APPROVED MINUTES OF THE QUALITY, SAFETY & EXPERIENCE COMMITTEE MEETING/ COFNODION CYMERADWYEDIG O GYFARFOD Y PWYLLGOR ANSAWDD, DIOGELWCH A PHROFIAD

DATE OF MEETING: **2:00 PM, Monday 15 September 2025**
VENUE: **Microsoft Teams**

PRESENT:
Anna Lewis (Hywel Dda UHB - Independent Board Member) (VC) (Chair)
Eleanor Marks (Hywel Dda UHB - HDUHB Vice Chair) (VC) (Vice Chair)
Sarah Harraway (Hywel Dda UHB - Independent Board Member) (VC)
Chantal Patel (Hywel Dda UHB - Independent Board Member) (VC)
Michael Imperato (Hywel Dda UHB - Independent Board Member) (VC)

IN ATTENDANCE:
Sharon Daniel (Hywel Dda UHB - Executive Director of Nursing, Quality & Patient Experience) (VC) (Lead Executive)
Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer) (VC)
Anna Chiffi (Hywel Dda UHB - Assistant Director of Nursing, Patient Safety, Quality) (VC)
Donna Coleman (Llais Cymru/Citizens Voice Body Representative) (VC)
Eiry Edmunds (Hywel Dda UHB - Cardiac Consultant) (Deputy Medical Director) (VC)
Ardiana Gjini (Hywel Dda UHB - Executive Director of Public Health) (VC)
Olwen Morgan (Hywel Dda UHB - Assistant Director of Nursing) (VC)
James Severs (Hywel Dda UHB - Executive Director of Allied Health Professions and Health Science) (VC)
Cathie Steele (Hywel Dda UHB - Interim Assistant Director of Nursing Assurance and Safeguarding) (VC)

Caroline Burgin (Hywel Dda UHB - Patient Safety and Assurance Manager) (VC)
Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning) (VC)
Subhamay Ghosh (Hywel Dda UHB – Associate Medical Director For Quality & Safety) (VC) (part)
Lisa Humphrey (Hywel Dda UHB - General Manager) (VC)
Diane Knight (Hywel Dda UHB - Service Delivery Manager for Theatres/DSU/PAC) (VC)
Senthil Kumar (Hywel Dda UHB - Consultant Physician) (VC)
Bethan Lewis (Hywel Dda UHB - Assistant Director of Public Health Strategic Business and Operations) (VC)
Caroline Lewis (Hywel Dda UHB - Service Delivery Manager ENT & General Surgery) (VC)
Joanne Wilson (Hywel Dda UHB - Director of Corporate Governance/Board Secretary) (VC)John Jenkins (Hywel Dda UHB - Committee Services Officer) (VC) (Secretariat)

MINUTES REF.	ITEM	ACTION
QSEC 25 (54)	WELCOME AND APOLOGIES	

Ms Anna Lewis welcomed all present to the Extraordinary Quality, Safety and Experience Committee (QSEC) meeting and advised that the purpose of the meeting was to receive assurance on three of the nine service areas considered fragile and under consideration through the Clinical Services Plan (CSP) consultation and advised that discussion of these services did not prejudice the CSP process and sought to enable the Board to be assured that the Committee had explored consideration of the services through the quality, safety and patient experience perspective.

Ms Anna Lewis advised that this was the first of three such sessions to examine the nine service areas with a second Extraordinary QSEC meeting scheduled in addition to the substantive meeting on 4 December 2025.

Apologies had been received from:

- Mr Mark Henwood, Executive Medical Director (Ms Eiry Edmunds deputising)

QSEC 25 (55) CRITICAL CARE

Ms Diane Knight introduced the deep dive into Critical Care and advised that the focus of the deep dive would `be on the Carmarthenshire element of the system as it presented the greatest fragility/challenge within the critical care system. The CSP has a broader scope & includes Withybush Hospital (WGH) and Bronglais Hospital (BGH) as a wider Health Board review.

Ms Knight advised that there had been a significant change to the Critical Care provision within Carmarthenshire in July 2022 due to a shortage of consultants within the Glangwili Hospital (GGH) and Prince Philip Hospital (PPH) Intensive Care Units (ICUs). Ms Knight advised that at that stage the number of consultants in post had reduced from 8 to 5 within a 5-month period due to a combination of retirement and ill-health.

Ms Knight advised that the consultant shortage in Carmarthenshire resulted in an amended patient pathway and escalation process from PPH ICU to GGH supported by a standard operating procedure (SOP).

Ms Knight advised that in January 2025 there had been a clinical-led decision made to apply professional judgement to the SOP which has led to a decrease in the number of patients remaining within the PPH ICU and an increase in the number of patients transferred to the GGH ICU. Ms Knight believed that the review and admission process had not changed. It had been previously agreed that a number of patients would remain within the PPH

ICU under the virtual care of the consultant group however in January 2025 the consultant group at Carmarthen felt that patients at PPH ICU could not be managed virtually from GGH and that all patients admitted to the PPH ICU at Level 2 (high dependency) or Level 3 critical care) would need to be transferred to GGH ICU and this process remains in place currently.

Ms Knight presented an analysis of data comparison from 1 January 2024 to 31 August 2024 compared to the same time period in 2025. Ms Knight advised that the only variable that had changed between the two periods was the clinical threshold for transfer of patients from PPH to GGH with the review, admission and referral processes having remained the same.

Ms Knight advised that there were 14 Critical Care Units in Wales that supported Level 3 patients with 4 of those located within Hywel Dda University Health Board (HDdUHB) which was reflective the dispersed population of the Health Board and the consequential challenges posed by such a dispersed population.

Ms Knight advised that the Faculty of Intensive Care Medicine (FICM) publishes the Guidelines for the Provision of Intensive Care Services (GPICS) detailing the recognised standards for critical care provision and made reference to the delivery of critical care services within a rural setting such as HDdUHB.

Ms Knight advised that the levels of dependency within Critical Care were:

- **Level 0:** patients whose needs can be met through the normal ward care in an acute hospital;
- **Level 1:** patients at risk of their condition deteriorating or recently relocated from higher levels of care and whose care can be met on an acute ward with additional advice and support from the Critical Care Team;
- **Level 2:** patients requiring more detailed observation or intervention or those stepping down from a higher level of care; and
- **Level 3:** patients requiring advanced repository support or basic respiratory support with the support of at least two organs systems and complex patients requiring support for multiple organ failure.

Ms Knight provided a review of the current Critical Care Capacity across the Health Board and advised that there were currently 20 Level 3 Critical Care beds with 1:1 nursing ratio however noted that with Level 2 patients requiring a 2:1 nursing ratio there was an opportunity to flex the bed capacity depending on the levels of patients admitted to the ICUs.

Regarding medical recruitment Ms Knight advised that in July 2025 a consultant lead for Critical Care had been appointed to support continuity and development of service provision within the Health Board.

Ms Knight advised that since January 2025, the Health Board was operating outside of the SOP with all Level 3 patients with multiple organ support or Level 2 patients predicted to require Level 3 care transferred to GGH at the earliest and safest opportunity. This decision was based on professional clinical judgement due to unresolved concerns of patient safety that were raised by ICU clinicians and the medical staffing challenge of having limited Specialty, Associate Specialist, and Specialist (SAS) doctors undertaking the senior ICU rota in Carmarthenshire created by recent staff departures to take up Deanery posts and 50% of offers of new posts declined within 10 days due to acceptance of alternative posts.

Ms Knight presented an assessment of the admission profile data at PPH and the current amended pathway but could not offer a rationale for the difference in numbers being admitted to the PPH ICU. It was apparent that the number of Level 2 patients retained at PPH had reduced and the number of patients transferred to GGH had increased. Ms Knight advised that a review of Datix incidents during the review period provided no indication of any patient safety or quality indicators that would have provided a rational for a reduction in the number of patients admitted to the PPH ICU.

Ms Knight advised that an assessment of the medical staffing within ICU in Carmarthenshire highlighted that 8 of the 9 currently funded consultant posts were currently filled with the consultant lead currently considering whether to recruit to the ninth post. Ms Knight advised that there were currently 22 funded SAS doctor posts with 16 currently in post, 2 currently on-boarding and 4 anticipated to be appointed from a current recruitment process that would result in full coverage of current on-call commitments.

Ms Knight advised that there were on-going clinically led discussions on the patient pathway at PPH as to whether it was necessary to formally amend the SOP with a need to maintain collaboration with medical recruitment and to support the medical stabalisation project while remaining committed to collaboration with the CSP process.

Mr Andrew Carruthers advised that he and Mr Mark Henwood had been engaged in on-going discussion with the medical and nursing teams within Critical Care at PPH to reiterate that the SOP that had been agreed by the Health Board Executive Team and approved by Board remained extant and that the change was in response to a heightened risk aversion from the consultant and ICU team at GGH and believed that the reduction in Level 2 being retained at PPH a result of the higher risk aversion. Mr Carruthers

believed that any discussion on a revision of the SOP was interconnected with the CSP process, and a decision could not be made that could potentially compromise the CSP process.

In response to a question from Ms Anna Lewis on whether there had been a change to clinical practice even if there had been no formal change to the SOP, Mr Carruthers believed that there was a level of complexity that was not uniform throughout the comparative time period and was highly dependent on individual clinical decision-making based on judgement and deliberation in accordance with the pathway in a subjective manner on a case-by-case basis.

Ms Eiry Edmunds agreed with Mr Carruthers and believed that there was no evidence of any changes to referral patterns and that further investigation was required to ascertain whether patients were being kept on wards longer and not being admitted to ICU. There was no evidence of any patients being inappropriately denied admission to ICU more in PPH than GGH or WGH. Mrs Sharon Daniel advised that the Health Board did record acuity data for all wards at PPH that could be reviewed retrospectively.

In response to a question from Mrs Daniel on whether there was any learning derived from an incident in December 2024, Ms Cathie Steel advised that the investigation was currently on-going however a review of the SOP on communication between Critical Care Units within the Health Board were undertaken to ensure patients were transferred in a timely manner.

Mrs Eleanor Marks believed that no inference was able to be made from a comparison of the 2024 and 2025 data and believed that any changes to procedure should have been presented to QSEC ahead of submission to Board for consideration as the change could be considered a service change and wished to receive assurance that the governance process had been followed.

Ms Donna Coleman advised that from a patient and family experience perspective that the travel distance between home and where patients received their care was a subject of strong feedback received through the CSP consultation process, especially for those without access to private modes of transport. Mrs Marks believed that there was a conundrum highlighted by the CSP consultation on the balance between the provision of the best possible care and the distance travelled for their care for both travel and for emotional and practical care-giver support.

In response to a question from Ms Sarah Harraway on the need for further investigation for why the overall number of referrals had decreased and what the drivers for that were, given that should the pattern reverse a significant level of additional pressure would be applied to ICU in GGH, Mrs Daniel advised that an analysis of trend data as opposed to snapshot data was required in addition **CS/DK**

to a consideration of the relevant staff survey data to triangulate the investigations further.

Ms Anna Lewis recognised that operational colleagues, both clinical and managerial, were committed to the provision of the best possible quality service in difficult and challenging circumstances and should always be supported to make the best decisions on a patient-by-patient basis for the patient quality, safety and experience.

Ms Anna Lewis believed that there was a need to undertake further investigations into the change in numbers of patients admitted to ICU at PPH and GGH that would not only inform what the drivers of the variation in numbers, it would also provide intelligence for the CSP process.

Ms Anna Lewis believed that there needed to be clarity on whether the clinical practice within ICU at PPH and GGH was going beyond the scope of the SOP and that there was a valid rationale for doing so or whether the SOP needed to be updated to reflect the changing circumstances within ICU in Carmarthenshire since July 2022 and that nothing should be done to undermine or prejudice the outcome to the CPS process and any long-term strategic work around Critical Care. Mrs Wilson agreed to review the governance process relating to the operation of the ICUs at PPH and GGH and to ensure there was no conflict with the CSP process. **JW**

Decision: The Quality, Safety and Experience Committee **RECEIVED** and **NOTED** the deep dive into Critical Care.

QSEC 25 (56) EMERGENCY GENERAL SURGERY

Ms Caroline Lewis presented the deep dive into Emergency General Surgery to provide the Committee with an understanding of the impact of the fragility of the service provision and the management of incidents, complaints, patient experience and risks, how the out-of-hours surgical service was being maintained while the CSP was being progressed together with an update on the management of the Emergency General Surgery (EGS) rota for GGH and WGH.

Ms Caroline Lewis advised that in November 2022, the WGH consultant rota was a 1 in 5 rota that had become fragile due to a vacancy and ill-health that was covered by internal locums from GGH, BGH and WGH that had existed until April 2023 when it was felt that it was unable to continue. Ms Lewis advised that an interim model had been developed whereby the consultant on-call undertook a week at BGH and then a week at GGH however there were issues with the level of SAS doctor cover at WGH.

In response to the continued fragility of the on-call rota, the service has managed the risks pertaining to EGS on-call with the use of Medacs Healthcare agency provision with 7 Medacs consultants appointed between 8 August 2022 and 20 July 2025. Ms Caroline Lewis advised that substantive and locum recruitment had been attempted during this period, however the service had experienced a challenge to recruit to and retain consultants at WGH. Following an Escalation Meeting the service had an extraordinary meeting with the Health Board Executive Team who had given permission to recruit three consultants; a substantive consultant at GGH and two substantive consultants at WGH.

Ms Caroline Lewis advised that WGH remained a 1 in 4 rota comprised of 2 substantive consultants, 1 NHS locum consultant and one vacancy from 26 September 2025 that would be filled through the use of Medacs agency provision pending the on-boarding of the recently recruited consultant. Ms Caroline Lewis advised that GGH operated a 1 in 8 rota with 7.5 whole time equivalent (WTE) consultants on the rota with weekend gaps on the rota covered by internal locum cover from GGH consultants.

Ms Caroline Lewis advised that Between May and November 2023 an interim model was put in place for the out-of-hours on-call at WGH whereby patients requiring surgery were transferred from WGH to BGH or GGH on alternating weeks however concern was expressed amongst consultants with this model, in particular relating to delays with the Welsh Ambulance Service Trust (WAST) transport. The delays in patient transfers and the associated Datix incidents reported resulted in the cessation of this model.

Ms Caroline Lewis advised that in May 2023 there was a Getting It Right First Time (GIRFT) visit to General Surgery that resulted in 22 recommendations being made, all of which were now complete with 5 of those recommendations relating to EGS.

Ms Caroline Lewis presented a benchmark of the Health Board service in comparison to other Health Boards in Wales GIRFT had made the recommendation to move to two general surgery on-call rotas as opposed to three. Ms Caroline Lewis advised that other Health Boards in Wales had centralised their general surgery rotas with three Health Boards in Wales operating a 1 in 16 rota that was considered more attractive to potential candidates when recruiting and retaining surgeons into vacancies.

Mrs Daniel believed that there was a need to explore the incidents and complaints relating to patient experience further so that the Committee could gain an assurance on the quality, safety and patient experience elements of the service provision and advised that key performance indicator (KPI) data would be collated and would contribute towards the CSP discussion. **CS/OM**

Mr Lee Davies believed that with both Critical Care and EGS, the Health Board had reached a position of service failure before starting a process to reconfigure the service and that there were lessons to be learned from both service areas in preparing the medium-term planning for future fragile services.

Ms Anna Lewis believed that there was a circular problem of medical recruitment, the volume of clinical work and rota volatility that were all interrelated to each other and that while progress had been demonstrated within recruitment the volume of work per site was considered relatively low and posed a problem for recruitment and retention and for the quality of outcomes that the Health Board wished to achieve.

In response to a question from Ms Anna Lewis on what the response to the GIRFT was, Ms Caroline Lewis advised that following the GIRFT inspection, a follow-up meeting had been undertaken with other Health Boards in Wales to review the actions taken against each recommendation.

In response to a question from Ms Anna Lewis on what improvements were being made in response to the inspection, Mrs Wilson advised that actions were tracked through AMaT [the Health Board's clinical audit assurance system] that were presented to the Integrated Quality, Financial Performance and Delivery (IQFPD) Group for review and agreed to share a report on the GIRFT recommendations following the general surgery inspection. [JW] **JW**

Mr Davies advised that there had been a recent change to the recruitment process for general surgery whereby the Health Board recruited to the general surgery service as a whole as opposed to site-specific recruitment with job plans amended to reflect the change and believed that this made the vacancy more appealing to prospective candidates and that this was an important lesson to be learned for recruitment to other services to provide more sustainable services. Mr Davies also advised that other Health Boards had developed distinct upper and lower gastrointestinal rotas that added to the Health Board's challenge of recruiting into more frequent rotas as also in competition with other Health Boards who maintained subspeciality rotas that clinicians were more comfortable working within. Mrs Marks believed that the Health Board needed to be more adaptive to be a more attractive option for potential recruits.

In response to a question from Mr Michael Imperato on whether the change in recruitment process from site-specific to service-specific amounted to a service change, Mr Carruthers advised that the change was more an employment contractual change for staff as opposed to a service change. Ms Coleman advised that a service change was a change that impacted upon patients and that a contractual change for staff was not considered a service change. In response to the rationale for site-specific recruitment,

Mr Carruthers believed that this was a historic legacy for the Health Board and the change was required to reflect the fact that HDdUHB covered a large geographical area and that it would be beneficial for the Health Board's ability to deploy staff to any of its sites regardless of any service model.

Ms Lisa Humphrey left the meeting

Decision: The Quality, Safety and Experience Committee **RECEIVED** and **NOTED** the deep dive into Emergency General Surgery.

QSEC 25 (57) STROKE SERVICES

Dr Senthil Kumar presented the deep dive into stroke services and advised that the focus of the deep dive would be on the patient experience and the impact of the fragility of the service on incidents, complaints and risk given that discussions on the quality of the service had been extensively considered as part of the CSP consultation process.

Dr Kumar advised that stroke services were provided from the four acute hospital sites within HDdUHB with fragility issues relating to the medical workforce and compliance with the 2023 national standards and advised that the Health Board did not have access to a specialised Hyper-Acute Stroke Unit (HASU) and had a limited Integrated Community Stroke Service (ICSS), and psychological therapies to support early support, discharge and after-stroke care. Dr Kumar advised that there was no seven-day cover for medicine, clinical nurse specialist or therapy services within stroke services.

Dr Kumar advised that stroke patients who present within 4.5 hours of symptom onset were eligible for thrombolysis and advised that this could be extended to 9 hours with computerised tomography (CT) profusion imaging that was an evolving service that was awaiting implementation at all HDdUHB acute hospital sites to increase the treatment window for stroke patients.

Dr Kumar explained the patient journey from the initial presentation at ED or alerted within the hospital they received a CT scan and acute treatment was commenced ahead of transfer to the acute stroke unit for acute assessment and commencement of the rehabilitation phase ahead of discharge with the appropriate support and early support discharge (ESD) where the patient was eligible and advised that ESD was only available from the WGH site at present with the other acute sites having a Community Integrated Stroke Team with limited therapy provision.

Dr Kumar presented an assessment of the Sentinel Stroke National Audit Programme (SSNAP) performance measures and

highlighted that of the four acute hospital sites GGH exhibited particular challenges around patient access to a stroke bed within 4 hours and had struggled with this KPI over the past 12 months.

Dr Kumar highlighted the concern related to the provision of speech and language therapy that scored low within the SNAPP KPIs and advised that despite occupational therapy scoring high, this related to patients receiving assessment within the first 72 hours where the Health Board performed well however there were performance issues relating to patients receiving 45 minutes of treatment per day that the Health Board was not meeting its targets for.

Dr Kumar advised that CT scan data highlighted that PPH had the best performance for the recent reporting period for 20 minutes scans with underperformance at the GGH and WGH sites however there was an overall positive comparison for HDdUHB compared to against the rest of Wales. Dr Kumar highlighted that the highest performance for attendance at a Stroke Unit within 4 hours is being seen at WGH with 83% for the period and the lowest performance was seen at the GGH site as noted previously however BGH, PPH and WGH performance was above the UK national benchmark of 48%.

Mr Subhamay Ghosh left the meeting

Dr Kumar presented an overview of the stroke-specific ward incidents recorded between December 2024 and August 2025 and believed that the figures were average for the four acute sites and highlighted that GGH received the greatest number of patients so having the highest number of incidents was to be expected. Dr Kumar advised that the Operational Stroke Group had analysed the incidents and advised that the incidents related to:

- Delays in diagnosis and treatment
- Communication and handover failures
- Medication and prescription management issues
- Service provision and workforce gaps
- Patient safety, environment and experience

Dr Kumar believed that the greatest element contributing to incidents related to communication, either between doctors and nurses, between nurses or to patients or relatives.

Dr Kumar believed that the aim was to receive zero complaints regarding the stroke service and believed that the eight complains received between December 2024 and August 2025 was not unreasonably high and advised that the themes of complaints received related to communication, delays in diagnosis and delays in referrals to stroke services and noted that none of the complaints were considered to be in the major category of complaints received.

Dr Kumar advised that patient and family feedback indicated overall positive feedback for clinical staff performance with staff described as kind, compassionate, professional and helpful. Patient dissatisfaction related to communication for appointment scheduling, bed availability and parking. 99.46% of patients rated their service at least 8 out of 10.

Dr Kumar advised that none of the four acute sites or rehabilitation units met the staffing levels recommended by the Royal College Clinical Guidance for Stroke with one WTE specialist stroke nurse covering weekdays at each acute site with 0.5 WTE shortage at the GGH site that given the volume of patients who attend GGH causing an issue that the senior nursing team were working to address with annual leave, sickness and study leave currently being covered by the general nursing workforce as opposed to a specialist stroke nurse. Dr Kumar advised that a similar situation existed with Stroke Physician cover being provided from the general physician workforce. Dr Kumar believed that there was a vulnerability of the reliance of one speciality stroke clinician.

Dr Kumar highlighted that the therapy disciplines did not have seven-day coverage and that there was limited provision of therapies for stroke services at all hour acute sites and only 1.8 WTE psychology service provision was available across all of the Health Board that Dr Kumar believed was making a positive difference for patients since its introduction in 2024 and believed would continue to evolve to provide enhanced therapy services for Health Board patients.

Dr Kumar believed that the rehabilitation services provided by the Community Integrated Stroke Team (CIST) needed to evolve and currently provided a 5-day a week service in each of the three counties within the Health Board area.

Dr Kumar highlighted a number of critical medical cover issues that the service had experienced with sickness cover and advised that each acute site currently operated independently of each other with a lack of depth to the medical workforce cover resulting in difficulty in providing cover without having a consequential impact on the location providing the cover. Dr Kumar believed that the difficulty in providing adequate cover highlighted the fragility of the service.

Dr Kumar made reference to the CSP process and advised that stroke services were one of the nine service areas identified as a fragile service with a number of options developed through the Options Development Process that had been subject to public consultation from 29 May 2025 to 31 August 2025 with multiple alternative options having been suggested by the public and stakeholders for further consideration. Dr Kumar advised that public consultations had been supported by representatives from Betsi Cadwaladr University Health Board (BCUHB) and Powys Health Teaching Board (PHTB).

Dr Kumar advised that an assessment had been undertaken in December 2023 to assess the indicative requirements of enabling the four acute sites to deliver stroke services to the standards recommended by the Royal College of Physicians and had been superseded by the CSP to consider how services could be delivered to provide improved services within the current resource with the CSP providing indicative costs of options ranging between £3.439m and £4.978m with an additional capital cost of £920k.

Dr Kumar advised of the development of a regional strategy for the provision of HASUs with the National Strategic Clinical Network for stroke having produced a programme plan to deliver changes and present options to deliver Comprehensive Regional Stroke Centres (CRSCs) across Wales with a clinical specification having been produced for consultation with modelling work on-going to be completed during Winter 2025. Dr Kumar advised that a consultation on the proposed options for Health Boards in Wales to consider was anticipated within Q4 2025/26.

Dr Kumar advised that the CT Perfusion that was due to be implemented in Wales as part of the Optimal Imagine Pathway and that at present none of the acute sites within HDdUHB had access to CT Perfusion due to workforce and capacity constraints within the radiology service.

In response to a question from Mr James Severs on whether there were any opportunities to improve the performance of direct access to CT scanning, Dr Kumar believed that the issue of patients not receiving a scan within 20 minutes of arrival at hospital at GGH was impacted by the heightened demand at GGH compared to the other acute sites and advised that the Operational Stroke Group had representation from the radiology service to develop options to improve performance at GGH.

In response to a question from Ms Edmonds on whether HDdUHB was an outlier within Health Boards in Wales in not providing CT Profusion, Dr Kumar advised that Cardiff and Vale University Health Board (CVUHB) undertook CT Profusion and Swansea Bay University Health Board (SBUHB) undertook CT Profusion between 9 am and 5 pm on weekdays depending on clinician availability. Dr Kumar advised that all Health Boards in Wales were working towards availability of CT Profusion within 2026.

Mr Davies believed that the change in the methodology for capturing SSNAP data would provide greater clarity on whether the Health Board had deficiencies in performance and that due to the nature of the evidence-based nature of the SSNAP data that poor performance was reflected in poor outcomes for HDdUHB patients.

In response to a question from Ms Anna Lewis on the role families played in the rehabilitation process of stroke patients and the benefit for patients of having family able to visit as often as possible for as long as possible improving the patient rehabilitation and the challenges faced by families having to travel great distances to visit patients, Dr Kumar believed that distance and travel to visit patients had been a highly emotive question raised through the CSP consultation process and believed that there was strong qualitative evidence to confirm the positive contribution of familiar visitation had on patients recovering from stroke and there was a need to develop quantitative data to further evidence the impact on patient recovery. Dr Kumar believed that there was a balance to be made between providing the highest quality services as possible and providing services as close to the patient as possible.

Decision: The Quality, Safety and Experience Committee **RECEIVED** and **NOTED** the deep dive into Stroke Services.

QSEC 25 (58) DATE OF NEXT MEETING

The date of the next regular QSEC meeting will be on 9 October 2025.