has resulted in this change. Examples include:

- Continued focus on supporting staff with training and education around the three incident types set out above.
- Teams undertaking EQIiP projects which have focused on reducing patient safety incidents.
- Changes in the way we report, for example the targeted work to remove duplicate incidents relating to pressure damage which develops or worsens in our care mentioned in this paper.

Triangulation of date

"Walkrounds" – the 'walkrounds' undertaken during 2024/2025 included both positive observations and areas for improvement. The positive observations included staff commitment, compassion, teamwork, and morale. The areas requiring improvement included workforce pressures including staff shortages in several areas particularly in Mental Health and Community nursing and reliance on temporary staff in those areas.

There has been work undertaken to review the nurse staffing levels on the Mental Health inpatient wards and the additional finance requirements have now been transacted into the budgets., with a recruitment plan in place to recruit the additional staff required.

There has been work undertaken within the community teams to consider the National Community Nursing Specification: Overarching principles, characteristics, and functions of Community Nursing in Wales (2022) and work towards the staffing principles set out in the document.

Health Inspectorate Wales (HIW) reports: one visit undertaken by HIW during 2024/2025 and two visits undertaken by HIW during 2023/2024 noted concerns around staffing levels. There has been work undertaken to review the nurse staffing levels in these areas which includes the mental health inpatients staffing review noted above. There has also been work undertaken within our Emergency Departments with the nursing workforce increased in both WGH and GGH, and work ongoing in the Emergency and Urgent Care Unit (EUCC) in BGH.

Duty of candour –During 2024/25, there were 132 patient safety incidents that triggered the duty of candour. There were 104 recorded as moderate harm, 19 as severe harm and 9 as catastrophic/death hduhb.nhs.wales/about-us/governance-arrangements/board-committees/quality-safety-and-experience-committee-qsec/qsec-10-june-2025/4-4-duty-of-candour-report-2024-25/. There is no comparable data for previous years as the Duty of Candour came into force on 1st April 2023. The themes of the patient safety incidents included in-patient slips, trips or falls (20% of the incidents) ; pressure damage that developed or worsened whilst receiving healthcare (11% of the incidents); inappropriate monitoring and/or escalation (8% of the incidents) and medication error/delay/omission (4% of the incidents).

The learning identified included:

- ensuring that required training has been completed and competency assessed,
- introduction of peer review of pressure damage to confirm grading,

- Use of body map for pressure damage
- the use of the cannula bundle and recording Visual Infusion Phlebitis (VIP) score
- importance of environment and patient safety huddles.
- Importance of assessing overall clinical picture
- Importance of completing NEWS correctly and escalating accordingly.

Staff wellbeing There is evidence that having the right nurse staffing levels has a positive impact on staff, with some studies showing that staff with the most demanding workloads were more likely to report job dissatisfaction exacerbated by missed breaks; poor compliance with mandatory training; emotional exhaustion and their intention to leave their job, Having the right number of staff, however, leads to an increase in people wanting to join the profession and improved retention figures (Aiken et al., 2012; Butler et al., 2019; Halm, 2019; Hill, 2017; MacPhee et al., 2017; Tellez, 2012, Van den Heede et al., 2013; Wynendale et al., 2019). Data we do have is shown below.

Staff Survey – whilst the positivity score for the theme patient safety increased from 48.5% in 2023 to 57.1% in 2024 (an increase of 8.7%) , the theme highlighted that staff feel unsafe in reporting errors, near misses or incidents and there is a perception that those that do report are treated unfairly and there is little feedback after doing so. Whilst the survey included all staff groups, this has implications for nursing. The Quality Assurance and Safety Team are:

- Considering additional areas for inclusion in newsletters and 7-minute briefings.
- Reminding investigation managers of the importance of documenting within the relevant section in the Datix Incident Module the feedback to the reporter which shows that the time taken by the reporter is valued.
- Working with Clinical Service Groups (where reporting levels are lower than expected) to develop trigger lists for incident reporting.
- Working with Clinical Service Groups to refocus the Scrutiny Panels to become Learning from Events Panels.
- Working with acute hospital pharmacy colleagues to consider how medication prescription errors identified before administration (near miss incidents) can be captured as these are captured within pharmacy systems rather than in Datix Cymru.

Percentage of staff how had had a Performance, Appraisal and Development Review (PADR) in the last 12 month – The data for Community and Integrated Medicine, Planned and Specialist Care and Mental Health and Learning Disabilities shows that as of August 2025, 82% of registered nurses and midwives have had a PADR, this compares to 72.6% in April 2023, 76.6% in April 2024 and 82.6% in April 2025.

Percentage staff compliance with the Core Skills Training Framework - The data for Community and Integrated Medicine, Planned and Specialist Care and Mental Health and Learning Disabilities shows that as of August 2025, 92.7% of registered nurses and midwives are compliant with the Core Skills Training Framework, this compares to 90.3% in April 2023, 91% in April 2024 and 91.5% in April 2025

Patient experience –

- **Complaints/concerns -** there was one complaint received in 2023 which was managed though PTR were the failure to maintain the planned roster was deemed to be a contributory factor to the nature of the complaint, this increased to six complaints in 2024. For the period January-July 2025 there has been one complaint were the failure to maintain the planned roster was deemed to be a contributory factor to the nature of the complaint.

- Feedback from the walk arounds included comments about the kindness and professionalism of staff.
- For the period April and May 2025, 203 compliment were received direct to wards, departments, or the Chief Executive/Chair's office and these highlighted the professionalism and compassionate care provided by healthcare teams.

Monitoring of key indicators

The number and level of harm of falls, pressure damage and medication errors are considered as part of any nurse staffing level review. Reviews are undertaken as a minimum of six monthly for those wards where Section 25B of the Nurse Staffing Levels (Wales) Act applies i.e. adult acute medical and surgical inpatient wards, paediatric inpatient wards. and for any Section 25A areas when a nurse staffing review is undertaken.

- Operational teams have scrutiny processes in place that enable incidents and complaints to be reviewed, and consideration given to what actions need to be taken and what learning can be shared. Scrutiny & Assurance Meetings are held for each acute site (with representation from community teams) to monitor and scrutinise inpatient falls, identifying causal factors and sharing learning to prevent recurrence.
- Outcomes from the Scrutiny & Assurance Meetings feed into the Clinical Care Groups Governance arrangements
- The Adult Inpatient Falls Reduction Improvement Group (AIFRIG) was established as a group of the Quality, Safety and Experience Sub Committee in May 2023. The role of the Group is to "review and analyse claims, learning from events and performance reports which will help inform operational direction and contribute to the reduction and improvement of inpatient falls. This group will now report into Integrated Quality, Financial Performance and Delivery Group.
- There are health board and advisory groups which focus on key aspects of care and monitor practice related issues. e.g. the Nutrition and Hydration Group, Falls Group and Medication Errors Review Group (MERG).

Argymhelliad / Recommendation

The Quality, Safety and Experience Committee is requested to take assurance that a review of the reduction of agency and bank staff initiative has not identified any adverse impact on the quality, safety, or experience outcomes of patients, however, this will continue to be closely monitored.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	2.1 Scrutinise, assess, and seek assurance in relation to the patient impact, quality and health outcomes of the services provided by the Board
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not appliable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	1. Safe 6. Person-Centred Choose an item. Choose an item.
Galluogwyr Ansawdd: Enablers of Quality:	3. Data to knowledge 4. Learning, improvement and research Choose an item.

Quality and Engagement Act (sharepoint.com)	Choose an item.
Amcanion Strategol y BIP: UHB Strategic Objectives:	1. Striving teams Choose an item. Choose an item. Choose an item.
Amcanion Cynllunio Planning Objectives	1 Workforce Stabilisation 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 Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Data extracted from Datix, Our Performance dashboard and papers presented to People Organisational Development Culture Committee
Rhestr Termau: Glossary of Terms:	RN – Registered Nurse HCSW – Health Care Support Worker
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	Not appliable

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not applicable
Ansawdd / Gofal Claf: Quality / Patient Care:	The report sets out Impact of Reduction of Agency and Bank Staff on Quality, Safety and Patient Experience
Gweithlu: Workforce:	Not applicable
Risg: Risk:	Not applicable
Cyfreithiol: Legal:	Not applicable
Enw Da: Reputational:	Not applicable
Gyfrinachedd: Privacy:	All data is anonymous
Cydraddoldeb: Equality:	Not applicable

4

30 Mins

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4 - Risk

4.1

4.1 - Unscheduled Care Deep Dive

Peter Skitt (Hywel Dda UHB - Clinical Care Group Service Director - Community & Integrated Medicine), Gareth Cottrell (Hywel Dda UHB - Deputy Chief Operating Officer)

Attachments

4.1 Unscheduled Care Programme.pdf

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.

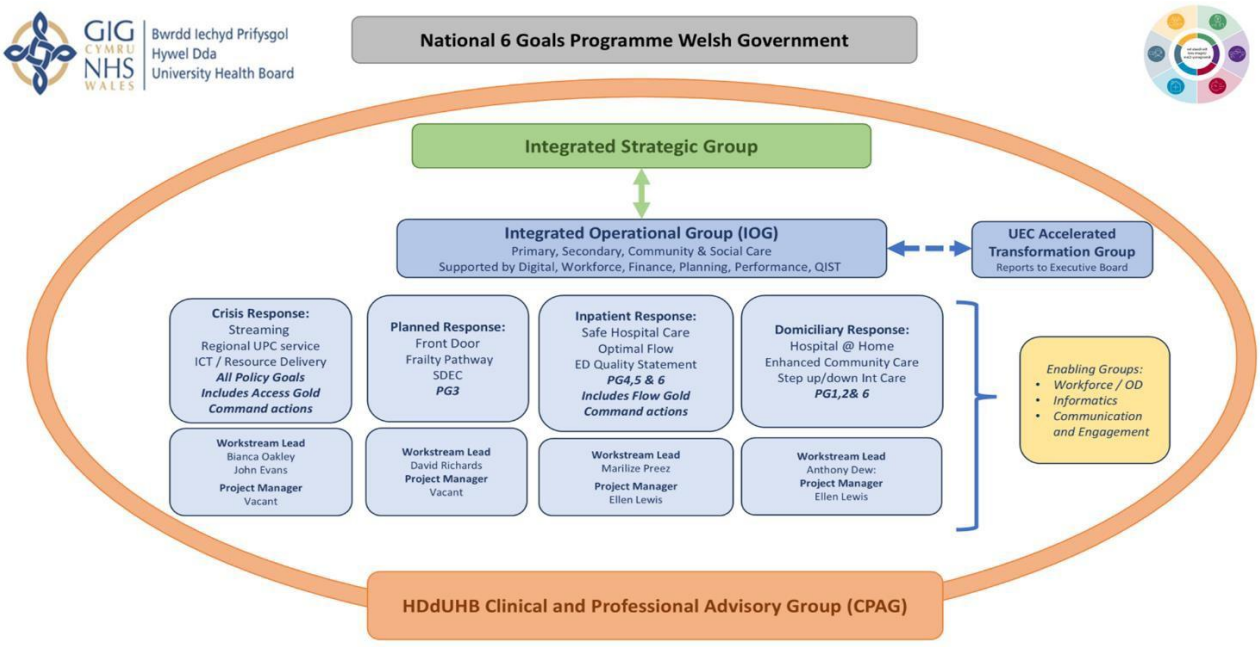
Meeting the Duty of Quality is the highest priority for the Programmes and its governance structures and oversight has developed significantly. The Senior Responsible Officers, Workstream Leads and Clinical lead head the agenda which is aligned to the six domains of quality as defined by the Duty of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

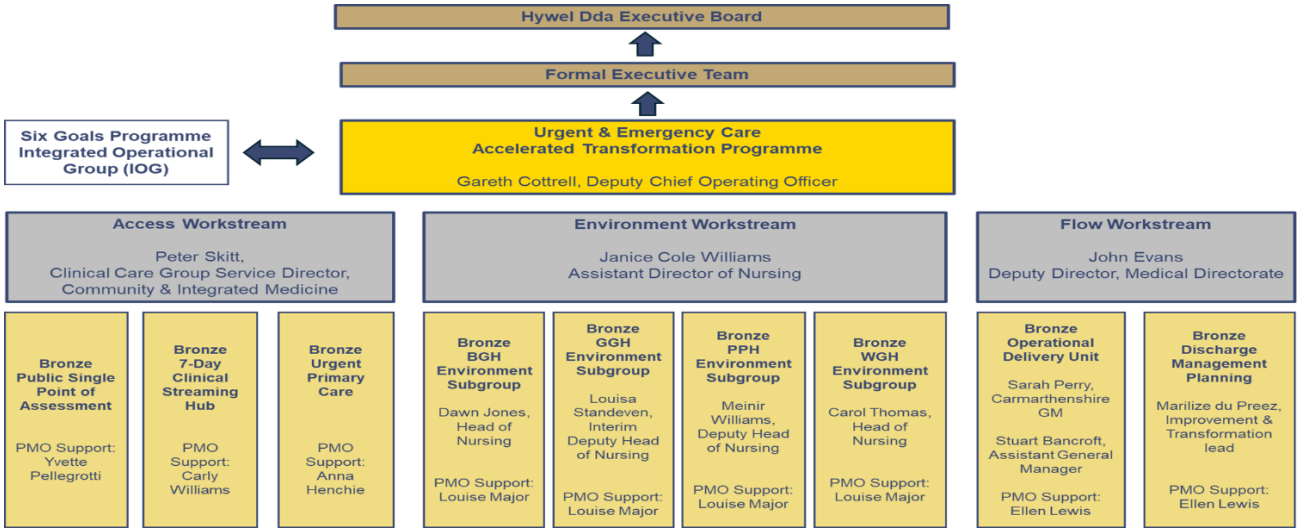


Asesiad / Assessment

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:





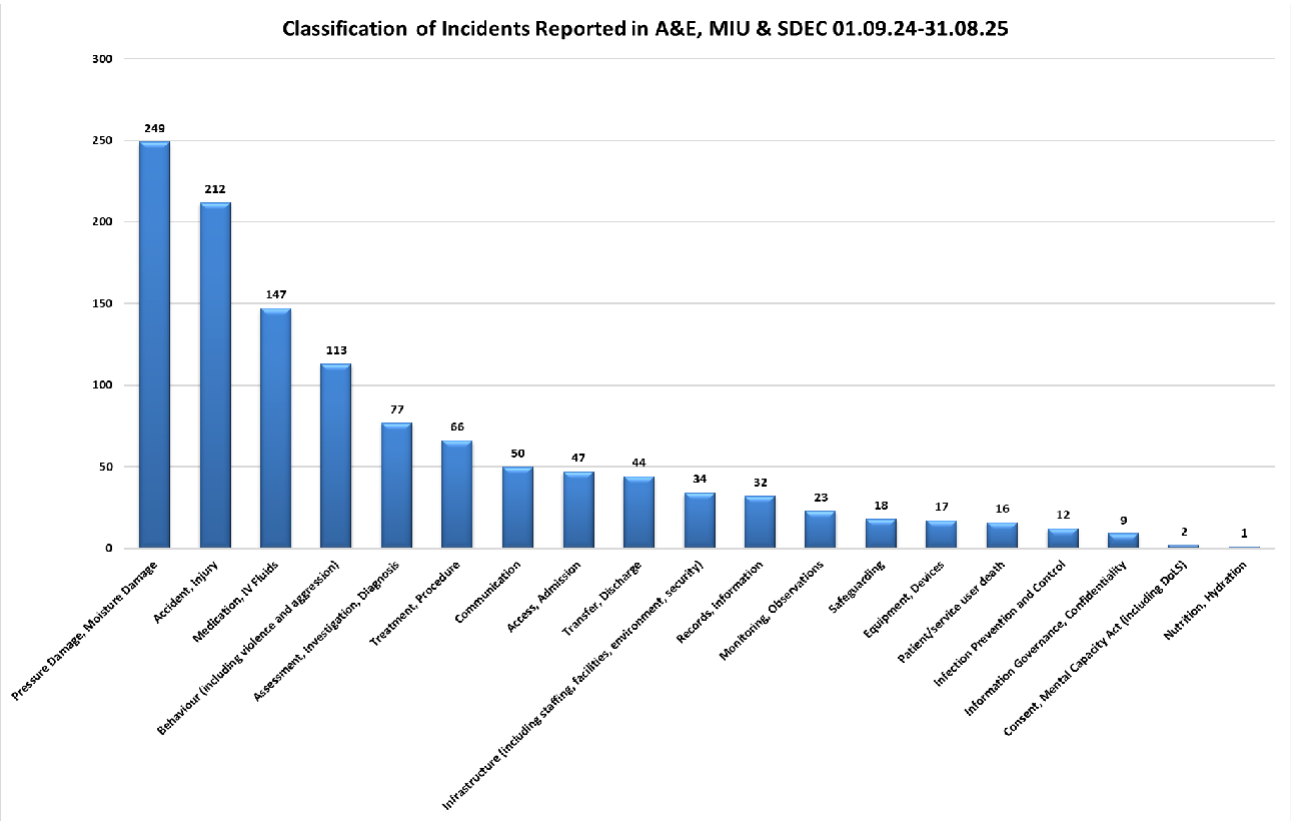
Both Programmes report to the Improving Quality and Performance and Delivery Group (Welsh Government) and the Improving Quality, Finance, Performance Delivery Group on a monthly basis. Furthermore, the Accelerating Transformation Programme reports to Formal Executive Team meetings on a fortnightly basis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

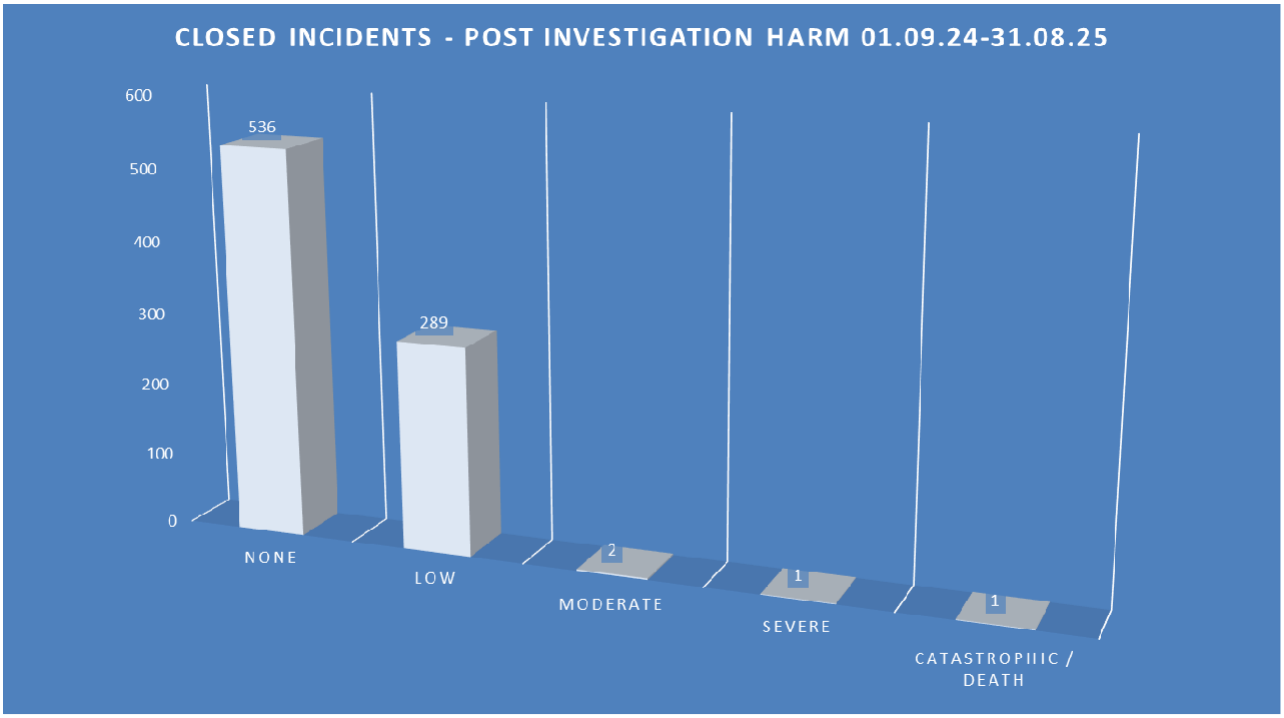
Safe Care

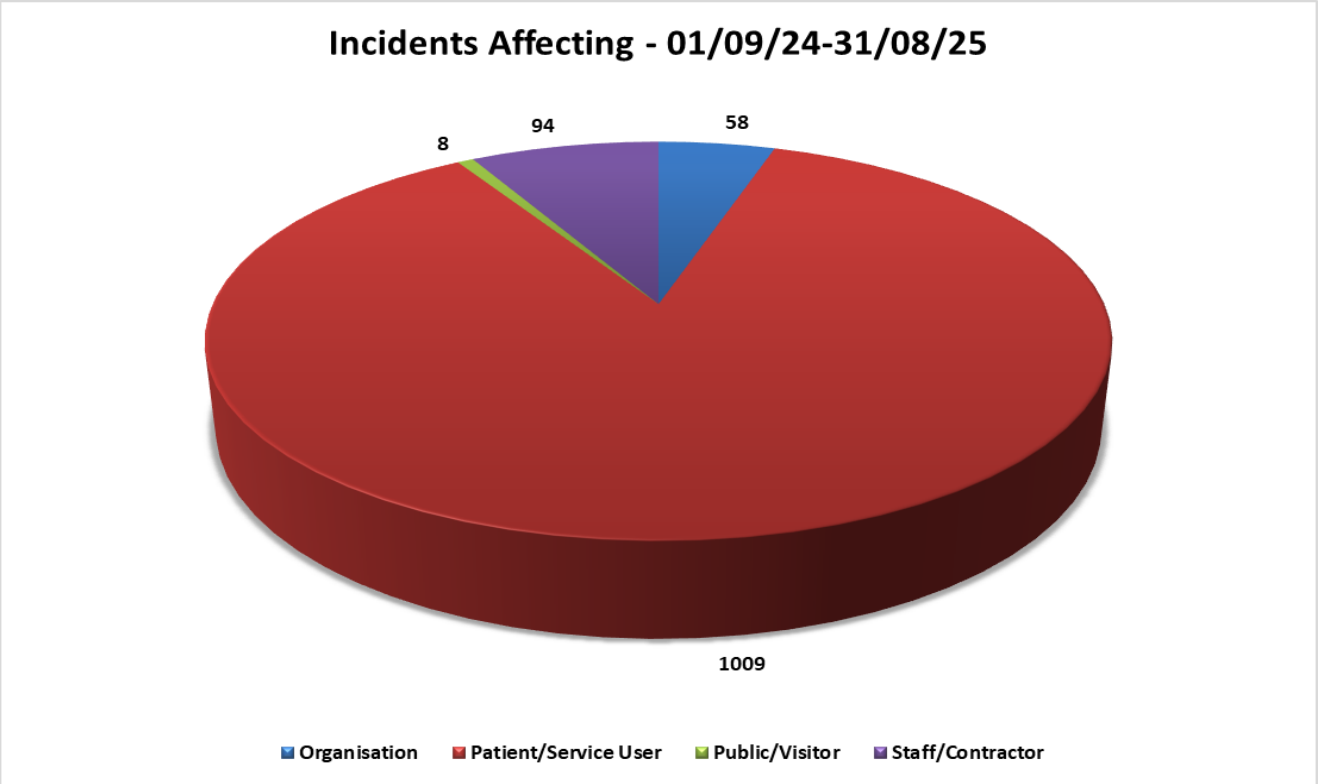
Incident reporting



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
CATASTROPIIIC / 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.

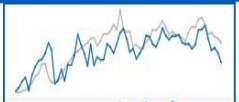
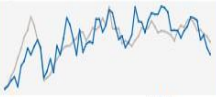
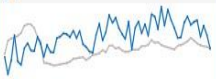
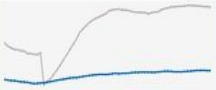
Summary Emergency Department Indicator Table (SEDIT) July 2025 Data/Get It Right First Time (GIRFT) Data:

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

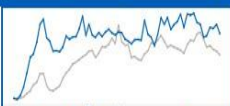
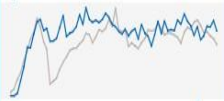
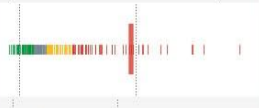
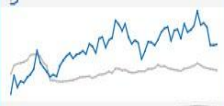
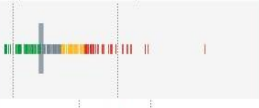
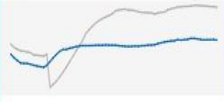
Click on a metric below to view further analysis.

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)

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	%	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.

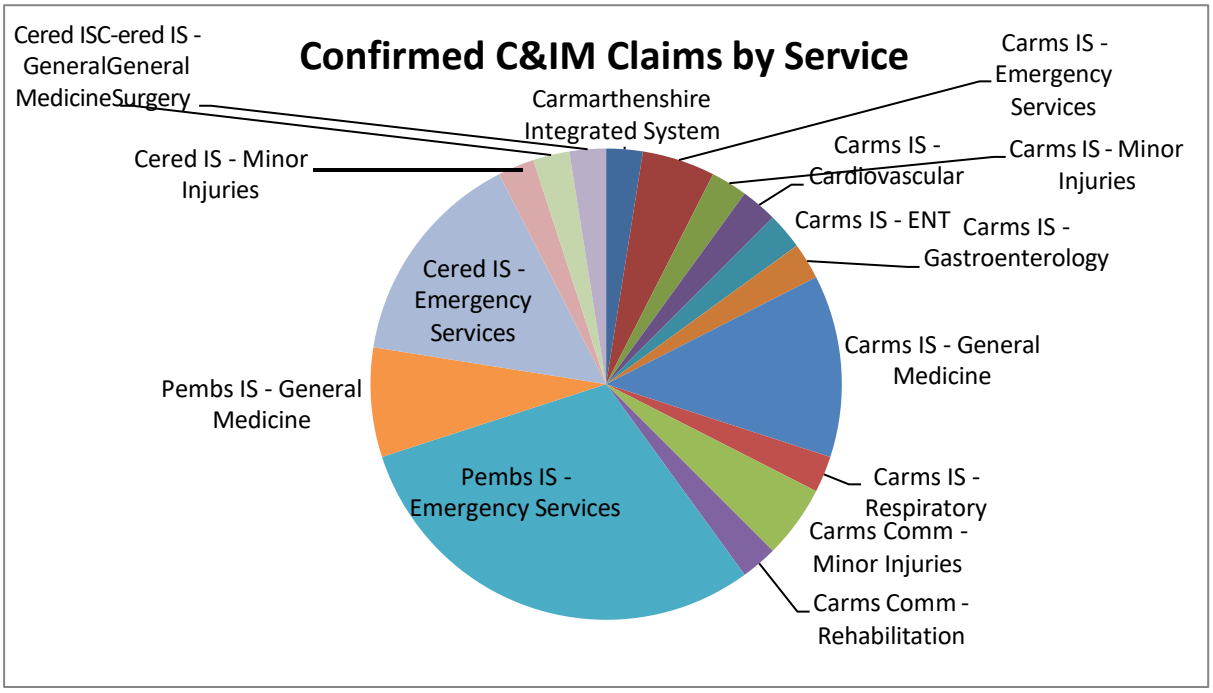
- Glangwilli General Hospital – 61
- Prince Philip Hospital – 11
- Carmarthenshire Community - 1
- Bronglais General Hospital – 43
- Ceredigion Community - 1
- Withybush General Hospital – 11
- Pembrokeshire Community – 6

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.

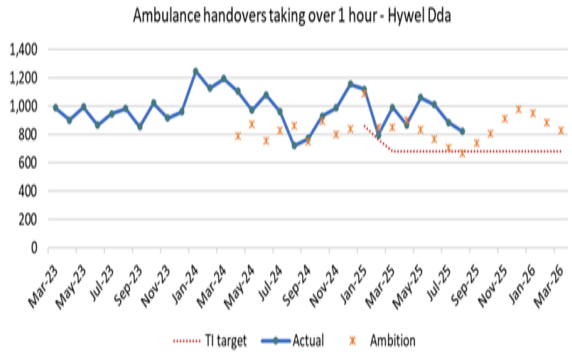
Urgent and Emergency Care Risk

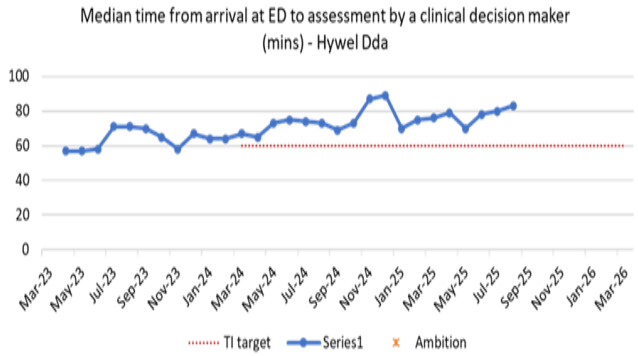
Date Identified	Risk Area	Risk Title	Risk Statement	Risk Owner	Risk Assigned	Severity	Likelihood	Risk Score	Mitigation Plan	Mitigated Severity	Mitigated Likelihood	Mitigated Risk Score
14/01/2025	Programme	Corporate	There is a risk to the consistent delivery of timely and high quality urgent and emergency 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

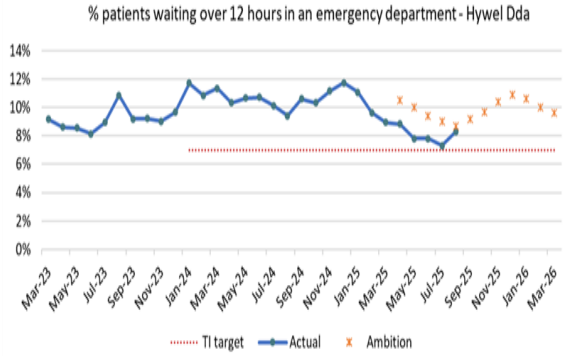
Risks are scrutinised on a monthly basis at both individual system and care group wide level. This ensures mitigations are updated and reviewed appropriately and on a regular basis. This also acts as a consistency check for the revised risk level, reported on a monthly basis.

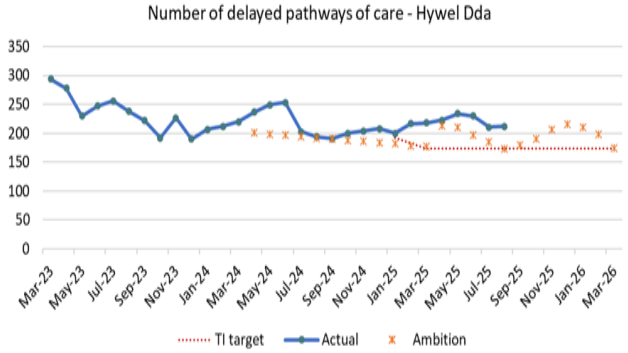
Timely

(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.

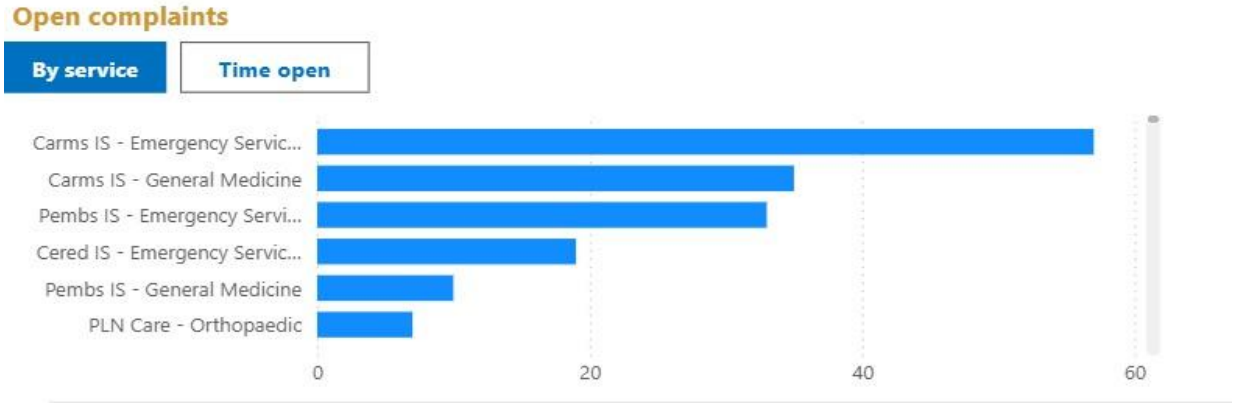
Equitable

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

4.2

4.2 - Public Interest Report- Verbal

Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Sharon Daniel (Hywel Dda UHB - Executive Director of Nursing, Quality & Patient Experience), Louise O'Connor (Hywel Dda Health Board - Assistant Director), Olwen Morgan (Hywel Dda UHB - Assistant Director of Nursing)

5

60 Mins

5 - Assurance

5.1

5.1 - Quality Assurance Report

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

Attachments

5.1 QS Assurance Report Oct2025.pptx

Appendix 1 Improving Patient Experience Report.pdf

Appendix 2 PSOW Annual Letter 2024-25.pdf

Appendix 3 HIW new NHS Wales Engagement Process.pdf

Appendix 3 HIW - NHS Engagement Process - Guidance for Health Boards and Tr~.pdf

App 4 HIW overdue actions.pdf



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

Quality and Safety Assurance Report

Quality, Safety and Experience Committee

October 2025

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
- Duty of Candour
- Patient Experience
- Complaints management
- Public Services Ombudsman for Wales Annual Letter
- Infection prevention and control
- Inspections and peer reviews including activity of Healthcare Inspectorate Wales (HIW)

Patient Safety Incidents and Nationally Reported Incidents

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

There were 15,280 incidents reported on Datix Cymru in Hywel Dda UHB between 1st September 2024 and 31st August 2025. Of these, 12,424 were Patient Safety Incidents.

Of the 12,424 patient safety incidents reported, 9,431 have been closed. 75 (0.8%) were closed as moderate, severe or catastrophic harm.

The top 3 incident classifications (patient safety incidents reported between 01/09/2024 and 31/08/2025 and closed as moderate, severe or catastrophic harm) were pressure damage (21); accident or injury (12); and treatment and procedure (8). This can be broken down further into the categories.

Pressure ulcer developed or worsened during care in this clinical care area/caseload	17
Slip, trip or fall	12
Treatment or procedure issues	7

A review of the themes within lessons learnt were provided to the Quality Safety and Experience Committee and IQFPD in July 2025. Work is underway to produce regular newsletters, and reporting to the Clinical Care Groups on the themes within their areas.

16 Incident Management Groups have been held to (22/09/2025) during September.

	Aug 2025	Sept 2025
Allied Health and Health Science	0	1
Community and Integrated Medicine	3	8
MH&LD	12	3
Planned & Specialist Care	2	2
Primary, Community Strategy & LTC	0	2

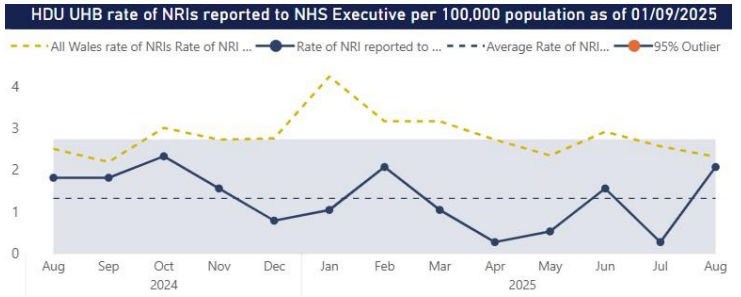
Diogel Safe

There were 59 Patient Safety Incidents reported to the NHS Executive between 1st September 2024 and 31st August 2025.

As of 4th September 2025, 33 incidents are open with NHS Performance and Improvement on the UHB Datix Cymru system (excluding those reported and awaiting confirmation of reference number).

27 incidents are been open with NHS Performance and Improvement for 90 days or more.

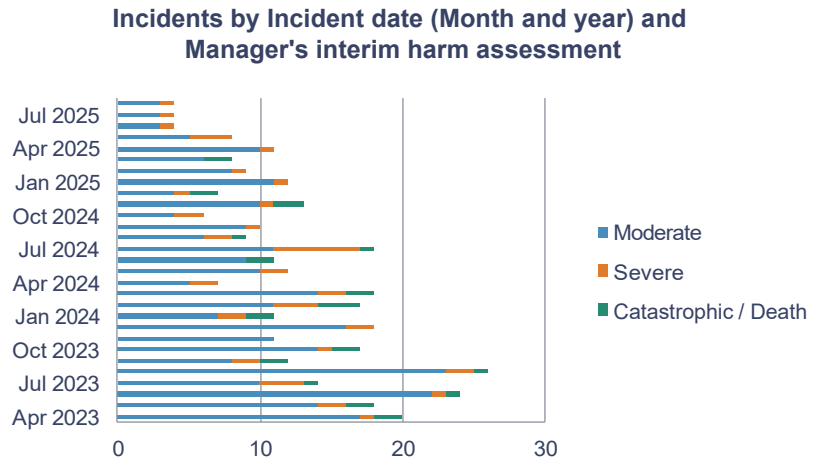
76 incidents reported as NRIs were closed by the Health Board between 01/08/2024 and 31/07/2025 (not including those where a downgrade form was submitted).



NRI category	Total
Pressure ulcer developed or worsened during care in this clinical care area/caseload	8
Neonate	7
Unexpected death	7
Treatment or procedure issues	3
Maternal	2
Self-harm / self-injurious behaviour	2
Clinical assessment, clinical diagnosis	1
Communication issues	1
Compliance with bundle/ guidance	1
Diagnostic testing - Radiology	1

Health Board Overview – Duty of Candour

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board



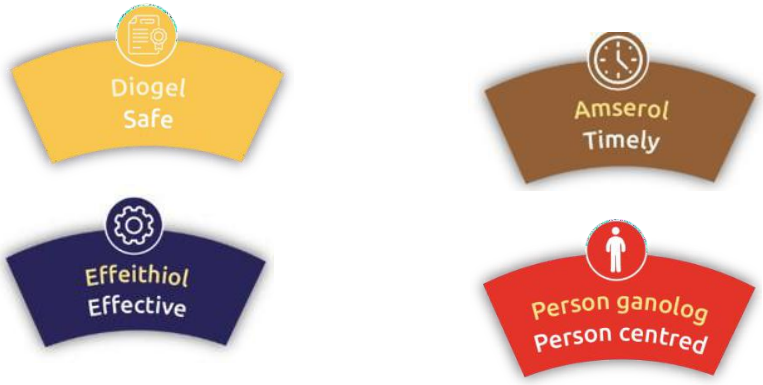
246 incident records have been closed where duty of candour had been triggered during the manager's initial assessment.

		Harm post investigation					
		None	Low	Moderate	Severe	Catastrophic / Death	Total
Manager's interim harm assessment	Moderate	14	48	143	3	1	209
	Severe	1	6	4	9	3	23
	Catastrophic / Death	3	5	1	2	3	14
	Total	18	59	148	14	7	246

Top 3 incident classifications

Incidents occurring after 01/04/2023 where duty of candour has triggered, and investigation has been closed.

Pressure Damage, Moisture Damage	**68**
Pressure ulcer developed or worsened during care in this clinical care area/caseload	59
Pressure ulcer present before admission to this clinical care area/caseload	6
Pressure from medical device present before admission to this clinical care area/caseload	2
Pressure from medical device developed or worsened in this clinical care area/caseload	1
Accident, Injury	**65**
Burns or scalds	1
Contact with object or animal	1
Slip, trip or fall	60
Patient injury	3
Treatment, procedure	**45**
Blood / plasma products transfusion	3
Treatment or procedure issues	42



Learning identified:

- Clear, complete, and accurate documentation of clinical decisions, patient consent and assessments
- Strengthening communication between clinical teams, ensuring prompt referrals and developing clear pathways for service delivery
- Early and repeated clinical examinations and timely escalation of care

People's Experience Feedback

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Since the introduction of the revised Welsh Patient Experience Survey in April 2025, the following tables represent the volume of surveys issued via FFT and those who access the Survey together with responses.

Friends and Family Test

Question:	Survey	2025 Apr	2025 May	2025 Jun	2025 Jul	2025 Aug	2025 Sept	Benchmark
1. How would you rate your overall experience?	NHS Wales People's Experience Survey (FFT)	88.0	87.0	86.9	87.8	88.5	86.5	85
5. Were you able to communicate in your preferred language?	NHS Wales People's Experience Survey (FFT)	95.5	95.2	95.6	96.0	95.9	94.7	85
Overall:		91.5	91.0	91.1	91.8	92.1	90.4	
Respondents:		1754	2293	2444	2580	2049	156	

NHS Wales People's Experience Survey

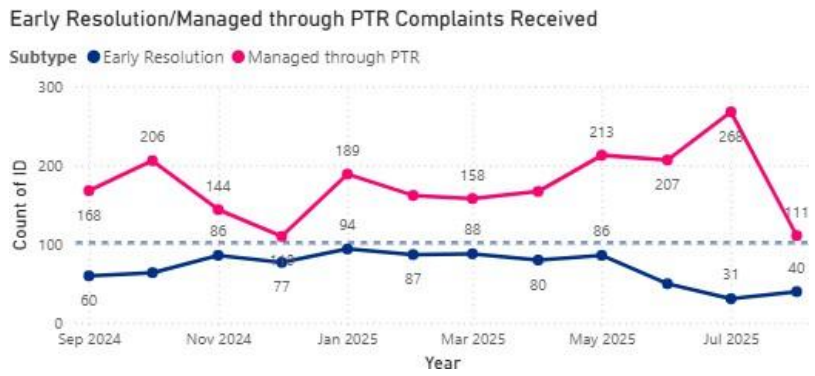
Question:	Survey	2025 Apr	2025 May	2025 Jun	2025 Jul	2025 Aug	2025 Sept	Benchmark
2. How would you rate your overall experience?	NHS Wales People's Experience Survey (PES)	79.1	79.7	78.3	80.5	80.9	73.4	85
6. Were you able to communicate in your preferred language?	NHS Wales People's Experience Survey (PES)	94.7	95.6	96.5	96.8	95.6	95.4	85
7. Was the time you waited:	NHS Wales People's Experience Survey (PES)	70.2	67.7	67.9	70.3	67.5	58.8	85
8. Did you feel well cared for?	NHS Wales People's Experience Survey (PES)	83.7	83.9	82.0	84.6	83.8	80.1	85
9. Were you treated with dignity and respect?	NHS Wales People's Experience Survey (PES)	91.1	91.6	90.2	91.9	91.6	86.5	85
10. Did you feel that you were listened to?	NHS Wales People's Experience Survey (PES)	87.4	87.4	85.6	88.1	88.1	83.0	85
11. Were you involved as much as you wanted to be in decisions about your care?	NHS Wales People's Experience Survey (PES)	87.1	86.5	85.1	87.9	87.8	87.1	85
12. Were things explained to you in a way you could understand?	NHS Wales People's Experience Survey (PES)	91.2	90.0	89.5	90.8	91.2	87.7	85
Overall:		85.5	85.3	84.3	86.3	85.8	81.5	
Respondents:		680	873	845	968	993	61	

Further information is provided in the patient experience report to Board which is attached as appendix 1

Health Board Overview – Complaints Management

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Number of complaints received by month (last rolling 12-month period) PTR)



Proportion of complaints within 30 working days (2024/25)

Q1 24/25

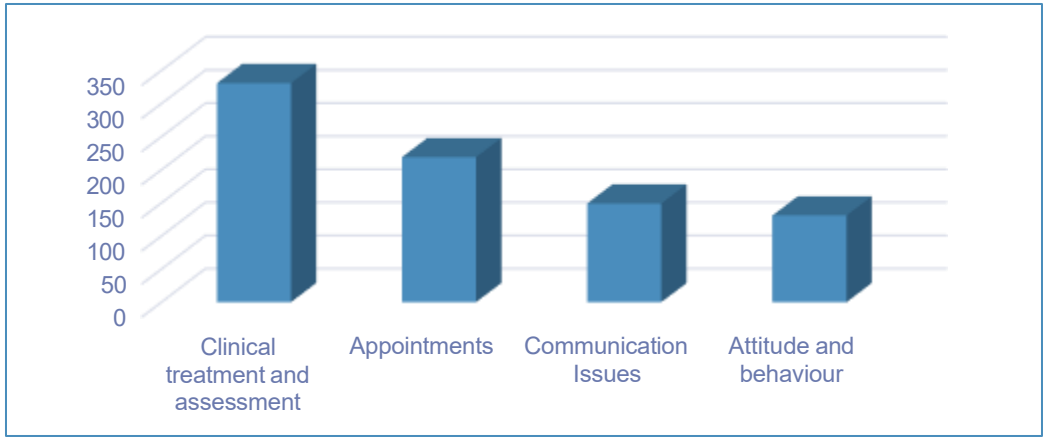


Q1 25/26



The above charts show that, based on Health Board data, the performance in Q1 25/26 is consistent with the same Quarter last year.

Top four themes of complaints since April 2025 to date (end Aug)



Main themes giving rise to complaints remain consistent; with A&E, T&O, Ophthalmology and Gynaecology receiving higher numbers of complaints in this category.

A quarter of all complaints about appointments and waiting times are linked to Ophthalmology services. Urology and dermatology also receive higher numbers in this theme.

As usually seen, complaints about communication, attitude and behaviour are spread across Health Board services. Ophthalmology and Dermatology have the highest numbers of complaints recorded in this area.

Comparisons should be considered in conjunctions with the number of services and interactions being delivered by teams, which can add a more balanced picture.

Health Board Overview – Outcomes from complaints

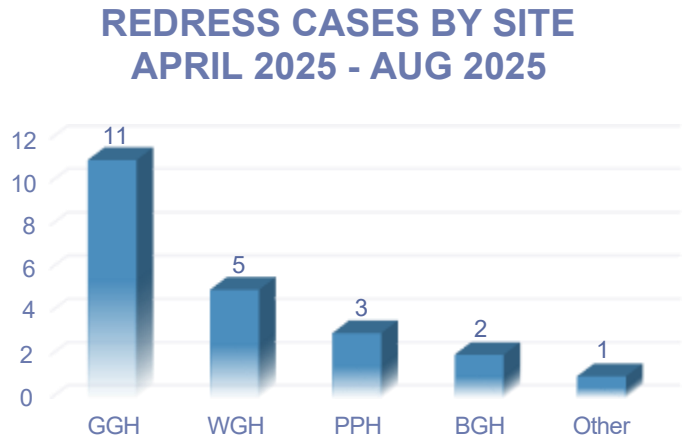
In the financial year 2025/26 so far (end August), 65% of complaints were closed within the 30-working day target timescale advised in the ‘Putting Things Right Regulations. The national target is 75%. This includes both formal investigations and cases handled as early resolutions:



Since the start of the financial year,, 17 complaints have identified a breach of duty of care which have not led to harm

24 cases have been escalated to redress because failings have, or may have, caused harm to patients. These have mostly occurred at our general hospital sites.

Learning from events reports will be produced following these incidents.



Learning from the Ombudsman

In Quarter 1 25/26 there were 9 interventions from the Ombudsman, which included 1 new investigation looking at the medical management and treatment of pancreatitis.

In Quarter 2 to date, there have been 10 interventions, including six new investigations. These include investigations into the diagnosis of Pulmonary Embolism, treatment of a bowel blockage and cancer, provision of appropriate pain relief, nursing care, treatment for Influenza A and record keeping.

There have been 20 decisions not to investigate since the start of the financial year and no final reports to date.

Public Services Ombudsman for Wales

- The Public Services Ombudsman for Wales has published her annual report. The report Turning the page - Annual Report and Accounts 2024/25 can be found on the PSOW website.

- The Health Board has also received the annual letter for 2024/25 from the PSOW. This is attached as appendix 2 to this report.

Infection Prevention and Control (IP&C)

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Quality Planning

- Organisation Annual Plan
- Annual IP&C work plan
- Infection Prevention Strategic Steering Group Work Plan
- WHCs relating to IP&C and Public Health
- WHC Antimicrobial Resistance (AMR) & Healthcare Acquired Infection (HCAI) Improvement Goals 2024/25
- Working with the Public Health team and primary care/ community services to prevent infection in high-risk populations/ community settings

Quality Control

- Standardisation of assurance/ scrutiny groups in progress
- Reports to and from Clinical Care Groups (CCG)/ Subgroups of Infection Prevention Strategic Steering Group (IPSSG)
- Review of Health Board (HB) 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 to Start Smart The Focus (SSTF) for each acute site
- All CCGs to review data within the Health Board Safety Dashboard and ensure that cases are reviewed (see Quality Improvement)
- Review of monthly data from HARP with internal HB analysis and scrutiny and use of infographics in CCGs
- Outbreak management meetings held as required.

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 and observational audits programme in place with improvement action plans produced
- Review of Synbiotix scores in relation to IP&C audit programme
- HPV in use in 3 acute sites
- HCID/infectious disease pathway training dates have been completed for GGH and BGH, dates in September and October for PPH and WGH
- Engagement in the National C.diff Learning Collaborative

Quality Assurance

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	Apr-25	May-25	Jun-25	Jul-25	Aug-25
Infections	Number of laboratory confirmed C.difficile cases with hospital onset	25% reduction, maintained for 3 months	8	Baseline (average Q3 23/24)	6	8	8	11	7	4
	Number of laboratory confirmed S.aureus bacteramia cases with hospital onset	33% reduction, maintained for 3 months	3	Baseline (average Q3 23/24)	2	3	3	3	4	5
	Number of laboratory confirmed E.coli bacteramia cases with hospital onset	25% reduction, maintained for 3 months	7	Baseline (average Q3 23/24)	5	6	5	7	10	6

- Aseptic Non-Touch Technique (ANTT) 82.58% compliance with HB critical care and other inpatient areas seeking accreditation
- Level 2 mandatory training at 75.56%. Mandatory training rates now reported at CCG meetings
- HPV enhanced cleaning now available at 3 acute sites
- IPC Environmental audits focusing on very high-risk and high-risk areas. Theatres, ITUs, and Maternity and oncology have been completed.
- HCAI and IP&C included within all CCG escalation improving together sessions (EITS)

IP&C continued

Filters for Table 1. and Chart 1.

Select count or rate: Rate per 1,000 admissions

Select all or hospital onset (HO)* specimens: All specimens

Table 1. Current FY rate per 1,000 hospital admissions of specimens by HB, Apr - Aug 25

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	2.09	0.06	1.27	3.15	1.12	0.35
Betsi Cadwaladr UHB	3.23	0.12	1.92	4.79	1.4	0.28
Cardiff and Vale UHB	2.9	0.25	2.07	4.42	1.88	0.33
Cwm Taf Morgannwg UHB	2.37	0.07	1.72	5.55	2.33	0.14
Hywel Dda UHB	2.9	0.25	1.95	6.22	2.2	0.37
Powys THB	13.16	0	1.64	1.64	0	0
Swansea Bay UHB	3.58	0.15	1.77	4.16	1.95	0.44
Velindre NHST	0	0	1.47	5.13	0	0
Wales	**2.81**	**0.14**	**1.74**	**4.54**	**1.69**	**0.31**



There is a mixed trend for HDUHB, with some infections improving and others being more challenging.

- MRSA rates in August increased, early cases review indicates that these cases are linked to cannulas/ invasive devices.
- E. coli bacteraemia rates remain high suggesting a need for targeted interventions for population base.

Filters for Table 1. and Chart 1.

Select HB: Hywel Dda UHB

Select count or rate: Rate per 1,000 admissions

Select all or hospital onset (HO)* specimens: All specimens

Table 1. Current FY rate per 1,000 hospital admissions of specimens by acute hospital in Hywel Dda UHB, Apr - Aug 25

Additional filters for Table 1.

Select month or FY: Current FY

Select organism group: All organisms

	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Bronglais General Hospital	2.2	0	3.77	8.49	2.83	0.94
Glangwili General Hospital	1.95	0.28	1.58	5.03	2.33	0.37
Prince Philip Hospital	2.78	0.21	1.71	4.92	1.07	0
Withybush General Hospital	2.36	0.39	1.96	8.84	2.75	0.39

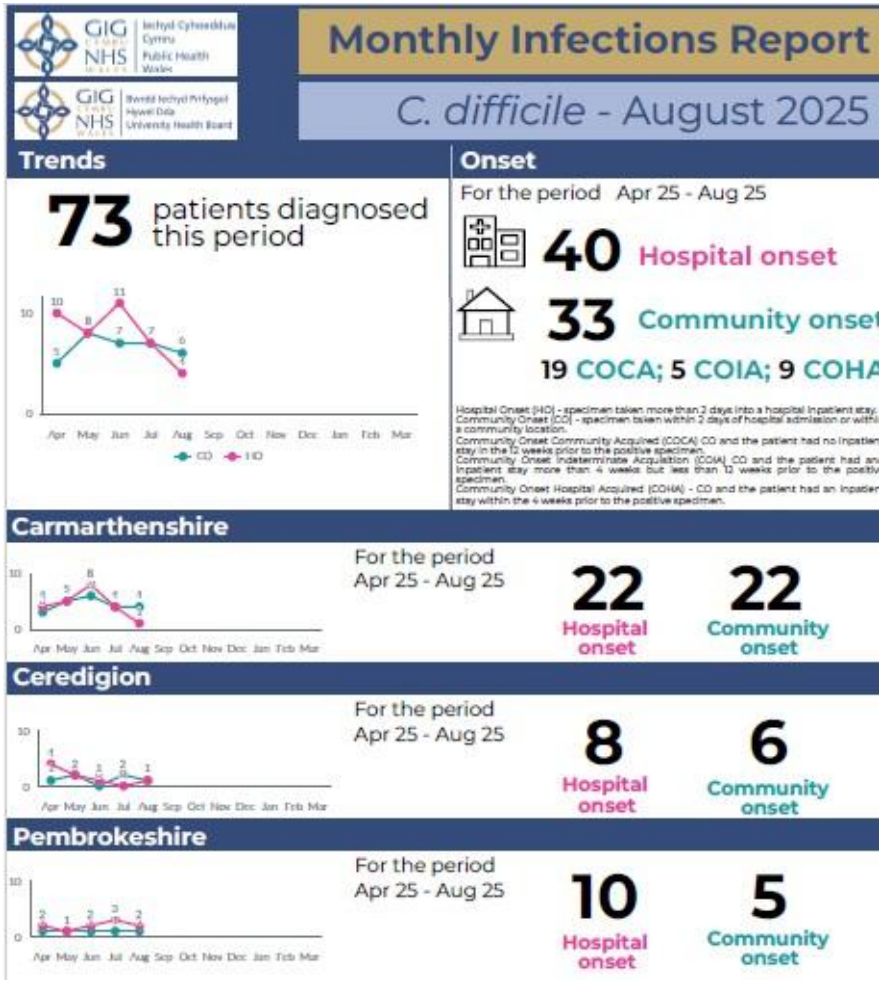
IP&C C.difficile

Number of hospital onset specimens from 01/04/25 to 31/07/25.



During this period there were 31 positive hospital onset cases and 30 positive community onset cases. During this period 4 patients had 2 positive samples, and 1 patient had 3 positive samples. These patients will be reviewed for suitability for Faecal Microbiota Transplantation (FMT).

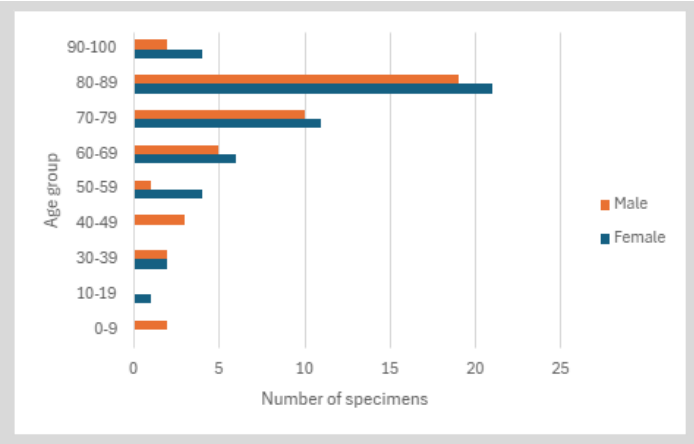
The C.diff collaborative has been discussed at the C.diff Infection (CDI) Improvement Group and projects are being reviewed. Many staff have taken part in interviews and focus groups relating to potential projects.



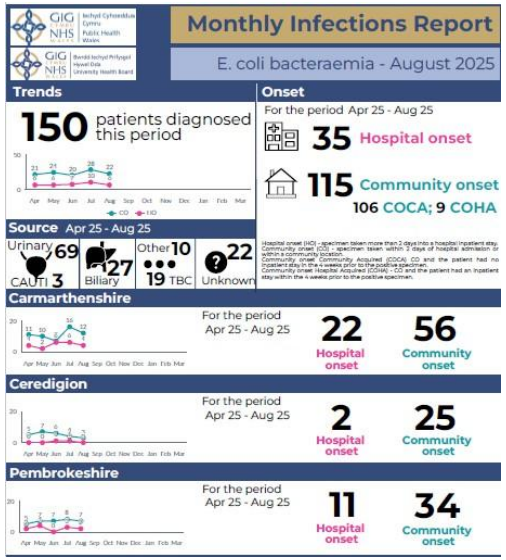
Diogel Safe

IP&C E.coli and S.aureus

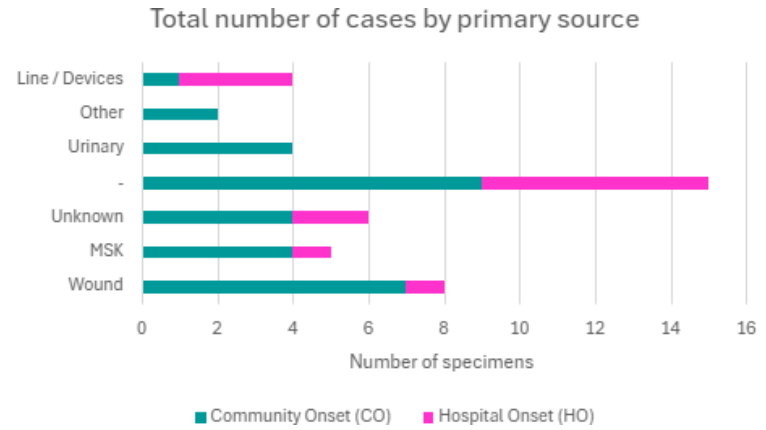
Age profile E.coli bacteraemia



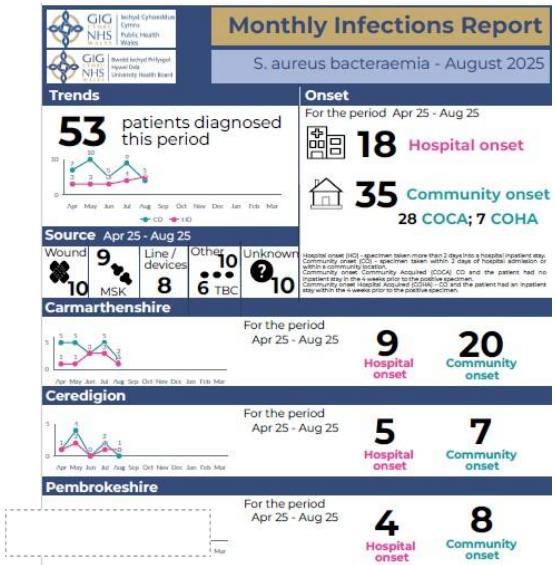
For E.coli number remain high, the above graph demonstrates the age profile for positive samples, showing the burden in the 80-89 bracket



Total number of cases of S.aureus bacteraemia by source



Some sources are still to be confirmed following further review and discussion



Actions

- ANTT compliance profiled and reported to all CCGs monthly, ANTT to be mandatory on ESR for HB. ANTT 82.58% compliance
- Hand hygiene encompassing bare below the elbow profiled and validation audits as indicated
- Ward manager/ Senior nurse hand hygiene audits now on Amat and monitored
- Burden for both infections remains in the community with proactive prevention work ongoing with public health

Diogel
Safe

HIW / CIW / HTA inspection activity:
22/08/2025 – 30/09/2025

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The Health Board have now seen 5 inspections during 2025; the first in Maternity Glangwili between 13th and 14th May 2025; the second inspection took place in WGH Radiology (Nuclear) 17th and 18th June 2025, the third at EUCC at Bronglais on 28th July 2025 and the fourth in Mynnyd Mawr at Prince Philip Hospital on 5th August 2025. The fifth inspection is in Derwyn ward at Glangwili 2nd September 2025 and feedback was recieved. The finalised inspections have been generally positive, but EUCC, Mynnyd Mawr and Derwyn ward raised immediate actions which have been addressed within the timeline provided. (see next slide for further information).

The Maternity Glangwili report was published on 14th August 2025, the WGH Radiology (Nuclear) report was published on 18th September 2025. The Health Board await the draft reports for EUCC at Bronglais, Mynnyd Mawr and Derwyn ward. No further reports from HIW or the HTA have been published in the period.

Healthcare Inspectorate Wales has introduced a new engagement process. Further information is attached as appendix 3.

As an update to the last report, the Health Board have received the following letters from HIW requesting assurance during the period detailed below. We also offer a conversation where more than one contact has been received on a topic:

Date of letter	HIW ref	Matter
20/05/2025	13271	Paediatric Medical Workforce – request for update on recruitment progress
20/05/2025	13274	St Non's Ward – request for update
20/05/2025	13272	North Ceredigion Mental Health provision – request for further information
06/06/2025	13747	WGH / Mental Health family concern
11/06/2025	13391	Critical Care – queries re public consultation
11/06/2025	13274	St Non's ward – further details requested / discussed with HIW in a meeting
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
24/07/2025	13747	WGH / Mental Health family concern – outcome date request. Response 29th July 2025 advise plan to share by 8th Aug 2025.

Date of letter	HIW ref	Matter
13/08/2025	13272	North Ceredigion Mental Health provision – request for update. Response sent 20th Aug 2025.
13/08/2025	14414	WGH concerns raised re ED discharge /re-enablement. Response sent 20th Aug 2025.
18/08/2025	13747	GH Bro Cerwyn / Mental Health family concern – outcome date requested. Responded to 22/08/2025 with content and plan to share on 12th Sept 2025.
20/08/2025	14043	GGH Radiology anonymous staffing concerns – update requested; met with HIW 20/08 & further response sent 22nd Aug 2025.
22/08/2025	14435	MH&LD / Service user raised concerns regarding unit after discharge. Response sent on time 22nd August 2025.
08/09/2025	14601	Bryngolau assurance - Service user raised concerns regarding unit cleanliness after discharge. Response sent 12th Sept 2025 (on time).

Areas requiring immediate assurance

The following areas were flagged in the last report to IQFPD and also to the SNMT

- Medication fridge temperature checks
- Resuscitation and other emergency trollies – checking in line with policy
- Signage for rooms where oxygen cylinders stored
- Temperature monitoring and escalation in rooms where medicine is stored

The following issues were flagged in the last report to IQFPD and also to the SNMT as immediate assurance actions in the HIW inspection of Derwen Ward:

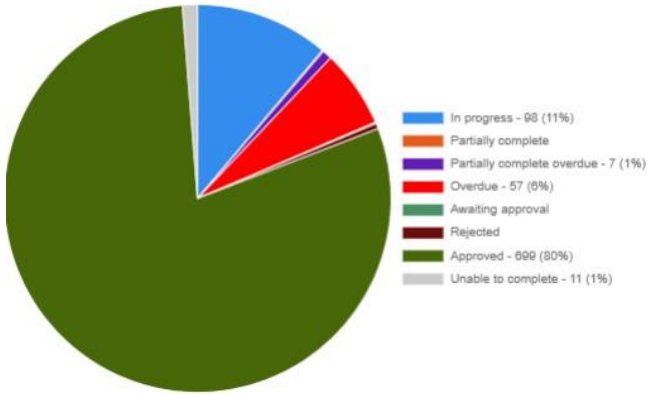
- Medication management processes were not robust and safe – no fridge checks evidenced.
- Environment of the ward – H&S risks which needs assurance including blood pressure cuffs not being decontaminated between patients, IV fluid room not locked, clutter and dust throughout the ward, toilets not cleaned; lack of storage space
- Lack of O2 tubing on the ward, only 2 had tubing since this was raised
- Wall suction units not working at full capacity & need to be tested
- Food given out by domestic staff who may have been involved in earlier hours in cleaning toilets - this could be a risk as contamination may still be on their uniforms
- During the tour of ward setting – patient records were seen being left and stored in various locations including an unlocked trolley and unlocked ward clerk's offices
- Sample of 6 patient records and NEWS scores was not accurately recorded, and not checked for 4 hours, and could have had a poor second result when checked;
- Lack of documentation of sepsis risk in records – staff were aware and display on wall re Sepsis but process not followed in records
- VTE not being completed in patient records
- Emergency trolley checks not evidenced as being completed consistently with some gaps in records.

Immediate assurance improvement plans have been sent to HIW and accepted as providing the required assurance. Implementation of the agreed actions will be monitored through the CCG Integrated Governance Groups and reported to IQFPD

HIW Quality Checks/Inspections: Reviews and inspections

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Improvement Actions relating to HIW reviews



Source: AMaT 30/09/2025

	Overdue	Partially complete (overdue)
Unplanned care (Mynnyd Mawr)	6	1
(Unplanned care) Derwen ward	20	0
Mental Health and Learning Disabilities (all)	19	4
Operational Allied Health and Health Science (all)	6	0
Planned and Specialist Care (maternity)	5	0
Jt Inspection Child Protection (Pembs)	10	1

	Position Feb 2024	Position as at 07/08/2025	Position as at 30/09/2025
Overdue	51	22	57
Partially complete (overdue)	17	5	7
Partially complete	1	1	1
In progress	119	25	98

The number of open HIW inspections has increased from 12 to 13, which has also demonstrated an increase in the number of open actions under review on AMaT.

See appendix 4 for all overdue actions

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
13	121/227 (53%)	1/1 (100%)	0	0	98	1	7	57	5	2	4	206

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
27	248/248 (100%)	18/18 (100%)	0	0	0	0	0	0	6	0	0	492

HIW Quality Checks/Inspections: Open reviews and inspections

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Code	Title	Type	Date of inspection	Origin	Recommendations	Actions
Healthcare Inspectorate Wales (HIW)/2024/395	Bryngolau Ward, Prince Philip Hospital	New	02/09/2024	Healthcare Inspectorate Wales (HIW)	40	51
Healthcare Inspectorate Wales (HIW)/2024/396	HIW Children and Young People Mental Health Review	New	05/02/2024	Healthcare Inspectorate Wales (HIW)	9	23
Healthcare Inspectorate Wales (HIW)/2025/628	HIW Derwen Ward 04054	New	02/09/2025	Healthcare Inspectorate Wales (HIW)	9	55
Healthcare Inspectorate Wales (HIW)/2022/19	HIW GGH IRMER Inspection (Nov 2022)	New	15/11/2022	Healthcare Inspectorate Wales (HIW)	21	36
Healthcare Inspectorate Wales (HIW)/2025/565	HIW GGH Maternity Services 03924	New	12/05/2025	Healthcare Inspectorate Wales (HIW)	13	23
Healthcare Inspectorate Wales (HIW)/2024/302	HIW Glangwili Hospital – Morlais Ward inspection	New	01/07/2024	Healthcare Inspectorate Wales (HIW)	9	18
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)	New	07/03/2023	Healthcare Inspectorate Wales (HIW)	40	33
Healthcare Inspectorate Wales (HIW)/2024/86	HIW IRMER Diagnostic Imaging x-ray department Withybush Hospital January 2024	New	31/01/2024	Healthcare Inspectorate Wales (HIW)	9	14
Healthcare Inspectorate Wales (HIW)/2023/69	HIW St Non, St Caradog, Canolfan Bro Cerwyn WGH	New	16/10/2023	Healthcare Inspectorate Wales (HIW)	19	25
Healthcare Inspectorate Wales (HIW)/2024/498	IRMER Regulations	New	01/10/2024	Healthcare Inspectorate Wales (HIW)	9	10
Healthcare Inspectorate Wales (HIW)/2025/587	Joint Inspection of Child Protection Arrangements (Pembrokeshire)	New	17/03/2025	Healthcare Inspectorate Wales (HIW)	21	34
Healthcare Inspectorate Wales (HIW)/2025/595	Mynydd Mawr Ward, Prince Philip HospitaL 03921	New	05/08/2025	Healthcare Inspectorate Wales (HIW)	3	16
Healthcare Inspectorate Wales (HIW)/2025/596	Nuclear Medicine IRMER WGH 03909	New	17/06/2025	Healthcare Inspectorate Wales (HIW)	26	42



Please Note: AMaT has changed how it displays inspections actions

To note an action is assigned to the corporate team for each inspection. The action is to review all evidence and approve final submission when all actions complete. If actions are overdue within the CCGs this will mean that the action for the corporate team is also overdue. The corporate action is not included within the report from HIW.

Recommendations

The Quality, Safety and Experience Committee (QSEC) is asked to note the contents of this report.

The Quality, Safety and Experience Committee 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
- Public Services Ombudsman for Wales Annual Letter
- Infection prevention and control
- Inspections and peer reviews including activity of Healthcare Inspectorate Wales (HIW)



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
5. Infection Prevention and Control – Rebecca Richards, Head of Infection Prevention and Control
6. Healthcare Inspectorate – Caroline Burgin, Patient Safety and Assurance



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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

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

Patient Experience Team
Tîm Profiad Y Claf

IMPROVING PEOPLE EXPERIENCE REPORT

September 2025



Introduction



Service user feedback is important to monitor the experience of those who access our services and the quality of care that they receive. This allows us to identify areas for improvement, to share good practice and learn from positive experiences.



It is our priority to act on all feedback received as part of our culture of improvement and to demonstrate that we are fulfilling our pledges as set out in the Charter. The Listening and Learning Sub-Committee will oversee the communication and implementation plan for the Charter. The Committee receives feedback from across concerns, compliments and experience.



The following information demonstrates how we are capturing service user feedback by encouraging our service users and providing different ways in which this can be provided. Most importantly, service users should feel that there has been a valuable purpose to them providing their feedback.

A Charter for People and Community Experience - your healthcare, your expectations, our pledge

WE WILL ALWAYS:
Treat you with dignity, respect and kindness.
Communicate with you in a way which meets your individual, language and communication needs.
Keep you informed and involved in decisions about your health and care services, and take into account your wishes and needs.
Provide safe and effective care, in the most appropriate and clean environment.
Ensure that your information is kept secure and confidential.
Support and encourage you to share your experiences of health care, both good and bad, to help us improve the way we do things.

Service User Feedback ‘at a Glance’ June 2025 - July 2025

We continue to receive many positive stories and comments about the services provided by our caring and compassionate sta
We are continually sharing and celebrating these achievements across the organisation. We will share information relating to t
figures later in the report.



NHS People’s Experience Framework

32,643 individuals were sent our new NHS Wales People’s Experience Friends and Family Test Survey, in the format required by the People’s Experience Framework. 5,406 responded representing a 16.5% response rate. **86.2% gave a Very Good or Good response** to the How would you rate your overall experience question.

12,795 were sent the NHS Wales People Experience Survey (PES). 1,933 responded, the areas of A&E received a higher volume of patient experience feedback.

240 compliments were received direct to wards, departments or Chief Executive/ Chair’s Office. These frequently highlight the professionalism and compassionate care provided by healthcare teams. Staff attitude and compassionate care were the main areas of appreciation.

In this period there has been one Investigation started by the Public Services Ombudsman for Wales. This will consider whether there were missed opportunities to make an earlier diagnosis of pulmonary embolism and whether clinical management after diagnosis was appropriate, timely and in line with guidance.

Complaints and enquires: 559 new cases were received into Patient Support Services. Of these, **459** were received as **enquiries.** The main reasons for enquiries and early resolution cases related to appointments / waiting list queries, attitude and behaviour and communication inefficiencies.

During the period, a total of **465 complaints were closed. 297** were responded to **within 5 working** days through the early resolution process.

1,284 calls were made to the 0300 0200 159 Patient support number of which 37 were via the medium of Welsh.

Patient feedback – Demographics

Gender Distribution

For this period, female respondents have again provided the most feedback, with a strong lean toward positive sentiment. Responses from non-binary or undisclosed genders were fewer and evenly spread across sentiment types.

Age Group Trends

As reported for the previous period, the older age groups tend to respond ; however, during this period there is an increase in those aged 45 who are happy to share their feedback. Age 65+ are providing more positives responses compared to other age groups

Disability

Around 40% of respondents report experiencing some degree of limitation in their day-to-day activities due to health conditions or disabilities. This insight will assist support services in tailoring their provisions to better meet the needs of affected individuals. An example of this data being used is within Glangwili hospital where they have been using data to improve patient areas. This includes a new sensory room for children, the team are also awaiting a delivery of ear defenders and cutlery for those with disabilities

Ethnic Group Representation

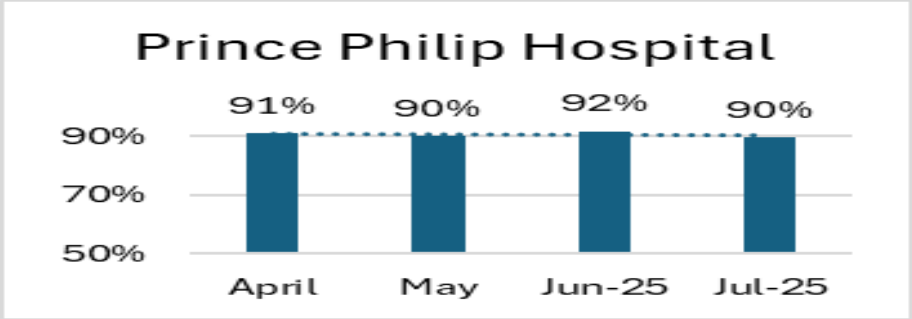
Over half of the respondents identified as Welsh, making it the predominant ethnic group represented in the survey. This insight is valuable for informing the development of culturally sensitive healthcare services and communication strategies. Staff are encouraged to take advantage of opportunities to learn the Welsh language, enabling them to engage confidently and respectfully with patients whose first language is Welsh

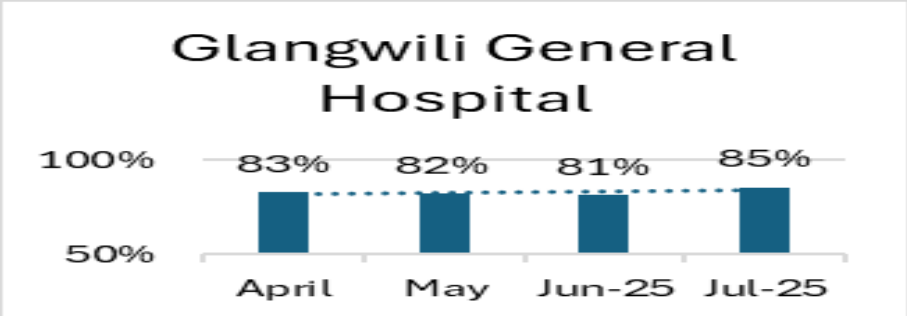
Religion

For this period there has been a fairly even split between Christian and non-religious respondents, with a small proportion choosing other or unspecified options.

Patient feedback –June – July 2025

Each graph represents this period's performance for different sites. The differences in the data can be attributed to various factors such as operational changes, seasonal variations, patient feedback, and external influences.





Minor Injuries Unit highlights prompt diagnosis and treatment, with staff consistently described as friendly, thorough, and efficient. Patients appreciated the speed and professionalism of care, though some negative comments lacked detail. Concerns were raised regarding infection control practices and communication, including reports of inadequate hand hygiene during triage.

Cardiology, patients praised the compassionate and professional approach of staff, particularly in managing urgent referrals. However issues with transport cancellations and poor coordination, which caused distress for some patients. Many patients provided ratings without accompanying comments, limiting insight into their experiences.

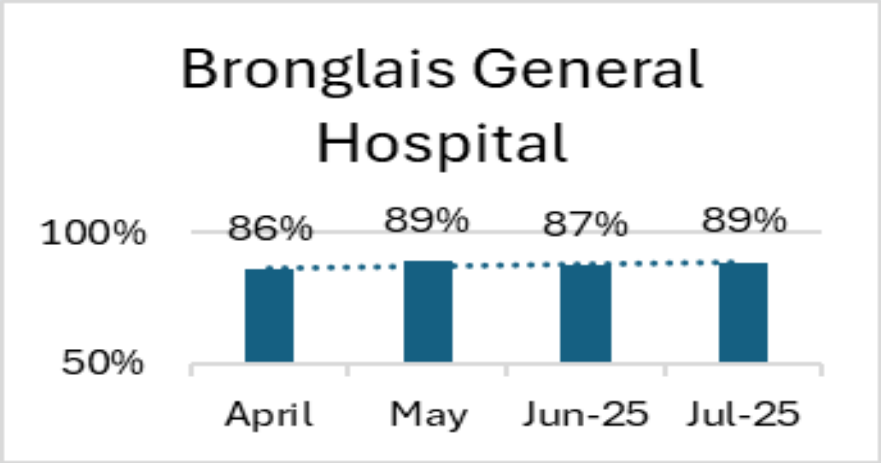
Accident & Emergency (A&E) received the highest volume of patient feedback. A significant proportion of negative comments were recorded, primarily linked to long waiting times, overcrowding, and limited comfort, indicating notable patient dissatisfaction in this department.

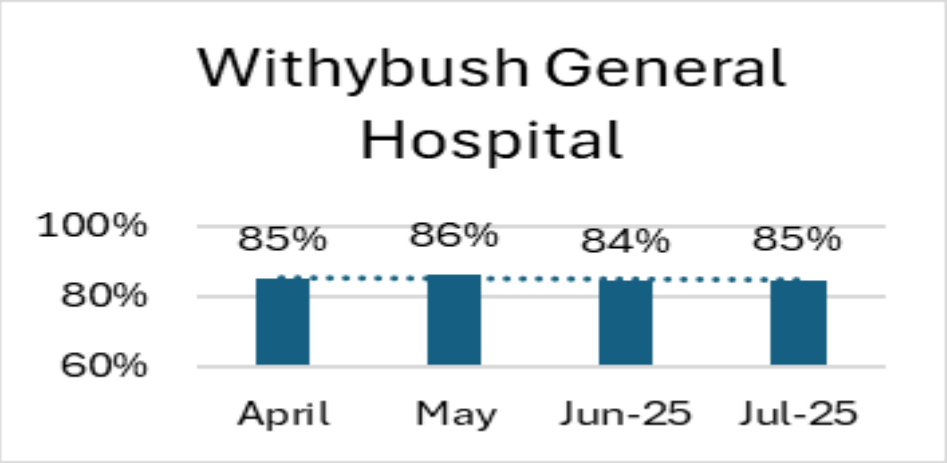
Services such as **Urology, Ear, Nose and Throat (ENT), and Ophthalmology** were consistently rated positively. Feedback suggests these departments deliver high-quality clinical care and maintain effective communication with patients, contributing to a more satisfactory experience.

Gastroenterology and General Surgery stood out for their low incidence of negative feedback, reflecting well-managed patient expectations and efficient care delivery. It is also notable that many patients at Glangwili Hospital provided ratings without accompanying comments, which limits the depth of insight into their experiences and may obscure specific areas for improvement.

Patient feedback –June – July 2025

Each graph represents this period's performance for different sites. The differences in the data can be attributed to various factors such as operational changes, seasonal variations, patient feedback, and external influences.

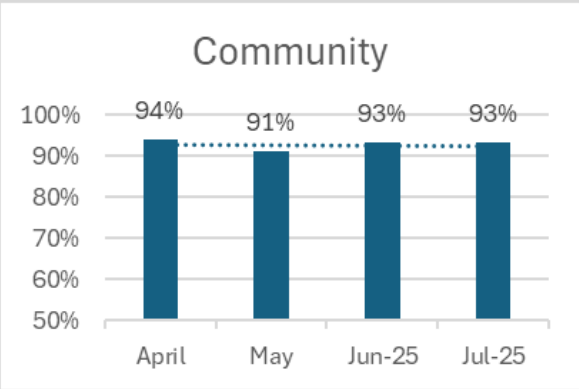




A&E received both positive and negative feedback across similar themes: communication, waiting times, environment, staff, and access. Negative comments peaked on Fridays and Saturdays, indicating possible service pressure during the weekend, while Tuesdays and Wednesdays saw less negative feedback.
Trauma & Orthopaedics was praised for staff professionalism but noted concerns about understaffing.
Gynaecology feedback highlighted helpful and caring staff.
Midwifery services were commended for supportive midwives, though some patients felt certain doctors did not listen.
Many patients provided ratings without accompanying comments, limiting insight into their experiences.

A&E Positive: Friendly and caring staff, efficient triage, quick response for urgent cases, and a clean, calm environment. Negative: Long waits (up to 9–11 hours), lack of trolley space, poor communication, and overcrowded conditions. Negative feedback often coincided with weekends and early-week surges.
Trauma & Orthopaedics Staff in the plaster room were described as considerate and helpful. Concerns about being short-staffed and delays in diagnostics (e.g. MRI).
Minor Injuries Unit Patients were often seen quickly and praised the thoroughness of care.
Cardiology The secretary was praised for handling urgent referrals with compassion.

Patient feedback - Overall feedback June- July 2025



Feedback received from **Cardigan Integrated Care Centre** and **Tenby Cottage Hospital** has been overwhelmingly positive. There was high praise for the staff, with many comments highlighting their helpfulness and caring approach. The majority of patient experiences were described as positive. However, recurring themes included concerns around waiting times and communication, which were mentioned frequently across responses.

Emergency Department Feedback and Improvement Initiatives

Most negative feedback continues to be associated with Emergency Departments (A&E), with concerns raised around waiting times and the overall patient experience.

At Bronglais Hospital, improvement work is underway within the EUCC (Emergency and Urgent Care Centre) waiting areas. This includes collaboration with the Communications and Arts in Health teams, as well as support from the Nutrition and Hydration team to enhance food provision and introduce an additional hydration station. The team is also investing in more comfortable, height-adjustable chairs to improve patient comfort. Ongoing customer service training is being delivered to staff to further enhance patient interactions.

At Glangwili Hospital (GGH), the quiet bereavement room has recently been refurbished to provide a more supportive environment for families. Further improvements are planned for the A&E department, including the installation of new worktops in the doctors' bays and a full refurbishment of the A&E reception area to improve patient confidentiality.

GGH Childrens room



GGH Learning Disability packs



Mental Health Patient Experience Feedback



The most frequently mentioned services in the patient feedback were **Community Mental Health Team – Adult Services, Adult Mental Illness, Old Age Psychiatry, and the Community Drug and Alcohol Team**. These areas received the highest volume of responses, indicating they are key points of contact for patients accessing mental health support.

Positive themes were consistently observed across services. Staff attitude was highly praised, with descriptors such as kind, friendly, understanding, and professional appearing repeatedly. Communication was another strong point, with patients appreciating being listened to and having their treatment and care explained clearly. Efficiency was also noted, with many patients reporting that they were seen quickly and that appointments ran on time.

However, several areas for improvement were identified. Waiting times were a recurring concern, with some patients reporting delays in being seen or experiencing long gaps between appointments. Continuity of care was also highlighted, with a few patients expressing concern about being discharged too soon or not receiving adequate follow-up. Environmental and accessibility issues were mentioned, including difficulties with parking, limited consultation room availability, and communication barriers such as language or hearing impairments.

Primary care Patient Experience Feedback

Most responses were received from **GP practices in Carmarthenshire**, where feedback leaned strongly positive. In contrast, Pembrokeshire had fewer responses and a more mixed sentiment.

Patients frequently praised respectful and thorough care. One noted, ”The receptionist treated me with respect and informed me they were running late. When the doctor saw me, he went through everything thoroughly.” Another highlighted, “Full review given as well as asthma review. Time taken to discuss concerns and proactive steps taken.”

Positive experiences also included feeling heard and supported: “I always feel really comfortable and am able to explain myself and be heard.” However, there were concerns regarding seeing a different doctor every time, access issues and communication.



Listening to Children, Parents - Carers

The Paediatric service continues to share updates through ‘You Said – We Did’ boards, ensuring families know their feedback is valued and acted upon.

To strengthen the voice of younger patients, a proactive feedback process has been embedded into daily ward routines. Staff now use a handover checklist that includes a prompt to collect feedback.
Child-friendly paper feedback forms are being used, which children and families find easier to engage with. Patient Experience Officers support the transfer of these responses into the digital system.
The service has reviewed feedback from children, parents, and carers, and remains grateful for the time taken to share experiences. Actions have been taken in response, and updates have been shared with relevant teams. There have been no main themes in the surveys.

Overall positive feedback
The kindness of staff, quality of food, allowing for parents to stay over, the i-pad and play-room were appreciated by staff. Parents reports feeling very comfortable staying in the facility, with staff regularly checking if parents required anything. Comments were received that help was always on hand, and any questions were answered professionally.

Survey Children aged 4- 11 Suggestions and Feedback
Visiting hours, unfortunately, no further details were provided about specific issues.
Service Response - Parents are welcome at majority of times, to maintain infection control and ensure adequate space, the team will manage the number of people around each bed. This information will be clearly communicated to patients, parents, and carers.

Responses to the Children's, Parents – Carers Survey

Survey 11 years Suggestions and Feedback

- Not enough thermometers staff saying they could not locate them
- More games
- More space for belongings

Service response

- Thermometers have been re-ordered due to loss and are being restocked.
- The playroom is well stocked; the play team has been asked to ensure children are aware of what is available.
- Storage space is limited; patients are advised to bring only essential items. Each bed has a personal locker.

Survey Parents – Carers suggestions

- Chair beds are suitable for short stays but uncomfortable over longer periods.
- Toilets could be cleaner, with bins emptied more frequently and toilet roll restocked.
- A more colourful environment was suggested to help children feel more relaxed.

Service response

- Buddy beds were funded through charitable donations. While not ideal for extended stays, they are suitable for short visits, with average stays under 2 days.
- Cleanliness concerns have been noted and escalated via the Call 4 Concern (C4C) process.
- Bright colours can overstimulate neurodiverse children; the ward uses neutral tones and seasonal decorations to maintain a child-friendly environment.

Compliments

The Patient Experience team continue to visit services to provide teams with certificates of appreciation. Teams provide feedback on how great it feels to receive this recognition and look forward to seeing this every week via the “Feel Good Friday” posts on Viva Engage. 240 **compliments** were received for this period compared to 203 for the previous period

I want to compliment the Early Supported Discharge Team at Withybush Hospital. My husband had a stroke in January and came home seven weeks ago. Having staff - who supported him on Ward 11 - continue to work for 6 weeks in the home has been invaluable. Having to get used to different people would have delayed his recovery - the transition was seamless. The physios, OTs and their assistants are a credit to you.

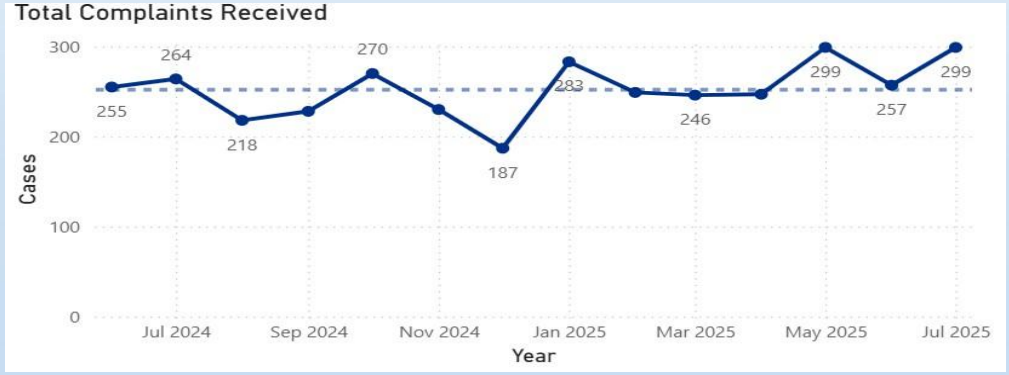
A&E patient expressed deep gratitude for the professionalism, empathy, and dedication of the staff, describing the experience as “amazing” and highlighting the importance of compassionate care during periods of high demand.



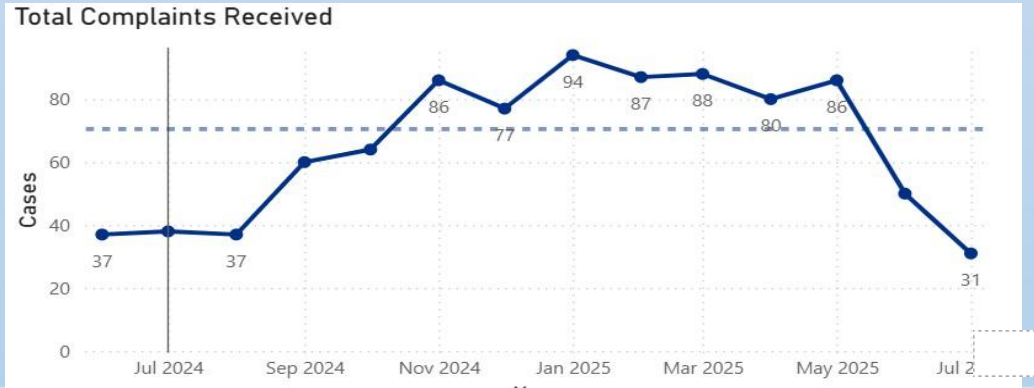
If patients were pleased with their treatment or care they can share their appreciation to an individual staff member or team, by giving them a big thank you by completing our 'Big Thank You' online form which can be located on https://hduhb.nhs.wales/healthcare/services-and-teams/patient-support-services-complaints-feedback/

Summary of Complaints and Concerns - Received June/ July 2025

In the reporting period June/ July 2025, **556** new concerns and complaints were received by the Health Board in total. Whilst this is only a small (3%) increase from the preceding period, numbers of new complaints have remained high in the first two quarters of the year to date:



81 of the complaints received in the period were managed as early resolution cases, with the aim of being resolved within five working days. Whilst there has been a significant increase in the amount of early resolutions since November 2024, the downward trend in this period reflects both the significant staffing challenges across Patient Support Services through the summer and a focus on overdue formal complaints.



64% of complaints closed in the period achieved the 30-working day timescale under Putting Things Right, which includes those cases handled as early resolutions. The target set by Welsh Government is 75%.

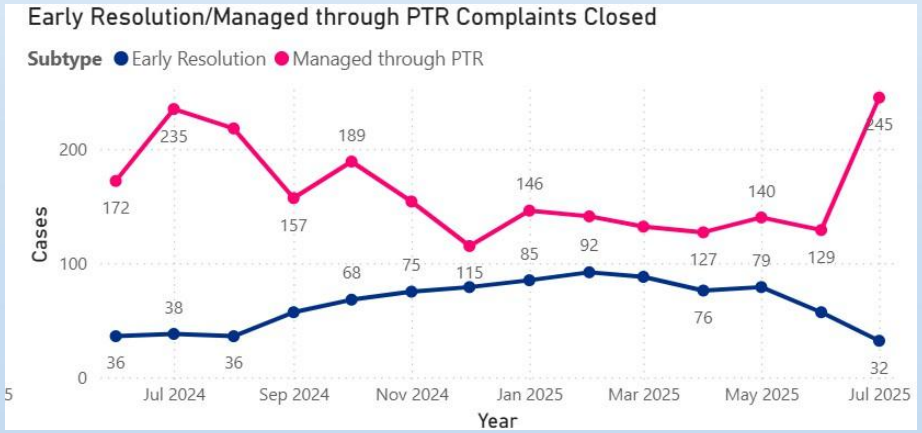
In anticipation of changes to the NHS Complaint Regulations, the Health Board continues to promote early resolutions as the preferred method for addressing concerns in a timely, reactive and person-centred manner. This does not replace the need for proportionate investigations where they are necessary.

The Health Board is working on a trajectory for improving timescales that will enable it to achieve the Welsh Government target.

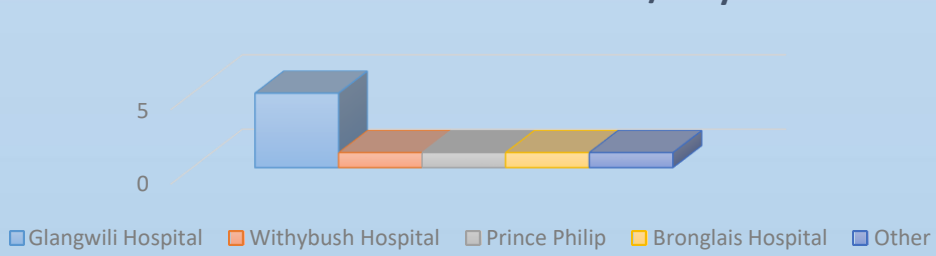


Summary of Outcomes from Complaints: June – July 2025

463 concerns and complaints were closed in the period June/ July 2025. Of these, **374** were managed as formal complaints and investigated under the Putting Things Right Regulations. The remainder (19%) were resolved through the early resolution process. The high closure in July represents a targeted drive by the Patient Support team to close overdue formal complaints.



9 cases were escalated to Redress in the reporting period, because failings have, or may have, caused harm to patients. These have occurred at the following sites:



In the same period, **8** complaints were upheld because of errors or omissions in care but were not found to have caused harm.

The significant failings in care identified in the June/ July 2025 period include a missed fracture, a delay to treat fracture and to consider surgery, and insufficient wound management. In addition, a failing in cystoscopy was identified, and an incident where insufficient advice during discharge from hospital had led to further unnecessary admission.

The top three services with the most formal (investigated) complaints individually in June/ July 2025 are:

PLN Care - Ophthalmology	36
PLN Care - Urology	20
Accident & Emergency	16

This shows a similar picture to the previous period, where Ophthalmology and A&E receive higher numbers of complaints. Gynaecology, Urology and Orthopaedics also receive higher numbers.

The most common themes giving rise to complaints remains unchanged in this period, remaining consistent with those seen at the end of Q1 and at the end of financial year 2024/25 also:

Clinical treatment/Assessment	141	29.56%
Appointments	96	20.13%
Communication Issues (including Language)	55	11.53%
Attitude and Behaviour	37	7.76%

Learning from the Ombudsman

In the period June/ July 2025 there has been one new investigation started by the Public Services Ombudsman for Wales. This will consider whether there were missed opportunities to make an earlier diagnosis of pulmonary embolism and whether clinical management after diagnosis was appropriate, timely and in line with guidance. In addition, there were:

- 7 instances recorded where complainants escalated their concerns to the Ombudsman and, following review, the Ombudsman decided not to investigate.
- 2 complaints made to the Ombudsman prematurely.
- 6 early resolution agreements made between the Health Board and the Ombudsman.

There have been no final reports received in June/ July 2025.

Learning from Complaints

On receipt of concerns raised by a member of the public, a review takes place and establishes whether there has been failings in care or treatment, and if there are opportunities to implement learning as result of the findings of the review. This is referred to an ‘Learning from Events’. Where failings in care are identified by the Ombudsman, a similar process takes place and actions are taken to improve future patient safety and experience. All Ombudsman reports are taken through the Listening and Learning Sub-Committee for discussion.

In the case of Mrs C, the Ombudsman’s investigation found that the patient’s urinary issues had not been appropriately investigated. The Ombudsman recommended that the Health Board conduct an audit of 10% of patients with urinary issues to assess whether they had been treated in accordance with the Welsh Continence Guidance, rectifying any deficiencies identified in the process. A full continence audit and improvement plan was actioned by the Health Board following this, with the Ombudsman confirming that they were satisfied that the actions taken had complied fully with the recommendation in July 2025.

In the case of Ms B, the Ombudsman found that her disabilities had not been appropriately managed by staff, including the allegation of inappropriate restraint. It was recommended that the Health Board develop a consistent method of logging admissions of patients with learning disabilities and to record training for staff regarding restrictive practices. A full action plan was produced following this, including targeted face to face training for priority services in respect of restrictive practices and the establishing of LD champions in hospital ward settings. The Ombudsman confirmed that she was satisfied with the actions taken in July 2025.



You Said…

…We Did



You Said…	…We Did
Feedback highlighted that the children's area of Glangwili Hospital, and general area in A&E felt outdated and in need of improvement.	A brand-new children's play area has been created, complete with a quiet sensory room to support children with additional needs. We also refurbished the quiet bereavement room, which was officially opened last week to provide a more comforting space for families. Further improvements are planned, including new worktops in the doctors' bays and a full refurbishment of the A&E reception area.
'Patients and visitors need better access to refreshments when attending A&E, especially during long waiting periods.'	Glangwili Hospital's A&E department has partnered with the hospital kitchens to run a two-week trial offering food and drink for patients between 07:30am and 6:30pm daily. We've also installed a new water fountain to ensure easy access to hydration throughout the day.
Feedback at our Withybush Hospital site identified the need for better parking arrangements for patients.	Patient and visitor only parking areas have been identified, and staff are provided with separate parking zones. This will help to ensure that visitor space is reserved for members of the public and this is supported by new parking wardens.

Ask for: Communications
01656 641150
caseinfo@ombudsman.wales

Date: 30 September 2025

PERSONAL & CONFIDENTIAL
Dr Neil Wooding
Hywel Dda University Health Board

Dear Dr Neil Wooding

Annual Letter 2024-25

Role of PSOW

As you know, our role as the Public Services Ombudsman for Wales is to consider complaints about public services, to investigate alleged breaches of the councillor Code of Conduct, to set standards for complaints handling by public bodies and to drive improvement in complaints handling and learning from complaints. We also undertake investigations into public services on own initiative.

Purpose of letter

Through this letter, we want to give you an update on our work, share key trends in complaints about local government in Wales and highlight any particular issues for your organisation, together with actions I would like your organisation to take.

Complaints about public services

This letter, as always, coincides with the publication of our Annual Report. Again, we saw an increase in the number of people contacting us about public services. Since 2019-20, the volume of new complaints about public services reaching our office has increased by 44%.

We also closed a record number of complaints about public services – 5% more than last year. This year, we intervened (found that something has gone wrong, and recommended how to put things right) in 18% of complaints that we closed. Positively, this year we resolved many more complaints early on. 87% of our interventions this year involved Early Resolution, compared to 70% in 2023-24.

We understand that people who come to us want their complaints resolved as quickly as possible and we are committed to dealing with them in a timely manner.

Overall, we assessed incoming complaints, or intervened with an Early Resolution, within an average of 4 weeks; well within our target of 6 weeks. We have also reduced the time it takes us to complete an average investigation, from 64 weeks in 2023-24, to 53 weeks this year.

During 2024-25, we received 949 complaints about health boards. This is an increase of only 1% since last year, and shows that the rate of increase in health board complaints is still slowing down. Still, we are now receiving 26% more complaints about health boards than in 2019-20.

Predictably, most complaints about health boards concern health services. By far, the most common area of these complaints is clinical treatment in hospital. In addition, about 16% of complaints about health boards related to complaint handling. This was a welcome drop from 18% the year before.

We intervened in 27% of health board complaints that we closed – compared to 31% last year.

In 2024-25, we received 130 complaints about Hywel Dda University Health Board and closed 131 – some complaints were carried over from the previous year. Hywel Dda University Health Board's intervention rate was 33%. You can find detailed information on complaints about your organisation that we handled this year can be found in the appendices.

We made 137 recommendations to your organisation during the year. To ensure that our investigations and reports drive improvement, we follow up compliance with the recommendations agreed with your organisation. In 2024-25, 140 recommendations were due. 89% of the recommendations due was complied with in the timescale agreed. Recommendations and timescales for complying with recommendations are always agreed with the public body concerned before being finalised, and we therefore expect organisations to comply within the timescales agreed.

Supporting improvement of public services

We continued our work on supporting improvement in public services.

During 2024-25, we concluded our second wider own initiative investigation which looked into unpaid carers' needs assessments in Wales. We considered whether 4 local councils – Caerphilly, Ceredigion, Flintshire and Neath Port Talbot - undertook carers' assessments in line with their statutory obligations.

We published the report on this investigation in October 2024. We found that only 2.8% of people in those council areas who identified as carers had received a needs assessment. In addition, only 1.5% had received a proper support plan following their assessment. Many carers were also not aware of their rights with regard to assessments and support services that might be available to them.

We identified some areas of good practice by the councils we investigated. However, we also made several recommendations including to:

- improve recording practices
- improve how information is shared with carers
- offer staff refresher training on carers' rights
- collaborate better with the healthcare sector.

We invited the other local councils in Wales to make similar improvements.

As we did in the case of our first own initiative investigation, we have been actively monitoring how organisations' have been complying with our recommendations.

We are planning to review compliance with the recommendations and any other impacts of the report in October 2025.

Currently 54 organisations across Wales operate our model complaints policy. This includes all local councils, all health boards and now most housing associations - representing about 85% of the complaints which we receive.

Our offer of free complaints handling training has remained popular and we provided a further 52 training sessions to public bodies across Wales during the year. This brings the total to 550 training sessions and 10,000 people, since 2020.

We have continued our work to publish complaints statistics, gathered from public bodies, with data published twice a year. We expect to publish the data on complaints handled by local councils in Wales during 2024-25 in the Autumn. This data allows us to see information with greater context – for example, during 2024-25, 6.13% of complaints made to NHS bodies went on to be referred to us.

Finally, this year we also published 1 thematic report, which included as case studies complaints about health boards:

- 'Equality Matters' (January 2025): a thematic report on inclusion and accessibility across public services.

This report includes general recommendations for public service providers, drawing on lessons learned from our casework.

Action we would like your organisation to take

Further to this letter can I ask that your organisation takes the following actions:

- Present my Annual Letter to the Board at the next available opportunity and notify me of when these meetings will take place.

- Consider the data in this letter, alongside your own data, to understand more about your performance on complaints, including any patterns or trends and your organisation's compliance with recommendations made by my office.

- Provide my office with a copy of the Health Board's Annual Report for 2024-25 on the Duty of Candour and Quality.

- Inform me of the outcome of the Board's considerations and proposed actions on the above matters at your earliest opportunity.

I would like to thank you, and your officers, for your continued openness and engagement with my office.

Yours sincerely

Michelle Morris
Public Services Ombudsman

Cc. Phil Kloer, Chief Executive, Hywel Dda University Health Board
Olivia Barker, PSOW Liaison Officer, Hywel Dda University Health Board

Information Sheet

Appendix A shows the number of complaints received by PSOW for all health boards in 2024-25. These complaints are contextualised by the population of each authority.

Appendix B shows the categorisation of each complaint received, and what proportion of received complaints represents for the Health Board.

Appendix C shows intervention rates for all health boards in 2024-25. An intervention is categorised by either an upheld complaint (either public interest or non-public interest), an early resolution, or a voluntary settlement.

Appendix D shows outcomes of the complaints which PSOW closed for the Health Board in 2024-25. This table shows both the volume, and the proportion that each outcome represents for the Health Board.

Appendix E shows the compliance performance of each health board.

Appendix A – Complaints received (overview)

Health Board	Complaints Received	Population	Received per 1,000 residents
Aneurin Bevan University Health Board	178	595412	0.30
Betsi Cadwaladr University Health Board	236	691991	0.34
Cardiff and Vale University Health Board	149	518269	0.29
Cwm Taf Morgannwg University Health Board	102	446514	0.23
Hywel Dda University Health Board	130	388139	0.33
Powys Teaching Health Board	20	134439	0.15
Swansea Bay University Health Board	134	389640	0.34
Welsh Ambulance Services University NHS Trust	24	-	-
Total	**973**	**3164404**	**0.28**

Appendix B – Complaints received (by organisation)

Hywel Dda University Health Board	Complaints Received	% Share
Admissions/discharge and transfer procedures	0	
Adult Mental Health	9	7%
Ambulance Services	0	
Appointment procedures (including outpatients)	6	5%
Care Homes	0	
Child and Adolescent Mental Health	0	
Clinical treatment in hospital	61	47%
Clinical treatment outside hospital; Dentist	1	1%
Clinical treatment outside hospital; GP	1	1%
Clinical treatment outside hospital; Other	6	5%
Clinical treatment outside hospital; Physiotherapist	2	2%
Complaints Handling	0	
Confidentiality	0	
Continuing care	1	1%
De-Registration	0	
Disclosure of personal information / data loss	0	
Funding	0	
Gender Identity Funding	1	1%
Health	26	20%
Housing	0	
Medical records/standards of record-keeping	0	
Medication > Prescription dispensing	0	
Non-medical services	0	
Nosocomial (Framework)	1	1%
Other	6	5%
Out of Hours GP care	0	
Patient list issues	4	3%
Poor/No communication or failure to provide information	2	2%
Prisoner Care	0	
Referral to treatment time	2	2%
Rudeness/inconsiderate behaviour/staff attitude	1	1%
Various Other	0	
Total	**130**	

Appendix C – Cases with PSOW intervention (overview)

Health Board	No. of interventions	No. of closures	% of interventions
Aneurin Bevan University Health Board	50	176	28%
Betsi Cadwaladr University Health Board	64	227	28%
Cardiff and Vale University Health Board	27	154	18%
Cwm Taf Morgannwg University Health Board	36	104	35%
Hywel Dda University Health Board	43	131	33%
Powys Teaching Health Board	6	25	24%
Swansea Bay University Health Board	33	136	24%
Welsh Ambulance Services University NHS Trust	4	29	14%
Total	**263**	**982**	**27%**

Appendix D – Complaint outcomes (by organisation) (* denotes intervention)

Hywel Dda University Health Board	Complaint Outcomes	% Share
Complaint investigation discontinued (with early resolution at assessment stages)*	0	
Complaint investigation discontinued (without settlement)	0	
Decision not to investigate complaint	39	30%
Early resolution*	33	25%
Matter out of jurisdiction	21	16%
Non-public interest report issued: complaint not upheld	3	2%
Non-public interest report issued: complaint upheld*	7	5%
Non-public interest report issued: complaint upheld with early resolution at assessment stage*	2	2%
Premature	25	19%
Public interest report issued: complaint upheld*	0	
Public Interest report issued: complaint upheld with early resolution at assessment stage*	0	
Special Interest Report*	0	
Voluntary settlement*	1	1%
Total	**131**	

Appendix E – Compliance performance comparison

Health Board	Number of recommendations made on complaints closed in 2024-25	Number of recommendations falling due in 2024-25	% of recommendations, complied with in line with agreed target date
Aneurin Bevan University Health Board	136	160	66%
Betsi Cadwaladr University Health Board	196	210	65%
Cardiff and Vale University Health Board	72	96	70%
Cwm Taf Morgannwg University Health Board	101	118	42%
Hywel Dda University Health Board	137	140	89%
Powys Teaching Health Board	16	12	33%
Swansea Bay University Health Board	86	86	64%
Welsh Ambulance Services University NHS Trust	18	6	33%

Chief Executives and Chairs
NHS Health Boards and Trusts Wales
Via Email

26 September 2025

Dear Chief Executive and Chair

Introduction of New NHS Engagement Process

I am writing to inform you of the introduction of Healthcare Inspectorate Wales' (HIW) new NHS Engagement Process, which will come into effect from **6 October 2025**. Please find attached the full guidance document, which outlines the process in detail.

Following a comprehensive review of our previous Relationship Manager (RM) model, HIW has developed a new, standardised, team-based approach to engagement with Health Boards and NHS Trusts in Wales. This new model is designed to ensure consistency, strengthen collaborative relationships, and enhance the flow of intelligence and information within HIW and between HIW and NHS Wales organisations.

This new approach is aligned with HIW's strategic priorities, objectives and values, supporting our shared aim of delivering safe, effective, and high-quality healthcare across Wales.

Planned engagement meetings will be maintained and will include other key staff within the organisation as appropriate.

The following table summarises the key differences between the previous RM model of engagement and the new NHS Engagement Process:

Previous RM Model	New NHS Engagement Process
Single Relationship Manager as main contact	Team-based approach led by Head of NHS Assurance, both clinical teams (Acute and Mental Health) and the intelligence team
Variable frequency and content of meetings	Regular, structured, intelligence-led meetings

Inconsistent correspondence and contact lists	Designated recipients for all assurance correspondence
Less systematic intelligence sharing	Consolidated intelligence and proactive risk identification
Less clarity on escalation	Clear escalation and communication routes
Limited focus on continuous improvement	Stronger emphasis on improvement, learning, and stakeholder engagement
Dispersed oversight	Central oversight by Head of NHS Assurance, both clinical teams and intelligence team

Please ensure that this document is shared with all members of the executive team.

Should you have any questions regarding the new process or require further clarification, please do not hesitate to contact the NHS Assurance Team at: HIW-NHSassurance@gov.wales

Thank you for your continued co-operation and commitment to improving healthcare services in Wales.

Yours sincerely,

Alun Jones
Chief Executive
Healthcare Inspectorate Wales
Cc.
Executive Director of Nursing
Executive Medical Director

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Healthcare Inspectorate Wales NHS Wales Engagement Process

Guidance for Health Boards and NHS Trusts



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Introduction

Healthcare Inspectorate Wales (HIW) is responsible for inspecting, reviewing and investigating NHS Wales services, to seek assurance that healthcare providers deliver safe and quality care to people. We consider how services comply with healthcare regulations and legislation, meet the **Health and Care Quality Standards 2023**, comply with Welsh Government strategy, policy and legislation, and adhere to professional standards and guidance relevant to their area of care.

Establishing and sustaining productive relationships with Health Boards and NHS Trusts is fundamental to the delivery of safe and effective care. In alignment with HIW's strategic priorities, our efforts are dedicated to ensuring that healthcare services throughout Wales are consistently safe, effective, and responsive to the needs of the population. Our key objectives include maintaining a firm emphasis on care quality as individuals access and transition between services, demonstrating agility in identifying and addressing emerging risks to patient safety, and fostering collaborative partnerships across the system to facilitate continuous improvement.

In line with HIW's set priorities and objectives, a review of the assurance process across all healthcare sectors was conducted in 2024. As a result, organisational changes were made, including the establishment of senior leadership positions, such as Head of NHS Assurance and Head of Independent Healthcare Assurance. This led to a revision of the engagement processes with NHS Wales organisations, resulting in the development of a new engagement model to replace the previous Relationship Manager (RM) model. The new NHS Wales Engagement Process will be introduced in October 2025.

Rationale for change

Review of relationship manager model of engagement

Our review of the RM model of engagement identified several areas for improvement. Although a designated point of contact was established for Health Boards and Trusts liaising with HIW, the overall approach to engagement found some inconsistencies, which included:

- Frequency of meetings
- Variability in the content of agendas
- Intermittent review of Committee and Board papers
- Variable stakeholder engagement
- Variability in RM oversight of an organisation's governance processes
- Gaps in understanding how NHS organisations assure themselves of delivering safe and effective care.

To address these issues, we have introduced a new NHS Wales engagement process. This process will provide a standardised, team-based approach to engagement, supported by intelligence and will promote clear communication through an integrated model aligned with HIW's priorities, objectives, and values.

Team-based model for NHS engagement

We have implemented a team-based approach to the NHS engagement process and this is fundamental to:

- **Ensure consistency and continuity**
  Provide a reliable and consistent point of contact between Health Boards, NHS Trusts, and HIW. This enables timely and accurate information flow to the appropriate team, reducing dependency on individual staff members and ensuring continuity during staff transitions.

- **Strengthen collaborative relationships**
  Foster deeper, more effective partnerships with NHS Wales organisations. A team-based approach ensures that engagement is not only consistent across NHS Wales but also more responsive to the unique needs and contexts of each organisation.

- **Build organisational intelligence**
  Maintain a centralised, collective knowledge base within HIW about each NHS Wales organisation. This knowledge will be drawn from multiple sources, including:

  - Direct engagement with Health Boards and Trusts
  - Insights and intelligence from external stakeholders
  - Intelligence from Welsh Government

- National datasets and performance indicators.

- **Enable proactive assurance and planning**
  Through systematic analysis of acquired intelligence, HIW will:

  - Identify emerging trends and risks
  - Respond swiftly to issues requiring immediate attention
  - Inform and adapt assurance planning processes
  - Facilitate two-way sharing of critical information with Welsh Government and other stakeholders, thus enhancing transparency and accountability.

Overview of the new NHS engagement model

With the new NHS engagement model, the Head of NHS Assurance is supported by two clinical teams and HIW's intelligence team. Collectively, they lead a coordinated approach that prioritises not just the gathering of intelligence, but its systematic analysis. This enables HIW to identify themes, trends, and potential risks across the healthcare system in Wales.

Strategic discussions will be held regularly with key clinical leads and executives, ensuring that topics, such as patient safety, governance, and quality are always at the forefront. When concerns arise, the model establishes clear, timely escalation routes so that issues are addressed swiftly and collaboratively. Throughout, there will be a strong emphasis on transparency, partnership, and two-way communication with stakeholders, ensuring that assurance activities are both proactive and responsive to the evolving needs of NHS Wales.

Expectations for Health Boards and NHS Trusts

Strategic and routine engagement

HIW maintains clear expectations for engagement with NHS Wales organisations, whether through in-person visits or remote interactions.

Joint meetings

Health Board and NHS Trusts are expected to engage with HIW through structured meetings as requested. These meetings will vary across HIW's teams and will focus on HIW's intelligence regarding ongoing or emerging risks, findings and follow-up from HIW's assurance activity, governance and leadership, quality of care, fragility of services, and strategic planning.

Transparency and evidence sharing

Health Boards and NHS Trusts must provide HIW with timely, accurate, and comprehensive data to support all HIW assurance work. They must also provide relevant documentation to HIW when requested and by any set deadlines, respond to assurance requests for information and evidence and participate in thematic discussions as required.

Duty of Quality

The Health and Social Care (Quality and Engagement) (Wales) Act 2020 expands the duty on NHS bodies in relation to quality. Health Boards and NHS Trusts are required to engage with Healthcare Inspectorate Wales (HIW) to demonstrate their effectiveness, safety, and care experience improvements. In meeting their quality responsibilities, NHS bodies should consider the Health and Care Quality Standards 2023 when making healthcare service decisions. Organisations are also advised to incorporate HIW's findings into quality reporting and ensure consistency with the Health and Care Quality Standards in service delivery decisions.

Continuous improvement and learning

Engagement with HIW should foster a culture of continuous improvement, including acting on inspection findings, sharing learning across the system, and demonstrating leadership and accountability. NHS bodies are expected to apply quality management systems and use feedback for service improvements. Health Boards and NHS Trusts should also escalate concerns through agreed channels and contribute to resolution processes.

Co-production and stakeholder engagement

HIW expects Health Boards and NHS Trusts to demonstrate how stakeholder views, including those of patients and staff, inform service design and improvement. This co-production approach includes listening to lived experiences and feedback, ensuring

inclusive and bilingual communication, and maintaining a focus on equality, diversity and inclusion.

Authority to enter and inspect

When conducting assurance work, NHS Wales organisation must be aware and respect that HIW staff are authorised to:

- Enter and inspect premises
- Interview people
- Inspect, take copies of and remove documents or records
- Take measurements, photographs and make recordings
- Gain access to any computer and associated apparatus
- Take other action, in accordance with the following legislation:
    - Health and Social Care (Community Health and Standards) Act 2003
    - Care Standards Act 2000
    - Health and Safety at Work Act 1974.

Planned engagement meetings with HIW

The minimum required engagement meetings per year and key attendees are presented in **Table 1** below.

Table 1: Planned engagement meetings – attendees

HIW Team	Health Board or Trust staff	Frequency
• Chief Executive • Director of Assurance • Head of NHS Assurance	✓ Chief Executive ✓ Chair (joint meeting)	Six months
• Head of NHS Assurance	✓ Chief Operating Officer	Six months
	✓ Selected Independent Members	Six months
• Acute Clinical Team	✓ Director of Nursing ✓ Medical Director ✓ Director of Allied Health and Therapies (joint meeting)	Four months
• Mental Health (MH) & Learning Disabilities (LD) Clinical Team	✓ Directors of MH & LD ✓ Clinical Leads for MH & LD ✓ MHA Administrators (joint meeting)	Four months

Meetings will be scheduled for at least one hour, or longer if necessary.

Additional meetings can be requested by either HIW or NHS Wales organisations as appropriate.

All engagement meetings will be structured and documented, and agendas will be intelligence-led and shared in advance.

Meeting outcomes will be recorded and shared with the relevant Health Board or NHS Trust, across HIW teams, and with relevant stakeholders as appropriate.

Correspondence regarding inspections or reviews

HIW has faced challenges in coordinating recipients for inspection correspondence, including reports and letters, within NHS organisations. Challenges arise when staff transition into new roles or when organisations request access for multiple individuals, which may not align with HIW's established procedures. Such situations can lead to outdated contact lists, ambiguity regarding information recipients, and the risk of confidential materials being accessed by unauthorised parties. These factors have the potential to delay communication and complicate follow-up actions following inspections.

For consistency, HIW will send written assurance correspondence concerning inspections and reviews to designated recipients in each NHS organisation. The designated recipients are responsible for disseminating information to their appropriate internal teams. This also applies to assurance activities within Dental and GP practices. The designated recipients are listed in **Table 2**.

Table 2: Recipients of HIW assurance correspondence

- Chief executive
- Chair
- Executive Director of Nursing
- Executive Medical Director
- Executive Director of Therapies and Allied Health
- A nominated team mailbox (such as Governance / Patient Safety Teams)

For clarity, HIW will no longer be sending assurance (inspection or review) correspondence to other individuals, such as primary care and community leads for Dental or GP inspections, neither will the ‘other individuals’ receive invitations to HIW’s secure sharing portal, Objective Connect. The above recipients will be responsible for sharing the relevant HIW documents with applicable organisation teams, and for uploading responses and evidence as appropriate, to the Objective Connect workspace.

It is pertinent to note that for any other correspondence, such as concerns or communications with HIW’s Investigation Teams, and ad hoc inspection communications with HIW’s Inspection Support team, we will communicate with other relevant individuals as appropriate.

Ongoing engagement with HIW

Communication with HIW staff will vary and will be dependent on the theme of the meeting or topic to be discussed. There will always be occasions when key staff within NHS organisations need to contact HIW and vice versa. This may be for general enquiries, discuss patient safety, care, or clinical issues, and non-clinical issues, such as service or organisational changes. In the first instance, **Table 3** highlights which team in HIW should be contacted, however, where appropriate your email may be directed to a different team to manage. Guidance on how to contact HIW is highlighted in Table 3 below.

Table 3: Guidance on contacting - key HIW teams

Example of Enquiry/ Notification:	Example of engagement need:	Who to contact:
General Enquiries.	Unsure of who to contact at HIW. Obtain team contact details. Query about HIW processes. Logging concerns prior to escalation to the Investigation Team. Raise concerns about HIW.	**HIW First Point of Contact (FPOC)** **Email:** HIW@gov.wales **Tel:** 0300 062 8163 **Link to:** Contact us **Link to:** Learning and Insight
Enquiries about a planned inspection or following an unannounced inspection.	Query about an upcoming HIW inspection. Query following completion of inspection. Query about accessing the Objective Connect Workspace.	**Inspection Support Team** **Email:** HIW.Inspections@gov.wales **Tel:** 0300 062 8163 **Link to:** Inspecting NHS Services
Review Service for Mental Health.	Use of the Mental Health Act and the interests of people whose rights are restricted under that Act. Requests for, and engagement about HIW's Second Opinion Appointed Doctor (SOAD) Service.	**Second Opinion Appointed Doctor (SOAD) Service** **Email:** HIW.RSMH@gov.wales **Tel:** 0300 062 8163 **Link to:** SOAD documents

Discuss clinical or patient quality and safety issues.	Clinical and/or patient quality and safety discussions.	**Acute Clinical Team** **Email:** HIW.AcuteClinical@gov.wales **Mental Health & Learning Disability Team** **Email** HIW.MentalHealth.Clinical@gov.wales **Tel:** 0300 062 8163
Non-clinical issues. Service or key organisational issues. Internal investigation report findings. Early warning of high-profile media reports.	Discuss urgent or planned operational issues, such as those impacting service delivery. Urgent notice about damage/ issues with the estate. Discuss key findings about internal investigations or reviews, such as culture, behavior and values reviews. An incident has occurred which will likely attract media attention, therefore provide an early notice to HIW.	**Head of NHS Assurance** **Email:** HIW-NHSassurance@gov.wales **Tel:** 0300 062 8163
Death in Custody (DIC) clinical review process.	Query about DIC clinical review process. Submission of key DIC documents, reports, improvement plans to support the review. Query about and ongoing or previous DIC clinical review.	**NHS Assurance Team** **Email:** HIW-NHSassurance@gov.wales **Tel:** 0300 062 8163 **Link to:** Death in Custody
Discuss a new or existing HIW concern case. Provide IR(ME)R incident notification.	Report a new concern. Enquire about an ongoing patient/ public concern. Whistleblowing concern. Submit an IR(ME)R notification.	**Investigations Team** **Email:** HIW.Concerns@gov.wales **Tel:** 0300 062 8163 **Link to:** Complaints about us (HIW) **Link to:** Whistleblowing **Link to:** Notifying IR(ME)R Incidents
Discuss escalation and enforcement process. Discuss Service of Concern (SOC) process.	Enquiry about HIW's escalation and enforcement process. Seek clarity about HIW's SOC process.	**Escalation & Enforcement Team** **Email:** HIW.Enforcement@gov.wales **Tel:**

Discuss existing/ active NHS Wales escalation case.	Discuss the organisation's designation as a SRSI. Submit information relating to HIW's SOC process or in line with the requirements as a SRSI.	0300 062 8163 **Link to:** Escalation
Query about the registration of a service, such as dental practice.	Query regarding the registration status of a Dental Practice within a health board's locality	**Registrations Team** **Email:** HIW.Registration@gov.wales **Tel:** 0300 062 8163 **Link to:** Registration Queries
Discuss HIW's communication, publication, media and social media processes.	Discuss HIW's website or social media content Engagement between Communication teams in NHS Wales organisations and HIW.	**Strategy & Communication Team** **Email:** HIW.comms@gov.wales **Tel:** 0300 062 8163 **Link to:** Publication schedule **Link to:** Keep up to date (Bulletins) **Link to:** Social media

Appendices

Appendix 1: Key changes from Relationship Manager (RM) engagement model

There are several key changes with the implementation of the new NHS Wales Engagement Model which include:

- The former RM role has been discontinued and superseded by an enhanced process designed to strengthen HIW's engagement with Health Boards and NHS Trusts
- The distribution list for HIW assurance correspondence within NHS Wales organisations has been revised to facilitate greater consistency and minimize errors
- Oversight of the NHS Engagement Process has transitioned to the Head of NHS Assurance, supported by two clinical teams and the intelligence team
- HIW clinical teams will conduct regular engagement meetings with executive leaders and key clinical leads, focusing on clinical themes, patient safety, governance, and quality
- The Head of NHS Assurance will hold planned non-clinical engagement meetings with Chief Operating Officers and Independent Members of the Board to discuss operational challenges, and where appropriate key findings from inspection
- The Partnerships Team will hold routine engagement meetings with external stakeholders, such as Llais, Audit Wales, Internal Audit, Royal Colleges, and representatives from NHS Performance and Improvement
- Escalation procedures within HIW have been further clarified and centrally coordinated.

Appendix 2: Sharing and use of information

HIW has several information sharing agreements with other organisations that we work closely with. These agreements set out the rationale for information sharing to assist the organisations in meeting their common statutory objectives and to focus on respective activities. They support the development of work programmes which are complementary, ensuring that there are clear processes in place for sharing information, risks, and concerns.

Where there are potential risks to public, patient or staff safety, HIW will share information with relevant authorities/organisations, such as the police, local authority safeguarding boards, and Health and Safety Executive. You can access the information sharing agreements on our website: **HIW's Memoranda of Understanding with other Organisations**.

All engagement activities and outcomes will be stored securely in HIW's secure electronic systems (known as Pwls and iShare). Evidence and intelligence will be used to inform strategic decisions, identify risks, and support continuous improvement across NHS Wales and the IHC sector.

General Data Protection Regulation (GDPR)

Under GDPR, we have a legal duty to protect any personal information we collect from you. We use leading technologies and encryption software to safeguard your data and keep strict security standards to prevent any unauthorised access to it.

Please see our website for further information on our **privacy policy**.

Appendix 3: Role of HIW teams within NHS Wales engagement

Some teams within HIW may not directly participate in the NHS Wales Engagement Process but will support HIW's relevant teams as appropriate.

Partnership, Intelligence and Methodology (PIM) Branch

The PIM Branch is made up of three teams: Partnership, Intelligence and Methodology. The branch supports HIW by gathering intelligence, assessing risks, developing inspection methodologies, and working with partners to help influence improvement across healthcare services. The branch ensures inspections are targeted and effective, helps manage concerns, and drives system-wide improvements through strategic analysis and collaboration.

Partnerships Team

The Partnerships Team maintains relationships and engagements with external stakeholders and manages HIW's Memoranda of Understanding with other Organisations.

This team also facilitates the bi-annual national Healthcare Summit, to share insights into the quality and safety of healthcare services provided by NHS Wales. Additional details regarding the Summit's purpose, and the participating organisations are available on our **website**.

The role of partnerships within the NHS Engagement Process is key in forging and maintaining strategic relationships between stakeholders to gain NHS assurance. Depending on the stakeholder, the 'purpose' of engagement may change, ranging from intelligence sharing and horizon scanning, to triangulating views on key NHS Wales issues, such as thematic risks or those within individual settings.

The team has developed a stakeholder map to maintain regular engagement, which includes organisations, such as Audit Wales, Llais, and NHS Wales Performance & Improvement. In addition, the team will attend key meetings across Welsh Government, Care Inspectorate Wales (CIW) and Estyn, to gather wider intelligence. The information obtained through these relationships and engagement opportunities will feed into HIW's Weekly Intelligence Group and will help inform proposals to undertake joint assurance work.

Intelligence Team

The Intelligence Team collects and analyses data from inspections, reviews, public feedback, and several external sources to identify risks and trends in healthcare services. The intelligence is used to inform HIW's Strategic Planning Board (SPB) and Risk and Escalation Committee (REC) and Senior Leadership Team (SLT), helping to plan or adjust

inspection priorities and respond to emerging issues. The team maintains dashboards and designs reports to help HIW's SLT to monitor performance and identify areas of concern.

The team also provides inspectors and reviewers with relevant intelligence to guide their work and ensure it is targeted and effective, and develops, analyses, and reports on surveys used during inspections and reviews. Additionally, the team drives transparency and improvement, by supporting HIW's Service of Concern process, enabling rapid action where standards of care are not me.

Intelligence is used to ensure HIW's assurance programme of work focuses on settings where patients are most at risk of not receiving optimal care. The team interprets a wide range of intelligence to make effective and appropriate decisions about how HIW utilises resources. To achieve this, systems and processes are in place to ensure decisions are consistent and based on evidence.

Key information feeds into the intelligence team through various sources (both internally and externally), and this is discussed in HIW's Weekly Intelligence Meetings. The collated information is presented to HIW's key teams, and to SPB and REC, to inform and reprioritise HIW's assurance work as appropriate.

The team also produces a briefing paper to help inform engagement discussions with Health Boards and NHS Trust clinical leads. The brief may include key findings, such as details of the Board, Quality and Safety Committee or Mental Health Legislation Committee meetings, Joint Executive Team meeting papers, or details from Integrated Medium-Term Plans, and data obtained through Welsh Government or nationally.

Methodology Team

The Methodology Team ensures that HIW's inspections, reviews, or investigations are carried out consistently, fairly, and effectively, using robust, evidence-based approaches, and considers the Health and Care Quality Standards 2023 and other regulations and legislation. The team designs and maintains standardised methodologies for assurance work, ensuring consistency and transparency across all HIW activities. Methodologies are also adapted to different healthcare sectors and specialties, considering unique risks and operational contexts, and when applicable, are bespoke to reviews work.

The team adapts to emerging risks and refines methodologies to respond to new challenges, enabling rapid and supportive advice for service improvement. In addition, the team ensures staff are trained in applying methodologies correctly and consistently, promoting continuous improvement in inspection practices.

For transparency, upon request, methodologies are available to healthcare services, and the team ensures they are accessible to stakeholders, reinforcing public trust in HIW's work.

The Methodology Team does not have a direct role in the NHS Engagement Process but may contact organisations if required.

Clinical Branch

The Clinical Branch is made up of two teams: Acute Clinical Team (ACT) and Mental Health and Learning Disabilities Team (MHLDT). The teams play a key role in ensuring that healthcare services across Wales meet high standards of safety, effectiveness, and person-centered care. They have a clinical oversight of HIW's work and provide clinical advice to inspectors and all teams across HIW where necessary. They also contribute to HIW's judgment, particularly in relation to patient safety, clinical governance, and the quality of care. In addition, they help interpret and apply the Duty of Quality in real-world settings.

Acute Clinical Team (ACT)

The ACT has a focus on all clinical settings within NHS Wales and the IHC sector, but excluding Mental Health and Learning Disability Services, which is the focus of the MHLDT.

Mental Health/ Learning Disabilities Team (MHLDT)

The remit of the MHLDT includes Mental Health and Learning Disability Services within both the NHS Wales and IHC sectors. The team focuses on clinical safety, legal compliance with the Mental Health Act (1983) and ensure that care is delivered in accordance with the **Code of Practice for Wales (2016)**.

- **NHS engagement meetings**
  The clinical teams lead on engagement with executive and/or senior clinical leads or managers in NHS Wales organisations. This is key in not only gaining assurance on how Health Boards and NHS Trusts gain their own assurance, but also in intelligence sharing, horizon scanning and gaining assurance on emerging risks and themes. During engagement meetings, there will also be an emphasis on quality, information sharing, early warning & escalation to identify potential problems using intel streams.

  The engagement meetings will provide an informal opportunity to share soft and hard intelligence and will offer a useful way to triangulate and corroborate information HIW is aware of, or to learn new information which may be relevant, and to identify new areas of risk which will be considered during HIW assurance activity. HIW's Intelligence Team will provide a briefing paper to the clinical teams prior to the planned engagement meetings.

The Review Service for Mental Health (RSMH) Team

The RSMH Team is part of HIW's broader assurance role to monitor compliance with the Mental Health Act and ensure high standards of care.

A crucial role within this team is the Second Opinion Appointed Doctor (SOAD) service. The team plays a pivotal role in safeguarding the rights of patients who are subject to the Mental Health Act 1983. When a patient is detained or liable to be detained under the Mental Health Act and refuses treatment (or lacks capacity to consent to treatment), a SOAD is appointed to review whether the proposed treatment is appropriate. This ensures that treatment decisions are not solely made by the treating clinician, adding a layer of independent oversight.

The SOAD process is designed to protect vulnerable individuals by ensuring that their treatment is lawful, ethical, and clinically justified. Therefore, SOADs are required to authorise specific treatments, such as medication beyond three months or Electroconvulsive Therapy (ECT), under sections 57, 58, and 62 of the Mental Health Act 1983.

Regulation and Escalation Branch

The Regulation and Escalation Branch is made up of three teams: Registration Team, Escalation and Enforcement Team and Investigations Team. The branch has a critical role in ensuring that independent healthcare services in Wales are safe, compliant, and meet regulatory standards. Additional it manages HIW's **Service of Concern (SOC) process for NHS Bodies in Wales.**

Registration Team

HIW is responsible for registering healthcare providers and managers of independent healthcare services in Wales, under the Care Standards Act 2000 and associated regulations. This includes Independent Hospitals, Clinics and Medical Agencies, and Private Dental Practices where providers offer private dental services outside of the NHS Framework. The Registration Team assesses whether a service requires registration and ensures that providers meet the National Minimum Standards before granting registration.

Enforcement & Escalation Team

The Enforcement and Escalation Team leads formal escalation processes, such as HIW's SOC process for NHS bodies in Wales. Additionally, when a registered service fails to meet its legal and regulatory obligations, HIW enforces compliance through structured processes appropriate within the Independent Healthcare (IHC) sector.

- **Escalation within NHS Wales**
  HIW prioritises action when standards are not met. To maintain transparency and public assurance about healthcare quality and safety, HIW uses a SOC process for NHS Wales bodies when it identifies significant service failures or systemic issues.

  This process allows HIW to identify and highlight 'Services Requiring Significant Improvement', thereby enhancing transparency regarding the discharge of its responsibilities. It ensures that targeted and timely actions are taken by relevant stakeholders, including Health Boards and Welsh Government, to maintain safe and effective care. Furthermore, this approach is designed to facilitate improvement and promote learning within an organisation's services and across NHS Wales.

  The SOC process and subsequent 'Service Requiring Significant Improvement' designation is distinct and separate to the NHS Wales Escalation and Intervention arrangements. However, this process will inform our view and help our contribution to the discussions on the overall status of NHS bodies in Wales.

Investigations Team

The team is integral to influencing and supporting patient safety and the quality of healthcare in Wales. It manages whistleblowers and public complaints, concerns, and statutory notifications, using this information to identify possible risks to patient safety or issues with standards of care.

- **Proactive intelligence sharing**
  The team helps HIW identify risks early by collecting intelligence from complaints, inspections, and statutory notifications.

- **Supporting escalation and intervention**
  Key intelligence is shared with HIW's Enforcement and Escalation Team in line with HIW's SOC process, and with the Director and Head of NHS Assurance to help inform tripartite discussions relating to NHS Escalation and Intervention Arrangements.

- **Embedding in engagement cycles**
  Investigation findings are integrated into routine engagement with NHS bodies, Llais, and other key stakeholders. This supports the call for continuous involvement and consultation in healthcare service delivery.

- **Driving improvement through insight**
  The team's investigations inform strategic improvement plans, helping HIW gain assurance that NHS organisations meet the Duty of Quality, and the Duty of

Candour under the Health and Social Services (Quality and Engagement) (Wales) Act 2020.

- **Collaborative working**
  The team works closely with HIW's Assurance Teams and Escalation and Enforcement, Intelligence, and Methodology teams, and with NHS bodies to ensure investigation findings are actionable and aligned with national priorities.

  The Investigations Team will directly engage with NHS Wales organisations as required, which is in addition to recipients of assurance correspondence.

Strategy and Communications Branch

The Strategy and Communications Branch is a cross-functional team responsible for strategic planning, policy analysis, communications, and engagement. The branch plays a pivotal role in shaping HIW's direction and ensuring its work is effectively communicated, understood.

- **Strategic responsibilities**
  Strategic planning includes the development of multi-year strategic plans, annual operational plans, and statutory publications such as the annual report. The branch reviews relevant national policy and legislation to assess their impact on healthcare services in Wales, producing internal briefings to support organisational planning and assurance activity. This work is aligned with national priorities, including the Well-being of Future Generations (Wales) Act and A Healthier Wales, and supports HIW's ability to respond to emerging risks and priorities.

- **Communications and engagement responsibilities**
  The branch leads HIW's communications and engagement activity, ensuring transparency in how findings, priorities, and impact are shared with stakeholders, including the public, NHS bodies, and independent healthcare providers. Communications promote improvement by highlighting good practice and lessons learned from inspections and reviews. The branch also manages HIW's website, social media channels, and press activity, ensuring messages are clear, accessible, and aligned with strategic objectives.

  Engagement is coordinated through a range of channels, including newsletters, consultation campaigns, and events, with the Stakeholder Advisory Group playing a key role in shaping inclusive approaches and informing HIW's work.

- **Cross-cutting functions**

Equality, diversity, and inclusion are embedded across all aspects of the branch's work, including the delivery of HIW's Equality, Diversity and Inclusion (EDI) Strategy. The team also provides internal advice and support on EDI, and for workforce development and wellbeing, empowering staff to fulfil strategic priorities with maximum effectiveness.

Business Management, Digital and Corporate Services Branch

The Business Management, Digital, and Corporate Services Branch is responsible for ensuring effective operational delivery across HIW. Responsibilities include finance, recruitment, First Point of Contact service, HR matters, governance, complaints, government business, inspection programme administration and purchasing and maintaining HIW's digital tools and equipment.

Within this branch sits the Inspection Support Team. This team provides administrative and logistical support to ensure HIW's inspection and regulatory activities run smoothly. This includes engaging with clinical peer reviewers and patient experience reviewers for HIW's assurance work, and with healthcare providers for both announced and following unannounced inspections. The team also manages HIW's secure Objective Connect workspaces to share and receive official sensitive documents.

Inspection Title	Reference Number	Inspection Date	Recommendation	Action	Clinical Care Group	Original Due Date	Progress Status	Risks
HIW GGH IRMER Inspection (Nov 2022)	Healthcare Inspectorate Wales (HIW)/2022/19/MD15/2	15/11/2022	The employer is required to provide HIW with details of the action taken to improve the ratification process for locally produced documentation so that information does not conflict with the employer's written procedure	To source a document control system.	Operational Allied Health and Health Science	30/09/2023	Overdue	On risk register- 1399
	Healthcare Inspectorate Wales (HIW)/2022/19/MD22/3	15/11/2022	The employer is required to provide an update on the action taken to ensure the employer's written procedure is adhered to by entitled referrers making a referral prior to exposures performed during surgical theatre cases.	CB to ensure all actions closed and evidence uploaded prior to closure of report	Operational Allied Health and Health Science	03/02/2025	Overdue	
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)	Healthcare Inspectorate Wales (HIW)/2023/29/MD1/1	07/03/2023	The health board must ensure that full and comprehensive mental health assessments and physical health assessments are always being completed in a timely manner, in line with the Mental Health (Wales) Measure 2010 under the Mental Health Act 1983.	a)Development of standards for physical health screening to be incorporated into Service Specifications.	Mental Health and Learning Disabilities	29/09/2023	Partially complete (Overdue)	
	Healthcare Inspectorate Wales (HIW)/2023/29/MD6/1	07/03/2023	The health board must ensure the inpatient ward round structure and arrangements in place allow for sufficient time for patients to be adequately discussed.	e)Coproduce a set of standards to underpin Ward MDT Review process to include a plan for implementation (including consistent approach to enabling service user and carer views within this process and consistent approach to documentation and communication of outcomes from ward reviews and discharge planning) and monitoring.	Mental Health and Learning Disabilities	29/09/2023	Overdue	
	Healthcare Inspectorate Wales (HIW)/2023/29/MD8/1	07/03/2023	The health board must ensure that all relevant staff complete training for timely and effective communication and information sharing relating to the patient discharge process.	h)Develop a training resource to provide guidance to all relevant staff on standards associated with the discharge planning and process.	Mental Health and Learning Disabilities	31/10/2023	Overdue	
	Healthcare Inspectorate Wales (HIW)/2023/29/MD25/3	07/03/2023	The health board must take action to manage the risks of insufficient staff numbers and temporary staffing needs on inpatient mental health wards.	p)Pilot application of the SAFECARE tool across an individual mental health inpatient ward to inform an approach to full implementation.	Mental Health and Learning Disabilities	30/11/2023	Overdue	
	Healthcare Inspectorate Wales (HIW)/2023/29/MD32/1	07/03/2023	The health board must consider undertaking a training needs analysis for inpatient and community mental health staff, to identify any training gaps and help ensure all staff have the appropriate knowledge and skills to effectively undertake their role.	u)Development of a MH/LD essential training framework to reflect training needs across MH/LD services based on a systematic TNA that can be reviewed at regular intervals and monitored for compliance.	Mental Health and Learning Disabilities	30/11/2023	Overdue	
	Healthcare Inspectorate Wales (HIW)/2023/29/MD25/4	07/03/2023	The health board must take action to manage the risks of insufficient staff numbers and temporary staffing needs on inpatient mental health wards.	q)Development of MH/LD targeted actions through the MH/LD Workforce Group to feed into board wide recruitment and retention plans.	Mental Health and Learning Disabilities	31/12/2023	Overdue	
	Healthcare Inspectorate Wales (HIW)/2023/29/MD1/3	07/03/2023	The health board must ensure that full and comprehensive mental health assessments and physical health assessments are always being completed in a timely manner, in line with the Mental Health (Wales) Measure 2010 under the Mental Health Act 1983.	CB to ensure all actions closed and evidence uploaded prior to closure of report	Mental Health and Learning Disabilities	05/05/2025	Overdue	
HIW St Non, St Caradog, Canolfan Bro Cerwyn WGH	Healthcare Inspectorate Wales (HIW)/2023/69/MD13/1	16/10/2023	The health board must ensure that safe holds are described in detail and that patient observations are recorded post any restraint or medical intervention in patient notes	To undertake a Directorate wide audit of Rapid Tranquilisation against standards for physical health monitoring within the Health Boards Rapid Tranquilisation Policy.	Mental Health and Learning Disabilities	31/03/2024	Overdue	
	Healthcare Inspectorate Wales (HIW)/2023/69/MD1/4	16/10/2023	The health board must ensure that staff have alarms and engage with staff to come up with solutions to make staff feel safer whilst working in a remote area.	CB to ensure all actions closed and evidence uploaded prior to closure of report	Mental Health and Learning Disabilities	05/05/2025	Overdue	
HIW IRMER Diagnostic Imaging x-ray department Withybush Hospital January 2024	Healthcare Inspectorate Wales (HIW)/2024/86/MD4/1	31/01/2024	The Employer is required to provide HIW with details of action taken to ensure that all written documentation in place include the required level of detail as set out within the employer's procedure for Quality Assurance programme document control.	1. A document control system needs to be sourced	Operational Allied Health and Health Science	31/12/2024	Overdue	1399 on risk register
HIW Children and Young People Mental Health Review	Healthcare Inspectorate Wales (HIW)/2024/396/MD32/1	05/02/2024	Health boards must explore the options available within their local CAMHS teams to facilitate a strengthened approach for communication and partnership working with GP clusters and/ or directly with GP practices.	S-CAMHS will discuss with GP Clusters to discuss an agreed approach to partnership working and improving communication, including the suggestion of a regular (bi-monthly) forum	Mental Health and Learning Disabilities	04/08/2025	Partially complete (Overdue)	

Inspection Title	Reference Number	Inspection Date	Recommendation	Action	Clinical Care Group	Original Due Date	Progress Status	Risks
	Healthcare Inspectorate Wales (HIW)/2024/396/MD35/1	05/02/2024	Health boards should ensure they review their methods of co-production of services with children and young people, and parents and carers.	S-CAMHS will continue to offer support for the Future MINDS Forum already established and ensure co-Production is a priority in reviewing Service Improvements, Policies and partake in recruitment	Mental Health and Learning Disabilities	04/08/2025	Partially complete (Overdue)	
HIW Glangwili Hospital – Morlais Ward inspection	Healthcare Inspectorate Wales (HIW)/2024/302/MD6/1	01/07/2024	The health board must ensure that the outstanding actions identified following the fire safety audit in February 2024 are completed and sustained.	To review the recommendations from the fire safety audit and agree an implementation plan.	Estates, and Facilities	31/12/2024	Partially complete (Overdue)	
	Healthcare Inspectorate Wales (HIW)/2024/302/MD1/2	01/07/2024	The health board must ensure that the visitor's room is made a more welcoming environment.	CB to ensure all actions are completed and evidence uploaded prior to closure	Mental Health and Learning Disabilities	04/03/2025	Overdue	
Bryngolau Ward, Prince Philip Hospital	Healthcare Inspectorate Wales (HIW)/2024/395/MD2/2	02/09/2024	The health board must implement a structured programme of suitable and appropriate therapeutic activities to support patients' health, wellbeing and rehabilitation.	CB to confirm all actions closed and evidenced	Mental Health and Learning Disabilities	31/03/2025	Overdue	
	Healthcare Inspectorate Wales (HIW)/2024/395/MD33/1	02/09/2024	The health board should consider the staff feedback about suggestions for training and implement regular, individualised training needs assessments.	Develop and deliver bespoke Older Adult Mental Health Clinical Risk training specifically around self-harm and suicidality, to all OAMH Wards.	Mental Health and Learning Disabilities	31/03/2025	Partially complete (Overdue)	
IRMER Regulations	Healthcare Inspectorate Wales (HIW)/2024/498/MD9/1	01/10/2024	Schedule 3 is re-organised with changes to core and specific training. Training in the amendment changes is required plus discipline specific review with additions to the "all modalities" elements probably most significant. A plan to cover any additions will be required.	Review training needs of practitioners and operators	Operational Allied Health and Health Science	30/06/2025	Overdue	
	Healthcare Inspectorate Wales (HIW)/2024/498/MD9/2	01/10/2024	Schedule 3 is re-organised with changes to core and specific training. Training in the amendment changes is required plus discipline specific review with additions to the "all modalities" elements probably most significant. A plan to cover any additions will be required.	CB to ensure all actions complete to allow for closure	Operational Allied Health and Health Science	30/06/2025	Overdue	
	Healthcare Inspectorate Wales (HIW)/2024/498/MD2/1	01/10/2024	Identify areas where more than one employer may be involved with and exposure and consider if the co-operation regulation needs actions. e.g. referrer (GP referrals), operator (third party imaging providers) or practitioner (out of hours practitioner service) has a different employer; to other duty holders	Co-operation between employers: consider where relevant	Operational Allied Health and Health Science	31/07/2025	Overdue	
	Healthcare Inspectorate Wales (HIW)/2025/587/MD11/1	17/03/2025	There can also be delays in health assessments being completed for children involved in the child protection process. Whilst the health board has identified improvements to address these concerns, ongoing delays mean protective actions to address risk can be adversely impacted.	School Nursing service to put in place processes to monitor compliance with complying with health assessments requests within timescales.	Planned and Specialist Care	30/06/2025	Partially complete (Overdue)	
	Healthcare Inspectorate Wales (HIW)/2025/587/MD5/1	17/03/2025	Training compliance is a concern, particularly for Level 3 safeguarding children training. Only 37% of medical and dental staff were compliant in December 2024. The provision of training is regularly available, but attendance levels are often low.	All services to put in place improvement plans to achieve 85% compliance across all professional groups with Level 3 training by 31st March 2026	Community & Integrated Medicine	30/09/2025	Overdue	
	Healthcare Inspectorate Wales (HIW)/2025/587/MD5/2	17/03/2025	Training compliance is a concern, particularly for Level 3 safeguarding children training. Only 37% of medical and dental staff were compliant in December 2024. The provision of training is regularly available, but attendance levels are often low.	All services to put in place improvement plans to achieve 85% compliance across all professional groups with Level 3 training by 31st March 2026	Planned and Specialist Care	30/09/2025	Overdue	Adequate access to Level 3 training. To mitigate the risk, priority staff identified to access training.
	Healthcare Inspectorate Wales (HIW)/2025/587/MD5/3	17/03/2025	Training compliance is a concern, particularly for Level 3 safeguarding children training. Only 37% of medical and dental staff were compliant in December 2024. The provision of training is regularly available, but attendance levels are often low.	All services to put in place improvement plans to achieve 85% compliance across all professional groups with Level 3 training by 31st March 2026	Mental Health and Learning Disabilities	30/09/2025	Overdue	
	Healthcare Inspectorate Wales (HIW)/2025/587/MD9/1	17/03/2025	Child protection supervision was not evident in the sample of files reviewed. There were inconsistences in record-keeping, with examples of minimal recordings and a lack of analysis.	Child safeguarding supervision via group, 1-1 and ad hoc supervision will promote child-centred practices and a shift from process-led safeguarding to person-centred practice that supports people to live safely and independently with attendees.	Nursing, Quality and Patient Experience	30/09/2025	Overdue	

Inspection Title	Reference Number	Inspection Date	Recommendation	Action	Clinical Care Group	Original Due Date	Progress Status	Risks
Joint Inspection of Child Protection Arrangements (Pembrokeshire)	Healthcare Inspectorate Wales (HIW)/2025/S87/MD12/1	17/03/2025	The reliance on CP medicals being completed by acute paediatricians in an out-of-county hospital, due to the lack of a service in Pembrokeshire, presents a long-standing and unresolved challenge to all agencies involved. The Health Board should consider how best to resolve theses issues to ensure a more timely and seamless service, both for agencies and for the children and families involved.	Work with Local Authority partners to agree an escalation process when health assessments are delayed.	Planned and Specialist Care	30/09/2025	Overdue	
	Healthcare Inspectorate Wales (HIW)/2025/S87/MD13/1	17/03/2025	The recording of ethnicity and language on the Health Board and police records is not consistent. Leaders should ensure accurate and clear record keeping of important demographic information.	Service Leads to incorporate into record keeping audits, evidence of important demographic information, e.g. ethnicity	Community & Integrated Medicine	30/09/2025	Overdue	
	Healthcare Inspectorate Wales (HIW)/2025/S87/MD13/2	17/03/2025	The recording of ethnicity and language on the Health Board and police records is not consistent. Leaders should ensure accurate and clear record keeping of important demographic information.	Incorporate evidence of genograms, chronologies and front sheets (WCCIS excepting) into Senior Nurse random HV and SN record keeping audit.	Planned and Specialist Care	30/09/2025	Overdue	
	Healthcare Inspectorate Wales (HIW)/2025/S87/MD14/1	17/03/2025	There was variability in the completion and quality of safeguarding documentation across services. This includes missing or incomplete genograms, chronologies, and front sheets.	Staff compliance of attendance at record keeping training to be scrutinised	Planned and Specialist Care	30/09/2025	Overdue	
	Healthcare Inspectorate Wales (HIW)/2025/S87/MD15/1	17/03/2025	Inter-agency communication requires improvement in many practice areas, for example between School Nurses and Social Workers. The absence of safeguarding records, including Care and Support Protection Plan (CASPP) and Core Group minutes, from health records is an indicator of disjointed communication.	Discussion related to ensuring CASPP and core group minutes are in a child's record to be discussed at team meetings and evidenced in minutes.	Nursing, Quality and Patient Experience	30/09/2025	Overdue	
	Healthcare Inspectorate Wales (HIW)/2025/S87/MD18/1	17/03/2025	Partners should ensure timely information sharing about emerging safeguarding themes and work together to disrupt and reduce such risks within the population and for individual children.	Prevention & emerging risks: HV and Midwifery to draft a Free Birth policy for consultation with regional multi-agency partners.	Nursing, Quality and Patient Experience	30/09/2025	Overdue	
HIW GGH Maternity Services 03924	Healthcare Inspectorate Wales (HIW)/2025/S65/MD8/2	12/05/2025	The health board must provide evidence of an improvement in staff mandatory safeguarding training compliance within eight weeks of the inspection date to confirm that action has been taken to improve compliance.	The Maternity Monthly Newsletter to be updated with all relevant information on accessing safeguarding training.	Planned and Specialist Care	20/08/2025	Overdue	
	Healthcare Inspectorate Wales (HIW)/2025/S65/MD11/1	12/05/2025	The health board must ensure that staff can access up-to-date guidelines and policies on WISDOM, including the dates they are due to be reviewed.	The Risk and Governance Newsletter will include a reminder to all staff that in the first instance guidelines and policies should be accessed via the Health Board intranet as there is greater governance around this.	Planned and Specialist Care	12/09/2025	Overdue	
	Healthcare Inspectorate Wales (HIW)/2025/S65/MD8/3	12/05/2025	The health board must provide evidence of an improvement in staff mandatory safeguarding training compliance within eight weeks of the inspection date to confirm that action has been taken to improve compliance.	Monitoring of compliance will be reviewed on a monthly basis across the service by the senior midwifery team, this will ensure a consistently increasing trajectory of compliance	Planned and Specialist Care	20/09/2025	Overdue	
	Healthcare Inspectorate Wales (HIW)/2025/S65/MD3/2	12/05/2025	The health board must ensure that all handovers are conducted using the SBAR format, and that service users' history and clinical risk is recorded on the patient information board and documented in the appropriate area within the clinical notes.	The Maternity Risk and Governance Newsletter to reiterate the importance of ensuring a holistic approach to handovers which is inclusive of relevant history and prudent to ensure efficient, timely and safe handover of care	Planned and Specialist Care	30/09/2025	Overdue	
	Healthcare Inspectorate Wales (HIW)/2025/S95/MD3/5	05/08/2025	Provide clear guidance and additional training to staff to ensure their understanding of the risks associated with temperature deviations, and the appropriate action to take in such circumstances.	Communicate to wider site within Professional Nurse forum (PNF), Medication Scrutiny and Assurance meeting.	Community & Integrated Medicine	28/08/2025	Partially complete (Overdue)	
	Healthcare Inspectorate Wales (HIW)/2025/S95/MD3/4	05/08/2025	Provide clear guidance and additional training to staff to ensure their understanding of the risks associated with temperature deviations, and the appropriate action to take in such circumstances.	Review training attendance and requirements of staff for Medication Safety & e-learning module.	Community & Integrated Medicine	01/09/2025	Overdue	
	Healthcare Inspectorate Wales (HIW)/2025/S95/MD1/2	05/08/2025	Ensure that ambient clinic room temperatures are monitored and recorded daily.	Awaiting costing for air-con for clinical room.	Community & Integrated Medicine	15/09/2025	Overdue	

Inspection Title	Reference Number	Inspection Date	Recommendation	Action	Clinical Care Group	Original Due Date	Progress Status	Risks
Mynydd Mawr Ward, Prince Philip HospitaL 03921	Healthcare Inspectorate Wales (HIW)/2025/595/MD3/6	05/08/2025	Provide clear guidance and additional training to staff to ensure their understanding of the risks associated with temperature deviations, and the appropriate action to take in such circumstances.	Further sharing and dissemination of learning within wider Health Board forum – Community & Integrated Medicine Clinical Care Group, Integrated Governance Group (Quality, Health & Safety); Senior Nurse Management Team (SNMT), and Medication Events Review Group (MERG).	Community & Integrated Medicine	19/09/2025	Overdue	
	Healthcare Inspectorate Wales (HIW)/2025/595/MD2/2	05/08/2025	Implement robust measures to maintain clinic room temperatures within recommended guidelines for safe medication storage.	The monitoring chart link requires to be embedded within the medicine policy for ease of access. This action has been requested and is underway.	Community & Integrated Medicine	30/09/2025	Overdue	
	Healthcare Inspectorate Wales (HIW)/2025/595/MD3/2	05/08/2025	Provide clear guidance and additional training to staff to ensure their understanding of the risks associated with temperature deviations, and the appropriate action to take in such circumstances.	Review the Medication Safety Study Day content – presentation to be updated to include medication storage and room temperature monitoring requirements.	Community & Integrated Medicine	30/09/2025	Overdue	
	Healthcare Inspectorate Wales (HIW)/2025/595/MD3/3	05/08/2025	Provide clear guidance and additional training to staff to ensure their understanding of the risks associated with temperature deviations, and the appropriate action to take in such circumstances.	Review Medicines Administration, Recording, Review, Storage & Disposal e-learning module content.	Community & Integrated Medicine	30/09/2025	Overdue	
	Healthcare Inspectorate Wales (HIW)/2025/628/MD2/1	02/09/2025	The health board must ensure that daily checks of the emergency resuscitation trolley are completed and documented daily.	To remind all ward clinical staff that they must perform and document daily checks of the emergency resuscitation trolley in line with the resuscitation policy. This includes verifying the presence and expiry dates of emergency equipment and medications, and ensuring the trolley is clean, secure, and ready for use.	Community & Integrated Medicine	15/09/2025	Overdue	
	Healthcare Inspectorate Wales (HIW)/2025/628/MD4/1	02/09/2025	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.	To remind all ward clinical staff of the requirement to decontaminate reusable equipment between each patient use, in line with the decontamination policy. This includes the use of approved cleaning products and adherence to IPC standards (including hand hygiene). The guidance will be reinforced during scheduled team meetings, with attendance recorded and key messages circulated within 3 working days.	Community & Integrated Medicine	15/09/2025	Overdue	
	Healthcare Inspectorate Wales (HIW)/2025/628/MD4/5	02/09/2025	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.	To ensure that decontamination wipes are routinely stocked and visibly available in all observation trolleys across clinical areas.	Community & Integrated Medicine	15/09/2025	Overdue	
	Healthcare Inspectorate Wales (HIW)/2025/628/MD5/2	02/09/2025	The health board must ensure that oxygen tubing and face masks are easily accessible for all bed areas on the ward.	To ensure oxygen delivery equipment including availability and readiness for use is included in daily ward checks. Any missing or damaged items to be reported or replaced promptly.	Community & Integrated Medicine	15/09/2025	Overdue	
	Healthcare Inspectorate Wales (HIW)/2025/628/MD5/4	02/09/2025	The health board must ensure that oxygen tubing and face masks are easily accessible for all bed areas on the ward.	To remind staff the importance of ensuring emergency and routine oxygen equipment is always accessible, as per resuscitation policy. This will be reinforced through staff meetings.	Community & Integrated Medicine	15/09/2025	Overdue	
	Healthcare Inspectorate Wales (HIW)/2025/628/MD6/2	02/09/2025	The health board must ensure wall suction units are fully operational	To ensure a check of the suction delivery units (availability and readiness) in daily ward checks. Any missing or damaged items are reported or replaced promptly.	Carmarthenshire Integrated System	15/09/2025	Overdue	
	Healthcare Inspectorate Wales (HIW)/2025/628/MD6/4	02/09/2025	The health board must ensure wall suction units are fully operational	Staff to be reminded of the importance of ensuring bedside suction is always adequate and accessible. This will be reinforced through staff meetings.	Carmarthenshire Integrated System	15/09/2025	Overdue	
	Healthcare Inspectorate Wales (HIW)/2025/628/MD7/1	02/09/2025	The health board must ensure that patient records are stored securely at all times.	To remind all ward staff of the requirement to store patient records in locked notes trollies as per Record Keeping policy. This will be reinforced through staff meetings.	Carmarthenshire Integrated System	15/09/2025	Overdue	

Inspection Title	Reference Number	Inspection Date	Recommendation	Action	Clinical Care Group	Original Due Date	Progress Status	Risks
	Healthcare Inspectorate Wales (HIW)/2025/628/MD8/1	02/09/2025	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: • IITaking appropriate action when NEWS scores are 3 or above • IIICompleting and documenting Sepsis Screening for those at risk of sepsis, such as a NEWS score of 5 or above • IIICompleting and documenting VTE risk assessments on admission and thereafter in line with local and national guidance.	To remind all ward clinical staff of their responsibility to document all risk assessments and associated actions in the patient record, in line with the Monitoring, Recording of Adult Physiological Observations and Response to Physical Deterioration Policy. This includes initial assessments, reassessments, and any interventions taken. The requirement will be reinforced through staff meetings and mandatory training sessions, with attendance recorded and compliance monitored through monthly documentation audits by the Senior Ward Manager.	Carmarthenshire Integrated System	15/09/2025	Overdue	
	Healthcare Inspectorate Wales (HIW)/2025/628/MD8/4	02/09/2025	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: • IITaking appropriate action when NEWS scores are 3 or above • IIICompleting and documenting Sepsis Screening for those at risk of sepsis, such as a NEWS score of 5 or above • IIICompleting and documenting VTE risk assessments on admission and thereafter in line with local and national guidance.	To arrange additional training to support the early recognition of a deteriorating patient.	Carmarthenshire Integrated System	15/09/2025	Overdue	
HIW Derwen Ward 04054	Healthcare Inspectorate Wales (HIW)/2025/628/MD9/3	02/09/2025	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.	To share the immediate actions findings at other forums such as the: 1.Community and Integrated Medicine Clinical Care Group Integrated Governance Meeting	Carmarthenshire Integrated System	18/09/2025	Overdue	
	Healthcare Inspectorate Wales (HIW)/2025/628/MD9/4	02/09/2025	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.	To share the immediate actions findings at other forums such as the: 2.Senior Nurse Management Team	Carmarthenshire Integrated System	22/09/2025	Overdue	
	Healthcare Inspectorate Wales (HIW)/2025/628/MD9/5	02/09/2025	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.	To share the immediate actions findings at other forums such as the: Integrated Quality, Finance, Performance and Delivery Group	Carmarthenshire Integrated System	24/09/2025	Overdue	
	Healthcare Inspectorate Wales (HIW)/2025/628/MD1/8	02/09/2025	The health board must ensure that checks of the drug refrigerator in the clinical room are monitored and recorded daily.	To further sharing and dissemination of learning within wider Health Board forum: 3.Medication Events Review Group (MERG).	Carmarthenshire Integrated System	26/09/2025	Overdue	
	Healthcare Inspectorate Wales (HIW)/2025/628/MD1/1	02/09/2025	The health board must ensure that checks of the drug refrigerator in the clinical room are monitored and recorded daily.	To remind all ward clinical staff of the requirement to consistently record the date and temperature reading in the dedicated logbook located in the clinical room, confirming completion of daily temperature checks.	Carmarthenshire Integrated System	30/09/2025	Overdue	
	Healthcare Inspectorate Wales (HIW)/2025/628/MD3/2	02/09/2025	The health board must ensure that sufficient domestic staff are available to clean the ward to maintain appropriate infection prevention and control (IPC)	Synbiotix audits to be aligned with the existing improvement plan including a review of the audit criteria to ensure they reflect current priorities and actions outlined in the plan.	Carmarthenshire Integrated System	30/09/2025	Overdue	
	Healthcare Inspectorate Wales (HIW)/2025/628/MD8/6	02/09/2025	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: • IITaking appropriate action when NEWS scores are 3 or above • IIICompleting and documenting Sepsis Screening for those at risk of sepsis, such as a NEWS score of 5 or above • IIICompleting and documenting VTE risk assessments on admission and thereafter in line with local and national guidance.	To reinforce to medical staff the requirement to complete and document the VTE Risk Assessment.	Carmarthenshire Integrated System	30/09/2025	Overdue	

Inspection Title	Reference Number	Inspection Date	Recommendation	Action	Clinical Care Group	Original Due Date	Progress Status	Risks
	Healthcare Inspectorate Wales (HIW)/2025/628/MD8/7	02/09/2025	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: • IITaking appropriate action when NEWS scores are 3 or above • IIICompleting and documenting Sepsis Screening for those at risk of sepsis, such as a NEWS score of 5 or above • IIICompleting and documenting VTE risk assessments on admission and thereafter in line with local and national guidance.	To promote the Hospital Acquired Thrombosis SharePoint which is available with current resources and information.	Carmarthenshire Integrated System	30/09/2025	Overdue	
	Healthcare Inspectorate Wales (HIW)/2025/628/MD8/9	02/09/2025	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: • IITaking appropriate action when NEWS scores are 3 or above • IIICompleting and documenting Sepsis Screening for those at risk of sepsis, such as a NEWS score of 5 or above • IIICompleting and documenting VTE risk assessments on admission and thereafter in line with local and national guidance.	To review of VTE risk assessment compliance findings to be discussed within the Carmarthenshire System Quality and Safety Governance meeting (feeding into our Clinical Care Group)	Carmarthenshire Integrated System	30/09/2025	Overdue	
	Healthcare Inspectorate Wales (HIW)/2025/628/MD1/6	02/09/2025	The health board must ensure that checks of the drug refrigerator in the clinical room are monitored and recorded daily.	To further sharing and dissemination of learning within wider Health Board forum: 1.Community & Integrated Medicine Clinical Care Group Integrated Governance Group (Quality, Health & Safety);	Carmarthenshire Integrated System	31/10/2025	Overdue	

5.2

5.2 - Criteria 2 Quality Impact Assessment Related Planning- To Follow

Cathie Steele (Hywel Dda UHB - Interim Assistant Director of Nursing Assurance and Safeguarding), Sian Jenkins (Hywel Dda UHB - Deputy Director of Finance), Sharon Daniel (Hywel Dda UHB - Executive Director of Nursing, Quality & Patient Experience)

Attachments

QSEC SBAR - Finance Deficit Criteria 2 QIA Process.pptx



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

Criteria 2 Financial Choices and Decisions Report 2025/26

Quality Safety and Experience Committee

9 October 2025

Situation

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Through the annual planning cycle ahead of 2025/26 the Health Board sought to balance delivery in the context of high quality, safe services which protected our population for the future, on balance with performance and financial requirements.

The Welsh Government (WG) expectation is that the Health Board should plan to deliver, as a minimum, the 2024/25 financial outturn of £24.1m. Despite improving the forecast to £30.0m, the response has been clear and WG continues to assert the requirement that £24.1m is delivered.

Given the timescales required to make a further financial improvement, this inevitably requires consideration of short-term options to curtail expenditure. The majority of the Health Boards budget is pre-committed in respect of substantive salaries to staff, primary contracts, long term agreements with other health providers, contracts with suppliers etc, as a result short term options are limited and necessitate consideration of reactive cuts as opposed to planned strategic alternatives.

The following slides provide and update on progress to date. Should further financial decisions be made in this meeting, a revised and updated presentation will be shared with stakeholders.

Background

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

The Board, at its meeting on the 27 March 2025, endorsed and approved the submission of the annual plan to Welsh Government (WG), noting that the financial plan does not deliver against our statutory requirement to. The 2025/26 financial plan represented a planned deficit of £31.5m, after the delivery of £44.4m of savings, split between £19.0m of recurrent and £25.4m of non-recurrent.

The Board, at its meeting on 31 July 2025, endorsed and approved a revised annual plan financial deficit of £30.0m, having made decisions to increase the savings target to £46.4m. Since the Board meeting on 31 July 2025, a further letter received from the Director General clarifying expectations that the Health Board should plan to deliver, as a minimum, the 2024/25 financial outturn of £24.1m

QIA Panels to consider proposals outlined in Criterion 1 were held on August 15th & 26th and presented to September Board. A QIA Panel was held on the 26th September to review the Category 2 proposals received. Category 2 Options are options which require more detailed assessment by CCGs to assess what can be delivered within specific services.

Due to the plethora of QIAs submitted a consolidated review was undertaken on some proposals e.g. overtime and contract agency.

Saving Option Categories

Saving options: Category 2

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Category 2: Options of consequences – options which require more detailed assessment by CCGs/Functions to assess what can be delivered within specific services.

Scheme	Opportunity Estimate Q1 £'000	Latest Updates including QIA feedback £'000	Opportunity Estimate Remaining £'000
Pause all overtime until the end of March	5,100	In respect of nursing, combined QIA received for agency and overtime implications; negative assessment. Current on contract agency spend approx £330k per month. RN vacancies / deficits will be significantly reduced from November 2025 (98.14wte NRNs due to start Sept /October 2025, M05 forecsts being reviewed to ensure alignment). Challenges will continue for GGH theatres and BGH EUCC, with emerging issues for critical care potentially. Surge beds will need to be withdrawn to enable further reductions. In respect of the nursing workforce, there is a statutory requirement ' to take all reasonable steps' which includes temporary nursing staff such as bank/agency. N.B. Increased review of on-contract HCSW agency planned via FCSG.	96
Reduce/eliminate all on contract agency	4,900		0
Local Authority shared costs	450	Opportunity framed linked to prior year charges, ongoing charges are framed in an existing (red) saving scheme. Seeking discussion with LA, reliant on successful engagement and concluding a position which clarifies the agreement in place. QIA cites negative impact in respect of withdrawal from the arrangement in it's entirity which may jeopardise the continued service provision at Garreglwyd if it can't be afforded by the LA and knock on to other services, however clarity on multiple aspects of charging is required which may generate a benefit.	450
Non-renewal of contracts and or digital licences	1,300	QIA negative impact in respect of the principle to remove digital contracts, impact being weaker infrastructure to support safe and reliable care e.g. electronic health records and clinical decision support. Detailed review of contracts has identified some opportunity with minimal impact.	75
Hold LTA 25/26 activity to budget	140	Replaced with Neurology double charge and TOPS service, reliant on commissioning discussions with SB, level of risk to delivery. Potential implications for regional relationships. Neurology QIA cited the benefit of clarifying commissioning arrangements, positive score.	70
MHLD - Delay recruitment linked to approved MH business Case (and other plans)	1,900	QIA references negative impact. Will necessiate ongoing variable pay. The reality of recruitment is generating some delays in roles/costs starting. **Element of recruitment slip £0.7m within M05 forecast.**	0
Dental recovery – consciously delay activity	300	Extend the time taken to recommission GDS contracts that have been handed back in order to slow expenditure. Shortfall in dental provision impacts urgent service demand. QIA included some positive scores, overall negative impact. Risk in respect of WG funding claw back, across dental underspend. **Already a significant benefit factored into the current forecast, unlikely more.**	0
Digital project investment case 2025/26: Integrated Digital Care Programme	300	QIA negative impact in preventing delivery of improvements linked to ePMA, eFlow and eObs. However timelines for delivery and recruitment / backfill arrangements enabling a level of slip, **£100k built into forecast at M05.**	0
Pause Radiology activity increases	1,300	QIA frames negative impact, linked to delays in patient care and potential harm, non delivery of WG performance targets.	0
Equipment / Stores Further Faster Provision	400	No QIA. Challenge of RPB funding constraints, but being explored latest slip estimate £238k	0
RIF Slip	240	No QIA. Challenge of RPB funding constraints	0
HB wide ban on travel, Q1 average travel expenses £232k per month, taxis £14k per month	TBC	No options forthcoming through QIA and financial assessment process. Challenge of clinical vs non-clinical travel. Taxi spend is linked to clinical activity (transporting clinical staff between sites or patient discharges). Separate scheme focused on maximising virtual meetings is a more targeted opportunity.	0
Review contracts of temporary staff (who have worked < 2 years)	TBC	No options forthcoming through QIA and financial assessment process	0
TOTAL Category 2	**16,330**		**691**

QIA Summary (category 2)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Scheme	IIA Matrix Scoring STEEEP	QIA Feedback Summary	
Pause all overtime until the end of March 2026	Negative impact in all domains with the impact being -16 or -25 Where the old QIA template was used, the impact in all domains was either 20 or 25 (except for the equitable domain in one assessment which scored 12)	The panel found it difficult to distinguish between "overtime" and "additional hours," noting that many submissions did not clearly articulate the quality impact or specify which type of hours were being referenced. There was concern that some services might not actually use overtime, but rather additional hours, which are paid differently and may not be budgeted in the same way. The quality of QIAs was inconsistent, with narratives often failing to describe the impact on each quality domain (e.g., safety, equitable care). The panel requested that QIA authors clarify and improve their submissions, ensuring each domain was properly considered and risk scores justified. There was consensus that greater scrutiny is needed over both overtime and additional hours through Clinical Care Group (CCG) processes supported by Roster Scrutiny Group. The panel suggested that oversight should be strengthened and that financial partners should be involved to understand the scale of overtime spending. The panel noted that simply pausing overtime would not necessarily yield clear or predictable savings, as the actual use and financial impact of overtime versus additional hours was not well understood. The need for finance business partner input was highlighted. The panel discussed the risk that pausing overtime could lead to service reductions or require alternative staffing solutions. They also noted the importance of distinguishing between clinical and non-clinical roles when considering the impact.	**5100**
Reduce/eliminate all on contract agency	Negative impact in all domains with the impact being -16 or -25 Where the old QIA template was used the impact in all domains was either 20 or 25	The panel found that many QIAs for reducing or eliminating on-contract agency staff were lacking in detail, with narratives often failing to clearly describe the specific quality impacts. This made it challenging to assess the true risks and implications. It was acknowledged that, while reducing agency use is preferred, complete elimination is not feasible due to ongoing service needs. The panel noted that agency staff are sometimes essential to maintain safe staffing levels, particularly in critical areas. The need for more detailed breakdowns of agency spend by staff group was highlighted, with finance partners expected to provide this information. The panel also discussed the importance of having robust escalation processes and standard operating procedures for requesting additional staffing, like those in place for nursing. The executive Team agreed Principles for Enhanced Financial Scrutiny for Locum Agency on October 1st. The panel noted that each speciality had unique requirements for variable pay and that this needed to be understood in further detail. e.g. the panel noted that reducing agency staff in primary care could have knock-on effects on secondary care, potentially increasing pressure elsewhere in the system. The panel emphasised the need for alignment with the organisation's strategic direction and when agency is required – consideration would need to be through the enhanced financial scrutiny process.	**490**

QIA Summary (category 2)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Scheme	IIA Matrix Scoring STEEEP	QIA Feedback Summary	Opportunity Estimate
Local Authority Shared Costs	S = -25 T = -25 E = -25 E = -8 E = -25 P = -25	It was unclear about which specific residential home or service the QIA referred to, and whether it overlapped with other ongoing contract reviews. The panel noted that the current activity levels and financial impact of withdrawing health element funding were unclear. They requested an executive paper detailing current service delivery and financials before any decision could be made. It was highlighted that the agreement in question was never formalised with a section 33 or service level agreement, and health had not referred any children for many years. The panel viewed this as a business decision requiring further detail and executive oversight. The QIA indicated significant risk if funding was withdrawn, but the panel noted the absence of a screening EQIA to support the risk assessment.	**450**
Non-renewal of contracts and or digital licences	S = -12 T = -16 E = -6 E = -8 E = not scored P = not scored	The panel discussed that reviewing and not automatically renewing contracts or digital licences should be standard business practice, especially if it leads to efficiency and cost savings. For the digital contracts QIA, the panel noted the need for more detail on which specific licences would be affected, as the impact could vary significantly depending on the system (e.g., Datix vs. CoPilot). They suggested that ideally, a separate QIA should be completed for each licence to accurately assess risks. The panel estimated a potential saving of £70,000–£80,000 but emphasised that this figure was not tied to a specific QIA and required further breakdown and confirmation from finance. The panel recognised that stopping certain digital licences could have significant operational impacts and requested additional detail on which licences were being considered for non-renewal. There was some confusion about whether QIAs should be submitted by individual services or as a single organisational submission, particularly for digital contracts. The QIA received from MHLD ND Non-renewal of contracts and or digital licences was not considered	**75**

QIA Summary (category 2)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Scheme	IIA Matrix Scoring STEEEP	QIA Feedback Summary	Opportunity Estimate
Hold LTA 25/26 activity to budget		No QIA received The panel noted that LTAs are driven by population need/activity & are managed by well established LTA Governance arrangements. Will require review by Director of Delivery.	**140**
MHLD - Delay recruitment linked to approved MH business Case	Negative impact in all domains with the impact being -25	The panel recognised significant risks across all domains if recruitment was delayed, as described in the narrative. Mental health staffing had been calculated and approved through the planning process for 2025/26. Recruitment should continue to follow the established FCSG (Financial Control Scrutiny Group) process. No EQIA screening had been completed for this proposal, and the panel noted that it was required.	**0**
Dental recovery – consciously delay activity	The panel found the QIA's impact score variable, with both positive (no further deterioration) and negative (no improvement) aspects	The QIA stated that the organisation has the worst NHS dental access across Wales, with no improvement in children's dental health over 15 years and increased urgent access, indicating a lack of proactive and preventive dentistry. The QIA considered pausing or suspending investment of the dental allocation into NHS General Dental Services, effectively maintaining the status quo rather than improving the service. The panel found the QIA's impact score variable, with both positive (no further deterioration) and negative (no improvement) aspects. However, it was clarified that failing to invest would not improve the poor current service, and there would be a negative impact by not reducing waiting times. The panel could not make a final decision and required further information and assessment before proceeding.	**0**

QIA Summary (category 2)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Scheme	IIA Matrix Scoring STEEEP	QIA Feedback Summary	Opportunity Estimate
Digital project investment case 2025/26: Integrated Digital Care Programme	S = -12 T = -12 E = -8 E = -12 E = no score P = -12	The panel discussed the proposed £300,000 investment for the modular Electronic Health Record (EHR) and questioned what would be delivered if less investment was made. It was acknowledged that digitalisation supports proactive care, population health management, and risk response, and that documentation quality is a known issue across the health board. The QIA did not provide detail on what would be delivered with reduced investment, and the risk of maintaining the status quo (including continued incidents, complaints, and manual processes) would remain if the proposal was not enacted. The panel noted that the QIA did not consider hidden financial costs associated with not having a digital record, such as ong oing scanning and incident management resource.	**0**
Pause Radiology activity increases	The old QIA template was used the impact in all domains was 15, 20 or 25	The panel could not support the proposal to pause radiology activity increases due to the known fragility of the radiology service. The QIA narrative did not clearly describe the impact on quality, and the panel found it difficult to assess the true risks because the submission did not address each quality domain in detail. The panel's decision was based more on their own knowledge of the service than on the QIA content itself. There was a recommendation for greater scrutiny over additional hours and overtime via the CCG process.	**0**
Equipment / Stores Further Faster Provision		No QIA received	**0**
RIF Slip	Negative impact in all domains with the impact being -25	The panel was concerned about potential reputational risk if RIF (Regional Integration Fund) slip was used as a savings mechanism, especially since unspent RIF funds typically need to be returned to the Regional Partnership Board. The panel noted significant risk scores across all domains, but these were not backed up by a clear EQIA screening or detailed narrative.	**0**

QIA Summary (category 2)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Scheme	**IIA Matrix Scoring STEEEP**	QIA Feedback Summary	Opportunity Estimate
HB wide ban on travel	The assessment had both negative and positive impacts S = 12 & - 9 T = no score E = 12 & - 9 E = 12 E = no score P = no score	The proposed HB-wide ban on travel would stop non-essential travel, with clinical travel continuing; meetings would move to virtual platforms like Microsoft Teams. There was uncertainty about the actual financial savings, as it was unclear how much current travel was essential (clinical, HR, disciplinary) versus non-essential (meetings). The panel discussed the need for a single QIA for the organisation, rather than multiple assessments, and suggested developing clear principles to guide the reduction of travel. Communication and principles for the travel reduction were being drafted and shared with executive leadership for feedback. The group agreed that a principles-based approach was preferable to a blanket ban, to ensure essential activities were not disrupted. These were agreed at Formal Executive Team Meeting on the 1st October.	0
Review contracts of temporary staff	In clinical areas, the impact of the scheme is negative with scores of -20 to -25	The discussion focused on reviewing contracts for temporary staff, specifically those on fixed-term contracts for more than two years. The panel agreed that decisions regarding temporary staff should go through the FCSG (Financial Control Scrutiny Group) process, with support from workforce and consideration of legal implications. The need for agreed principles and direction from the board was highlighted, and the panel had not yet fully assessed the proposal.	0

Enhanced Financial Scrutiny

To support this process the Executive Team agreed a set of principles to enable enhanced financial scrutiny at its meeting on the 1st October 2025. These are aligned to the following areas:

- Learning & Development:
  - Statutory & Mandatory Training
  - CPD or Conference Attendance
- Recruitment:
  - Non-patient Facing
  - Newly crated posts
  - Corporate Roles
  - Finder Fees
  - Expression of Interest Pathway
- On-Contact Agency & Locum Requests
- Off-Contact Agency & Locum Requests
- Pay:
  - Re-banding
  - Incremental Credit
  - Annex 21
- Travel Reduction
- Procurement Scrutiny
- Non Clinical Stationary

For information

- Category 1 QIA summary – previously shared

A Summary (category 1)

	Risk Score STEEEP	QIA Feedback Summary	Opportunity Estimate
Health Board Wide Recruitment Freeze on non-patient facing.	Red: 20 all domains	No QIA for the whole organisation – 9 individual QIAs received. This proposal was to freeze all existing vacancies and not replace future leavers to contribute to the nonrecurring savings target given. Consideration to equity, service delivery and impact on staff. Was given Panel Decision: Apply enhanced scrutiny process to all recruitment requests i.e. consideration/scrutiny at CCG then submission to FCSG for approval.	1127
MHLD Neurodevelopment Outsourcing Core Funding	Red: 20/25 cross all domains	Proposal to suspend further outsourcing of children and adult's ND diagnostic assessments. Action from Panel: Obtain more detail on impact from service: Subsequently discussed at EITS & IQFPD in September. Summary: £980k received from WG on condition that 3-year waits are eliminated and performance/capacity improvement of 30%. (In theory the £980k could be recalled if both conditions are not met in full). Plan developed to deliver the above that includes £897,600 spend on outsourcing 528 assessments and recruitment into 4 wte posts (awaiting approval) Category 1 saving identified of £580k in original proposal/paper: Panel decision: this cannot be achieved without compromising either one or both of the WG requirements and impact on quality(as per QIA). Update: Following a detailed review, slip identified of circa £230k – this is predominantly a saving against full year cost of employing 4 wte posts who are unlikely to be in post before the start of Qtr4 and some other minor slip/savings the team have managed to achieve. Revised Options: • Achieve £580k saving as per Category 1 list but run the risk of having to repay £980k to WG and further delay assessments for up to 341 patients. **Not Supported** • Achieve £230k saving - no risk of having to repay £980k to WG and reduce waiting times to max 3 year wait – no direct impact on patient quality/safety. **Realistic**	230

QIA Summary (category 1)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Scheme	Risk Score STEEEP	QIA Feedback Summary	Opportunity Estimate
Strategic Planning Budget	Red 15-20: safe, timely, efficient effective Amber: 10 equitable/person	Removal of budget and delay in the expenditure associated with Clinical Services Plan and the development of the next phase of works associated with the infrastructure requirement to support the implementation of the Health and Care Strategy. Action: Request further information on strategic planning budget and its implications although no impact on quality identified in the short term up to end of fy.	250
Cease minor Works Other than Essential	Positive and negative impact against all domains Risk scores between 4 & 9.	Proposal to review process, establish governance and control for new requests for minor works based on new criteria around essential or non-essential. Panel supported this QIA as it was strengthening the current arrangements and driving efficiency. Following Board discussion this was moved into a category 2 scheme to be further reviewed.	100
Pause Procurement Non-essential Equipment	Efficiency: Positive 5 Person Centred: Negative	Proposal Stop stationery / non-clinical requisitions and Pause non-essential non-clinical equipment. The panel noted negative score due to potential inequity between clinical & non-clinical groups. Decision: Supported QIA	41
Mandate Virtual Meetings	Amber: 9 all domains	Negative across all domains – linked to travel QIA. Exceptions caveated in the QIA e.g. interviews, disciplinary procedures, clinical duties Decision: Mandate virtual meetings although necessary to target 'non-essential' travel. Following Board Principles are being developed to enact the mandating of virtual meetings.	33

QIA Summary (category 1)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Scheme	Risk Score STEEEP	QIA Feedback Summary	Opportunity Estimate
Invest To save Fund	No QIA Received	No options forthcoming.	
Review group for all revenue requisitions	No QIA Received	No options forthcoming	
Tritch Release of funds related to completed projects	No Score	Proposal considered: To enable the systematic release of any uncommitted financial surplus within the budgets of completed projects under the Tritech & Innovation division. Negative impact identified (no score): Staff experience/morale. No impact score. Legal: Need to consider non-compliance with contractual terms. No impact score. Recommendation: No committed financial surplus within the budgets of ongoing initiatives be released. Ensuring protection of legally binding contracts.	0
Pause non-statutory CPD Training & Conferences	Amber: 6 all domains	Numerous QIAs received – reviewed WOD submission as overarching assessment. Panel noted impact on all leadership programmes which have supported a reduction in TI status. For CPD relating to clinical skills there is a direct impact on patient care. Action: Ensure enhanced scrutiny, enact temporary pause where appropriate, honour commitment already made & pursue options for charitable funding. Update Sept 9: Board decision to develop principles.	0
2025/26 Velindre LTA Position	No QIA received		0
Reduce/eliminate Off Contact Agency	Nil QIA for Off-Contract Agency Received.	Nil specific **Off-Contract Agency** QIAs submitted as nil used in Month 5. Panel decision: all Off-contract agency use should be eliminated except via formal escalation (FCSG). Action: Utilise enhanced scrutiny of off-contract agency requests via FCSG.	0

For information

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

- Category 3 QIA summary – Not Yet Assessed

Category 3: Least feasible – options which are either not deemed possible to pursue or require further exploration with Welsh Government.

Scheme	Opportunity Estimate Q1 £'000	Latest Updates including QIA feedback £'000	Opportunity Estimate Remaining £'000
Recovery Plan / Waiting List Funding to cost of delivery.	500	Planned care recovery will already be compromised in targeting variable pay initiatives. Despite opportunity being focused on core budget, there is a risk of additional WG monies confirmed for recovery initiatives not being released to afford insourcing/ outsourcing committed activity. Would require WG discussion.	0
HB wide recruitment freeze for patient facing roles	TBC	Risk of triggering variable pay in a number of clinical areas. FCSG process will continue to consider relevant roles.	0
Delay the Drugs NICE guidance implementation until 26/27	1,300	Statutory requirement	0
Strategic Planning budget including consultancy use, split B: CSP Consultancy	250	CSP consultancy costs already committed	0
TOTAL Category 3	**2,050**		**0**

Recommendation

- The Quality Safety & Experience Committee are asked to **Note** the process for assessing then quality impact of the proposed saving schemes and to take **Assurance** that any changes being considered have appropriate governance, scrutiny and mitigation arrangements in place.

5.3

5.3 - Temporary Service Changes in Ceredigion Community Mental Health Team

Amanda Davies (Hywel Dda UHB - Head of Service, Adult Mental Health)

Attachments

5.3 Ceredigion SBAR.QSEC October v4 (1).pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ANSER, DIOGELWCH & PROFEDD
QUALITY, SAFETY & EXPERIENCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	09 October 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Ceredigion Community Mental Health Service Medical and Nursing Position
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Andrew Carruthers, Chief Operating Officer
SWYDDOG ADRODD: REPORTING OFFICER:	Amanda Davies, Head of Service Adult Mental Health

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 report provides assurance to the Quality, Safety and Experience Committee that the temporary service changes to the GP referral pathway for routine mental health assessments at Ceredigion Mental Health Services (CMHT) are not having an adverse impact on patients and service users ahead of the request to Public Board in November 2025 to extend the arrangements for a further two months.

Cefndir / Background

Community Mental Health Services in Ceredigion consist of a Community Mental Health Team (CMHT) in the South and in the North, a Community Mental Health Centre (CMHC) which comprises of a CMHT and a Crisis Resolution and Home Treatment Team (CRHT).

Ceredigion does not have an adult in-patient ward locally as this is based in Carmarthen. This followed the ward closure of the mental health ward situated in Bronglais in 2004. Therefore, the provision of care in the community for individuals in Ceredigion is critical with a population alert to any changes in care delivery.

The current situation is continuing to impact patients under the care of community teams and there is an increase in admissions directly linked to a reduction of care and treatment options in the community. The absence of medical leadership also affects the remainder of the multi-disciplinary team in respect of morale, retention of staff and the potential to recruit to vacancies.

To ensure continued assurance around safety, the temporary service change introduced in March 2025, will remain focused on maintaining capacity for secondary care and urgent crisis response. This is assisted by redirecting routine GP referrals to the Single Point of Contact (SPOC) via the 111 Option 2 pathway.

In March GPs were advised to direct patients who require routine assessment to the 111 option 2 service to receive a telephone assessment from a Well Being Practitioner under the supervision of a Registered Nurse .If the GP is concerned that the patient may not contact the 111 option 2 service, they can contact the Professional Line (via 111 option 2) and provide the Call Handler the clinical details of the individual concerned .The Call Handler will electronically record this information to utilise when the patient contacts the team. For these identified patients, if the team does not receive any contact within 72 hours, staff will contact the patient directly to undertake an assessment.

This will also be further supported by enabling GPs to email the 111 Option 2 service directly, in addition to using the professionals' line.

GPs will now be able to email the 111 Option 2 generic inbox to notify the team of any individuals they are concerned about. If the identified person has not contacted the service within 72 hours of the GPs notification, the 111 Option 2 Team will proactively reach out to them directly.

This pathway aims to strengthen early intervention and ensure timely support for individuals who may be reluctant or unable to initiate contact themselves.

All contacts to 111 option 2, generate GP letters via Adastra, which will enable a GP to view the outcome of any assessment undertaken.

The teams in Ceredigion continue to accept urgent referrals for assessment, through the usual route of referral for patients who have imminent risk and require to be seen in person within the next 24 hours by the Mental Health Team. However, GPs have continued to send routine referrals to the CMHT despite communicate of the temporary change.

To reiterate, the benefits of the 111 option 2 service include:

1. Immediate access to mental health support: Individuals in need of mental health assistance can quickly connect with trained professionals through the 111 option 2 service.
2. Streamlined referral process: By centralising mental health referrals through 111 option 2, we can simplify the process and reduce potential delays in access to care. Those requiring an in-person assessment with a CMHT will still receive this assessment in a timely and responsive manner.
3. Crisis intervention: Individuals in mental health crises can receive immediate support and guidance through the 111 option 2 service, helping to prevent escalation and ensure safety.
4. Providing the right level of care, by the right person at the right time.

In summary, a change to the GP referral pathway would create capacity within secondary care community teams and facilitate timelier access to an assessment.

Asesiad / Assessment

Ceredigion mental health community services continue to have significant medical and nursing vacancies. The senior Psychiatry position remains fragile with no NHS Locum or Substantive post holders. The two CMHT Consultant posts are covered via Agency Locum cover and although both Doctors are Section 12(2) approved, they are not Approved Clinicians and hence this adds further workload to the already stretched senior substantive consultant workforce to ensure the AC and RC cover is provided for all the Ceredigion Adult Mental Health patients subject to the Mental Health Act. The Mental Health and Learning Disabilities Clinical Care

Group (MHLD CCG) continues to explore all possible recruitment options and workforce opportunities to exit from the agency locum position.

Therefore, the Health Board's significant clinical operational risks continue, despite a temporary service change that was introduced on 03/03/2025 for six months for GP routine referrals to be directed to the Single Point of Contact (SPOC) 111 option 2 Service.

The absence of medical leadership continues to impact on the ability to retain and recruit nursing staff, and currently, there are currently 4.14 WTE vacancies in the North Ceredigion Community Mental Health Centre (CMHC) and 2.62 WTE vacancies in South Ceredigion Community Mental Health Team (CMHT). Through the recent streamlining process, North Ceredigion CMHC will have two new staff members commencing at the end of September, which will assist with the deficits and ongoing recruitment advertisements are continuing.

The sickness levels for long term sickness for August 2025 are above average at 7.94% in the North and lower in the south at 5.73%, which has further impacted the staff that are reporting for work.

Data analysis on the 24/09/2025 for Part Two of Mental Health (Wales) Measure legislation illustrates there are 258 individuals in Ceredigion who hold 'Relevant Patient' (RP) status which determines eligibility status for Care Coordination (CC), 132 in the north and 126 in the south. This has a legislative requirement to be allocated a CC in 2 weeks, completion of a Care and Treatment Plan in 6 weeks and an annual review.

Mental Health (Wales) Measure legislation requires teams to report and maintain monthly Welsh Government performance targets for Part Two and Three.

Compliance for Part Two in North Ceredigion has shown a marginal improvement over the past five months. Starting from 49% in February, current compliance now stands at 55.28%. While this upward trend is encouraging, continued focus and targeted support will be essential to sustain and accelerate progress. Compliance for Part 3 has been maintained throughout the period.

The improvement trajectory for improvement is 70% compliance by January 2026. Recovery is impacted by the staff deficits within the North CMHT.

The required Welsh Government performance target is 90% for Part 2. Relevant Patients are required to have a Care and Treatment Plan which has been reviewed annual, and this is reported monthly to WG. The South Team is 94.12% and because compliance is reported to WG as a mean average this is not highlighted in that reporting process, but WG is aware of the figure for the North and is monitoring this.

Following the implementation of the revised referral pathway in March 2025, a weekly touchpoint meeting was established to monitor its impact. This was transitioned to a monthly format in June. The group's membership included senior representatives from the Clinical Care Group (CCG), including the Medical Director and Director of Mental Health, alongside colleagues from the Local Authority, third sector organisations, the Engagement and Communications Team, West Wales Action for Mental Health, and Primary Care.

Key performance indicators were monitored through routine data collection, with a particular focus on referral patterns and the utilisation of the 111 Option 2 service.

Referral data indicated a significant reduction in routine referrals to the Community Mental Health Team (CMHT), with a 63.16% decrease in North Ceredigion and a 58.34% decrease in

South Ceredigion, compared to the same six-month period in 2024. As anticipated, urgent referrals remained stable, reflecting the pathway's focus on routine referrals.

During this period, call volumes to the 111 Option 2 service increased across the three counties, although no notable rise was observed in calls originating from the Ceredigion area. One GP used the professional line to escalate a case to the 111 Option 2 team, and it is anticipated that the enhanced pathway will encourage greater use of this route.

Importantly, there has been no reported increase in serious incidents, Datix submissions, or complaints within the area since the pathway change was introduced.

All vacancies within the team continue to be actively advertised. Two qualified practitioners have recently been appointed to the CRHT service in the North CMHT. However, this progress has been offset by the departure of two staff members. In a positive development, a "Grow Your Own" nurse has commenced in September within the CRHT. This addition is expected to provide valuable extra support to the service and contribute to workforce sustainability.

Long-term sickness and maternity leave continue to impact team capacity. To help mitigate this, a live recruitment advert is currently in place to cover the long-term sickness within the North CMHT.

Additionally, two staff members are expected to commence via the streamlining process in late September, which should provide further support to the team.

Recruitment scoping for medical staff is ongoing. However, response has been limited, largely due to the geographical location of the teams, which presents challenges in attracting suitable candidates.

Ceredigion Teams	**North**	**South**	**CRHT**
CTP Caseload	132	126	-
Compliant CTPS	55.28%	94.12%	-
Waiting Times for Initial Assessment	42 days	28 days	-
Waiting Time for Medical Assessment	34 Weeks	3-4 weeks	-
Vacancies			
Band 6	1.02	0.75	2.44
Band 5	2	-	2
Band 3	0.62	1.87	-
Long Term Sickness	7.94	5.73%	0%
Mandatory Training %	80.5%	92.80%	93.22%
Latest In Month Sickness %	10.24%	13.09%	0.27%
SUI – NRI (overdue)	4	4	-
SI		4	
Complaints	2		1
Datix	-	-	-

Organisation risks

- Risk of Serious and Untoward Incident for an individual on a waiting list for routine assessment
- Risk of delayed treatment pathways for patients under assessment with the Crisis and Home treatment team and the Community Mental Health Team
- Staff retention and recruitment

- Staff wellbeing of the staff who are currently in work and increased pressures on their workload
- Local and National Reputational risk with a declining position of waiting periods and WG metrics
- Reduction in input to assessment and treatment plans for patients in the District General Hospital

- Negative patient experience for current patients receiving treatment under the team

- Increased demand on inpatient beds and increased number of Pathway of Care Delays position for Ceredigion patients where discharge from hospital is dependent on community care.

24/09/25 The current risk score for Ceredigion remains 20.

2090 – Risk to patient Care in the Ceredigion area due to workforce Capacity caused by inability to recruit to substantive posts. Currently there is insufficient mental health practitioner and mental health nurse capacity and limited consultant medical cover within the Ceredigion area. This is due to the rurality of the area and limited medical cover as support. Bank shifts are being offered for nursing staff with limited uptake.

Community mental health teams currently manage a caseload of patients receiving Clozapine medication and anti-psychotic medication via injection, alongside patients subject to Community Treatment Orders (under the Mental Health Act) and as referenced earlier, 'Relevant Patients' under Mental Health (Wales) Measure legislation. These patients require critical and essential clinical interventions and risk management.

These elements of secondary care delivery need to be prioritised above mental health assessments designated 'routine' at such a critical time of medical and nursing staffing deficits. Throughout the 6-month period these have been maintained, as a priority.

Argymhelliad / Recommendation

The Committee is asked to take assurance that the temporary service changes to the GP referral pathway for routine mental health assessments at Ceredigion Mental Health Services (CMHT) are not having an adverse impact on patients and service users ahead of the request to Public Board in November 2025 to extend the arrangements for a further two months.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.6 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:	2090 - Risk score 20
Parthau Ansawdd:	1. Safe

Domains of Quality Quality and Engagement Act (sharepoint.com)	2. Timely 6. Person-Centred 3. Effective
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	1. Leadership 2. Culture and valuing people 5. Whole systems persepctive 3. Data to knowledge
Amcanion Strategol y BIP: UHB Strategic Objectives:	5. Safe sustainable, accessible and kind care Choose an item. Choose an item. Choose an item.
Amcanion Cynllunio Planning Objectives	5 Mental health and CAHMS 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	4. Improve Population Health through prevention and early intervention, supporting people to live happy and healthy lives Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Not applicable
Rhestr Termau: Glossary of Terms:	WTE – Whole Time Equivalent
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ceisiadau Gofal Sylfaenol: Parties / Committees consulted prior to the Committee:	Formal Executive Team

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	N/A – cost neutral at worse
Ansawdd / Gofal Claf: Quality / Patient Care:	N/A – will provide more timely access to assessment

Gweithlu: Workforce:	N/A
Risg: Risk:	N/A – will reduce the documented risk
Cyfreithiol: Legal:	N/A – no legal challenges anticipated
Enw Da: Reputational:	N/A – no negative coverage anticipated
Gyfrinachedd: Privacy:	N/A
Cydraddoldeb: Equality:	e.g. potential negative/positive impacts identified in the Equality Impact Assessment (EqIA) documentation – follow link below • Has EqIA screening been undertaken? Yes/No (if yes, please supply copy, if no please state reason) • Has a full EqIA been undertaken? Yes/No (if yes please supply copy, if no please state reason) Equality Impact Assessment

5.4

5.4 - Occupational Therapies Paediatric Improvement Action Plan

Sara Quarrie (Hywel Dda UHB - Service Director for Allied Health Professions and Health Sciences)

Attachments

5.4 Occupational Therapy Paediatric Improvement Plan V0.1 2025 09 26.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 October 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Occupational Therapies Paediatric Improvement Plan
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Andrew Carruthers, Chief Operating Officer
SWYDDOG ADRODD: REPORTING OFFICER:	Sara Quarrie, Clinical Care Group Service Director Allied Health and Health Sciences

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

In April 2024, Quality, Safety and Experience Committee (QSEC) agreed that a targeted improvement plan was required to address the breaches in the 14-week referral to treatment performance for Paediatric Occupational Therapy.

Cefndir / Background

Throughout 2024 QSEC was updated on the improvement plan progress and the resulting impact on waiting times for children referred to Paediatrics Occupational Therapy. The improvement plan, which commenced in April 2024, has led to a well-established weekly clinical triage process, which continues to ensure that the most clinically urgent referrals are prioritised. Furthermore, efficient utilisation of clinic capacity has been achieved by implementation of Patient Initiated Follow- Up (PIFU). Further service efficiencies are being scoped within North Ceredigion. Patient experience and staff experience will be captured to ensure that benefits are realised, and to seek learning prior to consideration of further roll-out. Equitable access to the service has been addressed by targeted improvement work in relation to the need for consistent application of the Access Policy, aligning to the Was Not Brought Policy. This has resulted in a reduction in the variation in appointment management. The previous assurance report, presented in December 2024, showed a modest but sustained reduction in the number of patients waiting for Paediatric Occupational Therapy.

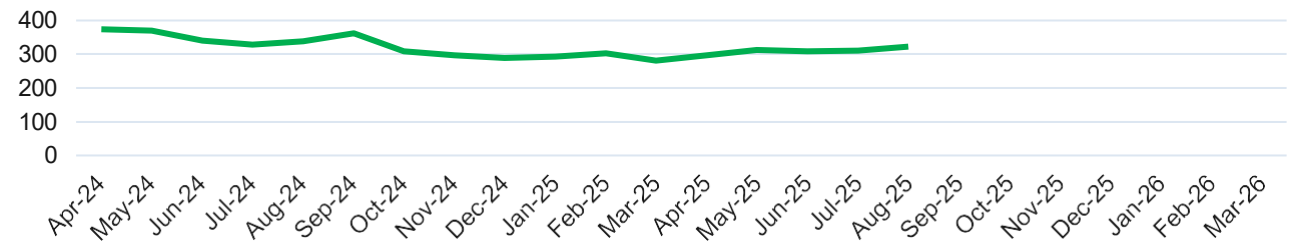


Figure 1 Occupational Therapy - Number of patients breaching 14-week wait per month (April 2024 - April 2025)

Asesiad / Assessment

At the beginning of 2025 changes in service capacity (staffing reduction and an accommodation move) led to the rate of improvement in the number of children waiting more than 14 weeks to reduce. The net effect is a reduction of new appointments available since February 2025, and therefore an increase in the number of children waiting (and resulting breeches) as shown in Figure 1 above.

Since April 2025, the revised operating model sees Occupational Therapy services sitting within the Allied Health and Health Science Clinical Care Group, led by a newly appointed Service Director and Assistant Director of Quality, Safety and Experience.

The key risks related to patient waiting times are captured within the CCG risk register:

ID	Title	Initial Score	Current Score	Last Reviewed
736	Inability to achieve 14-week Referral To treatment (RTT) time for children referred to Occupational Therapy.	16	12	05.09.2025
2109	Risk that we are not able to provide safe and robust clinical leadership to the Paediatric Occupational Therapy Service	25	20	08.09.2025

The current mitigations and actions are summarised below:

- Address temporary reduction in clinical hours.
    - Extend staff additional working hours whilst implementing recruitment for retirements and maternity leaves, 31.05.2025- 31.11.2025
    - Ongoing recruitment to bank Occupational Therapy workforce, to provide additional workforce resilience
    - Review/risk assess if can temporarily move workforce from another team by 30.09.2025
- Clinical risk profile.
    - Continue to focus on clinical prioritisation of urgent and non-urgent cases, and continuation of weekly review of current capacity, identifying additional support to address any shortfalls
- Increase service capacity and efficiency via group interventions, reduction in staff travel time and process efficiencies
    - Increase the Service Lead hours to provide additional capacity to scope and implement additional service efficiencies, by 31.11.2025
    - Increase number of group sessions, including the introduction of sensory workshops by 31.11.2025

- Address co-dependencies such as infrastructure (clinic accommodation) and accessibility (venues sited closer to home) to increase in the number of clinics within community venues, by 31.11.2025
- Implement a pan-health board equipment prescription process, to maximise efficiency or pan county working, by 31.11.2025
- Continue work to ensure caseloads are within set limits (and throughput)

A programme of service evaluation which included a detailed demand and capacity analysis is underway and has recently identified (23.09.2025) an opportunity to increase productivity by 13 new patients per week across Paediatric Occupational Therapy service which has the potential to provide the required capacity to meet demand (given the low number of new patient numbers currently seen per clinic). Due to the recent identification of this action (and supporting data), it has not yet been reflected on the relevant risk register (but will be added in due course).

Argymhelliad / Recommendation

The Committee is asked to take assurance from the progress made to ensure that a future delivery model can bring sustained improvement and in time reduce waiting times for all children to below the 14 week target.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.8 - 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 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. 3.9 – 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:	Risk ID: 736. Inability to achieve 14-week Referral to Treatment time for children referred to Occupational Therapy Risk score:12 Risk ID: 2109 Risk that we are not able to provide safe and robust clinical leadership to the Paediatric Occupational Therapy Service Risk score 20
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)	3. Data to knowledge 4. Learning, improvement and research 5. Whole systems perspective
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio	4 Planned care, diagnostics and cancer Recovery

Planning Objectives	7 Primary and community strategic plan
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:	Nil to note
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:	IQFPDG was informed and updated on Occupational Therapy performance during the months of April and May 2025 in line with the new governance structure that commenced 1st April 2025.

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
Ariannol / Gwerth am Arian: **Financial / Service:**	Nil to note
Ansawdd / Gofal Claf: **Quality / Patient Care:**	Quality impact via delays to OT input and interventions
Gweithlu: **Workforce:**	Workforce impact as stressors noted in workforce from impact of long waiting (complaints and staff moral injury in delaying intervention)
Risg: **Risk:**	Risk ID: 736. Inability to achieve 14-week Referral to Treatment time for children referred to Occupational Therapy Risk score:12 Risk ID: 2109 Risk that we are not able to provide safe and robust clinical leadership to the Paediatric Occupational Therapy Service Risk score 20
Cyfreithiol: **Legal:**	Some potential re litigation from delayed interventions
Enw Da: **Reputational:**	Some reputation risk due to delays interventions
Gyfrinachedd: **Privacy:**	Nil to note
Cydraddoldeb: **Equality:**	Nil to note

5.5

5.5 - Maternity and Neonatal Assessment

Cerian Llewellyn (Hywel Dda UHB - Interim Head of Midwifery)

Attachments

5.5 Mat Neo National Assessment FINAL.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 October 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	National Maternity and Neonatal Services Assessment
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Mrs Sharon Daniel, Executive Director of Nursing, Quality and Patient Experience
SWYDDOG ADRODD: REPORTING OFFICER:	Ms Cerian Llewelyn, Interim 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 provides assurance on progress and next steps in response to internal benchmarking that has taken place in response to an All- Wales assurance assessment of maternity and neonatal services based on the preliminary data available. The assessment is due to commence on the 20th October 2025.

Cefndir / Background

Earlier this year Jeremy Miles MS, Cabinet Secretary for Health and Care announced commissioned an all-Wales assurance assessment of maternity and neonatal services 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

This nationally commissioned assurance assessment is part of a suite of interventions which the Welsh Government is committed to ensure that the maternity and neonatal safety support programme remains contemporary and responsive to changing evidence for improved outcomes. It will focus on assessing maternity and neonatal services across Wales against the criteria within the National Quality Statement and Quality Standards. It will identify areas of good practice and those where there may be residual risk or concern within maternity and neonatal care.

The assessment will be multi-faceted and aims to provide independent assurance on the quality and safety of maternity and neonatal services across Wales, drawing on learning from recent reviews across the UK, including in Swansea Bay. The work will be led by NHS Wales Performance & Improvement and supported by an independent Chair and an Oversight Board.

Though the Independent Review of Maternity and Neonatal Services at Swansea Bay University Health Board identified a number of key recommendations, this report is not in isolation. A number pf major reports into maternity care in England, Northern Ireland and Wales in the last five years have included:

- Review of Maternity Services at Cwm Taf Morgannwg Health Board (Panel, 2022)

- Independent Review of Maternity Care at The Shrewsbury and Telford Hospitals (Ockenden, 2022)
- Maternity and Neonatal services at East Kent (Kirkup, 2023)
- Enabling Safe Quality Midwifery Services and Care in Northern Ireland (Renfrew, 2024)
- The UK Birth Trauma Report to Parliament (2024)

All reports have provided an extensive number of recommendations arising from a range of different themes which are broadly consistent across reviews and unfortunately have identified a number of key themes:

- Women frequently feel discounted in their care
- Families can be harmed by poor care which lacks compassion. Not only can the harms caused by poor care be life-changing for the family and the child, but the emotional impacts on both the mother and birth partner can frequently become a disease burden in themselves.
- The risk profile of women giving birth is increasing in some areas. Women can give birth later, lifestyle factors may create ill health, and women may present to maternity services at a later stage when they are in subsequent pregnancies
- Staff are not always able to deliver the care that they are trained for and want to provide, and safe staffing is cited as an issue in almost all reviews.
- Monitoring, escalation and rapid intervention are not where they should be. Boards are often not sufficiently aware of issues in maternity, and staff on wards are not getting sufficient access to the information that they need to provide them with insight on how their services are performing.
- There is insufficient scrutiny applied when things go wrong. Investigations are of poor quality, women and families do not get the early and compassionate answers they seek, organisations can easily look evasive, and the whole system fails to learn and improve

The Independent Review of Maternity and Neonatal Services at Swansea Bay University Health Board identified 10 priority recommendations

- Establish a single point of access for maternity triage for all women
- Delivery of consistent care with senior clinical staff oversight
- Implementation of Maternity Early Warning Scores (MEWS)
- Improve quality of Investigations
- Delivery of compassionate and trauma-informed care
- Improvements in governance processes
- Attendance for all maternity staff for fetal monitoring training
- Develop and implement a robust process for booking and prioritising women undergoing induction of labour (IOL)
- Review and revise all policies and procedures within the maternity and neonatal service to ensure consistent delivery of care

- Develop and implement a wider engagement plan

Asesiad / Assessment

The maternity and neonatal service at Hywel Dda has undertaken a detailed benchmark exercise to ensure alignment with the priority areas. For each recommendation HUDHB was able to provide evidence to assure against each priority area, with some additional areas for consideration which would further enhance compliance. Further information can be found in appendix 1; HDUHB Benchmark against the SBUHB recommendations, 2025)

- To undertake a national perinatal (maternity and neonatal), quality and safety assessment in partnership with service users, providers and system leaders.
- Identify unwarranted variation in care quality and outcomes in neonatal and maternity services
- Safety and quality concerns are acted on and rapidly improved
- Learning to be shared with health boards as it becomes apparent to allow rapid action to improve the safety of maternity and neonatal care.

This will be achieved by adopting a multi-faceted approach which will be applied to all Health Boards in Wales. A National Perinatal Assurance Assessment Touch Point has been established between NHS Performance & Improvement with Health Board representative (notably the Director and Head of Midwifery) to ensure a cohesive approach and to ensure an opportunity for the cascade of information with the first meeting occurring on the 11th September 2025.

The overall methodology

- Utilise Swansea Bay methodology
- A desk top review of current quality and safety data from health boards (this will be collated from nationally available data with an expectation of HB's to provide locally available data – exact data definitions are yet to be agreed)
- A survey of staff and services user experience (exact data collection methodology to be confirmed)
- Announced site visits on observations of care and service delivery across maternity and neonatal services, this will consider the "15 step methodology" and will focus on appreciative enquiry
- An assessment of clinical governance structure, leadership for risk management, incident management, training, experience feedback mechanisms, workforce planning, acuity assessment, mortality reviews and learning.
- Participation events with women and their families' experiences to highlight areas of concern and improvement. including advocacy groups and charities, obstetricians, midwives and students, and interdisciplinary professional colleagues throughout
- A case note review to ensure compliance with evidenced care standards of a representative selection of cases from 1 July 2025. graded using an established grading

of care scoring system – target is 10% of all births which will equate to a review of 25 casenotes per month

Alongside the Oversight Panel there is an expectation that each organisation will undertake a self-assessment which will include 8 domains,
The 8 Domains of the Organisational Self Assessment, the organisation will select from 4 statements to assess against in each domain:

- Organisational culture and values
- Clinical and professional leadership
- Governance and accountability structures
- Quality of care and service user outcomes
- Staff experience, voice, and engagement
- Service user, carer, and community involvement
- Equity, diversity, and inclusion
- Learning, improvement, and innovation capacity

Early identification of key priorities for Hywel Dda UHB

Having completed a detailed benchmark against the Independent SBUHB report and viewed alongside the information of the purpose and stricture of the Oversight Panel two initial priorities have been identified:

1. Perinatal Engagement Measures (PEMs) are a key recommendation from the Maternity and Neonatal Safety Support Programme and will support a unified approach to data collection of service user experience during pregnancy birth and following birth (with the addition of neonatal unit experience if relevant). The deadline for implementation was September 2025, in order to work towards this deadline a dedicated task and finish group has been established to prioritise this piece of work, and it is supported by the Local Perinatal Champion and Consultant Midwife. Hywel Dda had encountered a number of issues from a data and coding perspective. The PALS team are now prioritising this piece of work to progress to the final stage of implementation which includes local testing to ensure validity. Though PEMs delivered via CIVICA is not yet available, the perinatal service at HDUHB has a breadth of data which provides rich insight into service user experience with a dedicated and concerted effort to ensure that the voice of marginalised groups is also included. Whilst the service recognises the value in PEMs it is important to consider the richness and depth of data around patient experience already readily available at HDUHB.

   Maternity and Neonatal Voices Partnership (MNVP): Paid Chair. The Maternity and Neonatal Safety Support Programme Cymru recommended that each Health Board have a commissioned budgeted MNVP model which includes renumeration of the Lay Chair. The Health Board has previously established a MNVP, however this was on a voluntary basis and engagement of service users reduced over time until it was agreed that the voluntary based model was unsustainable, and the development of a budgeted model was agreed to be necessary to ensure sustainability and alignment across Wales.

A HB specific job description has been developed however in view of the current financial climate in HDUHB and following exploration with the finance business partner, it has not been possible to proceed with the proposal via the maternity / neonatal budgeted establishments and therefore alternate funding sources are being explored which includes the possibility of Charitable Funds on the basis of a fixed term pilot model to enable consideration of long term funding options. An application has been submitted to support the request for charitable funds and work is progressing. Whilst this work progresses, the Maternity and Neonatal service continues to engage with service users utilising mechanisms currently in place which produces both depth and breadth of service user feedback.
Argymhelliad / Recommendation • The Committee are asked to take assurance from the steps 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.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	Provide assurance that all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality and safety of care provided.
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 3. Effective 4. Efficient
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply Choose an item. Choose an item. 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	Not Applicable 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	4. Improve Population Health through prevention and early intervention, supporting people to live happy and healthy lives Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: **Further Information:**

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No financial impact or capital requirements:
Ansawdd / Gofal Claf: Quality / Patient Care:	No adverse quality and/or patient care outcomes/impacts anticipated
Gweithlu: Workforce:	No adverse existing or future staffing impacts
Risg: Risk:	There is a potential risk if the HB is unable to facilitate the recommendations around service user experience Further information on integrated impact assessment
Cyfreithiol: Legal:	No legal impacts or likelihood of legal challenge anticipated
Enw Da: Reputational:	Yes, although there are no specific concerns this is potential for political or media interest. Further information on integrated impact assessment
Gyfrinachedd: Privacy:	No potential impact on individual's privacy rights or confidentiality and/or the potential for an information security risk due to the way in which information is being used/shared, was identified

Cydraddoldeb: **Equality:**	The national assessment will underpin the principles of equality, diversity and inclusion. This is especially relevant when outcomes for service who access maternity services are disproportionally poorer if they are marginalised

5.6

5.6 - Listening and Learning Sub Committee Update Report

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

The next meeting is taking place on 10 November 2025.

6

6 - For Information

6.1

6.1 - QSEC Work Plan 2024-25

Attachments

Draft QSEC Work Programme 2025 26 (3).pdf

QUALITY SAFETY & EXPERIENCE COMMITTEE WORK SCHEDULE APRIL 2025 – MARCH 2026

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 2025 – March 2026

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2025	10 June 2025	15 August 2025	8 October 2025	5 December 2025	13 February 2026
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 On Governance Arrangements 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 2025	10 June 2025	15 August 2025	8 October 2025	5 December 2025	13 February 2026
Self-Assessment - Six month review of actions August 2026	**Chair**	**JW**			✓			✓final report
Patient/Staff Story	**LOC/ Service Leads**		✓ Urgent and Emergency Care	✓	✓	Staff Story Cadog Ward Frailty Unit	✓	✓
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**	**SD LOC**		✓				
Fragile Service Update Report *(TI 32, 33, & 35)*	**SD**	**SG/CS**		✓				
Clinical Audit Programme for Approval	**MH**	**IB**					✓ (outcome from reviews to	

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2025	10 June 2025	15 August 2025	8 October 2025	5 December 2025	13 February 2026
							be included June 2026)	
Patient Experience Framework	**SD**	**LOC**		✓				
Learning Framework Report *(TI 48)*	**SD**	**CS**				✓		
Getting it Right First Time Governance Review	**JW**	**JW**		✓				
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) • Paediatrics Service Changes BGH • WHC's overview *(every other meeting) (TI 52)*	**SD**	**CS**	✓	✓	✓	✓	✓	✓
Unscheduled Emergency Care Deep Dive including GIRFT Reports and Action Plans	**AC**	**PS**	✓			✓		
Mental Health and Learning	**AC**	**RTP**	✓					

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2025	10 June 2025	15 August 2025	8 October 2025	5 December 2025	13 February 2026
Disabilities (MHLD) Deep Dive								
Epilepsy in Learning Disabilities Services	**AC**	**LC/ KI**			✓			
Patient Communication Strategy	**MD**	**SH**				✓		
Sonography - The impact on patient experience and clinical outcomes due to Risk 787: Workforce Pressures in Ultrasound Services	**AC**				✓			
Primary Care Quality and Safety and Experience Deep Dive	**JP**	**RB**	✓					
Waiting List Management	**SD**	**MP**					✓	
Auditor General Report on Cancer Services	**AC**	**LH**		✓				
Infection Prevention and Control in the Community	**AG**	**MH**	✓					
Update Report on the Quality Improvement Strategic Framework 2023- 2026	**SD**	**MD**	✓					
Planned Care Review- Impact of Long Waits	**AC**	**PG**				✓		
Duty of Candour Annual Report 2024/25	**SD**	**CS**		✓				
Duty of Quality Annual Report 2024/25	**SD**	**CS**			✓			
Nurse Staffing Levels (Wales) Act: Assurance Reports (as required) – Annual Report and Spring Calculation Cycle	**SD**	**HH**		✓		✓		

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2025	10 June 2025	15 August 2025	8 October 2025	5 December 2025	13 February 2026
Nurse Staffing Levels Impact of Reduction of Agency and Bank Staff on quality, safety and patient experience annual review report	**SD**	**HH**				✓		
CHKS Report	**MH**	**MH**		✓				
Cleanliness Standards Audit report and Action Plan	**JS**	**SC/ EB**		D	✓			
Outcome from Maternity Business Care – Date tbc	**AC**	**CL**						
Occupational Therapies Paediatric Improvement action plan	**AC**	**PG**		D		✓		
Patient Experience by Demographic	**SD**	**LOC**			✓			
Clinical Care Group Updates								
Mental Health and Learning Disabilities	**AC**	**RTP**						✓
Community and Integrated Medicine	**AC**	**ALI**					✓	
Operational Allied Health Services	**AC**	**SQ**					✓	
Planned and Specialist Care	**AC**	**PG**				✓		
Estates and Facilities	**JS**	**EB**						

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2025	10 June 2025	15 August 2025	8 October 2025	5 December 2025	13 February 2026
Public Health	**AG**	**BL**						✓
Group Update Reports								
Infection Prevention Strategic Steering Group	**SD**	**CS**						✓
Strategic Safeguarding Steering Group	**SD**	**MND**					✓	
Risks								
Sub Committee Update Reports								
Quality, Safety and Experience	✓	✓	✓	✓	✓ Disestablished		✓ Report on impact of revised governance arrangements	
Listening and Learning:	✓	✓	✓	✓	✓	✓	✓ TOR for Annual Review	✓
For Information								
HIW Annual Report							✓	
JCC Quality Safety Outcomes Sub Committee			✓	✓	✓	✓	✓	✓
Work plan 2025/26			✓	✓	✓	✓	✓	✓
Patient Experience Report			✓	✓	✓	✓	✓	✓

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2025	10 June 2025	15 August 2025	8 October 2025	5 December 2025	13 February 2026
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 Committee for comments, points of accuracy and matters arising within 10 days of the meeting	**CSO**	**CSO**	✓	✓	✓	✓	✓	✓
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 QSEC and Board	**CSO**	**CSO**	✓	✓	✓	✓	✓	✓
Prepare schedule of meetings	**CSO**	**CSO**					✓	
QSEC Annual Work Programme	**CSO**	**CSO**	✓	✓	✓	✓	✓	✓

Initials

SD- Sharon Daniel	CSO-Katie Lewis	AL- Anna Lewis	LOC- Louise O'Connor	MH- Mark Henwood
AC- Andrew Carruthers	CL: Cerian Llewellyn	CS- Cathie Steele	SG- Subhamay Ghosh	JS- James Severs
HH- Helen Humphreys	CG- Ceri Griffiths	KJ- Keith Jones	RW- Rachel Williams	AG- Ardiana Gjini
KG- Kathy Greaves	GRD- Gail Roberts Davies	CL- Caroline Lewis	Ps: Peter Skitt	SC: Simon Chiffi
BL- Bethan Lewis	LC- Liz Carroll	SA- Shaun Ayres	MD- Mandy Davies	LH- Lisa Humphreys

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7 - Date of Next Meeting : 4 December 2025