Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Quality and Safety Assurance Report

Quality, Safety and Experience Committee

August 2026

Situation

The purpose of this report is to provide the Quality, Safety and Experience Committee with assurance regarding the effectiveness of the Health Board's Quality Management System by:

- identifying emerging risks and variation
- reviewing the effectiveness of quality controls
- understanding learning from incidents, concerns, complaints and regulatory activity
- monitoring improvement actions and trajectories
- seeking assurance that learning is translated into sustainable improvement.

Appendices to this report

- Quality Management System Strategic Framework - refresh
- HIW Improvement Actions – overdue

QMS Strategic Framework refresh — July 2026

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Refresh to the Board-approved March 2023 framework

The QMS remains the formal system for planning, controlling, improving and assuring quality. The 2026 update strengthens ward-to-Board line of sight, with sharper focus on outcomes, value and demonstrable impact.

2023 — Board-approved framework

2026 — Updated position

2029 — Embedded QMS discipline

Core test

Does the system improve outcomes, experience, equity, reliability and value — not just governance process?

What the refresh adds

- Duty of Quality live: decisions, learning and accountability
- Outcomes and value set QMS priorities
- Ward-to-Board line of sight: CCGs → QSIG → QSEC → Board
- QISF 2026–2029 targets improvement to risks and priorities
- Standard reports: data, learning, action, trajectory and gaps
- Closed-loop evidence for harm, complaints, HIW/PSOW and fragile services

The updated QMS Strategic Framework is attached as appendix 1

Common QMS logic

Standards & outcomes → **Data &** feedback → **Learning** → **Improvement** action → **Impact &** assurance

Patient Safety Incidents

Diogel Safe

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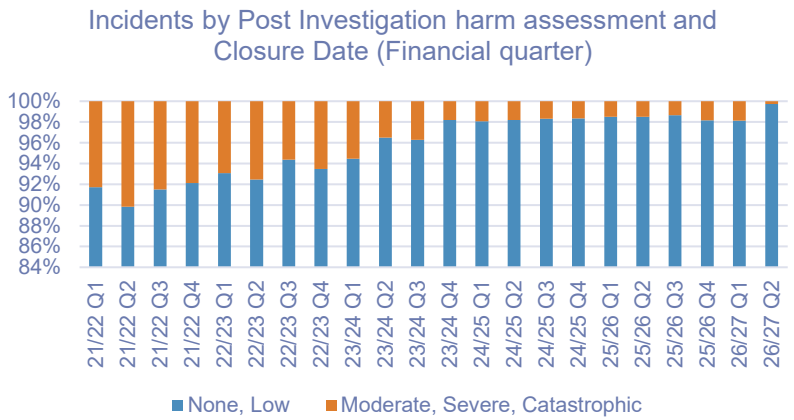
There were 15,202 incidents reported on Datix Cymru in Hywel Dda UHB between 01/07/2025 to 30/06/2026. Of these, 12,152 were Patient Safety Incidents.

Of the 12, 016 patient safety incidents reported, 9,339 have been closed. 96 (1.0%) were closed as moderate, severe or catastrophic harm.



A review, using the support of AI, identified the main themes, within the lessons learned of patient safety incidents closed in quarter 1 2026/27 were:

Rank	Theme	Count	Recommended improvement action
1	Documentation & accurate clinical records	688	Standardise documentation audits and feedback by service.
2	Risk assessment, care planning & reassessment	676	Mandate dynamic risk/care-plan review after deterioration, transfer, fall, pressure damage, or change in condition.
3	Communication, handover, escalation & pathways	336	Introduce reliable handover/escalation checks for discharge, transfer, referrals and follow-up.
4	Medicines, prescribing, discharge & vaccination safety	254	Strengthen prescribing, medicines reconciliation, repeat-medication and vaccine guidance checks.
5	Staff education, policy & competency	191	Target training to recurring gaps, with evidence of completion and assurance testing.

1 Standard

Patient safety incidents are reported, reviewed, closed and converted into learning that strengthens controls.

2 Data

15,202 Datix incidents; 12,152 patient safety incidents; 9,339 closed; 96 closed moderate+ harm.

3 Learning

Main themes: documentation, risk reassessment, handover / escalation, medicines and staff education.

4 Action

CCGs receive top themes and will set improvement plans with owners, deadlines and assurance evidence.

Clinical Care Group themes in lessons learned and recommended improvement actions – Incidents closed Q1 2026/27

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Each Clinical Care Group has been provided with the top three lessons learned themes for incidents allocated to their area of responsibility. Each CCG was asked to consider a focused improvement plan with monthly assurance reporting

Operational Allied Health and Health Science

- diagnostic turnaround
- referral/follow-up tracking
- documentation retrieval
- clearer escalation between services.

Mental Health and Learning Disabilities

- timely Datix/safeguarding recording,
- quality of risk/care-plan reviews,
- clear escalation pathways

Primary Care

- prescribing controls
- vaccine guidance updates
- repeat-medication checks
- clearer communication/documentation with practices and partner services

Community and Integrated Medicine

- Dynamic risk reassessment
- Documentation quality audits
- Safer handover/escalation processes

Planned and Specialist Care

- documentation accuracy,
- discharge/transfer handover reliability,
- risk review before procedures or discharge

Source: Datix listing report run on incidents closed between 01/04/2026 and 30/06/2026.

Quality Assurance & Safety Team

7 Minute Patient Safety Briefing

Patient Safety Incidents closed during Q1 2026

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Background

The purpose of this 7-minute briefing is to bring to you some of the learning themes through patient safety incidents closed in quarter 1 2026/27

7 MINUTE SAFETY BRIEFING

1. Documentation
2. Reassess the risks
3. Escalation
4. Communication
5. Medicines & Discharge
6. Policies & Prompts
7. Reflection

Organisational lessons briefing template

Capture the learning, improvement response and reflection in one seven-minute discussion.

1 Document clearly and promptly

Consider: Would another staff member understand the care, decision, and next step from my record?

2 Reassess risk when things change

Consider: Has the patient's condition, mobility, environment, medication, or care setting changed

3 Escalate early when concerned

Consider: If I am worried, have I escalated and documented who I informed?

4 Close the communication loop

Consider: Has the receiving person/team understood and accepted responsibility for the next action?

5 Check medicines & discharge details carefully

Consider: Are medicines, allergies, prescriptions, discharge letters & safety-netting complete before the patient leaves?

6 Use policies & prompts, not memory alone

Consider: Have I followed the relevant checklist, pathway, guideline or assessment tool?

7 Reflect and share learning

Consider: What adverse event have I witnessed? Did I report it via Datix Cymru to ensure that the learning is considered and captured? What could I do differently next time, and have I shared that learning with my team?

Learning from near misses and incidents is important.
Please report any adverse event via Datix Cymru

Nationally Reportable Incidents (NRIs)

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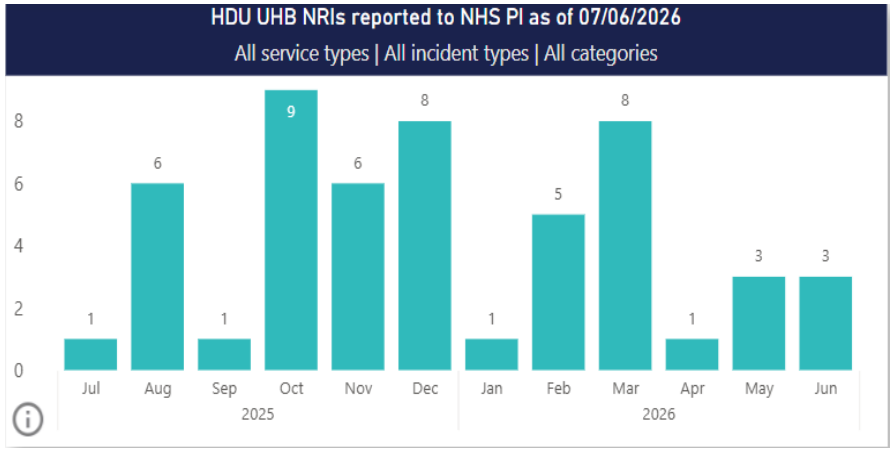
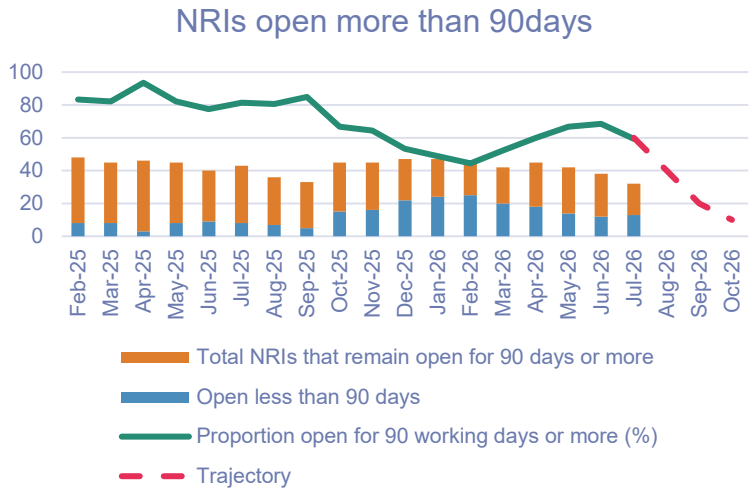
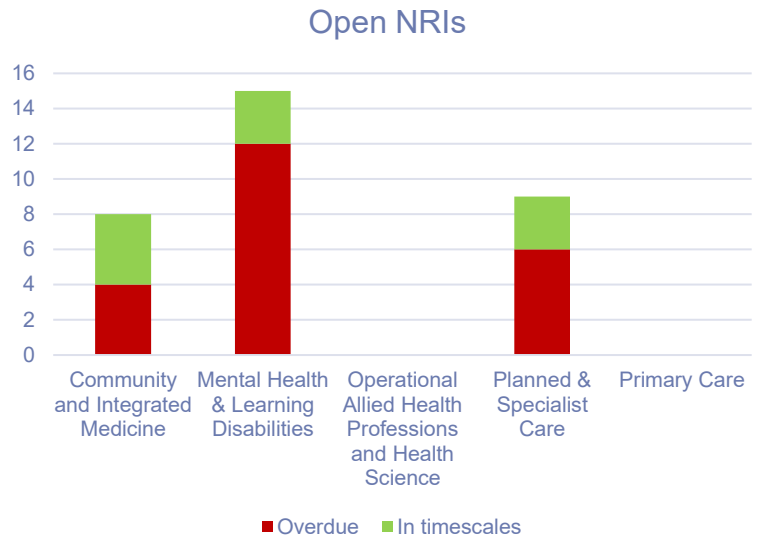
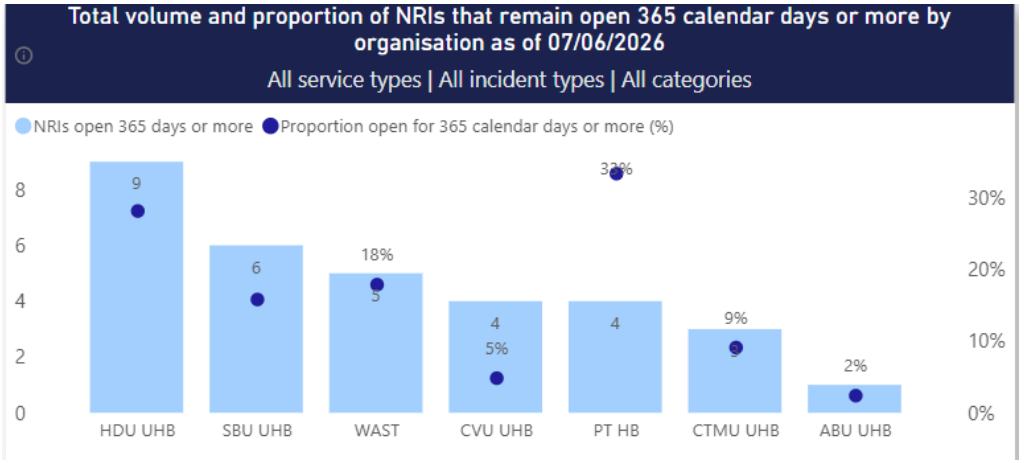






Source: Beacon Dashboard
12/07/2026

Source: Datix Cymru 06/07/2026



Note NHS P&I have changed this to open more than 365 days and we are clearly an outlier

Number of days since reporting to NHS Wales Performance and Improvement

	0-60days	61-90days	91-120days	121-180days	>180days	Total
Community and Integrated Medicine	2	1	1	1	3	8
Mental Health & Learning Disabilities	1	4	1	1	9	16
Operational Allied Health Professions and Health Science	0	0	0	0	0	0
Planned & Specialist Care	3	2	0	2	1	8
Primary Care	0	0	0	0	0	0
Totals	6	7	2	4	13	32

Never Events

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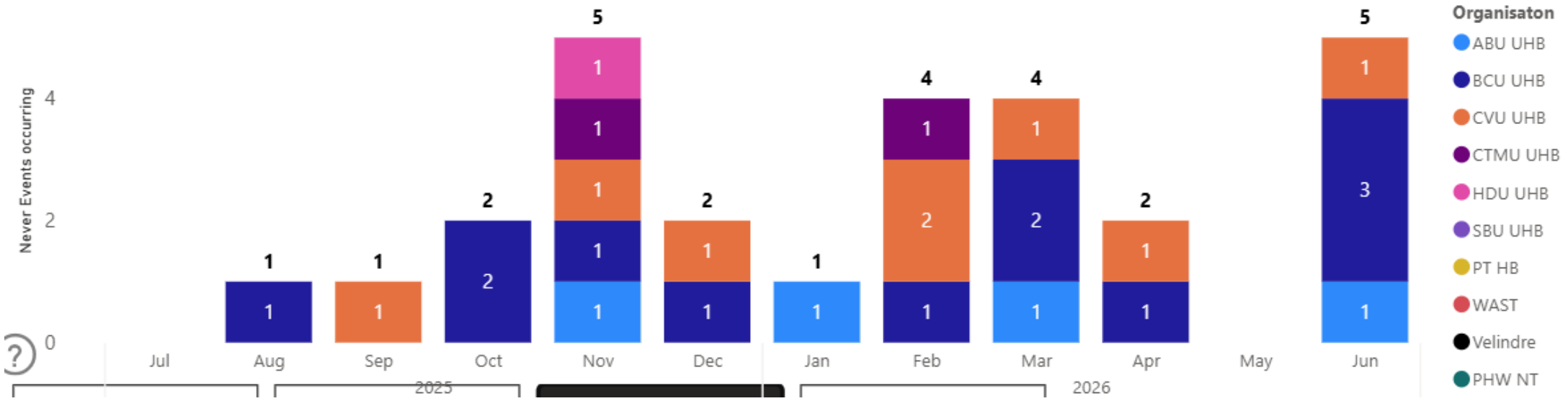
HDU UHB Never Events occuring (by incident date, Jul-25 to Jun-26) as of 07/06/2026

Year	2025						2026					
Never Event	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Retained foreign object post procedure	0	0	0	0	1	0	0	0	0	0	0	0
Total Never Events	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Source: Beacon Dashboard 12/07/2026

All Wales Never Events reported to NHS PI (Jul-25 to Jun-26) as of 07/06/2026



Top themes in lessons learned and recommended improvement actions – NRIs closed Q4 2025/26 and Q1 2026/27

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Rank	Top theme	Incidents matched	Evidence / examples	Recommended improvement actions
1	Communication, handover and cross-service coordination	28 of 38	Recurring gaps in discharge communication, referral follow-up, MDT/cross-service working, GP/community pharmacy links, family/carer communication and closed-loop updates. Example IDs: 85672, 45597, 48762, 50255, 58183.	Implement a standard SBAR-style handover/referral/discharge template; require closed-loop confirmation for high-risk referrals, discharge medication changes and incidental findings; ensure family/carer concerns are listened to, documented and signposted; audit compliance monthly by service area.
2	Timely escalation, reassessment and risk recognition	24 of 38	Lessons repeatedly cite delayed escalation, missed red flags, failure to reassess deterioration, abnormal CTG/imaging/lab findings, syncope, sepsis, failure to mobilise, and mental health risk. Example IDs: 85672, 45597, 48762, 50255, 58183.	Define explicit red-flag escalation triggers and senior review timeframes for high-risk pathways; introduce “reassess if not improving” prompts; embed stop-if-in-doubt rules for safety-critical procedures; run scenario-based training on escalation and diagnostic vigilance.
3	Documentation, records and care planning	24 of 38	Common learning includes incomplete clinical reasoning, missing discharge letters, weak care plans/CTPs/WARRNs, undocumented MDT decisions, unclear data entry and insufficient evidence of concerns raised. Example IDs: 85672, 45597, 50255, 58183, 58427.	Mandate documentation of clinical reasoning, risk formulation, escalation decisions and patient/family discussions; standardise discharge checklists and care-plan updates; use electronic prompts for mandatory fields; include record-keeping quality in governance audits and feedback.

1 Standard

NRIs and Never Events are reported promptly, investigated to required standards, closed within timescales and used to reduce recurrence.

2 Data

32 open NRIs: 13 open >180 days. 1 Never Event. 38 closed NRIs reviewed; 35% deemed avoidable.

3 Learning

Themes: communication, escalation, reassessment and documentation.

4 Action

Prioritise NRI recovery and cross-service controls for handover, red flags and documentation assurance.

Source: Datix listing report run on NRIs including never events closed with NHS P&I between 01/01/2026 and 30/06/2026. 38 incidents included. Incidents can map to more than one theme.

Inquests and Regulation 28

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HDU UHB Regulation 28 - Prevention of Future Death Reports from Feb-26 to Jul-26 - related reports selected

Report Category	Link	Reports
Child Death (from 2015)		**1**
HDUHB		**1**
Report date: 27/02/2026 Ref: (2026-0118)		1
Wales prevention of future deaths reports (2019 onwards)		**1**
HDUHB		**1**
Report date: 27/02/2026 Ref: (2026-0118)		1
Total		**1**

Source: Beacon Dashboard 12/07/2026

All Wales Regulation 28 - Prevention of Future Death Reports since 2022 - all categories of report (as of 10/07/2026)

Date of report	Ref	Report link	ABU	BCU	CVU	CTM	HDU	SBU	PT	WAST	Welsh Gov.	Velindre	PHW	Total org.
06/03/2026	2026-0131													1
27/02/2026	2026-0118													8
05/02/2026	2026-0063													2
04/02/2026	2026-0055													1
02/02/2026	2026-0050													1
13/01/2026	2026-0016													1
16/12/2025	2025-0628													1
24/10/2025	2025-0538													1
06/10/2025	2025-0492													2
12/09/2025	2025-0464													1
02/09/2025	2025-0445													1
31/07/2025	2025-0394													1
28/07/2025	2025-0384													1
22/07/2025	2025-0370													1
22/07/2025	2025-0373													1
21/05/2025	2025-0236													1
21/05/2025	2025-0238													1
21/05/2025	2025-0240													1
11/04/2025	2025-0189													1
19/03/2025	2025-0153													1
17/03/2025	2025-0145													1
07/03/2025	2025-0127													1
06/03/2025	2025-0126													1
24/02/2025	2025-0105													1
Total			**40**	**64**	**28**	**28**	**7**	**13**	**6**	**46**	**14**	**2**		**10**

Report Key

Report sent to single health board/trust:

Report sent to multiple health boards/trusts:

[Prevention of Future Death Reports Archive - Courts and Tribunals Judiciary]

Health Board Overview: Complaints Management

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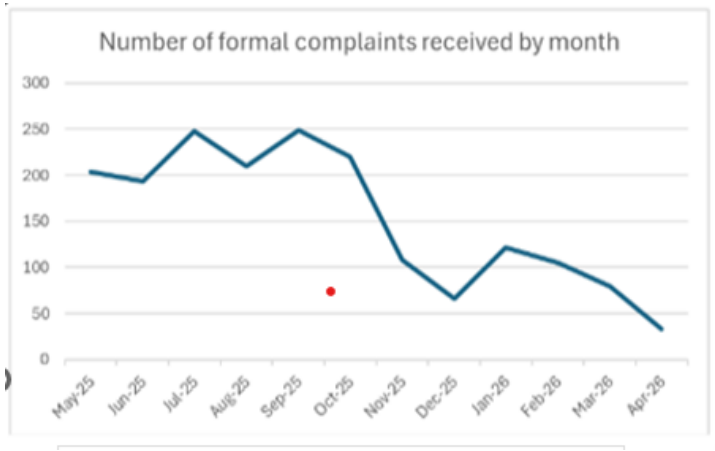

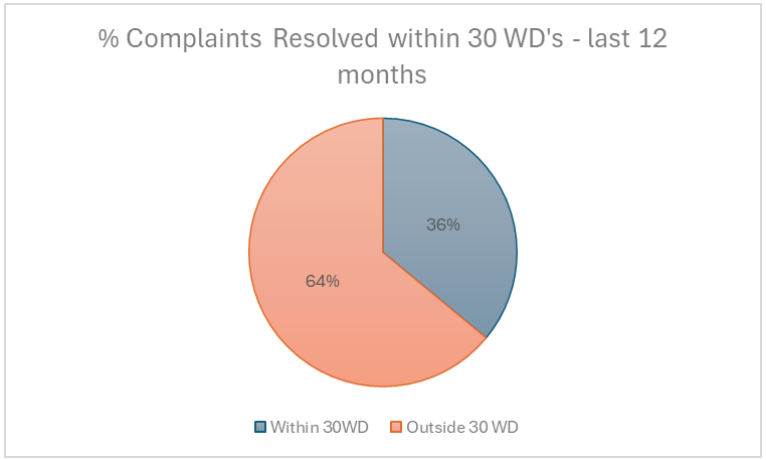

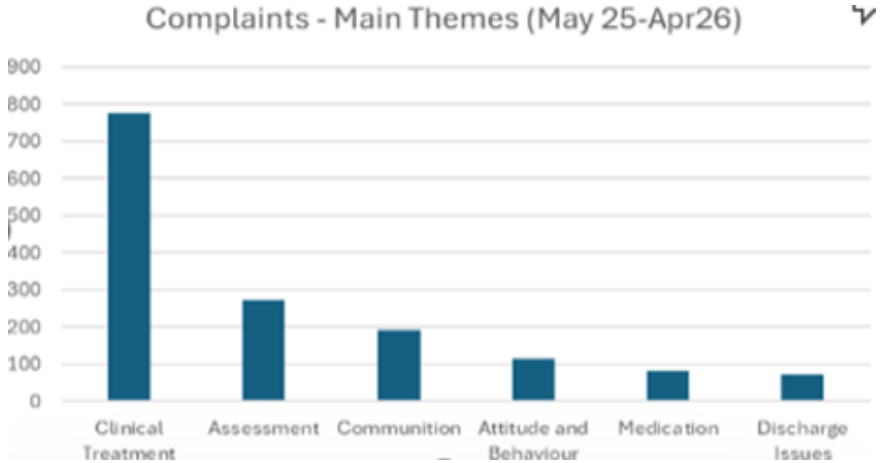

The main reason giving rise to complaints remain consistent, with clinical treatment, appointments/ waiting times, communication and behaviour being the main themes.

The reduction in the overall number of complaints received reflects the drive towards early resolution, especially since the beginning of 2026 where there was an increased focus on early resolution in anticipation of the new 'Listening to People' complaint regulations. Since coming into effect in April, Patient Support Services are resolving as much as possible through early resolution or other appropriate pathways, so that proportionate and formal investigation is reserved for those cases where a detailed review is most needed.

Health Board Overview: Outcomes and Closure Trajectory

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In the last 12 months, 52 cases have been escalated to Redress due to failings in care that may have caused harm to patients. Listen from Events (LfE) reports are produced following these events.

Both cases fully upheld by the Ombudsman in the year 2025/26 were issued as Public Interest reports. Although there were 13 new investigations started by the Ombudsman, there were also 84 decisions not to investigate.

Since the start of April 2026, there is closer working between the Patient Safet and Complaints Teams in terms of triaging new concerns (incidents and complaints) and analysing themes of clinical and service issues across the Health Board.

Reducing backlog of Putting Things Right (PTR) complaints

The closure of the remaining low-level PTR complaints has been successful and close to trajectory with only 8 complaints left to close. For more complex complaints, we are currently running a few weeks behind schedule, although it is likely that by the time we reach the end of June target marker (144 cases remaining), we will be very close to realigning with the trajectory (projection is that we will have 175 cases open under PTR by end of June). Any cases that are delayed without explanation are being grouped by service and escalate to Directors for support.

Update of Listening to People (LTP)

From our first full month's data on LTP, the uptake of listening discussion has been fairly low. DatixCymru is being modified on an all-Wales basis to better capture reporting fields linked to LTP.

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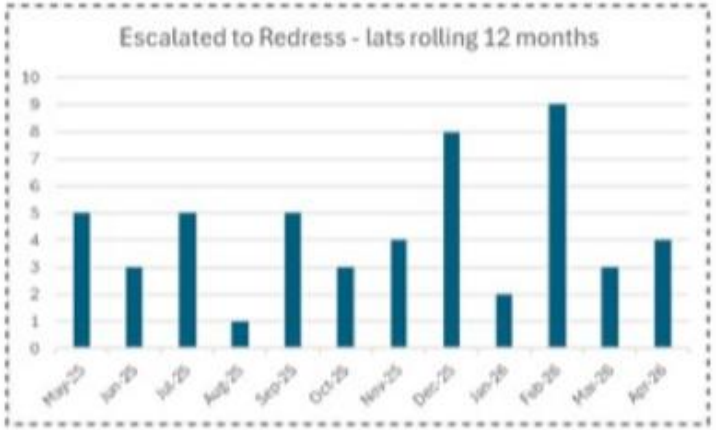

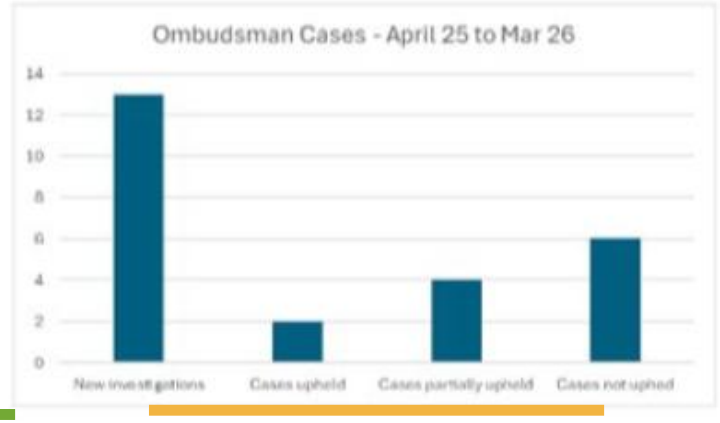

1 Standard

Complaints are triaged and resolved under PTR / LTP, with redress and learning where harm may have occurred.

2 Data

Complaints reducing; 36% closed within 30WD. Main themes: clinical treatment, assessment, communication. 52 redress; 8 PTR left.

3 Learning

Early resolution improving; clinical, waiting-time and communication themes still drive concerns.

4 Action

Sustain early resolution, improve LTP capture, close PTR backlog and triangulate complaints, incidents and redress.

People's Experience Feedback

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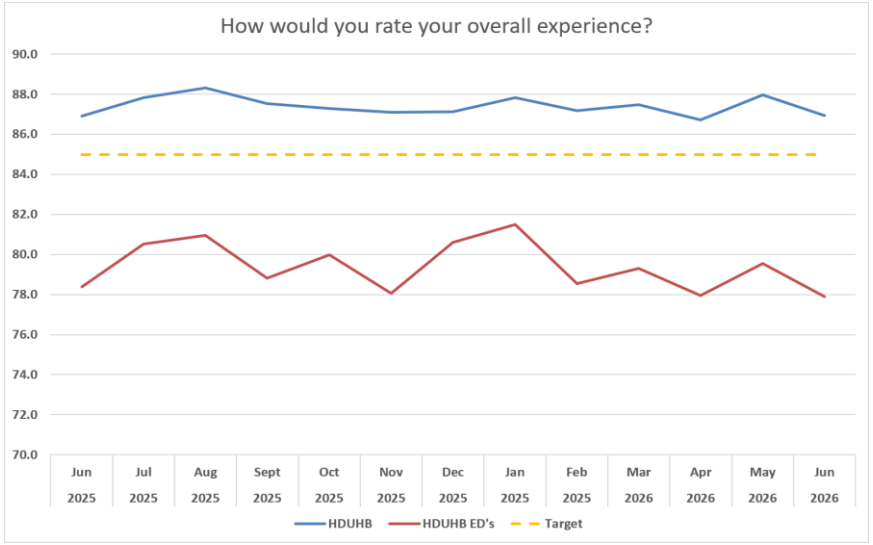

Measure name	Jun-26 Actual %
I am treated with dignity and respect	83.90%
Things were explained to me in a way I could understand	89.10%
I was able to communicate in my preferred language	95.70%

- **Across both Emergency Department and Manin Health Board datasets there is strong consistency in what drives a positive experience, Staff Attitude and Compassion, Feeling Well Cared For, clear communication and feeling listened to and Efficient Services.**
- **Services continue to achieve very high levels of patient satisfaction, with almost 9 in 10 patients reporting a positive experience.**
- **Emergency Department feedback remains positive overall but is significantly affected by waiting times and communication challenges. These arears are typically 11% points lower than other services**
- **A small number of mental health and community specialties recorded notably higher proportions of negative responses in experience data. Numbers are relatively small, so these should be interpreted cautiously, but they may warrant local review.**
- **Waiting times are the most prominent source of dissatisfaction across all feedback and remain the single biggest factor depressing patient experience scores.**
- **Hospital parking and access arrangements continued to be a recurring theme, contributing to stress before appointments and treatment.**
- **The most significant opportunities for improvement in patient experience relate to reducing waits, keeping patients informed and improving appointment and access arrangements.**

1 Standard

Patient experience feedback is captured, themed and used to improve communication, compassion and care environment.

2 Data

Feedback values compassion, clear communication and teamwork; challenges focus on ED waits, environment and updates.

3 Learning

Patients feel reassured by empathy and clarity; waits, discomfort and poor updates increase anxiety.

4 Action

Strengthen updates during waits, improve waiting environments and share feedback themes with teams for action.

Infection Prevention and Control (IP&C): Strategic Overview

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Quality Planning

- An organisational improvement plan for 2026/27 was presented to the Infection Prevention Strategic Steering Group (IPSSG) on 02/06/2026, providing strategic direction and oversight for delivery.
- An annual IP&C team workplan is in place to support delivery of agreed infection prevention and control priorities.
- Collaborative planning is in place with Public Health, with engagement across primary care and community services to reduce infection risk in high-risk populations.
- Self-assessment is underway against the Quality Statement for Infection Prevention and Control, the Welsh Health Circular antimicrobial resistance and healthcare-acquired infection improvement goals 2025-2027, and the NHS Wales National Standards of Healthcare Cleanliness 2025.

Quality Control

- Governance and scrutiny routes are being standardised.
- Reporting through Clinical Care Groups and IPSSG structures is established.
- Policies are under review, aligned to All-Wales policy and the National Infection Prevention and Control Manual.
- Self-assessment against the C. difficile framework is underway.
- Surveillance data are reviewed against reduction expectations through safety dashboards.
- Antimicrobial stewardship compliance is reviewed across acute sites.

Quality Improvement

- Learning from hospital-onset and healthcare-acquired infection reviews is translated into action plans and thematic learning.
- Managed practices are supported through infection learning summaries.
- Environmental and observational audits have been reinstated in high-risk areas, with action tracking through AMaTS.
- Synbiotix scores are reviewed alongside the audit programme.
- Hydrogen peroxide vapour (HPV) decontamination is deployed across four acute sites.
- The 2026/27 training model shifts level 2 training to e-learning with targeted local delivery for emerging risks.
- Engagement in the national C. difficile learning collaborative continues and IV-to-oral switch work are progressing with Clinical Care Group ownership.

IP&C Strategic Overview continued

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Quality Assurance

The programme is supported by established plans and governance routes, self-assessment against national standards, policy review, audit and surveillance mechanisms, antimicrobial stewardship oversight, and a defined 2026/27 improvement workplan (see appendix), providing a clear framework for ongoing assurance and monitored delivery.

Performance de-escalation summary

Latest position key

- Goal achieved
- Making good progress towards goal
- Minimal progress made or decline from previous month
- Same as baseline or worse

	Measure	De-escalation criteria	Baseline	Baseline	Goal	Mar-26	Apr-26	May-26	Jun-26
Infections	Number of laboratory confirmed C.difficile cases with hospital onset	25% reduction, maintained for 3 months	8	Baseline (average Q3 23/24)	6	1	8	7	9
	Number of laboratory confirmed S.aureus bacteramia cases with hospital onset	33% reduction, maintained for 3 months	3	Baseline (average Q3 23/24)	2	4	5	3	4
	Number of laboratory confirmed E.coli bacteramia cases with hospital onset	25% reduction, maintained for 3 months	7	Baseline (average Q3 23/24)	5	4	5	6	6

All CCGs to review progress against the HB Safety Dashboard

Review of monthly data from Hospital Antibiotic Review Programme (HARP) with internal HB analysis and scrutiny

Aseptic Non-Touch Technique (ANTT) training 85.04% compliance

Level 2 mandatory training at 86.76%, some staff groups significantly lower

IP&C overall trend

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Table 1. Current FY rate per 1,000 hospital admissions of specimens by HB, Apr - Jun 26

Additional filters for Table 1.

Select month or FY: Current FY

Select organism group: All organisms

- < than same period last FY
- = same period last FY
- > than same period last FY

	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Aneurin Bevan UHB	1.78	0.21	1.49	3.41	1.03	0.25
Betsi Cadwaladr UHB	3.29	0.18	2.84	5.86	1.58	0.36
Cardiff and Vale UHB	2.86	0.27	2.2	5.13	1.53	0.47
Cwm Taf Morgannwg UHB	2.83	0.14	1.52	5.51	1.93	0.48
Hywel Dda UHB	3.27	0.14	2.2	6.18	1.28	0.14
Powys THB	17.75	0	0	5.92	0	0
Swansea Bay UHB	5.12	0.2	1.38	4.14	2.43	0.46
Velindre NHST	1.17	0	1.17	4.68	2.34	0
Wales	**3.06**	**0.19**	**1.93**	**4.88**	**1.56**	**0.34**

Table 1. Current FY count of specimens by HB, Apr - Jun 26

Additional filters for Table 1.

Select month or FY: Current FY

Select organism group: All organisms

- < than same period last FY
- = same period last FY
- > than same period last FY

	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Aneurin Bevan UHB	50	6	42	96	29	7
Betsi Cadwaladr UHB	73	4	63	130	35	8
Cardiff and Vale UHB	43	4	33	77	23	7
Cwm Taf Morgannwg UHB	41	2	22	80	28	7
Hywel Dda UHB	46	2	31	87	18	2
Powys THB	6	0	0	2	0	0
Swansea Bay UHB	78	3	21	63	37	7
Velindre NHST	1	0	1	4	2	0
Wales	**338**	**21**	**213**	**539**	**172**	**38**

IP&C Outbreaks / Incidents

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June/ July 2026 -

Site	Ward	Pathogen	Impact
PPH	Bryngolau	Scabies	9/06/26 to 17/06/26. 2 patients and 1 staff member. Classic scabies. Mix of Permethrin and Ivermectin used.
GGH	Derwen	Norovirus	26/06/26 to 30/06/26. 1 patient and 2 Staff
GGH	Steffan and bay CDU	Scabies (Norwegian)	06/07/26 declared. Affecting 1 patient admitted in May, discharged to a care home and returned into CDU in July, transferred to Steffan. 8 blocked beds. Whole ward treatment advised. Ivermectin required for patient and staff treatment which presented challenges in prescribing.
GGH	Cadog	Scabies	10/07/26 declared. 3 patients and 2 staff. 2 blocked beds.

Incidents

- Due to increased prevalence in the Hywel Dda region Scabies is becoming more challenging to manage. Further work is required to define pathways for treatment and review.
- Stenotrophomonas Maltophilia colonisation on Intensive Therapy Unit (ITU) GGH- review ongoing due to 1 case in May 2026
- Verona Integron-Encoded Metallo (VIM), Pseudomonas aeruginosa (PA) and Vancomycin-Resistant Enterococci (VRE) on Derwen Ward- monitoring and surveillance ongoing
- 11th August changes to transmission-based precautions (TBPs) will take place. Transmission routes will be contact and air. The impact to the HB should be minimal and Health and Safety have been briefed due to the FFP3 fit testing element.

Outbreaks Lessons Learnt

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Theme	Lesson Learnt
Early Identification & Isolation	Improve early identification and isolation of symptomatic patients at entry points to prevent bay-level spread. Relaunch on TBPs aligned to the NICPM will strengthen this.
Care-Home Admission Identification (due to high levels of transmission in closed settings)	Ensure early recognition of care-home residents to trigger risk-based isolation/testing pathways. Strengthen comms from the integrated IPC team in Public health to acute.
Staff Sickness & Attendance	Reinforce “do not attend work when unwell” for staff, with clear sickness reporting lines. Factor in scabies outbreaks
Testing	Ensure staff request the correct tests in a timely manner and IPC precautions are implemented
Handover & Result Tracking	Improve clinical ownership of symptom tracking and test result follow-up.
Training	Improve staff understanding and awareness around treatment and management through opportunistic/ targeted training. In May and June targeted scabies awareness training was provided.

IP&C C. difficile infection

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

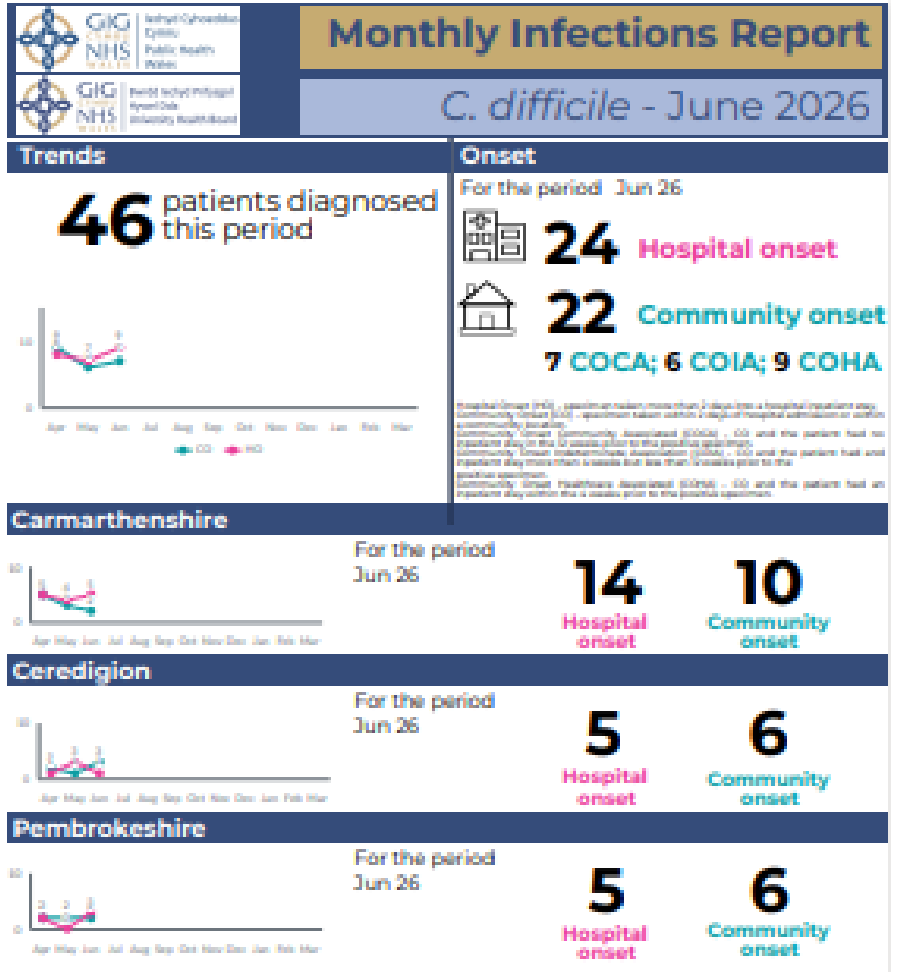
Improvement Goal: To reduce the overall burden of C. diff infection by at least 25% against the 2024-25 counts

Table 2. Monthly count and rate of C. difficile in Hywel Dda UHB, 2026/27

Additional filters for Table 2.
Select FY: 2026/27

*Community onset (CO) - specimen taken in a community location or less than 3 days into a hospital inpatient stay

	Total count	CO* count	HO** count	% HO***	Total rate per 1,000 hospital admissions	Total rate per 100,000 population
2026/27	46	22	24	52%	3.27	47.41
April 2026	17	9	8	47%	3.32	53.15
May 2026	13	6	7	54%	2.54	39.33
June 2026	16	7	9	56%	4.17	50.02



- The Welsh Health Circular relating to Antimicrobial resistance and Healthcare Associated infections 2025 to 2027 sets an improvement goal: to reduce the overall burden of C. diff infection by at least 25% against the 2024-25 counts. There were 184 cases of C.difficile in 2024/25 FY, for 2026/27 Financial Year the Health Board would need to achieve 138 cases or less to meet the improvement goal.
- All hospital onset infections or those likely to be healthcare associated are currently incident reported and discussed at the Healthcare Acquired Infection Assurance Group Meetings for each site, with key learning shared.
- Attendance at these meetings is variable and stood down due to operational pressures
- EPMA will be piloted in July and this will provide stronger antimicrobial stewardship for clinicians.

Genomically and epidemiologically linked clusters identified during reporting period (June 2026)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

During the reporting period, several genomically and epidemiologically linked C. difficile clusters were found across Hywel Dda University Health Board sites. These clusters are episodes where cross-infection could not be excluded, based on whole genome sequencing, overlapping ward exposure, or shared environmental links.

- **Bronglais General Hospital:** 0 clusters identified.
- **Prince Philip Hospital:** 0 clusters identified.
- **Glangwili General Hospital:** 5 clusters identified:
    - Steffan (closed)
    - Teifi (closed)
    - Preseli (closed)
    - Preseli (re-opened)
    - Padarn (open)
- **Withybush General Hospital:** 3 clusters identified:
    - Ward 4 (closed)
    - Ward 12 (open)
    - Ward 10 (open)
- **Community Hospitals:** 1 cluster identified at Amman Valley Hospital (closed).

Patterns observed reinforce the importance of:

- Managing patient movement and prolonged admissions
- Maintaining environmental cleaning standards, especially in high-turnover areas
- Ongoing vigilance in acute and assessment units
- Recognising the interface between acute, community and care-home settings

Learning identified

1. Most clusters are small

The identified clusters generally involve only 2–4 linked patients rather than large ward outbreaks, suggesting transmission events are being detected early.

2. Patient movement remains a recurring risk

Several clusters involved patients moving between:

- acute wards,
- assessment units,
- community hospitals,
- and primary care settings.

This reinforces your existing learning point about the importance of managing patient flow and cross-setting transmission.

C. difficile infection: Learning identified and actions

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Learning Identified	Recommendations for the CCGs
Mattress cleaning: Ensure consistent, documented cleaning and decontamination	• Monthly mattress audits for wards/ departments • Mattress checking on discharge reinforced in line with decontamination and mattress cleaning policy
Hydrogen Peroxide Vapour (HPV) deep cleaning: Ensure HPV is used for all required deep cleans regardless of patient flow pressures.	• Trigger HPV decontamination in all required scenarios, even during operational pressures. • Non-compliance to be reported
Commode cleaning: Lack of assurance commodes have been cleaned and dirty commodes found in clinical areas.	• The Infection Prevention Indicator Audits (IPIAs) have recently been completed for ward areas and are being diseminated. Meetings and action plans will be required to address findings.

PREVENT C. DIFF
PROTECT PATIENTS

The national Prevent C. diff staff-facing campaign has been shared across the organisation with comms support. The campaign has also been included in CCG update reports.

IP&C E. coli bacteraemia

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Table 2. Monthly count and rate of E. coli bacteraemia in Hywel Dda UHB, 2026/27

Additional filters for Table 2.
Select FY: 2026/27

*Community onset (CO) - specimen taken in a community location or less than 3 days into a hospital inpatient stay

	Total count	CO* count	HO** count	% HO***	Total rate per 1,000 hospital admissions	Total rate per 100,000 population
2026/27	87	70	17	20%	6.18	89.67
April 2026	29	24	5	17%	5.66	90.67
May 2026	29	23	6	21%	5.66	87.74
June 2026	29	23	6	21%	7.56	90.67

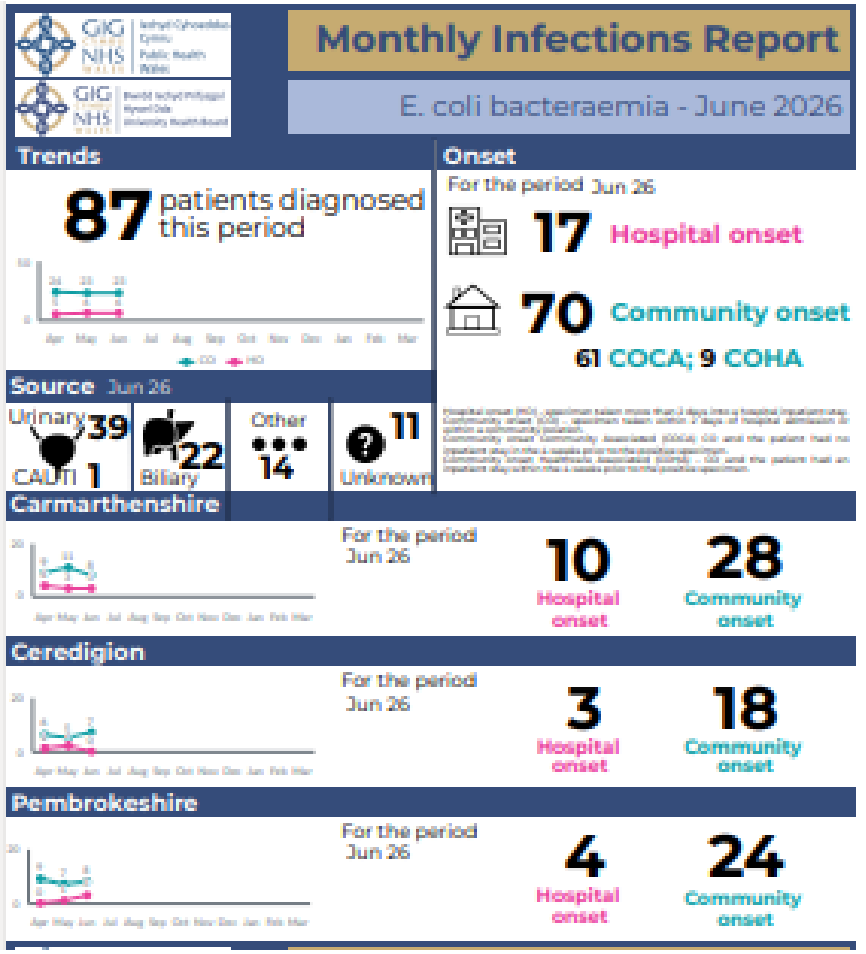
Infections primarily community-onset, linked to urinary tract and some catheter-related infections.

There were 60 cases of E.coli bloodstream infections in 2024/25, for 2026/27 the Health Board would need to achieve 54 cases or less to meet the improvement goal.

The burden of E.coli bacteraemia remains to be in the community.

Learning Identified	Recommendations for the CCGs
Adherence to catheter bundles: Gaps in bundles and room for improvement with compliance	• Compliance to be monitored through IPIAs • Aseptic Non Touch Technique (ANTT) compliance review
Many cases related to complex pre-existing conditions requiring microbiology input: Complexity	• Ensure early multidisciplinary team (MDT) involvement for high-risk patients (microbiology, pharmacy, urology as needed). • Introduce proactive review of patients with recurrent UTIs or urological conditions.
Patient hand hygiene: Poor patient hand hygiene can increase infection risk	• Compliance to be monitored through Infection Prevention Indicator Audits • Reiterate the mealtime coordinator role in supporting patient hand hygiene

Improvement Goal: A reduction of at least 10% in cases of hospital onset E. coli blood stream infection (BSI) is expected vs the cases in 2024-2025.



IP&C S.aureus bacteraemia

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Meticillin-Sensitive Staphylococcus (MSSA Improvement Goal: A decrease of at least 20% compared to the 2024/25 baseline counts for all Health Boards.
MRSA Improvement Goal: All Health Boards should have fewer MRSA BSI cases in 2025/26 than in 2024/25.

Filters for Table 2. and Charts 2-5.	Select HB	Select organism
	Hywel Dda UHB	MSSA bacteraemia

Data download is currently unavailable. To request data please email mailto:HARP@wales.nhs.uk

Table 2. Monthly count and rate of MSSA bacteraemia in Hywel Dda UHB, 2026/27

Additional filters for Table 2.
Select FY: 2026/27

*Community onset (CO) - specimen taken in a community location or less than 3 days into a hospital inpatient stay

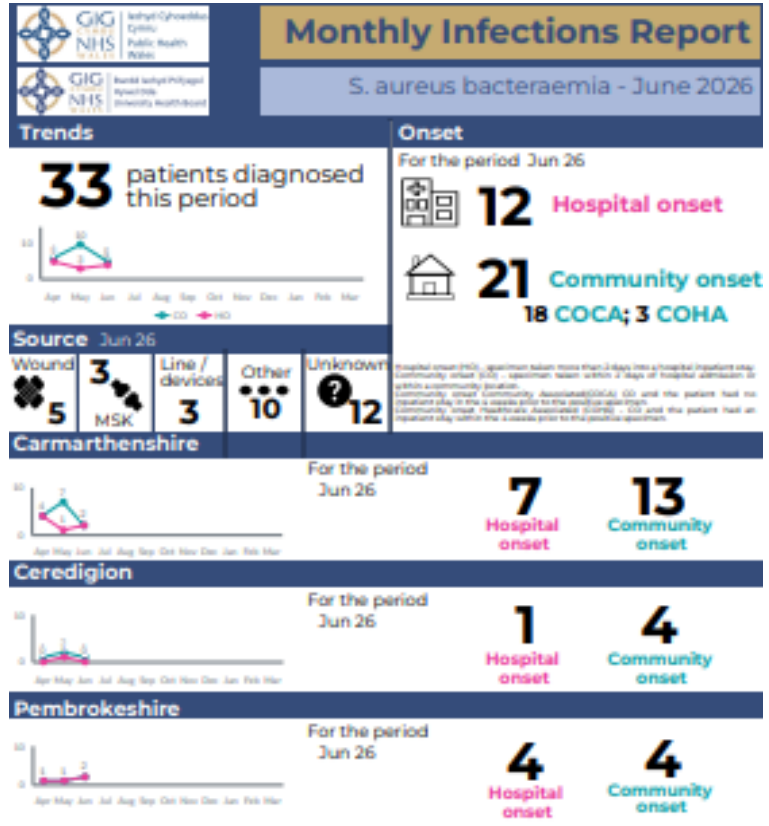
	Total count	CO* count	HO** count	% HO***	Total rate per 1,000 hospital admissions	Total rate per 100,000 population
2026/27	31	19	12	39%	2.20	31.95
April 2026	11	6	5	45%	2.15	34.39
May 2026	11	8	3	27%	2.15	33.28
June 2026	9	5	4	44%	2.35	28.14

Table 2. Monthly count and rate of MRSA bacteraemia in Hywel Dda UHB, 2026/27

Additional filters for Table 2.
Select FY: 2026/27

*Community onset (CO) - specimen taken in a community location or less than 3 days into a hospital inpatient stay

	Total count	CO* count	HO** count	% HO***	Total rate per 1,000 hospital admissions	Total rate per 100,000 population
2026/27	2	2	0	0%	0.14	2.06
April 2026	0	0	0	0%	0.00	0.00
May 2026	2	2	0	0%	0.39	6.05
June 2026	0	0	0	0%	0.00	0.00



- The burden of S.aureus bloodstream infections (BSI) is seen within the community.
- The Welsh Health Circulars Antimicrobial resistance and Healthcare Associated infections 2025 to 2027 sets an improvement goal for both MSSA and Meticillin-Resistant Staphylococcus (MRSA).
- MSSA Improvement Goal: A decrease of at least 20% compared to the 2024/25 baseline counts for all Health Boards.
- MRSA Improvement Goal: All Health Boards should have fewer MRSA BSI cases in 2025/26 than in 2024/25. 11 cases of MRSA BSIs for 2024/25.
- 122 cases of MSSA BSIs in 2024/25, for 206/27 the Health Board would need to achieve 98 cases to meet the improvement goal.

S.aureus bacteraemia: Learning identified and actions

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Learning Identified	Recommendations for the CCGs
PVC bundle not completed: Gaps in peripheral vascular catheter (PVC) bundle compliance increase risk of infection	• Compliance to be monitored through IPIAs- recent IPIAs have showed continued poor compliance. This will be fed back to the areas and presented to the relevant CCGs.
Cases appearing across all ward areas: Distribution suggests system-wide issues rather than isolated ward-specific practice gaps. Burden remains in the community.	• Conduct thematic analysis across all affected ward areas to identify common contributory factors • Increase oversight through ward assurance rounds focused on invasive device care.
ANTT compliance needs improvement: Variation in compliance levels	• Reinforce ANTT training and competency assessments across all clinical teams. • Share good practice examples and feedback with teams to improve reliability.

IP&C: topic-by-topic assurance view

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Convert the detailed infection slides into a consistent assurance view: status, evidence, action and impact.

Topic	What the data says	Learning / risk	Action and impact to evidence
Outbreaks	Scabies, norovirus and resistant organisms; TBP changes due.	Early isolation, care-home flagging, testing, handover and staff sickness controls.	Show TBP relaunch / training reducing spread, blocked beds and repeat outbreaks.
C. difficile	Goal: ≤138 vs 184 baseline; clusters at GGH, WGH and community sites.	Patient movement plus cleaning, HPV and commode assurance remain key risks.	Report monthly count vs target, cluster learning and audit action closure.
E. coli BSI	Goal: ≥10% hospital-onset reduction; target ≤54 vs 60 baseline.	Catheter bundle, ANTT, complex UTI / urology pathways and hand hygiene.	Evidence bundle compliance, MDT review and UTI pathway action impact.
S. aureus BSI	MSSA: ≥20% reduction; MRSA fewer than 2024/25 baseline.	PVC bundle, ANTT and device-care reliability; burden remains community-wide.	Show ward assurance, competency checks and thematic review outcomes.

Example assurance view: replace long narrative with a consistent QMS read-across

IP&C: QMS assurance summary

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

A sharper IP&C section can show whether infection controls are working, what learning is driving change, and what QSEC needs to challenge or escalate.

1 Standard

WHC HCAI / AMR goals, cleanliness standards and IP&C policies define the quality expectations.

2 Data

Track outbreaks, hospital / community onset, clusters, audit scores and progress against C. diff, E. coli, MSSA and MRSA goals.

3 Learning

Recurring risks: patient movement, isolation, TBPs, cleaning assurance, device care, ANTT and result tracking.

4 Action

CCGs convert learning into owned improvement plans, targeted training, audits and escalation where controls are unreliable.

5 Impact

Reports should show trajectory, reduced avoidable infection risk, audit improvement and sustained control after outbreaks.

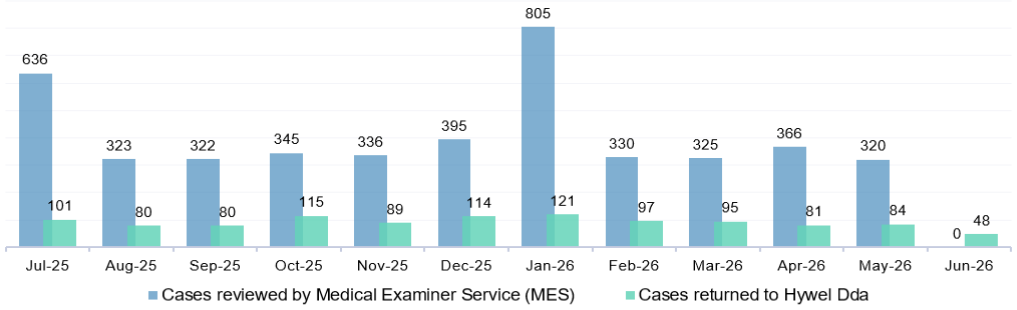
Illustrative QMS structure for the IP&C section

Mortality Overview:

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

As demonstrated in the adjacent slide, between 1 July 2025 and 30 June 2026 the mortality trend remained consistent with expected seasonal variation, with increased mortality observed during the winter period, although winter deaths were lower in 2026 than previous years.

The graph below demonstrates the correlation between the number of cases reviewed by the Medical Examiner Service and those referred to the Health Board for further review.

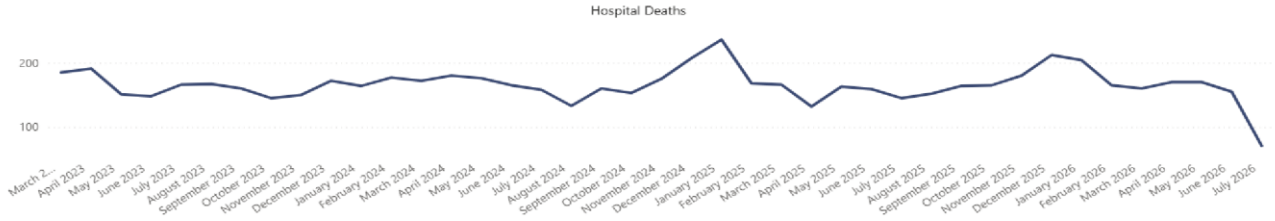


Note: *June cases are still being received, and the Medical Examiner review report has not yet been received. June review figures are therefore provisional and subject to change.*

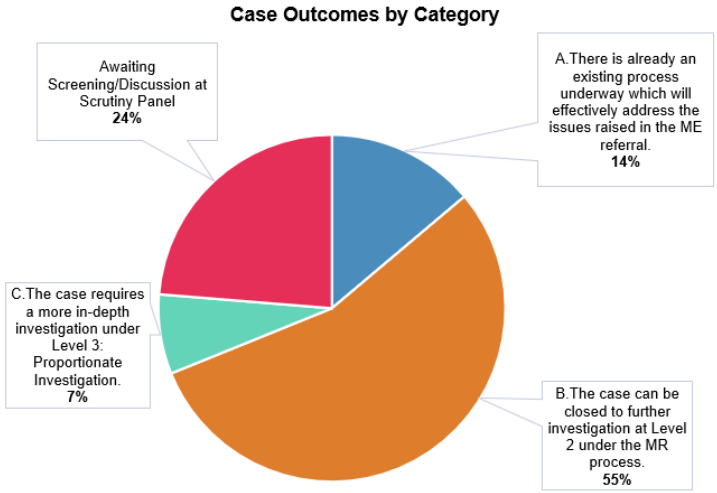
Those cases referred to the Health Board for further review are categorised into categories:

- ***A:*** *There is already an existing process underway which addresses the concerns raised by the Medical Examiner*
- ***B:*** *The case can be closed to further investigation at level 2 under the Mortality Review process*
- ***C:*** *The case requires a more in-depth investigation under level 3: Proportionate Investigation*

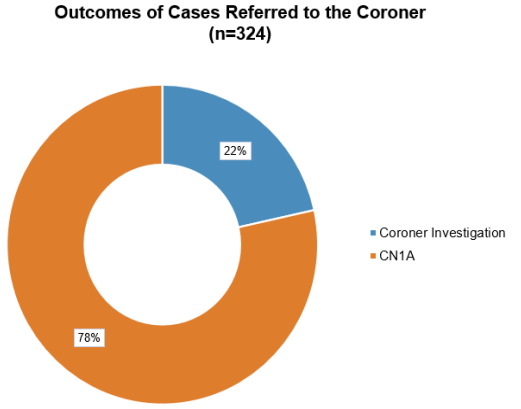
Hospital Location	2025	August 2025	September 2025	October 2025	November 2025	December 2025	January 2026	February 2026	March 2026	April 2026	May 2026	June 2026
Amman Valley Hospital	1	0	0	0	3	6	1	1	1	1	2	0
Bronglais General Hospital	19	9	14	21	21	29	26	34	23	29	28	16
Glangwili General Hospital	42	58	56	51	60	80	61	51	56	62	42	61
Hafan Derwen Hospital	2	1	2	1	4	1	0	2	0	1	1	1
Llandovery Hospital	0	3	1	1	2	2	1	1	0	1	2	1
Park House Court Nursing Home	0	0	0	0	1	0	1	1	1	0	0	1
Prince Philip Hospital	34	34	26	28	35	31	46	34	37	31	39	30
South Pembrokeshire Hospital	1	1	2	2	0	1	2	1	1	1	3	3
Tregaron Hospital	0	0	0	0	0	0	0	0	0	0	0	0
Ty Bryngwyn Mawr	7	4	9	8	6	6	7	3	7	6	7	10
Withybush General Hospital	39	42	54	53	48	56	59	37	34	38	46	32
Total	**145**	**152**	**164**	**165**	**180**	**212**	**204**	**165**	**160**	**170**	**170**	**155**



The proportion of these categories for the specific time period can be seen in the pie chart below:



Coroner referral outcomes are included in the pie chart below:

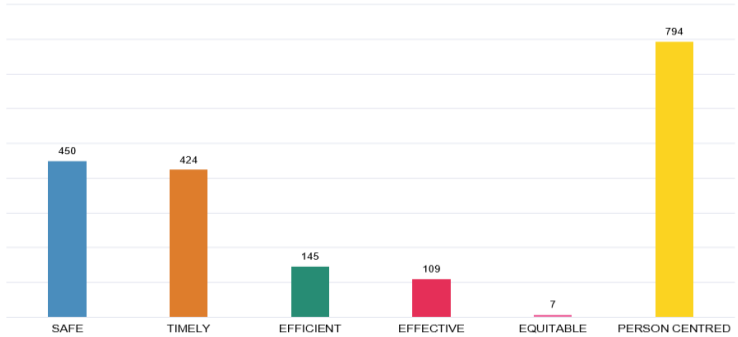


Note: *Outcome data are taken directly from the Medical Examiner Service (MES) letter and reflect the information available at the time of case upload.*

Mortality themes and performance:

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

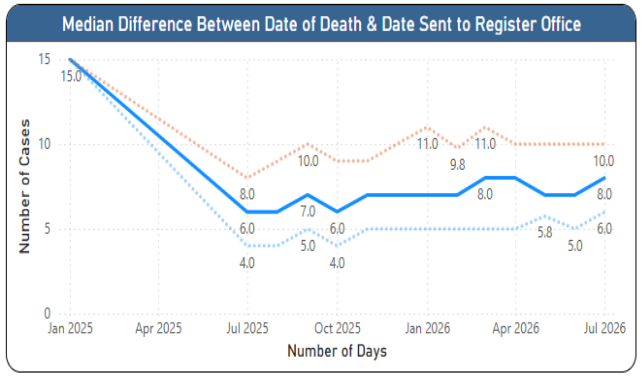
STEEEP themes identified through the Medical Examiner Review are demonstrated in the graph below:

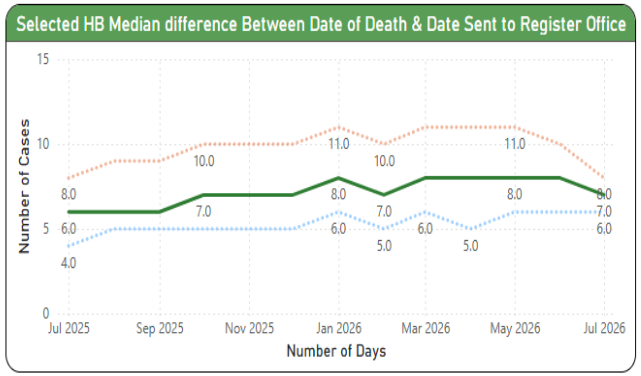


***Note:** Themes are selected by the MES and multiple themes may be assigned to a single case. As theme selection is based on professional judgement, the findings should be considered subjective.*

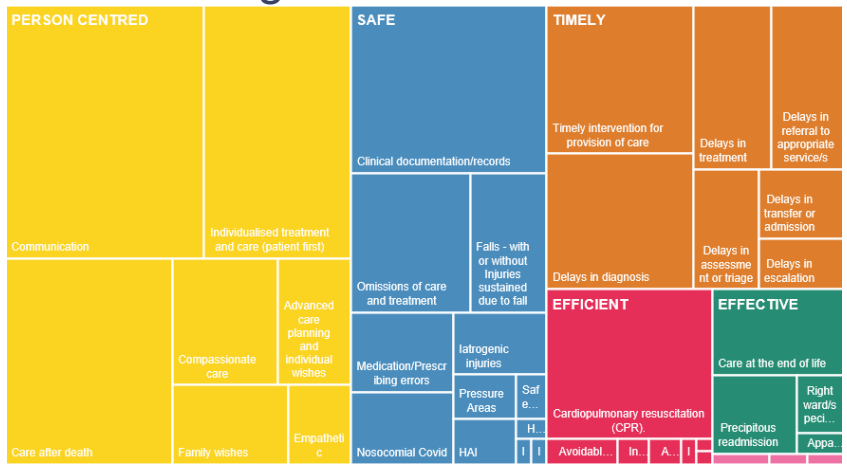
We are in the process of analysing the STEEEP themes that are being identified through the proportionate investigations being undertaken, this will be used to compare themes against the Medical Examiner STEEEP data.

Since July 2025, the median time between death to registration has remained relatively stable at 7 days. This is broadly consistent with the national median of 8 days, indicating performance in line with national benchmarks.



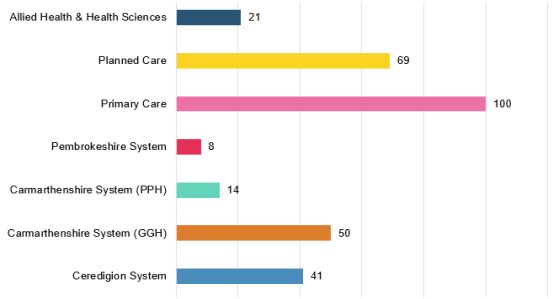


Distribution of learning themes across STEEEP themes:



Since July 2025, there has been a consistent downward trajectory for outstanding Mortality Proportionate Investigations, with completed investigations being discussed within the learning from mortalities panel and themes presented at the Mortality Scrutiny Group and Grand Round sessions.

The graph below outlines the outstanding proportionate investigations per system:



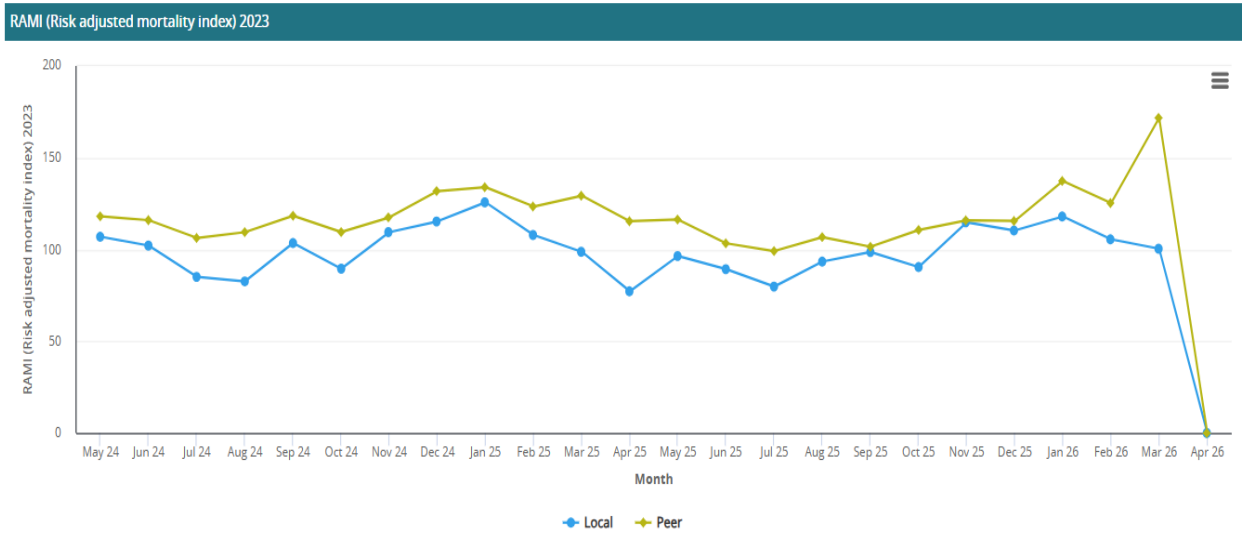
***Note:** The figures shown relate to open proportionate investigations associated with cases received between July 2025 and June 2026. Investigations that have since been completed and returned are not represented within these numbers.*

Mortality: Deep dive into RAMI data

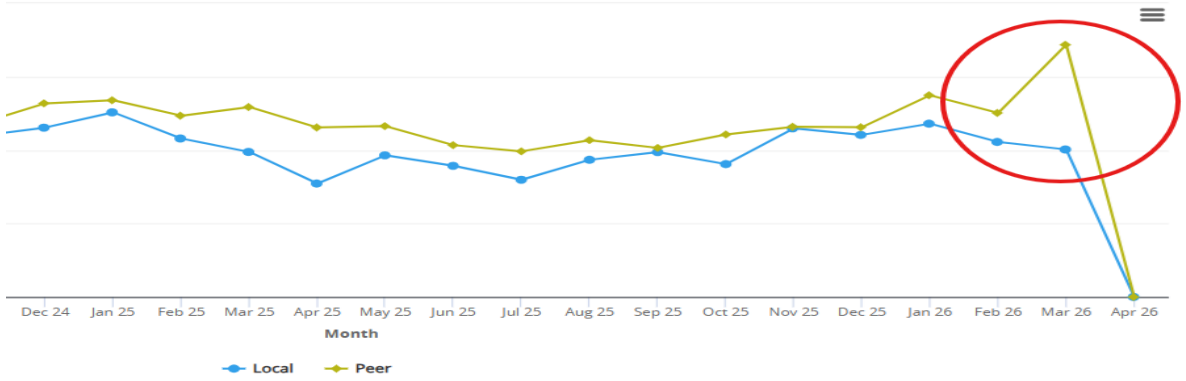
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Hywel Dda uses the RAMI, derived from CHKS data as a key indicator within its quality and safety framework. RAMI provides a standardised way of comparing observed patient deaths with expected patient deaths.

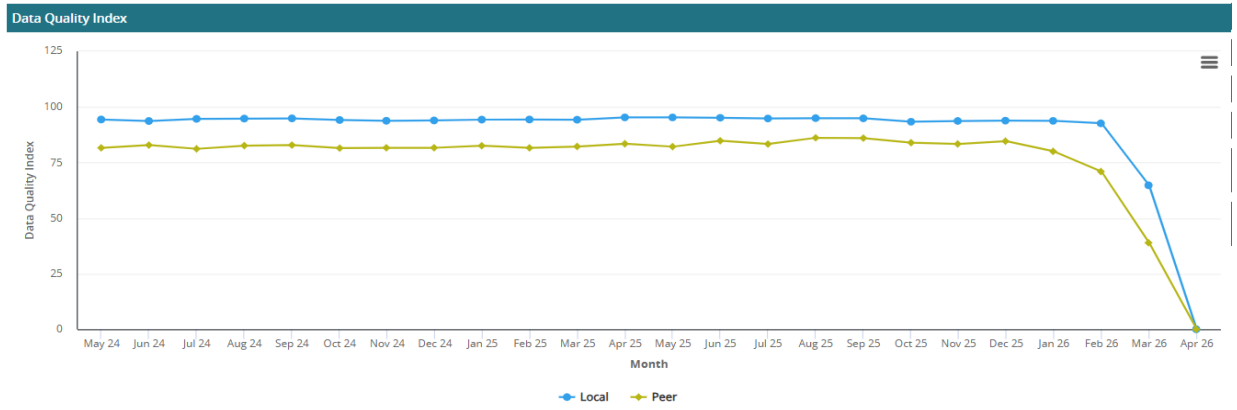
A deep dive was conducted on Risk Adjusted Mortality Index (RAMI) data 2025 – 2026 to understand the accuracy of an apparent rise in RAMI reported in February 2026 (132). The rise in February has now been corrected with the update of submitted coding data to CHKS . The latest CHKS adjacent graph demonstrates close tracking to peer rates for HDUHB RAMI.
CHKS processes uncoded patients as low risk which reduces expected deaths and **inflates** the RAMI score.



The Below Peer chart in green relates to other health boards across Wales which also show a typical RAMI pattern.
As shown in the graph, March 2026 for peers shows a RAMI of 172 which Is the effect we previously observed in HDUHB for February 2026.



The graph below demonstrates the data quality index which tracks the quality of recorded data.
The data quality for Hywel Dda is better than peer organisations in Wales, the higher-than-expected RAMI in Feb 26 is a normal artefact of the lag in coding of patient data.
As expected, this artefact has disappeared with the submission of new data for Feb 26.



Health Inspectorate Wales (HIW) / Care Inspectorate Wales (CIW) / Human Tissue Authority (HTA) inspection activity: 05/05/2026 - 12/07/2026

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Date of letter	HIW ref	Matter
06/07/2026	17564	WGH Mental Health assessment and prolonged wait for assessment in A&E
26/06/2026	17488	BGH • Welsh language provision • MCA assessment
25/06/2026	17497	GGH - Derwen Ward • Staffing model • Treatment room • Workload pressures • Care delivery and patient safety • Internal escalation
10/06/2026	17243	PPH Concerns regarding Section 136 suite in Bryngofal Ward

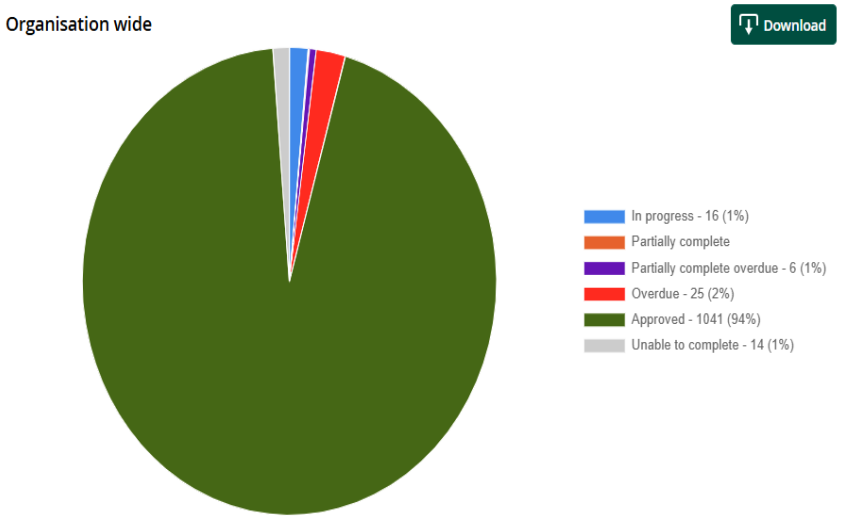
Date of letter	HIW ref	Matter
14/04/2026	16659	• O2 provision / care community • Monitoring of O2 provision • Unsafe O2 management
25/02/2026	16228	• GGH Palliative • Added a bed to a 2 bedroom • Felt lack of care & self discharge
27/01/2026	15863	PPH ward 4 • Personal care for a patient during a 6 day length of stay on ward 4 • Governance and oversight in place on the ward
22/01/2026	15877	GGH • Inside isolation room environment hygiene • Ward environment IPC • Shared spaces hygiene • Wheelchair storage areas hygiene • Cleaning supervision concerns hygiene
24/11/2025	15323	Theatres GGH • Staff training and experience • Staffing levels, burnout and turnover • Patient safety risks and incident reports • Staff wellbeing and morale • Senior management and culture concerns
23/10/2025	15014	A&E GGH • poor hygiene and infection control practice, • lack of response to concerns raised about hygiene and safety, • personal safety risks and insufficient staff training, • inadequate incident follow up • general concerns relating to staff training not being addressed
08/10/2025	13391	Update on CSP consultation for Critical Care

*Those shown in grey type have been previously reported to QSIG

HIW Quality Checks/Inspections: Reviews and inspections

Improvement Actions relating to HIW reviews

Source: AMaT 27/07/2026



	Overdue	Partially complete (overdue)
Community and Integrated Medicine	8	3
Digital	1	
Estates and Facilities	1	
Mental Health and Learning Disabilities	5	
Nursing, Quality and Patient Experience	4	1
Operational Allied Health and Health Science	5	
Planned and Specialist Care	1	2

	Position as at 05/05/2026	Position as at 27/07/2026
Overdue	32	25
Partially complete (overdue)	10	6
Partially complete	1	1
In progress	24	16
Rejected (to be resubmitted)	3	0

Open HIW inspections

No. of inspections	MD	SD	WN	PIR	Actions							
					In progress	Partially complete	Partially complete (Overdue)	Overdue	Unable to complete	Completed (awaiting approval)	Rejected	Completed
12	161/216 (75%)	0	0	0	16	1	6	25	8	0	0	350

Note for each open inspection, an action is created for the QAS Team to confirm with HIW closure of the inspection actions (this is not included within the HIW inspection report). Therefore. if actions are overdue, the action for QAST will also be overdue.

HIW Quality Checks/Inspections: Open reviews and inspections

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Code	Title	MD	SD	WN	PIR	Actions							
						In progress	Partially complete	Partially complete (Overdue)	Overdue	Unable to complete	Completed (awaiting approval)	Rejected	Completed
Healthcare Inspectorate Wales (HIW)/2026/833	Enlli Ward- Bronglais Hospital	0	0	0	0	0	0	0	0	0	0	0	0
Healthcare Inspectorate Wales (HIW)/2025/716	HIW Cwm Seren LSU & PICU	10/15 (67%)	0	0	0	4	0	0	2	0	0	0	15
Healthcare Inspectorate Wales (HIW)/2025/628	HIW Derwen Ward 04054	26/32 (81%)	0	0	0	1	1	0	7	0	0	0	116
Healthcare Inspectorate Wales (HIW)/2022/19	HIW GGH IRMER Inspection (Nov 2022)	19/21 (90%)	0	0	0	0	0	0	2	0	0	0	34
Healthcare Inspectorate Wales (HIW)/2025/565	HIW GGH Maternity Services 03924	11/13 (85%)	0	0	0	2	0	0	0	0	0	0	21
Healthcare Inspectorate Wales (HIW)/2023/29	HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)	19/40 (48%)	0	0	0	0	0	0	2	4	0	0	27
Healthcare Inspectorate Wales (HIW)/2025/750	HIW Improvement plan – Community Learning Disability Team	2/6 (33%)	0	0	0	5	0	0	2	0	0	0	3
Healthcare Inspectorate Wales (HIW)/2024/86	HIW IRMER Diagnostic Imaging x-ray department Withybush Hospital January 2024	7/9 (78%)	0	0	0	0	0	1	1	1	0	0	11
Healthcare Inspectorate Wales (HIW)/2024/498	IRMER Regulations	7/9 (78%)	0	0	0	0	0	0	3	0	0	0	7
Healthcare Inspectorate Wales (HIW)/2025/587	Joint Inspection of Child Protection Arrangements (Pembrokeshire)	17/21 (81%)	0	0	0	0	0	3	4	0	0	0	27
Healthcare Inspectorate Wales (HIW)/2025/595	Mynydd Mawr Ward, Prince Philip HospitaL 03921	20/24 (83%)	0	0	0	1	0	2	1	2	0	0	52
Healthcare Inspectorate Wales (HIW)/2025/596	Nuclear Medicine IRMER WGH 03909	23/26 (88%)	0	0	0	3	0	0	1	1	0	0	37

HIW Quality Checks/Inspections:

105 recommendations made by HIW in Q4 2025/25 and Q1 2026/27

Main themes of learning from HIW inspections

- Estates, environment & equipment safety
- Governance, audit, monitoring & assurance
- Records, documentation & accessibility
- Access, pathways, waiting lists & timely care
- Mandatory training / staff competence
- Patient dignity, safety & fundamental care
- Patient feedback, experience & involvement
- Workforce capacity, recruitment & retention
- Escalation, risk management & senior oversight

Health board-wide learning from the inspections undertaken

- Standardise audit and assurance processes across services.
- Strengthen ownership, escalation and senior oversight for overdue actions.
- Improve consistency of documentation, care planning and evidence capture.
- Monitor mandatory training proactively, not only after inspection.
- Embed patient/service-user feedback into improvement plans.
- Treat estates/equipment safety as a recurring assurance priority.
- Use inspection findings to identify cross-service risks, not just site-specific fixes.

5 Impact

Outstanding HIW actions have the potential to adversely affect the Health Board's reputation and may impact the assurance and confidence placed in the organisation by Welsh Government and NHS Performance and Improvement.

1 Standard

HIW actions and identified trends help define the standards and quality expectations required across services.

2 Data

HIW actions, themes and trends identified across multiple areas highlight recurring priorities and emerging areas of concern

3 Learning

Cross-cutting themes and trends can be used to support organisational learning and continuous improvement across the Health Board

4 Action

CCGs convert identified learning into accountable improvement plans, ensuring actions are targeted, monitored, and appropriately escalated when barriers prevent completion.

HIW Quality Checks/Inspection actions / ownership :

All open HIW actions are subject to twice-monthly monitoring and follow-up by the Quality Assurance and Safety Team.

In response to concerns raised by QSEC regarding ownership, accountability and timely completion of actions, additional escalation measures have been implemented.

These have included communication with action owners regarding QSEC discussions, targeted escalation of overdue actions, inclusion of outstanding HIW actions on CCG governance agendas, and enhanced use of Power BI reporting to identify and escalate priority actions requiring immediate attention.

- **An appendix to this report contains all open HIW action plans, with responsible lead names anonymised.**
- **Open HIW actions are subject to quarterly progress reporting to HIW and remain under review until evidence of completion has been provided and evidenced.**

Quality Improvement - strategic overview

- The refreshed Hywel Dda Quality Improvement Strategic Framework 2026-2029 outlines how we will engage and enable the whole workforce to improve the quality of its services. Our aim is to deliver a healthcare system of the highest quality, with excellent outcomes for our patients and our population. The QI approach outlined within the framework supports the Health Board in bringing together a single quality system to meet its goals and improve overall customer and patient care.
- Embedding a culture of continuous improvement and learning across the organisation supports the delivery of our Quality Management System (QMS), alongside the nationally and locally adopted Institute for Healthcare Improvement (IHI) Model for Improvement. Together, these provide a consistent, evidence-based approach to improvement practice. This integrated, whole-system approach strengthens the organisation's ability to deliver high-quality, sustainable care and fosters a shared culture of quality at every level.

Our 6 Strategic QI Focus Areas for 2026–2029:

1. Reducing Avoidable Harm and Improving Reliability of Care
2. Improving Flow, Timeliness and Access Across Pathways
3. Strengthening Value, Productivity and Prudent Use of Resources
4. Enhancing Patient, Carer and Community Experience Through Coproduction
5. Supporting Prevention and a Social Model of Health and Care
6. Building Sustainable Improvement Capability Where It Delivers Greatest Impact

Quality Improvement- delivery

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

The **Quality Improvement and Service Transformation (QIST)** team has an overarching goal of establishing ways of working to improve quality and safety that maximise value, remove waste and support our workforce to identify the root causes of problems in systems and processes and to develop sustainable solutions.

Some key improvement workstream supported by QIST:

- Hospital flow and discharge (supporting Handover 45, ED performance, discharge processes, redirection policy, Pathway of Care delays)
- Patient communication for urgent and emergency care
- Preventing deconditioning
- Waiting List Support
- Acute frailty
- Falls prevention
- Nutrition and Hydration
- Medicines management incidents
- Pressure damage
- Hospital – Acquired thrombosis
- Treatment Escalation Plans

The **Enabling Quality Improvement in Practice (EQIiP) programme** remains our key delivery vehicle for building QI capacity and capability across the organisation, alongside supporting key improvement projects.

- Currently on Cohort 8 (overall 117 projects to date)
- 936 Participants across all cohorts (since 2019)
- Cohort 8 (15 projects) - focussed on improved customer experience linked to waiting times, cancellations, poor communication, unwarranted variation in care delivery, processes and pathways, inequalities, and poor patient outcomes, experience and feedback.

QI Coach development

- From 11 (Cohort 1) to 58 active Improvement Coaches across the organisation
- Aim to have a QI coach in every department and service across the organisation.

EQIiP

Galluogi Gwella Ansawdd yn Ymarferol
Enabling Quality Improvement in Practice

EQliP Cohort 8 Projects

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

The FAIR-IRON Project	Radiology Nurse Led Pre Assessment	Project Constipation	Improving the rheumatology patient experience	Improving Access and Uptake of the Diabetes Prevention Programme for Individuals Diagnosed with Gestational Diabetes
Lack of recognition of early signs of deterioration and appropriate escalation	Healthy Ageing	Improving the patient experience within adult inpatient settings through nursing supported psychological interventions	Rostering for efficient staffing, safety and patient experience	MSK Physiotherapy Referral pathway
Introducing One at a Time Approach in a rural Child & Adolescent Local Primary Mental Health Support Service	Community By Design x 20four7 Prevention Model	Building Trust, One Conversation at a Time	Reducing the amount of inappropriate (DNACPR) decisions for adults with a Learning Disability within Hywel Dda	Enhancing Trauma Informed Maternity Care

Recommendations

The Committee is asked to:

1. Take assurance regarding the effectiveness of the Quality Management System controls described within this report.
2. Note the principal themes emerging from incidents, complaints, patient feedback, inquests, regulatory activity and IPC surveillance.
3. Seek assurance that learning is translated into measurable improvement through agreed improvement plans.
4. Highlight any areas where additional scrutiny or support is required.

Authors

Collation of report: Cathie Steele, Interim Assistant Director of Nursing, Assurance and Safeguarding

Sections:

1. Patient Safety Incident Reporting – Cathie Steele, Interim Assistant Director of Nursing, Assurance and Safeguarding
2. Nationally reportable incidents – Cathie Steele, Interim Assistant Director of Nursing, Assurance and Safeguarding
3. Duty of Candour – Cathie Steele, Interim Assistant Director of Nursing, Assurance and Safeguarding
4. Patient experience – Louise O'Connor, Assistant Director for Legal Services and Patient Experience
5. Complaints Management – Louise O'Connor, Assistant Director for Legal Services and Patient Experience
6. Inquests and Regulation 28 – Gaynor Kynaston, Head of Legal Services
7. Infection Prevention and Control – Rebecca Richards, Head of Infection Prevention and Control
8. Mortality themes and performance – Yeung Ng, Mortality Lead and Consutlant Urologist
8. Healthcare Inspectorate – Caroline Burgin, Patient Safety and Assurance
9. Quality Improvement- Marilize du Preez, Interim Head of Quality Improvement and Service Transformation

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Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

The Duty of **Candour**

Openness and honesty should be at the heart of every relationship between those providing treatment and care and those experiencing it.

DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG

SAFE | SUSTAINABLE | ACCESSIBLE | KIND

Mental Health and Learning Disabiltiies				
Inspection Title	Recommendation	Action	Original Due Date	Progress Status
HIW Improvement plan – Community Learning Disability Team	Implement a robust quality assurance process for care plans and risk assessments. Standardise record-keeping practices and ensure all documents are accessible to relevant staff.	Create and implement a system for clear and consistent tagging of all documents on electronic patient record system to ensure files are accessible and identifiable.	31/10/2026	In progress
HIW Improvement plan – Community Learning Disability Team	Implement a robust quality assurance process for care plans and risk assessments. Standardise record-keeping practices and ensure all documents are accessible to relevant staff.	Create and implement an audit tool and process to establish baseline care planning and risk assessment practices to inform further quality improvement in this area.	31/07/2026	In progress
HIW Improvement plan – Community Learning Disability Team	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.	30/06/2026	Overdue

HIW Improvement plan – Community Learning Disability Team	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.	Complete recruitment into Advanced Clinical Practitioner training place for CLDT to increase pipeline of complimentary, non-medical roles.	31/10/2026	In progress
HIW Improvement plan – Community Learning Disability Team	Ensure all relevant staff complete BLS training and refresher courses within required timescales. Monitor compliance regularly and provide targeted support where needed.	Improve mandatory training compliance to meet health board expected level through co-ordination of training bookings through the business support manager role onto training places, introducing a monthly report to monitor training completion and booked places, ensuring protected time to attend training.	31/05/2026	Fully complete (Approved)
HIW Improvement plan – Community Learning Disability Team	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.	31/05/2026	Overdue
HIW Improvement plan – Community Learning Disability Team	Ensure all eligible individuals receive annual health checks. Provide targeted training for clinicians on the specific health needs of people with learning disabilities.	The Learning Disability Health Facilitation team will deliver a pilot with one primary care cluster to support the transition of annual health checks into the GP core contract, completing GP register validation and targeted LD awareness training, and using the findings to produce recommendations for ongoing quality improvement.	31/10/2026	In progress
HIW Improvement plan – Community Learning Disability Team	Strengthen transition planning and improve collaboration with education and health partners to ensure seamless access and continuity of care.	CLDT managers will be invited to attend the CCG transition planning meetings to improve planning and collaboration for transition into adult services.	31/03/2026	Fully complete (Approved)
HIW Improvement plan – Community Learning Disability Team	Strengthen transition planning and improve collaboration with education and health partners to ensure seamless access and continuity of care.	Transition to be made a standing agenda item on all CLDT referral meeting agendas	31/03/2026	Fully complete (Approved)

HIW Cwm Seren LSU & PICU	The health board must consider the patient feedback highlighted in the report, and how the unit can make improvements to enhance the patient experience.	Patient feedback highlighted in the report is considered throughout the action plan under sections 2, 3, 4, 5 and 7	30/09/2026	In progress
HIW Cwm Seren LSU & PICU	The health board must ensure that patients have access to a wide range of meaningful activities, both within the unit and the community, and that alternatives are available for those who cannot leave the setting.	The unit will enhance its existing activity programme by ensuring every patient has an interests/hobbies profile completed within 72 hours of admission and by introducing quarterly audits and monthly patient-feedback processes to monitor the range, relevance, and accessibility of meaningful activities offered both within the unit and in the community. Managment teams will discuss and agree a process of capturing and reviewing the data relating to activity provision.	30/04/2026	Fully complete (Approved)
HIW Cwm Seren LSU & PICU	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.	30/03/2026	In progress
HIW Cwm Seren LSU & PICU	The health board must ensure that gym equipment is repaired and that there are enough trained staff to support patients in using the gym.	New gym equipment (funding approved on 15th December 2025) to be ordered and installed.	31/03/2026	Fully complete (Approved)
HIW Cwm Seren LSU & PICU	The health board must ensure that mattresses provided in mental health inpatient settings are suitable for long-term use and meet appropriate standards for comfort and durability.	Inspect all mattresses in PICU and LSU to ensure current suitabilty for use, meeting hospital and IPC standards.	30/01/2026	Fully complete (Approved)
HIW Cwm Seren LSU & PICU	The health board must ensure that mattresses provided in mental health inpatient settings are suitable for long-term use and meet appropriate standards for comfort and durability.	Order mattresses to create replacement stock as part of furniture replacement scheme across Adult Mental Health wards.	30/04/2026	Fully complete (Approved)
HIW Cwm Seren LSU & PICU	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.	Introduce direct access to the CIVICA platform for patients to provide anonymous feedback via QR codes which will be prominently displayed across all ward areas, ensuring visibility and accessibility for both patients and carers.	30/01/2026	Fully complete (Approved)

HIW Cwm Seren LSU & PICU	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.	30/06/2026	Overdue
HIW Cwm Seren LSU & PICU	The health board must ensure that garden areas are maintained and made safe.	Obtain quotes and complete cleaning of both gardens (LSU and PICU) and arrange a maintenance schedule.	31/03/2026	Fully complete (Approved)
HIW Cwm Seren LSU & PICU	The health board must continue to develop and monitor the 'Eclip' project to improve mealtime variety and freshness, ensuring patient feedback is acted upon.	Roll out of Synbiotix Meal Ordering System to improve the process of ordering in advance and gather patient feedback.	31/03/2026	Fully complete (Approved)
HIW Cwm Seren LSU & PICU	The health board must continue to develop and monitor the 'Eclip' project to improve mealtime variety and freshness, ensuring patient feedback is acted upon.	Introduce a four-week rolling menu with the aim of achieving 90% satisfaction on meal variety, and a system for ward managers to review satisfaction rates on a 3 monthly basis.	31/03/2026	Fully complete (Approved)
HIW Cwm Seren LSU & PICU	The health board must continue to develop and monitor the 'Eclip' project to improve mealtime variety and freshness, ensuring patient feedback is acted upon.	Improve the quality of cooked chill evening meals by delivering additional training for ward and catering staff.	31/03/2026	Fully complete (Approved)
HIW Cwm Seren LSU & PICU	The health board must ensure that all fire safety blankets are in date and subject to regular checks as part of its fire safety and equipment maintenance programme.	The requirement to check that all fire safety blankets are in date will be added to the annual annual fire risk assessment.	30/01/2026	Fully complete (Approved)
HIW Cwm Seren LSU & PICU	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.	30/06/2026	Overdue
HIW Cwm Seren LSU & PICU	The health board must ensure that all outstanding estates and environmental issues identified during the inspection are addressed promptly and effectively, with robust senior management oversight and clear accountability.	The health board will ensure that all outstanding estates and environmental issues identified during the inspection are addressed by confirming estates jobs are raised for all issued raised, establishing ward-level responsibility for weekly monitoring of progress and confirming completion, and implementing an escalation route to the Clinical Care Groups Accommodation Strategy Group for senior-management oversight until all actions are resolved.	30/09/2026	Fully complete (Approved)

HIW Cwm Seren LSU & PICU	The health board must ensure that all oxygen cylinders are in date and subject to regular checks as part of its medicines management and equipment safety processes.	The service will implement a schedule of regular nightly checks of oxygen cylinder expiry dates across all Mental Health Inpatient Wards	01/03/2026	Fully complete (Approved)
HIW Cwm Seren LSU & PICU	The health board must ensure that mandatory training compliance for BLS and ILS is improved by providing sufficient training sessions, protected time for staff to attend, and robust monitoring of completion rates.	Ward Managers will improve resuscitation-training compliance by directly booking staff onto ESR-listed training and rostering them in advance, while continuing to review monthly compliance data and taking timely action to address any shortfalls.	31/07/2026	Fully complete (Approved)
HIW Cwm Seren LSU & PICU	The health board must ensure that all staff complete mandatory training in a timely manner and are supported to attend	The Health Board will improve mandatory-training compliance on the Unit by implementing already agreed revised ward staffing establishments which include headroom to support protected time for training. The Health Board required level of mandatory training compliance will be achieved by completing recruitment to these posts with Ward Managers monitoring monthly compliance and escalating any barriers to attendance for timely resolution.	31/07/2026	In progress
HIW Cwm Seren LSU & PICU	The health board must ensure that psychological support and therapeutic activities are prioritised by addressing the current vacancy for a psychologist and implementing clear plans to provide timely access for patients.	The health board will strengthen access to psychological support and therapeutic activities by securing approval to recruit to the Forensic Consultant Psychologist post under Annex 21 to widen the applicant pool.	31/03/2026	Fully complete (Approved)
HIW Cwm Seren LSU & PICU	The health board must ensure that senior managers have direct oversight of estates management, including regular review of the estates job tracker and escalation of overdue tasks.	the Health Board will strengthen senior-management oversight of estates management by reviewing and updating the Accommodation Strategy Group's terms of reference to include responsibility for reviewing the estates job tracker and escalating overdue tasks, ensuring regular attendance by senior managers and estates leads, and implementing a standing agenda item for monitoring and escalation of overdue estates actions.	31/03/2026	Fully complete (Approved)

HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)	The health board must ensure that full and comprehensive mental health assessments and physical health assessments are always being completed in a timely manner, in line with the Mental Health (Wales) Measure 2010 under the Mental Health Act 1983.	a) Development of standards for physical health screening to be incorporated into Service Specifications.	29/09/2023	Fully complete (Approved)
HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)	The health board must ensure that full and comprehensive mental health assessments and physical health assessments are always being completed in a timely manner, in line with the Mental Health (Wales) Measure 2010 under the Mental Health Act 1983.	b) Further development of Care Partner to capture physical health screening in line with above standards through electronic forms.	30/11/2023	Fully complete (Approved)
HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)	The health board must ensure that when staff complete patient risk assessments, the method should reflect the requirements set out within national guidance.	c) Review of WARRN training provision and monitoring of uptake to inform longer term, sustainable approach and ability to provide targeted practice development in response to lessons learnt from SI's.	29/09/2023	Fully complete (Approved)
HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)	The health board must ensure that carers assessments are routinely offered and where required, undertaken for relevant individuals, in line with The Mental Health Act 1983 Code of Practice.	d) All teams to compile evidence folders for certification against Investors in Carers standards by a September 2023 and commence implementation of an annual review process.	29/09/2023	Fully complete (Approved)
HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)	The health board must ensure the inpatient ward round structure and arrangements in place allow for sufficient time for patients to be adequately discussed.	e) Coproduce a set of standards to underpin Ward MDT Review process to include a plan for implementation (including consistent approach to enabling service user and carer views within this process and consistent approach to documentation and communication of outcomes from ward reviews and discharge planning) and monitoring.	29/09/2023	Fully complete (Approved)

HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)	The health board must ensure that arrangements are in place to enable prompt communication and information sharing between inpatient and community teams during the discharge process.	f) Establish a discharge review task and finish group in order to undertake a baseline assessment against NICE guidelines for Transition between inpatient mental health settings and community or care home settings (NG 53).	29/09/2023	Unable to complete

HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)	The health board must ensure that arrangements are in place to enable prompt communication and information sharing between inpatient and community teams during the discharge process.	g) And review the health boards current Discharge Policy (# 370 Discharge and Transfer of Care Policy) to ensure additional standards that underpin safe practice in MH discharges (in line with NICE guidelines) are incorporated.	29/09/2023	Unable to complete
HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)	The health board must ensure that all relevant staff complete training for timely and effective communication and information sharing relating to the patient discharge process.	h) Develop a training resource to provide guidance to all relevant staff on standards associated with the discharge planning and process.	31/10/2023	Fully complete (Approved)
HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)	The health board must ensure that adequate administrative support is available within inpatient mental health units.	i) Full roll out of Band 4 Admin roles to ensure consistent cover across all wards.	30/09/2023	Fully complete (Approved)
HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)	The health board must provide assurances on the arrangements in place to ensure that patients have access to inpatient beds when required and the mitigations against risks associated with using beds already allocated to other patients who are on section 17 leave.	j) Strategic review of bed utilisation to inform prediction / trajectories of future need, support removal of delayed transfers of care, to enable service planning and responsiveness.	31/12/2023	Fully complete (Approved)

HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)	The health board must ensure that there are adequate arrangements in place for the management and storage of any paper patient records across the health board mental health services: a) to ensure a standardised approach to allow for efficient access to patient information; b) to maintain the security of patient data and clinical information.	k) Develop procedural guidance and standards for uploading paper records to the Electronic Patient Record across the MH/LD Directorate	31/08/2023	Fully complete (Approved)
HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)	The health board must ensure that there are adequate arrangements in place for the management and storage of any paper patient records across the health board mental health services: a) to ensure a standardised approach to allow for efficient access to patient information; b) to maintain the security of patient data and clinical information.	l) Scope actions needed to implement full transition to paper free clinical records across the MH/LD Directorate and feed into the health boards digital strategy work.	30/09/2023	Fully complete (Approved)
HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)	The health board must provide assurances on the electronic patient clinical records systems in place, within its mental health services, to allow for essential information to be shared electronically between inpatient and community services.	m) Development of process to enable timely access of clinical records for temporary staff eg temporary staff log ins that are issued locally.	30/11/2023	Unable to complete
HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)	The health board must take action to manage the risks of insufficient staff numbers and temporary staffing needs on inpatient mental health wards.	n) Review the health boards safe staffing escalation process to ensure this is fully reflective of processes across the MH/LD directorate.	31/07/2023	Fully complete (Approved)
HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)	The health board must take action to manage the risks of insufficient staff numbers and temporary staffing needs on inpatient mental health wards.	o) Review application of MH safe staffing principles and Welsh Levels of Care (Version 3 once published) for use across MH services.	30/09/2023	Fully complete (Approved)
HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)	The health board must take action to manage the risks of insufficient staff numbers and temporary staffing needs on inpatient mental health wards.	p) Pilot application of the SAFECARE tool across an individual mental health inpatient ward to inform an approach to full implementation.	30/11/2023	Fully complete (Approved)

HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)	The health board must take action to manage the risks of insufficient staff numbers and temporary staffing needs on inpatient mental health wards.	q) Development of MH/LD targeted actions through the MH/LD Workforce Group to feed into board wide recruitment and retention plans.	31/12/2023	Fully complete (Approved)
HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)	The health board must provide HIW with an update on how it is assured that community teams within its mental health services have sufficient capacity to meet their patient caseloads.	r) Review application of MH safe staffing principles and version 3 of All Wales Staffing Levels for use across community teams.	30/09/2023	Fully complete (Approved)
HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)	The health board must provide HIW with an update on how it is assured that community teams within its mental health services have sufficient capacity to meet their patient caseloads.	s) Undertake evaluation of the current caseload weighting tool in place across community mental health teams to determine use and effectiveness.	30/09/2023	Fully complete (Approved)
HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)	The health board must ensure CRHT's have appropriate facilities to allow staff to undertake the full requirements of their roles.	t) Resolve CRHT access to space within all emergency departments.	31/07/2023	Fully complete (Approved)

HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)	The health board must consider undertaking a training needs analysis for inpatient and community mental health staff, to identify any training gaps and help ensure all staff have the appropriate knowledge and skills to effectively undertake their role.	u) Development of a MH/LD essential training framework to reflect training needs across MH/LD services based on a systematic TNA that can be reviewed at regular intervals and monitored for compliance.	30/11/2023	Overdue
HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)	The health board must ensure that all staff across the mental health services are aware of how to access support, and that timely access to occupational health and well-being support is available to staff when required.	v) Develop a Directorate Staff Engagement and Organisational and Development Plan, supported by colleagues from Workforce to include consideration of effective communication mechanisms that will gather feedback to inform, shape and promote wellbeing support.	31/03/2024	Fully complete (Approved)

HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)	The health board should ensure there is adequate and consistent engagement with all staff around the audit arrangements in place across its mental health services, and that staff are made aware of all audit result and any actions required for improvement.	w) Develop a Directorate audit framework and plan, with the support of the Clinical Audit Team, that reflects local ward/team based audits and wider Health Board requirements to include:- - Testing assurance of consistent implementation of CAT and Physical Health Screening - Testing assurance of appropriate completion of WARRN - Routine reporting and monitoring of compliance with routine offer of carers assessments - Audit of compliance with Ward Round (MDT Review) standards - Routine report and monitoring of compliance with communication of discharge notifications, discharge letters and discharge summaries against NICE guideline standards - Record Keeping Documentation Audit to include completion and uploading of discharge checklists and communication of discharge plans - Testing assurance of the quality of discharge letters - Routine reporting and monitoring of	31/12/2023	Fully complete (Approved)
HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)	The health board should ensure there is adequate and consistent engagement with all staff around the audit arrangements in place across its mental health services, and that staff are made aware of all audit result and any actions required for improvement.	x) Develop a plan to engage frontline staff on the delivery and contribution of the clinical audit programme.	31/12/2023	Fully complete (Approved)
HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)	The health board should ensure there is adequate and consistent engagement with all staff around the audit arrangements in place across its mental health services, and that staff are made aware of all audit result and any actions required for improvement.	y) Training of relevant staff to be provided in order to utilise Audit and Management and Tracking (AMaT) once clinical audit programme has been agreed	31/12/2023	Fully complete (Approved)
HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)	The health board should ensure there is adequate and consistent engagement with all staff around the audit arrangements in place across its mental health services, and that staff are made aware of all audit result and any actions required for improvement.	z) Update reports on progress of the clinical audit programme to be provided to MHLD QSEG in order to provide oversight on outcomes.	31/03/2024	Fully complete (Approved)

HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)	The health board must ensure arrangements are in place to routinely review and update mental health policies and procedures, which includes sharing any updated documents with all staff across the mental health services as a whole.	aa) Strategic review of forward plan for written control documents across MH/LD services for 2023/24 to identify co dependencies and establish integrated planning and development for documents that span pathways and services.	30/09/2023	Fully complete (Approved)
HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)	The health board must ensure arrangements are in place to routinely review and update mental health policies and procedures, which includes sharing any updated documents with all staff across the mental health services as a whole.	bb) Engagement and Organisational and Development Plan, supported by colleagues from Workforce to identify effective communication mechanisms that include a coordinated approach to embedding lessons, promoting safety culture and sharing practice and policy updates.	31/03/2024	Fully complete (Approved)
HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)	The health board must ensure that risk registers are routinely reviewed, and that consideration is given to risk identification and risk management processes. This must include assuring itself that key staff are adequately trained in identifying risks and their management.	cc) MH/LD Directorate to hold a “risk workshop” in order to review and challenge where necessary the existing risks on the risk register to ensure mitigating actions, milestones and expected outcomes are clearly articulated.	31/07/2023	Fully complete (Approved)

HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)	The health board must consider how it can audit the process in place for social worker identified incidents, which are documented within Datix, and that feedback, learning and actions are shared with them as applicable.	dd) Review options for enabling Social Workers who provide a service on behalf of the health board to have direct access to DATIX, establish a process to implement this which includes routine access to DATIX for all new Social Workers joining mental health teams and processes to amend access when moving or leaving the team. Identity existing Social Workers to set up system access and training to enable full use of DATIX and feedback mechanisms within the system.	31/07/2023	Unable to complete
HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)	The health board must ensure that any staff who report incidents via Datix are provided with feedback, including any actions taken and learning identified.	ee) Amend the service line reporting template for MH/LD Quality, Safety and Experience Group to include service line data in relation to incident management process to strengthen consistency of reporting, oversight and monitoring of compliance with Datix incident management and feedback process.	31/07/2023	Fully complete (Approved)
HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)	The health board must ensure that there is a process in place to share learning or actions identified following incidents are cascaded across all teams within its mental health services.	ff) Engagement and Organisational and Development Plan, supported by colleagues from Workforce to identify effective communication mechanisms that include a coordinated approach to embedding lessons, promoting safety culture and sharing practice and policy updates.	31/03/2024	Fully complete (Approved)
Planned Care - Maternity				

HIW GGH Maternity Services 03924	The health board should consider how to encourage staff to increase their confidence in using the Welsh language and ensure that all Welsh speaking staff are easily identifiable to service users.	The service will ensure that lanyards are available to all staff to highlight that they are able to communicate in Welsh. The Maternity Monthly Newsletter will signpost all staff to Welsh language courses to increase awareness and confidence	22/08/2025	Fully complete (Approved)
HIW GGH Maternity Services 03924	The health board should consider how to encourage staff to increase their confidence in using the Welsh language and ensure that all Welsh speaking staff are easily identifiable to service users.	The Maternity Monthly Newsletter will signpost all staff to Welsh language courses to increase awareness and confidence to speak Welsh.	30/11/2025	Fully complete (Approved)
HIW GGH Maternity Services 03924	The health board must implement the early reporting of national incidents in line with the Welsh Government National Incident Reporting Policy, and consider downgrading later, where appropriate.	The service and Health Board can confirm measures are embedded to review and comply with the early reporting of national reportable incidents, in line with the Welsh Government National Reporting Policy. All incidents are and will be considered for reporting during early IMG discussions and if an act or inaction is identified an NRI will be reported at the earliest possible point possible.	07/08/2025	Fully complete (Approved)
HIW GGH Maternity Services 03924	The health board must ensure that all handovers are conducted using the SBAR format, and that service users' history and clinical risk is recorded on the patient information board and documented in the appropriate area within the clinical notes.	The Health Board will ensure a standardised SBAR approach to handover which will be monitored by the senior clinicians at each handover	31/08/2025	Fully complete (Approved)
HIW GGH Maternity Services 03924	The health board must ensure that all handovers are conducted using the SBAR format, and that service users' history and clinical risk is recorded on the patient information board and documented in the appropriate area within the clinical notes.	The Maternity Risk and Governance Newsletter to reiterate the importance of ensuring a holistic approach to handovers which is inclusive of relevant history and prudent to ensure efficient, timely and safe handover of care	30/09/2025	Fully complete (Approved)
HIW GGH Maternity Services 03924	The health board should consider formalising the huddle/handover process which should be documented and re-convened at any point of the day if required. This could be considered once an electronic system is introduced which should be monitored for compliance to ensure effectiveness of handover of care.	HIW have accepted the response and removed the paragraph therefore no action plan required	07/08/2025	Fully complete (Approved)

HIW GGH Maternity Services 03924	The health board should consider how to improve the BSOTS audit process to reflect an analysis and learning outcomes process, based on areas of non-compliance.	An audit of the BSOTS to be conducted which will include compliance across areas of BSOTS guidance. The data from the audit will be utilised to develop a clear and objective action plan for areas of improvement and learning outcomes will be disseminated service and Health Board wide	17/10/2025	Fully complete (Approved)
HIW GGH Maternity Services 03924	The health board should consider how to improve the BSOTS audit process to reflect an analysis and learning outcomes process, based on areas of non-compliance.	The data from the audit will be utilised to develop a clear and objective action plan for areas of improvement and learning outcomes will be disseminated service and Health Board wide	11/11/2025	Fully complete (Approved)
HIW GGH Maternity Services 03924	The health board should review the process for verbal orders of prescriptions to eliminate the potential risk of medication errors.	Staff to be reminded via the Maternity Monthly Newsletter and during group supervision delivered by the Clinical Supervisors for Midwives that verbal orders prescriptions are permitted only in exceptional circumstances when in the nurses' professional judgment, patient safety or care would otherwise be compromise. Posters to be placed in all clinical areas to remind staff of the above.	30/10/2025	Fully complete (Approved)
HIW GGH Maternity Services 03924	The health board should review the process for verbal orders of prescriptions to eliminate the potential risk of medication errors.	An audit of verbal prescriptions to be undertaken to identify areas for improvement	31/10/2025	Fully complete (Approved)
HIW GGH Maternity Services 03924	The health board should ensure that all hand gel containers in ward areas and at the entrances contain hand gel to minimise the risk of infection to service users, visitors and staff.	In collaboration with Hotel Services all staff to be reminded that in the event that a hand gel is not readily available this should be escalated and replaced without delay	30/07/2025	Fully complete (Approved)
HIW GGH Maternity Services 03924	The health board must provide evidence of an improvement in staff mandatory safeguarding training compliance within eight weeks of the inspection date to confirm that action has been taken to improve compliance.	A detailed action plan to be produced and agreed along with senior leaders from the Safeguarding Team to ensure improved compliance with mandatory safeguarding training.	20/09/2025	Fully complete (Approved)
HIW GGH Maternity Services 03924	The health board must provide evidence of an improvement in staff mandatory safeguarding training compliance within eight weeks of the inspection date to confirm that action has been taken to improve compliance.	The Maternity Monthly Newsletter to be updated with all relevant information on accessing safeguarding training.	20/08/2025	Fully complete (Approved)

HIW GGH Maternity Services 03924	The health board must provide evidence of an improvement in staff mandatory safeguarding training compliance within eight weeks of the inspection date to confirm that action has been taken to improve compliance.	Monitoring of compliance will be reviewed on a monthly basis across the service by the senior midwifery team, this will ensure a consistently increasing trajectory of compliance	20/09/2025	Fully complete (Approved)
HIW GGH Maternity Services 03924	The health board should ensure that a whole system approach is introduced for the checking and recording of medical devices and equipment to ensure that they are working effectively and safe to use in the event of an emergency.	During the inspection a mixed method of both paper and digital forms of equipment and medical device was in place, the service to implement a single whole system method of medical device and equipment checks to avoid any future inconsistencies.	30/08/2026	In progress
HIW GGH Maternity Services 03924	The health board should ensure that consistent daily checking and recording of fridge temperature checks is introduced to ensure that medication is stored at the required temperature.	Daily fridge check and accurate recording of temperatures to be formally embedded within the daily checks and compliance monitored by the labour ward manager	22/08/2025	Fully complete (Approved)
HIW GGH Maternity Services 03924	The health board must ensure that staff can access up-to-date guidelines and policies on WISDOM, including the dates they are due to be reviewed.	The Risk and Governance Newsletter will include a reminder to all staff that in the first instance guidelines and policies should be accessed via the Health Board intranet page as there is greater governance around this.	12/09/2025	Fully complete (Approved)
HIW GGH Maternity Services 03924	The health board must ensure that staff can access up-to-date guidelines and policies on WISDOM, including the dates they are due to be reviewed.	As WISDOM is an externally support webpage, the maternity service along with the central policies team will work with the provider to review and monitor guidelines and ensure that all guidelines are in date	12/09/2025	Fully complete (Approved)
HIW GGH Maternity Services 03924	The health board should reflect on the comments and observations on page 23 of the report, including upskilling midwives working within the enhanced monitoring unit and consider whether further improvements could be made to address these areas.	There is a newly established core team which has been developed to provide holistic care in the enhanced monitoring unit, a training needs analysis to be conducted to identify specific areas for improvement.	30/08/2025	Fully complete (Approved)
HIW GGH Maternity Services 03924	The health board should reflect on the comments and observations on page 23 of the report, including upskilling midwives working within the enhanced monitoring unit and consider whether further improvements could be made to address these areas.	PROMPT 2025/2026 mandatory training programme has been reviewed and updated and will reflect recognition and management of the deteriorating patient to reflect a broader culture of learning	30/11/2025	Fully complete (Approved)
HIW GGH Maternity Services 03924	The health board must ensure that mandatory training compliance is improved.	The data report of compliance with mandatory training to be updated to reflect rolling compliance in line with standards, this will support enhanced monitoring of compliance in real time.	31/10/2025	Fully complete (Approved)

HIW GGH Maternity Services 03924	The health board must ensure that mandatory training compliance is improved.	The service will undertake a scoping exercise of specific areas of mandatory training where improvement is required, a plan to increase compliance to be embedded and reviewed by senior leaders.	31/10/2025	Fully complete (Approved)
Integrated Medicine and Community Services				
HIW Derwen Ward 04054	The health board must ensure that checks of the drug refrigerator in the clinical room are monitored and recorded daily.	To remind all ward clinical staff of the requirement to consistently record the date and temperature reading in the dedicated logbook located in the clinical room, confirming completion of daily temperature checks.	30/09/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure that checks of the drug refrigerator in the clinical room are monitored and recorded daily.	To undertake spot checks the over the next month.	30/09/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure that checks of the drug refrigerator in the clinical room are monitored and recorded daily.	To conduct weekly spot checks to verify compliance with daily medication checks as outlined in the medication policy. Any discrepancies or missed entries to be documented and escalated to the Senior Nurse Manager within 24 hours for prompt resolution.	30/09/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure that checks of the drug refrigerator in the clinical room are monitored and recorded daily.	To undertake spot checks of the results monthly to ensure sustained compliance.	31/10/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure that checks of the drug refrigerator in the clinical room are monitored and recorded daily.	To review the training attendance and requirements of staff for Medication Safety & e-learning module and report and report findings, with improvement actions if required, at the Medication Scrutiny Meeting.	31/10/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure that checks of the drug refrigerator in the clinical room are monitored and recorded daily.	To further sharing and dissemination of learning within wider Health Board forum: 1. Community & Integrated Medicine Clinical Care Group Integrated Governance Group (Quality, Health & Safety);	31/10/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure that checks of the drug refrigerator in the clinical room are monitored and recorded daily.	• To further sharing and dissemination of learning within wider Health Board forum: 2. Senior Nurse Management Team (SNMT),	17/11/2025	Fully complete (Approved)

HIW Derwen Ward 04054	The health board must ensure that checks of the drug refrigerator in the clinical room are monitored and recorded daily.	To further sharing and dissemination of learning within wider Health Board forum: 3.Medication Events Review Group (MERG).	26/09/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure that checks of the drug refrigerator in the clinical room are monitored and recorded daily.	To undertake the medication audit, which is recorded on AMAT, in accordance with the medication policy. (The audit was last completed in June 2025 and is usually repeated six-monthly. Actions arising from the audit will be developed in an improvement plan and reviewed within one month to ensure compliance and continuous improvement.)	31/10/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure that daily checks of the emergency resuscitation trolley are completed and documented daily.	To remind all ward clinical staff that they must perform and document daily checks of the emergency resuscitation trolley in line with the resuscitation policy. This includes verifying the presence and expiry dates of emergency equipment and medications, and ensuring the trolley is clean, secure, and ready for use.	15/09/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure that daily checks of the emergency resuscitation trolley are completed and documented daily.	To conduct weekly spot checks to verify compliance with daily resuscitation trolley checks as outlined in the resuscitation policy. Any discrepancies or missed entries will be documented and escalated to the Senior Nurse Manager within 24 hours for prompt resolution.	15/09/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure that daily checks of the emergency resuscitation trolley are completed and documented daily.	To undertake spot checks of the results to ensure sustained compliance.	31/10/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure that daily checks of the emergency resuscitation trolley are completed and documented daily.	To inform all relevant staff of the updated emergency readiness procedures through a scheduled team meeting led by the Senior Nurse Manager. The importance of maintaining emergency preparedness to be reinforced during the session, and attendance to be recorded.	10/10/2025	Fully complete (Approved)

HIW Derwen Ward 04054	The health board must ensure that daily checks of the emergency resuscitation trolley are completed and documented daily.	To undertake the medication audit, which is recorded on AMAT, in accordance with the medication policy. (The audit was last completed in June 2025 and is usually repeated six-monthly. Actions arising from the audit will be developed in an improvement plan and reviewed within one month to ensure compliance and continuous improvement.)	31/10/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure that sufficient domestic staff are available to clean the ward to maintain appropriate infection prevention and control (IPC)	To undertake spot checks of domestic staff compliance with hand hygiene and PPE when in clinical areas. Findings and remedial actions to be reported to the Infection Prevention Strategic Steering Group.	31/10/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure that sufficient domestic staff are available to clean the ward to maintain appropriate infection prevention and control (IPC)	Synbiotix audits to be aligned with the existing improvement plan including a review of the audit criteria to ensure they reflect current priorities and actions outlined in the plan.	30/09/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure that sufficient domestic staff are available to clean the ward to maintain appropriate infection prevention and control (IPC)	To monitor audit outcomes, and address any gaps identified through targeted actions within 2 weeks of each audit cycle.	31/10/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure that sufficient domestic staff are available to clean the ward to maintain appropriate infection prevention and control (IPC)	To continue to report and review the findings from Synbiotix audits at each monthly Carmarthenshire System Infection Prevention and Control Locality Meeting. Any identified issues will be discussed with agreed actions recorded and monitored for progress at subsequent meetings.	31/10/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure that multi patient use items such as BP cuffs, are appropriately decontaminated between use and that clean equipment is correctly labelled.	To remind all ward clinical staff of the requirement to decontaminate reusable equipment between each patient use, in line with the decontamination policy. This includes the use of approved cleaning products and adherence to IPC standards (including hand hygiene). The guidance will be reinforced during scheduled team meetings, with attendance recorded and key messages circulated within 3 working days.	15/09/2025	Fully complete (Approved)

HIW Derwen Ward 04054	The health board must ensure that multi patient use items such as BP cuffs, are appropriately decontaminated between use and that clean equipment is correctly labelled.	To review training attendance and requirements of staff for IPC e-learning module. Training compliance will be monitored via Carmarthenshire System Infection Prevention and Control Locality Meeting.	29/10/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure that multi patient use items such as BP cuffs, are appropriately decontaminated between use and that clean equipment is correctly labelled.	To conduct weekly spot checks to verify compliance with routine decontamination of equipment, as per decontamination policy. Any discrepancies or missed entries will be documented and escalated to the Senior Nurse Manager within 24 hours for prompt resolution.	15/09/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure that multi patient use items such as BP cuffs, are appropriately decontaminated between use and that clean equipment is correctly labelled.	To undertake spot checks of the results to ensure sustained compliance.	31/10/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure that multi patient use items such as BP cuffs, are appropriately decontaminated between use and that clean equipment is correctly labelled.	To ensure that decontamination wipes are routinely stocked and visibly available in all observation trolleys across clinical areas.	15/09/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure that multi patient use items such as BP cuffs, are appropriately decontaminated between use and that clean equipment is correctly labelled.	To check the availability of the wipes during weekly environmental checks, with 100% compliance expected. Any shortages will be reported to the Team and replenished to support staff adherence to decontamination guidance.	31/10/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure that oxygen tubing and face masks are easily accessible for all bed areas on the ward.	To review each bed space to ensure oxygen tubing and face masks are available, as per resuscitation policy and stored in a consistent, easily accessible location.	15/09/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure that oxygen tubing and face masks are easily accessible for all bed areas on the ward.	To ensure oxygen delivery equipment including availability and readiness for use is included in daily ward checks. Any missing or damaged items to be reported or replaced promptly.	15/09/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure that oxygen tubing and face masks are easily accessible for all bed areas on the ward.	To undertake spot checks the over the next month. The findings will be reported to the Senior Nurse and 100% compliance will be expected.	31/10/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure that oxygen tubing and face masks are easily accessible for all bed areas on the ward.	To remind staff the importance of ensuring emergency and routine oxygen equipment is always accessible, as per resuscitation policy. This will be reinforced through staff meetings.	15/09/2025	Fully complete (Approved)

HIW Derwen Ward 04054	The health board must ensure wall suction units are fully operational	To review of each bed area and ensure wall suction units are fully operational and adequate suction available.	15/09/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure wall suction units are fully operational	To ensure a check of the suction delivery units (availability and readiness) in daily ward checks. Any missing or damaged items are reported or replaced promptly.	15/09/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure wall suction units are fully operational	To undertake weekly spot checks to ensure compliance with the daily checks. The findings will be reported to the Senior Nurse.	15/09/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure wall suction units are fully operational	Staff to be reminded of the importance of ensuring bedside suction is always adequate and accessible. This will be reinforced through staff meetings.	15/09/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure that patient records are stored securely at all times.	To remind all ward staff of the requirement to store patient records in locked notes trollies as per Record Keeping policy. This will be reinforced through staff meetings.	15/09/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure that patient records are stored securely at all times.	To review the training attendance and requirements of staff for Information Governance e-learning and report the findings to the Carmarthenshire Integrated Performance and Business Management Care Group, with a clear plan for improvement if required.	31/10/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure that patient records are stored securely at all times.	To ensure that the daily environmental checks include verification that patient records are stored securely and appropriately, in line with information governance standards. Any breaches will be reported to the Ward Manager immediately and addressed within 24 hours.	15/09/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure that patient records are stored securely at all times.	To undertake weekly spot checks to ensure compliance with 100% adherence expected. The findings will be reported to the Senior Nurse.	31/10/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure that patient records are stored securely at all times.	To progress with recruitment of Ward Clerk to support with timely return of notes for patients who are no longer admitted onto the ward.	30/11/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure that patient records are stored securely at all times.	To undertake a site review of notes trollies and develop a replacement programme.	31/10/2025	Fully complete (Approved)

HIW Derwen Ward 04054	The health board must ensure that all staff have received training and complete patient risk assessments appropriately and take the relevant action in line with local or national guidance, and document this in patient records. This includes: •Taking appropriate action when NEWS scores are 3 or above •Completing and documenting Sepsis Screening for those at risk of sepsis, such as a NEWS score of 5 or above •Completing and documenting VTE risk assessments on admission and thereafter in line with local and national guidance.	To remind all ward clinical staff of their responsibility to document all risk assessments and associated actions in the patient record, in line with the Monitoring, Recording of Adult Physiological Observations and Response to Physical Deterioration Policy. This includes initial assessments, reassessments, and any interventions taken. The requirement will be reinforced through staff meetings and mandatory training sessions, with attendance recorded and compliance monitored through monthly documentation audits by the Senior Ward Manager.	15/09/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure that all staff have received training and complete patient risk assessments appropriately and take the relevant action in line with local or national guidance, and document this in patient records. This includes: •Taking appropriate action when NEWS scores are 3 or above •Completing and documenting Sepsis Screening for those at risk of sepsis, such as a NEWS score of 5 or above •Completing and documenting VTE risk assessments on admission and thereafter in line with local and national guidance.	To review the current training compliance of staff for NEWS 2 e-learning module and develop a plan to ensure timely completion of the e-learning module. Training compliance will be monitored via RADAR scrutiny meeting.	13/11/2025	Fully complete (Approved)

HIW Derwen Ward 04054	The health board must ensure that all staff have received training and complete patient risk assessments appropriately and take the relevant action in line with local or national guidance, and document this in patient records. This includes: •Taking appropriate action when NEWS scores are 3 or above •Completing and documenting Sepsis Screening for those at risk of sepsis, such as a NEWS score of 5 or above •Completing and documenting VTE risk assessments on admission and thereafter in line with local and national guidance.	To review the current training compliance of staff for classroom ILS/BLS and develop a plan to ensure timely completion of the learning. Training compliance will be monitored via RADAR scrutiny meeting.	13/11/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure that all staff have received training and complete patient risk assessments appropriately and take the relevant action in line with local or national guidance, and document this in patient records. This includes: •Taking appropriate action when NEWS scores are 3 or above •Completing and documenting Sepsis Screening for those at risk of sepsis, such as a NEWS score of 5 or above •Completing and documenting VTE risk assessments on admission and thereafter in line with local and national guidance.	To arrange additional training to support the early recognition of a deteriorating patient.	15/09/2025	Fully complete (Approved)

HIW Derwen Ward 04054	The health board must ensure that all staff have received training and complete patient risk assessments appropriately and take the relevant action in line with local or national guidance, and document this in patient records. This includes: •Taking appropriate action when NEWS scores are 3 or above •Completing and documenting Sepsis Screening for those at risk of sepsis, such as a NEWS score of 5 or above •Completing and documenting VTE risk assessments on admission and thereafter in line with local and national guidance.	To undertake weekly spot checks to verify compliance accurate NEWS scoring and escalation of sepsis as per guidance. Any discrepancies or missed entries are documented and escalated to the Senior Nurse Manager within 24 hours for prompt resolution.	15/09/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure that all staff have received training and complete patient risk assessments appropriately and take the relevant action in line with local or national guidance, and document this in patient records. This includes: •Taking appropriate action when NEWS scores are 3 or above •Completing and documenting Sepsis Screening for those at risk of sepsis, such as a NEWS score of 5 or above •Completing and documenting VTE risk assessments on admission and thereafter in line with local and national guidance.	To reinforce to medical staff the requirement to complete and document the VTE Risk Assessment.	30/09/2025	Fully complete (Approved)

HIW Derwen Ward 04054	The health board must ensure that all staff have received training and complete patient risk assessments appropriately and take the relevant action in line with local or national guidance, and document this in patient records. This includes: •Taking appropriate action when NEWS scores are 3 or above •Completing and documenting Sepsis Screening for those at risk of sepsis, such as a NEWS score of 5 or above •Completing and documenting VTE risk assessments on admission and thereafter in line with local and national guidance.	To promote the Hospital Acquired Thrombosis SharePoint page which is available with current resources and information.	30/09/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure that all staff have received training and complete patient risk assessments appropriately and take the relevant action in line with local or national guidance, and document this in patient records. This includes: •Taking appropriate action when NEWS scores are 3 or above •Completing and documenting Sepsis Screening for those at risk of sepsis, such as a NEWS score of 5 or above •Completing and documenting VTE risk assessments on admission and thereafter in line with local and national guidance.	To review the VTE Site Improvement plan currently in place to ensure it covers the findings of HIW.	15/09/2025	Fully complete (Approved)

HIW Derwen Ward 04054	The health board must ensure that all staff have received training and complete patient risk assessments appropriately and take the relevant action in line with local or national guidance, and document this in patient records. This includes: •Taking appropriate action when NEWS scores are 3 or above •Completing and documenting Sepsis Screening for those at risk of sepsis, such as a NEWS score of 5 or above •Completing and documenting VTE risk assessments on admission and thereafter in line with local and national guidance.	To review of VTE risk assessment compliance findings to be discussed within the Carmarthenshire System Quality and Safety Governance meeting (feeding into our Clinical Care Group)	30/09/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure that all the findings in this immediate improvement plan are not systemic across all other wards within the hospital and the wider health board.	To share the immediate actions with all Heads of Nursing across the health board and request that spot checks be undertaken.	15/09/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure that all the findings in this immediate improvement plan are not systemic across all other wards within the hospital and the wider health board.	To share the immediate actions through the Community and Integrated Medicine Professional Nurse Forum.	31/10/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure that all the findings in this immediate improvement plan are not systemic across all other wards within the hospital and the wider health board.	To share the immediate actions findings at other forums such as the: 1.Community and Integrated Medicine Clinical Care Group Integrated Governance Meeting	18/09/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure that all the findings in this immediate improvement plan are not systemic across all other wards within the hospital and the wider health board.	To share the immediate actions findings at other forums such as the: 2.Senior Nurse Management Team	22/09/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure that all the findings in this immediate improvement plan are not systemic across all other wards within the hospital and the wider health board.	To share the immediate actions findings at other forums such as the: Integrated Quality, Finance, Performance and Delivery Group	24/09/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure that all the findings in this immediate improvement plan are not systemic across all other wards within the hospital and the wider health board.	To support with individual ward review to monitor and ensure compliance with actions. Where compliance is found to not be in place, immediate remedial activity to commence.	01/10/2025	Fully complete (Approved)

HIW Derwen Ward 04054	The health board must ensure that all the findings in this immediate improvement plan are not systemic across all other wards within the hospital and the wider health board.	To present the Quality Improvement audit results for all wards (inclusive of actions at the Care Group Quality and Safety Group for assurance.	16/10/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure more health promotion information is available to patients, such as healthy eating, smoking cessation materials and information from charities such as Age Cymru Dyfed to support elderly vulnerable people.	Assign a team of staff from the ward to lead the development and implementation of a visual display board in a communal area of the ward. Collaborate with the Health Board's Public Health Team and external partners (e.g., Age Cymru Dyfed).	30/11/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure more health promotion information is available to patients, such as healthy eating, smoking cessation materials and information from charities such as Age Cymru Dyfed to support elderly vulnerable people.	Remind staff via staff meeting, of the 'every contact counts' principles and reinforce communication of health promotion topics during routine care interactions.	30/11/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure more health promotion information is available to patients, such as healthy eating, smoking cessation materials and information from charities such as Age Cymru Dyfed to support elderly vulnerable people.	Work commenced to scope local project to embed health promotion at ward level along Making Every Contact Count principles with Assistant Director of Public Health Directorate. This will include scoping appropriate literature, wider training and strengthening sign posting, advice and guidance.	31/01/2026	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure: • The dignity and respect of patients is met consistently including drawing curtains and closing doors whilst staff are administering to patients' personal needs and when patients are using a bedpan • Clean linen is always available for patients on the ward.	Ensure staff consistently maintain patient dignity by drawing curtains and closing doors during personal care activities, including when patients are using a bedpan. Senior ward manager or a designated team member will conduct weekly spot checks to verify compliance in line with Health Board Values and Behaviours Framework.	30/11/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure: • The dignity and respect of patients is met consistently including drawing curtains and closing doors whilst staff are administering to patients' personal needs and when patients are using a bedpan • Clean linen is always available for patients on the ward.	All staff to be reminded of the Health Board Values and Behaviours Framework. The framework will be reinforced during scheduled team meetings, with attendance recorded and key messages circulated to all staff.	31/12/2025	Fully complete (Approved)

HIW Derwen Ward 04054	The health board must ensure: •The dignity and respect of patients is met consistently including drawing curtains and closing doors whilst staff are administering to patients' personal needs and when patients are using a bedpan •Clean linen is always available for patients on the ward.	Review of training compliance and requirements of staff for Equality, Diversity and Human Rights e-learning module to be undertaken. Training compliance will be monitored, with 100% compliance of all staff, currently attending work, expected.	31/12/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure: •The dignity and respect of patients is met consistently including drawing curtains and closing doors whilst staff are administering to patients' personal needs and when patients are using a bedpan •Clean linen is always available for patients on the ward.	Review of current Service Level Agreement for linen provision on Derwen Ward to be completed. Increase linen order as per needs of service due to increased demand and activity on the ward.	31/12/2025	Fully complete (Approved)
HIW Derwen Ward 04054	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.	Review of signage has been completed following recent refurbishment of Derwen ward. New signage has been ordered to support all patients, including dementia friendly. Escalate order of signage and support facilities team to place new signage.	30/11/2025	Fully complete (Approved)
HIW Derwen Ward 04054	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.	Discuss the 'What Matters to Me' initiative and 'Butterfly Scheme' during a ward meeting and provide all staff with a copy of the presentation.	30/11/2025	Fully complete (Approved)
HIW Derwen Ward 04054	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.	31/12/2025	Overdue

HIW Derwen Ward 04054	The health board must ensure staff answer call bells in a timely manner to maintain patient safety, dignity and quality care.	All staff to be reminded to ensure all patients have access to call bells and that staff answer the bells in a timely manner. This will be reinforced during scheduled team meetings, with attendance recorded and key messages circulated to all staff.	30/11/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must urgently review the provision of physiotherapy services on the ward, to ensure patients receive timely and appropriate assessments and care to support their recovery and prevent delays with discharge.	Recruitment into 2wte B6 physiotherapy posts for Trauma & orthopaedics & surgical to be completed – these posts had been vacant for a significant amount of time.	31/10/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must urgently review the provision of physiotherapy services on the ward, to ensure patients receive timely and appropriate assessments and care to support their recovery and prevent delays with discharge.	Support return of B7 following long-term absence period.	31/10/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must urgently review the provision of physiotherapy services on the ward, to ensure patients receive timely and appropriate assessments and care to support their recovery and prevent delays with discharge.	Clinical prioritisation tool to be developed for a consistent approach to prioritising patient care / those at risk of deterioration.	31/10/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must urgently review the provision of physiotherapy services on the ward, to ensure patients receive timely and appropriate assessments and care to support their recovery and prevent delays with discharge.	Rehabilitation currently on the Therapies risk register (2145)	02/09/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must urgently review the provision of physiotherapy services on the ward, to ensure patients receive timely and appropriate assessments and care to support their recovery and prevent delays with discharge.	Physiotherapy team to continue engagement with Ward Board Rounds, to support Goal 5 Optimal Flow.	02/09/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must urgently review the provision of physiotherapy services on the ward, to ensure patients receive timely and appropriate assessments and care to support their recovery and prevent delays with discharge.	Central recruitment for Band 3 deficits across the whole site has commenced in October, with first cohort of staff due to start induction end of November. This will reduce deficits on the ward and release Assistant Practitioner and rehab support workers to work within the expected role to support with Rehabilitation delays.	30/11/2025	Fully complete (Approved)

HIW Derwen Ward 04054	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.	Ensure the ward is equipped with appropriate tools and materials to support patients with sensory and communication needs, including hearing aids, visual aids, large-print materials, and translation or interpretation resources. Work with the Health Board's Equality and Diversity Team, Speech and Language Therapy, and Audiology departments to source appropriate materials. Engage ward staff in identifying common patient needs and practical solutions.	15/12/2025	Fully complete (Approved)
HIW Derwen Ward 04054	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.	31/01/2026	Overdue
HIW Derwen Ward 04054	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.	20/02/2026	Overdue

HIW Derwen Ward 04054	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.	A poster will be displayed on the ward entrance outlining staff uniform colours and corresponding staff grades. To promote clarity and reassurance for those accessing the ward	15/12/2025	Fully complete (Approved)
HIW Derwen Ward 04054	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.	In collaboration with the ward team, undertaken a thorough decluttering of the day room. This will involve the removal of unnecessary items, ensuring appropriate storage of essential equipment, and reorganisation of the space to enhance safety, accessibility, and the overall environment for patients and staff.	15/12/2025	Fully complete (Approved)
HIW Derwen Ward 04054	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.	To establish a practice of daily environmental checks to ensure that the day room remains clutter-free, promoting a safe, welcoming, and therapeutic environment for patients, staff, and visitors.	15/12/2025	Fully complete (Approved)

HIW Derwen Ward 04054	The health board must ensure all staff: •Wear name badges and that these clearly display staff who can speak Welsh •Always update patients with their plan of care or treatment •Are reminded they must treat patients in a kind and caring manner.	Reinforce the importance of wearing name badges to staff. This will be discussed in the staff meeting.	30/11/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure all staff: •Wear name badges and that these clearly display staff who can speak Welsh •Always update patients with their plan of care or treatment •Are reminded they must treat patients in a kind and caring manner.	New name badges have been ordered for staff, those who can speak Welsh will have the 'Iaith Gwaith' emblem included.	30/11/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure all staff: •Wear name badges and that these clearly display staff who can speak Welsh •Always update patients with their plan of care or treatment •Are reminded they must treat patients in a kind and caring manner.	Arrange bespoke training with the Welsh Language team to support staff to be able to make the initial meet and greet in Welsh.	31/12/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure all staff: •Wear name badges and that these clearly display staff who can speak Welsh •Always update patients with their plan of care or treatment •Are reminded they must treat patients in a kind and caring manner.	Arrange with the Welsh Language team for additional Welsh resources to be delivered to the ward e.g. lanyards.	30/11/2025	Fully complete (Approved)

HIW Derwen Ward 04054	The health board must ensure the relevant equipment is made to support patient mobility when required.	The ward has different height sized toilets and has seat raisers if required. Staff to be reminded via staff meeting the importance of completing manual handling assessments on patients on admission, and documenting if amendments are required e.g. toilet heights. Monitor the compliance through undertaking WNCR monthly audits. Outcome of assessment to be communicated and discussed with the patient.	31/12/2025	Fully complete (Approved)
HIW Derwen Ward 04054	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.	Derwen ward has had a recent full refurbishment, new flooring included. Review of tiled areas to identify broken tiles and Minor Works request to be completed to support repairs.	15/12/2025	Fully complete (Approved)

HIW Derwen Ward 04054	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.	Synbiotix audits will be fully aligned with the existing improvement plan. The Senior Nurse Manager will review audit criteria and ensure they reflect current priorities and actions outlined in the plan. Audit outcomes will be monitored monthly, and any gaps identified will be addressed through targeted actions within 2 weeks of each audit cycle.	31/12/2025	Fully complete (Approved)
HIW Derwen Ward 04054	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 findings from Synbiotix audits will continue to be reviewed at each monthly Carmarthenshire System Infection Prevention and Control Locality Meeting. The Hotel Services Manager will ensure audit outcomes are submitted at least 3 working days in advance, and any identified issues will be discussed with agreed actions recorded and monitored for progress at subsequent meetings.	31/12/2025	Fully complete (Approved)

HIW Derwen Ward 04054	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	01/04/2026	Overdue
HIW Derwen Ward 04054	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.	IP&C precautions will be reinforced in staff meeting, in line with the Standard Infection Prevention and Control Precautions Policy. Attendance will be monitored and minutes shared with the team.	30/11/2025	Fully complete (Approved)

HIW Derwen Ward 04054	The health board must ensure that where appropriate, family members, such as next of kin or those with Health and Welfare Lasting Power of Attorney are kept fully informed of decision relating to care of the patient, such as patient subject to a DoLS.	Review of current training compliance and requirements for staff for Mental Capacity E-learning module, with 100% compliance of all staff, currently attending work, expected.	31/12/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure that where appropriate, family members, such as next of kin or those with Health and Welfare Lasting Power of Attorney are kept fully informed of decision relating to care of the patient, such as patient subject to a DoLS.	Staff to be reminded via staff meeting the importance of communication with patients and families regarding decision relating to the care of a patient.	20/11/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must strengthen the safeguarding processes on the ward which includes robust documentation and accessibility to safeguarding policies and Wales Safeguarding Procedures.	Review of current training compliance and requirements for staff for Level 2 Adult Safeguarding E-learning module, with 100% compliance of all staff, currently attending work, expected.	31/12/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must strengthen the safeguarding processes on the ward which includes robust documentation and accessibility to safeguarding policies and Wales Safeguarding Procedures.	Staff to be reminded via staff meeting the availability of safeguarding resources via the HB Safeguarding intranet page. Icon to be added to ward computer desktop to support accessibility.	30/11/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure that the relevant medical devices, such as air mattresses are accessible in a timely manner.	Staff to be reminded via staff meeting, accessibility of air mattresses are via Synbiotix request. Encourage staff to escalate any delays in receiving such equipment.	30/11/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure that fluid balance charts are completed for all applicable patients.	Fluid balance training is covered in ILS training, see actions for recommendation 15.	03/09/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure a clear process is implemented that captures changes in patient condition and the need for skin pressure reassessment.	All clinical staff will be reminded of their responsibility to document all risk assessments and associated actions in the patient record, in line with the Prevention and Management of Pressure Ulcer Policy. This includes initial assessments, reassessments, and any interventions taken. The requirement will be reinforced through staff meetings and mandatory training sessions, with attendance recorded and compliance monitored through monthly documentation audits by the Senior Ward Manager.	31/12/2025	Fully complete (Approved)

HIW Derwen Ward 04054	The health board must ensure a clear process is implemented that captures changes in patient condition and the need for skin pressure reassessment.	Review training attendance and requirements of staff for Pressure Ulcer Risk Assessment E-learning module, with 100% compliance of all staff, currently attending work, expected.	31/12/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure that there is a robust system in place for timely escalation of care, consistent use of screening tools and adherence to best practice guidelines, including sepsis.	All clinical staff will be reminded of their responsibility to document all risk assessments and associated actions in the patient record, in line with the Monitoring, Recording of Adult Physiological Observations and Response to Physical Deterioration Policy. This includes initial assessments, reassessments, and any interventions taken. The requirement will be reinforced through staff meetings and mandatory training sessions, with attendance recorded and compliance monitored through monthly documentation audits by the Senior Ward Manager.	31/12/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure that there is a robust system in place for timely escalation of care, consistent use of screening tools and adherence to best practice guidelines, including sepsis.	Review training attendance and requirements of staff for NEWS 2 e-learning module. Training compliance will be monitored via RADAR scrutiny meeting.	31/12/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure that there is a robust system in place for timely escalation of care, consistent use of screening tools and adherence to best practice guidelines, including sepsis.	Review training attendance and requirements of staff for classroom ILS/BLS. Training compliance will be monitored via RADAR scrutiny meeting	31/12/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure that there is a robust system in place for timely escalation of care, consistent use of screening tools and adherence to best practice guidelines, including sepsis.	Arrange additional training to support the early recognition of a deteriorating patient.	31/12/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure that nutritional risk assessments are completed and ensure patients are offered alternative meals where appropriate to meet their nutritional needs.	Review training attendance and requirements of staff for All Wales Nutrition Risk Screening Tool E-learning module, with 100% compliance of all staff, currently attending work, expected.	31/12/2025	Fully complete (Approved)

HIW Derwen Ward 04054	The health board must ensure that nutritional risk assessments are completed and ensure patients are offered alternative meals where appropriate to meet their nutritional needs.	All patients' meals are aligned via Synbiotix System, which is signed by the nurse in charge of the patient. Spot audit of Synbiotix System, in line with patients' nutrition assessment, to be completed by Senior Ward Manager.	31/12/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must consider fully implementing electronic patient record system to access and manage patient records appropriately.	Electronic flow system planned launch in November 2025, for whole of HB.	30/11/2025	Fully complete (Approved)
HIW Derwen Ward 04054	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.	28/02/2026	Overdue
HIW Derwen Ward 04054	The health board must consider fully implementing electronic patient record system to access and manage patient records appropriately.	Electronic Prescribing (ePMA) system planned launch April 2026 for HB wide.	31/10/2026	In progress

HIW Derwen Ward 04054	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.	30/11/2025	Overdue
HIW Derwen Ward 04054	The health board must ensure that: •Care planning to promote independence is completed consistently and reflects individual patient needs •There is supporting documentation to support discharge planning •Copy of DNACPR forms are provided to patients •Catheter records are completed in full •There is greater integration between paper and electronic records.	All clinical staff will be reminded of their responsibility to document all risk assessments and associated actions in the patient record, in line with all care plans including discharge planning. This includes initial assessments, reassessments, and any interventions taken. The requirement will be reinforced through staff meetings and mandatory training sessions, with attendance recorded and compliance monitored through monthly documentation audits by the Senior Ward Manager.	31/12/2025	Fully complete (Approved)

HIW Derwen Ward 04054	The health board must ensure that: •Care planning to promote independence is completed consistently and reflects individual patient needs •There is supporting documentation to support discharge planning •Copy of DNACPR forms are provided to patients •Catheter records are completed in full •There is greater integration between paper and electronic records.	All clinical staff will be reminded of their responsibility to provide patients with a copy of DNACPR form, in line with the All Wales Policy for DNACPR. The requirement will be reinforced through staff meetings, with attendance recorded and compliance monitored through monthly documentation audits by the Senior Ward Manager.	31/12/2025	Fully complete (Approved)
HIW Derwen Ward 04054	he health board must ensure that both the ward and the treatment room are appropriately staffed as intended to maintain safe and timely care.	Central recruitment to be engaged re Band 3 deficits across the whole site has commenced in October, with first cohort due to start induction end of November. This will reduce deficits on the ward and release Assistant Practitioner and rehab support workers to work within the expected role.	30/11/2025	Fully complete (Approved)
HIW Derwen Ward 04054	he health board must ensure that both the ward and the treatment room are appropriately staffed as intended to maintain safe and timely care.	Nurse Staffing Level review to be completed for the Autumn cycle, to support the current Nurse Staffing Levels on Derwen.	31/10/2025	Fully complete (Approved)
HIW Derwen Ward 04054	he health board must ensure that both the ward and the treatment room are appropriately staffed as intended to maintain safe and timely care.	Staff to be reminded in ward meeting to raise Red Flags on the Safe Care system when staffing is not met and not appropriate.	30/11/2025	Fully complete (Approved)
HIW Derwen Ward 04054	he health board must ensure that both the ward and the treatment room are appropriately staffed as intended to maintain safe and timely care.	Review of Red Flags completed by Senior Nurse Manager and staff redeployed dependant on whole system review of staffing.	03/09/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure hospital staff work closely with social care teams to ensure that patients are discharged promptly when medically fit.	Weekly ‘Deep Dive’ meetings in place, attended by Local Authority, Therapies and Nursing Teams. Action focussed meeting to support timely discharges.	03/09/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure hospital staff work closely with social care teams to ensure that patients are discharged promptly when medically fit.	Weekly escalation meetings of complex patients and long stay patients – meeting supported by Local Authority colleagues and lead nurses for discharge.	03/09/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure hospital staff work closely with social care teams to ensure that patients are discharged promptly when medically fit.	Discharge workshop arranged in collaboration with external stakeholders involved with discharge support.	31/10/2025	Fully complete (Approved)

HIW Derwen Ward 04054	The health board must ensure hospital staff work closely with social care teams to ensure that patients are discharged promptly when medically fit.	Discharge SharePoint page available with current resources and information. All staff will be encouraged to review the resource page via staff meeting.	30/11/2025	Fully complete (Approved)
HIW Derwen Ward 04054	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.	03/09/2025	Overdue
HIW Derwen Ward 04054	The health board must complete a training needs analysis for its community nursing staff, to appropriately support them to adequately manage urology patients at home and minimise the need for patients reattending the ward for less complex nursing care procedures.	Lack of staff awareness within acute setting regarding community services available to support admission avoidance for catheter care. Clinical Lead Nurse for Community to present in GGH Professional Nurse Forum, to raise awareness of services available in the community, reinforce importance of COBWEB referral process and strengthen handover processes to the community teams.	30/11/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must consider the staff feedback around the patient specialty, their acuity and dependency in line with the establishment and the ongoing impact of vacancies and unfilled shifts, impacting both patients and staff. Consideration should also be given to the staffing required to manage attendances through the treatment room.	Central recruitment to be engaged re Band 3 deficits across the whole site has commenced in October, with first cohort due to start induction end of November. This will reduce deficits on the ward and release Assistant Practitioner and rehab support workers to work within the expected role.	30/11/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must consider the staff feedback around the patient specialty, their acuity and dependency in line with the establishment and the ongoing impact of vacancies and unfilled shifts, impacting both patients and staff. Consideration should also be given to the staffing required to manage attendances through the treatment room.	Nurse Staffing Level review to be completed for the Autumn cycle, to support the current Nurse Staffing Levels on Derwen.	31/10/2025	Fully complete (Approved)

HIW Derwen Ward 04054	The health board must consider the staff feedback around the patient specialty, their acuity and dependency in line with the establishment and the ongoing impact of vacancies and unfilled shifts, impacting both patients and staff. Consideration should also be given to the staffing required to manage attendances through the treatment room.	Staff to be reminded in ward meeting to raise Red Flags on the Safe Care system when staffing is not met and not appropriate.	30/11/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must consider the staff feedback around the patient specialty, their acuity and dependency in line with the establishment and the ongoing impact of vacancies and unfilled shifts, impacting both patients and staff. Consideration should also be given to the staffing required to manage attendances through the treatment room.	Review of Red Flags completed by Senior Nurse Manager and staff redeployed dependant on whole system review of staffing.	03/09/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure that: •All relevant staff complete portable oxygen cylinder training in line with national patient safety alerts •Ensure all staff are supported to attend mandatory training in a timely manner.	Support all staff to complete E-learning module for the safe use, storage and set up of medical gas cylinders, with 100% compliance of all staff, currently attending work, expected.	31/01/2026	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure that: •All relevant staff complete portable oxygen cylinder training in line with national patient safety alerts •Ensure all staff are supported to attend mandatory training in a timely manner.	Introduce information posters to the areas of the ward that store medical gas cylinders, outlining the importance of safe storage, in line with the Medicines Policy. This information will be shared via staff meeting.	15/12/2025	Fully complete (Approved)
HIW Derwen Ward 04054	The health board must ensure that: •All relevant staff complete portable oxygen cylinder training in line with national patient safety alerts •Ensure all staff are supported to attend mandatory training in a timely manner.	Further sharing and dissemination of learning within Medication Events Review Group (MERG).	31/01/2026	Fully complete (Approved)
Mynydd Mawr Ward, Prince Philip HospitaL 03921	Ensure that ambient clinic room temperatures are monitored and recorded daily.	Air-handling unit (For heating & cooling) being repaired by Estates department.	14/08/2025	Fully complete (Approved)
Mynydd Mawr Ward, Prince Philip HospitaL 03921	Ensure that ambient clinic room temperatures are monitored and recorded daily.	Awaiting costing for air-con for clinical room.	15/09/2025	Unable to complete

Mynydd Mawr Ward, Prince Philip HospitaL 03921	Ensure that ambient clinic room temperatures are monitored and recorded daily.	Thermometer now in place and messaging reinforced to ward staff/pharmacy re daily room temperature checks. Daily compliance checks to be monitored by Charge Nurse/Sister (as well as via SNM Medication Audit)	06/08/2025	Fully complete (Approved)
Mynydd Mawr Ward, Prince Philip HospitaL 03921	Ensure that ambient clinic room temperatures are monitored and recorded daily.	Email sent to all ward/clinical areas to ensure thermometers (temperature) are monitored and recorded between 12noon and 3pm.	14/08/2025	Fully complete (Approved)
Mynydd Mawr Ward, Prince Philip HospitaL 03921	Implement robust measures to maintain clinic room temperatures within recommended guidelines for safe medication storage.	Treatment Room & Fridge Temperature Monitoring chart requires amending to capture the escalation actions in the event of high temperature. This action has been requested and is underway.	30/09/2025	Fully complete (Approved)
Mynydd Mawr Ward, Prince Philip HospitaL 03921	Implement robust measures to maintain clinic room temperatures within recommended guidelines for safe medication storage.	The monitoring chart link requires to be embedded within the medicine policy for ease of access. This action has been requested and is underway. They are now imbedded into the new policy and it is out for a 2 week consultation that will finish this week (updated 23/02/26)	30/09/2025	Fully complete (Approved)

Mynydd Mawr Ward, Prince Philip HospitaL 03921	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.	31/10/2025	Partially complete (Overdue)
Mynydd Mawr Ward, Prince Philip HospitaL 03921	Implement robust measures to maintain clinic room temperatures within recommended guidelines for safe medication storage.	Six Monthly Medication audit, conducted by Senior Nurse Managers, has been amended to include the daily clinical room temperatures monitoring (This was not part of the audit previously. This will be on AmAT by September).	12/08/2025	Fully complete (Approved)
Mynydd Mawr Ward, Prince Philip HospitaL 03921	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.	Ensure staff are aware of the Medicines Policy. Disseminate and discuss within Ward meeting, ensuring they are aware of the escalation plan within the Ward Medicines Storage policy if temperatures go above recommended level.	28/08/2025	Fully complete (Approved)
Mynydd Mawr Ward, Prince Philip HospitaL 03921	Provide clear guidance and additional training to staff to ensure their understanding of the risks associated with temperature deviations, and the appropriate action to take in such circumstances.	Review the Medication Safety Study Day content – presentation to be updated to include medication storage and room temperature monitoring requirements.	30/09/2025	Fully complete (Approved)

Mynydd Mawr Ward, Prince Philip HospitaL 03921	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.	30/09/2025	Partially complete (Overdue)
Mynydd Mawr Ward, Prince Philip HospitaL 03921	Provide clear guidance and additional training to staff to ensure their understanding of the risks associated with temperature deviations, and the appropriate action to take in such circumstances.	Review training attendance and requirements of staff for Medication Safety & e-learning module.	01/09/2025	Fully complete (Approved)
Mynydd Mawr Ward, Prince Philip HospitaL 03921	Provide clear guidance and additional training to staff to ensure their understanding of the risks associated with temperature deviations, and the appropriate action to take in such circumstances.	Communicate to wider site within Professional Nurse forum (PNF), Medication Scrutiny and Assurance meeting.	28/08/2025	Fully complete (Approved)
Mynydd Mawr Ward, Prince Philip HospitaL 03921	Provide clear guidance and additional training to staff to ensure their understanding of the risks associated with temperature deviations, and the appropriate action to take in such circumstances.	Further sharing and dissemination of learning within wider Health Board forum – Community & Integrated Medicine Clinical Care Group, Integrated Governance Group (Quality, Health & Safety); Senior Nurse Management Team (SNMT), and Medication Events Review Group (MERG).	19/09/2025	Fully complete (Approved)

Mynydd Mawr Ward, Prince Philip HospitaL 03921	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.	Medicines Policy currently being reviewed and updated to capture the requirements in relation to the treatment room and fridge temperature monitoring. Policy is out of date but has been agreed an extension pending completion of review.	10/10/2025	Fully complete (Approved)
Mynydd Mawr Ward, Prince Philip HospitaL 03921	The health board must implement a structured programme of therapeutic activities on the ward, to ensure patients' social, cultural and wellbeing needs are met.	To embed a robust and structured approach to patient rehabilitation on the ward.	30/11/2025	Fully complete (Approved)
Mynydd Mawr Ward, Prince Philip HospitaL 03921	The health board must implement a structured programme of therapeutic activities on the ward, to ensure patients' social, cultural and wellbeing needs are met.	To undertake a spot check audit of the documentation and documented physiotherapy plans which to enable Rehabilitation Support Workers to continue delivering therapy interventions in the absence of full registrant staffing.	31/12/2025	Fully complete (Approved)
Mynydd Mawr Ward, Prince Philip HospitaL 03921	The health board must urgently address the garden environmental issues and ensure equitable access to support patients' physical and mental well-being.	The Garden Project has received formal support from the Board, with work scheduled to commence in February 2026. A dedicated Task and Finish Group has been established to oversee planning, implementation, and delivery of the refurbishment of the new garden area.	31/07/2026	In progress
Mynydd Mawr Ward, Prince Philip HospitaL 03921	The health board must ensure patients are provided with a range of appropriate and accessible information to support their health promotion and improvement and help them understand their care.	With involvement of ward staff, develop a visual display board which includes the use of health promotion posters and signposting information. This will be within a communal area to share key health messages.	15/10/2025	Fully complete (Approved)
Mynydd Mawr Ward, Prince Philip HospitaL 03921	The health board must ensure patients are provided with a range of appropriate and accessible information to support their health promotion and improvement and help them understand their care.	To remind staff of that every contact counts principles and remind them to discuss health promotion topics during routine care interactions.	31/10/2025	Fully complete (Approved)
Mynydd Mawr Ward, Prince Philip HospitaL 03921	The health board must review the surge bed arrangements on the ward, to ensure patients' privacy and dignity are protected and infection prevention and control is maintained.	Surge capacity has been recorded on the risk register and is currently reviewed monthly.	31/10/2025	Fully complete (Approved)

Mynydd Mawr Ward, Prince Philip HospitaL 03921	The health board must review the surge bed arrangements on the ward, to ensure patients' privacy and dignity are protected and infection prevention and control is maintained.	Strengthened Patient Flow meeting takes place twice daily at 8:30am and 3pm. This includes RTDC to promote discharge before 12pm with any issues escalated to Manager of the Day, which is communicated on the Health Board calls which take place twice daily at 10am and 4pm.	31/10/2025	Fully complete (Approved)
Mynydd Mawr Ward, Prince Philip HospitaL 03921	The health board must review the surge bed arrangements on the ward, to ensure patients' privacy and dignity are protected and infection prevention and control is maintained.	The Ward Manager is responsible for Identifying patients suitable for the surge area taking into account infection control status, mobility and patient's needs.	31/10/2025	Fully complete (Approved)
Mynydd Mawr Ward, Prince Philip HospitaL 03921	The health board must review the surge bed arrangements on the ward, to ensure patients' privacy and dignity are protected and infection prevention and control is maintained.	Deep Dive of patient's takes place weekly with all Ward Sisters re patients estimated date of discharge to ensure forward planning of any requirements to enable a safe and prompt discharge. This meeting is chaired by the Discharge Liaison Senior Nurse Manager. Carmarthenshire System Escalation meeting twice weekly to highlight delays in Discharge Planning (MDT approach – community, Social services, LTCT, Therapy, Acute).	31/10/2025	Fully complete (Approved)
Mynydd Mawr Ward, Prince Philip HospitaL 03921	The health board must review the surge bed arrangements on the ward, to ensure patients' privacy and dignity are protected and infection prevention and control is maintained.	DLN is assigned to MMRU, also working alongside community, to ensure any unforeseen issues regarding discharge are dealt with promptly to avoid unnecessary admissions or delayed discharges. The Health Board has an established boarding protocol, which is currently under review to implement a standardised patient boarding risk assessment across all wards.	31/01/2026	Fully complete (Approved)
Mynydd Mawr Ward, Prince Philip HospitaL 03921	The health board must ensure 'This is Me' documentation is completed to support personalised, person-centred care.	To discuss the 'What Matters to Me' initiative during a ward meeting, and provide all staff with a copy of the presentation.	31/10/2025	Fully complete (Approved)
Mynydd Mawr Ward, Prince Philip HospitaL 03921	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.	30/10/2025	Unable to complete

Mynydd Mawr Ward, Prince Philip HospitaL 03921	The health board must declutter the patient day room and ensure patients are informed of its availability and purpose to improve access, encourage social interaction, and support wellbeing.	In collaboration with the ward team, undertaken a thorough decluttering of the day room. This will involve the removal of unnecessary items, ensuring appropriate storage of essential equipment, and reorganisation of the space to enhance safety, accessibility, and the overall environment for patients and staff.	31/10/2025	Fully complete (Approved)
Mynydd Mawr Ward, Prince Philip HospitaL 03921	The health board must declutter the patient day room and ensure patients are informed of its availability and purpose to improve access, encourage social interaction, and support wellbeing.	To establish a practice of daily environmental checks to ensure that the day room and dining area remain clutter-free, promoting a safe, welcoming, and therapeutic environment for patients, staff, and visitors.	31/10/2025	Fully complete (Approved)
Mynydd Mawr Ward, Prince Philip HospitaL 03921	The health board must declutter the patient day room and ensure patients are informed of its availability and purpose to improve access, encourage social interaction, and support wellbeing.	To ensure that, following the monthly Synbiotix audits the targeted actions are recorded and actions completed.	30/11/2025	Fully complete (Approved)
Mynydd Mawr Ward, Prince Philip HospitaL 03921	The health board must declutter the patient day room and ensure patients are informed of its availability and purpose to improve access, encourage social interaction, and support wellbeing.	To continue to review the findings from Synbiotix audits at each monthly Carmarthenshire System Infection Prevention and Control Locality Meeting and quarterly Hospital Patient environment meeting. The Hotel Services Manager will ensure audit outcomes are submitted at least 3 working days in advance, and any identified issues will be discussed with agreed actions recorded and monitored for progress at subsequent meetings.	31/12/2025	Fully complete (Approved)
Mynydd Mawr Ward, Prince Philip HospitaL 03921	The health board must urgently review the physiotherapy provision on the ward, to ensure patients receive timely and appropriate assessments, along with suitable therapeutic support during the interim period.	To embed a robust and structured approach to patient rehabilitation on the ward.	30/11/2025	Fully complete (Approved)
Mynydd Mawr Ward, Prince Philip HospitaL 03921	The health board must ensure that all patient information boards provide relevant, accessible, and up-to-date information.	To ensure staff are aware how to access to materials in other languages as required by the local population.	07/10/2025	Fully complete (Approved)
Mynydd Mawr Ward, Prince Philip HospitaL 03921	The health board should introduce a clear and pictorial ‘Who’s Who’ board to support patient and visitor awareness of staff roles and identities.	To seek clarification from the Information Governance Team regarding the use of pictorial board.	07/10/2025	Fully complete (Approved)

Mynydd Mawr Ward, Prince Philip HospitaL 03921	The health board should introduce a clear and pictorial ‘Who’s Who’ board to support patient and visitor awareness of staff roles and identities.	To remind staff of the requirement to wear identification badges. The Senior Ward Manager or a designated team member will conduct a daily check that all staff have they’re identification badges.	07/10/2025	Fully complete (Approved)
Mynydd Mawr Ward, Prince Philip HospitaL 03921	The health board should introduce a clear and pictorial ‘Who’s Who’ board to support patient and visitor awareness of staff roles and identities.	A poster is displayed on the ward notice board outlining staff uniform colours and corresponding staff grades. To promote clarity and reassurance for those accessing the ward	07/10/2025	Fully complete (Approved)
Mynydd Mawr Ward, Prince Philip HospitaL 03921	The health board must review the ward visiting arrangements to ensure appropriate facilities for patients and visitors to meet in private.	In collaboration with the ward team, undertaken a thorough decluttering of the day room. This will involve the removal of unnecessary items, ensuring appropriate storage of essential equipment, and reorganisation of the space to enhance safety, accessibility, and the overall environment for patients and staff.	31/10/2025	Fully complete (Approved)
Mynydd Mawr Ward, Prince Philip HospitaL 03921	The health board must: •Ensure all patients, including those in surge beds, are provided with a reliable means to alert staff when assistance is needed, to maintain patient safety and uphold standards of responsive care •Review the environmental and safety issues associated with the use of the surge beds on the ward to uphold patient safety and quality of care •Ensure the use of surge beds is risk assessed, time limited, and used only during high escalation periods •Continue to manage the use of surge beds in line with policy, ensuring appropriate staffing, oversight and consideration for patient needs whilst actively working toward eliminating their use.	To remind the Senior Nurse on duty that they are responsible for ensuring that all patients within the surge area are provided with a manual call bell to maintain safety and facilitate communication.	07/10/2025	Fully complete (Approved)

Mynydd Mawr Ward, Prince Philip HospitaL 03921	The health board must: •Ensure all patients, including those in surge beds, are provided with a reliable means to alert staff when assistance is needed, to maintain patient safety and uphold standards of responsive care •Review the environmental and safety issues associated with the use of the surge beds on the ward to uphold patient safety and quality of care •Ensure the use of surge beds is risk assessed, time limited, and used only during high escalation periods •Continue to manage the use of surge beds in line with policy, ensuring appropriate staffing, oversight and consideration for patient needs whilst actively working toward eliminating their use.	members of staff are allocated to the area to provide continuous supervision and support. 'Baywatch' monitoring is implemented to ensure visibility and oversight of patient activity, promoting prompt response to patient needs and enhancing overall safety within the environment	07/10/2025	Fully complete (Approved)
Mynydd Mawr Ward, Prince Philip HospitaL 03921	The health board must ensure that BLS and ILS training courses are made available to all staff as a matter of urgency. Staff compliance must be improved promptly to maintain patient safety	To review the training records to ensure that they are accurate and current and to develop a clear trajectory to improve staff compliance rates where all staff will be compliant by March 2026. This will be monitored through the assurance scrutiny meetings.	15/10/2025	Fully complete (Approved)
Mynydd Mawr Ward, Prince Philip HospitaL 03921	The health board must ensure boxed hand towels are stored correctly to maintain effective IPC standards.	To ensure boxed hand towels are stored correctly in accordance with the Health Board's infection prevention and control (IPC) standards.	15/10/2025	Fully complete (Approved)
Mynydd Mawr Ward, Prince Philip HospitaL 03921	The health board must ensure the ward's echocardiogram (ECG) is serviced within set timescales to support patient safety.	To ensure that the ward's echocardiogram (ECG) is serviced within the required timescales, in line with the health board's commitment to supporting patient safety	07/10/2025	Fully complete (Approved)
Mynydd Mawr Ward, Prince Philip HospitaL 03921	The health board must engage with ward staff to review the impact of surge capacity on staffing pressures and ensure that safe staffing levels are maintained across all areas.	Strengthened Patient Flow meeting takes place twice daily at 8:30am and 3pm. This includes RTDC to promote discharge whilst also recording staffing on all ward areas.	07/10/2025	Fully complete (Approved)
Mynydd Mawr Ward, Prince Philip HospitaL 03921	The health board must engage with ward staff to review the impact of surge capacity on staffing pressures and ensure that safe staffing levels are maintained across all areas.	Acuity is being monitored through reporting on safe care	07/10/2025	Fully complete (Approved)

Mynydd Mawr Ward, Prince Philip HospitaL 03921	The health board must engage with ward staff to review the impact of surge capacity on staffing pressures and ensure that safe staffing levels are maintained across all areas.	NSL discussions which incorporates surge staffing discussions.	07/10/2025	Fully complete (Approved)
Mynydd Mawr Ward, Prince Philip HospitaL 03921	The health board must engage with ward staff to review the impact of surge capacity on staffing pressures and ensure that safe staffing levels are maintained across all areas.	A monthly scrutiny meeting to be arranged to review and address any reported staffing issues, with a dedicated agenda item focused on infrastructure, ensuring that appropriate actions are identified and implemented.	07/10/2025	Fully complete (Approved)
Mynydd Mawr Ward, Prince Philip HospitaL 03921	The health board must ensure that all staff are up to date with mandatory sepsis training to support safe and effective clinical care.	To review the training records to ensure that they are accurate and current and to develop a clear trajectory to improve staff compliance rates where all staff will be compliant by March 2026. This will be monitored through the assurance scrutiny meetings.	07/10/2025	Fully complete (Approved)
Mynydd Mawr Ward, Prince Philip HospitaL 03921	The health board must ensure that staff meetings are conducted regularly to encourage staff engagement and feedback.	To reinstate the monthly ward meeting via teams and forward plan dates for the meeting	15/10/2025	Fully complete (Approved)
Mynydd Mawr Ward, Prince Philip HospitaL 03921	The health board must implement measures to ensure all outstanding mandatory training is completed, regularly monitored, and that staff receive appropriate support to complete the training in a timely manner.	To review the training records to ensure that they are accurate and current and to develop a clear trajectory to improve staff compliance rates where all staff will be compliant by March 2026. This will be monitored through the assurance scrutiny meetings.	07/10/2025	Fully complete (Approved)
Mynydd Mawr Ward, Prince Philip HospitaL 03921	The health board must implement measures to ensure all outstanding mandatory training is completed, regularly monitored, and that staff receive appropriate support to complete the training in a timely manner.	Monthly scrutiny meetings to be scheduled, where key performance areas, including mandatory training compliance, will be reviewed. These meetings provide an opportunity to monitor progress, identify areas for improvement, and ensure that staff remain up to date with essential training requirements.	07/10/2025	Fully complete (Approved)
Mynydd Mawr Ward, Prince Philip HospitaL 03921	The health board must: •Ensure Putting Things Right guidance is prominently displayed •Implement a structured process to routinely capture patient feedback and use this to inform improvements in patient care.	With involvement of ward staff, develop a visual display board which includes the use of health promotion posters and signposting information. This will be within a communal area to share key health messages.	15/10/2025	Fully complete (Approved)

Mynydd Mawr Ward, Prince Philip HospitaL 03921	The health board must: •Ensure Putting Things Right guidance is prominently displayed •Implement a structured process to routinely capture patient feedback and use this to inform improvements in patient care.	To explore mechanisms for capturing patient feedback with the Patient Experience Team	15/10/2025	Fully complete (Approved)
Mynydd Mawr Ward, Prince Philip HospitaL 03921	The health board must ensure that all staff are compliant with Duty of Candour training and are appropriately supported to understand and apply its principles in their roles.	To ensure staff are aware that information is available about Duty of Candour on the Hywel Dda intranet resources within the Quality, Assurance and Safety information. This includes the duty of candour staff training video.	07/10/2025	Fully complete (Approved)
Mynydd Mawr Ward, Prince Philip HospitaL 03921	The health board must ensure that all staff are compliant with Duty of Candour training and are appropriately supported to understand and apply its principles in their roles.	To undertake a weekly (for a period of four weeks) validation of manager's interim harm assessment for patient safety incidents reported on Mynydd Mawr This will be in addition to the established monthly validation of all patient safety incidents closed in the month.	30/11/2025	Fully complete (Approved)
Mynydd Mawr Ward, Prince Philip HospitaL 03921	The health board must strengthen its approach to information governance by ensuring all patient-identifiable information is securely stored in accordance with GDPR requirements	To remind all clinical areas the requirement to store patient records in locked as per Record Keeping policy. This will be reinforced through staff meetings.	07/10/2025	Fully complete (Approved)
Mynydd Mawr Ward, Prince Philip HospitaL 03921	The health board must strengthen its approach to information governance by ensuring all patient-identifiable information is securely stored in accordance with GDPR requirements	To review training attendance and requirements of staff for Information Governance e-learning. Training compliance will be monitored via Carmarthenshire Integrated Performance and Business Management Care Group.	07/10/2025	Fully complete (Approved)
Mynydd Mawr Ward, Prince Philip HospitaL 03921	The health board must strengthen its approach to information governance by ensuring all patient-identifiable information is securely stored in accordance with GDPR requirements	To include in the daily environmental checks, verification that patient records are stored securely and appropriately, in line with information governance standards. Any breaches will be reported to the Ward Manager immediately and addressed within 24 hours. Compliance will be reviewed weekly by the Ward Manager, with 100% adherence expected.	07/10/2025	Fully complete (Approved)
Safeguarding / Child Protection				

Joint Inspection of Child Protection Arrangements (Pembrokeshire)	There can also be delays in health assessments being completed for children involved in the child protection process. Whilst the health board has identified improvements to address these concerns, ongoing delays mean protective actions to address risk can be adversely impacted.	Disseminate a 7 minute briefing emphasising timescales and responsibilities for completing ICP reports and health assessments in a timely way, following up Strategy Meeting outcomes, Care & Support Protection Plan, Core Group minutes and Duty To Report outcomes.	31/07/2025	Fully complete (Approved)
Joint Inspection of Child Protection Arrangements (Pembrokeshire)	There is variation in the quality of leadership across Hywel Dda University Health Board (HDUHB), ranging from proactive approaches to safeguarding practices to missed opportunities for professional challenge and the absence of supervision. Safeguarding training compliance is generally poor and requires a renewed focus and drive by managers to improve attendance.	Clinical Care Groups (CCG) to review systems in place for professional ownership and proactive approaches to safeguarding and report to Strategic Safeguarding Steering Group.	31/12/2025	Fully complete (Approved)
Joint Inspection of Child Protection Arrangements (Pembrokeshire)	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.	31/12/2025	Partially complete (Overdue)

Joint Inspection of Child Protection Arrangements (Pembrokeshire)	Quality assurance can be inconsistent, capacity being a specific factor, notably for children's services and HDUHB. In the absence of clear quality assurance processes being implemented, leaders do not have sufficient line of sight on compliance or practice quality.	Implement a UHB corporate safeguarding and service audit programme	31/03/2026	Fully complete (Approved)
Joint Inspection of Child Protection Arrangements (Pembrokeshire)	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	30/09/2025	Fully complete (Approved)
Joint Inspection of Child Protection Arrangements (Pembrokeshire)	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	30/09/2025	Partially complete (Overdue)

Joint Inspection of Child Protection Arrangements (Pembrokeshire)	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	30/09/2025	Overdue
Joint Inspection of Child Protection Arrangements (Pembrokeshire)	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	30/09/2025	Fully complete (Approved)
Joint Inspection of Child Protection Arrangements (Pembrokeshire)	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	30/11/2025	Overdue
Joint Inspection of Child Protection Arrangements (Pembrokeshire)	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	30/11/2025	Fully complete (Approved)
Joint Inspection of Child Protection Arrangements (Pembrokeshire)	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	30/11/2025	Fully complete (Approved)

Joint Inspection of Child Protection Arrangements (Pembrokeshire)	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 Achieving 85% compliance remains challenging. Aim to do so by 28.03.36	30/11/2025	Partially complete (Overdue)
Joint Inspection of Child Protection Arrangements (Pembrokeshire)	Child protection supervision was not evident in the sample of files reviewed. There were inconsistences in record-keeping, with examples of minimal recordings and a lack of analysis.	Records audit in School Nursing and Health Visiting to evidence child protection supervision in records.	31/03/2026	Fully complete (Approved)
Joint Inspection of Child Protection Arrangements (Pembrokeshire)	Child protection supervision was not evident in the sample of files reviewed. There were inconsistences in record-keeping, with examples of minimal recordings and a lack of analysis.	Records audit in School Nursing and Health Visiting to evidence child protection supervision in records.	31/03/2026	Fully complete (Approved)
Joint Inspection of Child Protection Arrangements (Pembrokeshire)	Safeguarding group supervision compliance is low due to poor attendance and the approach not being implement for some relevant groups (such as CAMHS, Sexual Health Services and Allied Health Professionals). Similarly, attendance at monthly peer review sessions is inconsistent. Safeguarding supervision is an important element of reflection and learning and should be prioritised, alongside safeguarding training.	Report on group supervision uptake by Staff Group to Heads of Service monthly.	31/03/2026	Fully complete (Approved)

Joint Inspection of Child Protection Arrangements (Pembrokeshire)	Safeguarding group supervision compliance is low due to poor attendance and the approach not being implement for some relevant groups (such as CAMHS, Sexual Health Services and Allied Health Professionals). Similarly, attendance at monthly peer review sessions is inconsistent. Safeguarding supervision is an important element of reflection and learning and should be prioritised, alongside safeguarding training.	Report on Peer Supervision attendance to the quarterly Planned and Specialist Care Safeguarding Delivery Group	31/03/2026	Fully complete (Approved)
Joint Inspection of Child Protection Arrangements (Pembrokeshire)	Safeguarding group supervision compliance is low due to poor attendance and the approach not being implement for some relevant groups (such as CAMHS, Sexual Health Services and Allied Health Professionals). Similarly, attendance at monthly peer review sessions is inconsistent. Safeguarding supervision is an important element of reflection and learning and should be prioritised, alongside safeguarding training.	Exceptions in compliance with safeguarding supervision attendance to be escalated to the Asst. Director in each CCG and non-compliance reported to the Strategic Safeguarding Steering Group	31/03/2026	Fully complete (Approved)
Joint Inspection of Child Protection Arrangements (Pembrokeshire)	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.	31/03/2026	Overdue
Joint Inspection of Child Protection Arrangements (Pembrokeshire)	Child protection supervision was not evident in the sample of files reviewed. There were inconsistences in record-keeping, with examples of minimal recordings and a lack of analysis.	Child safeguarding supervision via group, 1-1 and ad hoc supervision will promote child-centred practices and a shift from process-led safeguarding to person-centred practice that supports people to live safely and independently with attendees.	30/09/2025	Fully complete (Approved)
Joint Inspection of Child Protection Arrangements (Pembrokeshire)	There is a tendency to lose focus on individual children if a sibling's situation is regarded as more urgent or complex. Assessments, plans and meetings must maintain focus on the individual needs and outcomes of all children in sibling groups.	Evidence of the voice of the child and family to be incorporated into service record keeping audits.	31/03/2026	Fully complete (Approved)

Joint Inspection of Child Protection Arrangements (Pembrokeshire)	There can also be delays in health assessments being completed for children involved in the child protection process. Whilst the health board has identified improvements to address these concerns, ongoing delays mean protective actions to address risk can be adversely impacted.	School Nursing service to put in place processes to monitor compliance with complying with health assessments requests within timescales.	30/06/2025	Fully complete (Approved)
Joint Inspection of Child Protection Arrangements (Pembrokeshire)	The reliance on CP medicals being completed by acute paediatricians in an out-of-county hospital, due to the lack of a service in Pembrokeshire, presents a long-standing and unresolved challenge to all agencies involved. The Health Board should consider how best to resolve theses issues to ensure a more timely and seamless service, both for agencies and for the children and families involved.	Work with Local Authority partners to agree an escalation process when health assessments are delayed.	30/09/2025	Fully complete (Approved)
Joint Inspection of Child Protection Arrangements (Pembrokeshire)	The recording of ethnicity and language on the Health Board and police records is not consistent. Leaders should ensure accurate and clear record keeping of important demographic information.	Service Leads to incorporate into record keeping audits, evidence of important demographic information, e.g. ethnicity	30/09/2025	Fully complete (Approved)
Joint Inspection of Child Protection Arrangements (Pembrokeshire)	The recording of ethnicity and language on the Health Board and police records is not consistent. Leaders should ensure accurate and clear record keeping of important demographic information.	Incorporate evidence of genograms, chronologies and front sheets (WCCIS excepting) into Senior Nurse random HV and SN record keeping audit.	30/09/2025	Fully complete (Approved)
Joint Inspection of Child Protection Arrangements (Pembrokeshire)	There was variability in the completion and quality of safeguarding documentation across services. This includes missing or incomplete genograms, chronologies, and front sheets.	Staff compliance of attendance at record keeping training to be scrutinised	30/09/2025	Fully complete (Approved)
Joint Inspection of Child Protection Arrangements (Pembrokeshire)	Inter-agency communication requires improvement in many practice areas, for example between School Nurses and Social Workers. The absence of safeguarding records, including Care and Support Protection Plan (CASPP) and Core Group minutes, from health records is an indicator of disjointed communication.	Discussion related to ensuring CASPP and core group minutes are in a child's record to be discussed at team meetings and evidenced in minutes.	30/09/2025	Fully complete (Approved)

Joint Inspection of Child Protection Arrangements (Pembrokeshire)	Health practitioners do not consistently follow-up on significant events such as domestic abuse incidents or following the receipt of DTRs. Records do not evidence any analysis of the incidents or plans to respond to them. Practitioners should work with children and their families to avoid situations arising that are likely to lead to the child experiencing abuse, neglect and harm.	Draft and support the implementation of a SOP for the storage and response to domestic incidents for HV, SN and Primary Care.	31/08/2025	Fully complete (Approved)
Joint Inspection of Child Protection Arrangements (Pembrokeshire)	Health practitioners do not consistently follow-up on significant events such as domestic abuse incidents or following the receipt of DTRs. Records do not evidence any analysis of the incidents or plans to respond to them. Practitioners should work with children and their families to avoid situations arising that are likely to lead to the child experiencing abuse, neglect and harm.	HV and SN to include evidence of analysis and response to safeguarding concerns and incidents in record keeping audits.	31/12/2025	Fully complete (Approved)
Joint Inspection of Child Protection Arrangements (Pembrokeshire)	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.	31/12/2025	Overdue

Joint Inspection of Child Protection Arrangements (Pembrokeshire)	Partners should ensure timely information sharing about emerging safeguarding themes and work together to disrupt and reduce such risks within the population and for individual children.	Prevention & emerging risks: HV and Midwifery to draft a Free Birth policy for consultation with regional multi-agency partners.	30/09/2025	Fully complete (Approved)
Joint Inspection of Child Protection Arrangements (Pembrokeshire)	Partners should ensure timely information sharing about emerging safeguarding themes and work together to disrupt and reduce such risks within the population and for individual children.	Prevention & emerging risks: Review strategies across the multi-agency partnership to reduce substance ingestion by young children	31/12/2025	Fully complete (Approved)
Joint Inspection of Child Protection Arrangements (Pembrokeshire)	The absence of the child's voice and lived experience was a theme in respect of some school aged children. Leaders should work with practitioners and the local authority to strengthen the voice of the child in records and ensure timely information sharing of important documents.	Explore with multi-agency partners opportunities for multi-agency training and audit to enable strength based and person centred safeguarding.	31/03/2026	Fully complete (Approved)
Joint Inspection of Child Protection Arrangements (Pembrokeshire)	There are occasions when it would be beneficial to have wider multi-agency contributions to these meetings (strategy discussions). For example, referrers and allocated social workers are rarely included in strategy discussions, as these meetings are convened by CCAT and the police. As a minimum, appropriate practitioners, with responsibility for child protection in the police and social services, should be involved. The local authority should consider how urgent is the discussion, how many agencies need to be involved, and the seriousness of the risk. What is important is to gather sufficient information to form an initial judgement. Partners should work together to develop effective systems for partners to consistently contribute to strategy discussions and meetings.	Continue to pursue and participate in multi-agency discussions to enable health representation at strategy meetings.	31/03/2026	Fully complete (Approved)
Joint Inspection of Child Protection Arrangements (Pembrokeshire)	Learning from the JICPA to be incorporated into child safeguarding group supervision.	Learning from the JICPA to be incorporated into child safeguarding group supervision.	31/12/2025	Fully complete (Approved)
Operational Allied Health and Health Professions				

HIW GGH IRMER Inspection (Nov 2022)	The health board is required to provide HIW with details of the action taken to improve the provision of relevant health promotion information within the Diagnostic Imaging Dept	Health promotional material has been ordered and will be in place as soon as it has been delivered. Introduce a process whereby the content will be reviewed / updated regularly	28/02/2023	Fully complete (Approved)
HIW GGH IRMER Inspection (Nov 2022)	The health board is required to provide HIW with details of the action taken to improve the print quality of appointment letters sent to patients	Create a working group to standardise the letter format for radiology using the HB guidelines	30/09/2023	Fully complete (Approved)
HIW GGH IRMER Inspection (Nov 2022)	The health board is required to provide HIW with details of the action taken to improve the print quality of appointment letters sent to patients	Instigate a process whereby the service will only send printed copies of letters and not photocopy any letters with immediate action.	19/05/2023	Fully complete (Approved)
HIW GGH IRMER Inspection (Nov 2022)	The employer is required to provide HIW with details of the action taken to promote an effective and consistent approach to staff recording patient identity checks, pregnancy enquiries and exposure doses.	A review of the procedure for patient identify checks will be undertaken to update the Employer's Procedure (EP).	30/06/2023	Fully complete (Approved)
HIW GGH IRMER Inspection (Nov 2022)	The employer is required to provide HIW with details of the action taken to promote an effective and consistent approach to staff recording patient identity checks, pregnancy enquiries and exposure doses.	Introduce an audit to be performed on compliance with identity checks.	30/06/2023	Fully complete (Approved)
HIW GGH IRMER Inspection (Nov 2022)	The employer is required to provide HIW with details of the action taken to review and revise the employer's written procedure for non-medical imaging exposures so that it includes reference to Tuberculosis (TB) screening	Introduce a process whereby all Employer's Procedures will be reviewed in February 23 and updated to include all examinations currently performed.	30/04/2023	Fully complete (Approved)
HIW GGH IRMER Inspection (Nov 2022)	The employer is required to provide HIW with details of the action taken to review and revise the employer's written procedures providing guidance on making a referral so that they reflect the need to avoid using acronyms and include reference to current guidance where applicable	All Employer's Procedures will be reviewed in February 23 and updated to include that we do not accept referral forms with acronyms. We will also ensure that all referrers receive a copy of the Employers Procedures for referrers.	30/06/2023	Fully complete (Approved)
HIW GGH IRMER Inspection (Nov 2022)	The employer is required to provide HIW with details of the action taken to review and revise the DAG for CT referrals so that it includes more detail for the indications for orthopaedic CT and major trauma CT.	Introduction of a process to review the DAG to ensure more detail is included for CT referrals.	30/06/2023	Fully complete (Approved)

HIW GGH IRMER Inspection (Nov 2022)	The employer is required to provide HIW with details of the action taken to review and revise the DAG for CT referrals so that it includes more detail for the indications for orthopaedic CT and major trauma CT.	Introduction of a process to review the DAG to ensure more detail is included for CT referrals.	30/04/2023	Fully complete (Approved)
HIW GGH IRMER Inspection (Nov 2022)	The employer is required to provide HIW with details of the action taken to review and revise the employer's written procedure for the use and review of diagnostic reference levels so that it provides details of the frequency for reviewing logbooks	Introduction of a procedure to review EP's to include the logbook checking frequency.	30/04/2023	Fully complete (Approved)
HIW GGH IRMER Inspection (Nov 2022)	The employer is required to provide HIW with details of the action taken to review and revise the employer's written procedure for the use and review of diagnostic reference levels so that it provides details of the frequency for reviewing logbooks	Instigate an audit to check compliance as part of the audit schedule.	30/04/2023	Fully complete (Approved)
HIW GGH IRMER Inspection (Nov 2022)	The employer is required to provide HIW with details of the action taken to review and revise the employer's written procedure for the assessment of patient dose and administered activity so that it includes details of the procedure for exposures performed in surgical theatres and interventional radiography	Introduction of a procedure to review all Employer's Procedures to include theatre procedures and interventional radiography	30/06/2023	Fully complete (Approved)
HIW GGH IRMER Inspection (Nov 2022)	The employer is required to provide HIW with details of the action taken to promote a consistent approach for the process and presentation of clinical audits.	Instigate a procedure to promote a consistent approach for process and presentation of clinical audits.	30/03/2023	Fully complete (Approved)
HIW GGH IRMER Inspection (Nov 2022)	The employer is required to provide HIW with details of the action taken to revise the employer's written procedure to identify individuals entitled to act as referrer, practitioner or operator so that it clearly sets out the position in relation to anaesthesia associates	Introduce a procedure to review all Employer's Procedures to include the position on anaesthesia associate. The policy will be clearly reworded to reflect that only registered professionals are able to refer	30/06/2023	Fully complete (Approved)
HIW GGH IRMER Inspection (Nov 2022)	The employer is required to provide HIW with details of the action taken to maintain a complete and up to date record of the training, entitlement and scope of practice for entitled duty holders, including non-medical referrers	A review of the entitled duty holder matrix will be undertaken with the suggested change being made to provide a more thorough record.	30/06/2023	Fully complete (Approved)

HIW GGH IRMER Inspection (Nov 2022)	The employer is required to provide HIW with details of the action taken to demonstrate competency has been assessed: 1) for those practitioners entitled to justify exposures to carers and comforters 2) for staff performing operator roles in surgical theatres. The employer's written procedure to establish dose constraints and guidance for the exposure of carers and comforters must also be reviewed and revised to clarify the arrangements for the justification of such exposures by the practitioner	Instigate the development of a training document which will provide assurance and information to staff about the specific roles. These competencies will be added to matrix.	31/08/2023	Fully complete (Approved)
HIW GGH IRMER Inspection (Nov 2022)	The employer is required to provide HIW with details of the action taken to demonstrate competency has been assessed: 1) for those practitioners entitled to justify exposures to carers and comforters 2) for staff performing operator roles in surgical theatres. The employer's written procedure to establish dose constraints and guidance for the exposure of carers and comforters must also be reviewed and revised to clarify the arrangements for the justification of such exposures by the practitioner	The Employer's Procedure will be updated to include the justification process.	30/06/2023	Fully complete (Approved)
HIW GGH IRMER Inspection (Nov 2022)	The employer is required to provide HIW with details of the action taken to demonstrate competency has been assessed: 1) for those practitioners entitled to justify exposures to carers and comforters 2) for staff performing operator roles in surgical theatres. The employer's written procedure to establish dose constraints and guidance for the exposure of carers and comforters must also be reviewed and revised to clarify the arrangements for the justification of such exposures by the practitioner	Introduce a process to establish dose constraints and add to Employer Procedures.	30/06/2023	Fully complete (Approved)

HIW GGH IRMER Inspection (Nov 2022)	The employer is required to provide HIW with details of the action taken to develop and implement written protocols, where appropriate, for paediatric patient	A process has been introduced to review all adult protocols.The review will inform the development and implementation of paediatric protocols.	30/07/2023	Fully complete (Approved)
HIW GGH IRMER Inspection (Nov 2022)	The employer is required to provide HIW with details of the action taken to improve the ratification process for locally produced documentation so that information does not conflict with the employer's written procedure	A process has been introduced whereby the Lead Radiographer coordinates all written documentation to ensure no conflict with the employers written procedures	30/04/2023	Fully complete (Approved)
HIW GGH IRMER Inspection (Nov 2022)	The employer is required to provide HIW with details of the action taken to improve the ratification process for locally produced documentation so that information does not conflict with the employer's written procedure	To source a document control system.	30/09/2023	Overdue
HIW GGH IRMER Inspection (Nov 2022)	The employer is required to provide HIW with details of the action taken to: • ensure staff are aware of the current written examination protocols to use • ensure the written protocols clearly identify the author • ensure staff can access protocols in the event of a system failure	Hard copies of the protocols are available at all times in the department. A process will be undertaken to ensure any remaining old copies of protocols are removed and that the author is identified	30/03/2023	Fully complete (Approved)

HIW GGH IRMER Inspection (Nov 2022)	The employer is required to provide HIW with details of the action taken to: • ensure staff are aware of the current written examination protocols to use • ensure the written protocols clearly identify the author • ensure staff can access protocols in the event of a system failure	Written examination protocols will be made available to all staff in electronic and paper formats for all areas.	28/02/2023	Fully complete (Approved)
HIW GGH IRMER Inspection (Nov 2022)	The employer is required to provide HIW with details of the action taken to: • ensure staff are aware of the current written examination protocols to use • ensure the written protocols clearly identify the author • ensure staff can access protocols in the event of a system failure	Staff have been briefed on protocols and any changes to protocols as they are made via team meetings.	19/05/2023	Fully complete (Approved)
HIW GGH IRMER Inspection (Nov 2022)	The health board is required to provide HIW with details of the action taken to respond to the less favourable staff comments noted in the 'Quality of Management and Leadership' section of this report	The management team have approached the Health Board's values and culture team for expert advice on how to ensure the staff's voices are heard and action taken.	30/05/2023	Fully complete (Approved)
HIW GGH IRMER Inspection (Nov 2022)	The health board is required to provide HIW with details of the action taken to respond to the less favourable staff comments noted in the 'Quality of Management and Leadership' section of this report	A series of staff engagement events are planned to instigate 'culture change' within the department and empower staff's confidence in the management	30/05/2023	Fully complete (Approved)
HIW GGH IRMER Inspection (Nov 2022)	The health board is required to provide HIW with details of the action taken to respond to the less favourable staff comments noted in the 'Quality of Management and Leadership' section of this report	Staff meetings are being strengthened and a regular schedule of meetings are being arranged in advance and circulated to staff.	30/05/2023	Fully complete (Approved)
HIW GGH IRMER Inspection (Nov 2022)	The employer is required to provide HIW with details of the action taken to: • review and revise the employer's written procedure for making enquiries of individuals of childbearing potential so that it reflects the diversity of the gender spectrum in the population • review and revise appointment letters so they reflect the diversity of the gender spectrum in the population	A review of the enquiries of individuals of child bearing potential Employer's Procedure will be undertaken and updated with any gender specific reference to be removed.	30/06/2023	Fully complete (Approved)

HIW GGH IRMER Inspection (Nov 2022)	The employer is required to provide HIW with details of the action taken to: • review and revise the employer's written procedure for making enquiries of individuals of childbearing potential so that it reflects the diversity of the gender spectrum in the population • review and revise appointment letters so they reflect the diversity of the gender spectrum in the population	A review of all service documentation including letters and posters will be undertaken with any gender specific reference to be removed	30/04/2023	Fully complete (Approved)
HIW GGH IRMER Inspection (Nov 2022)	The health board is required to provide HIW with details of the action taken to improve the system of providing staff with updates on patient experience feedback.	Process introduced whereby any feedback is displayed in work areas and emailed to the staff involved.	19/05/2023	Fully complete (Approved)
HIW GGH IRMER Inspection (Nov 2022)	The health board is required to provide HIW with details of the action taken to improve the system of providing staff with updates on patient experience feedback.	Instigate a monthly feedback memo displaying all feedback from patients.	19/05/2023	Fully complete (Approved)
HIW GGH IRMER Inspection (Nov 2022)	The health board is required to provide HIW with details of the action taken to improve the system of providing staff with updates on patient experience feedback.	Patient experience is also shared at the Radiology Quality Safety and Patient Experience Meeting	19/05/2023	Fully complete (Approved)
HIW GGH IRMER Inspection (Nov 2022)	The employer is required to provide HIW with details of the action taken to review and revise the employer's written procedure for non-medical imaging exposures so that it includes details of all such exposures currently being performed	Introduce a process whereby all Employer's Procedures will be reviewed in February 23 and updated to include all examinations currently performed.	30/06/2023	Fully complete (Approved)
HIW GGH IRMER Inspection (Nov 2022)	The employer is required to provide an update on the action taken to ensure the employer's written procedure is adhered to by entitled referrers making a referral prior to exposures performed during surgical theatre cases.	Reinforcement of referral process with all appropriate staff being reminded of the process.	30/05/2023	Fully complete (Approved)
HIW GGH IRMER Inspection (Nov 2022)	The employer is required to provide an update on the action taken to ensure the employer's written procedure is adhered to by entitled referrers making a referral prior to exposures performed during surgical theatre cases.	Introduction of an audit to check compliance with the referral process.	30/05/2023	Fully complete (Approved)

HIW IRMER Diagnostic Imaging x-ray department Withybush Hospital January 2024	The Employer is required to provide HIW with details of the action taken to revise and update the employer's written procedure and flow chart for pregnancy enquiries for staff must be updated to ensure it includes reference to the circumstances when a pregnancy test should be considered and how the result will be effectively communicated	Employers Procedure 8 to be reviewed and updated to reflect the circumstances when a pregnancy test should be considered, recorded and communicated. Mitigation – not accepting verbal confirmation of pregnancy status, it must be written on the request form or checked via Welsh Clinical Portal during the review period. This will be communicated across all sites.	01/07/2024	Fully complete (Approved)
HIW IRMER Diagnostic Imaging x-ray department Withybush Hospital January 2024	The Employer is required to provide HIW with details of the action taken to revise and update the employer's written procedure for pregnancy enquiries to include gender inclusive language.	Employers Procedure 8 to be reviewed and amended to include gender inclusive language.	01/07/2024	Fully complete (Approved)
HIW IRMER Diagnostic Imaging x-ray department Withybush Hospital January 2024	The employer must ensure that outcomes and changes to practice following clinical audits are clearly documented for multidisciplinary teams through the department to ensure that audits sufficiently demonstrate action plans, re-audit and leaning points. The use of a consistent audit report template should be instigated for all clinical audits performed by radiology across the health board.	1. Disseminate audit template widely across Radiology sites within the Health Board and at the Clinical Audit Meeting.	31/08/2024	Fully complete (Approved)
HIW IRMER Diagnostic Imaging x-ray department Withybush Hospital January 2024	The employer must ensure that outcomes and changes to practice following clinical audits are clearly documented for multidisciplinary teams through the department to ensure that audits sufficiently demonstrate action plans, re-audit and leaning points. The use of a consistent audit report template should be instigated for all clinical audits performed by radiology across the health board.	2. Review compliance of audit template after Clinical Audit Meeting in July 2024.	31/08/2024	Fully complete (Approved)

HIW IRMER Diagnostic Imaging x-ray department Withybush Hospital January 2024	The Employer is required to provide HIW with details of action taken to ensure that all written documentation in place include the required level of detail as set out within the employer's procedure for Quality Assurance programme document control.	1. A document control system needs to be sourced	31/12/2024	Overdue
HIW IRMER Diagnostic Imaging x-ray department Withybush Hospital January 2024	The Employer is required to provide HIW with details of action taken to ensure that all written documentation in place include the required level of detail as set out within the employer's procedure for Quality Assurance programme document control.	2. Interim solution – current paper and electronic shared policies and procedures (both local and health board wide) will be reviewed and amended with version control to the same standard as Employers Procedure 14. needs to be sourced	31/12/2024	Fully complete (Approved)
HIW IRMER Diagnostic Imaging x-ray department Withybush Hospital January 2024	Employer must provide HIW with details of action taken to manage entitlement of all duty holders (medical, non-medical and third party across the site). They must provide an action plan detailing when this process will be completed and the mitigation in place in the meantime to promote patient safety.	1.Non-medical referrers (NMRs) to have ongoing bi-annual review. Historic NMRs to be identified and to undergo same process.	01/09/2024	Fully complete (Approved)

HIW IRMER Diagnostic Imaging x-ray department Withybush Hospital January 2024	Employer must provide HIW with details of action taken to manage entitlement of all duty holders (medical, non-medical and third party across the site). They must provide an action plan detailing when this process will be completed and the mitigation in place in the meantime to promote patient safety.	2. All Medical/third party referrers to be identified by implementation of the new PACS and RIS system which will move entirely to electronic referrals.	31/12/2025	Fully complete (Approved)
HIW IRMER Diagnostic Imaging x-ray department Withybush Hospital January 2024	Employer must provide HIW with details of action taken to manage entitlement of all duty holders (medical, non-medical and third party across the site). They must provide an action plan detailing when this process will be completed and the mitigation in place in the meantime to promote patient safety.	3. Mitigation Whilst awaiting the new RISP system we have been implementing an electronic requesting system which is recording all grades of referrers and referrers cannot be added to the system unless they have GMC/GDC/Non-medical referrer entitlement. A list of foundation doctors are flagged to us via medical staffing which is checked by radiographers prior to accepting requests. Six monthly Health Board wide communication from Medical Director/ Executive Director of Therapies and Health Science/ Executive Director of Nursing, Quality and Patient Experience to all medical and non-medical referrers working within their teams, to ensure they are aware of their referrer responsibilities and required training under IR(ME)R 2017. This will also be disseminated via “quick guide for e-IRMER support for Radiology” and global intranet communication.	31/05/2024	Unable to complete

HIW IRMER Diagnostic Imaging x-ray department Withybush Hospital January 2024	The employer must provide HIW with details of action taken to review and update the process of non-medical referrer clinical evaluation to ensure appropriate up to date training on how to clinically evaluate chest and musculoskeletal general radiography is being performed.	All non-medical referrers who have indicated that they can clinically evaluate images will be reviewed and the matrix will be updated to reflect this. Staff training records will be obtained, appraised and reviewed bi-annually. Audits will be required to ensure competencies are maintained and continuation of referral rights. Failure to supply these documents will be escalated to the Executive Director of Therapies and Health Science/ Executive Director of Nursing, Quality and Patient Experience. An action plan will be developed to ensure that an ongoing process is undertaken, whereby all non-medical referrers are aware of their responsibilities under IR(ME)R 2017.This is to ensure that all non-medical referrers undertake up to date training and provide assurance to the employer that this has been completed in line with Ionising Safety Policy.	31/08/2024	Fully complete (Approved)
HIW IRMER Diagnostic Imaging x-ray department Withybush Hospital January 2024	The health board must provide HIW with details of action taken to ensure that all staff are aware of the duty of candour and the implications for their role.	Training provision has been identified via the Health Board lead for training and in addition staff will attend online training to ensure compliance with Duty of Candour.	31/12/2024	Fully complete (Approved)
HIW IRMER Diagnostic Imaging x-ray department Withybush Hospital January 2024	The department should review and update information in leaflets and appointment letters to improve inclusivity.	Patient information will be reviewed and amended to remove gender specific language and improve inclusivity. This will be translated. This will also be replicated across all radiology departments within the Health Board.	31/08/2024	Fully complete (Approved)
HIW IRMER Diagnostic Imaging x-ray department Withybush Hospital January 2024	The health board must consider the feedback percentages from staff and make a plan to address the issues.	Ongoing support from the Organisational Development Department to continue work to improve departmental relationships and communication. Staff will be encouraged to provide feedback around any concerns regarding the standard of care provided and forums are available to allow staff to communicate suggestions for improvement.	31/08/2024	Fully complete (Approved)

IRMER Regulations	Software delivering an exposure, controlling or influencing the extent of an exposure directly assisting in the clinical evaluation of an exposure must be included on the radiation equipment inventory. Inventory must include fields listed in reg 15(2) (company, brand, version, original install date, current install date). It must be kept current with software changes	Software must be added to the radiation equipment inventory	09/05/2025	Fully complete (Approved)
IRMER Regulations	Identify areas where more than one employer may be involved with and exposure and consider if the co-operation regulation needs actions. e.g. referrer (GP referrals), operator (third party imaging providers) or practitioner (out of hours practitioner service) has a different employer; to other duty holders	Co-operation between employers: consider where relevant	31/07/2025	Overdue
IRMER Regulations	A process must be in place to ensure that appropriate action is taken based on analysis of unintended or accidental exposures. This may also require more consideration of the process of analysing incidents	Add taking appropriate action to the processes of analysing radiation incidents	30/06/2025	Fully complete (Approved)
IRMER Regulations	Particular relevance to new employer procedure re making, amending and cancelling referrals. However duty is to comply with all EPs so implies they must be available to referrers. Also recommended that where possible referrers are informed of this new duty. Might also be impacted by co-operation between employers	All referrers need to have access to employers procedures and be made aware they must comply	31/07/2025	Fully complete (Approved)
IRMER Regulations	Interventional procedures are now explicitly listed in 12 (3)(c)	Clarify the diagnostic reference levels apply to interventional procedures	09/05/2025	Fully complete (Approved)
IRMER Regulations	The following employer’s procedures have been amended in schedule 2 (f), (j), (l) and 2 new ones have been added (o) & (p).	Update Employer’s procedures	31/05/2025	Fully complete (Approved)
IRMER Regulations	Employer’s procedure to cover required action on audit findings	Clinical Audits must be undertaken and their findings acted upon	09/05/2025	Fully complete (Approved)
IRMER Regulations	This must be cascaded to referrers. The process for errors in referrals will need to be amended to take into account this procedure, the new duty on referrers to comply and if relevant the need for co-operation between employers	A new procedure is required detailing the making, amending and cancelling of referrals	30/05/2025	Fully complete (Approved)

IRMER Regulations	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	30/06/2025	Overdue
Nuclear Medicine IRMER WGH 03909	The health board is to ensure the following information is clearly displayed in the waiting areas at the department: •General health promotion information on healthy eating, physical activity and mental •Information advising patients to inform staff of relevant medical conditions •Advising patients to inform staff of relevant medical conditions. This information must also be included in appointment letters sent to patients.	Source general health posters for display in patient waiting areas.	01/10/2025	Fully complete (Approved)
Nuclear Medicine IRMER WGH 03909	The health board is to ensure the following information is clearly displayed in the waiting areas at the department: •General health promotion information on healthy eating, physical activity and mental •Information advising patients to inform staff of relevant medical conditions •Advising patients to inform staff of relevant medical conditions. This information must also be included in appointment letters sent to patients.	Have general health flyers available for patients to take away.	01/10/2025	Fully complete (Approved)

Nuclear Medicine IRMER WGH 03909	The health board is to ensure the following information is clearly displayed in the waiting areas at the department: •General health promotion information on healthy eating, physical activity and mental •Information advising patients to inform staff of relevant medical conditions •Advising patients to inform staff of relevant medical conditions. This information must also be included in appointment letters sent to patients.	Display posters to advise patients to inform staff of relevant medical conditions.	01/10/2025	Fully complete (Approved)
Nuclear Medicine IRMER WGH 03909	The health board is to ensure the following information is clearly displayed in the waiting areas at the department: •General health promotion information on healthy eating, physical activity and mental •Information advising patients to inform staff of relevant medical conditions •Advising patients to inform staff of relevant medical conditions. This information must also be included in appointment letters sent to patients.	Review and amend (as appropriate) appointment letters to advise patients to inform staff of relevant medical conditions. To be implemented into new RIS system.	31/10/2025	Fully complete (Approved)
Nuclear Medicine IRMER WGH 03909	There was prominent signage reminding patients, in English and multilingual languages, to inform staff if they were pregnant, though breastfeeding was not referenced on the signage. However, patient letters did provide detailed instructions for those who were pregnant or breastfeeding, including preparation guidance. Relevant information was made available to patients about the associated benefits and risks of the intended exposure.	Develop/amend signage to inform staff if patients are breastfeeding and having Nuclear Procedures.	31/10/2025	Fully complete (Approved)

Nuclear Medicine IRMER WGH 03909	The health board must consider the need for designated waiting areas so that patients who have been injected with a radiopharmaceutical can wait for their scan in an area away from other patients.	Develop segregated waiting area for patients who are returning after having been injected with a radiopharmaceutical. This will be raised at RPG and an appropriate location will be allocated.	31/12/2026	Fully complete (Approved)
Nuclear Medicine IRMER WGH 03909	The employer with support from medical physics must ensure that appropriate information is included in appointment letters in relation to radiation risks.	Develop patient information in appointment letter to contextualise radiation risk. This will be incorporated into the new RIS system.	31/10/2025	Fully complete (Approved)
Nuclear Medicine IRMER WGH 03909	The health board must ensure that there is information available in accessible formats, including in large print, for the patients at the department.	Develop large read print and easy read patient information to be offered to patients at the time booking and prior to the procedure.	01/01/2026	Fully complete (Approved)
Nuclear Medicine IRMER WGH 03909	The employer should consolidate the two procedures on the referral process into one.	Review relevant Employers Procedures to amalgamate EP5 and EP25.	01/01/2026	Fully complete (Approved)
Nuclear Medicine IRMER WGH 03909	The employer must ensure that one clear set of DRLs for all procedures are displayed.	Amended DRL has been issues, following advice from MPE.	30/08/2025	Fully complete (Approved)
Nuclear Medicine IRMER WGH 03909	The employer must ensure that both Annex 1 of the Ionising Safety Policy and the employer's procedure (EP1) are reviewed for potential duplication and one document is used to cover the entitlement process.	Review of Ionising Safety Policy and Employers Procedure 1. Discussion with Medical Physics to decide which document is most appropriate for the entitlement process to remain.	01/01/2026	Fully complete (Approved)
Nuclear Medicine IRMER WGH 03909	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.	01/01/2026	Unable to complete

Nuclear Medicine IRMER WGH 03909	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.	Ensure all entitlement documentation is completed prior to the duty holder being able to perform the task unsupervised.	01/01/2026	Fully complete (Approved)
Nuclear Medicine IRMER WGH 03909	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.	Review all job titles within Employers Procedures	01/01/2026	Fully complete (Approved)
Nuclear Medicine IRMER WGH 03909	The employer must ensure that the list of 'Current holders of the RPA 2000 Certificate of Competence to act as a Medical Physics Expert (MPE)' is checked annually, to ensure that all MPEs appointed remain on the list.	Entitlement documents for all MPEs will be added to the IR(ME)R audit cycle by Site Lead Superintendent Radiographers. Overseen by MEG.	01/10/2025	Fully complete (Approved)
Nuclear Medicine IRMER WGH 03909	The employer must ensure thar the entitlement matrix is updated annually when the individual's entitlement is reviewed and that this accurately reflects competency records.	The entitlement matrix will be updated on a three-monthly basis and will be added to the IR(ME)R audit cycle by Site Lead Superintendent Radiographers. Overseen by MEG and/or when the individual's entitlement is reviewed as part of annual PADR process or when they have additional tasks added.	01/01/2026	Fully complete (Approved)
Nuclear Medicine IRMER WGH 03909	The employer must ensure that the employer's procedure includes the correct duty holder to justify nuclear medicine procedures, for pregnant or breastfeeding individuals.	Review Employers Procedure 8 to amend the duty holder required to justify Nuclear Medicine procedures.	01/01/2026	Fully complete (Approved)
Nuclear Medicine IRMER WGH 03909	The employer must consider the environment under which the clinical evaluation is taking place and ensure any risk to the clinical evaluation is minimised.	Alternative reporting office locations have been offered. In addition, this will be reported to operational managers to explore further accommodation opportunities for quiet space reporting for reporting radiologists and reporting radiographers.	31/08/2025	Fully complete (Approved)

Nuclear Medicine IRMER WGH 03909	The employer must ensure that all audits are discussed at regular meetings, to ensure actions are completed and learning shared.	All clinical audits to be recorded on a centrally held clinical audit programme. All clinical audits to be presented at the bi-monthly meeting. Actions and learning outcomes will be tracked and shared with all Radiology staff.	01/06/2026	Fully complete (Approved)
Nuclear Medicine IRMER WGH 03909	The employer must ensure that the relevant employer's procedure includes: •Details on the formal process and responsibilities of identifying and conducting both clinical and IR(ME)R audits •Reference to the audit report templates that should be used •Specific terminology to ensure clarity between clinical and IR(ME)R audits.	Employers Procedure 21 to be reviewed and amended to include: •Details on the formal process and responsibilities of identifying and conducting both clinical and IR(ME)R audits •Reference to the audit report templates that should be used and included as an appendix. •Specific terminology to ensure clarity between clinical and IR(ME)R audits.	01/01/2026	Fully complete (Approved)
Nuclear Medicine IRMER WGH 03909	The employer must improve the audit process for nuclear medicine by: •Setting dates in advance to discuss clinical audits at clinical audit meetings •Discussing nuclear medicine audits (IR(ME)R and clinical) at the wider radiology department audit meetings •Reviewing and formalising IR(ME)R audit schedule.	The bi-monthly clinical audit meeting will include an agenda item "next clinical audits" to ensure clinical audit programme is	31/03/2026	Fully complete (Approved)
Nuclear Medicine IRMER WGH 03909	The employer must improve the audit process for nuclear medicine by: •Setting dates in advance to discuss clinical audits at clinical audit meetings •Discussing nuclear medicine audits (IR(ME)R and clinical) at the wider radiology department audit meetings •Reviewing and formalising IR(ME)R audit schedule.	The bi-monthly clinical audit meeting will be structured to include a range of clinical audits from differing modalities and specialities.	31/03/2026	Fully complete (Approved)

Nuclear Medicine IRMER WGH 03909	The employer must improve the audit process for nuclear medicine by: •Setting dates in advance to discuss clinical audits at clinical audit meetings •Discussing nuclear medicine audits (IR(ME)R and clinical) at the wider radiology department audit meetings •Reviewing and formalising IR(ME)R audit schedule.	Reviewing and formalising to IR(ME)R audit schedule at MEG.	28/10/2025	Fully complete (Approved)
Nuclear Medicine IRMER WGH 03909	The employer must ensure that the relevant employer's procedure is updated to include: •Clarity on the circumstances of informing or not informing patient •Making it clear that the relevant practitioner, referrer and operator should always be informed of any CSAUEs •The process in place for recording and analysing accidental or unintended exposures including near misses •References to nuclear medicine equipment.	Employers Procedure 19 to be reviewed and updated to include: •Clarity on the circumstances of informing or not informing patient	01/01/2026	Fully complete (Approved)
Nuclear Medicine IRMER WGH 03909	The employer must ensure that the relevant employer's procedure is updated to include: •Clarity on the circumstances of informing or not informing patient •Making it clear that the relevant practitioner, referrer and operator should always be informed of any CSAUEs •The process in place for recording and analysing accidental or unintended exposures including near misses •References to nuclear medicine equipment.	Employers Procedure 19 to be reviewed and updated to include: Making it clear that the relevant practitioner, referrer and operator should always be informed of any CSAUEs	01/01/2026	Fully complete (Approved)

Nuclear Medicine IRMER WGH 03909	The employer must ensure that the relevant employer's procedure is updated to include: •Clarity on the circumstances of informing or not informing patient •Making it clear that the relevant practitioner, referrer and operator should always be informed of any CSAUEs •The process in place for recording and analysing accidental or unintended exposures including near misses •References to nuclear medicine equipment.	Employers Procedure 19 to be reviewed and updated to include: The process in place for recording and analysing accidental or unintended exposures including near misses	01/01/2026	Fully complete (Approved)
Nuclear Medicine IRMER WGH 03909	The employer must ensure that the authorisation guidelines and the employer's procedure is updated to correctly reflect the process and ensure there is clarity on who is authorising the exposure to carers and comforters.	References to Nuclear Medicine will be removed from the CT DAG The Nuclear Medicine DAG will also be reviewed and re-issued	28/10/2025	Fully complete (Approved)
Nuclear Medicine IRMER WGH 03909	The employer must ensure that the authorisation guidelines and the employer's procedure is updated to correctly reflect the process and ensure there is clarity on who is authorising the exposure to carers and comforters.	The Employer's Procedure will be amended to offer specific guidance to staff, and including recording of authorisation following advice from MPE.	28/10/2025	Fully complete (Approved)
Nuclear Medicine IRMER WGH 03909	The employer must ensure there is a formal SLA in place for nuclear medicine medical physics support.	Develop and finalise formal SLA for Nuclear Medicine Medical Physics support.	01/03/2026	Fully complete (Approved)
Nuclear Medicine IRMER WGH 03909	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.	Replacement of the gamma camera to be completed.	01/04/2027	In progress
Nuclear Medicine IRMER WGH 03909	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.	01/06/2026	In progress

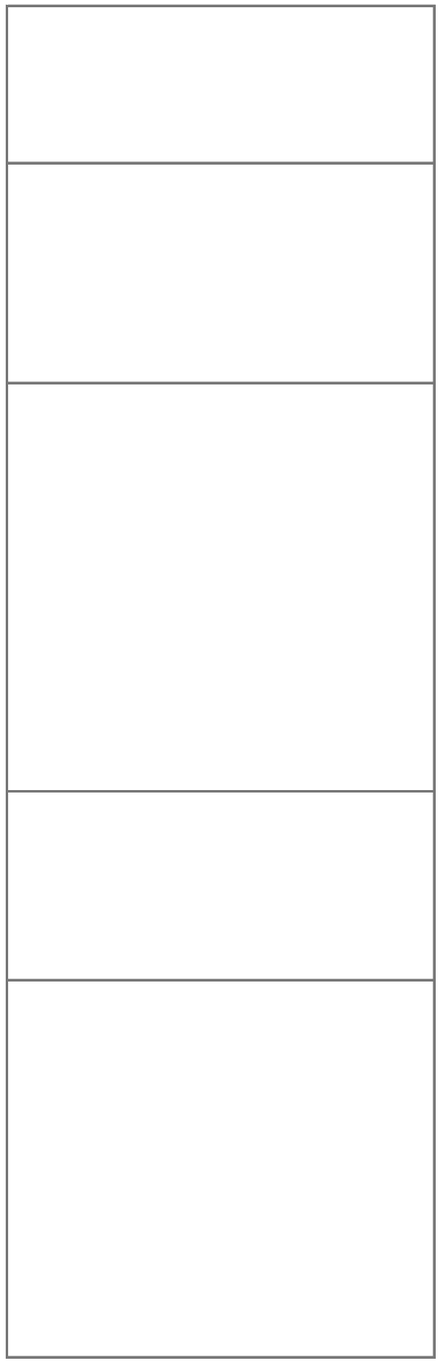
Nuclear Medicine IRMER WGH 03909	The employer must ensure that the replacement of the gamma camera is completed, and contingency plans are put in place as a matter of priority to reduce the risk of this identified current single point of failure.	Exploration of an SLA arrangement with a neighbouring Health Board - approved at CCG (May 26)	01/06/2026	Fully complete (Approved)
Nuclear Medicine IRMER WGH 03909	The employer must ensure that: •The adjuvant drugs used in nuclear medicine are part of the formulary •The nuclear medicine protocols are ratified and approved to ensure compliance with regulation 240 of the Human Medicines Regulations 2012.	Nuclear Medicine drugs have been added to the Formulary.	28/08/2025	Fully complete (Approved)
Nuclear Medicine IRMER WGH 03909	The employer must ensure that: •The adjuvant drugs used in nuclear medicine are part of the formulary •The nuclear medicine protocols are ratified and approved to ensure compliance with regulation 240 of the Human Medicines Regulations 2012.	Nuclear Medicine protocols to be reviewed, amended and ratified appropriately by Head of Radiology Services Manager, in consultation with the ARSAC licence holders and MPE to ensure compliance with regulation 240 of the Human Medicines Regulations 2012.	01/01/2026	Fully complete (Approved)
Nuclear Medicine IRMER WGH 03909	The health board is required to reflect on some of the less favourable responses from staff throughout this report and inform HIW of the actions they will take to address these issues.	Finalisation of an action plan has been to explore in detail the responses from the staff survey	01/01/2026	Fully complete (Approved)
Nuclear Medicine IRMER WGH 03909	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.	01/06/2026	Overdue
Nuclear Medicine IRMER WGH 03909	The health board must ensure that staff complete the relevant oxygen cylinder training.	All relevant Radiology staff will complete mandatory oxygen cylinder training.	01/12/2025	Fully complete (Approved)
Nuclear Medicine IRMER WGH 03909	The health board must ensure that staff complete the relevant oxygen cylinder training.	Discussions with Learning and Development to add the mandatory training module to be added to all clinical staff ESR records.	01/12/2025	Fully complete (Approved)

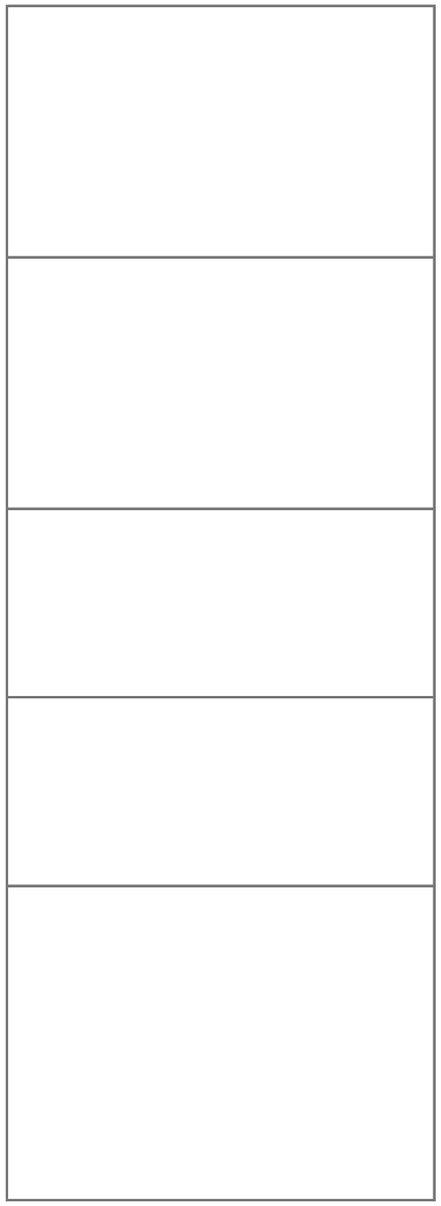
Nuclear Medicine IRMER WGH 03909	The employer must ensure that: •A document list of relevant IR(ME)R theoretical training is introduced and completed by staff •The relevant employer's procedure states the process for the review of training records and how the review of training records is recorded.	Preceptorship document to be developed for Nuclear Medicine staff to include theoretical IR(ME)R training prior to entitlement. Advice will be sought from the UHB preceptorship lead.	01/01/2026	Fully complete (Approved)
Nuclear Medicine IRMER WGH 03909	The employer must ensure that: •A document list of relevant IR(ME)R theoretical training is introduced and completed by staff •The relevant employer's procedure states the process for the review of training records and how the review of training records is recorded.	Process added to Employers Procedure around review of training records.	01/01/2026	Fully complete (Approved)
Nuclear Medicine IRMER WGH 03909	The health board must ensure that processes are in place to ensure that staff are treated fairly and equally and that any instances of discrimination will not be tolerated and appropriate action taken.	Finalisation of an action plan has been to explore in detail the responses from the staff survey	01/01/2026	Fully complete (Approved)

Comments/Updates
Service update 27/5/26- A Task and Finish Group met on 22 April 2026 to identify a set of standardised document tags to support both (1) the efficient identification of multiple documents for audit purposes and (2) improved search functionality for clinicians when locating specific records. An agreed list of tags for implementation within Care Partner has been developed and approved by the Task and Finish Group. The Service Manager is currently liaising with the Care Partner lead to enable these tags within the system
Service update 27/5/26- this is underway, checking off with AHPs to ensure it is reflective of the MDT. Service update 23/6/26- Following discussion and review of the original HIW requirement in action 3 of the attached —to “standardise record-keeping practices and ensure all documentation is accessible to relevant staff”—it has been determined that a service evaluation of the documentation would be a more appropriate initial approach. Undertaking a service evaluation will enable the development of clear, agreed standards to support consistent and accessible record-keeping practices. Once these standards have been established and embedded, a formal audit can then be undertaken to assess compliance and provide assurance of quality. Service update 1/7/26- formulated the service evaluation format and will now commence the evaluation August/September.

Service update 27/5/26- Both prospective candidates for the Advanced Nurse Practitioner (ANP) training pathway have withdrawn from the process. In response, the service is proactively reviewing its workforce strategy to ensure delivery against this action. This includes considering a refreshed expression of interest to Learning Disability nursing staff to support internal development, alongside exploring a national recruitment approach to attract suitably qualified candidates who already meet the ANP requirements.

4 x staff have commenced there training but the end date for the training is July 2026



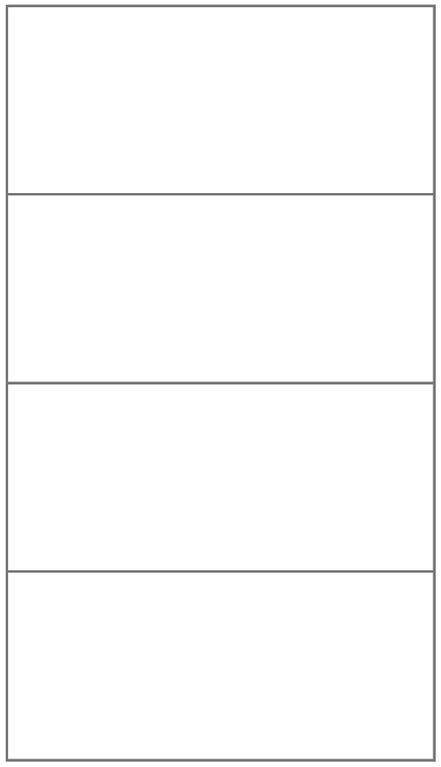


Multi disciplinary Discharge Review Task and Finish Group established. Training provided to the group by the Clinical Effectiveness Team on the process of benchmarking and use of the AMaT system to record, track and monitor benchmarking work. Initial scoping undertaken of NG 53. Due to the large scale and size of NG 53, decision taken to prioritise section 1.5 Hospital Discharge recommendations for benchmarking. Project management support identified to coordinate benchmarking activity. Contributors to benchmarking identified and process set up to engage and obtain information from them.
Update 10/10/23 Due to the large scale and size of NG 53, decision taken to prioritise section 1.5 Hospital Discharge recommendations for benchmarking. Project management support identified to coordinate benchmarking activity however now impacted by long term absence in team. Revised timescale 31/01/24.

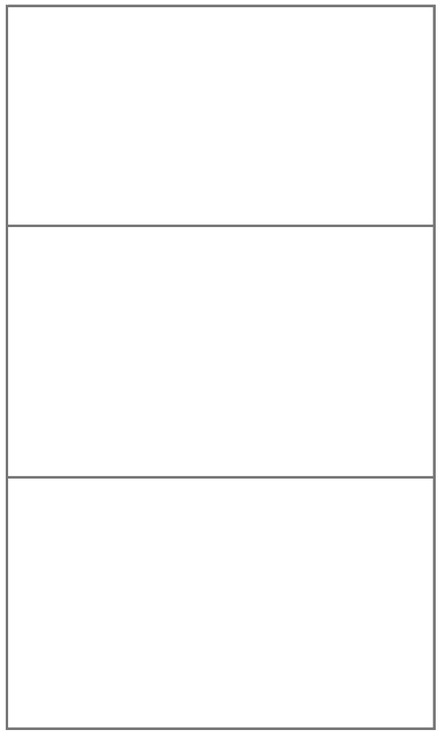
Update 23/05/24 Local Project Management Capacity remains impacted by long term absence. All Wales Patient

Update 10/10/23 Review of Health Board Policy #370 Discharge and Transfer of Care underway however detailed input from mental health services incumbent on local standards interpreted from NICE guidelines as per action MD7/1 therefore delayed. Revised timescale for completion 28/02/24. Update 09/05/24 Review of Health Board Policy #370 Discharge and Transfer of Care still underway. Health Board Discharge Strategy Group established with Mental Health representation. Revised timescale for completion October 2024. Update 13/11/24 Health Board decision taken to withdraw Policy #370 Discharge and Transfer of Care and instead refer to national standards for discharge and create a local discharge toolkit to support staff in implementing safe and effective discharge. Information on mental health pathways, liaison contacts and material for the public on 111 option 2 service are to be added. National standards for discharge from Mental Health Wards are currently being developed through the All

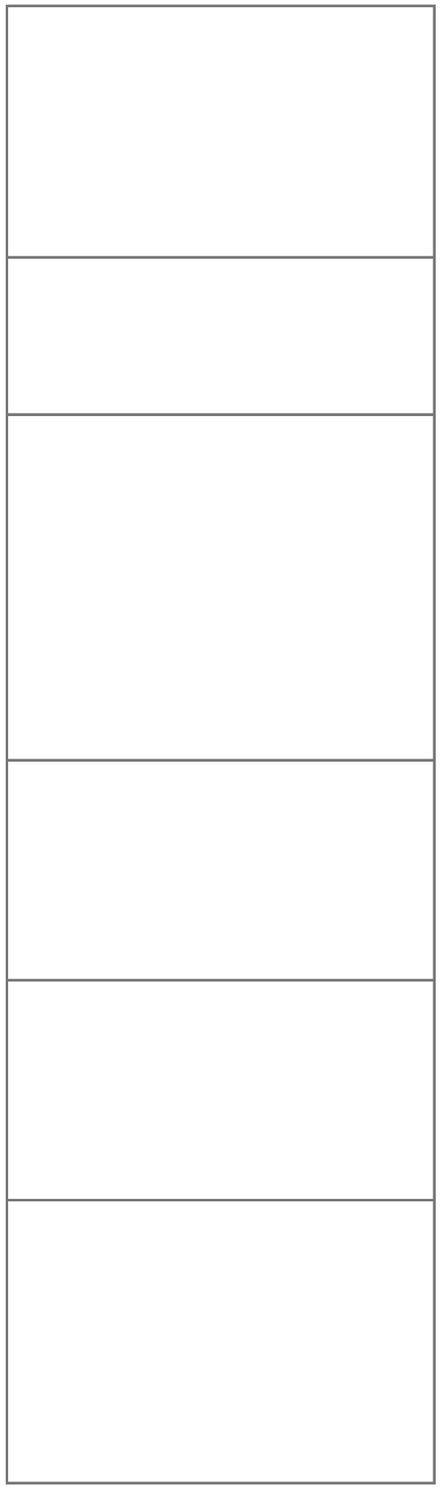
Update 23/08/24 Processes put in place to support Care Partner access for Student Nurses.



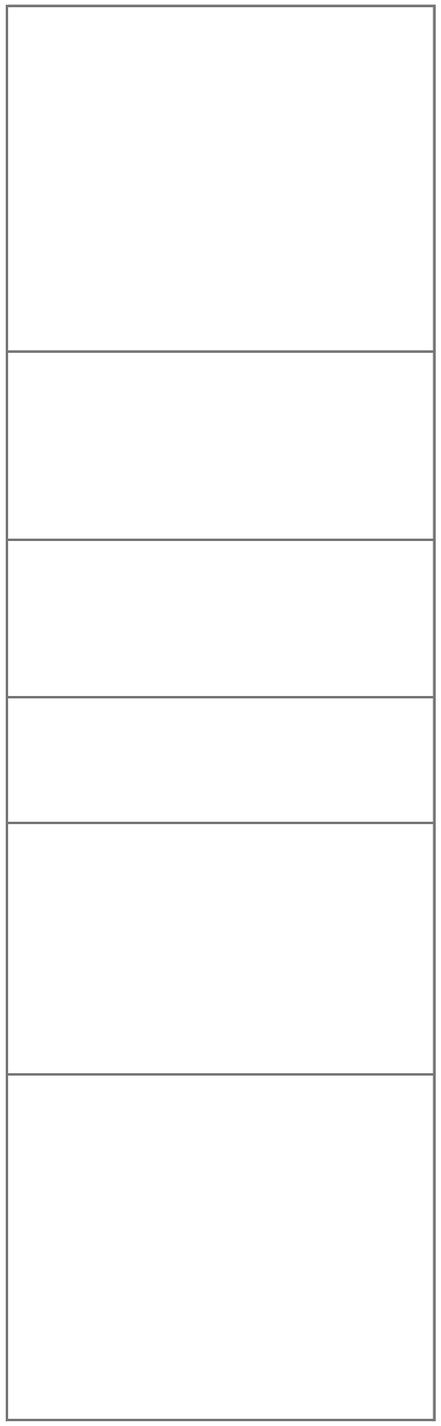
Update 22/11/23 Training Needs Analysis tool developed by Learning and Development Team to be piloted across MHLD services. Update 24/05/24 Update. Progress with action delayed due to directorate capacity to facilitate pilot of TNA tool. Directorate to re engage with Learning and Development to agree a plan to progress. Completion date therefore revised to 30/09/24. Update 30/06/2025: Capacity has remained a challenge and the CCG to re-engage with Learning and Development to agree a plan to progress. To also progress appointment of Head of Nursing, and an additional post. Revised completion date 31st October 2025. 25/11/2025: Recent bid for HEIW Funding has been approved which incorporates funding to support completion of this piece of work. Next steps to be agreed with Assistant Director of People Planning. Revised completion date 31/03/2026. Update 30/12/25 Meeting planned to take	

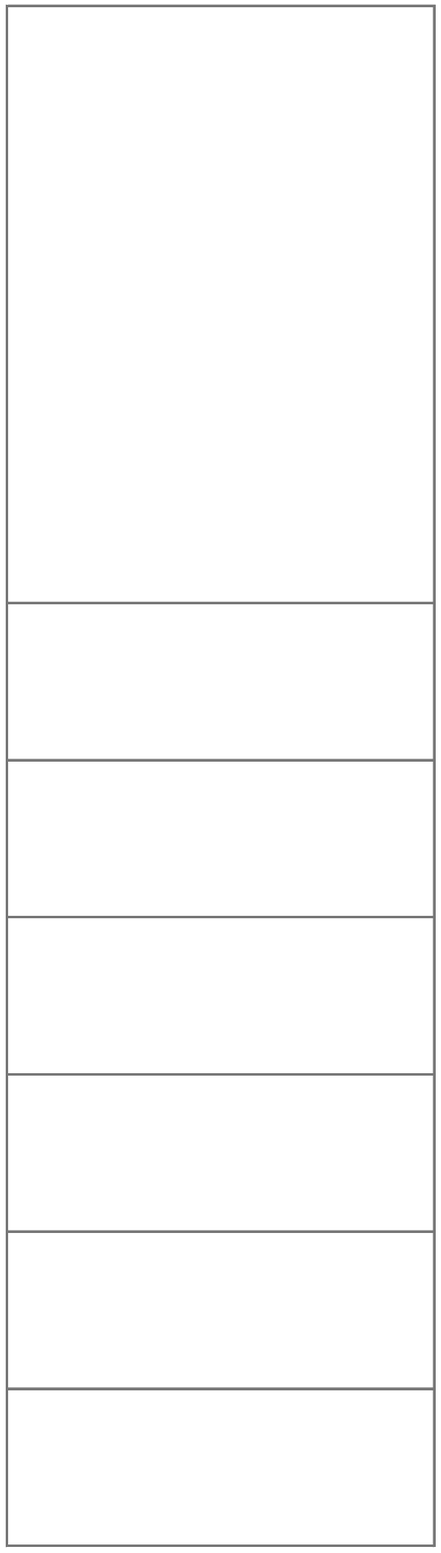


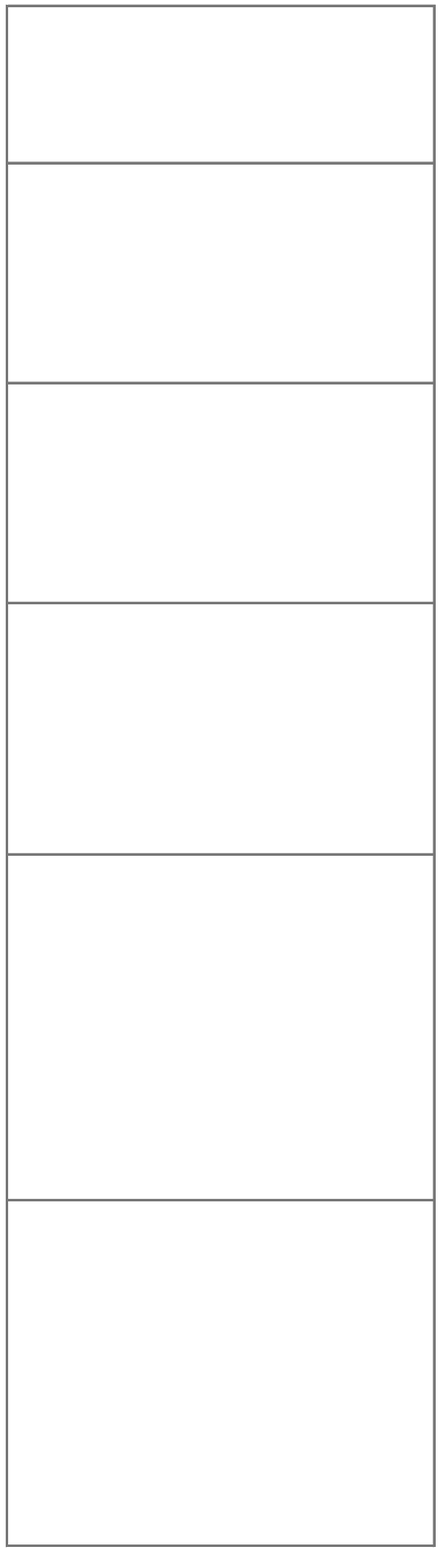
Update 10/10/23 Options to enable direct access to Datix for social workers who provide a service on behalf of the health board has been explored and the ability to provide access through the Patient Safety Team has been confirmed. Details of existing Social Workers are being gathered in order to establish Datix accounts and instigate training. Revised timescale for completion 31/11/23. Update 22/11/23 Details of existing Social Workers have been gathered and Datix accounts have been requested. Update 23/08/24 This action has been completed in part however cannot be completed fully. Social workers operating within integrated teams across MHLD do now have access to datix to be able to record an incident and receive feedback. Training has been offered to relevant local authority location managers to support this. Degrees of integration of social workers with CMHTs varies across Local Authority areas. Social Workers within Ceredigion and Pembrokeshire teams are not integrated and therefore do not have

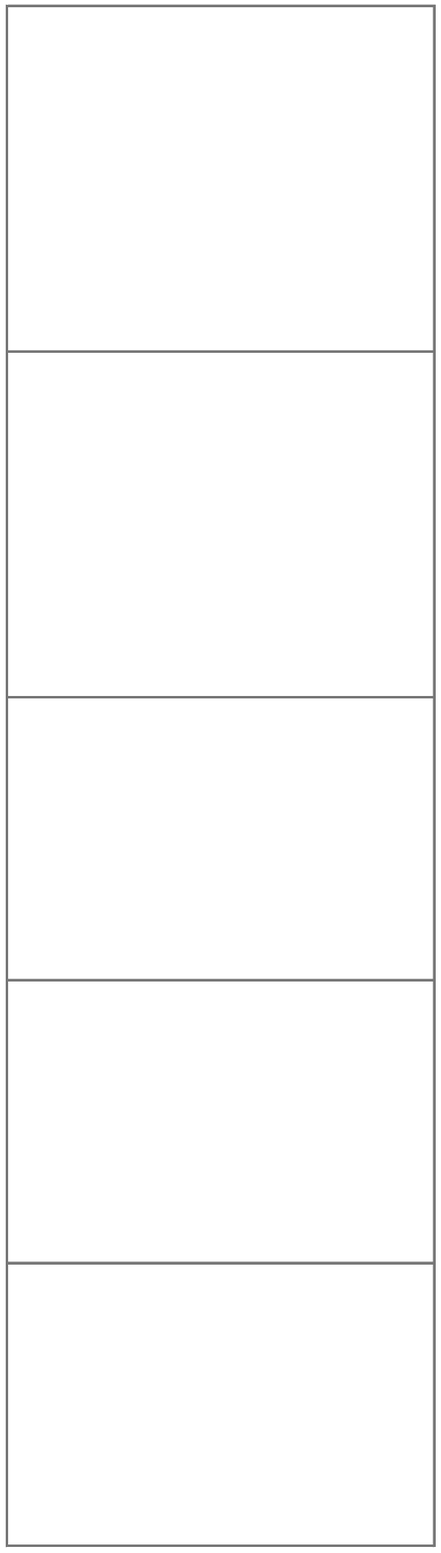


Integrated

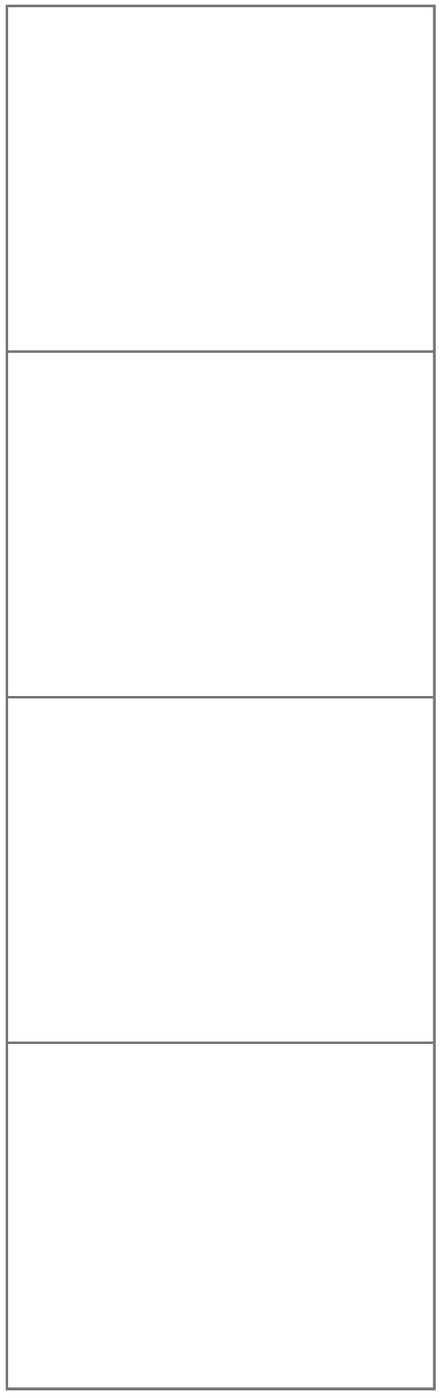


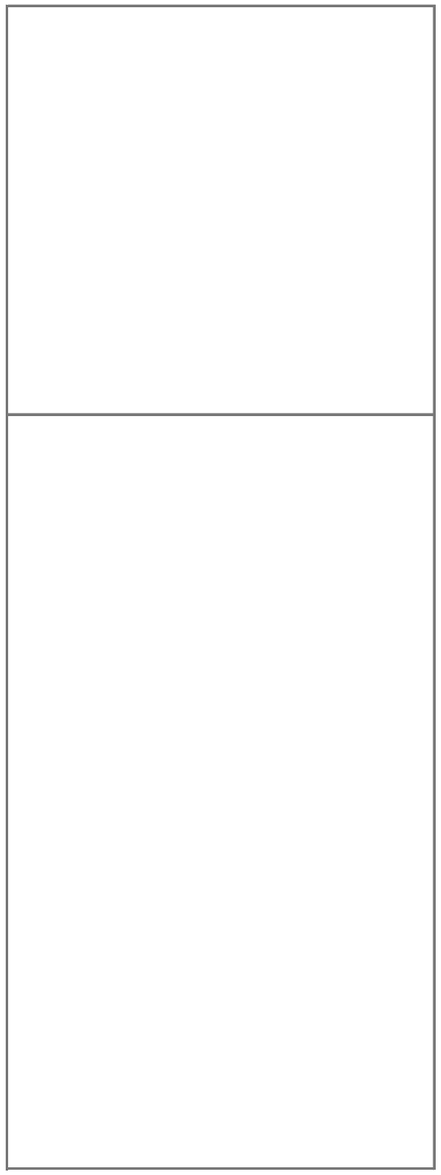




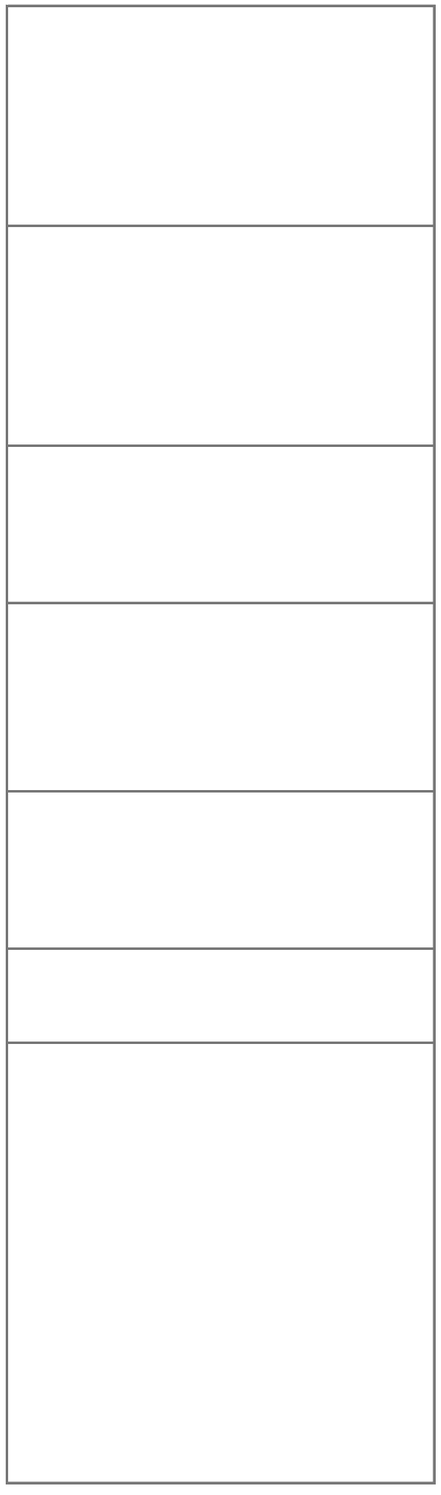


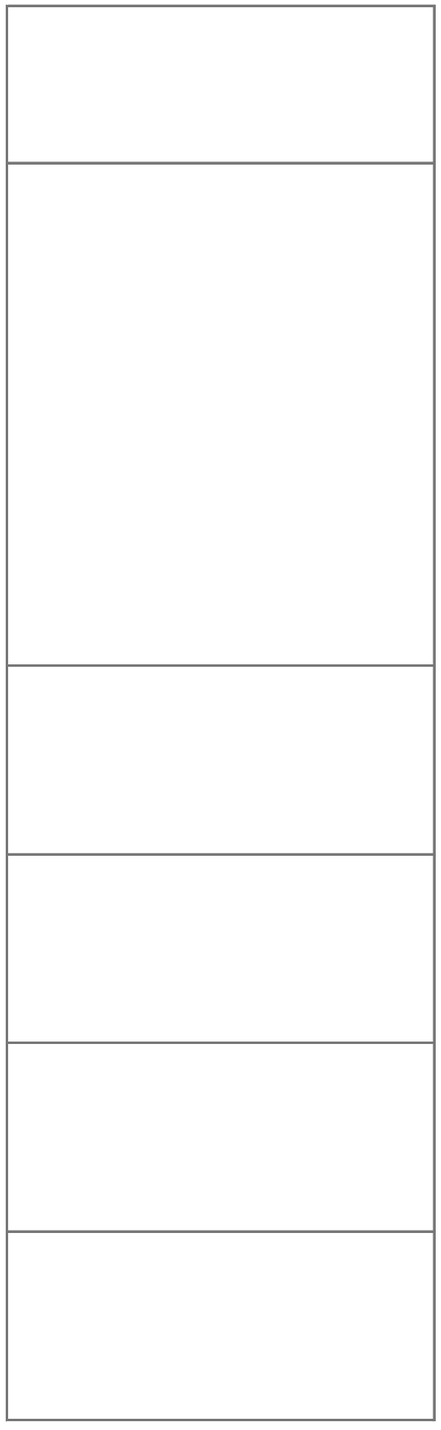
23/07/2026 - evidence uploaded of staff booked onto training sessions
23/07/2026 - email uploaded as evidence requesting Sensory Loss Training for the ward





Update 18/5- we submitted a SBAR to the Executive Director of WFOD in March seeking approval to go to consultation with staff. Lisa wasn't happy to approve at the time and asked us to review the rotas that had been developed and consider more family-friendly rota patterns. We have completed this piece of work and submitted them to finance to ensure that they are viable within the budget envelope that we have. Last week, we gained feedback from the finance team that the new rotas are viable therefore we are looking to resubmit our SBAR to Lisa by May 31st 2026 seeking approval to go to consultation with the staff.



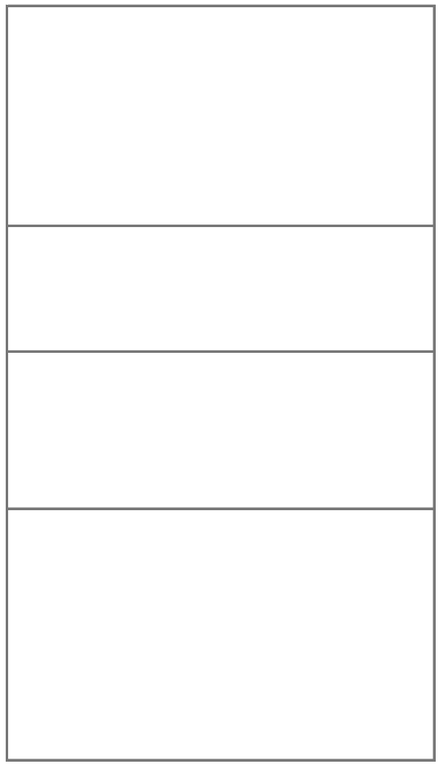


26/3/26- update: It's challenging to prove an intended go live date for eObs, so I have included a screen shot of the key milestones from the project plan (I cannot share the wider document due to confidentiality) and have highlighted Key Milestone M8 eObs integrated solution indicating a go live of 21st April on page 1 (also highlighted Milestone M6, which also confirms Flow Go live achieved in Nov 25). It's worth noting the timescales for eObs have slipped, and we are currently working through re-planning. We don't have a confirmed date for Go Live yet, which may be a little later in the year than April, and this will need to go to the Project Steering group for approval update 18/5/26-(eObs System) - we are scheduled to go live in GGH on 23rd June. This date is currently at risk due to a number of factors outside of our control, however I will provide an update as the position becomes clearer over the next couple of weeks. 23/07/2026 - eobs went live on Gwenllian
update 18/5/26- ePMA phased rollout to commence in September 2026 with expectation to roll out in GGH in December 2026

Update 9.3.26- Scanning was completed – but we are yet to implement internal scanning properly – this is the paper going to SG on 16th – i.e. what we scan – do we do scan on demand or chip away at the backlog. If it's a new date you need then I would say April 2026 – new financial year. Update 18/05/2026 - We are due to commence day-forward scanning into the current EDRMS (Cito) in the next few weeks - however we are currently out to tender on the procurement of a new EDRMS which will be awarded in July so more tailored comms re. the digitisation of health records and the transition/hybrid period with regards to where these will be accessed etc. will follow. Update 1/7/2026. Due to ongoing issues with the current EDRMS, a decision was made to further delay day-forward scanning until the procurement and implementation of the new EDRMS is complete and the migration from one system to another is finalised. The new EDRMS will not be implemented until September 2026 - and it is yet unknown how long the actual migration of records

Due date amened back to original date as agreed by HIW as dates cannot be altered by Service 22/06/2026- amended original date back to Sep-25. Revised date= Sep-26. JD

update2.9.25-Capital Bid number CB 25/26-11 was submitted on the 15.08.2025. Please liaise with the Capital Team for updates on this. This is a Capital AMAT action.

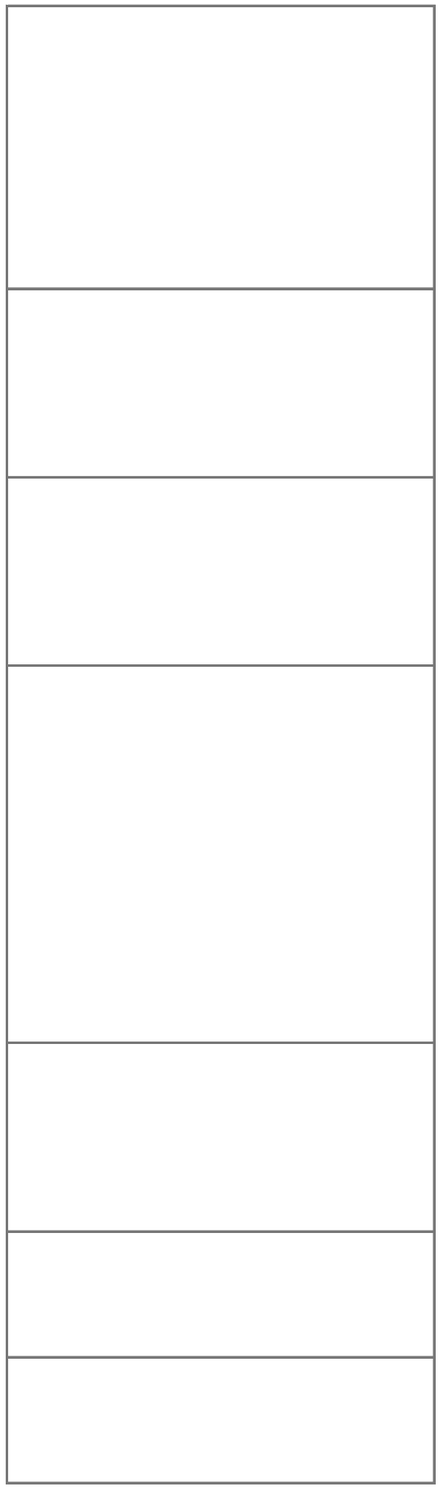


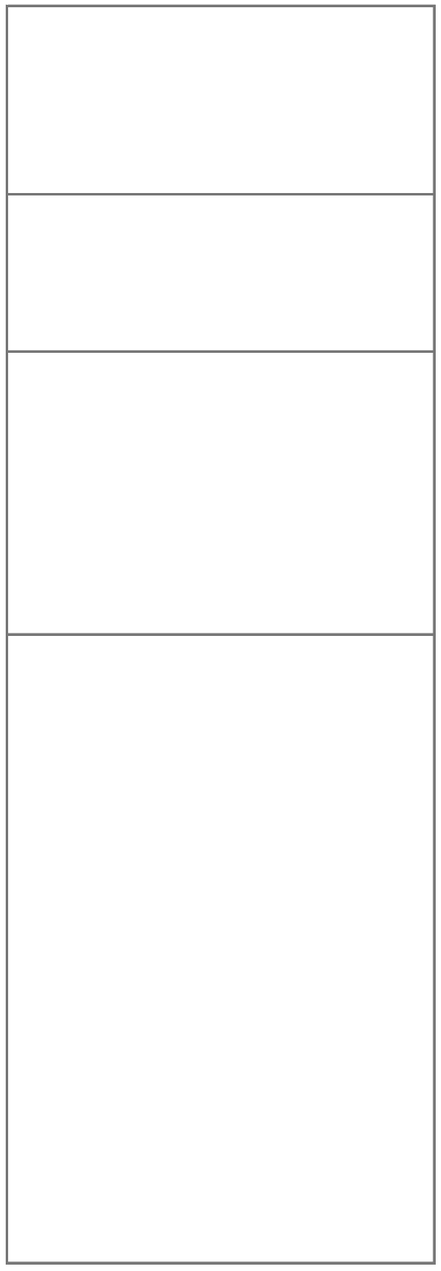
Temperature Controlled Medicines Task and finish group September 2025 Update 9/3/26 : The Temperature Control Medication Task and Finished Group has met a number of times. A draft 'manging temperature excursion in ambient storage area storing medicines' procedure is out for comment from the group. This will be a Health Board wide procedure which will sit within the Medication Management Policy (under review) . Comments due to be reviewed 19th March 2026. Fiona John (Senior Nurse Medicines Management) has reviewed the daily monitoring room temperature log chart to incorporate the time that medication room temperatures are recommended to be checked (Task and finish group determined the optimal times for recording) and also the temperature ranges are within the chart. This chart has been disseminated to all sites via the Heads of Nursing. Claire Davies. Update 7/4/26 : Temperature Controlled Medicines Task and finish group due to meet 9/4/26. Amendments have been made to the 'manging temperature

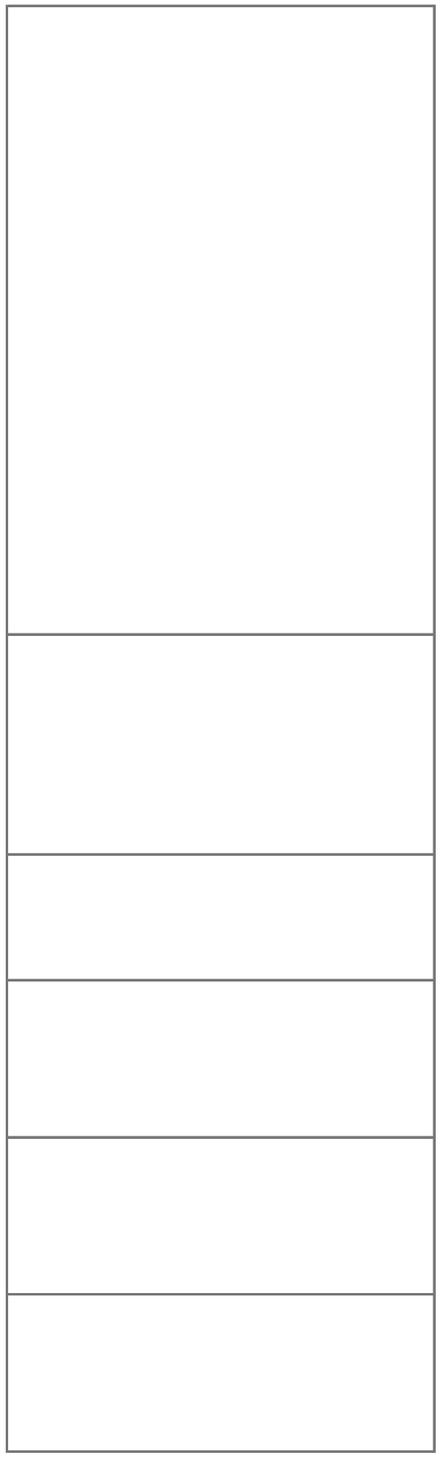
All Wales Group are updating this work underway, working with HIW for editing to ensure capability with ESR This is an All Wales piece of work that is underway. No clear time scale on completion. Group to meet in the next month. Updated 7/10/25 No new update to give .Work remains to be done on this. Working with HEIW on this piece of work. (updated 29:12:25) This work remains to be with the All Wales group. No updated available. (Updated 03/02/2026) This Piece of work is with HEIW. No definitive answer to when it will be completed by them. I have completed all of the ask form the inspection. (updated 23/02/26) This remains with HEIW. A meeting is to be arranged to get an update. (updated 23/03/26) service update 1.4.26- This work is now being reviewed by a wider All Wales team. The review period runs until 10 April. Once this period has ended, the document will be finalised, subject to any comments received.(updated 01/04/26) Meeting

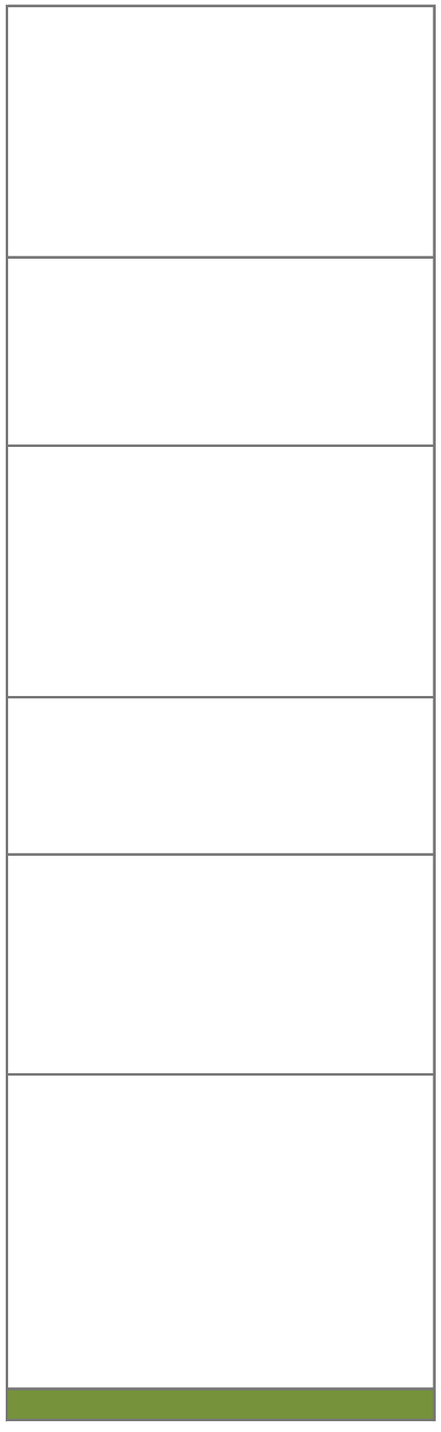
03/03/2026 Planned work for garden to start July 2026. https://hywelddahealthcharities.nhs.wales/news/charity-news/work-begins-on-new-therapeutic-gardens-at-prince-philip-hospital/

We do not have a "This is me" section on WNCR









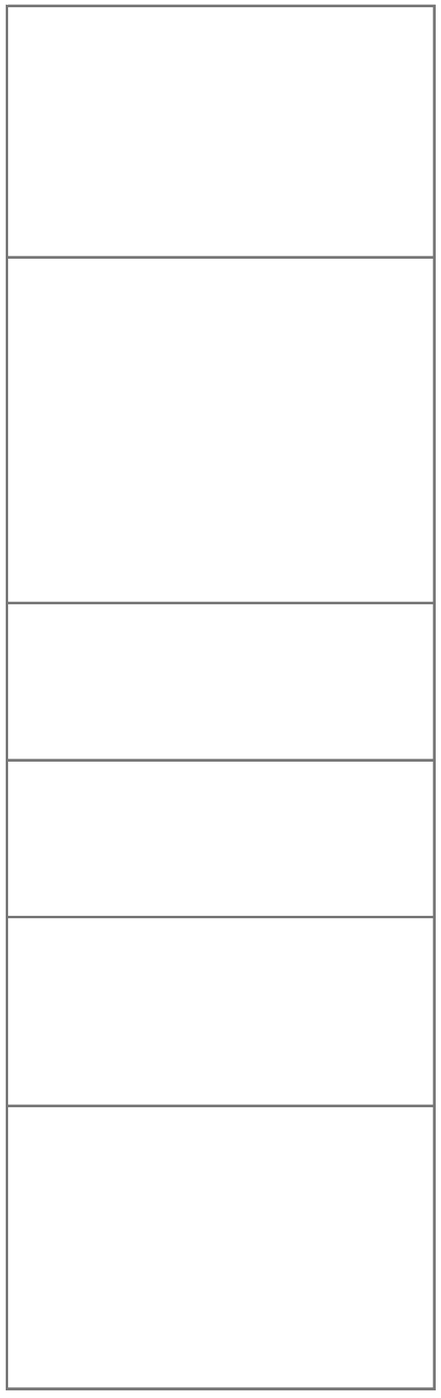
This improvement plan is agreed with Clinical Care Groups, but an update on progress is to be reported to the November 2025 Strategic Safeguarding Steering Group. 28/01/2026: Just recruited into Head of Safeguarding with role commenced on 1st of January 2026 (Charlotte Westacott). Updated responsible person for this action to Cathie Steele on advice from Anna Chiffi. Revised completion date of March 2026. 17/02/2026 - this action is for the CCGs as relates to resource within the CCG and not within the corporate team. Therefore each CCG will be required to provide an update to the SSSG meeting scheduled for 26/02/2026 20/2/26- on request of Cathie Steele action returned to original owner as these are service specific actions and not corporate actions – the ownership needs to be within the CCGs 20.5.26- Dr F Hassan identified as SG lead-

As this action 'sits' within Nursing, Medical Quality, Safety & patient Experience the ADoN OM will be the overall action lead, assisted by IA, AMD. CCGs to identify targeted improvement plans and report to Strategic Safeguarding Steering Group November 2025. Achieving required 85% compliance remains a significant challenge. Expectation to achieve significant compliance improvement by 28.03.26 30/03/2026 update from PE updated from medical perspective new clinical lead have been appointed for acute paeds and SBCU who has been tasked with reviewing the medical training of child protection. A new lead doctor for SG has been appointed who will work with the individual clinical leads reviewing training requirements. There is quarterly delivery group SG meeting where nurse training is reviewed and areas of non compliance is addressed with the senior nurse managers. (Non-Compliance is <85%)

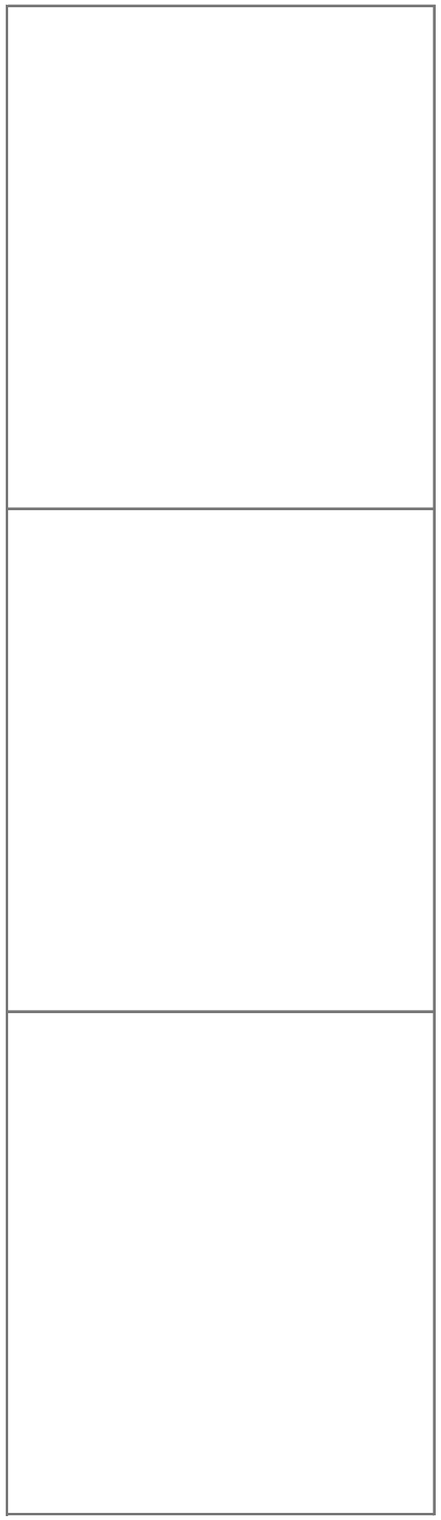
CCGs to identify targeted improvement plans and report to Strategic Safeguarding Steering Group November 2025. 20/5/26- NHS|CSTF|Safeguarding Children - Level 1 - 3 Years|26/26|218|0.77% NHS|CSTF|Safeguarding Children - Level 2 - 3 Years|26/26|218|0.77% NHS|CSTF|Safeguarding Children - Level 3 - 3 Years|26/26|166|1.54%
This is an action that has been assigned to each CCG. Responsibility needs to sit within the CCG and not with the Safeguarding Team. Overall action lead changed back to CCG by Cathie Steele. 22/06/2026- Original completion date amended back to Nov-25. Revised completion date = October 2026

As this 'sits in Nursing, Medical, Quality & patient Experience the Assistant Director of Nursing, Quality, Safety & patient Experience should be the overall action lead, assisted by the Care Group Associate Medical Director, IA. 30/03/2026 update from PE updated from medical perspective new clinical lead have been appointed for acute paeds and SBCU who has been tasked with reviewing the medical training of child protection. A new lead doctor for SG has been appointed who will work with the individual clinical leads reviewing training requirements. There is quarterly delivery group SG meeting where nurse training is reviewed and areas of non compliance is addressed with the senior nurse managers. (Non-Compliance is <85%)
Senior Nurse Audit in Health Visiting evidences the occurance of Child Protection supervision in records. In regards to recording this in electronic records, work is underway to develop an electronic form. School Nursing Senior Nurses now scrunitsing Team Leader's records audits on a monthly basis. School Nursing record keeping audit tool updated to include evidencing access to or consideration for need for supervision in records.

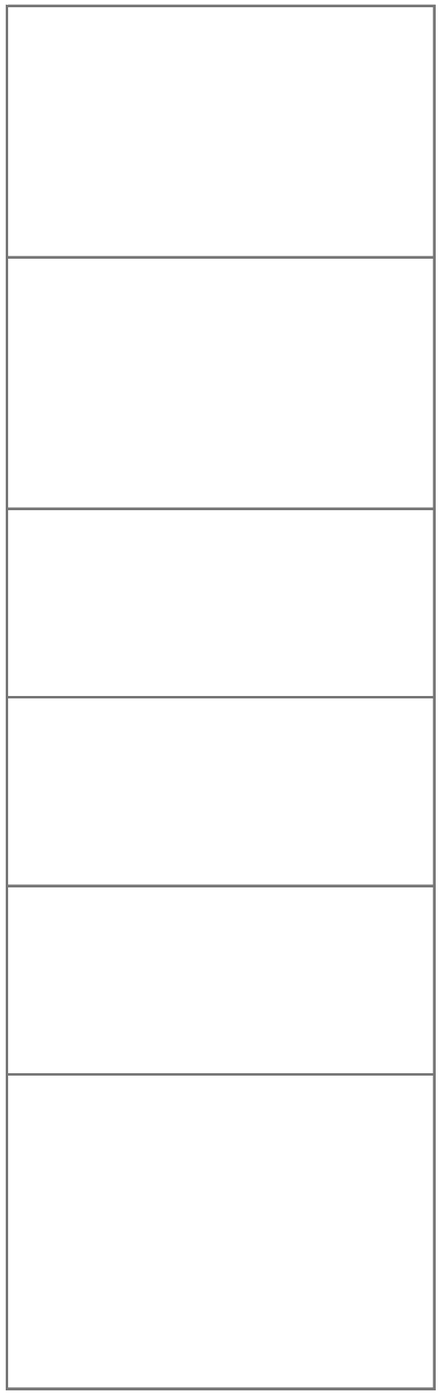
HDdUHB are engaging well with this pilot and are represented at the Strategic and Practitioner groups.

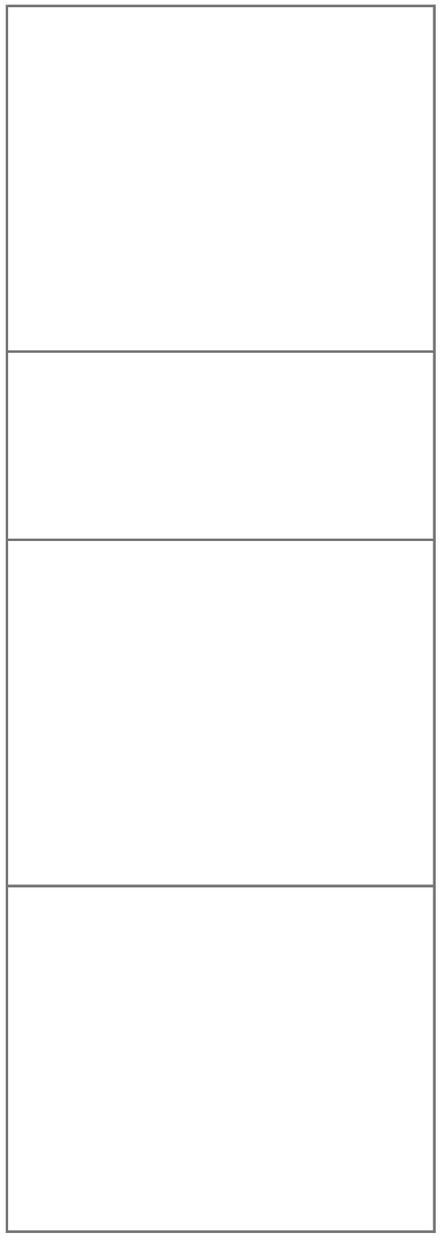


A review planning group has been established. 12/01/2026 - safe guarding lead and clinical lead appointments out to advert. The plan is to implement a new pathway in March 2026. 13/04/26 - Named Doctor for Safeguarding and Clinical Lead for Acute paediatrics both appointed and roles commenced in March 2026. The ability to develop a sustainable and effective SG pathway is proving challenging due to the availability of clinicians and the complexity/ acuity of ward/ on-call work- which is compounded by absence and vacancy. Immediate focus is on the improvement of safeguarding training which is being revised and realigned to RCPCh standards with training dates identified over the coming months. Where safeguarding cases are difficult to secure and additional capacity is needed, this is temporarily supported by the Head of Safeguarding and service delivery teams to secure reviews in as timely a fashion as possible. The work to develop a sustainable pathway continues and is now led by the new named doctor- with service



Update 23/11/23 added to risk register Requirement escalated in exception report to OQSEC 09/01/2024 6/9/24- Update: This action cannot be completed at this time as it requires additional investment. I will be escalating this in my next QSEG report. 13/12/24- Update- presented to QSEG- on annual plan to employ quality radiographer. Have considered document from other services. Remains ongoing. On risk register Feb 2025- Update need for document control system and quality lead Radiographer included in Radiology annual plan March 2025 update- HB annual plan approved by the Board on 28/03/2025 which has included the Quality Lead Radiographer and document control system. Steps will be put in place shortly to recruit to the post and procure a document control system.





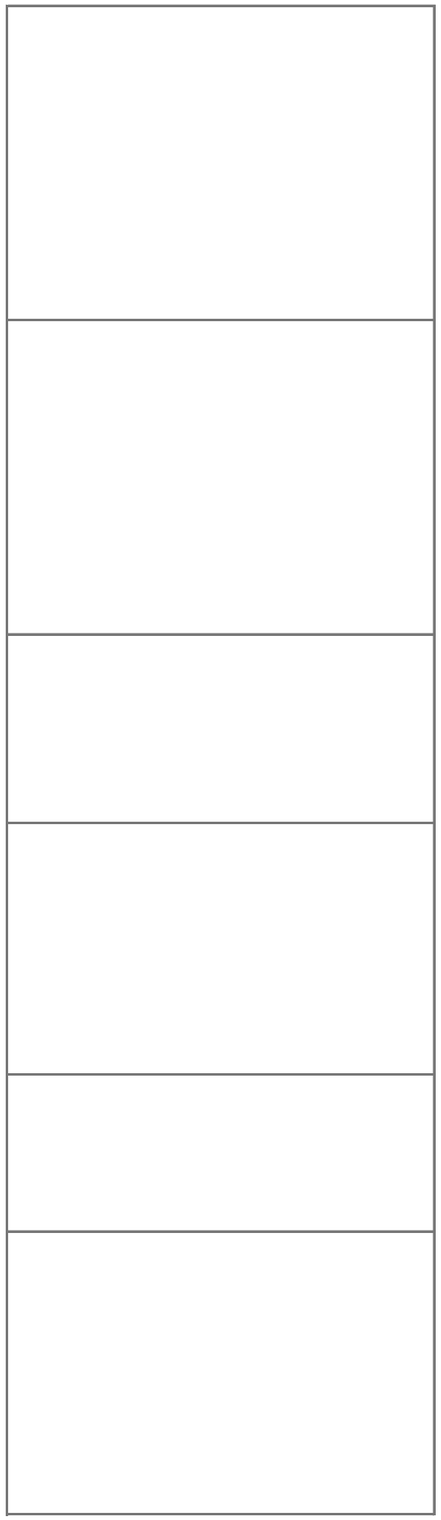
13/12/24- presented to QSEG- ongoing review and remains on risk register. Feb 2025- Update need for document control system and quality lead Radiographer included in Radiology annual plan March 2025 update- HB annual plan approved by the Board on 28/03/2025 which has included the Quality Lead Radiographer and document control system. Steps will be put in place shortly to recruit to the post and procure a document control system. April 2025- Quality Manager recruitment should be complete by Aug 2025 and an immediate must do within the workplan will be sourcing the quality control system. September 25 - OCP starting in Oct 25 - three month process. Expected to advertise post in Dec/Jan 26 - in post May 26. Post needs to be filled before action can be closed - expected Dec 2026 May 2026- OCP has been signed at Executive level on 22nd May with the 6 week consultation phase to start in June which will move forward the position to appoint a QA lead Radiographer and then

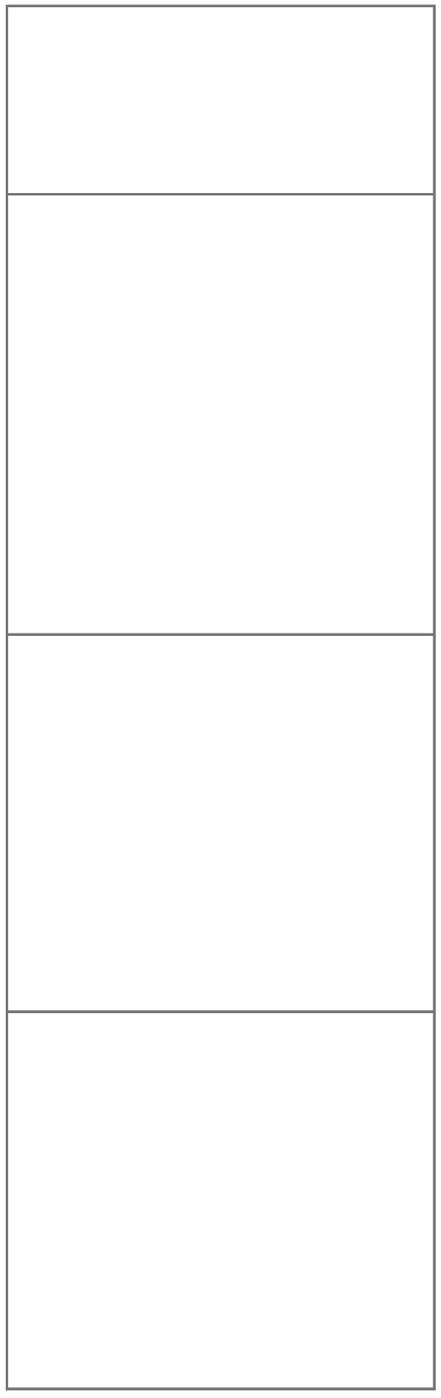
Update to HIW 29/07/24, the above action has been superseded by an action to review policy.

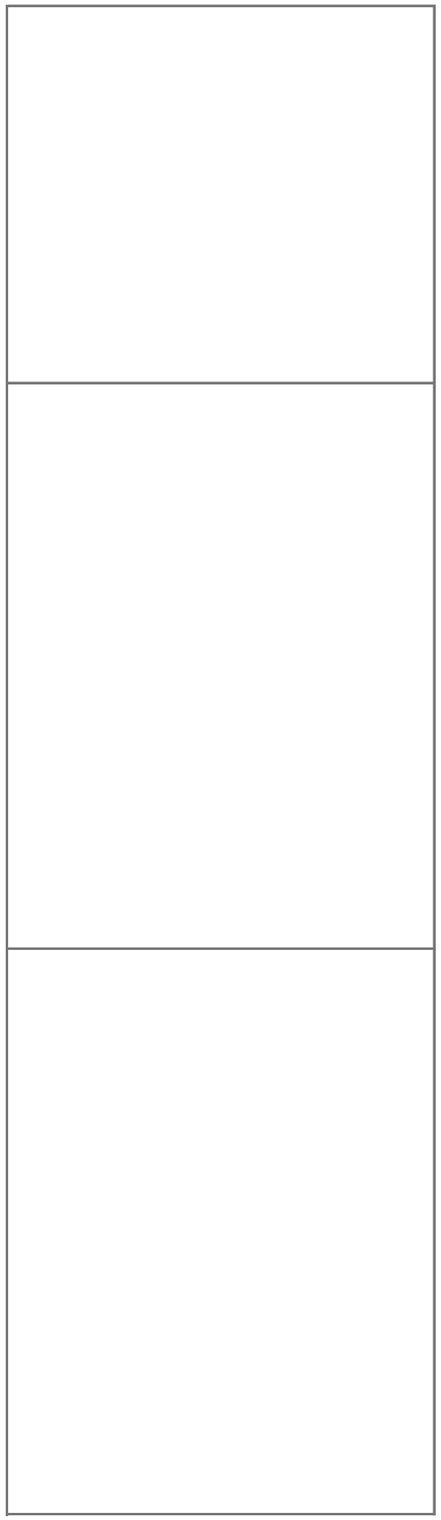
Update 3.9.25- All Wales approach – FO taking to AWIQF for update and progress. no progress All wales - will consider HB approach until All Wales policy sorted. Meeting will be arranged with MPE - Simon Evans. meeting delayed due to inspection revised target date 31.9.26

update 3.9.25- Query sent to SE on 21/7 re All Wales progress made to date revised target date 31.1.26, update 12.11.25 need action from JA/MH to ensure E-IRMER is added as mandatory. - email sent to JA /MH to see what progress has been made. revised target date 31.4.26 - still awaiting process to ensure mandatory training for medical staff - extend to 30/9/26

update Jan 26 - due to fragility in management team and absence of HoS alongside the introduction of the new RISP system has caused this action (EP update) to not be completed on time. Progress has been made in developing a new entitlement document however the system for this is currently being procured by the health board in 2026 (Robert James-Senior Project Manager), likely complete 1/9/26. Until this time an MS form has been created, it is currently with MPE to review for suitability. needs new software - end of 26/27







Previous contingency plan has been sourced. Draft contingency plan written and awaiting review by Deputy Head of Radiology 23/06/26

reviewed and updated - awaiting financial approval . updated due date 1/9/26