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

Assurance and Risk Report

Quality, Safety and Experience Committee – 11 August 2026

Situation

This report provides the Quality, Safety and Experience Committee (QSEC) with the status of the corporate risks, recommendations from audit and inspections reports, Welsh Health Circulars (WHCs), and Ministerial Directions (MDs) within its remit.

The Committee is asked to seek assurance from the Lead Executive Directors that there are processes in place to oversee the corporate risks to ensure these are being managed effectively, that recommendations from audit and inspections, and that WHCs and MDs are being implemented by the Health Board.

Principal risks and operational risks are reported at alternate meetings and will be presented to QSEC at its next meeting in October 2026, along with Welsh Health Circulars.

Corporate Risks:	Audit and Inspection Reports	Welsh Health Circulars	Ministerial Directions
11	28	26	0

Risk Management - Overview

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Effective risk management requires a 'monitoring and review' structure to be in place to ensure that risks are effectively identified and assessed, and that appropriate controls and responses are in place.

The Health Board's risk management process is recorded via the Datix Risk Register module, and enables risks to be recorded at either principal, corporate or operational level. An escalation process is in place to ensure that risks which require escalation or de-escalation are done via appropriate approval processes and governance arrangements.

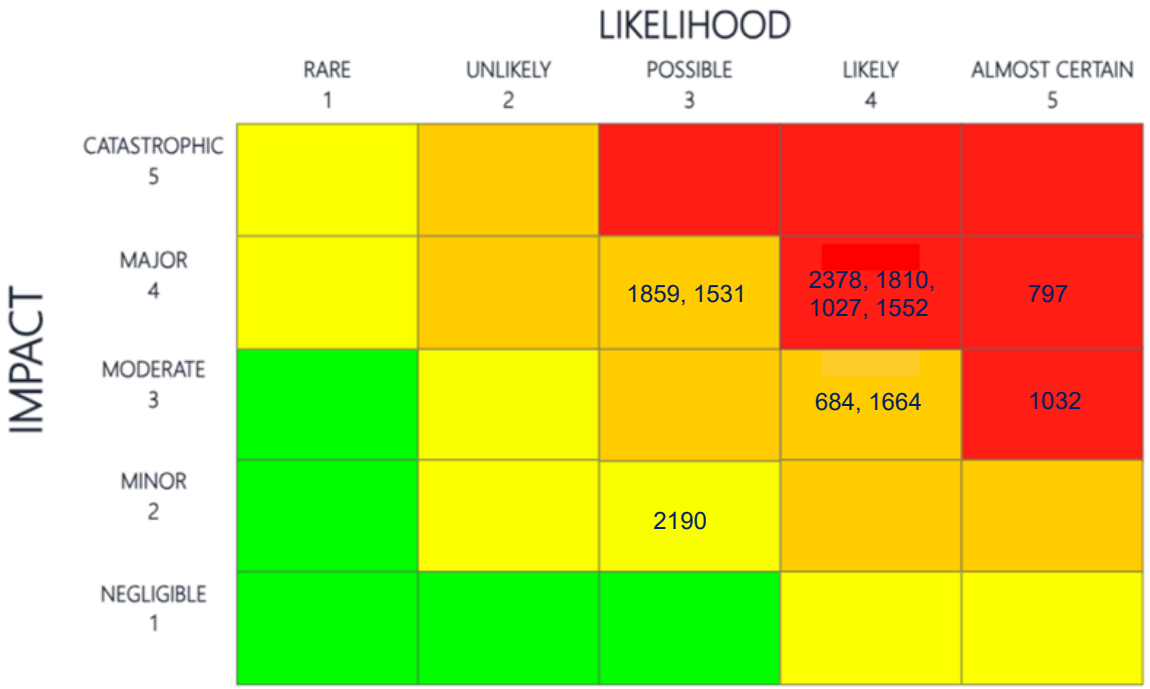
The Health Board operates within the widely accepted "Three Lines of Defence" model to ensure the appropriate responsibility is allocated for the management, reporting and escalation of risk.

Risks are aligned to an appropriate Clinical Care Group or Executive Function (hereto referred to as "Functions"), and each has a designated risk lead responsible for reviewing in a timely and comprehensive manner.

The Board's Committees are responsible for the monitoring and scrutiny of corporate and operational risks within their remit and providing assurance to the Board that risks are being managed effectively and report areas of significant concern (e.g where the risk appetite is exceeded, or there is a lack of action).

Committees are also responsible for reviewing risks over tolerance and where appropriate, recommend the 'acceptance' of risks that cannot be brought within risk appetite.

Corporate Risks assigned to QSEC



Each risk on the Corporate Risk Register (CRR) has been mapped to a Board level Committee to ensure that risks on the CRR are being managed appropriately, taking into account gaps in controls, planned actions and agreed tolerances, and to provide assurance to the Board through their update report on the management of these risks.

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

These risks have been identified by individual Directors via a top down and bottom-up approach and are either:

- Associated with the delivery of the Health Board objectives; or
- Significant escalated operational risks that are of significant concern and require corporate oversight and management.

There are 11 corporate risks currently aligned to QSEC (of the 26 that are on the CRR as of 3 July 2026).

The following slides provide a summary of the reportable corporate risks aligned to QSEC. The Risk Register attached at **Appendix 1,** provides full detail of the risk, including control measures in place, a risk action plan to further manage and mitigate the risk, an expected date to achieve the noted Target Risk Score, and sources of assurance.

Corporate Risks aligned to QSEC by Clinical Care Group / Function, and Risk Domain

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The risks aligned to the Committee highlight that the Health Board:

- is experiencing significant workforce fragility;
- has insufficient organisational capacity to meet current and forecast demand;
- is reliant on ageing infrastructure, equipment and estate capacity;
- faces financial constraints and funding dependencies; and
- has competing operational, strategic and national priorities.

The impact of reportable risks include:

- potential for patient harm and poorer outcomes arising from delays in care
- challenges in maintaining sustainable service delivery
- the pace and scope of service improvement
- non-compliance with regulatory, statutory and performance requirements

The CRR highlights that risks have consequences beyond individual service and will require cross-directorate risk action plans to fully address and mitigate. Common actions noted across the risks demonstrate the need to:

- strengthen workforce capacity and resilience;
- investment in infrastructure, equipment and estate capacity;
- improving operational performance and demand management via improved patient flow and waiting list initiatives; and
- securing funding and collaborative support to enable implementation of long-term risk reduction measures.

Corporate Risks assigned to QSEC

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Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Current Risk Score (CRS)	Target Risk Score (TRS)	Expected Date to Achieve TRS	Included in Annual Plan 2026/27?
797 – Risk of adverse patient and workforce outcomes if health board wide ultrasound services are unsustainable	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	**25** → (Reviewed 29/06/2026)	**10**	31/03/2030	**Yes, 13 WTE sonographer recruitment; 30 WTE right sizing identified**

Rationale for Current Risk Score (CRS)

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

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

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

This risk is currently under review, and in the process of being split between Obstetric and Non-Obstetric, and due to be presented to Formal Executive Team in August 2026.

Rationale for the Target Risk Score on next slide

Corporate Risks assigned to QSEC

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

Corporate Risks assigned to QSEC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Current Risk Score (CRS)	Target Risk Score (TRS)	Expected Date to Achieve TRS	Included in Annual Plan 2026/27?
1810 – Risk to delivering effective and timely cancer service due to Aseptic Unit facilities being non-compliant with Quality Assurance of Aseptic Preparation Services (QAAPS).	Medical	Medical Director	**20** ➔ (Reviewed 05/07/2026)	**5**	31/12/2026	**No**

Rationale for Current Risk Score (CRS)

Withybush Aseptic Unit is the only remaining aseptic unit within the Health Board capable of producing cancer treatments. It remains non-compliant with regulatory standards, with audits in 2024 and 2025 identifying significant risks relating to staffing, resources and maintenance of the Quality System, increasing the risk of closure. Temporary measures are in place to reduce contamination risks and delay closure (see control measures), but these are not sustainable due to the ageing infrastructure. Closure of the unit would leave no local means of supplying certain cancer treatments for Hywel Dda patients. The risk score was increased to 20 due to limited workforce resilience and insufficient capacity to maintain the Quality System. The service requires two pharmacists to undertake core daily operational activities yet only two substantive pharmacists are in post, one of whom is due to leave on 1 August 2026. This leaves little capacity for Quality System maintenance and development. Mitigating actions, including bank pharmacist arrangements and an MOU with other Health Boards, are unlikely to be in place before this date. Consequently, the likelihood of service disruption or failure is increasing, and the risk score may need to rise to 25, as service failure is becoming almost certain without additional staffing resilience. An Invest-to-Save proposal to strengthen staffing resilience is currently awaiting Finance Team approval.

Rationale for Target Risk Score (TRS)

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

Corporate Risks assigned to QSEC

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Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Current Risk Score (CRS)	Target Risk Score (TRS)	Expected Date to Achieve TRS	Included in Annual Plan 2026/27?
1552 – Risk of insufficient mortuary capacity due to current and anticipated future demand	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	**20** → (Reviewed 29/06/2026)	**8**	31/08/2026	**No**

Rationale for Current Risk Score (CRS)

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

Rationale for Target Risk Score (TRS)

The TRS is based on the outcome of escalating the body storage capacity concerns to Integrated Quality Finance Performance and Delivery (IQFPD) in June 2025. Funding stream discussed with Executive Director of Finance (July 2025) with further meetings and support from planning team to ensure long-term sustainable solution implemented when reasonably possible. TRS and expected date to achieve of August 2026 agreed by Formal Executive Team in November 2025. Assurance provided by the Executive Director of Finance that financial support will be received to enact short-term measures to ensure appropriate capacity available for winter pressure period. Further discussions will be held with finance and planning to discuss a sustainable and future proof plan to ensure TRS achieved and maintained.

Corporate Risks assigned to QSEC

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Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Current Risk Score (CRS)	Target Risk Score (TRS)	Expected Date to Achieve TRS	Included in Annual Plan 2026/27?
1027 – Risk to delivery of timely urgent and emergency care due to demand exceeding current capacity	Community & Integrated Medicine	Chief Operating Officer	**20** ➔ (Reviewed 29/06/2026)	**8**	~~31/03/2026~~ 31/10/2028	**Yes – Priority Bundle A**

Rationale for Current Risk Score (CRS)

The most recent available data highlights sustained high operational pressures across all acute sites with increased escalation levels throughout April and May 2026. Although some key performance metrics show improvement over the last year, all are above Targeted Intervention (TI) targets in May 2026 (i.e. average time to clinical assessment in ED in May: 80 mins, TI target: 60 mins; Numbers of >1hr ambulance handovers: 754, TI target: 680, POCDs 186, TI target: 174 and % ED Waits>12 hrs, 9.9%, TI target: 7%.

Actions to improve flow include implementation of the 7-day Clinical Streaming, Hospital at Home and Optimal SDEC services were agreed at Public Board in January 2026.

The Board has approved the business case in January 2026, with implementation currently underway. Additional control measures have been implemented but system pressures remain with De-escalation targets consistently not being met, therefore the current risk score remains at 20 (since February 2026).

Rationale for Target Risk Score (TRS)

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

Corporate Risks assigned to QSEC

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Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Current Risk Score (CRS)	Target Risk Score (TRS)	Expected Date to Achieve TRS	Included in Annual Plan 2026/27?
2378 – Risk of being unable to consistently deliver safe, sustainable and timely Emergency Department services across all hospital sites.	Community & Integrated Medicine	Chief Operating Officer	**20** **(NEW)** (Reviewed 19/06/2026)	**9**	31/10/2027	**N/A –** new risk raised in 26/27

Rationale for Current Risk Score (CRS)

The risk score reflects the persistent and system-wide nature of the Emergency Department (ED) fragility across the Health Board. All three EDs are designated Tier 1 Emergency Services, however current medical workforce models do not consistently meet Royal College of Emergency Medicine (RCEM) standards (1:12 in Withybush General Hospital (WGH)/ Bronglais General Hospital (BGH) & 1:18 in Glangwili General Hospital (GGH).
The HB remains funded to a 1:5 consultant rota at GGH and 1:3 rota at WGH, with no formal on-call arrangement at BGH. These arrangements are insufficient to provide resilient senior decision-making, particularly overnight and weekends. This has resulted in frequent reliance on agency cover, variable continuity of care, and repeated escalation when minimum staffing thresholds cannot be maintained. In addition, there is no single, coordinated medical workforce strategy for Emergency Medicine or the supporting acute specialties. Gaps in specialty support (particularly WGH where there is no resident General Surgery or Trauma & Orthopaedics registrar out of hours, and no on-site Paediatric, Obstetric or Gynaecology services) further increase the risk and limit mitigation options during periods of escalation.
These workforce pressures coincide with sustained flow challenges, high acuity presentations, and constrained physical capacity, resulting in prolonged ED length of stay, care in non-designated areas, and repeated system escalation. Adverse impacts are highly likely to recur and could have major consequences for patient safety, staff wellbeing, and organisational performance.

Rationale for the Target Risk Score on next slide

Corporate Risks assigned to QSEC

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Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Current Risk Score (CRS)	Target Risk Score (TRS)	Expected Date to Achieve TRS	Included in Annual Plan 2026/27?
2378 – Risk of being unable to consistently deliver safe, sustainable and timely Emergency Department services across all hospital sites.	Community & Integrated Medicine	Chief Operating Officer	**20** **(NEW)** (Reviewed 19/06/2026)	**9**	31/10/2027	**N/A –** new risk raised in 26/27

Rationale for Target Risk Score (TRS)

The target risk score reflects a position where Emergency Department services are stabilised but remain under active management, recognising the scale and complexity of the challenge. Reduction to the target score would be achieved through incremental but sustained improvement rather than a single intervention. This includes implementation of a Health Board-wide ED medical workforce strategy aligned to national standards, improved rota resilience through substantive recruitment, and strengthened specialty support models – particularly for WGH. Further reduction would be supported by the establishment of robust, site-specific Business Continuity Plans, clearer escalation triggers linked to workforce and flow thresholds, and embedded senior oversight through strengthened governance structures. At the target score, while operational pressure and demand variability would remain, controls would be sufficient to reduce the likelihood and impact of harm, limit care in non-designated areas, and provide greater assurance of sustainability and staff wellbeing. Reducing this risk to a 9 will require alternative models for ED service delivery requiring consultation/engagement.

Corporate Risks assigned to QSEC

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Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Current Risk Score (CRS)	Target Risk Score (TRS)	Expected Date to Achieve TRS	Included in Annual Plan 2026/27?
1032 – Risk to the timely diagnosis and treatment of mental health and learning disabilities clients due to demand and capacity	Mental Health & Learning Disabilities	Chief Operating Officer	**20** → (Reviewed 28/04/2026)	**12**	31/12/2030	**No**

Rationale for Current Risk Score (CRS)

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

This risk has been reviewed and a new corporate risk is due to be presented to Formal Executive Team in August 2026 for approval to better reflect the needs led approach now being adopted.

Rationale for the Target Risk Score on next slide

Corporate Risks assigned to QSEC

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Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Current Risk Score (CRS)	Target Risk Score (TRS)	Expected Date to Achieve TRS	Included in Annual Plan 2026/27?
1032 – Risk to the timely diagnosis and treatment of mental health and learning disabilities clients due to demand and capacity	Mental Health & Learning Disabilities	Chief Operating Officer	**20** → (Reviewed 28/04/2026)	**12**	31/12/2030	**No**

Rationale for Target Risk Score (TRS)

The Clinical Care Group has prioritised implementation of the Welsh Patient Administration System (WPAS) in Children's Autism Spectrum Disorder (ASD) service which has enabled improved reporting and waiting list management and to determine trajectories of improvement in waiting times. While trajectory plans are in place, the Health Board has recognised Welsh Government (WG) targets will not be achieved by the service in its current format, with a further deteriorating position in performance anticipated, compounded by the end of procurement contracts with external providers in March 2026.

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

This risk has been reviewed and a new corporate risk is due to be presented to Formal Executive Team in August 2026 for approval to better reflect the needs led approach now being adopted.

Corporate Risks assigned to QSEC

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Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Current Risk Score (CRS)	Target Risk Score (TRS)	Expected Date to Achieve TRS	Included in Annual Plan 2026/27?
1664 – Risk to ophthalmology service delivery due to a national shortage Consultant Ophthalmologists and the inability to recruit	Planned & Specialist Care	Chief Operating Officer	**16** → (Reviewed 10/06/2026)	**8**	31/03/2028	**No –** part of CSP

Rationale for Current Risk Score (CRS)

Increased demand and reduced capacity continues to be a challenge. Balancing Eye Care Measures for R1 patients (high risk) with Ministerial Measures for longest waiting patients presents a conflicting priority to the service with limited capacity. The service has provided additional Age-related Macular Degeneration (AMD) sessions on weekends, however these additional sessions have not been enough to meet the demand across all counties in the Health Board (HB). Patient delays continue across the HB. AMD continues to be prioritised impacting on the provision of general clinics, having an impact on the wider ophthalmology service and patient experience. The current non-medical workforce establishment is not aligned to service needs. The current R1 delivery at 42% with the WG target for R1 delivery set at 95%. The current waiting list for new patients is 11,552. The service is currently delivering 0 patients waiting at stage 1 over 52 weeks for March 2026 and this is expected to be maintained through to the end of March 2026. The stage 4 104 weeks, is in a breach of 2 for March 2026 currently with potential solutions being worked through to be 0 by the end of March 2026. 7301 patients have been 100% delayed for their follow up appointment.

In February 2026, the Board agreed to progress the Clinical Service Plan Option 99 of the Clinical Service Plan and to establish the Aberaeron Integrated Care Centre as a diagnostic hub. The service is currently reviewing the estates and workforce required on each site to deliver Option 99. A Vitreoretinal Consultant is currently being onboarded for the region.

Rationale for the Target Risk Score on next slide

Corporate Risks assigned to QSEC

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Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Current Risk Score (CRS)	Target Risk Score (TRS)	Expected Date to Achieve TRS	Included in Annual Plan 2026/27?
1664 – Risk to ophthalmology service delivery due to a national shortage Consultant Ophthalmologists and the inability to recruit	Planned & Specialist Care	Chief Operating Officer	**16** → (Reviewed 10/06/2026)	**8**	31/03/2028	**No –** part of CSP

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

Corporate Risks assigned to QSEC

Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Current Risk Score (CRS)	Target Risk Score (TRS)	Expected Date to Achieve TRS	Included in Annual Plan 2026/27?
684 – Risk to the timely investment and replacement of Radiology equipment and supporting infrastructure	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	**16** ➔ (Reviewed 29/06/2026)	**8**	Not known	**No –** reliant on NIECP funding

Rationale for Current Risk Score (CRS)

The Health Board's aged imaging equipment continues to break down, disrupting diagnostic services and affecting Referral to Treatment (RTT) targets, with delays in diagnosis and treatment for patients. Replacement of CT and MRI scanners has reduced downtime, but recurrent failures of other key equipment highlight the need for further investment. A rolling programme and prioritisation process are in place to manage installations. The Gamma camera at WGH, the only unit of its kind in the Health Board, has suffered repeated breakdowns, leading to HIW-reportable IRMER incidents. At GGH, a new CT scanner has been installed, but the original unit continues to fail due to outdated technology, undermining resilience at the major trauma site. Like-for-like replacement is not always cost-effective or compliant with regulatory and warranty requirements, and infrastructure upgrades (e.g such as air handling, water chillers, and accommodation adjustments) are required to ensure long-term resilience.

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

Rationale for the Target Risk Score on next slide

Corporate Risks assigned to QSEC

Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Current Risk Score (CRS)	Target Risk Score (TRS)	Expected Date to Achieve TRS	Included in Annual Plan 2026/27?
684 – Risk to the timely investment and replacement of Radiology equipment and supporting infrastructure	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	**16** ➔ (Reviewed 29/06/2026)	**8**	Not known	**No -** reliant on NIECP funding

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

Corporate Risks assigned to QSEC

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Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Current Risk Score (CRS)	Target Risk Score (TRS)	Expected Date to Achieve TRS	Included in Annual Plan 2026/27?
1531 – Risk of being unable to safely support the Consultant on-call rota at WGH & GGH due to workforce pressures	Planned & Specialist Care	Chief Operating Officer	**15** → (Reviewed 22/06/2026)	**5**	01/05/2027	**No – part of CSP**

Rationale for Current Risk Score (CRS)

A substantive Upper Gastro-Intestinal (GI) Consultant has been successfully recruited following the departure of the Medacs agency locum consultant at WGH. Following five unsuccessful recruitment campaigns for a second Upper GI Consultant at WGH, a decision has been taken to advertise the post at GGH while maintaining the current WGH rota arrangements. The job description and advert are currently being updated, and the post is scheduled to be advertised at the beginning of July 2026.

Rationale for Target Risk Score (TRS)

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

Corporate Risks assigned to QSEC

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Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Current Risk Score (CRS)	Target Risk Score (TRS)	Expected Date to Achieve TRS	Included in Annual Plan 2026/27?
1859 – Risk of poor patient outcomes and experience due to inability to effectively recognise and manage acute deterioration	Director of Nursing, Quality & Patient Experience	Director Nursing, Quality & Patient Experience	**15** → (Reviewed 25/06/2026)	**10**	~~31/12/2025~~ ~~30/06/2026~~ 31/03/2027	**No**

Rationale for Current Risk Score (CRS)

By the end of 2025, unplanned Intensive Therapy Unit (ITU) admissions from ward areas at WGH had reduced by 10%, while rates at GGH remained unchanged. Despite this, some sites experienced increased ward-based cardiac arrest rates in 2025, a trend that has continued into early 2026.
WGH recorded a 40% increase in cardiac arrests (16 in 2024 to 23 in 2025). Although all cases were reviewed by the Resuscitation Team, limited medical involvement may have reduced opportunities for learning; this has been escalated to the RADAR Lead and Deputy Medical Director.
PPH recorded a 70% increase (7 to 12 cases), with elevated rates continuing into 2026. Scrutiny meetings have been in place since January 2026. Contributing factors may include the revised ITU service model, greater acuity of patients managed onwards, and patient flow pressures.
In contrast, BGH and GGH saw reductions in cardiac arrest rates between 2024 and 2025, supported by regular multidisciplinary scrutiny meetings and case reviews, which may have improved recognition and escalation of deteriorating patients.
The Resuscitation Council UK reports a national average of 0.9 cardiac arrests per 1,000 admissions. In 2026, rates exceeded this benchmark at BGH (1.38), while GGH (0.64), PPH (0.71), and WGH (0.37) remained below it.

Rationale for Target Risk Score (TRS)

The full implementation of the actions outlined in the risk action plan is expected to reduce the likelihood and impact of this risk to the target score of 10. The Target Risk Score (TRS) date was revised in June 2026 to March 2027, as key systems remain under development and have not yet been fully implemented. The revised date allows sufficient time for implementation and embedding of these systems by the end of the financial year.

Corporate Risks assigned to QSEC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Current Risk Score (CRS)	Target Risk Score (TRS)	Expected Date to Achieve TRS	Included in Annual Plan 2026/27?
2190 – Risk of delay in Continuing Healthcare (CHC) direct payments due to short timescale, limited resources & lack of WG policy guidance	Community & Integrated Medicine	Chief Operating Officer	**9** → (Reviewed 17/07/2026)	**12**	31/08/2026	**No**

Rationale for Current Risk Score (CRS)

The Regulatory Impact Assessment (RIA) identified the likelihood of 5 cases per LA of individuals who had previously declined a CHC assessment now likely to seek assessment and a Direct Payments (DP) package of care, with estimated costs of £5.5m new costs to Health Boards. There will also be additional requests from newly eligible individuals and from those already eligible who may now seek to have their needs met through DPs rather than through other models.

The Health Board has now procured a system to manage/deliver DP to comply with the requirements of the WG policy issued in April 2026. The next step is to implement the system and review the process. The likelihood of the risk has now been reduced and will be evaluated further once the system is fully implemented Health Board has received WG funding to address additional resources and specialist expertise to support implementation.

Formal approval from Chief Operating Officer to be sought to de-escalate from the Corporate Risk Register in August 2026.

Rationale for Target Risk Score (TRS)

All Health Boards in Wales require a consistent approach to direct payments. An system has now been procured from an external provider.

Expected date to achieve Target Risk Score of 31st August 2026 in line with the action to implement managed direct payment system/model is currently on track.

Risk Themes

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk owners can assign one or more themes to their risks, enabling targeted oversight by subject matter experts and strengthening the Health Board's second line of assurance. While each risk is reported through the committee most closely aligned to its primary impact, risk themes capture additional contributory factors and areas of exposure, allowing risks to be considered from a broader organisational perspective. This supports more comprehensive risk oversight and improves the Health Board's understanding of risk appetite, risk capacity and cumulative risk exposure across related risks and themes.

Following a review in June 2026, **five new risk themes** were introduced within Datix to align with the revised Quality and Safety Intelligence Group (QSIG) governance structure and its associated sub-groups. The broad themes of "Patient Safety" and "Quality" were retired and replaced with more specific themes, complementing the existing STEEEP Domains of Quality captured within Datix. Theme owners and QSIG Reporting Group Chairs will receive a bi-monthly thematic risk register (to commence in August 2026) to identify emerging trends, recurring issues and risk clusters, and to consider whether existing controls remain effective or whether additional mitigating actions are required. This revised approach is intended to enhance thematic risk intelligence, strengthen organisational oversight and support more effective escalation and management of risks across the Health Board.

Risk theme	Theme description	Sub-Committee/Group theme reported to	Number of risks
HTA Compliance (NEW)	A risk that involves complying with the regulations and legislation under the Human Tissue Act.	Human Tissue Authority Assurance Group	**5**
Nutrition and Hydration (NEW)	A risk in relation to patient care and treatment relating to nutrition and hydration	Nutrition & Hydration Group	**19**
Resuscitation (NEW)	A risk in relation to patient care and treatment relating to resuscitation and DNACPR	RADAR Group	**3**
Acute Deterioration / NEWS (NEW)	A risk in relation to patient care and treatment relating to acute deterioration and NEWS scores / lack of escalation	RADAR Group	**14**
Medical Exposure / IRMER (NEW)	A risk relating to the guidance and regulations for Health Board staff and patients in the use of Ionising Radiation for or medical equipment for treatment purposes and the deliberate exposure of patients to ionising radiation for diagnostic, therapeutic, or health monitoring purposes, with safety and optimisation	Medical Exposures Group	**0**

Risk Themes

Risk theme	Theme description	Sub-Committee/Group theme reported to	Number of risks
Fragile Services	A fragile service is one where there is a risk or the actual delivery of a diminished service or a service being unable to be delivered due to staffing / or other challenges	Fragile Services Oversight Group	**212**
Infection Control	A risk 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	Infection Prevention Strategic Steering Group	**32**
Medication	A risk that involves the prescribing, dispensing or supply, administration or monitoring of medicines.	Medicines Management Oversight Group	**25**
Medical Devices	A risk relating to a medical device, which is 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.	Medical Devices Group	**37**
NICE/National Guidance	Risks related to the Health Board's ability to comply with evidence-based guidance for health and care.	Effective Clinical Practice	**119**
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.	Strategic Safeguarding Group	**31**

Risk Themes

Risk theme	Theme description	Sub-Committee/Group theme reported to	Number of risks
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.	Mental Capacity Act and Consent Group	**0**
Deprivation Of Liberty Standards (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 • patient with a DoLS authorisation can be discharged).	Mental Capacity Act and Consent Group	**1**

Audits and Inspections - Overview

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

The Health Board remains in 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 'Leadership and Governance' from Level 3 to Level 1, 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;
- Support the implementation and realisation of GIRFT and the national programme reviews opportunities;
- Support the implementation and realisation of the three Ps policy, GIRFT, theatre optimisation, CIN optimisation programmes and related national improvement recommendations; and
- Develop a prompt response to any HIW unannounced inspections, Audit Wales and Royal College recommendation, developing and completing action plans that demonstrate sustainable evidence.

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, and any barriers to completion clearly noted.

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

Audits and Inspections - Overview

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

At its meeting on 11 June 2026, the Quality, Safety and Experience Committee considered the organisation's progress in implementing recommendations arising from audits, inspections and regulatory reviews. The Committee recognised the work undertaken to date, and the impact of operational pressures on staff across the organisation. However, QSEC identified areas of concern, including:

- The pace of the implementation of recommendations remains slow, with a significant number of recommendations exceeding agreed implementation dates;
- A lack of clear accountability and ownership for delivering some of the oldest and most longstanding recommendations; and
- The quality of management responses to recommendations, with actions not consistently being SMART.

Missed timescales and limited demonstrable progress undermines confidence in the organisation's ability to translate learning into quality improvement at pace. The implementation of recommendations will support improvements in service delivery and performance, and promote the learning from reviews and inspections translates into meaningful and timely change for patients.

Since the previous report presented to QSEC, a letter was issued from the Chair of the Committee to Executive Directors requesting support to implement improvements including:

- Clear named Executive and officer ownership for all recommendations, particularly the oldest and of highest risk
- Appropriate and constructive challenge is made to auditors or inspectorates at the outset, where recommendations are not deliverable or proportionate, to ensure expectations are achievable
- Responses to recommendations are SMART (Specific, Measurable, Achievable, Relevant and Time-bound), outcome-focused and clearly linked to measurable improvement
- Realistic and deliverable timescales are set and avoid overly optimistic deadlines which contribute to repeated missed dates of implementation
- A focused approach is taken to address the backlog of overdue recommendations, with particular attention to those where no barriers have been identified.

Whilst the number of open reports and overdue reports have remained broadly consistent since the previous Assurance and Risk report to QSEC in June 2026, there has been a **slight improvement** in the number of reports where barriers to completion have been noted on AMAT – **reducing from 19 to 16**. It is also recognised that of the overdue reports, 3 have recently lapsed in June 2026. Performance in the implementation of recommendations for each CCG and Function continue to be monitored and assessed through the Health Board's internal escalation framework via the Governance domain. Overall Health Board performance relating to the implementation of recommendations is presented to the Audit and Risk Assurance Committee (ARAC) at alternate meetings.

The following slides detail the current progress made on recommendations aligned to QSEC.

Audits and Inspection reports assigned to QSEC
(Page 1 of 5)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

There are currently 28 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) with further detail presented to QSEC via item 4.1 on the agenda (Quality Assurance Report).

Full detail of recommendations that are overdue are included in **Appendix 2.**

Date of report	Report Issued By	Report Title	Clinical Care Group/ Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommend-ations in original report	Overdue	In progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Barriers to Completion
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~~ Apr-28	5	3	0	2	0	0	0	0	Recruitment challenges and lack of available suitable clinical space to provide service.
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	~~Sep-23~~ ~~Aug-25~~ Apr-27	19	1	0	18	0	0	0	0	Recurrent and non-recurrent finance required.
May-23	HIW	Mental Health Discharge Review	Mental Health and Learning Disabilities	Nursing, Quality and Patient Experience	Mar-24	~~Mar-26~~ Dec-26	40	1	0	36	0	3	0	0	No barriers noted.
Sep-23	NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	Planned and Specialist Care	Chief Operating Officer	Dec-24	~~Dec-24~~ ~~Aug-25~~ ~~Jun-26~~ Sep-26	9	2	0	7	0	0	0	0	Financial barriers to provide training and workforce challenges.
Jan-24	HIW IRMER	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~~ Apr-27	9	1	0	7	0	0	0	1	No barriers noted.

Audits and Inspection reports assigned to QSEC
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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 recommend-ations in original report	Overdue	In progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Barriers to Completion
Jun-24	Welsh Risk Pool	Welsh Risk Pool Concerns Assessment (December 2024)	Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	Mar-25	~~Mar-25~~ ~~Jul-25~~ Mar-27	11	1	0	8	2	0	0	0	Organisational pressures and re-organisation, in addition to pending restructure of investigation framework and learning arrangements
Oct-24	HIW	IRMER Regulations	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	Jul-25	~~Jul-25~~ ~~Jan-26~~ ~~Apr-26~~ Sep-26	9	2	0	7	0	0	0	0	No barriers noted.
Oct-24	Internal Audit	Falls Management Final Internal Audit Report October 2024	Nursing, Quality and Patient Experience	Nursing, Quality and Patient Experience	May-25	~~May-25~~ ~~Dec-25~~ Aug-26	6	2	0	4	0	0	0	0	No barriers noted.
Mar-25	HIW	Joint Inspection of Child Protection Arrangements (Pembrokeshire)	Nursing, Quality and Patient Experience	Chief Operating Officer	Mar-26	~~Mar-26~~ Oct-26	21	4	0	16	1	0	0	0	Access to Level 3 training. Paediatric Consultant workforce. The policy will need to include multi-agency partners.

Audits and Inspection reports assigned to QSEC
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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 recommend-ations in original report	Overdue	In progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Barriers to Completion
May-25	HIW	HIW GGH Maternity Services	Planned and Specialist Care	Chief Operating Officer	Sep-26	Sep-26	13	0	1	12	0	0	0	0	No barriers noted - no overdue recommendations
Jun-25	HIW IRMER	Nuclear Medicine IRMER WGH	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	Apr-27	Apr-27	26	3	0	23	0	0	0	0	Fragility of management.
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	0	0	0	Included in scope of delayed discharge IA report planned to be reported to Oct26 ARAC
Aug-25	HIW	Mynydd Mawr Ward, Prince Philip Hospital	Community & Integrated Medicine	Chief Operating Officer	Jul-26	Jul-26	24	4	1	16	3	0	0	0	No barriers noted.
Aug-25	Audit Wales	Discharge Planning Progress Update – Hywel Dda University Health Board August 2025	Community & Integrated Medicine	Chief Operating Officer	Mar-26	~~Apr-26~~ Aug-26	1	1	0	0	0	0	0	0	No barriers noted.
Aug-25	Audit Wales	Urgent and Emergency Care: Flow out of Hospital – West Wales Region	Community & Integrated Medicine	Chief Operating Officer	Jun-26	N/K	13	9	0	1	2	1	0	0	No barriers noted
Aug-25	Peer Review	Getting it Right First Time (GIRFT) – Assurance Review of Ambulance Patient Handover Process	Community & Integrated Medicine	Chief Operating Officer	Jun-26	N/K	26	26	0	0	0	0	0	0	Awaiting management responses to be added by service to AMaT
Sep-25	HIW	Derwen Ward, Glangwili General Hospital	Community & Integrated Medicine	Chief Operating Officer	Nov-25	Oct-26	32	5	0	27	0	0	0	0	No barriers noted.

Audits and Inspection reports assigned to QSEC
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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 recommend-ations in original report	Overdue	In progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Barriers to Completion
Oct-25	NHS Wales Performance and Improvement	SDEC National Review 2025	Community & Integrated Medicine	Chief Operating Officer	Nov-26	Nov-26	12	11	1	0	0	0	0	0	No barriers noted
Nov-25	NHS Wales Performance and Improvement	Adult Eating Disorders Mapping & Progress Update National Report	Mental Health and Learning Disabilities	Chief Operating Officer	May-26	~~May-26~~ Nov-26	3	1	2	0	0	0	0	0	No barriers noted.
Nov-25	HIW	HIW Improvement plan – Community Learning Disability Team	Mental Health and Learning Disabilities	Chief Operating Officer	Oct-26	Oct-26	6	2	2	2	0	0	0	0	No barriers noted.
Dec-25	Internal Audit	Patient Experience Final Internal Audit Report 2025/26	Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	Jun-26	~~Jun-26~~ N/K	5	4	0	1	0	0	0	0	No barriers noted.
Dec-25	HIW	Cwm Seren LSU and PICU	Mental Health and Learning Disabilities	Chief Operating Officer	Sep-26	Sep-26	15	3	2	9	1	0	0	0	No barriers noted.
Dec-25	NHS Wales Performance and Improvement	NHS Performance and Improvement Report on Urgent and Emergency Care Opportunities: WGH site	Community & Integrated Medicine	Chief Operating Officer	Mar-26	~~Mar-26~~ Mar-27	8	6	0	2	0	0	0	0	No barriers noted.
Feb-26	Internal Audit	Managed Practices Final Internal Audit Report 2025/26	Primary Care	Chief Operating Officer	Jun-26	~~Jun-26~~ Sep-26	6	4	0	2	0	0	0	0	No barriers noted.

Audits and Inspection reports assigned to QSEC
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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 recommend-ations in original report	Overdue	In progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Barriers to Completion
Feb-26	Audit Wales	Review of the Management of Outpatients	Planned and Specialist Care	Chief Operating Officer	Mar-27	Mar-27	2	1	1	0	0	0	0	0	No barriers noted.
May-26	Audit Wales	Are radiology services improving – a progress update Hywel Dda University Health Board May 2026	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	Nov-28	Nov-28	4	0	4	0	0	0	0	0	No barriers noted – no overdue recommendations
Jun-26	Internal Audit	Infection Prevention & Control Final Internal Audit Report 2025/26	Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	Jun-26	~~Jun-26~~ N/K	4	0	0	0	4	0	0	0	No barriers noted – awaiting formal approval to close as all recommendations noted as complete
Jun-26	Internal Audit	GP Out of Hours Final Internal Audit Report 2025/26	Primary Care	Chief Operating Officer	Sep-26	Sep-26	7	0	7	0	0	0	0	0	No barriers noted – no overdue recommendations

Implementation of Welsh Health Circulars

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

All Welsh Health Circulars (WHCs) are managed via the Audit Management and Tracking system (AMaT), which gives leads direct access to update and upload relevant evidence to demonstrate compliance with their requirements. Each WHC is assigned a status category. The table below outlines the definition of each category, the number of WHCs assigned to each as of July 2026, and the number completed since the previous report.

Status Category	Definition	Number of WHCs
Overdue	The WHC is behind schedule to the timescale provided by the Lead officer or as stipulated in the WHC, or a plan (with date for implementation) is not yet in place.	7
Unable to Complete	The WHC cannot be implemented due to existing barriers and/or it is no longer relevant/appropriate for the Health Board. Formal sign-off by the CCG/Function Lead is required prior to escalation to the Executive Team for formal approval via operational governance structures.	4
Pending Decision	The WHC is pending a decision in order to implement e.g. outcomes of annual planning process, approval of funding requests, outcome of a QIA panel. Committee updates will detail whether the WHC is overdue or not whilst decision pending.	0
In Progress	The WHC is currently in progress, and within the agreed original timeframe for implementation.	8
Reliant on External Factors	The WHC is considered to be outside the gift of the Health Board to currently implement, e.g. reliant on an external organisation to implement.	2
Complete Pending Formal Approval	The Service / Function have completed the WHC and are currently awaiting formal approval to close.	2
Complete	The WHC has been confirmed as completed by the CCG / Function Lead and formal approval to close has been received.	3

Oversight of the delivery of WHCs has been included in Clinical Care Group (CCG) Terms of Reference, with the requirement to escalate appropriately instances of non-compliance.

The timely implementation of WHCs is included within the Governance domain of the Health Board's internal escalation framework, with services escalated in instances of non-compliance.

WHCs - Overdue

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Name of WHC	Clinical Care Group / Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	Reason for Overdue Status	Impact of non-compliance according to risk assessment	Next Steps
019-22: Non-Specialised Paediatric Orthopaedic Services **Issued June 2022**	Planned & Specialist Care	Chief Operating Officer / CCG Service Director for Planned & Specialist Care	**Original implementation date not met** **Original Completion Date:** 30/04/2025 **Revised Completion Date:** Not Known	No risk identified on Datix.	The Trauma and Orthopaedics Service Leads are in the process of drafting a Maturity Matrix to address the requirements of this WHC. The Maturity Matrix will need to be dealt with by multiple CCGs due to the requirements set out in the Service Specification relating to this WHC. Once the Trauma and Orthopaedics have completed their elements of the WHC the WHC can then be re-assigned to Primary Care as per the action of January 2025 Escalation meeting.
002-24: Standards for Competency Assurance of Non-Medical Prescribers in Wales **Issued March 2024**	Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	**Original implementation date not met** **Original Completion Date:** 31/03/2026 **Revised Completion Date:** 31/03/2029	No risk identified on Datix.	Parts 1 and 2 of the Welsh Health Circular have been completed, including submission of the nominated lead, position statement and action plan to HEIW. Work is ongoing to achieve Part 3 compliance, which requires arrangements for the employment, supervision and review of non-medical prescribers. Key developments include maintaining an up-to-date Health Board register, development of electronic data capture processes, review of the non-medical prescribing policy, and delivery of CPD sessions in partnership with Swansea University. Although full compliance by the March 2026 deadline was not achieved, Welsh Government has advised that having the required processes in place, supported by a three-year implementation plan for existing staff, would constitute reasonable progress towards full implementation. Overall, the Health Board continues to make good progress against the requirements of the WHC.

WHCs - Overdue

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

Name of WHC	Clinical Care Group / Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	Reason for Overdue Status	Impact of non-compliance according to risk assessment	Next Steps
006-24: National Clinical Guideline for Stroke, for the UK and Ireland **Issued March 2024**	Community & Integrated Medicine	Chief Operating Officer / CCG Service Director for Community & Integrated Medicine	**Original implementation date not met** **Original Completion Date:** 30/04/2025 **Revised Completion Date:** Not Known	**Risk Ref:** 2409 **Current Risk Score:** 20 **Impacts:** Delayed assessment and treatment of patients; Increased length of stays	The Health Board has identified Stroke as being one of the fragile services that is being reviewed by the Clinical Services Plan (CSP). As such, the 5 key recommendations of this WHC cannot be fully implemented until the outcomes of the CSP have been determined. Risk associated with WHC is on Datix (2409) and a QIA was presented to the panel in September 2025. The QIA panel did not accept the QIA and further work required from the CCG. The panel agreed that future QIAs should be signed off by the Stroke Strategy Group or CCG, and that the process should ensure proposals are clear and supported by appropriate oversight.
041-24: Ambulance patient handover guidance **Issued October 2024**	Community & Integrated Medicine	Chief Operating Officer / CCG Service Director for Community & Integrated Medicine	**Original implementation date not met** **Original Completion Date:** 31/12/2025 **Revised Completion Date:** 30/11/2026	**Risk Ref:** 1027 **Current Risk Score:** 20 **Impacts:** Delayed assessment and treatment of patients; Increased serious incident	Ambulance Handover 45 group established between Welsh Ambulance Services University (WAST), Health Board and Local Authority. Site based Ambulance Handover 45 plans developed. A Programme Plan will be agreed between Health Board and WAST, detailing timescales and owners of actions. Any delay in progress to be escalated through UEC Programme Group and National escalation meetings.

WHCs - Overdue

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

Name of WHC	Clinical Care Group / Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	Reason for Overdue Status	Impact of non-compliance according to risk assessment	Next Steps
006-26: Listening to People: The amended NHS Wales complaints, incidents and redress process **Issued March 2026**	Nursing, Quality & Patient Experience Directorate	Director of Nursing, Quality & Patient Experience	***Awaiting implementation date**	No risk identified on Datix.	Awaiting implementation date from WHC lead
013-26: Publication of Quality Statements for Mental Health, and Self-Harm **Issued April 2026**	Mental Health and Learning Disabilities	Chief Operating Officer / CCG Service Director for Mental Health and Learning Disabilities	***Awaiting implementation date**	No risk identified on Datix.	Awaiting implementation date from WHC lead
024-26: Regulation 28 Prevention of Future Deaths Report –Assurance on alarm "latching" functionality in acute monitored environments **Issued May 2026**	Nursing, Quality & Patient Experience Directorate	Director of Nursing, Quality & Patient Experience	***Awaiting implementation date**	No risk identified on Datix.	Awaiting implementation date from WHC lead

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

WHCs – Unable to Complete

Welsh Health Circular	Clinical Care Group / Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	Reason for Unable to Complete Status	Impact of non-compliance according to risk assessment	Next Steps
026-18: Phase 2 – primary care quality and delivery measures **Issued July 2018**	Primary Care	Chief Operating Officer	National work around this transformational model was suspended due to the COVID-19 pandemic and has never progressed further. Currently the primary care quality and delivery measures within the new dashboards are being used as equivalent quality indicators. As such, the implementation date for this WHC is currently noted as not known. **Original Completion Date**: 16/07/2018 **Revised Completion Date**: Not Known	No risk identified on Datix.	National work around this transformational model was suspended due to the COVID-19 pandemic and has not progressed further. The WHC has been escalated to the Chief Operating Officer to seek approval to close based on the use of alternative quality indicators (internal and national dashboards) as equivalent quality indicators. Hyperlinks to the dashboards have been provided on the system AMaT as evidence of compliance by alternative means.

WHCs – Unable to Complete

Welsh Health Circular	Clinical Care Group / Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	Reason for Pending Decision Status	Impact of non-compliance according to risk assessment	Next Steps
006-18: Framework of Action for Wales, 2017-2020 (Not Available Online) **Issued Feb 2018**	Planned & Specialist Care	Chief Operating Officer / CCG Service Director for Planned and Specialist Care	Service unable implement due to funding requirements. **Original Completion Date**: 30/04/2022 **Revised Completion Date**: Not Known	**Risk Ref :**1457 **Current Risk Score:** 12 **Impacts:** Patients unable to access specialist care in a timely manner, closer to home; Additional pressures on GP capacity	An Ear Wax Management service has been implemented across the Health Board; however, additional funding is required to complete phase two of the relevant WHC, currently reflected under risk 1457 (risk score 12) relating to the recruitment of Advanced Practitioner Audiologists. The WHC was not identified as a priority by the CCG for inclusion within the 2026/27 annual plan.
017-19: Living with persistent pain in Wales guidance – **Issued May 2019**	Planned & Specialist Care	Chief Operating Officer / CCG Service Director for Planned and Specialist Care	Service unable implement due to funding requirements. **Original Completion Date:** 31/01/2025 **Revised Completion Date:** Not known	**Risk Ref:** 2120 **Current Risk Score:** 12 **Impacts:** Patients unable to access specialist care in a timely manner, breaches in achieving RTT	There is currently a 12+month waiting list for the Biopsychosocial service (BPS) within the Health Board. The service needs to be upscaled across the Health Board to be compliant with the requirements of this WHC. Significant investment is required in order to increase the capacity of the BPS service within the HB to meet the current demand. The WHC was not identified as a priority by the CCG for inclusion within the 2026/27 annual plan.

WHCs – Unable to Complete

Welsh Health Circular	Clinical Care Group / Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	Reason for Pending Decision Status	Impact of non-compliance according to risk assessment	Next Steps
009-21: School Entry Hearing Screening pathway - **Issued March 2021**	Planned & Specialist Care	Chief Operating Officer / CCG Service Director for Planned & Specialist Care	Service unable implement due to funding requirements. **Original Completion Date**: 31/01/2023 **Revised Completion Date**: Not Known	**Risk Ref:** 1456 **Current Risk Score:** 8 **Impacts:** Detrimental impact on quality, accuracy and consistency of screening services provided	Implementation of this WHC requires the transfer of school hearing examinations from School Nursing to Audiology, supported by additional systems, processes and funding. The WHC was not identified as a priority by the CCG for inclusion within the 2026/27 annual plan.

WHCs - In Progress

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Welsh Health Circular	Clinical Care Group/Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	UHB Implementation Date
030-23: New 2023 National Safety Standards for Invasive Procedures (NatSSIPS2) by the Centre for Perioperative Care (CPOC) and Patient Safety Notice PSN 034 **Issued August 2023**	Medical Directorate	Medical Director	Sep-26
016-24: Healthy Child Wales Programme: for school aged children **Issued April 2024**	Planned & Specialist Care	Chief Operating Officer / CCG Service Director for Planned & Specialist Care	Sep-26
039-25: AMR and HCAI Improvement Goals for 2025 – 2027 **Issued October 2025**	Nursing, Quality & Patient Experience Directorate	Director of Nursing, Quality & Patient Experience	Mar-27
024-25: NHS Wales hearing care: future approach to audiology services **Issued December 2025 (NEW)**	Planned & Specialist Care	Chief Operating Officer / CCG Service Director for Planned & Specialist Care	Jan-31
051-25: Safety netting discharge leaflets for adults and children **Issued December 2025**	Nursing, Quality & Patient Experience Directorate	Director of Nursing, Quality & Patient Experience	Dec-26
001-26: Timelines and responsibilities for implementing the patient and family-initiated escalation approach, Call4Concern **Issued January 2026**	Nursing, Quality & Patient Experience Directorate	Director of Nursing, Quality & Patient Experience	Dec-26
015-26: All Wales General Practice and Health Board Clinical Interface Standards **Issued April 2026**	Medical Directorate	Medical Director	Apr-27
014-26: NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme for 2026/27 **Issued April 2026**	Medical Directorate	Medical Director	Apr-27

WHCs - In Progress

Welsh Health Circular	Clinical Care Group/Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	UHB Implementation Date
015-26: All Wales General Practice and Health Board Clinical Interface Standards **Issued April 2026**	Medical Directorate	Medical Director	Mar-26
004-25: NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme for 2026/27 **Issued April 2025**	Medical Directorate	Medical Director	Mar-26

WHCs – Reliant on External Factors

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Welsh Health Circular	Clinical Care Group / Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	Reason for External Status	Impact of non-compliance according to risk assessment	UHB Implementation Date
040-23: The NHS Wales: Newborn and Infant Physical Examination Cymru (NIPEC) **Issued November 2023**	Planned & Specialist Care	Chief Operating Officer / CCG Director for Planned & Specialist Care	The service is currently compliant with all aspects of this WHC apart from the data capture requirements, for which no national system is currently available. An all-Wales data system is awaited. As such, the implementation date for this WHC is currently noted as not known.	**Risk Ref:** 2019 **Current Risk Score:** 20 **Impacts:** Decrease in staff morale and a negative impact on service leads.	N/K
033-18: Airborne Isolation Room Requirements **Issued July 2018**	Nursing, Quality & Patient Experience Directorate	Director of Nursing, Quality & Patient Experience	Architectural Projects Team undertook Project Feasibility Report in July 2024 and provided estimate of costs £1,419,946.25 (including contingency fund of £109,416), with project time of 48 weeks from project brief development to completion of works to install negative pressure isolation suite in Clinical Decisions Unit (CDU) GGH. To date, funding not allocated for this project and whilst issue has been raised at 'All Wales High Consequence Infectious Disease Group' hosted by Public Health Wales, there has been no indication of central funding being considered by Welsh Government to support improvement and to move work forward. In the meantime, out turn costs continue to escalate and it is recognised that estimated costs of 2024 may have increased. As of March 2026, Head of Infection confirmed WHC remains unable to be progressed due to funding ('unable to complete'), noting Swansea Bay University Health Board and Aneurin Bevan University Health Board are in a similar position.	**Risk Ref:** 1640 **Current Risk Score:** 15 **Impacts:** Increased risk of transmitting infectious disease	N/K

WHCs – Complete Pending Formal Approval For Closure

Welsh Health Circular	Clinical Care Group/Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	UHB Implementation Date
004-25: NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme for 2025/26 **Issued April 2025**	Medical Directorate	Medical Director, Medical Directorate	Apr-26
037-25: Infected Blood Inquiry: Implementation of Recommendation 7e: Implementing SHOT reports **Issued September 2025**	Operational Allied Health Professions & Health Sciences	Chief Operating Officer & Executive Director of Allied Health Professions & Health Sciences/ CCG Service Director for Operational Allied Health Professions & Health Sciences	Feb-26

WHCs – Complete and Approved

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Welsh Health Circular	Clinical Care Group/Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	UHB Implementation Date	Date WHC completed (i.e. exec approval received).
017-25: Tranexamic Acid use: Recommendation 7a of the Infected Blood Inquiry (IBI) **Issued May 2025**	Planned & Specialist Care	Chief Operating Officer / CCG Service Director for Planned & Specialist Care	Jan-26	Jun-26
007-26: Critical UK-wide Bone Cement Shortage – Immediate National Requirements for NHS Wales (no link currently available) **Issued February 2026**	Planned & Specialist Care	Chief Operating Officer / CCG Service Director for Planned & Specialist Care	Mar-26	Jun-26
006-25: Recording of Mental Health Outcome Measures **Issued May 2025**	Mental Health & Learning Disabilities	Chief Operating Officer / CCG Service Director for Mental Health & Learning Disabilities	Apr-26	Jun-26

Implementation of Ministerial Directions

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

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

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

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

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

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

Recommendations

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

Risk Management

- **RECEIVE ASSURANCE** that identified controls are in place and working effectively;
- **RECEIVE ASSURANCE** that all planned actions are credible and deliverable, and in line with agreed plans, and will be implemented within stated timescales and will reduce risks further and/or mitigate the impact should risks materialise.

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, any barriers to delivery and subsequent impacts of non/late delivery, and assurance that the risks associated with these are being managed effectively.

Welsh Health Circulars

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

Ministerial Directions

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

DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG

SAFE | SUSTAINABLE | ACCESSIBLE | KIND

GIG CYMRU NHS WALES

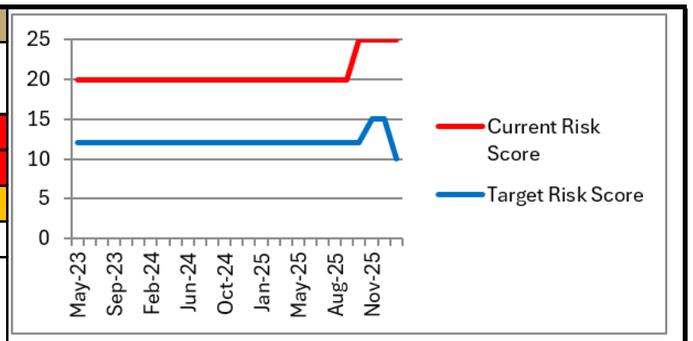
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

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

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

Risk ID:	**797**	**Corporate Risk Description:**	There is a risk that health board wide ultrasound services are unsustainable. This is caused by - Demand increase across NOUS and Maternity Ultrasound pathways requires 34 148 additional scanning hours. - Workforce establishment does not match demand. - Workforce vacancies long standing (national shortage, training pipeline 3 years with large supervision requirement). - Unable to move staff between sites to cover as all sites unable to meet minimum standards required. - Occupational Health impact from workloads reducing workforce available (RSI). This could lead to an impact/affect on - Patient outcomes = delays to scans resulting in delays to treatment or death (cancer and maternity pathways) - Workforce outcomes = staff harm from RSI resulting in long term injury from too much scanning of similar types (unable to job plan appropriately due to demand and vacancies). Quality, complaints and audit - (5) Totally unacceptable level or quality of treatment/service. Gross failure of patient safety if findings not acted on. Inquest/ombudsman inquiry. Gross failure to meet national standards / performance requirements. Safety of patients - (4) Major injury leading to long-term incapacity/disability. Requiring time off work for >14 days. Increase in length of hospital stay by >15 days. Mismanagement of patient care with long-term effects. Finance including Claims - (5) Claim(s) >£1 million. Probability = >95%
Does this risk link to any Directorate (operational) risks?		1349 (WGH), 1658 (RSI), 1936 (maternity)	

Risk Rating:(Likelihood x Impact)	
Domain:	Quality/Complaints/Audit
Inherent Risk Score (L x I):	5×5=25
Current Risk Score (L x I):	5×5=25
Target Risk Score (L x I):	2×5=10
Expected Date To Achieve TRS:	31/03/2030
Trend:	⟷



Rationale for CURRENT Risk Score:	Rationale for TARGET Risk Score:
This risk was escalated from 20 to 25 due to increased fragility in available workforce, due to 2.0WTE retirements in Jan 2026. Impact score of 5 due to: A totally unacceptable level or quality of treatment/service: Patients on maternity and cancer pathways are waiting too long for scans required for intervention Gross failure of patient safety if findings not acted on. Concerns regarding noncompliance with Welsh Maternity screening targets Gross failure to meet national standards / performance requirements. Waiting times non-interventional ultrasound are up to 35 weeks Vascular ultrasound is not available 7 days a week Probability score of 5 / >95% likelihood The service is no longer able to sustain a safe baseline capacity to provide routine and urgent non obstetric imaging alongside obstetric scanning Monday to Friday, 09:00-17:00 on the WGH site (see separate risk 1349).	Impact of service failure remains the probability of service failure is the aim of mitigating actions. Probability target of 5-25% (2) In Jan 2026 target date was reviewed and extended. Justification for this change is the timeline for Radiology Leadership OCP and recruitment to bring in the leadership required to mitigate the gaps in controls thus requires extended timelines due to pathways changes and training timelines. In addition Annual Planning 2026/27 priorities for AH and HS CCG include further mitigation of this risk via capacity being added of 13WTE (£710 352) therefore likelihood scoring reduces to a 2 (5-25% probability). 2030 target date This timeline is due to training timelines it will take at least three years to train a workforce if 2026/27 Annual Planning funding is provided to Radiology.

Key CONTROLS Currently in Place:	Gaps in CONTROLS			
(The existing controls and processes in place to manage the risk)	**Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**

Insourcing NOUS undertaking 150 scans per week - funded by WG until 31.3.26. Funding for 26/27 from budget (4.0 vacancies). Locum/Agency capacity - 1.0WTE secured. there are 2.0 agency requests unfilled. Prioritisation of maternity growth scan workload by referring clinician - urgency allocated on referral form by referring clinicians. Training pipeline (supported practice educator) - 5.0WTE in post (end of training Jan 2027), 1.0WTE Midwife sonographer (in preceptorship). MSK and Vascular pathways via AHP extended practice roles (some Physiotherapy and Podiatry pathways in place to support ultrasound workload) Demand vs capacity scanning gap is £710, 352 /13 WTE workforce - Annual Plan 26/27 approved.	Health board wide governance of ultrasound pathways Pathway workforce diversification - Training pipeline does not meet demand or workforce turnover. Training capacity (trainees available but inadequate internal capacity to train) Centralised booking - due to commence June 26 to improve cross site cover. Insourcing/outsourcing/Agency/Locum capacity	Develop and implement a plan to help alleviate pressures through increasing the number of growth scan checks undertaken by midwives.	Llewellyn, Cerian	Completed	The date of completion of this action has been changed to 31/01/2026 as the midwife identified for training did not start until Jan 2025 due to lack of process to support the clinical aspects and a change in maternity management. Maternity and child health are required to advise of the plan to utilise the skills of the trainee midwife sonographer and also any plans to train more staff. June 2025: Midwife sonographer is now undertaking required training and expected to qualify in January 2026. Jan 26 - midwife sonographer has undertaken course and starting preceptership
		Radiology management restructuring as part of stabilisation plan. new posts needed to provide a longer term solution to issue. Not possible with current management structure and stability risk	Procter, Sarah	~~30/06/2026~~ 31/03/2027	Informal consultation received alternative proposal Dec 2025, workshop with stakeholders scheduled early Jan 2026. Informal consultation extended until Feb 2026.Changes made to OCP awaiting exec approval - hoping to start April 26 OCP started JUne 26 - expected recruitment Mar 27
		Training pipeline - 5.0WTE Trainee sonographers scheduled to complete training.	Procter, Sarah	31/01/2027	25/11/2025 - New action.
		Training pipeline - 1.0WTE midwife sonographer completed training.	Procter, Sarah	Completed	midwife sonographer has completed the course.

Insourcing/Outsourcing - procurement conversation with current provider of ultrasound capacity relating to adding more scanning capacity for obstetric ultrasound capacity (2000 scans) on top of current contract	Procter, Sarah	Completed	25/11/2025 - new action 29/12/2025 - Chasing of provider who is reporting capacity to meet this demand but is not able to complete the scanning when we have handed over this scanning work. Now a meeting is required to push for this capacity to be released or statement that provider is unable to source the capacity so other options can be sourced.
Agency capacity - throughout 2025/26 2.0WTE out for advert with agency (AG1 (HR form for agency approval) valid until 2027)	Procter, Sarah	31/01/2027	25/11/2025 - AG1 approved for 2.0WTE until Jan 2027, out with Agencies during 2025/26. No interest this year as yet.
Insourcing/Outsourcing - Provider has confirmed capacity but has not been able to pick up scans when allocated. Therefore contract meeting with Deputy HoS (SP) and Director of Performance and Planning (KJ) scheduled (14.01.2026) to understand barrier to release in capacity,	Procter, Sarah	Completed	meeting undertaken - further capacity unlocked
Pathway workforce diversification - Maternity have indicated capacity within Midwifery workforce to complete growth scans. Analysis underway to identify % of scanning and therefore % WTE transfer.	Procter, Sarah	~~28/02/2026~~ 31/08/2026	26/2/26 - SBAR shared with Director of midwifery - awaiting answer. 16/02/2026- meetings with Maternity continue. Paper shared with Director of Midwifery to outline governance around 1.26WTE Sonography capacity moving to Midwifery. Changes made to SBAR and validation by director of delivery's team. Further changes made to SBAR - agreed by director of midwifery. Paper to be submitted in May. Delay with approved from midwifery - work ongoing

Demand vs Capacity - Submit as a priority for 2026/27 Annual Planning (£710 352 / 13 WTE) additional funding required to meet demand	Quarrie, Sara	Completed	This demand and capacity gap funding was submitted as a priority by the AH and HS CCG in the Annual Planning 2026/27 workshop on the 21.11.2025.
Demand vs Capacity - Clinical validation support from NHS Performance & Improvement (intended outcome is to reduce inappropriate referrals to u/s modality and redirect to alternative and more appropriate modalities).	Procter, Sarah	Completed	Approval given to seek support meeting scheduled SP and NHS Performance and Improvement 16.01.2026 to agree implementation. validation Work started 19.1.26
Demand and Capacity - Skill mix vacancies in u/s to create 1.0WTE 8A - Job description to be sent to job matching	Procter, Sarah	~~28/02/2026~~ 31/08/2026	Action agreed in Dec 2025. delay due to workload - JD in process - delay due to workload pressure on lead,
Midwife sonographer undertaking preceptorship to be able to work independently - radiology supporting	Procter, Sarah	29/01/2027	new action

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
8 week USC Ante-natal screening Wales	Waiting list monitoring - Live dashboard review by Radiology Leadership (daily) and monthly formal submission of performance * week data to Welsh government (see iPAR).	2nd			IQFPDG 26/11/2025 - SBAR - Ultrasound Fragility - Corporate risk 797					
	Performance monitored at Executive Improving Together Sessions	2nd								

Report Issued By	Report Title	Recommendation Reference	Priority Level	Recommendation	Management Response	Recommendation Owner	Original Completion Date	Revised Completion Date	Status Category
Delivery Unit	Review of Dermatology Services in Wales Hywel Dda University Health Board	DU_RDS_HDUHB_1019_001	N/A	R1. Health board to invest and support in an additional consultant whole time equivalent, considering increasing the number by a minimum 1 WTE with opportunities of other medical specialities such as plastic surgery to support locally and other dermatology units to support remotely	Awaiting management response	Ceri Wisdom	Sep-25	~~Sep-25~~ ~~Jun-26~~ N/K	Overdue
Delivery Unit	Review of Dermatology Services in Wales Hywel Dda University Health Board	DU_RDS_HDUHB_1019_004	N/A	R4. Re- establish the organisations patch testing service	Awaiting management response	Ceri Wisdom	Sep-25	~~Sep-25~~ Apr-28	Overdue
Delivery Unit	Review of Dermatology Services in Wales Hywel Dda University Health Board	DU_RDS_HDUHB_1019_005	N/A	R5. Allow access to the identified clinic space in outpatients to expand.	Awaiting management response	Ceri Wisdom	Sep-25	~~Sep-25~~ Apr-28	Overdue
HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 November (Publication date 16 February 2023)	HIW_160223_DIDGGH_017b	High	R17b. 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 procedures.	To source a document control system.	Head of Radiology/Superintendent Radiographer	Sep-23	~~Sep-23~~ ~~Aug-25~~ Apr-27	Overdue
HIW	Mental Health Discharge Review	HIW_MHDR_05052023_032	N/A	R32. 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.	Further Action 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.	Assistant Director of Nursing MH/LD	Nov-23	~~Nov-23~~ ~~Sep-24~~ ~~Oct-25~~ ~~Mar-26~~ Sep-26	Overdue
NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	DU_RPPICYP_004b	N/A	R4. The HB should explore opportunities for improved psychological interventions and patient outcomes by sharing resources and professional expertise, to enhance joint clinical work between SCAMHS and Paediatric Psychology.	Identify and implement opportunities for improved psychological interventions & patient outcomes across Paediatrics and S-CAMHS	Nick Davies	Jul-24	~~Jul-24~~ ~~Mar-26~~ Sep-26	Overdue
NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	DU_RPPICYP_005b	N/A	R5. The HB should ensure equity of training availability and budgets, supervision, and professional leadership between directorates to ensure all staff have equal opportunities for development and support.	Internal review within paediatrics to identify appropriate development of psychological provision within paediatrics, leadership structures and pathways in line with governance arrangements of the wider health board	Nick Davies	Nov-24	~~Nov-24~~ ~~Jun-26~~ N/K	Overdue
NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	DU_RPPICYP_005d	N/A	R5. The HB should ensure equity of training availability and budgets, supervision, and professional leadership between directorates to ensure all staff have equal opportunities for development and support.	Paediatric Service to co-produce an annual training plan to include advice and direction from Professional lead and shared training opportunities with SCHAMS	Nick Davies	May-24	~~May-24~~ Sep-26	Overdue
NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	DU_RPPICYP_005e	N/A	R5. The HB should ensure equity of training availability and budgets, supervision, and professional leadership between directorates to ensure all staff have equal opportunities for development and support.	Identifying gaps in funding and provision for development in paediatric psychology	Nick Davies	Jul-24	~~Jul-24~~ Sep-26	Overdue
HIW IRMER	HIW IRMER Diagnostic Imaging x-ray department Withybush Hospital January 2024	HIW_IRMER_DIWGH_0124_004a	N/A	R4. 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	Faith Whitecross	Dec-24	~~Dec-24~~ ~~Aug-25~~ Apr-27	Overdue
Welsh Risk Pool	Welsh Risk Pool Concerns Assessment (December 2024)	WRP_CA_122024_006	N/A	R6. HDUHB to ensure all action plans and evidence of actions undertaken are uploaded to the Datix Cymru System.	Establish a process to ensure all actions associated with moderate or above concerns should be uploaded to the AMAT system and to ensure action plan is linked to the datix record.	Mrs Louise O'Connor	Mar-25	~~Mar-25~~ Mar-27	Overdue
HIW IRMER	IRMER Regulations	HIW_IRMER_1024_002		R2. Identify areas where more than one employer may be involved with an 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	Fiona Osell	Jul-25	~~Jul-25~~ ~~Jan-26~~ ~~Apr-26~~ Sep-26	Overdue

Report Issued By	Report Title	Recommendation Reference	Priority Level	Recommendation	Management Response	Recommendation Owner	Original Completion Date	Revised Completion Date	Status Category
HIW IRMER	IRMER Regulations	HIW_IRMER_1024_009		R9. 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	Fiona Osell	Jun-25	~~Jun-25~~ ~~Jan-26~~ ~~Apr-26~~ Sep-26	Overdue
Internal Audit	Falls Management Final Internal Audit Report October 2024	HDUHB-2425-10_002	Medium	R2. Previous internal audit recommendation reiterated: A delivery plan for the Falls Strategy should be completed identifying key milestones and timescales for completion. This should form the basis of progress monitoring to QSEC.	Chair of Inpatient Falls Group to clarify strategic direction and responsibility for development of a HDUHB Falls Strategy direction through submission of a SBAR to the executive team for guidance on the direction of a Falls Strategy and agreement on whether we are aiming for a preventative focus sitting with Public Health, or a management focus aligned to 6 Goals workstreams, deconditioning, frailty and dementia.	Executive Lead for Falls / Chair of Inpatient Falls Group	Mar-25	~~Mar-25~~ ~~Apr-25~~ ~~Dec-25~~ ~~May-26~~ Aug-26	Overdue
Internal Audit	Falls Management Final Internal Audit Report October 2024	HDUHB-2425-10_006	Medium	R6. More detailed and frequent (e.g. annual) falls reporting to QSEC, including MFRA compliance, a summary of falls incident themes and trends and action taken to prevent recurrence.	The Inpatient Falls Group will provide an annual report to QSEC (commencing May 2025) which will include oversight of falls improvement work including EQLIP programmes and QI initiatives; compliance with NAIF audits and actions plans, compliance with MFRA reporting, trends and themes of falls incidents including closure timeliness and learning from events / themes identified.	Chair of Inpatient Falls Group	May-25	~~May-25~~ ~~Dec-25~~ Aug-26	Overdue
HIW	Joint Inspection of Child Protection Arrangements (Pembrokeshire)	HIW_ JICPA_0325_003	N/A	R3. The quality of leadership varies significantly by service. In some areas, such as health visiting and school nursing, there is strong professional ownership and proactive approaches to safeguarding. However, the absence of supervision, professional challenge, and reflection is notable. Records frequently show repeated concerns without escalation, suggesting missed opportunities to lead safeguarding practice with vision and purpose.	Clinical Care Groups to identify resource to implement safeguarding specialist roles to support professional ownership and proactive approaches to safeguarding, e.g. Emergency Departments as priority area.	Cathie Steele	Dec-25	~~Dec-25~~ ~~Mar-26~~ Oct-26	Overdue
HIW	Joint Inspection of Child Protection Arrangements (Pembrokeshire)	HIW_ JICPA_0325_005b	N/A	R5. 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	Paula Goode	Mar-26	~~Mar-26~~ N/K	Overdue
HIW	Joint Inspection of Child Protection Arrangements (Pembrokeshire)	HIW_ JICPA_0325_005c	N/A	R5. 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	Peter Skitt	Sep-25	~~Sep-25~~ N/K	Overdue
HIW	Joint Inspection of Child Protection Arrangements (Pembrokeshire)	HIW_ JICPA_0325_005e	N/A	R5. 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- Above plans (JICPA / 09) to be reported to Strategic Safeguarding Steering Group	Peter Skitt	Nov-25	~~Nov-25~~ Oct-26	Overdue
HIW	Joint Inspection of Child Protection Arrangements (Pembrokeshire)	HIW_ JICPA_0325_005h	N/A	R5. 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- Above plans (JICPA / 09) to be reported to Strategic Safeguarding Steering Group	Paula Goode	Mar-26	~~Mar-26~~ N/K	Overdue
HIW	Joint Inspection of Child Protection Arrangements (Pembrokeshire)	HIW_ JICPA_0325_008	N/A	R8. The Health Board's numerous IT systems do not support the timely collation and sharing of information, when safeguarding concerns arise. Leaders should identify opportunities to strengthen information sharing arrangements.	The Health Board will support the development and implementation of the Safeguarding Linc system in development.	Anthony Tracey	Mar-26	~~Mar-26~~ N/K	Overdue
HIW	Joint Inspection of Child Protection Arrangements (Pembrokeshire)	HIW_ JICPA_0325_017	N/A	R17. 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.	CP Medical Pathway: Convene review planning group and scoping meeting. Map current job plans, rota commitments and workload (community vs acute). Draft Options Appraisal (e.g. community-led, acute-led, hybrid model). Final recommendations and implementation plan.	Tracy Owen	Dec-25	~~Dec-25~~ ~~Mar-26~~ N/K	Overdue

Report Issued By	Report Title	Recommendation Reference	Priority Level	Recommendation	Management Response	Recommendation Owner	Original Completion Date	Revised Completion Date	Status Category
HIW IRMER	Nuclear Medicine IRMER WGH	HIW_IRMER_NM_WGH_0625_009a	N/A	R9. The employer must ensure that: • All IR(ME)R entitlement and training competency documentation is completed in full, with the appropriate signatures, in a timely manner and before entitlement is granted • The employer's procedure contains reference to the correct titles of staff.	Develop new entitlement document which reflects all duty holders under IR(ME)R.	Faith Whitecross	Jan-26	~~Jan-26~~ ~~Feb-26~~ ~~May-26~~ Mar-27	Overdue
HIW IRMER	Nuclear Medicine IRMER WGH	HIW_IRMER_NM_WGH_0625_020b	N/A	R20. The employer must ensure that the replacement of the gamma camera is completed, and contingency plans are put in place as a matter of priority to reduce the risk of this identified current single point of failure.	Contingency plans to be developed in the event of service or equipment failure.	Sarah Stance	Jun-26	~~Jun-26~~ Nov-26	Overdue
HIW IRMER	Nuclear Medicine IRMER WGH	HIW_IRMER_NM_WGH_0625_023	N/A	R23. The employer must ensure that the SLA for the Provision of Radiopharmaceuticals with Swansea Bay University Health Board is reviewed and updated.	SLA for the Provision of Radiopharmaceuticals with Swansea Bay University Health Board will be reviewed and updated.	Owain Williams	Jun-26	~~Jun-26~~ Sep-26	Overdue
Internal Audit	Discharge Management (Follow Up) Final Internal Audit Report 2024/25	HDU-2425-34_001	High	R1. Documentation of Discharge Planning Of the 100 patient records reviewed within WNCR, eight had partially completed discharge elements whilst 19 had not been completed. A sample of 20 patient manual medical notes were tested. A total of four files had been identified where there was limited discharge planning documentation evident of patient clinical file and the WNCR discharge section had been partially or not completed.	No evidence was received by Internal Audit to support the implementation of the agreed management actions including (i) staff education and required compliance with the WNCR system following the development of the SharePoint site, and (2) a review of WNCR records for to ensure compliance with requirements. Testing was undertaken on a sample of 50 patients discharged from acute hospital sites during April 2025 to ensure the discharge element within the WNCR system has been fully completed. Concluding testing, we identified 34 out of the 50 sampled patients had a completed discharge element on their WNCR record, with high levels of compliance displayed for WithybushGeneral Hospital patients	Anna Chiffi	Mar-25	N/K	Overdue
Audit Wales	Discharge Planning Progress Update – Hywel Dda University Health Board August 2025	AW_DPPU_HDUHB_0825_001c	N/A	R1 To make more effective use of its discharge lounges, the Health Board should: 1.1. actively promote the use of discharge lounges in its discharge planning process and associated training; 1.2. undertake work to understand why patients appropriate for discharge lounges are not being moved to the discharge lounge; and 1.3. monitor the use of discharge lounges, including the length of time patients remain in discharge lounges.	Historically, it has been believed that for a patient to be conveyed to a discharge lounge that all elements of the discharge checklist must be complete and the discharge lounge is a waiting room for transport only. We have commenced a significant amount of training pertaining to discharge to culturally influence and develop professional understanding, accountability and ownership. Specifically, this training includes Discharge to Recover and Assess alongside Criteria Led Discharge. Our training percentage is currently demonstrating low compliance in these areas; therefore, the target is to reach a minimum of 80% within our registered nurses and Allied Health Professional workforce.	Anna Chiffi	Mar-26	~~Mar-26~~ Aug-26	Overdue
Audit Wales	Discharge Planning Progress Update – Hywel Dda University Health Board August 2025	AW_DPPU_HDUHB_0825_001d	N/A	R1 To make more effective use of its discharge lounges, the Health Board should: 1.1. actively promote the use of discharge lounges in its discharge planning process and associated training; 1.2. undertake work to understand why patients appropriate for discharge lounges are not being moved to the discharge lounge; and 1.3. monitor the use of discharge lounges, including the length of time patients remain in discharge lounges.	The Health Board has recognised that there is a requirement for a competency profile review for nursing staff working in our discharge lounges to enable patients that require final clinical interventions to have these completed in the discharge lounge. Examples of these competencies include dressings and IV administration.	Anna Chiffi	Dec-25	~~Dec-25~~ ~~Apr-26~~ Aug-26	Overdue
Audit Wales	Urgent and Emergency Care: Flow out of Hospital – West Wales Region	AW_U&EC_WWR_0825_001c	N/A	R1. To ensure that only those with a service need are on the relevant waiting lists, the Health Board should ensure its staff only place patients on a waiting list that is relevant to their specific post discharge care needs, rather than placing them on multiple different waiting lists as a means of simple securing earlier discharge	D2RA allocation – development of specific pathways across the HB, e.g. Rehabilitation pathway	Marilize Preez	Jun-26	~~Jun-26~~ N/K	Overdue

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Audit Wales	Urgent and Emergency Care: Flow out of Hospital – West Wales Region	AW_U&EC_WWR_0825_004d	N/A	R4. To embed a consistent approach to discharge planning, the Health Board and local authorities should ensure processes are in place to communicate the new discharge planning guidance to all relevant health and social services staff, including those working on a temporary basis. Roll out of the guidance should be supported by an ongoing programme of refresher training and induction training for new staff	To further support understanding and implementation of discharge planning training videos are being developed. The videos will provide practical guidance and reinforce best practices.	Marilize Preez	Jun-26	~~Jun-26~~ N/K	Overdue
Audit Wales	Urgent and Emergency Care: Flow out of Hospital – West Wales Region	AW_U&EC_WWR_0825_005b	N/A	R5. To provide clarity to all staff on how the referral process for social care should work across the region, the Health Board, working with local authorities, should ensure that the new discharge planning guidance clearly sets out the point in the discharge planning process referrals for social care should be	As a region, we are involved in the All-Wales single referral process which will be for all local authorities/HB- following recommendation from POCD delivery meeting ww are undergoing a review of referral pathways to ensure consistency across 3 local authorities	Marilize Preez	Jun-26	~~Jun-26~~ N/K	Overdue
Audit Wales	Urgent and Emergency Care: Flow out of Hospital – West Wales Region	AW_U&EC_WWR_0825_006a	N/A	R6. To improve the quality of information contained in patient case notes, the Health Board should ensure all staff involved in discharge planning fully understand the importance of documenting comprehensive information in patient case-notes, and in addition implement a programme of case-note audits focused on the quality of record keeping	The Health Board 195, Clinical Record Keeping Policy (2023) is in place to provide clear professional and organisational standards for effective record keeping that all clinical staff must adhere to. With the aim that these standards will enable live, accurate, current and comprehensive information about the care provided to our patients.	Anna Chiffi	Jun-26	~~Jun-26~~ N/K	Overdue
Audit Wales	Urgent and Emergency Care: Flow out of Hospital – West Wales Region	AW_U&EC_WWR_0825_007a	N/A	R7. To encourage collaborative solutions to discharge planning and data sharing, the Health Board and local authorities should ensure relevant professionals from key partners, who can share information and enable efficient discharge, attend relevant multi-disciplinary ward rounds at all acute hospital sites, as is the case in Glangwili Hospital. This may include physiotherapists, social workers, occupational therapists, care and repair or other relevant professionals	These meetings are already in situ across the HB footprint, and the roll out of collaborative communication is supporting a culture of info sharing and positive shared risk. Optimal flow - refers to board rounds not ward rounds. There is multidisciplinary team (MDT) representation at board rounds, but this is limited due to workforce challenges which is a constraint to attendance. Ad hoc board round audits are undertaken.	Anna Chiffi	Jun-26	~~Jun-26~~ N/K	Overdue
Audit Wales	Urgent and Emergency Care: Flow out of Hospital – West Wales Region	AW_U&EC_WWR_0825_007b	N/A	R7. To encourage collaborative solutions to discharge planning and data sharing, the Health Board and local authorities should ensure relevant professionals from key partners, who can share information and enable efficient discharge, attend relevant multi-disciplinary ward rounds at all acute hospital sites, as is the case in Glangwili Hospital. This may include physiotherapists, social workers, occupational therapists, care and repair or other relevant professionals	Ad hoc board round audits are undertaken.	Anna Chiffi	Jun-26	~~Jun-26~~ N/K	Overdue
Audit Wales	Urgent and Emergency Care: Flow out of Hospital – West Wales Region	AW_U&EC_WWR_0825_007d	N/A	R7. To encourage collaborative solutions to discharge planning and data sharing, the Health Board and local authorities should ensure relevant professionals from key partners, who can share information and enable efficient discharge, attend relevant multi-disciplinary ward rounds at all acute hospital sites, as is the case in Glangwili Hospital. This may include physiotherapists, social workers, occupational therapists, care and repair or other relevant professionals	Escalation process in place across the region for complex discharge planning, including multi professional MDT's	Anna Chiffi	Jun-26	~~Jun-26~~ N/K	Overdue
Audit Wales	Urgent and Emergency Care: Flow out of Hospital – West Wales Region	AW_U&EC_WWR_0825_008b	N/A	R8. To enable social workers to effectively triage patients at the point of referral, the Health Board, working with local authorities, should improve the completeness of referrals from ward staff to social care	Identifying what a 'good' referral is and working with colleagues to identify this - this is part to the trusted assessor and competencies.	Marilize Preez	Jun-26	~~Jun-26~~ N/K	Overdue
Audit Wales	Urgent and Emergency Care: Flow out of Hospital – West Wales Region	AW_U&EC_WWR_0825_009d		R9. To ensure effective sharing of information, the Health Board and local authorities should implement ways in which information can be shared between organisations, including opportunities to provide multi-agency access to existing access to organisational systems and ultimately joint IT solutions	The Health Board has entered into a 10 year Digital Partnership with CGI who will support digital transformation across a number of key areas within the Health Board and will include working with LA partners.	Anthony Tracey	Jun-26	~~Jun-26~~ N/K	Overdue

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Audit Wales	Urgent and Emergency Care: Flow out of Hospital – West Wales Region	AW_U&EC_WWR_0825_010a	N/A	R10. To ensure consistency across acute hospital sites, the Health Board should apply a standard approach to recording patient discharge information on hospital wards using digital	The Health Board currently utilises MIYA as its digital system for capturing patient data. This platform records the Optimal Hospital Flow indicators that support effective discharge planning, including clinical optimisation status, Red2Green actions, and Discharge to Recover to Assess (D2RA) pathway allocation. Next month the Health Board is moving over to a new patient digital capture system.	Carolyn Williams	Jun-26	~~Jun-26~~ N/K	Overdue
Audit Wales	Urgent and Emergency Care: Flow out of Hospital – West Wales Region	AW_U&EC_WWR_0825_010b	N/A	R10. To ensure consistency across acute hospital sites, the Health Board should apply a standard approach to recording patient discharge information on hospital wards using digital	There is Health and Social Care representation at Length of Stay discharge planning meetings to share and record patient discharge information	Anna Chiffi	Jun-26	~~Jun-26~~ N/K	Overdue
Audit Wales	Urgent and Emergency Care: Flow out of Hospital – West Wales Region	AW_U&EC_WWR_0825_013	N/A	R13. To enable impact to be demonstrated, the Health Board should ensure that its updates on delivery against the Six Goals Programme contain anticipated outcomes	The UEC Six Goals Programme now reports on detailed metrics at both the IQFPD and IQPD meetings monthly. These are centred on the Targeted intervention metrics of Ambulance Handover, ED waiting times, ED assessment times and Pathway of Care Delays. Additionally, information is provided around discharges before mid-day and Length of stay metrics. All information is presented with an explanation of the current status and corrective actions relating to the individual metric.	Thomas Alexander	Jun-26	~~Jun-26~~ N/K	Overdue
HIW	Mynydd Mawr Ward, Prince Philip Hospital	HIW_MMW_PPH_0825_001b	N/A	R1. Ensure that ambient clinic room temperatures are monitored and recorded daily.	Awaiting costing for air-con for clinical room.	Mr Stewart Evans	Sep-25	~~Sep-25~~ N/K	Overdue
HIW	Mynydd Mawr Ward, Prince Philip Hospital	HIW_MMW_PPH_0825_002c	N/A	R2. Implement robust measures to maintain clinic room temperatures within recommended guidelines for safe medication storage.	The requirement of the daily treatment room temperature check process and compliance will be reviewed and amended within a Quality Improvement Health Board Wide Task and Finish group. ToR being devised. Dates being arranged.	Cathie Steele	Oct-25	~~Oct-25~~ Oct-26	Overdue
HIW	Mynydd Mawr Ward, Prince Philip Hospital	HIW_MMW_PPH_0825_003c	N/A	R3. 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.	Fiona John	Sep-25	~~Sep-25~~ Oct-26	Overdue
HIW	Mynydd Mawr Ward, Prince Philip Hospital	HIW_MMW_PPH_0825_008b	N/A	R8. The health board must ensure 'This is Me' documentation is completed to support personalised, person-centred care.	Through the WNCR monthly audit, undertake a check of compliance.	Louise Ellis	Oct-25	~~Oct-25~~ N/K	Overdue
Peer Review	Getting It Right First Time (GIRFT) - Assurance Review of Ambulance Patient Handover Process	GIRFT_APH_0825_001	N/A	R1. The organisational leadership and culture of care in a Health Board is of the utmost importance in ensuring that prompt ambulance patient handover becomes business as usual. Health Board Executives should work with local clinical leaders to communicate the importance of timely ambulance patient handover. Health Board Executives should model this visibly and repeatedly to all staff	Management action to be confirmed by the service	Gareth Cottrell	Jun-26	~~Jun-26~~ N/K	Overdue
Peer Review	Getting It Right First Time (GIRFT) - Assurance Review of Ambulance Patient Handover Process	GIRFT_APH_0825_002	N/A	R2. Health Boards should use the GIRFT 'SEDIT tool' and baseline data to support capacity planning across the hospital footprint, ensuring 24/7 access to safe care and treatment of patients arriving by emergency ambulance.	Management action to be confirmed by the service	Matt Willis	Jun-26	~~Jun-26~~ N/K	Overdue
Peer Review	Getting It Right First Time (GIRFT) - Assurance Review of Ambulance Patient Handover Process	GIRFT_APH_0825_003	N/A	R3. The committee and sufficiently senior nominated Health Board and WAST leads should regularly come together to review ambulance patient pathway data to identify opportunities to better manage patients in the community where safe to do so. This should include an assessment of 'hear and treat' and 'see and treat' performance to enable a collective understanding of patient activity.	Management action to be confirmed by the service	Louise Cullum	Jun-26	~~Jun-26~~ N/K	Overdue

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Peer Review	Getting It Right First Time (GIRFT) - Assurance Review of Ambulance Patient Handover Process	GIRFT_APH_0825_004	N/A	R4. The committee, WAST and Health Boards should regularly review and benchmark service provision matched to ambulance case mix and pattern of daily demand by local and regional area. Data should inform the delivery of robust community and alternative pathways by Health Boards which are clearly communicated to ambulance clinicians. This should include direct access pathways to enable patients to bypass the emergency department when safe and appropriate to do so.	Management action to be confirmed by the service	Matt Willis	Jun-26	~~Jun-26~~ N/K	Overdue
Peer Review	Getting It Right First Time (GIRFT) - Assurance Review of Ambulance Patient Handover Process	GIRFT_APH_0825_005	N/A	R5. Communication before the patient arrives: Health Boards should ensure ambulance clinicians have access to a care co-ordination service (i.e. navigation or flow hubs) that can accept or transfer care of suitable patients and support the flow into their services.	Management action to be confirmed by the service	Bianca Oakley	Jun-26	~~Jun-26~~ N/K	Overdue
Peer Review	Getting It Right First Time (GIRFT) - Assurance Review of Ambulance Patient Handover Process	GIRFT_APH_0825_006	N/A	R6. Patients requiring immediate resuscitation: Where a patient requires immediate life-saving treatment on arrival at hospital the ambulance crew must provide a pre-alert to the hospital. WAST and Health Boards should have agreed processes in place based on national guidance for identifying, communicating and managing pre-alert cases.	Management action to be confirmed by the service	Vicky Hughes	Jun-26	~~Jun-26~~ N/K	Overdue
Peer Review	Getting It Right First Time (GIRFT) - Assurance Review of Ambulance Patient Handover Process	GIRFT_APH_0825_007	N/A	R7. Patients requiring immediate resuscitation: When an ambulance arrives at hospital with a patient who requires immediate life-saving treatment, the patient must be taken immediately to the resuscitation area. Effective hospital escalation should be in place to enable this seamlessly.	Management action to be confirmed by the service	Vicky Hughes	Jun-26	~~Jun-26~~ N/K	Overdue
Peer Review	Getting It Right First Time (GIRFT) - Assurance Review of Ambulance Patient Handover Process	GIRFT_APH_0825_008	N/A	R8. Patients requiring specialist emergency treatment: Patients requiring treatment for conditions such as STEMI, vascular, burns, stroke or obstetric conditions should be taken directly to receiving units other than the hospital emergency department in line with the agreed local or regional pathway.	Management action to be confirmed by the service	Vicky Hughes	Jun-26	~~Jun-26~~ N/K	Overdue
Peer Review	Getting It Right First Time (GIRFT) - Assurance Review of Ambulance Patient Handover Process	GIRFT_APH_0825_009	N/A	R9. Patients requiring specialist emergency treatment: Additional pathways must be agreed between WAST and Health Boards who have a responsibility for clearly communicating their expectations to the Trust. WAST has a responsibility to ensure ambulance clinicians are informed of Health Board expectations and maintain a regularly updated directory of services	Management action to be confirmed by the service	Louise Cullum	Jun-26	~~Jun-26~~ N/K	Overdue
Peer Review	Getting It Right First Time (GIRFT) - Assurance Review of Ambulance Patient Handover Process	GIRFT_APH_0825_010	N/A	R10. Patients requiring specialist emergency treatment: Health Boards should incorporate regular audits of compliance with these pathways as part of annual clinical audit forward planning activity. The NHS Executive will also periodically audit compliance.	Management action to be confirmed by the service	Vicky Hughes	Jun-26	~~Jun-26~~ N/K	Overdue
Peer Review	Getting It Right First Time (GIRFT) - Assurance Review of Ambulance Patient Handover Process	GIRFT_APH_0825_011	N/A	R11. Ambulance patient handover on arrival: Booking in: Booking in of patients must take place immediately on arrival at the emergency department or other admitting areas. WAST staff will complete an electronic Patient Clinical Record (ePCR) for all patients	Management action to be confirmed by the service	Vicky Hughes	Jun-26	~~Jun-26~~ N/K	Overdue
Peer Review	Getting It Right First Time (GIRFT) - Assurance Review of Ambulance Patient Handover Process	GIRFT_APH_0825_012	N/A	R12. Booking in: The ePCR will be processed by the receiving hospital for all patients conveyed by WAST depending on local protocols. This should be matched to the patient and uploaded to Welsh Clinical Portal when the care episode is complete.	Management action to be confirmed by the service	Matt Willis	Jun-26	~~Jun-26~~ N/K	Overdue
Peer Review	Getting It Right First Time (GIRFT) - Assurance Review of Ambulance Patient Handover Process	GIRFT_APH_0825_013	N/A	R13. Triage / signposting: Patients should be assessed on arrival at the hospital receiving area and treated for the acute condition they have presented with; remembering frailty can co-exist with the presenting acute complaint	Management action to be confirmed by the service	Vicky Hughes	Jun-26	~~Jun-26~~ N/K	Overdue
Peer Review	Getting It Right First Time (GIRFT) - Assurance Review of Ambulance Patient Handover Process	GIRFT_APH_0825_014	N/A	R14. .Triage / signposting: Guidelines should be in place for safe and effective triage and streaming of patients to the correct area (e.g. majors, minors, same day emergency care, acute frailty teams etc), and to identify patients who are 'fit to sit' in the waiting area. These processes should be standardised between Health Boards and WAST.	Management action to be confirmed by the service	Vicky Hughes	Jun-26	~~Jun-26~~ N/K	Overdue

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Peer Review	Getting It Right First Time (GIRFT) - Assurance Review of Ambulance Patient Handover Process	GIRFT_APH_0825_015	N/A	R15. On arrival a detailed summary must be given by WAST to support triage/initial assessment by Health Board clinicians. This will include clinical information and also considerations of other personal and social information where relevant. Processes should be implemented by Health Boards regarding the grade/training/ level of experience required for this task.	Management action to be confirmed by the service	Vicky Hughes	Jun-26	~~Jun-26~~ N/K	Overdue
Peer Review	Getting It Right First Time (GIRFT) - Assurance Review of Ambulance Patient Handover Process	GIRFT_APH_0825_016	N/A	R16. Senior clinical decision makers should consistently be present at the hospital front door and their presence supported and strengthened as part of local escalation plans when pressures build in the system.	Management action to be confirmed by the service	Vicky Hughes	Jun-26	~~Jun-26~~ N/K	Overdue
Peer Review	Getting It Right First Time (GIRFT) - Assurance Review of Ambulance Patient Handover Process	GIRFT_APH_0825_017	N/A	R17. Patients are to be handed over at a definitive destination of care, with both ambulance and hospital staff complying with the dual pin process, inputting individual staff ID pins into the HAS screen. For those areas where HAS screens are not available, Health Boards and WAST should ensure that equally robust arrangements are in place to ensure rapid handover, within 15 minutes of arrival.	Management action to be confirmed by the service	Louise Cullum	Jun-26	~~Jun-26~~ N/K	Overdue
Peer Review	Getting It Right First Time (GIRFT) - Assurance Review of Ambulance Patient Handover Process	GIRFT_APH_0825_018	N/A	R18. Health Boards should deliver safe, sustainable, staffing levels for emergency departments and acute receiving areas, able to flex to meet demand, with appropriate levels of seniority available for timely assessment and supervision, in line with expectations set within the Quality Statement for Care in an Emergency Department. Staff of all grades should have clear lines of responsibility and accountability and an appropriate level of supervision, (e.g. resident doctors, health care assistants and clinical practitioners).	Management action to be confirmed by the service	Vicky Hughes	Jun-26	~~Jun-26~~ N/K	Overdue
Peer Review	Getting It Right First Time (GIRFT) - Assurance Review of Ambulance Patient Handover Process	GIRFT_APH_0825_019	N/A	R19. Management of handover delays: Patients and their carers should be kept fully informed of the reason for any delay and the progress in resolving it.	Management action to be confirmed by the service	Louise Cullum	Jun-26	~~Jun-26~~ N/K	Overdue
Peer Review	Getting It Right First Time (GIRFT) - Assurance Review of Ambulance Patient Handover Process	GIRFT_APH_0825_020	N/A	R20. Management of handover delays: WAST crews should not routinely be responsible for monitoring patients over prolonged periods outside emergency departments or other admitting areas, and hospital clinicians should be responsible for overseeing the assessment of patients	Management action to be confirmed by the service	Vicky Hughes	Jun-26	~~Jun-26~~ N/K	Overdue
Peer Review	Getting It Right First Time (GIRFT) - Assurance Review of Ambulance Patient Handover Process	GIRFT_APH_0825_021	N/A	R21. If delays occur immediate action must be taken by the Health Board to resolve them. Where ambulances are delayed beyond 30 minutes the actions must include: The WAST Operational Delivery Unit (ODU) and the hospital operational team must be notified immediately.	Management action to be confirmed by the service	Louise Cullum	Jun-26	~~Jun-26~~ N/K	Overdue
Peer Review	Getting It Right First Time (GIRFT) - Assurance Review of Ambulance Patient Handover Process	GIRFT_APH_0825_022	N/A	R22. If delays occur immediate action must be taken by the Health Board to resolve them. Where ambulances are delayed beyond 30 minutes the actions must include: Health Boards should have in place appropriate procedures and identified individuals for the management, flow and co-ordination of patients arriving by ambulance.	Management action to be confirmed by the service	Alison Bishop/Stuart Bancroft	Jun-26	~~Jun-26~~ N/K	Overdue
Peer Review	Getting It Right First Time (GIRFT) - Assurance Review of Ambulance Patient Handover Process	GIRFT_APH_0825_023	N/A	R23. If delays occur immediate action must be taken by the Health Board to resolve them. Where ambulances are delayed beyond 30 minutes the actions must include: Hospital staff must ensure that the patient has been assessed and moved immediately into an appropriate clinical space if there is a risk to patient safety.	Management action to be confirmed by the service	Anna Chiffi	Jun-26	~~Jun-26~~ N/K	Overdue
Peer Review	Getting It Right First Time (GIRFT) - Assurance Review of Ambulance Patient Handover Process	GIRFT_APH_0825_024	N/A	R24. Delays of over 60 minutes are unacceptable and should be exceptional. They must be clearly visible to the Health Board Executive teams and monitored through quality and safety management systems. After 60 minutes of delay the following actions must take place if they have not already: The WAST ODU should be informed for escalation to the national system leads and must be notified immediately where there is a risk a patient will wait in excess of four hours.	Management action to be confirmed by the service	Alison Bishop/Stuart Bancroft	Jun-26	~~Jun-26~~ N/K	Overdue

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Peer Review	Getting It Right First Time (GIRFT) - Assurance Review of Ambulance Patient Handover Process	GIRFT_APH_0825_025	N/A	R25. After 60 minutes of delay the following actions must take place if they have not already: Hospital wards must increase their ability to pull patients safely from the acute areas at times of peak demand. This should be risk managed to ensure that patients are treated in a suitable clinically supervised area with appropriately qualified staff. A patient's safety is the utmost priority and any infection control, or any other risk including deconditioning, should be managed proactively.	Management action to be confirmed by the service	Anna Chiffi	Jun-26	~~Jun-26~~ N/K	Overdue
Peer Review	Getting It Right First Time (GIRFT) - Assurance Review of Ambulance Patient Handover Process	GIRFT_APH_0825_026	N/A	R26. After 60 minutes of delay the following actions must take place if they have not already: Formal ambulance diverts should be put in place in line with local and national escalation processes agreed between the Health Board and WAST	Management action to be confirmed by the service	Alison Bishop/Stuart Bancroft	Jun-26	~~Jun-26~~ N/K	Overdue
HIW	Derwen Ward, Glangwili General Hospital	HIW_DW_GGH_0925_012c	N/A	R12. The health board must ensure that: •The signage is improved to ensure it is more dementia friendly •Person-centred tools like “This is Me” and the “Butterfly Scheme” are used to fully support patients with cognitive impairments.	Monitor the above compliance through undertaking WNCR monthly audits. Findings to be shared in HB documentation steering group.	Trudy Bryant	Dec-25	~~Dec-25~~ N/K	Overdue
HIW	Derwen Ward, Glangwili General Hospital	HIW_DW_GGH_0925_015b	N/A	R15. The health board must ensure that the: •Ward has the relevant equipment and materials to support patients with hearing, sight and language difficulties •Meet the team board is updated with a description of the uniform colours worn by staff and their roles •The patient day room is decluttered, and patients are informed of its availability and purpose to improve access, encourage social interaction and support wellbeing.	10% of Derwen ward staff to attend Hearing Loss Bitesize Webinar and RNIB Vision Friends training in line with Sensory Loss Awareness Month in November. Staff who have attended the training to share learning through staff meeting and GGH Assurance Scrutiny Meeting.	Trudy Bryant	Jan-26	~~Jan-26~~ N/K	Overdue
HIW	Derwen Ward, Glangwili General Hospital	HIW_DW_GGH_0925_015c	N/A	R15. The health board must ensure that the: •Ward has the relevant equipment and materials to support patients with hearing, sight and language difficulties •Meet the team board is updated with a description of the uniform colours worn by staff and their roles •The patient day room is decluttered, and patients are informed of its availability and purpose to improve access, encourage social interaction and support wellbeing.	Liaise with the Diversity and Inclusion team to arrange bespoke Sensory Loss Training for the ward.	Louisa Standeven	Feb-26	~~Feb-26~~ N/K	Overdue
HIW	Derwen Ward, Glangwili General Hospital	HIW_DW_GGH_0925_018d	N/A	R18. The health board must ensure that: •Damaged areas, such as broken tiles and cracked floors are repaired to limit potential IPC issues •Cleaning records are displayed in the toilets on the ward •Hand gel on the ward is in date to maintain its effectiveness •Disposable curtains are marked with a date the curtains were hung, to ensure they are replaced in a timely manner, or sooner if soiled •There is a separation of duties between domestic staff cleaning the ward and serving food •The relevant precautions are taken when treating isolated patients including closing doors.	The Facilities Team will begin implementing a new model of cleaning provision (that includes split catering and cleaning) across all acute hospital sites. This will include the recruitment of additional staff to improve cleanliness standards and the introduction of revised rotas and shift patterns tailored to each site’s operational needs. PPH – Jan 8th 2026 GGH – Jan 8th 2026 WGH – Apr 1st 2026 BGH – Apr 1st 2026	Elin Brock	Apr-26	~~Apr-26~~ N/K	Overdue

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HIW	Derwen Ward, Glangwili General Hospital	HIW_DW_GGH_0925_026b	N/A	R26. The health board must consider fully implementing electronic patient record system to access and manage patient records appropriately.	Electronic Observations to be piloted on Towy Ward (GGH) in December 2025, with a plan to launch early 2026 HB wide.	Sarah Charles	Feb-26	~~Feb-26~~ N/K	Overdue
HIW	Derwen Ward, Glangwili General Hospital	HIW_DW_GGH_0925_026d	N/A	R26. The health board must consider fully implementing electronic patient record system to access and manage patient records appropriately.	Implementation of Cito Digital Health Document Repository programme to store digital patient health records. Phase 1 of external scanning is due for final completion in November 2025.	Sarah Charles	Nov-25	~~Nov-25~~ Sep-26	Overdue
HIW	Derwen Ward, Glangwili General Hospital	HIW_DW_GGH_0925_029e	N/A	R29. The health board must ensure hospital staff work closely with social care teams to ensure that patients are discharged promptly when medically fit.	Delayed pathways of care are the subject of performance review for the Health Board and Local Authority partners. They are measured and reported on a national basis monthly using an agreed set of criteria to identify the delay. Community Management Teams (CMT) ensure that arrangements are in place for the census to be undertaken on a monthly basis and the outcome validated in collaboration with Local Authority (LA) partners.	Anna Chiffi	Sep-25	~~Sep-25~~ Sep-26	Overdue
NHS Wales Performance and Improvement	SDEC National Review 2025	NHSWALESP&I_SDECNR_1025_001	N/A	R1. We recommend that there is a workforce review be undertaken for Medical and nursing workforce	Management action to be confirmed by the service	Dan Owen	Jun-26	~~Jun-26~~ N/K	Overdue
NHS Wales Performance and Improvement	SDEC National Review 2025	NHSWALESP&I_SDECNR_1025_002	N/A	R2. We recommend the health board as a priority review the current ED practices and processes for referral into the medical SDEC Unit. Going into the winter period there cannot be patients sat within the emergency departments that could be seen and treated elsewhere	Management action to be confirmed by the service	David Richards	Jun-26	~~Jun-26~~ N/K	Overdue
NHS Wales Performance and Improvement	SDEC National Review 2025	NHSWALESP&I_SDECNR_1025_003	N/A	R3. The model at GGH surgical SDEC needs to be reviewed and strengthened	Management action to be confirmed by the service	Caryl Bowen	Jun-26	~~Jun-26~~ N/K	Overdue
NHS Wales Performance and Improvement	SDEC National Review 2025	NHSWALESP&I_SDECNR_1025_004	N/A	R4. Significant inconsistencies exist across the health board, spanning both nursing and medical models	Significant inconsistencies exist due to non-aligned budgets and staffing models. This was highlighted by the Health Board internal SDEC peer review in 2023 and work has been undertaken to align these through the right sizing of the 5-day workforce and extension into 7/7 through the SDEC medical model business case. This was successfully approved at public board in January 2026 and is currently in implementation phase	Karen Brown	Jun-26	~~Jun-26~~ N/K	Overdue
NHS Wales Performance and Improvement	SDEC National Review 2025	NHSWALESP&I_SDECNR_1025_006	N/A	R6. A review of the Business cases already submitted to support the modelling for SDEC and Acute Frailty services across HDUHB	7-day SDEC business case submitted and approved by Board in January 2026. WGH is set to go live in December 2026, BGH and GGH will follow in subsequent years. Review and evaluation periods are set against the implementation and the UEC Programme Group governance structure will ensure oversight and monitoring	Thomas Alexander	Jun-26	~~Jun-26~~ N/K	Overdue
NHS Wales Performance and Improvement	SDEC National Review 2025	NHSWALESP&I_SDECNR_1025_007	N/A	R7. Review of Neuro Rehab/Oncology corridor and Podiatry/Vascular corridor to support a SDEC acute clinical unit model. This model will pull together the Porth Preseli team 1 Consultant, x2 ANPs x1 PA, COTE consultant to lead frailty	Management action to be confirmed by the service	Caryl Bowen	Jun-26	~~Jun-26~~ N/K	Overdue
NHS Wales Performance and Improvement	SDEC National Review 2025	NHSWALESP&I_SDECNR_1025_008	N/A	R8. We recommend that an SOP is written and agreed for the surgical SDEC model at WBH and the CAU is discussed as a combined SDEC provision as by definition	WGH have reviewed this and agreed that surgical SDEC model is not to be progressed at this point	Jess Svetz	Jun-26	~~Jun-26~~ N/K	Overdue
NHS Wales Performance and Improvement	SDEC National Review 2025	NHSWALESP&I_SDECNR_1025_009	N/A	R9. Workforce fragility to be added to risk register WBH	This will be addressed with 7-Day SDEC implementation	Jess Svetz	Jun-26	~~Jun-26~~ N/K	Overdue
NHS Wales Performance and Improvement	SDEC National Review 2025	NHSWALESP&I_SDECNR_1025_010	N/A	R10. We recommend the Health Board review and update their SDEC Standard Operating Procedures (SOPs) to ensure they reflect current national guidance, best practice, and the operational realities of delivering high-quality, safe same-day care	Management action to be confirmed by the service	David Richards	Jun-26	~~Jun-26~~ N/K	Overdue

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NHS Wales Performance and Improvement	SDEC National Review 2025	NHSWALESP&I_SDECNR_1025_011	N/A	R11. Overall, there needs to be further investment by the HB in SDEC facilities in order to fully realise the potential of these units, which is significant if there is the investment	Management action to be confirmed by the service	Peter Skitt	Jun-26	~~Jun-26~~ N/K	Overdue
NHS Wales Performance and Improvement	SDEC National Review 2025	NHSWALESP&I_SDECNR_1025_012	N/A	R12. In collaboration with WAST colleagues strengthen the WAST direct access pathways into SDEC	Management action to be confirmed by the service	David Richards	Jun-26	~~Jun-26~~ N/K	Overdue
NHS Wales Performance and Improvement	Adult Eating Disorders Mapping & Progress Update National Report	NHSP&I_AED_1125_003	N/A	R3. Enhanced EDS and diabetes team collaboration to share expertise and develop pathways for T1DE (Type 1 Diabetes with Disordered Eating) patients, including enhancing screening and early identification of eating disorders and developing joint clinics for patients with disordered eating and a co-occurring diabetes diagnosis.	Meet with Diabetes team to explore agreeing a shared pathway and shared care protocol to outline the arrangements for screening, early identification and joint clinics for T1DE.	Myfina Lewis-Williams (Service Manager – Eating Disorders Service)	May-26	~~May-26~~ N/K	Overdue
HIW	HIW Improvement plan – Community Learning Disability Team	HIW_CLDT_1125_002a	N/A	R2. Develop and deliver a workforce strategy to reduce reliance on locum staff. Prioritise recruitment and retention of permanent psychiatrists to ensure continuity and quality of care.	Review the existing strategy for recruitment of psychiatrists to the Learning Disabilities Service, acknowledging the longstanding challenges of the rural context and considering whether any emerging or alternative workforce options may be feasible in the future.	Dr Warren Lloyd	Jun-26	~~Jun-26~~ N/K	Overdue
HIW	HIW Improvement plan – Community Learning Disability Team	HIW_CLDT_1125_004	N/A	R4. Review and manage OT waiting lists to ensure timely access, prioritising high-risk cases. Implement measures to reduce waiting times and improve service responsiveness.	Create a workplan for newly appointed Band 7 Occupational Therapist, upon commencement in post, that prioritises reducing OT waiting lists.	Kelly Southway	May-26	~~May-26~~ N/K	Overdue
Internal Audit	Patient Experience Final Internal Audit Report 2025/26	HDU-2526-16_001a	Medium	R1. Peoples Experience Framework: The Peoples Experience Strategy The Improving People and Community Experience Charter requires updating to reflect the new People's Experience Framework (2025), which recommends that all NHS Wales organisations have in place People's Experience Strategy. Whilst the Charter outlines what patients can expect when using Health Board services, a strategically endorsed document would provide a structured plan and set measurable objectives to enable the Health Board to drive improvements and monitor progress in achieving these. The Health Board has developed a self-assessment tool which has been endorsed by the Listening & Learning Sub-Committee but this is yet to be distributed for completion at service level (in part due to the recent operational restructure).	The self-assessment tool will be distributed to CCGs for completion at service level and the outcome used to inform the refresh of the Charter and set the patient experience workplan for the Health Board.	Jeff Bowen, Head of Patient Experience	Jan-26	~~Jan-26~~ N/K	Overdue
Internal Audit	Patient Experience Final Internal Audit Report 2025/26	HDU-2526-16_001b	Medium	R1. Peoples Experience Framework: The Peoples Experience Strategy The Improving People and Community Experience Charter requires updating to reflect the new People's Experience Framework (2025), which recommends that all NHS Wales organisations have in place People's Experience Strategy. Whilst the Charter outlines what patients can expect when using Health Board services, a strategically endorsed document would provide a structured plan and set measurable objectives to enable the Health Board to drive improvements and monitor progress in achieving these. The Health Board has developed a self-assessment tool which has been endorsed by the Listening & Learning Sub-Committee but this is yet to be distributed for completion at service level (in part due to the recent operational restructure).	As part of the refresh, we will consider the merits of replacing the Charter with a formal strategy. Regardless, we will ensure that the revised document satisfies the requirements of the new Framework and it will be strategically endorsed. A workplan will be developed to support delivery of the refreshed Charter/Strategy, these will be replicated at CCG level	Jeff Bowen, Head of Patient Experience	Jun-26	~~Jun-26~~ N/K	Overdue

Report Issued By	Report Title	Recommendation Reference	Priority Level	Recommendation	Management Response	Recommendation Owner	Original Completion Date	Revised Completion Date	Status Category
Internal Audit	Patient Experience Final Internal Audit Report 2025/26	HDU-2526-16_002	Medium	R2. Civica System Functionality Civica has automated escalation protocols for notification and escalation of poor/negative feedback received. Whilst this functionality is used in other NHS Wales organisations, it is not currently in use in Hywel Dda. Civica also has functionality to capture follow-up actions and outcomes through its Action Log feature, which is designed to support progress tracking and accountability. This tool enables the recording of actions arising from feedback and assigns responsibility to relevant staff or departments, and monitors completion status and deadlines, thereby enhancing management oversight. This functionality is not in use in Hywel Dda.	The benefits of using the real-time alerts function for poor and very poor feedback will be explored and a decision taken as to whether this will be implemented within Hywel Dda. We will pilot use of the action logging functionality within Outpatient Services by the end of March 2026, with a view to wider implementation across the whole Health Board by December 2026 if this proves successful. Consideration will be given to how this aligns with other systems such as Datix for the purposes of triangulation and overall improvement planning.	Jeff Bowen, Head of Patient Experience	Apr-26	~~Apr-26~~ N/K	Overdue
Internal Audit	Patient Experience Final Internal Audit Report 2025/26	HDU-2526-16_003	Medium	R3. Civica System Engagement There are no Civica users within the Estates & Facilities Service Group.It is not possible to assess system use at service level and we were unable to confirm which areas are in receipt of push reports. Service areas spoken with during the review demonstrated variation in system engagement. Engagement with and use of the system at service level varies.	Civica user access list will be reviewed to identify and address any gaps in service coverage. Standard push reports will be established for all service areas to ensure consistency. 'How to' guides will be developed to support service areas in engaging with and building confidence in using the system more efficiently and effectively, including establishing bespoke dashboards and reports.	Jeff Bowen, Head of Patient Experience	Apr-26	~~Apr-26~~ N/K	Overdue
Internal Audit	Patient Experience Final Internal Audit Report 2025/26	HDU-2526-16_005a	High	R5. Clarity of Expectations of Service Areas in Managing Patient Experience Data Responsibility for interpreting and acting upon patient experience feedback rests with individual services. Roles and responsibilities in this regard are not clearly defined - there is no guidance on expected actions from service areas, and nothing setting out how service areas will analyse, action and use feedback to inform service improvements.	Roles, responsibilities and expectations will be documented in guidance.	Jeff Bowen, Head of Patient Experience	Mar-26	~~Mar-26~~ N/K	Overdue
Internal Audit	Patient Experience Final Internal Audit Report 2025/26	HDU-2526-16_005b	High	R5. Clarity of Expectations of Service Areas in Managing Patient Experience Data Responsibility for interpreting and acting upon patient experience feedback rests with individual services. Roles and responsibilities in this regard are not clearly defined - there is no guidance on expected actions from service areas, and nothing setting out how service areas will analyse, action and use feedback to inform service improvements.	As part of the self-assessment process, service areas will be required to develop plans setting out their commitment and local arrangements for ensuring and demonstrating that feedback is analysed, acted on and used to drive improvement.	Jeff Bowen, Head of Patient Experience	May-26	~~May-26~~ N/K	Overdue
HIW	Cwm Seren LSU and PICU	HIW_CwmSeren_LSU&PICU_1225_003a	N/A	R3. The health board must ensure that gym equipment is repaired and that there are enough trained staff to support patients in using the gym.	4 members of staff will achieve appropriate level 2 gym instructor training enabling them to support gym care plans for the All patient population of Cwm Seren. This is a 6 week course and will be achieved by the end of March 2026.	Ms Caitriona Quinlan	Mar-26	~~Mar-26~~ N/K	Overdue
HIW	Cwm Seren LSU and PICU	HIW_CwmSeren_LSU&PICU_1225_005b	N/A	R5. The health board must engage with the patient group to gain a deeper understanding of their experiences and concerns and use this insight to drive meaningful improvements in care.	Revisit existing processes in place, facilitated by West Wales Action for Mental Health, to gather patient feedback and report to ward managers, leading to documented summaries and improvement actions.	Ms Caitriona Quinlan	Jun-26	~~Jun-26~~ N/K	Overdue
HIW	Cwm Seren LSU and PICU	HIW_CwmSeren_LSU&PICU_1225_009	N/A	R9. The health board should engage with staff and patients to confirm the need for a low stimulus space and gather input on design features that would best support patient wellbeing.	The PICU team will work with staff and patients to confirm the need for a low-stimulus space and co-design its key features through structured engagement sessions, after which a fully costed funding proposal for the required works and equipment will be completed and submitted to the health board.	Miss Charlie Prosser	Jun-26	~~Jun-26~~ N/K	Overdue

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NHS Wales Performance and Improvement	NHS Performance and Improvement Report on Urgent and Emergency Care Opportunities: WGH site	NHSP&I_U&EC_WGH_1225_001b	N/A	R1. The review has been informed that from June 2025 daily ED board rounds take place to discuss all patients awaiting in patient bed that includes the clinical pathway, the accepting consultant and ward they will be admitted onto. During the follow up visit the ED board round did not take place due to time capacity of the ED team. In response to whether board rounds were established practice in ED, it was reported that their occurrence remains inconsistent and variable. In view of that we could not gain assurance that these were embedded as suggested. There was no evidence of a visual escalation tool being used within the department, although there was evidence within the site sitrep report of ED escalation.	Implement Miya Flow White Board to ensure effective management of patients waiting for beds	Jo Dyer	Jan-26	~~Jan-26~~ Oct-26	Overdue
NHS Wales Performance and Improvement	NHS Performance and Improvement Report on Urgent and Emergency Care Opportunities: WGH site	NHSP&I_U&EC_WGH_1225_002	N/A	R2. We were not able to gain assurance during the return visit that escalation into this area had been added on to the site escalation plans and therefore it was not clear how the system was responding to overcrowding and also the significant risk currently being held in ED	Update the Site Escalation Plan to include clear ED overcrowding triggers and response actions, and ensure staff are briefed on how to activate them.	Joseph Matthews	Feb-26	~~Feb-26~~ Oct-26	Overdue
NHS Wales Performance and Improvement	NHS Performance and Improvement Report on Urgent and Emergency Care Opportunities: WGH site	NHSP&I_U&EC_WGH_1225_003	N/A	R3. This will be picked up as part of the GIRFT review, however the site reset action plan indicates that from the 1st October 2025 there will be senior consultants in ED leading on Rapid Assessment & Triage during peak hours	Ensure senior consultants in ED leading on RAT during peak hours	Vicki Hughes	Mar-26	~~Mar-26~~ Mar-27	Overdue
NHS Wales Performance and Improvement	NHS Performance and Improvement Report on Urgent and Emergency Care Opportunities: WGH site	NHSP&I_U&EC_WGH_1225_005	N/A	R5. Site meetings: We were informed that the final meeting of the day continued to remain inconsistent in terms of attendance resulting in an inaccurate presentation of discharge profile for the remainder of the day. This is something we recommend is further tightened up on moving forward.	Ensure consistent attendance at the final site meeting each day so the discharge profile is accurate and complete.	Carol Thomas	Jan-26	~~Jan-26~~ N/K	Overdue
NHS Wales Performance and Improvement	NHS Performance and Improvement Report on Urgent and Emergency Care Opportunities: WGH site	NHSP&I_U&EC_WGH_1225_006	N/A	R6. GGH and WGH - inter site clinical pathways remain a concern, we further recommend that this is revisited by the respective senior management teams	Develop of clear clinical pathway SOPs	Joseph Matthews	Mar-26	~~Mar-26~~ Oct-26	Overdue
NHS Wales Performance and Improvement	NHS Performance and Improvement Report on Urgent and Emergency Care Opportunities: WGH site	NHSP&I_U&EC_WGH_1225_008	N/A	R8. There is currently a review of the current senior nurse manager portfolios and therefore this action is on hold until the portfolios have been agreed.	Agree portfolios	Carol Thomas	Mar-26	~~Mar-26~~ N/K	Overdue
NHS Wales Performance and Improvement	HDUHB Winter Sprints Resets Opportunities Assessment	NHSWALESP&I_WSROA_1225_002	N/A	R2. Standardise communication behaviours and expectations across all sites.	Management action to be confirmed by the service	Peter Skitt	Jun-26	~~Jun-26~~ N/K	Overdue
NHS Wales Performance and Improvement	HDUHB Winter Sprints Resets Opportunities Assessment	NHSWALESP&I_WSROA_1225_003	N/A	R3. Implement weekly senior rota for consistent professional to professional dialogue	Management action to be confirmed by the service	Anna Chiffi	Jun-26	~~Jun-26~~ N/K	Overdue
NHS Wales Performance and Improvement	HDUHB Winter Sprints Resets Opportunities Assessment	NHSWALESP&I_WSROA_1225_004	N/A	R4. Improve accuracy and reliability of system reporting and surge declarations.	Management action to be confirmed by the service	Matthew Willis	Jun-26	~~Jun-26~~ N/K	Overdue
NHS Wales Performance and Improvement	HDUHB Winter Sprints Resets Opportunities Assessment	NHSWALESP&I_WSROA_1225_007	N/A	R7. Review staffing numbers for cleaners in winter preparedness	Management action to be confirmed by the service	Peter Jones	Jun-26	~~Jun-26~~ N/K	Overdue
NHS Wales Performance and Improvement	HDUHB Winter Sprints Resets Opportunities Assessment	NHSWALESP&I_WSROA_1225_008	N/A	R8. Publish surge risk assessments and implement de-escalation gates.	Management action to be confirmed by the service	Anna Chiffi	Jun-26	~~Jun-26~~ N/K	Overdue
NHS Wales Performance and Improvement	HDUHB Winter Sprints Resets Opportunities Assessment	NHSWALESP&I_WSROA_1225_010	N/A	R10. Strengthen leadership behaviours: clarity, consistency, accountability.	Management action to be confirmed by the service	Peter Skitt	Jun-26	~~Jun-26~~ N/K	Overdue
NHS Wales Performance and Improvement	HDUHB Winter Sprints Resets Opportunities Assessment	NHSWALESP&I_WSROA_1225_015	N/A	R15. Use the reluctant discharge guidance to support patients with the right decision	Management action to be confirmed by the service	Peter Skitt	Jun-26	~~Jun-26~~ N/K	Overdue

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NHS Wales Performance and Improvement	HDUHB Winter Sprints Resets Opportunities Assessment	NHSWALESP&I_WS ROA_1225_016	N/A	R16. Strengthen documentation quality standards.	Management action to be confirmed by the service	Anna Chiffi	Jun-26	~~Jun-26~~ N/K	Overdue
NHS Wales Performance and Improvement	HDUHB Winter Sprints Resets Opportunities Assessment	NHSWALESP&I_WS ROA_1225_017	N/A	R17. Ensure shared HB LA access to up to date patient data.	Need a project scope. Perhaps achievable action within year is to agree a plan against this with Digital team?	Peter Skitt	Jun-26	~~Jun-26~~ N/K	Overdue
NHS Wales Performance and Improvement	HDUHB Winter Sprints Resets Opportunities Assessment	NHSWALESP&I_WS ROA_1225_018	N/A	R18. Create single integrated view of flow, delays and EDDs.	Need a project scope. Perhaps achievable action within year is to agree a plan against this with Digital team?	Peter Skitt	Jun-26	~~Jun-26~~ N/K	Overdue
NHS Wales Performance and Improvement	HDUHB Winter Sprints Resets Opportunities Assessment	NHSWALESP&I_WS ROA_1225_019	N/A	R19. Move toward 7 day therapy and SDEC services.	Management action to be confirmed by the service	Thomas Alexander	Jun-26	~~Jun-26~~ N/K	Overdue
NHS Wales Performance and Improvement	HDUHB Winter Sprints Resets Opportunities Assessment	NHSWALESP&I_WS ROA_1225_020	N/A	R20. Align medical rota to support weekend discharge planning	Initial meeting to be set up with Carly Hill, as it is not clear who is responsible for this	Peter Skitt	Jun-26	~~Jun-26~~ N/K	Overdue
NHS Wales Performance and Improvement	HDUHB Winter Sprints Resets Opportunities Assessment	NHSWALESP&I_WS ROA_1225_021	N/A	R21. Improve weekend transport/pharmacy alignment	Management action to be confirmed by the service	Peter Skitt	Jun-26	~~Jun-26~~ N/K	Overdue
NHS Wales Performance and Improvement	HDUHB Winter Sprints Resets Opportunities Assessment	NHSWALESP&I_WS ROA_1225_022	N/A	R22. Review therapy workforce model HB wide.	Management action to be confirmed by the service	Sara Quarrie	Jun-26	~~Jun-26~~ N/K	Overdue
NHS Wales Performance and Improvement	HDUHB Winter Sprints Resets Opportunities Assessment	NHSWALESP&I_WS ROA_1225_023	N/A	R23. Align pharmacy and transport processes across both organisations.	Management action to be confirmed by the service	Peter Skitt	Jun-26	~~Jun-26~~ N/K	Overdue
NHS Wales Performance and Improvement	HDUHB Winter Sprints Resets Opportunities Assessment	NHSWALESP&I_WS ROA_1225_024	N/A	R24. Fast track community therapy where safe (Trusted Assessor models).	Management action to be confirmed by the service	Sara Quarrie	Jun-26	~~Jun-26~~ N/K	Overdue
NHS Wales Performance and Improvement	HDUHB Winter Sprints Resets Opportunities Assessment	NHSWALESP&I_WS ROA_1225_025	N/A	R25. HB wide workforce review of HCSW, nursing, therapy, medical	Management action to be confirmed by the service	Daniel Owen	Jun-26	~~Jun-26~~ N/K	Overdue
NHS Wales Performance and Improvement	HDUHB Winter Sprints Resets Opportunities Assessment	NHSWALESP&I_WS ROA_1225_026	N/A	R26. Introduce reserve lists and pooled recruitment.	Management action to be confirmed by the service	Sally Owen	Jun-26	~~Jun-26~~ N/K	Overdue
NHS Wales Performance and Improvement	HDUHB Winter Sprints Resets Opportunities Assessment	NHSWALESP&I_WS ROA_1225_027	N/A	R27. Strengthen IPC workforce for winter resilience.	Management action to be confirmed by the service	Rebecca Richards	Jun-26	~~Jun-26~~ N/K	Overdue
NHS Wales Performance and Improvement	HDUHB Winter Sprints Resets Opportunities Assessment	NHSWALESP&I_WS ROA_1225_029	N/A	R29. Reduce unnecessary patient moves.	Management action to be confirmed by the service	Peter Skitt	Jun-26	~~Jun-26~~ N/K	Overdue
NHS Wales Performance and Improvement	HDUHB Winter Sprints Resets Opportunities Assessment	NHSWALESP&I_WS ROA_1225_030	N/A	R30. Improve repatriation processes.	Management action to be confirmed by the service	Bethan Andrews	Jun-26	~~Jun-26~~ N/K	Overdue
NHS Wales Performance and Improvement	HDUHB Winter Sprints Resets Opportunities Assessment	NHSWALESP&I_WS ROA_1225_031	N/A	R31. Fix paramedic to SDEC pathway with clear referral processes	Management action to be confirmed by the service	David Richards	Jun-26	~~Jun-26~~ N/K	Overdue

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NHS Wales Performance and Improvement	HDUHB Winter Sprints Resets Opportunities Assessment	NHSWALESP&I_WSROA_1225_032	N/A	R32. Introduce GP OOH escalation cards.	Management action to be confirmed by the service	David Richards	Jun-26	~~Jun-26~~ N/K	Overdue
NHS Wales Performance and Improvement	HDUHB Winter Sprints Resets Opportunities Assessment	NHSWALESP&I_WSROA_1225_033	N/A	R33. Expand MIU streamlining capability.	Management action to be confirmed by the service	Vicky Hughes	Jun-26	~~Jun-26~~ N/K	Overdue
Internal Audit	Managed Practices Final Internal Audit Report 2025/26	HDU-2526-25_001	Medium	R1. Inconsistent Risk Management Practices Risk management practices are inconsistent, with practicelevel risk registers are maintained by practices in Carmarthenshire but not by those in Pembrokeshire. The risks on these registers are not recorded on Datix. In addition: • Target scores have not been identified so it is not clear whether the risks are within or above tolerance (and therefore whether further action and/or escalation is required). • In some cases the risk assessment matrix had not been correctly applied to determine the current risk assessment score and RAG rating, which could cause confusion and misinterpretation of the risk significance. • Ashgrove risks had not been reviewed since April 2025	Risks for all MPs will be reviewed, streamlined and captured and managed via the Datix system. All risks will be reviewed and discussed through the Managed Practice IGG QHS meeting escalating as appropriate into the Primary Care CSG IGG QHS meeting.	Anna Swinfield	Mar-26	~~Mar-26~~ ~~Apr-26~~ N/K	Overdue
Internal Audit	Managed Practices Final Internal Audit Report 2025/26	HDU-2526-25_002	Medium	R2. Risk Monitoring & Reporting Risk a standing agenda item for the Managed Practices Integrated Governance Group meetings and there is evidence of discussion of a specific risk (Tenby Surgery water ingress). However, risk registers (Datix or otherwise) have not been presented and discussed.	The individual MP risk register will be presented and discussed at each Managed Practice IGG meeting. Managed Practices will be reminded that they are responsible for their individual Practice risk monitoring and reporting.	Anna Swinfield	Mar-26	~~Mar-26~~ ~~Apr-26~~ N/K	Overdue
Internal Audit	Managed Practices Final Internal Audit Report 2025/26	HDU-2526-25_003	High	R3. Budget Setting Budgets are based on historic GMS contract allocations at the point of becoming a managed practice, in some cases many years ago, and are therefore require review and updating to reflect actual requirements. Workforce establishment reviews were ongoing at the time of audit with an anticipated completion date of March 2026.	Managed practice budgets will be reviewed and updated where appropriate to achieve better alignment with GMS contract funding arrangements, and incorporate the outcomes of the ongoing workforce establishment reviews.	Anna Swinfield	Jun-26	~~Jun-26~~ Sep-26	Overdue
Internal Audit	Managed Practices Final Internal Audit Report 2025/26	HDU-2526-25_004	Medium	R4. Complaints Registers We were unable to confirm whether complaints registers are maintained for Ashgrove, Penrhyn or Neyland practices. The registers maintained by Minafon, Sarn and Tenby do not follow a consistent format – the registers used in Minafon and Sarn are more comprehensive. Complaints received and managed by the practices are not graded in line with Putting Things Right guidance.	A standard template will be issued to managed practices for recording complaints received by the practice. All formal complaints will be captured on Datix to ensure there is appropriate oversight and support provided (where required) to ensure that the complaint is managed and responded to in accordance with the PTR regulations. All complaints will be reviewed by the Managed Practice IGG QHS meeting	Anna Swinfield	Mar-26	~~Mar-26~~ N/K	Overdue
Audit Wales	Review of the Management of Outpatients	AW_RMO_0226_001a	N/A	R1. The Health Board should develop a longer-term outpatient plan to address current and future service challenges. The Health Board should ensure the plan is: • aligned with its long-term strategy and enabling plans such as digital and estates; • based on current and projected future demand for services; • costed, at minimum for the medium term (3-5 years); • supported by resource plans i.e. financial, workforce and infrastructure; • supported by clear delivery actions and milestones; and • approved by the Board.	The Care group will consolidate all key work to date. A full review of available estate will be scoped in line with longer term Clinical Service strategy and fragile services delivery working in collaboration with our estates and capital departments.	Lisa Humphrey	Jun-26	~~Jun-26~~ N/K	Overdue

Report Issued By	Report Title	Recommendation Reference	Priority Level	Recommendation	Management Response	Recommendation Owner	Original Completion Date	Revised Completion Date	Status Category
Audit Wales	Review of the Management of Outpatients	AW_RMO_0226_001 b	N/A	R1. The Health Board should develop a longer-term outpatient plan to address current and future service challenges. The Health Board should ensure the plan is: • aligned with its long-term strategy and enabling plans such as digital and estates; • based on current and projected future demand for services; • costed, at minimum for the medium term (3-5 years); • supported by resource plans i.e. financial, workforce and infrastructure; • supported by clear delivery actions and milestones; and • approved by the Board.	Future delivery is dependent on the outcome of the HDUHB strategy objectives and the Clinical Service Planning (CSP) outcomes	Lisa Humphrey	Jun-26	~~Jun-26~~ N/K	Overdue
Audit Wales	Review of the Management of Outpatients	AW_RMO_0226_001 c	N/A	R1. The Health Board should develop a longer-term outpatient plan to address current and future service challenges. The Health Board should ensure the plan is: • aligned with its long-term strategy and enabling plans such as digital and estates; • based on current and projected future demand for services; • costed, at minimum for the medium term (3-5 years); • supported by resource plans i.e. financial, workforce and infrastructure; • supported by clear delivery actions and milestones; and • approved by the Board.	Initial costings will be worked on to include estates work needed and co- dependant recruitment of skilled staff.	Lisa Humphrey	Jun-26	~~Jun-26~~ N/K	Overdue
Audit Wales	Review of the Management of Outpatients	AW_RMO_0226_001 d	N/A	R1. The Health Board should develop a longer-term outpatient plan to address current and future service challenges. The Health Board should ensure the plan is: • aligned with its long-term strategy and enabling plans such as digital and estates; • based on current and projected future demand for services; • costed, at minimum for the medium term (3-5 years); • supported by resource plans i.e. financial, workforce and infrastructure; • supported by clear delivery actions and milestones; and • approved by the Board.	OPD workforce plan is currently looking at different models of care to support our population. This is being led by the Nursing team. This would include extended roles, staff working to top of their licence, increasing training opportunities, specialist skills. This includes nursing support staff such as Health Care Support Workers.	James Sheldon	Jun-26	~~Jun-26~~ N/K	Overdue
Audit Wales	Review of the Management of Outpatients	AW_RMO_0226_001 e	N/A	R1. The Health Board should develop a longer-term outpatient plan to address current and future service challenges. The Health Board should ensure the plan is: • aligned with its long-term strategy and enabling plans such as digital and estates; • based on current and projected future demand for services; • costed, at minimum for the medium term (3-5 years); • supported by resource plans i.e. financial, workforce and infrastructure; • supported by clear delivery actions and milestones; and • approved by the Board.	Capacity and demand planning will underpin required models of OPD delivery including use of digital technology and WG mandated use of CIN pathways	James Sheldon	Jun-26	~~Jun-26~~ N/K	Overdue
Audit Wales	Review of the Management of Outpatients	AW_RMO_0226_001 g	N/A	R1. The Health Board should develop a longer-term outpatient plan to address current and future service challenges. The Health Board should ensure the plan is: • aligned with its long-term strategy and enabling plans such as digital and estates; • based on current and projected future demand for services; • costed, at minimum for the medium term (3-5 years); • supported by resource plans i.e. financial, workforce and infrastructure; • supported by clear delivery actions and milestones; and • approved by the Board.	Workforce training needs analysis completed and initiated	James Sheldon	Jun-26	~~Jun-26~~ N/K	Overdue