Date	**11/08/2026**
Time	**09:30 - 12:30**
Location	**Microsoft Teams Meeting**

Quality, Safety & Experience Committee

HDD_Quality, Safety & Experience Committee

NHS Wales

Agenda - 11 August 2026

1 Governance

09:30, 20 min

1.1 Declarations of Interest

Eleanor Marks (Hywel Dda UHB - HDUHB Vice Chair)

1.2 Minutes from the Previous Meeting and Table of Actions

Eleanor Marks (Hywel Dda UHB - HDUHB Vice Chair)

1.3 Committee Self Assessment

Joanne Wilson (Hywel Dda UHB - Director of Corporate Governance/Board Secretary)

2 Risk

50 min

2.1 Urology Deep Dive and Carers Story

Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Neil Griffiths (Hywel Dda UHB - Service Delivery Manager of Urology and Rheumatology)

2.2 Epilepsy in Learning Disabilities Update

Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Olwen Morgan (Hywel Dda UHB - Assistant Director of Nursing), Dana Scott (Hywel Dda UHB - Director of Midwifery & Professional Governance for Women & Children)

2.3 Assurance and Risk Report- Executive Leads

3 Break

10 min

4 Clinical Care Group Reports

30 min

4.1 Allied Health Professions and Health Sciences

Sara Quarrie (Hywel Dda UHB - Service Director for Allied Health Professions and Health Sciences), Angela Bell (Hywel Dda UHB - Assistant Director Quality, Safety + Patient Experience for Allied Health + Health Sciences)

4.2 Facilities

Elin Brock (Hywel Dda UHB - Head of Research, Innovation & Improvement), Jo Bradburn (Hywel Dda UHB - Deputy Director of Allied Health Professions)

4.3 Estates

Simon Chiffi (Hywel Dda UHB - Head of Operations), Jo Bradburn (Hywel Dda UHB - Deputy Director of Allied Health Professions)

5 Assurance

1 hr

5.1 Quality Assurance Report

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

5.2 Listening and Learning Sub Committee Update Report and Annual Report 2026/27

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

5.3 Safeguarding Assurance Report

Charlotte Westacott (Hywel Dda UHB - Head of Safeguarding)

5.4 Inpatient Falls Assurance Report

Anna Chiffi (Hywel Dda UHB - Assistant Director of Nursing, Patient Safety, Quality)

5.5 Management of Outpatients

Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Lisa Humphrey (Hywel Dda UHB - General Manager), Paula Goode (Hywel Dda UHB - Service Director for Planned and Specialist Care)

6 Escalation Report

10 min
Sharon Daniel (Hywel Dda UHB - Executive Director of Nursing, Quality & Patient Experience)

7 Policies/ Procedures for Approval

7.1 309 - Continuing NHS Healthcare Operational Policy to Support Framework for Implementation

Tracy Devantier (Hywel Dda UHB - Performance and Improvement Manager)

7.2 1097 Corporate Safeguarding Policy

Charlotte Westacott (Hywel Dda UHB - Head of Safeguarding)

7.3 982 Incident, Near Miss and Hazard Reporting and Management Procedure

Cathie Steele (Hywel Dda UHB - Interim Assistant Director of Nursing Assurance and Safeguarding), Caroline Burgin (Hywel Dda UHB - Patient Safety and Assurance Manager)

8 For Information

8.1 QSEC Work Plan 2026/27

9 Date of Next Meeting : 8 October 2026

Table of contents

11/08/2026 09:30 - 12:30

1 - Governance 9

1.1 - Declarations of Interest 10

1.2 - Minutes from the Previous Meeting and Table of Actions 11

Attachments

2026-06-11 - Quality Safety _ Experience Committee - Minutes 12

QSEC TOA 11 June 2026 35

1.3 - Committee Self Assessment 36

Attachments

SBAR Committee Self Assessment Update Report Aug 26 37

2 - Risk 41

2.1 - Urology Deep Dive and Carers Story 42

Attachments

Deep Dive Urology 2 B 43

Carers Story 74

2.2 - Epilepsy in Learning Disabilities Update 81

2.3 - Assurance and Risk Report- Executive Leads 82

Attachments

QSEC CRR WHC MD Report - August 2026 FINAL 83

Appendix 1 - QSEC Corporate Risk Register 129

Overdue Audit Inspection Recommendations aligned to QSEC 135

3 - Break 150

4 - Clinical Care Group Reports 151

4.1 - Allied Health Professions and Health Sciences 152

Attachments

Clinical Care Group Update Report- Operational Allied health and Health Sci~ 153

4.2 - Facilities 166

Attachments

Facilities Service Group report 167

4.3 - Estates 178

Attachments

Estates Care Group 179

5 - Assurance 191

5.1 - Quality Assurance Report 192

Attachments

3.1 QS Assurance Report Aug 2026 v0.1 CB additions 193

Appendix Assurance Report Action plans extracted July 2026 (002) 233

5.2 - Listening and Learning Sub Committee Update Report and Annual Report 2026/27 560

Attachments

LLSC August 2026 561

LLSC Annual Review 2526 2 564

5.3 - Safeguarding Assurance Report 572

Attachments

Safeguarding report to QSEC Aug 26 573

5.4 - Inpatient Falls Assurance Report 580

Attachments

Inpatient Falls Assurance report 581

Bronglais Decaffeinated Drinks Patient Story 588

5.5 - Management of Outpatients 595

Attachments

QSEC SBAR - R7 Audit Wales Report - Management of Outpatients 596

6 - Escalation Report 603

Attachments

QSEC Escalation Update - August 2026 604

7 - Policies/ Procedures for Approval 621

7.1 - 309 - Continuing NHS Healthcare Operational Policy to Support Framework for Implementation 622

Attachments

CHC Operational policy SBAR June 26 623

309 - LTC Operational Policy -v4 for approval 628

EqIA Screening form July 2026 757

7.2 - 1097 Corporate Safeguarding Policy 763

Attachments

Policy 1097 Safeguarding 764

1097-CorporateSafeguardingPolicy v2 (002)(003)(004) 768

1097 EqIA Screening form May 26 790

7.3 - 982 Incident, Near Miss and Hazard Reporting and Management Procedure 795

Attachments

QSEC 982 Incident, Near Miss and Hazard Reporting and Management Procedure 796

982 - Incident reporting procedure v4 for qsec 800

982 - Equality Impact Assessment 20 07 2026 827

8 - For Information 835

8.1 - QSEC Work Plan 2026/27 836

Attachments

Draft QSEC Work Programme 2026 27 837

9 - Date of Next Meeting : 8 October 2026 845

1

09:30, 20 Mins

---

1 - Governance

1.1 **09:50,**

1.1 - Declarations of Interest

Eleanor Marks (Hywel Dda UHB - HDUHB Vice Chair)

HDdUHB Register of Board Members Interests 2026-27

1.2

1.2 - Minutes from the Previous Meeting and Table of Actions

Eleanor Marks (Hywel Dda UHB - HDUHB Vice Chair)

Attachments

2026-06-11 - Quality Safety Experience Committee - Minutes.pdf

QSEC TOA 11 June 2026.pdf

UNAPPROVED MINUTES OF THE QUALITY, SAFETY AND EXPERIENCE COMMITTEE MEETING

DATE OF MEETING: **9:30 AM, Thursday 11 June 2026**

VENUE: **Tresaith Meeting Room, Corporate Headquarters, Picton Terrace/Microsoft Teams Meeting**

PRESENT:
Eleanor Marks (Chair of the Committee and Vice Chair of the Health Board)
Michael Imperato (Independent Member)
Chantal Patel (Independent Member)
Neil Prior (Independent Member)

IN ATTENDANCE:
Sharon Daniel (Executive Director of Nursing, Quality and Patient Experience) (Lead Executive Director)
Mark Henwood (Executive Medical Director)
Andrew Carruthers (Chief Operating Officer)
James Severs (Executive Director of Allied Health Professions and Health Science)
Ardiana Gjini (Executive Director of Public Health)
Nadine Gould (Deputy Director of Nursing, Quality and Patient Experience)
Cathie Steele (Interim Assistant Director of Nursing Assurance and Safeguarding)
Miranda Metha (Llais Cymru/Citizens Voice Body Representative) (VC)
Louisa Morris (Clinical Director for Clinical Effectiveness) (VC)
Charlotte Wilmshurst (Assistant Director of Assurance and Risk)

Ian Bebb (Clinical Audit Manager) (VC) (part)
Karen Brown (Associate Medical Director – CIMCG) (VC) (part)
Caroline Burgin (Patient Safety and Assurance Manager) (VC) (part)
Liz Carroll (Service Director – Mental Health and Learning Disabilities Clinical Care Group) (VC) (part)
Anna Chiffi (Assistant Director of Nursing, Patient Safety and Quality) (VC) (part)
Paula Goode (Service Director for Planned and Specialist Care) (VC)
Andrew Homfray (Interim Service Delivery Manager) (VC) (part)
Helen Humpries (Head of Nursing for Professional Standards and Regulation) (VC) (part)
Amorelle Jones (Ophthalmology Service Delivery Manager) (VC) (part)
Bethan Lewis (Assistant Director of Public Health Strategic Business and Operations) (VC) (part)
Julia McCarthy (Head of Long Term Care) (VC) (part)
Miranda Metha (Llais Cymru/Citizens Voice Body Representative) (VC)
Dana Scott (Director of Midwifery and Professional Governance for Women and Children) (VC)
Anne Simpson (Head of Strategic Commissioning) (VC) (part)
Peter Skitt (Clinical Care Group Service Director – Community and Integrated Medicine) (VC) (part)
Rebecca Temple-Purcell (Assistant Director of Nursing, Patient Safety, Quality and Experience) (VC) (part)
Charlotte Wilmshurst (Assistant Director of Assurance and Risk)

UNAPPROVED

John Jenkins (Hywel Dda UHB - Committee Services Officer) (Secretariat)

MINUTES REF.	ITEM	ACTION

QSEC 26 (38) WELCOME AND APOLOGIES

Mrs Eleanor Marks welcomed all those present to the Quality, Safety and Experience Committee (QSEC) meeting.

Apologies had been received from:

- Cllr Rhodri Evans
- Ms Louise O'Connor
- Mr Subhamay Ghosh (Dr Louisa Morris deputising)
- Mrs Joanne Wilson (Ms Charlotte Wilmshurst deputising)

QSEC 26 (39) DECLARATIONS OF INTEREST

There were no declarations of interest.

QSEC 26 (40) MINUTES FROM THE PREVIOUS MEETING AND TABLE OF ACTIONS

The minutes of the QSEC meeting held on 9 April 2026 were reviewed and agreed as an accurate record of proceedings.

The Table of Actions was reviewed, and it was noted that all the actions were complete other than QSEC 26 (22) ('Risk and Assurance Report') where it was advised that an update on overdue Welsh Health Circulars (WHCs) would be presented to the QSEC meeting on 11 August 2026.

Decision: The Quality, Safety and Experience Committee:

- **APPROVED** the minutes of the Quality, Safety and Experience Committee meeting held on the 9 April 2026 as a correct record of proceedings; and
- **REVIEWED** and **NOTED** the Table of Actions from the Quality, Safety and Experience Committee meeting on the 9 April 2026.

QSEC 26 (41) RISK AND ASSURANCE REPORT- EXECUTIVE LEADS

UNAPPROVED

Ms Charlotte Wilmshurst introduced the Risk and Assurance Report to the Committee to provide an oversight on the principal risks, operational risks and review of audits and inspections aligned to the Committee.

Ms Wilmshurst advised that there were a significant number of operational risks aligned to the Committee and that the report sought to provide assurance to the Committee on how the risks were managed and the oversight arrangements in place. The risks have been themed and aligned to the STEEEP principles. The intention from Q2 2026/27 was to develop risk themes aligned to the reporting groups of the Quality and Safety Intelligence Group and share these with the Chairs of each Group and relevant subject matter experts to provide greater assurance on how the risks were managed, to improve the identification of trends and enable greater organisational controls.

In respect of audit and inspections, the Committee noted that there were 29 reports assigned to QSEC, with 62 recommendations (out of 340 recommendations) that have exceeded their original implementation date contained within those reports.

In response to a question from Ms Chantal Patel on how the information relating to how the impact of the risks to patient care was captured, Ms Wilmshurst advised that the risk description recorded the impact with the responsibility to mitigate the potential risk to patient harm.

In response to an observation from Mr Michael Imperato on a number of risks having a target completion date of 2030, Ms Wilmshurst believed that this reflected the level of capacity within the organisation and that management have tried to set realistic completion dates for target risk scores as opposed to repeatedly revising the date. Mr Neil Prior added whilst the risk themes were helpful, the number of risks aligned to the Committee was overwhelming, and some of the target risk scores seemed quite ambitious. In respect of the audit and inspection section of the paper, Mr Prior observed that that a number of these recommendations were overdue, and the paper did not provide assurance that these were going to be resolved which raised questions about ownership and whether these were going to be progressed. Ms Wilmshurst noted that less than a fifth of recommendations were overdue and that this reflected that a number of risks and audit and inspections recommendations were challenging to implement due to capacity and operational pressures. Mr James Severs believed that capacity was not the only barrier to mitigation of risk with capital resource constraints often a barrier to mitigating risk, particularly in respect of those related to the estate infrastructure.

Mrs Sharon Daniel believed that there was a need to ensure that whatever actions arose from audit and inspection

UNAPPROVED

recommendations were SMART (specific, measurable, achievable, relevant and time-bound) and as responsible officers, have a responsibility to influence internal audit recommendations to ensure they are deliverable. In respect of risk, three risks were noted with a risk score of 25 aligned to one Clinical Care Group (CCG) with a significant level of risk relating to Urgent and Emergency Care (UEC) and questioned whether there was training available for staff on risk tolerance and mitigating actions. Ms Wilmshurst advised that risk training was provided, and risks were scored against a risk matrix however risk scoring can be subjective, and further work was needed to ensure risk owners felt psychologically safe to set realistic target risk scores and dates to achieve.

The Committee recognised the potential impact to patients behind these significant risks and audit and inspection recommendations, and recognised Executive's responsibility to challenge management on their perception of the scale and significance of these risks.

In response to a question from Mrs Eleanor Marks on whether there was any challenge to the scoring of risk, Mr Andrew Carruthers advised that the 2025-26 planning cycle was highly risk-focussed which led to much activity on reviewing risk scores and developing new risks. With the new governance structure, assurance was provided that a number of these risks had been escalated for discussion. The CCGs review risks with their service groups on a regular basis, with the most significant risks reported to CCG monthly performance meetings and reported to the Operations Delivery Group, chaired by Mr Carruthers. Mr Carruthers further advised that deep dives were conducted on individual risks, predominantly on the corporate risks, but also on the highest scoring risks.

Whilst acknowledging that the number of risks seemed overwhelming, Mr Carruthers advised that this is reflective of the number of risks that the CCGs are trying to manage across the organisation operationally. A number of these risks were identified as issues that could not be addressed due to resourcing constraints and formed part of our decision making as a Board when approving the Annual Plan for 2026/27. The risks also reflect the geographical spread of the Health Board and the number of services operating across our sites, as the same risk could appear four times on the risk registers due to the same risk occurring at the Health Board's four acute sites. In response to a question from Mrs Marks on whether the four risks could be combined into a single risk, Ms Wilmshurst advised that the mitigation and management at each site would be different mitigations and therefore separate risk assessment would be appropriate.

Mrs Marks believed that the level of risk experienced within secondary care that stretched the capacity of the system would

UNAPPROVED

continue until mitigation was undertaken to move more activity to primary care, with a need to progress work in the public health space in terms of prevention. Dr Ardiana Gjini agreed and noted that the shift into primary and community services and increased focus on preventative public health measures would help to reduce system pressures and level of a number of operational risks across the Health Board, however this would need investment which would need to come from disinvestment in other areas. This may have need a new view of risk appetite and risk tolerance in order to make this shift of moving services out of acute setting, into a community and primary setting.

Mr Carruthers believed significant mitigation would be delivered through the delivery of the primary and community Services strategic plan and the implementation of Community by Design with the challenge for the Health Board on how it makes Community by Design part of the Health Board's core business by realigning resources and configuring our services differently to transform the way we delivery healthcare.

Mr Prior reasserted his concerns that there were overdue recommendations with no barriers noted, and therefore it was unclear why these have not been implemented, which raised questions about the Health Board's commitment to listen to external organisations' feedback on our current delivery, which should be as important as having strategic conversations about service configuration. The Committee agreed the next report on the position of audit and inspection recommendation should not only detail Executive ownership but also provide assurance on the accountability for delivering the oldest, and the most basic recommendations, at pace.

The Committee concluded that it was assured that there was high awareness of the risks within the report, and the processes in place, however, was not yet assured on the ambition and pace to implement them and would continue to challenge this so long as it remained concerned on the risks.

Decision: The Quality, Safety and Experience Committee, in relation to the areas presented in the report: -

RISK MANAGEMENT

- **RECEIVED ASSURANCE** that the principal risks are being refreshed and will be reported to the Board in July; and
- **RECEIVED ASSURANCE** that there are processes in place to oversee operational risks to ensure these are being managed effectively.

AUDITS, INSPECTIONS AND REGULATORY REPORTS

UNAPPROVED

- **RECEIVED PARTIAL ASSURANCE** from the lead Executive Director or Supporting Officer on the management of recommendations raised in audit, inspection and regulatory reports within their area of responsibility, particularly in respect of confirming the full implementation of recommendations, any barriers to delivery and subsequent impacts of non/late delivery, and assurance that the risks associated with these are being managed effectively. The Committee were assured that the governance and oversight arrangements were in place, stronger assurance was requested regarding accountability, the pace of implementation of overdue recommendations, and the delivery of timely and sustainable improvements where recommendations remained outstanding.

- **Update Report to Board**: The Quality, Safety and Experience Committee were **ASSURED** that there were processes in place to oversee the management of the risks aligned to the Committee despite the significant number of principal and operational risks aligned to the Committee however there was only **PARTIAL ASSURANCE** was received on the accountability and the pace of implementation of overdue recommendations, and the delivery of timely and sustainable improvements where recommendations remained outstanding.

QSEC 26 (42) OPHTHALMOLOGY DEEP DIVE

Ms Paule Goode and Ms Amorelle Jones joined the meeting

Ms Amorelle Jones presented a deep dive into Ophthalmology Services to the Committee to provide assurance on the performance of the service and the impact of capacity, workforce and pathway pressures on the quality, safety and timely access to care for patients.

Ms Jones advised that the service utilised the corporate performance dashboard to oversee the risks to the service and noted that the main corporate risk, Risk 1664 ('Risk to ophthalmology service delivery due to a national shortage Consultant Ophthalmologists and the inability to recruit'), was anticipated to be de-escalated shortly due to the imminent onboarding of two Speciality and Specialist (SAS) doctors and a regional vitreoretinal (VR) consultant.

Ms Jones advised that the intravitreal therapy (IVT) pathway was considered fragile as articulated within Risk 2142 ('Risk of being unable to provide consistent IVT service due to lack of specialist staff to allow capacity to meet demand') with the mitigating actions

UNAPPROVED

planned for the outsourcing of patients to ensure the timely and effectiveness of treatment. Ms Jones advised that the additional cost pressure of outsourcing was balanced against the risk of sight loss to patients and the need to restart patients who breach their treatment time at the start of their drug regime carried an additional cost.

Ms Jones noted that the availability and replacement of equipment was a risk to the efficient, safe and effective delivery of care exacerbated as services are provided at multiple locations across the Health Board. Ms Jones advised that while this provided care closer to the location of the patient, it had a consequential impact on staffing with a need to address the longer-term arrangements as outlined in the Clinical Services Plan (CSP).

The Committee were reassured that the number of complaints received within the service had decreased in the preceding 12 months. Whilst this was linked to a revision in the complaints management process ensuring that enquiries were managed in a timelier manner, the number of overdue complaints had remained static. Patient feedback had been positive as a result of the outsourcing of patients to a private provider.

In relation to incidents, on average there are five incidents per month. Nine incidents currently open at present with the longest waiting incident currently at 237 days. Ms Jones advised that monthly deep dives were undertaken with the most recent deep dive resulting in 20 incidents being closed. Most incidents related to delays in care despite progress being made, with 62% of patients seen within target in April 2026 and seven consecutive months of improvement having been delivered. Stage 1 outpatient waiting time had been reduced from a high of 8,915 breaches in June 2024 to 3,368 breaches in April 2026.

In response to a question from Mrs Patel on what level of assurance could be provided beyond the activity metrics that patients were not experiencing deterioration and irreversible harm from waiting for treatment, Ms Jones noted that there were 10,000 R1 patients on the follow-up list with work being undertaken to review each individual patient to ensure those with the longest delay received treatment first, with scans being undertaken within community settings to enable patients to be removed from the follow-up list who did not require a follow-up appointment to free up capacity for those patients with the highest priority.

Ms Paula Goode added that within the CCG, ophthalmology was considered a priority area with clinical urgency based on the prevention of harm. The strategic intent is to focus on the clinical urgency to minimize risk and prevent harm. Ms Goode advised that a redesign of the management team had been undertaken with work undertaken to review each individual patient to clinically validate urgency to prioritise patients and ensure patient visibility.

UNAPPROVED

Mr Imperato noted that the CSP remained the long-term solution and questioned what actions were being undertaken in the interim period to provide a clear line of sight to continuing the positive performance trajectory. Mrs Daniel also questioned what actions were being progressed to strengthen the workforce and develop advanced practice roles and whether the plan was reliant on external recruitment. Ms Jones noted that there was a current senior workforce challenge in the long term however there were actions in progress to 'grow our own' ophthalmology workforce to develop advanced nurse practitioners from within the existing workforce to enable them to provide IVT injections.

In response to a question from Mr Severs on the opportunities in place to maximise the existing workforce, Ms Jones believed that there were opportunities to increase the technician workforce within the service and to undertake a desktop clinical review of patients to prioritise doctor diagnostic capacity.

Mrs Marks questioned the pace and ambition of the delivery of services to patients, to which Ms Jones advised that previously the focus has been on referral to treatment (RTT) however there now needed to be a shift to a focus on R1 compliance for the most clinically important patients.

Ms Jones advised that working within a regional space offered both benefits and challenges with Swansea Bay University Health Board (SBUHB) receiving more benefit from regional recruitment than Hywel Dda University Health Board (HDdUHB), and that she would discuss regional recruitment with Mr Henwood as there was a need for the Health Board to recruit its own consultant as opposed to sharing a regional solution with SBUHB. Ms Goode advised that there was still a need for a regional solution for out-of-hours care to ensure that patients could access urgent eyecare services 24/7. **AJ/MH**

Ms Paula Goode and Ms Amorelle Jones left the meeting

Decision: The Quality, Safety and Experience Committee **RECEIVED ASSURANCE** on the current position of ophthalmology services, including the impact of capacity, workforce and pathway pressures on quality, safety, effectiveness and timely access to care.

Update Report to Board: The Quality, Safety and Experience Committee were **ASSURED** by the current position of the Ophthalmology Service and wished to explore further what additional support Allied Health professions could deliver within the service and the potential that could be realised by regional working with Swansea Bay University Health Board.

UNAPPROVED

QSEC 26 (43) QUALITY ASSURANCE REPORT

Ms Cathie Steele introduced the Quality Assurance Report to the Committee and highlighted the increasing pressures in Nationally Reportable Incident (NRI) closure rates despite a zero-tolerance across the Health Board. System-wide learning was underway to ensure that the Health Board was learning in a timely manner. The objective was to have no overdue NRI closure rates other than those that related to external incidents outside of the control of the Health Board that reduces the ability of the Health Board to investigate such incidents itself. NRIs had been added to the safety dashboard. There is also a focus on complaints and providing a timely response, facilitated by the implementation of the Listening to People Regulations on 1 April 2026, with the aim of closing historic complaints. Ms Steele advised that there had been a significant number of complaints closed relating to waiting times, especially with Emergency Departments (EDs).

The Committee was provided with a strategic overview of infection prevention and control (IP&C) with governance and scrutiny routes standardised with reporting through the CCG structure now established. Ms Steele advised that policies were being reviewed to ensure alignment to the All-Wales policy and the National Infection Prevention and Control manual. The launch of the national Clostridioides difficile (C. diff) campaign has taken place with the aim of shifting the focus to the impact on patients.

Ms Steele presented the Infection Control Improvement Plan to the Committee for approval and advised that the focus was on moving to system-wide learning through all portfolios for the next six months. In response to a question from Mr Prior on how the impact of that learning would be measured and assessed in a year's time, Ms Steele advised that there would be a behavioural science focus with a number of quality improvement projects undertaken with outcomes measured. Projects will be undertaken and overseen by the C. diff Project Group. Action plans will be revised to ensure that they are embedded within the Health Board and are proactive and not reactive. Mrs Daniel advised that the safety dashboard and key performance indicators (KPIs) would be reviewed to triangulate the data to ensure that the level of harm and the level of complaints were reduced to demonstrate that the learning had been successfully implemented.

Ms Dana Scott advised that care reviews were being carried out on wards with self-monitoring and peer monitoring being undertaken and it was anticipated that the standards on wards would be recognised as having improved through inspection. The Quality and Assurance Team are doing spot-check inspections on the same level as inspections undertaken by Health Inspectorate Wales (HIW).

UNAPPROVED

Mr Imperato queried the ability of the Health Board to benchmark against the national context, whereby Ms Steele advised that data was available through an All-Wales dashboard.

In response to a question from Ms Patel on learning and improvement and how the Health Board distinguished between activity and impact and how improvement could be sustained, Ms Steele believed that by taking a proactive and learning system-wide approach it would enable changes to be sustained.

Mr Prior questioned the ownership of overdue inspections, to which Ms Steele advised that ownership lay with the relevant CCG. In response to a further question from Mr Prior on escalation with reference to Child Protection in Pembrokeshire and with how the Health Board professionally escalated issues, Mrs Steele advised that escalation processes were currently being reviewed. Mrs Daniel advised that a report on safeguarding would be presented to the QSEC meeting on 11 August 2026.

Mr Prior questioned the process for ensuring actions were undertaken in a timely manner. Mrs Steele advised that the Quality Assurance and Safety Team followed up Healthcare Inspectorate Wales (HIW) actions and the Risk Team also followed up HIW actions in addition to other actions recorded on the Audit Management and Tracking (AMAT) system with CCGs reporting on their actions plans through the Strategic Safeguarding Steering Group.

Mrs Marks felt that while assurance could be received that there were processes in place to oversee the actions that more work needed to be undertaken to ensure that the actions were carried out. Ms Wilmshurst advised that reports were provided to each function monthly.

Mrs Steele believed that advising those responsible for completing overdue outstanding actions that the matter had been discussed at QSEC would encourage improvement. Mrs Marks suggested that a letter from the Chair of QSEC be prepared to present to those responsible for updating and completing recommendations to encourage progress. **CW**

Decision: The Quality, Safety and Experience Committee:

- **RECEIVED ASSURANCE** that processes are in place to review, monitor and improve the quality of the Health Board's service through:
    - Patient Safety Incidents
    - Nationally reported patient safety incidents
    - Never Events
    - Patient Experience
    - Complaints management
    - Inquests and Regulation 28
    - Infection prevention and control

UNAPPROVED

- Inspections and peer reviews including activity of Healthcare Inspectorate Wales
- **APPROVED** the Infection Prevention and Control Organisational Improvement Plan for 2026-27.

Update Report to Board: The Quality, Safety and Experience Committee were **ASSURED** that processes were in place to review, monitor and improve the quality of the Health Board's services however believed that there was a need to ensure that the actions identified through the Quality Assurance Report were undertaken.

QSEC 26 (44) DUTY OF CANDOUR REPORT 2025/26

Ms Caroline Burgin joined the meeting

Ms Steele introduced the Duty of Candour 2025/26 Annual Report to the Committee. The Health Board is required by the Health and Social Care (Quality and Engagement) (Wales) Act 2020 to produce and present the report for approval by the Board. A Duty of Quality Report is also required under the Act and this will be presented to the QSEC meeting on 11 August 2026.

Ms Steele confirmed that it was intended for the public. In response to an observation from Mr Prior that the report seemed to be written for Board Members as the target audience, Ms Steele advised that the report would be forwarded to the Communications Team to ensure that it was in a format and language that would be better received by a member of public reading the report. **CS**

Mr Imperato asked what the Duty of Candor Annual Report gave a member of the public beyond information and whether there was a sufficiently purposeful ending for the reader, including what they could do next or how the organisation wanted them to engage. Ms Caroline Burgin welcomed the feedback and acknowledged that the current format had been carried over from previous years and that the Duty of Candour framework was still relatively new in Wales. Ms Burgin agreed that the language and presentation needed to become more accessible and accepted that sections describing cases being downgraded might be misinterpreted as minimising issues rather than explaining process.

The Committee was advised that the report was a statutory requirement and that it was to be presented to the Board for approval no later than 6 months following the end of the reporting period.

In response to a question from Ms Patel on whether the Duty of Candor Annual Report resulted in any changes in practice within

UNAPPROVED

the Health Board, Ms Steele believed that it did as it enabled the Health Board to learn, and that near misses were equally as important as actual incidents that caused patient harm.

Decision: The Quality, Safety and Experience Committee:

- **PROVIDED FEEDBACK** on the draft Duty of Candour Annual Report for 2025/26; and
- **RECOMMENDED FOR APPROVAL** to the Board subject to review by the Communications Team to ensure that the report was in a format suited for the public audience.

QSEC 26 (45) QUALITY ASSURANCE REPORT FOR COMMISSIONED SERVICES

Ms Julia McCarthy and Ms Anne Simpson joined the meeting

Ms Anne Simpson presented the Quality Assurance Report for Commissioned Services with SBUHB, Cardiff and Vale University Health Board (CVUHB) and the NHS Wales Joint Commissioning Committee (NWJCC) to the Committee.

Ms Simpson advised that an analysis of the data did not suggest any isolated issues in any single service area so much as repeated system-level themes, adding that SBUHB was a high-volume secondary and tertiary provider for HDdUHB, and that the number of incidents was consistent across both Health Boards with just over 1,000 incidents and 160 complaints from HDdUHB patients within SBUHB services. The main themes identified were within high-volume specialties and often related to delays in communication or information failures. A Commissioning and Contracting Oversight Group has recently been established to monitor and review contract and commissioning arrangement where appropriate.

In relation to waiting times when seen through a quality and safety lens that there were a small number of patients waiting over 52 weeks for treatment aligned to the number of complaints. The Health Board is taking a structured approach with recovery plans in place including patient-specific updates and the use of the appropriate oversight forums.

Ms Simpson highlighted an urgent service risk within paediatric neurology services as a result of the loss of outreach clinics previously provided by CVUHB. There were plans to reinstate the clinics for 6 months which reduced the immediate risk to HDdUHB patients however the service remained fragile.

Ms Julia McCarthy delivered a presentation on the assurance arrangements for commissioned care within nursing homes and advised that HDdUHB commissioned care for 618 residents and a

UNAPPROVED

further 80 individuals in the community who were in receipt of continuing healthcare (CHC). The Health Board maintains active oversight of each of these commissioned arrangements through a programme of overviews and assessments. The Health Board Team undertakes quarterly unannounced monitoring visits to providers. These take place at various times of the day and at weekends and findings are reported to the relevant contract management forums.

The Committee heard that the Health Board sought to build and maintain relationships with the managers of the care homes that it commissioned. A dedicated nurse acts as a single point-of-contact with each provider. Ms McCarthy believed that the aim of the relationship was to promote a partnership approach to the provision of care to the patient.

Ms McCarthy highlighted risk identification and advised that patient safety was paramount. There is timely escalation of any concerns identified with appropriate safeguarding processes in place. Risks are regularly reviewed to reflect that patient need is ever-changing to ensure that individuals receive their care in the most appropriate setting at all times. The Health Board works with the relevant local authority to review the risk. Where risks or concerns were identified, action plans with agreed timescales were implemented with providers. Shared intelligence with local authorities is utilised to identify risk as early as possible. Ms McCarthy advised that contract termination was an option of last resort with a balance struck with the provider between support and challenge that seeks to sustain a strong relationship and ensure accountability. There were regular meetings with care home managers and that the Health Board provided training opportunities to providers in addition to the provision of professional support such as from dieticians and pharmacist support.

In response to a question from Mr Imperato on how the Health Board assessed providers, Ms McCarthy advised that a unified tool was used in conjunction with local authorities for all providers. This ensures a standardised assessment and that any significant concerns identified are escalation and a corrective plan implemented with RAG ratings. Weekly visits are undertaken to review all aspects of the environment such as kitchens, food and menu plans, environmental assessments that included an inspection of mattresses, equipment such as hoists, PAT testing to review the suitability of placements. Ms McCarthy advised that high-cost placements were reviewed more frequently so if the needs of the patient reduced, they were moved to a less high-intensive location so that in addition to saving money it also released capacity for other patients to utilise.

Mrs Marks queries the value judgements of providers, Ms Nadine Gould advised that clinical and non-clinical reviews were undertaken to provide assurance. In response to a question from

UNAPPROVED

Ms Patel on how complaints were assessed to identify areas of emerging concern before they became a significant concern, Ms Simpson advised that the underlying data was triangulated to develop further reporting.

Ms Steele advised that for each commissioned service, the Health Board held regular meetings with other Health Boards such as SBUHB and Powys Health Teaching Board (PHTB) to provide quality assurance data and review Long Terms Arrangements (LTAs) with quality data such as Patient-Recorded Outcome Measures (PROMs) and Patient-Reported Experience Measures (PREMs) to identify early warnings.

Ms Julia McCarthy and Ms Anne Simpson left the meeting

Decision: The Quality, Safety and Experience Committee:

Swansea Bay University Health Board and NHS Wales Joint Commissioning Responsibility

- **NOTED** the overall quality and safety position for commissioned services.
- **ACKNOWLEDGED** that Swansea Bay University Health Board incident, complaints and claims data identify recurring system themes, particularly delays and communication.
- **NOTED** the emerging risk relating to tertiary paediatric neurology provision.
- **RECEIVE ASSURANCE** that issues are being actively monitored and escalated through commissioning arrangements.

Long Term Care Assurance for Commissioned Nursing Homes

- **NOTED** and **RECEIVED ASSURANCE** on the arrangements in place for commissioned nursing homes, including monitoring, escalation, and partnership working, and to take assurance that robust processes are in place to identify concerns, support improvement, and escalate issues through agreed governance and Provider Performance routes where required.

Update for Board:

The Committee were **ASSURED** that the Health Board's commissioning arrangements were being actively monitored and escalated where appropriate to ensure the quality and safety of services for Hywel Dda University Health Board patients through services commissioned through partner organisations.

UNAPPROVED

The Committee were **ASSURED** that the Long Term Care Assurance for Commissioned Nursing Homes report provided useful assurance on the oversight of commissioned services however believed that future reporting should demonstrate more clearly how triangulated intelligence is impacting decision-making and how the Health Board was reflecting on its effectiveness as a commissioning body.

QSEC 26 (46) CLINICAL AUDIT PROGRAMME FOR APPROVAL

Mr Ian Bebb joined the meeting

Mr Ian Bebb presented the Clinical Audit Programme to the Committee for approval and advised that the programme was constructed following requests to senior governance and quality forums within the Health Board and CCGs with the 2026-27 programme having been broadened to include input from the Audit and Risk Assurance Committee (ARAC) and QSEC to ensure that the programme aligned closely with the organisational priorities of the Health Board.

In response to a query from Mr Prior on the nature of the clinical audits, Mr Bebb confirmed that the audits were internal reviews undertaken by the Health Board with recommendations made through the clinical audits followed up with all clinical audits recorded and tracked on the AMaT system and that the audits formed part of the formal clinical audit programme.

Mr Bebb advised that the programme was informed from a range of sources including complaints data, National Institute of Clinical Excellence (NICE) guidance, the risk register and strategic organisational requests.

In response to a question from Mr Severs on the timescales of responses, Mr Bebb advised that most audits were continuous in nature in comparison to regular one-off audits.

Mr Ian Bebb left the meeting

Decision: The Quality, Safety and Experience Committee **DISCUSSED** and **APPROVED** the Clinical Audit Programme for 2026/27.

QSEC 26 (47) NURSE STAFFING LEVELS SPRING CYCLE REPORT

Ms Helen Humpries joined the meeting

UNAPPROVED

Mrs Daniel introduced the Nurse Staffing Levels Spring Cycle report to the Committee to provide assurance that the Health Board was meeting its statutory duty to calculate nurse staffing levels for all wards within the scope of Section 25B of the Nurse Staffing Levels (Wales) Act 2016.

Ms Helen Humpries presented the outcome of the Spring 2026 cycle and advised that there had been a number of changes following the Spring 2026 cycle with an additional 2.72 WTE Registered Nurse (RN) requirement on Ward 10 at Withybush Hospital (WGH) to provide an additional RN on duty over seven days and a reduction of 2.52 WTE Band 4 Assistant Practitioners based on patient acuity.

There had been a change in the proportion of long days being worked by Nursing Support Workers on Cadog Ward at Glangwili Hospital (GGH) and a change in the proportion of long days being worked by RNs and Nursing Support Workers on Angharad Ward at Bronglais Hospital (BGH).

Ms Humpries advised that the changes had been a result of reviews undertaken into ward capacity, specialities, infection control data and national guidance.

The report contained the financial implications of the changes to the nurse staffing levels and that this had been presented to the Executive Team on 3 June 2026. The annual nurse staffing levels assurance report had been reported to Board on 28 May 2026, with a three-year report due to be produced in 2027 that would articulate the impact of nurse staffing on key performance indicators (KPIs).

In response to a question from Ms Patel on how sustainable the nurse staffing levels were, Ms Humpries advised that reviews were undertaken in areas where the nurse staffing level requirements had not been met with any concerns raised with the relevant senior nurse and highlighted within the assurance report. Mitigating measures, such as redeploying staff from other wards, were considered within the assurance report, to inform how to meet the requirements of the Nurse Staffing Levels (Wales) Act.

Ms Helen Humpries left the meeting

Decision: The Quality, Safety and Experience Committee:

- **RECEIVED ASSURANCE** that Hywel Dda University Health Board is meeting its statutory duty to calculate nurse staffing levels for all wards within the scope of Section 25B of the Nurse Staffing Levels (Wales) Act 2016.
- **RECEIVED ASSURANCE** that, by presenting this report Hywel Dda University Health Board is fulfilling its statutory requirement to provide a written update on nurse staffing levels for each relevant ward to the Board (or its delegated

UNAPPROVED

committee) where there has been a service change affecting staffing levels or were deemed necessary by the designated person (Paragraph 12).
- **NOTED** the content of the Annual Assurance Report.

Update Report to Board: The Committee wished to **ASSURE** the Board that the Health Board was compliant with the requirements of the Nurse Staffing Levels (Wales) Act 2016.

QSEC 26 (48) CLINICAL CARE GROUP REPORTS: MENTAL HEALTH AND LEARNING DISABILITIES

Ms Karen Brown, Ms Liz Carroll, Ms Anna Chiffi, Mr Peter Skitt and Ms Rebecca Temple-Purcell joined the meeting

Ms Rebecca Temple-Purcell introduced the Mental Health and Learning Disabilities (MHLD) CCG report to the Committee to provide an update on progress and to provide assurance on the quality improvement work undertaken within the CCG in relation to the publication of a new national Mental Health and Wellbeing Strategy.

Ms Temple-Purcell advised that the aim of the Welsh Government (WG) Mental Health and Wellbeing Strategy (2024-2034) was to align the practices of the Health Board to a clear vision of equitable and patient-centred care and support.

A significant level of improvement work has been undertaken by the CCG to strengthen the governance processes relating to complaints and incidents, with the establishment of a Serious Incident Learning Forum that would provide oversight of performance and outcomes going forward.

Ms Temple-Purcell advised that an overview of the risks aligned to the CCG identified that the themes related to delays to access timely services and workforce gaps and challenges with some areas of the Health Board more affected than others. Ms Temple-Purcell advised that measures to extend the Practice Team and the use of digital pathways were being pursued with the use of outsourced services to address patient waiting times.

Mr Imperato asked what actions were being taken to address the workforce gaps and the impact on delivery and financial impact. Ms Temple-Purcell advised that there the significant gaps within medical staffing were being addressed with a pro-active approach being taken to fill the gaps using innovative measures, such as overseas recruitment and the establishment of a clinical fellowship programme. There was also work being undertaken to develop non-medical roles such as advanced clinical practitioners to support the delivery of care to bridge the medical workforce gaps

UNAPPROVED

and advised of the Workforce Management Group for workforce planning that reported to the Medical Director.

In response to a supplementary question from Mr Imperato on whether the additional measures were working, Ms Temple-Purcell believed that there had been positive feedback on improvements to non-medical vacancies, especially within the Ceredigion county system driven by the provision of training of non-medical roles. Work had also been undertaken to renew the staffing establishment levels within in-patient services to reduce the reliance on bank and agency nursing staffing.

Ms Patel inquired how artificial intelligence (AI) and digital platforms was being used to support assessment that would improve the patient experience. Ms Temple-Purcell responded that HDdUHB was consistent with the practice used in other Health Boards, with work being undertaken to evaluate the possibilities to understand fully how AI and digital solutions were working and not generating additional risk.

Ms Liz Carroll advised that the MHLD service had a specific consultant challenge, which had led to a review being undertaken of the learning disability medical workforce supported by discussions with the Medical Directorate to examine the use of non-medical roles. Mr Henwood advised that a review of the use of variable pay would be presented to the Finance and Performance Committee (FPC) on 30 June 2026.

Ms Rebecca Temple-Purcell left the meeting

Decision: The Quality, Safety and Experience Committee **RECEIVED ASSURANCE** on the quality governance arrangements in place within the Mental Health and Learning Disabilities Clinical Care Group in relation to quality, safety and patient experience.

QSEC 26 (49) CLINICAL CARE GROUP REPORTS: PUBLIC HEALTH

Ms Bethan Lewis joined the meeting

Ms Bethan Lewis presented the Public Health CCG report to the Committee to provide an overview of governance and operational delivery within the Public Health function to protect health, prevent harm and improve wellbeing and believed that the report demonstrated how the governance structure within the Directorate had become more integrated and demonstrated the quality activity within health protection, communicable disease control, immunisation oversight, disease prevention work, smoking cessation and health coaching.

UNAPPROVED

Mrs Marks queried on how staff engagement within the wider community could be promoted, Ms Lewis advised that the Health Board utilised the services of its Community Outreach Team to engage with communities that were traditionally reluctant to engage with the Health Board and access services and sought to embed health protection and health coaching within communities, within GP practices and other community venues, and sought to link in with established 'trusted voices' within communities to encourage an improvement in the update of Health Board services.

Ms Lewis believed that there were a number of good examples within the Health Board such as pop-up clinics within the community, the close linkage between smoking cessation work and the Immunisation Team and representation at community events, strong linkages with third-sector organisations and the deployment of a mobile vehicle across the Health Board.

Ms Marks questioned how the wider Health Board workforce could be encouraged to be health ambassadors within their community, Ms Lewis believed that the 'Make Every Contact Count' programme was an important platform from which to promote health protection and it was being explored how best training for new starters could be utilised to use staff to have health coaching conversations and also to not miss opportunities to speak to out-patients and also to engage with Local Authorities and social care colleagues.

Ms Patel enquired what interventions had the greatest impact from the shift of resources into prevention, Ms Lewis believed that immunisation had the single, greatest impact on population health and advised that HDdUHB had the leading impact in Wales for smoking cessation and vaping and nicotine replacement.

Mrs Daniel highlighted incident reporting and noting the high level of incidents within nurseries within the county of Pembrokeshire, Ms Lewis noted that there had been an outbreak of gastrointestinal symptoms in Pembrokeshire in Winter 2025/26 and that Public Health Wales (PHW) were leading in response with the Health Board engaged with Local Authority Leads through the Quality Health Protection Oversight Group and believed that the Health Board had strong Healthy Schools and Health Pre-School Team. Ms Lewis also believed that the spike in Pembrokeshire could also be attributed to better reporting within the county. Dr Gjini advised that reporting was voluntary and that such self-reporting would inherently be subjective.

Dr Gjini believed that all Health Board staff should be supported to promote health protection and to prevent ill-health and believed that the 'Make Every Contact Count' programme needed to be scaled up with the Health Board's three constituent Local Authorities and Public Service Boards (PSBs) all requesting for 'Make Every Contact Count' training to be expanded. Dr Gjini

UNAPPROVED

advised that all consultant new starters received training and that there was positive engagement with the Medical Education Team and that the Health Board was a leader in medical education development for foundation doctors.

Dr Gjini noted that there had been specific engagement with the farming and fishing communities within the community outreach programme and that the health coaching service had been expanded and had been included within the Health Board's Annual Plan for 2026/27.

Ms Bethan Lewis left the meeting

Decision: The Quality, Safety and Experience Committee **RECEIVED ASSURANCE** on the quality governance arrangements in place within the Public Health Directorate in relation to quality, safety and patient experience.

QSEC 26 (50) CLINICAL CARE GROUP REPORTS: COMMUNITY AND INTEGRATED MEDICINE

Ms Anna Chiffi presented the Community and Integrated Medicine (CIM) CCG report to the Committee and highlighted that incident management within the CCG continued to present a challenge however noted that there had been significant improvement in reducing the number of long-term incidents that had been open for more than 60 days and 120 days.

Ms Chiffi highlighted the on-going safety concerns relating to boarding and care within non-designated clinical areas. Work is being progressed with patient flow initiatives, clinical streaming and assessment models, strengthening discharge coordination and oversight of pathways of care delays through improved senior decision-making at the front door of the acute setting. Ms Chiffi noted that a thematic analysis of complaints indicated the areas of greatest complaints related to communication with patients and families, delays in care and discharge and environmental concerns. The report also acknowledged the workforce challenge within the medical workforce across the Health Board's acute sites.

Ms Chiffi believed that the introduction of the Listening to People framework would strengthen patient feedback and drive service improvement through the triangulation of incidents, complaints and patient experience.

Mr Imperato questioned what changes had been made to the CCG structure to provide quality assurance, Ms Chiffi advised that the structure of the CIM CCG had evolved to establish processes for all three county systems to integrate additional elements into

UNAPPROVED

the system. The organisational change process (OCP) aims to ensure that there is appropriate workforce to ensure an integrated pathway from community to acute settings that was captured by Quality and Safety meetings. Mr Carruthers believed that the OCP would address the historic geographic challenges moving from county or site-specific view to a speciality overview across the Health Board.

Mrs Marks believed that there was a need for the promotion of efficient working to overcome the financial constraints, Mr Peter Skitt believed that workforce gaps caused a financial challenge and created inefficiency with a need to strengthen the substantive workforce to promote efficiency. Mr Carruthers believed that there was an inherent structural inefficiency through the historic organisation of the Health Board.

Ms Karen Brown, Ms Anna Chiffi, and Mr Peter Skitt left the meeting

Decision: The Quality, Safety and Experience Committee: **RECEIVED ASSURANCE** on the governance arrangements in place across Community and Integrated Medicine Clinical Care Group and **NOTED** the progress made in strengthening oversight and improvement activity.

QSEC 26 (51) ESCALATION REPORT

Mrs Daniel presented the Escalation Report to the Committee and believed that the data contained within the report indicated that improvements had been realised in relation to hospital acquired infections. This reduction had not yet become reliable, however the significant improvement exhibited in Q4 2025/26 was noted by the Committee, with acknowledgement that the criteria for de-escalation required three consecutive months of improvement.

The Health Care Associated Quality Improvement Plan would focus on targeted and high impact interventions in areas where the numbers of infections were highest. This would support the delivery of the Health Board's targeted intervention (TI) deescalation criteria.

In response to an observation from Mrs Marks that it was difficult to sustain improvements in relation to hospital acquired infections when the numbers were so low, Mrs Daniel advised that she would be meeting with NHS Wales Performance and Improvement to further understand the de-escalation criteria.

Decision: The Quality, Safety and Experience Committee:

UNAPPROVED

- **NOTED** the current position that infection performance has shown periods of improvement but not sustained compliance;
- **NOTED** that fragile services arrangements are established but not yet fully embedded;
- **NOTED** that further work is required to:
    - embed a consistent fragile services approach
    - provide a consolidated Board-level view of risk and trajectory
- **DISCUSSED** and scrutinised the ongoing variability in:
    - Hospital Acquired Infections (criteria 22–24)
    - Fragile Services (criteria 10–14)
- **RECOGNISED** that system reliability and consistency have not yet been achieved
- **SUPPORTED** strengthening infection prevention reliability and improving training compliance

QSEC 26 (52) **EXTENSION OF 'SERVICE USER ACCESS POLICY – PSYCHOLOGICAL THERAPIES.' POLICY NUMBER: 1133**

Mr Andrew Homfray joined the meeting

Mr Carruthers presented the extension of Policy 1133 ('Service User Access Policy – Psychological Therapies') to the Committee for approval.

Mr Carruthers advised that the request for the extension was to ensure the continuity of the current policy while the development of an all-Wales policy was implemented at a national level.

Mr Carruthers noted that the development of the national policy had been influenced by work undertaken within HDdUHB with the request was not to approve a new local policy however to retain the current policy on an interim basis until the all-Wales policy was confirmed.

Mr Carruthers advised that should the development of the all-Wales policy not be implemented within the next six months then the current policy would be reviewed and updated and presented to the Committee for approval.

Mr Andrew Homfray left the meeting

Decision: The Quality, Safety and Experience Committee is approved the extension of Policy 1133 by 6 months to allow the All-Wales document to be taken through the relevant governance and implemented across Wales.

UNAPPROVED

QSEC 26 (53) QSEC WORK PLAN 2026-27

Mrs Marks presented the Committee Work Plan to the Committee for review.

In response to a question from Mr Prior on the inclusion of a patient or staff story to the QSEC agenda, Mrs Daniel confirmed that it was the intention to include a patient story within the agenda at the Committee meeting on 11 August 2026.

Decision: The Quality, Safety and Experience Committee **REVIEWED** and **NOTED** the Committee Work Plan 2026/27.

QSEC 26 (54) DATE OF NEXT MEETING

The next meeting was noted as scheduled for 11 August 2026 at 9.30.

UNAPPROVED

QUALITY, SAFETY AND EXPERIENCE COMMITTEE (QSEC)/ PWYLLGOR ANSAWDD, DIOGELWCH A PHROFIAD
11/06/2026
TABLE OF ACTIONS/TABL GWEITHREDOEDD

Key: AC-Andrew Carruthers; AJ-Amorelle Jones; CS-Cathie Steele; CW-Charlotte Wilmshurst; MH-Mark Henwood; SD-Sharon Daniel

MEETING DATE	MINUTE REF	ACTION	LEAD	TIME SCALE	PROGRESS
09/04/2026	QSEC (26) 22	Risk and Assurance Report • To provide a status update on the overdue Welsh Health Circulars and ensure there is a risk aligned on the Datix Risk Register	SD, AC	11/08/2026	Complete This will be reported in the August Assurance and Risk Report
11/06/2026	QSEC (26) 43	QUALITY ASSURANCE REPORT • To draft a commication for the Chair of the Committee to send to Executive Directors requesting that risks are updated and completed in a timely manner.	CW	11/08/2026	In progress
11/06/2026	QSEC 26 (42)	OPHTHALMOLOGY DEEP DIVE • To discuss the regional recruitment needs of the Health Board's Ophthalmology Service with Medical Director.	AJ, MH	11/08/2026	Complete
11/06/2026	QSEC 26 (44)	DUTY OF CANDOUR REPORT 2025/26 • To send the Duty of Candour 2025/26 Annual Report to the Communications Team for review to ensure that it is presentable for public consumption.	CS	11/08/2026	Complete The Duty of Candour was subsequently approved by Board on 25 June 2026

1.3

1.3 - Committee Self Assessment

Joanne Wilson (Hywel Dda UHB - Director of Corporate Governance/Board Secretary)

For discussion

Attachments

SBAR Committee Self Assessment Update Report Aug 26.pdf

Pwyllgor Ansawdd, Diogelwch a Phrofiad/ Quality, Safety and Experience Committee

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	**11 AUGUST 2026**
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Quality, Safety and Experience Committee (QSEC) Self-Assessment Outcome Report 2025/26 – Progress Update
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Joanne Wilson, Director of Corporate Governance/Board Secretary
SWYDDOG ADRODD: **REPORTING OFFICER:**	Charlotte Wilmshurst, Assistant Director of Assurance and Risk

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/ For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to provide an update to the actions agreed by the Quality, Safety and Experience Committee (QSEC) in response to the outcomes from the QSEC Self-Assessment 2025/26 process.

Cefndir / Background

In February 2026, QSEC received a report which presented the outcomes of the QSEC Self-Assessment 2025/26 process. For QSEC, this involved the completion of a short digital form which requested feedback on the following areas:

- Oversight and Impact on Quality & Safety
- Data, Indicators, and Assurance
- Culture and Accountability
- Risk Recognition and Response
- Continuous Improvement and Committee Effectiveness

Asesiad / Assessment

The following actions were agreed in response to the outcomes of the QSEC Self-Assessment 2025/26:

Area for improvement	By Whom	By When	Update
Ensure report authors receive feedback on the quality of their papers being brought to Committee to improve and	Executive Leads	March 2026	Operational governance arrangements have been reviewed and strengthened. The 'New Ways of Working' processes have been

develop. More focus on the key themes such as risk, outcomes, impacts relating to patients etc.			implemented which provide regular touchpoints and opportunities for this feedback to be incorporated.
To strengthen operational governance arrangements to reduce reporting of urgent service issues/changes and facilitate more proactive reporting of risks before they materialise.	Chief Operating Officer	July 2026	Operational governance arrangements have been reviewed and strengthened as part of the 'New Ways of Working'. More specifically, the following governance structure and processes have been implemented which provide regular touchpoints for feedback, focus on key themes, to identify service fragility that may otherwise result in urgent service issues/changes and facilitate more proactive reporting of risks before they materialise.

Argymhelliad / Recommendation

The Quality, Safety and Experience Committee is asked to take assurance from the progress made against the actions being undertaken to improve its effectiveness.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	10.5 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any Sub-Committees established. In doing so, account will be taken of the requirements set out in the NHS Wales Quality & Safety Committee Handbook.
Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	Not applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	Choose an item. Not Applicable Choose an item. Choose an item. Choose an item. Choose an item.
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	Not Applicable Choose an item. Choose an item. Choose an item. Choose an item.

Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable Choose an item. Choose an item. Choose an item. Choose an item.
Nodau Cynllunio 2026/27 Planning Goals 2026/27	Not Applicable Choose an item. Choose an item. Choose an item. Choose an item. Choose an item. Choose an item. Choose an item.
Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	10. Not Applicable Choose an item. Choose an item. Choose an item. Choose an item. Choose an item. Choose an item. Choose an item.
Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau) A Social Model for Health and Wellbeing: (*complete for strategic change and/or significant service changes)*	Not Applicable Choose an item. Choose an item. Choose an item. Choose an item. Choose an item. Choose an item. Choose an item.
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	QSEC Terms of Reference QSEC Self-Assessment Outcome Report
Rhestr Termau: Glossary of Terms:	Contained within the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	QSEC Chair Director of Corporate Governance

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No direct impacts
Ansawdd / Gofal Claf: Quality / Patient Care:	No direct impacts

Gweithlu: **Workforce:**	No direct impacts
Tegwch Iechyd: **Health Equity:**	No direct impacts
Risg: **Risk:**	No direct impacts
Cyfreithiol: **Legal:**	No direct impacts
Enw Da: **Reputational:**	No direct impacts
Gyfrinachedd: **Privacy:**	No direct impacts
Cydraddoldeb: **Equality:**	No direct impacts

2

50 Mins

---

2 - Risk

2.1

2.1 - Urology Deep Dive and Carers Story

Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Neil Griffiths (Hywel Dda UHB - Service Delivery Manager of Urology and Rheumatology)

For assurance

Attachments

Deep Dive Urology 2 B.pdf

Carers Story.pdf



Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Deep Dive: Urology

Quality, Safety and Experience Committee

August 2026

Situation

In November 2025, the Quality, Safety and Experience Committee received a report outlining the fragility of Urology services across Hywel Dda University Health Board and the associated risks to patient care, service delivery and staff sustainability.

Urology Fragility Deep Dive

This update provides the Committee with:

- An overview of the current position of the Urology service.
- Progress made against the actions and mitigations presented in November 2025.
- An update on quality, safety, patient experience and clinical risks associated with ongoing service fragility.
- A summary of improvements achieved and the key challenges that remain.
- The actions being taken to support service resilience whilst longer-term solutions continue to be developed through the Clinical Services Plan and associated recovery programmes.



This paper outlines the current clinical, operational and patient experience impacts of service fragility and the measures in place to mitigate risk and improve patient outcomes.

Executive Assurance Summary

Urology Deep Dive Follow-up (Position Since November 2025)

Overall Assurance Assessment: Moderate Assurance (Improving but Fragile)

- Since the Committee received the Urology Fragility Deep Dive in November 2025 the service has delivered recovery actions within its direct control. Significant improvements have been achieved in diagnostic pathways, governance oversight, workforce resilience and patient pathway coordination.
- However, despite these improvements, the service remains fragile. The principal risk has shifted from pathway design and governance processes to insufficient recurrent capacity, particularly within theatres, specialist nursing and diagnostics. These constraints continue to impact timely treatment and limit sustainable recovery of both cancer and routine pathways.







Improvements Delivered Since November 2025

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

Cancer Diagnostic Pathway Strengthened

- Magnetic Resonance Imaging (MRI) outsourcing implemented.
- Additional local anaesthetic transperineal prostate biopsy (LATP) biopsy capacity established.
- Pathology turnaround times reduced from over two weeks to approximately one week.
- Prostate Decision Clinic introduced.

Patient Experience Improvements

- Dedicated Prostate Pathway Co-ordinator introduced.
- Clinical Nurse Specialist (CNS) recruitment progressed.
- Faster communication of diagnosis and treatment options.

Workforce Resilience Improved

- Replacement Consultant Urologist appointed.
- Sustainable 1:7 consultant on-call rota to be restored from October 2026.
- Business case submitted to modernise middle-grade rota arrangements.

Governance Strengthened

- No incidents remain open beyond 60 days.
- Follow-up management improved.
- Continued reduction in delayed follow-up patients.

Stones Pathway Improvement

- Dedicated stones treatment list established.
- Long-standing stent pathway constraint partially addressed.



Risks Remaining

Cancer Performance

- Urology remains the lowest-performing Health Board in Wales for Unscheduled Care (USC) performance despite demonstrable improvement in backlog position.
- Diagnostic gains are not yet translating into sustained treatment performance.

Routine Waiting Times

- Approximately 200 routine patients are expected to remain in breach due to prioritisation of cancer activity.

Patient Experience

- Delays, communication challenges and pathway uncertainty remain recurring themes within complaints and patient feedback.

Workforce Fragility

- CNS capacity remains below levels seen in comparable organisations and continues to impact patient support and pathway management.

Theatre Capacity

- The absence of the additional two theatre days per week identified within the Annual Plan remains the single greatest constraint to recovery.
- This now represents a Quality, Safety and Experience risk rather than simply an operational capacity issue.

System Dependencies

- Positron Emission Tomography (PET)-CT access through tertiary providers.
- Wider diagnostic and infrastructure constraints.
- Recurrent funding required to close workforce and capacity gaps.



Assurance Statement

The Committee can be assured that the Urology Service has delivered actions within its direct control since November 2025 and that governance, diagnostics, workforce resilience and pathway coordination have improved.

However, the service remains operationally fragile, and quality risks persist due to insufficient theatre, workforce and diagnostic capacity. Sustainable recovery of cancer performance, referral to treatment (RTT) waits and patient experience is unlikely to be achieved without organisational support to address these remaining system constraints.



Assurance Summary

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Domain	Position	Improvements Since October 2025	Residual Risk
Safety	Improving	MRI outsourcing, LATP expansion, faster pathology reporting, improved governance oversight	Treatment delays remain a patient safety risk due to theatre capacity
Timely	Significant Challenge	USC backlog reduced, diagnostics improved, strong front-end RTT position	Poor USC performance; routine RTT breaches remain
Effective	Improving	Prostate Decision Clinic, Pathway Coordinator, pathway improvements	Diagnostic gains not yet fully translating to treatment performance
Efficient	Good Progress	Lowest Did not attent (DNA) rates, follow-up validation, Galeas pathway trial benefits	Further gains constrained by capacity limits
Equitable	Risk Remains	Improved diagnostic access and pathway coordination	Variation in waits due to workforce and theatre constraints
Person-Centred	Improving	Prostate Decision Clinic, Pathway Coordinator, CNS recruit[illegible]s	Delays and uncertainty remain common complaint themes



Supporting Evidence

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Safety

- USC pathway
- Incidents and complaints
- Stones pathway

Timeliness

- RTT performance
- Cancer performance
- National comparisons

Effectiveness

- Annual Plan delivery
- Diagnostic improvements
- Workforce developments

Efficiency

- Outpatient productivity
- Follow-up management
- Innovation and pathway redesign

Equitable & Person-Centred

- Patient and carer experience
- Complaints themes
- CNS and pathway coordination

Recovery, Risks & Next Steps

- Remaining fragility
- Capacity constraints
- Improvement priorities

Patient and carer experience

Why this story matters

- The patient's journey highlights that whilst timely diagnosis and treatment are critical, the overall experience of care is equally shaped by communication, coordination, support and access to services. The story demonstrates the significant impact that delays, uncertainty and fragmented communication can have on both patients and carers throughout the cancer pathway.

What We Heard	Impact on Patient/Carer	Service Response
Poor communication at critical moments, including delivery of diagnosis and results	Distress, uncertainty and loss of confidence	**Prostate Decision Clinic** established to provide rapid consultant-led discussions of diagnosis and treatment options; CNS expansion planned to improve communication and patient support.
No single point of contact and fragmented care coordination	Patients and carers felt responsible for navigating the system themselves	**Prostate Pathway Co-ordinator** introduced and additional CNS capacity prioritised to improve pathway oversight, patient tracking and support.
Long periods of uncertainty whilst awaiting tests and results	Increased anxiety and psychological burden	MRI outsourcing, additional biopsy capacity and improved pathology turnaround times introduced to reduce diagnostic delays.
Difficulty accessing advice and support	Repeated chasing by patients and carers	**Development of CNS workforce** and improved pathway coordination to provide more accessible support throughout the patient journey.
Holistic support services highly valued but not consistently signposted	Missed opportunities for emotional and practical support	Expansion of CNS support and strengthened cancer pathway coordination aimed at improving access to support services earlier in the pathway.
Delays in treatment pathways created ongoing worry and stress	Reduced patient confidence and poorer experience	**Focus on USC recovery, increased LATP capacity, MRI outsourcing and ongoing request for additional theatre capacity to reduce pathway delays.**







Annual Plan Delivery

The actions proposed to address USC performance, diagnostic capacity and treatment backlogs were included within the Urology Annual Plan submitted to the Health Board in November 2025.

Implemented / In Progress

- MRI outsourcing continued to support diagnostic demand and reduce bottlenecks.
- Flexi-cystoscopy capacity improved through implementation of the Galeas urine biomarker pathway, releasing approximately three clinical sessions per week.
- Medical staffing costs will reduce following the retirement of a consultant not contributing to the on-call rota, and replacement starting with on-call duties in October generating a recurrent additional hours spend saving.



Outstanding / Partially Funded Priorities

- Additional theatre capacity (2 weekly sessions or equivalent weekend WLI capacity) remains required to address the USC backlog and reduce delays for cancer and benign patients.
- Additional Clinical Nurse Specialist capacity (2 x Band 7 CNS posts) remains required to support the 28-day diagnostic pathway, patient tracking and improved patient experience.
- Additional weekend LATP capacity remains required to mitigate variation in demand and improve treatment resilience.
- Sustainable workforce investment remains required to support prospective consultant and middle-grade rota arrangements (Registrar and Clinical Fellow).

What We Have Achieved Since October

- **Increased MRI Capacity**

Introduced outsourced MRI capacity in response to diagnostic delays and a backlog exceeding four weeks within Hywel Dda. Reduced pressure on the diagnostic pathway and supported earlier cancer diagnosis.

- **Strengthened Clinical Nurse Specialist Support**

Recruitment to a dedicated Prostate Clinical Nurse Specialist post is underway, with interviews taking place on 16 July 2026 and Introduced a Prostate Pathway Co-ordinator from June.

- **Introduced Prostate Decision Clinic**

Implemented a dedicated Prostate Decision Clinic for high-risk (CPG 3+) patients, led by Mr Ng, Mr Moosa and Mr Aniah. Patients are now able to receive and discuss their diagnosis within one week of reporting, significantly reducing waiting times and uncertainty.

- **Expanded LATP Capacity**

Introduced an additional LATP list at Prince Philip Hospital, ring-fenced for patients requiring biopsy following MRI. Helps to address key pathway bottlenecks and improve timely access to diagnostics. Weekly starting from 23rd July.

- **Improved Pathology Turnaround Times**

Worked collaboratively with Pathology colleagues to prioritise reporting of outstanding results. Reduced turnaround times from over two weeks to approximately one week, supporting faster clinical decision-making and improved patient experience.



Defining a Good Service for the Health Board

- Consistent achievement of the 28-day Faster Diagnosis Standard and 62-day USC target, reducing clinical risk and delays to treatment.
- Sustainable 24/7 emergency rota with full prospective cover and reduced reliance on temporary staffing arrangements.
- Reduced dependence on outsourcing and waiting list initiatives through improved in-house capacity.
- Continued improvement in patient experience, communication and complaint reduction.
- Equitable Clinical Nurse Specialist (CNS) provision aligned to comparable Health Boards.
- Adequate diagnostic, treatment and theatre capacity to meet demand and prevent backlog growth.

Earlier diagnosis, improved outcomes, reduced risk, better patient experience, stronger workforce resilience and improved system efficiency.



RTT Performance

RTT Position and Capacity Challenge

Since the Urology Fragility Deep Dive in November 2025, the service has continued to prioritise Urgent Suspected Cancer (USC) diagnostics and treatment in response to increasing demand and national performance requirements.

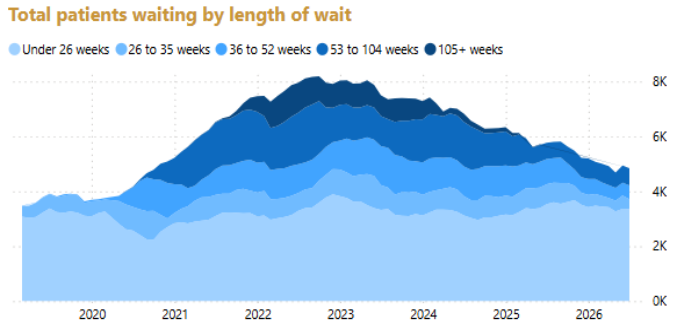
This has enabled improvements within the cancer pathway but has required significant theatre and diagnostic capacity to be redirected away from routine activity.

Current capacity is insufficient to meet both USC demand and routine RTT demand. As a result, **approximately 200 routine patients are expected to remain in breach**, with available theatre capacity being utilised to support cancer diagnostics and treatment.

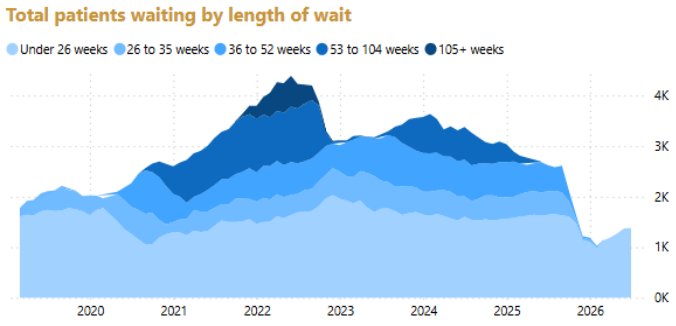
The position reinforces the key message set out within the Urology Annual Plan: **an additional two theatre days per week are required to provide sufficient capacity for both cancer and routine pathways.**

Without this investment, the service will continue to face difficult choices between maintaining cancer performance and reducing routine waiting times, with limited ability to sustainably recover the RTT backlog.

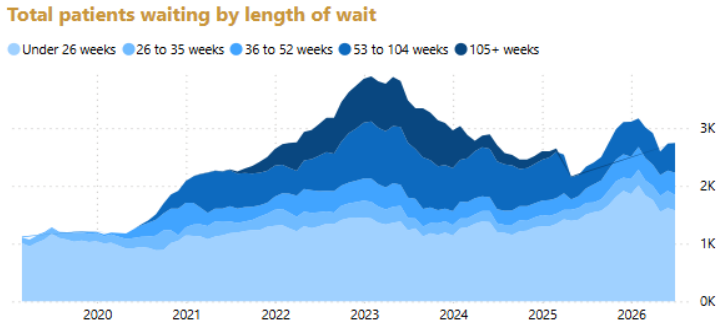
Key Message: The fundamental constraint remains unchanged. Current theatre capacity is inadequate for demand, and delivery of the Annual Plan requirement for **two additional theatre days per week** is essential to stabilise the service and support recovery across both cancer and routine pathways.



Total Waiting List



Stage 1 Waiting List



Stage 4 Waiting List



Source: Corporate Performance Dashboard.

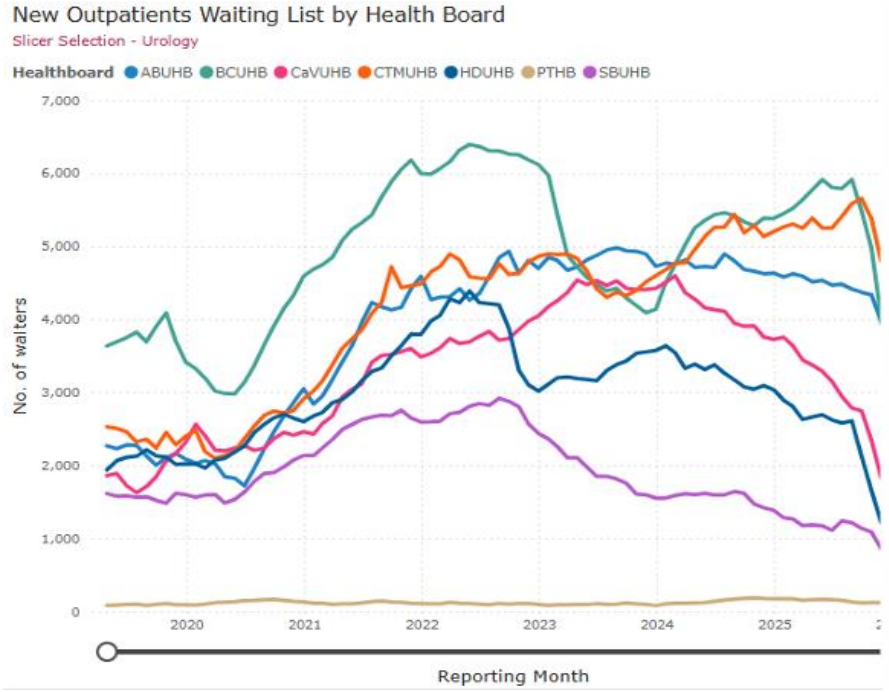
RTT Performance. National Comparison

Hywel Dda remains one of only two Health Boards in Wales with no patients waiting over 52 weeks for a first outpatient appointment and has maintained a sub-26-week wait, reflecting strong performance at the front end of the RTT pathway.

As more patients progress to diagnostic and treatment stages, the principal constraint is now theatre capacity. Delivery of the two additional theatre days per week identified in the Annual Plan is essential to support both USC demand and routine RTT recovery.



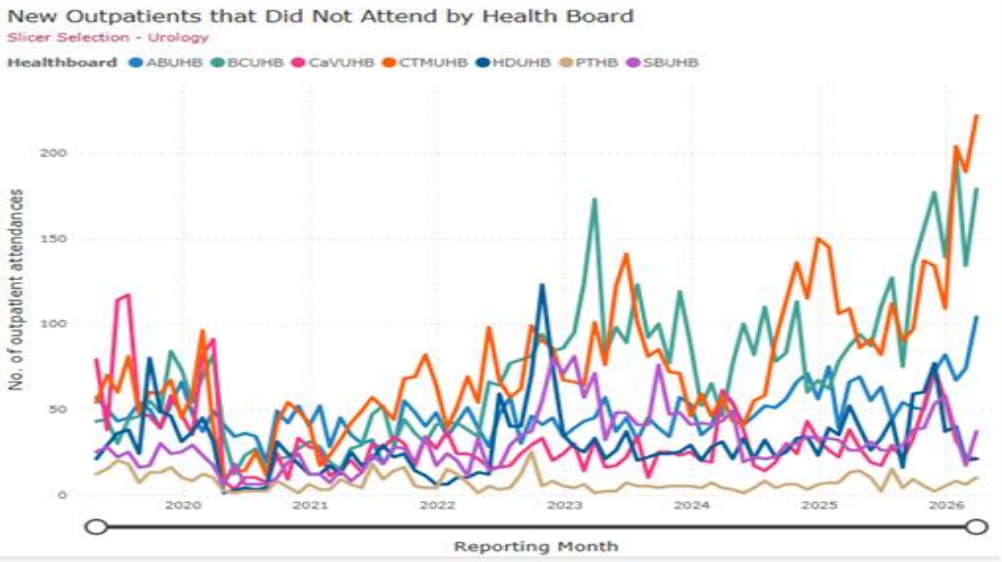
Source: Urology CIN Data set October 25



Source: Urology CIN Data set May 26

RTT Performance. Efficiency

- The focus on outpatient efficiency is demonstrated in the low 'Did not Attend' rates for all Outpatient Appointments compared with the national picture
- Hywel Dda continues to have the lowest Urology DNA rates in Wales, with non-attendance rates of 3.9% for new outpatient appointments and 2.3% for follow-up appointments, outperforming the national average.
- Performance has been supported through continuous waiting list validation and the introduction of direct telephone booking for patients approaching a breach position, maximising appointment utilisation and supporting timely access to care.



Mar-26	
Follow-Ups	
Health Board	DNA Rate
ABUHB	2.30%
BCUHB	3.60%
C&VUHB	3.40%
CTMUHB	4.10%
HDUHB	2.30%
PTHB	1.30%
SBUHB	3.40%

Mar-26	
New Outpatients	
Health Board	DNA Rate
ABUHB	5.90%
BCUHB	7.70%
C&VUHB	5.30%
CTMUHB	7.20%
HDUHB	3.90%
PTHB	3.10%
SBUHB	4.30%



Source: Urology CIN Data set May 26

Theatre Capacity/Stones Pathway

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Progress Achieved against Stones Patient Pathway and Ureteroscopy Delays (Risk Register 1308)

- A new fortnightly Stones list has been established at Glangwili Hospital, utilising Day Surgery Unit (DSU) and Derwen Ward treatment room capacity to treat patients with ureteric stents.
- This has delivered an immediate reduction in waiting times and provided a solution to a long-standing pathway constraint that has persisted for over four years.



Critical Capacity Gap

- Despite this improvement, the single greatest constraint facing the Urology service remains insufficient theatre capacity.
- The service continues to require two additional Urology theatre days per week, as identified in the Annual Plan, to meet current demand for both cancer and routine patients.
- Current capacity is being prioritised towards USC diagnostics and treatment, resulting in approximately 200 routine patients remaining in breach and limiting recovery of the wider RTT backlog.

The additional theatre capacity would:

- Increase capacity for USC diagnostics and treatment.
- Reduce delays for both cancer and routine patients.
- Support RTT recovery and reduce long-wait breaches.
- Improve utilisation of existing outpatient and diagnostic improvements.
- Provide a sustainable solution to the service's most significant operational risk.

Cancer Performance

The USC plan (Risk Register 2117) "*Urology diagnostic backlog and trajectory to 28-day diagnosis compliance*"

A number of improvements have been implemented since October, including MRI outsourcing, increased LATP biopsy capacity, reduced pathology turnaround times and the introduction of a dedicated **Prostate Pathway Co-ordinator** in June 2026. Early evidence suggests improved pathway oversight and stabilisation of the number of USC patients waiting over 62 days.

Further improvement is anticipated following recruitment to the **Prostate CNS post**, with interviews scheduled for 16 July 2026.

Whilst these interventions have strengthened the diagnostic pathway, progress remains constrained by a combination of treatment, diagnostic and reporting capacity limitations.

Although **MRI outsourcing** and additional biopsy capacity have improved access to diagnostics, patients continue to experience delays associated with **pathology reporting capacity** and access to specialist imaging **PET-CT scans**, which are provided through tertiary centres, can experience waiting times of up to eight weeks, delaying completion of staging investigations and subsequent treatment decisions.

These delays sit outside direct Urology control but have a significant impact on achievement of the 28-day diagnosis standard and the 62-day USC pathway.

Planned theatre expansion has not materialised and weekend support removed following the cessation of Prices at Par Rates (PAAR)-funded theatre staffing arrangements.

Diagnostic performance is improving, but sustainable recovery of the USC pathway is dependent on the additional theatre capacity identified within the Annual Plan.

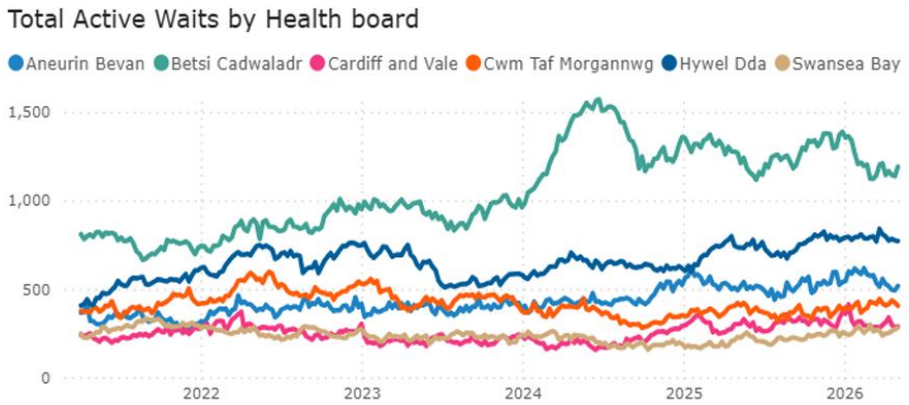


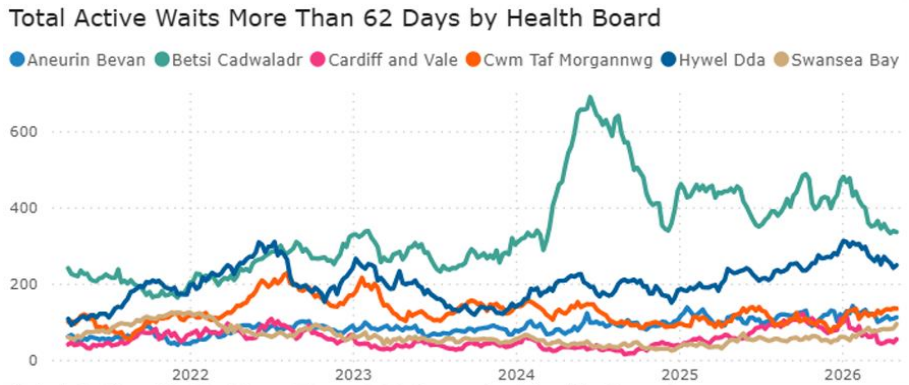
Cancer Performance. USC National data

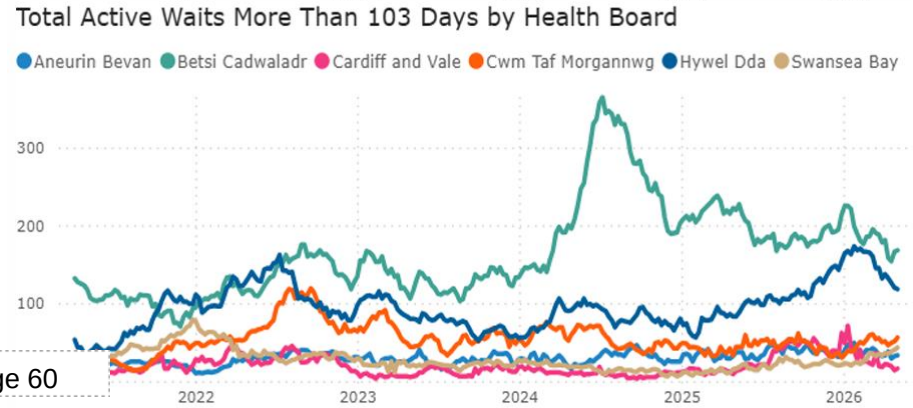
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

National Data Comparison

- Whilst Urology continues to have the second longest overall cancer pathway waits in Wales, there has been sustained improvement throughout 2026, with both active waits over 62 days and over 103 days reducing consistently as a result of targeted pathway interventions and increased focus on cancer performance.
- These gains remain fragile and are increasingly dependent on diverting limited capacity towards USC activity. As outlined throughout this paper, insufficient theatre capacity, workforce constraints and funding gaps continue to place recovery at risk, reinforcing the requirement for the additional two theatre days per week identified within the Annual Plan.







Amserol
Timely

Effeithiol
Effective

Source: Urology CIN Data set May 26

Cancer Performance. Pathway Plan

Urology USC Improvement plan presented to the Integrated Quality Finance Performance Delivery Group (IQFPD) on 8 October 2025

The improvement trajectory presented in October anticipated a short-term decline in performance followed by sustained recovery from November 2025 onwards, driven by:

- MRI outsourcing reducing diagnostic delays.
- Increased LATP capacity and pathway redesign.
- Additional weekend recovery activity.
- Improved coordination across the prostate cancer pathway.

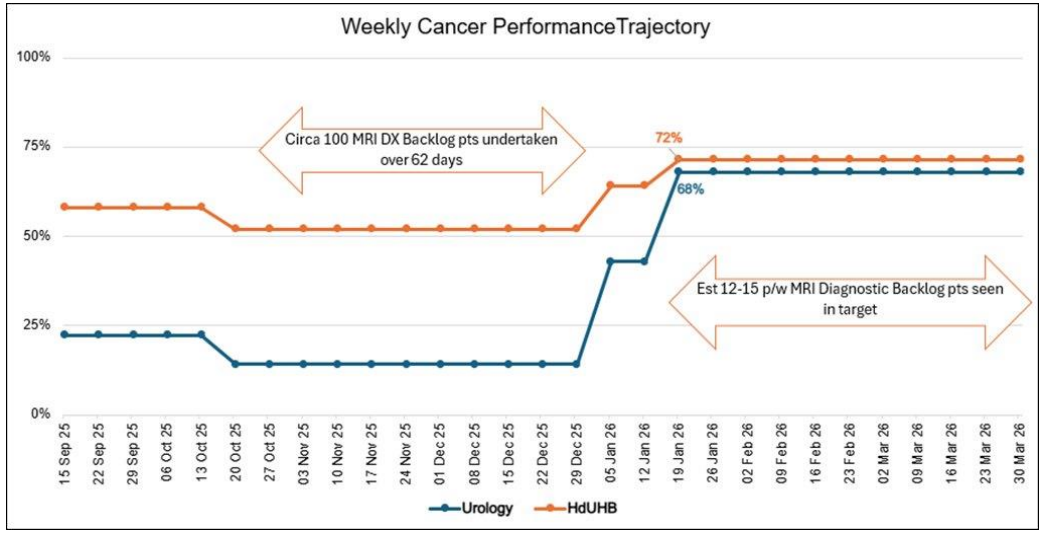
The planned decline in performance was greater and longer than anticipated because several key assumptions underpinning the recovery plan were not realised:

- The additional theatre capacity required within the Annual Plan was not secured.
- Weekend theatre recovery activity could not be sustained following the cessation of PAAR-funded staffing arrangements.
- Planned weekend LATP recovery sessions were not maintained.
- Growing USC demand continued to outpace available diagnostic and treatment capacity.
- Ongoing delays in pathology reporting and tertiary PET-CT capacity limited the ability to consistently achieve diagnostic and treatment milestones within the USC pathway.

Key Message

Recovery actions delivered measurable reductions in backlog volumes and strengthened pathway performance. However, the absence of sustainable theatre capacity prevented improvements in diagnostics from being translated into the planned improvements in cancer performance.





Cancer Performance Prostate Pathway

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Key Headlines

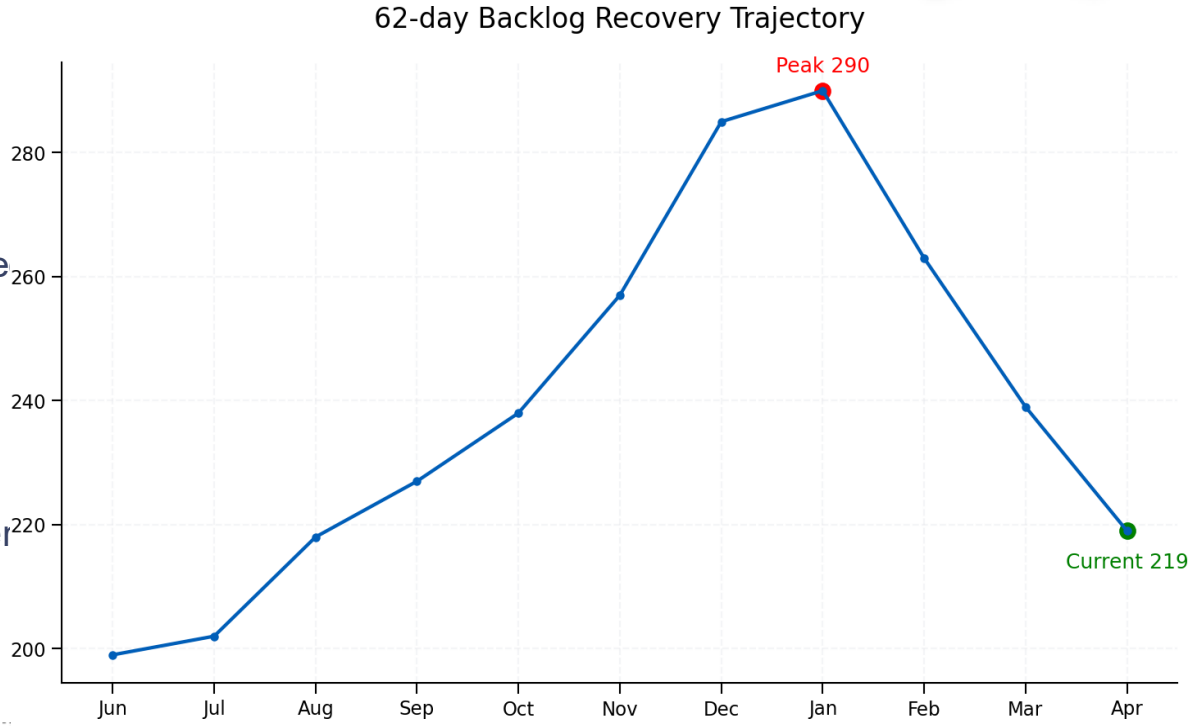
- Urology USC backlog reduced from 290 patients in January to 219 in April 2026, demonstrating that pathway interventions were having the intended impact.
- MRI outsourcing, improved pathology turnaround times, increased LATP capacity and enhanced pathway coordination contributed to a sustained reduction in backlog volumes during early 2026.
- The expected improvement in performance did not fully materialise as planned capacity assumptions were not maintained.

Why the Trajectory Changed

- Additional theatre capacity identified within the Annual Plan was not secure
- Weekend theatre recovery activity ceased following the removal of PAAR-funded staffing arrangements.
- Planned weekend LATP recovery sessions could not be sustained.
- Increasing USC demand continued to place pressure on limited treatment capacity.
- Diagnostic improvements increased throughput into treatment stages faster than theatre capacity was able to accommodate.

Amserol
Timely

Effeithiol
Effective

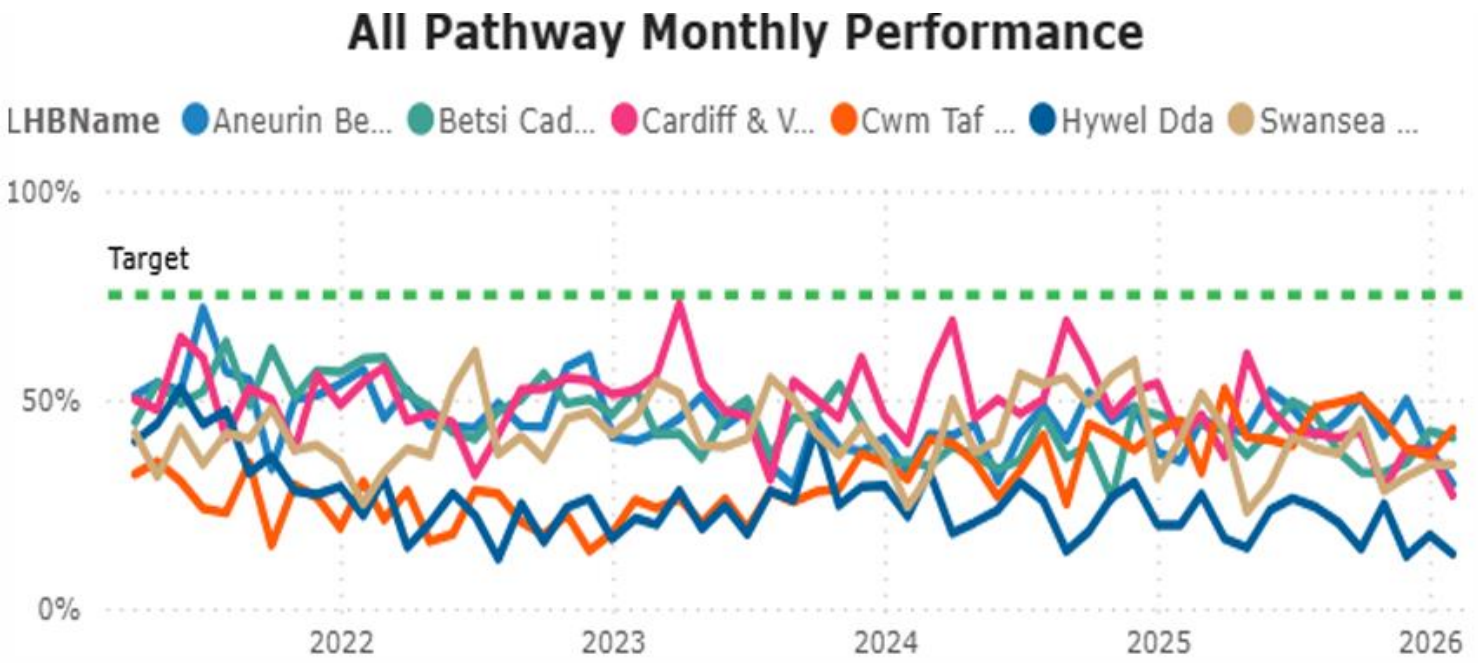


Cancer Performance. National Comparison

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

National Monthly Performance Data

- Backlog volumes have reduced and pathway controls have improved, demonstrating that recovery actions are effective. However, diagnostic improvements have increased throughput into treatment stages faster than treatment capacity has grown. As a result, performance remains amongst the poorest in Wales despite genuine underlying improvement.



HB	Performance
AB UHB	46.4%
BC UHB	42.4%
CTM UHB	37.8%
CV UHB	43.2%
HD UHB	25.0%
SB UHB	41.5%
All-Wales	**38.9%**

Oct 25

HB	Performance
AB UHB	29.7%
BC UHB	40.8%
CTM UHB	42.9%
CV UHB	27.1%
HD UHB	13.0%
SB UHB	34.4%
All-Wales	**30.5%**

May 26

Amserol Timely

Effeithiol Effective

Source: Urology CIN Data set October 25/May 26

Incident and Complaint Themes

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Primary themes

Complaint themes closely mirror findings from the patient/carer story, with delays, communication difficulties and lack of a consistent point of contact representing recurring themes. Whilst complaints have reduced following implementation of the Pathway Coordinator role and diagnostic improvements, residual concerns remain linked to CNS capacity and treatment delays caused by theatre constraints.

- **Delays in diagnosis and treatment** remain the most common source of patient concern, particularly where patients progress through diagnostics but subsequently experience waits for treatment.
- **Communication at key stages of cancer pathways** continues to feature within patient feedback, with patients and carers reporting uncertainty whilst awaiting results, treatment decisions and pathway updates.
- **Cancelled or delayed virtual follow-up appointments** have also generated complaints, leading to concerns regarding continuity of care and access to timely information.
- **Capacity-related delays within complex diagnostic pathways**, including imaging, pathology and treatment services, continue to impact patient experience and pathway performance.

Actions implemented

- Established a **Prostate Decision Clinic** to provide earlier consultant-led discussions following diagnosis.
- Introduced a dedicated **Prostate Pathway Co-ordinator** to improve pathway oversight, communication and patient tracking.
- Implemented a **weekly follow-up validation process** to improve management of outpatient and virtual follow-up pathways.
- Developed a proposal for additional Clinical Nurse Specialist (CNS) capacity to strengthen patient support, communication and care coordination.



Residual risk

- These actions have delivered measurable improvements; however, the underlying themes have not been fully eliminated. The remaining risks are increasingly linked to workforce and capacity constraints rather than pathway design or governance processes.

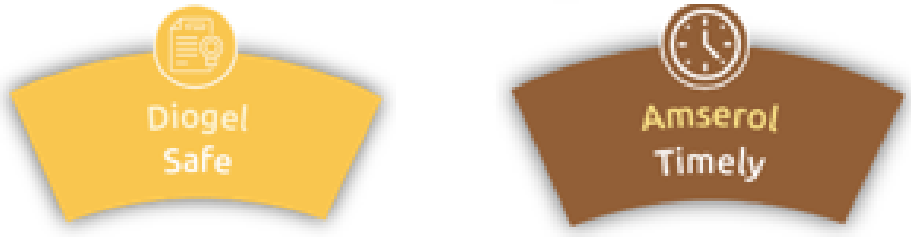
Until additional CNS and theatre capacity are secured, there remains a risk that communication challenges, pathway coordination issues and treatment delays will continue to impact patient experie rate complaint.

Workforce Developments

Emergency Rota Sustainability

- Recruitment is complete for a new Consultant Urologist who will commence in **October 2026**, following staff retirement and re-establishing a sustainable **1:7 Consultant on-call rota**. This is expected to significantly reduce rota fragility and reliance on Additional Duty Hours (ADH).
- A full **SBAR/Business Case** has been submitted to the Clinical Care Group seeking approval for a **Registrar Development Fellow and Clinical Fellow model** to modernise the middle-grade and cross-cover rotas. The proposal converts recurrent ADH expenditure into substantive workforce capacity, improving resilience, recruitment and retention whilst delivering recurrent savings.
- Subject to approval, the proposals are expected to reduce annual ADH expenditure, strengthen workforce sustainability and provide a longer-term solution to medical rota stability across the service.

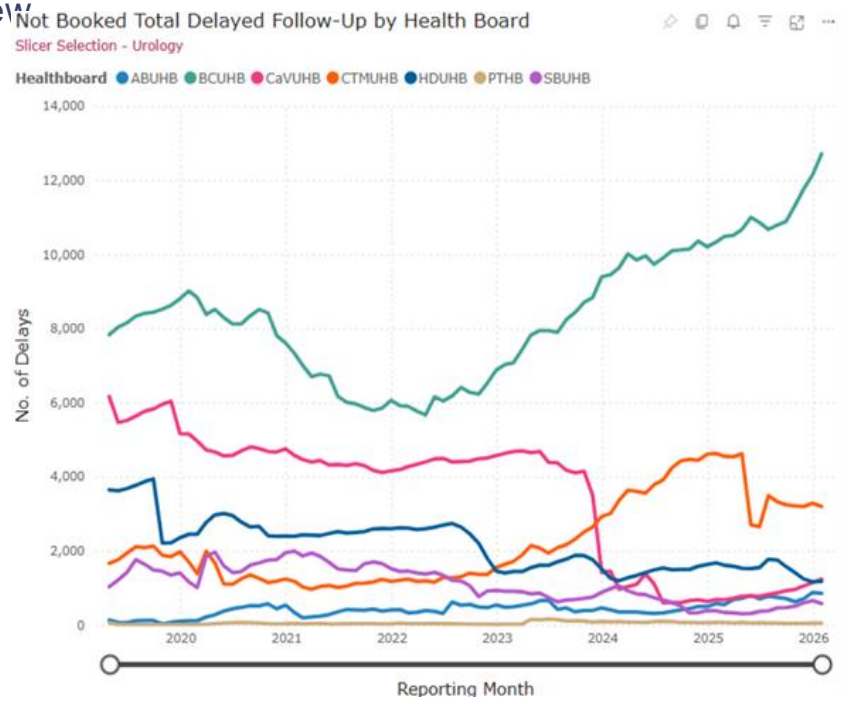
Significant progress has been made towards stabilising the emergency rota. Consultant recruitment addresses the on-call consultant gap, while approval of the workforce modernisation business case is now the critical next step in delivering a sustainable medical staffing model.

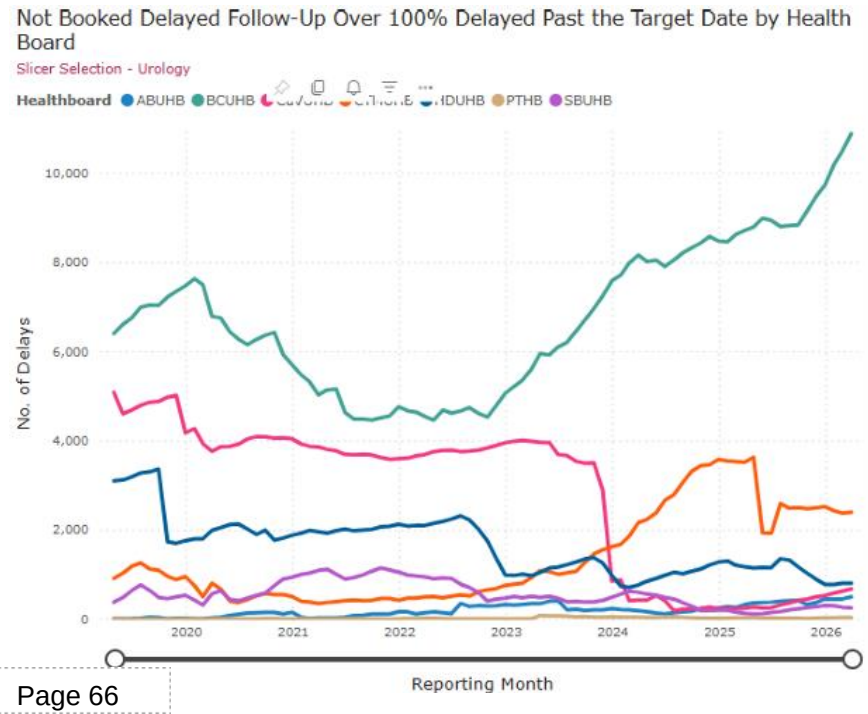


Follow up management

Improving Follow-Up Position

- Urology continues to demonstrate improvement in the management of delayed follow-up patients, with national data showing a sustained reduction in both overall delayed follow-ups and those delayed by more than 100%
- Improvements have been driven through a structured programme of weekly validation, list cleansing, increased use patient initiated Follow up (PIFU)/ Seen on Symptom (SOS) pathways and targeted CNS-led review of follow-up waiting lists.
- Further opportunities remain through remote PSA monitoring, pathway redesign and expansion of CNS capacity, reducing the need for traditional outpatient follow-up appointments and improving access for patients requiring urgent review.





Capacity Constraints

- Insufficient theatre capacity now represents a quality, safety and experience risk rather than solely an operational challenge. Capacity constraints require prioritisation of cancer and urgent patients, resulting in prolonged waits for routine patients and limiting the Health Board's ability to deliver timely treatment across all patient groups.
- Diagnostic improvements including MRI outsourcing, increased LATP capacity, improved pathology turnaround times and pathway coordination have strengthened performance but cannot fully translate into improved cancer outcomes without additional Main Theatre Diagnostic and treatment capacity.
- Diagnostic pathway performance remains vulnerable to external dependencies, including pathology turnaround times and access to tertiary PET-CT imaging, with some patients experiencing waits of up to eight weeks for staging investigations prior to treatment planning.
- USC demand continues to grow, requiring prioritisation of cancer activity and limiting the service's ability to recover routine RTT waits. Approximately 200 routine patients are expected to remain in breach as a consequence.
- Financial pressures remain significant, with recurrent funding gaps across workforce, theatre and diagnostic capacity preventing implementation of the full Annual Plan.





The service has largely delivered the actions within its control. The principal barrier to recovery is now capacity rather than pathway design, with the requirement for two additional Urology theatre days per week remaining unresolved.

Actions Taken

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Since the Urology Fragility Deep Dive in November 2025, the service has delivered a significant programme of recovery and redesign despite ongoing capacity and funding constraints.



- Improved outpatient access, maintaining **no patients waiting over 26 weeks for a first outpatient appointment.**
- Achieved the **lowest Urology DNA rates in Wales** through continuous validation and direct booking processes.
- Introduced **MRI outsourcing** to address diagnostic delays and support the USC pathway.
- Increased **LATP biopsy capacity**, including a dedicated prostate biopsy pathway and additional capacity at Prince Philip Hospital.
- Established a **Prostate Decision Clinic**, enabling rapid consultant review and diagnosis discussions for high-risk patients.
- Introduced a dedicated **Prostate Pathway Co-ordinator**, improving pathway oversight and contributing to stabilisatior of USC waits.
- Reduced pathology reporting turnaround times through joint working with Pathology colleagues.
- Delivered a **new fortnightly Stones List**, providing the first sustainable improvement in ureteroscopy capacity for several years.
- Achieved sustained reductions in **USC patients waiting over 62 days and 103 days**, and reduced the overall prostate cancer backlog during early 2026.
- Improved management of follow-up pathways, reducing delayed follow-ups and patients delayed by more than 100% of their target review date.
- Stabilised governance processes with **no incidents remaining open beyond 60 days.**
- Recruited a replacement Consultant Urologist to commence in October 2026, restoring a sustainable **1:7 Consultant on-call rota** and reducing reliance on ADH expenditure.
- Submitted a workforce modernisation business case to stabilise the Registrar and Clinical Fellow rotas through substantive investment and reduced ADH dependence.





Improvement Priorities

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Immediate Priorities (2026/27)

- Secure the **two additional Urology theatre days per week** identified within the Annual Plan to support USC recovery, RTT improvement and backlog reduction.
- Complete recruitment to the **Prostate CNS post** and continue development of the CNS workforce to improve patient experience, pathway coordination and MDT effectiveness.
- Embed the benefits of MRI outsourcing, increased LATP capacity, the Prostate Decision Clinic and the Prostate Pathway Co-ordinator role to deliver further improvements in the cancer pathway.
- Develop a dedicated improvement programme for the Bladder Cancer Pathway, focusing on diagnostic cystoscopy capacity, reducing delays within the flexi-cystoscopy pathway and improving compliance with cancer performance standards
- Continue collaborative work with Pathology and Radiology improving compliance with the 28-day diagnosis standard and reducing delays within USC pathways.
- Implement the workforce modernisation proposals for the Registrar and Clinical Fellow rotas to reduce ADH reliance and improve service resilience.
- Support the incoming Consultant Urologist commencing in October 2026 to restore a sustainable 1:7 Consultant on-call rota.

The service has demonstrated that pathway redesign and targeted investment deliver improvement. The next stage of recovery now depends on addressing the remaining capacity gap. Without the additional theatre capacity identified in the Annual Plan, sustainable improvement in cancer performance, RTT waits and patient experience will remain challenging despite the progress already achieved.



Innovation

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Delivering Innovation Today

- Galeas Bladder Cancer Pathway
  - Early adoption of the Galeas urine biomarker pathway to support bladder cancer diagnostics.
  - Reducing reliance on invasive surveillance procedures and releasing valuable clinical capacity.

- Holmium Laser Enucleation of the Prostate (HoLEP) Service Development
  - Charitable funding bid submitted to establish a HoLEP service from September 2026.
  - Providing a modern treatment option for men with Benign prostatic hyperplasia (BPH) bladder outflow obstruction and reducing reliance on external providers.

- Expansion of Day Case Surgery
  - Planned relocation of Greenlight Laser activity to the Day Surgery Unit at Prince Philip Hospital.
  - Creating additional capacity for day-case bladder outlet obstruction (BOO) surgery and improving patient flow through the surgical pathway.

Future Ambitions

- High Intensity Focused Ultrasound (HIFU)
- Exploring opportunities to develop Wales' first HIFU service for the treatment of prostate cancer
- Potential collaboration with Moondance Cancer Initiative to support service development.
- Supporting access to innovative, minimally invasive treatment closer to home for patients across Wales.



Expected Outcomes and Ongoing Work

- Continued reduction in USC backlog volumes through strengthened prostate and bladder cancer pathways, improved diagnostics and enhanced pathway coordination.
- Improved resilience of the medical workforce through restoration of a sustainable 1:7 Consultant on-call rota and implementation of workforce modernisation proposals.
- Further improvements in patient experience through expansion of CNS support, improved communication and reduced pathway delays.
- Continued reduction in delayed follow-ups and optimisation of outpatient capacity through validation, PIFU and digital monitoring solutions.
- Development of a dedicated improvement programme for the bladder cancer pathway, reducing diagnostic delays and improving pathway performance.
- Strengthened governance oversight, maintaining low complaint and incident levels with no incidents open beyond 60 days.

Critical Dependency

- Sustainable recovery of cancer performance, RTT waits and patient outcomes remains dependent on addressing the fundamental capacity gap within the service, specifically the provision of the two additional Urology theatre days per week identified within the Annual Plan.

The service has delivered substantial improvement despite ongoing fragility. The majority of operational and pathway actions have been implemented; however, future progress is now primarily constrained by capacity and investment rather than service design. Securing the required theatre, workforce and diagnostic capacity will be critical to achieving sustainable recovery and delivering the standard of Urology service expected by the Health Board.





GIG CYMRU NHS WALES
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

The six domains of quality

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board



Our health care system is a high quality, highly reliable and safe system that avoids preventable harm, maximising the things that go right and learning from when things go wrong to prevent them occurring again. People's health, safety and welfare are actively promoted and protected; risks are identified and monitored, where possible, risks to safety are reduced or prevented and this is delivered by appropriate numbers of suitably skilled workforce



Our health care system ensures people have access to the high-quality advice, guidance and care they need quickly and easily, in the right place, first time. We care for those with the greatest health need first, and where treatment is identified as necessary, we treat people based on their identified and agreed clinical priority



Our health care system ensures decision-making, care and treatment reflects evidence-based best practice, to ensure that people receive the right care to achieve the optimal outcomes possible for them and that matter to them. We design transformative, evidenced-based, whole-of-life pathways that cover prevention, care and treatment, rehabilitation and embed these into local service delivery.



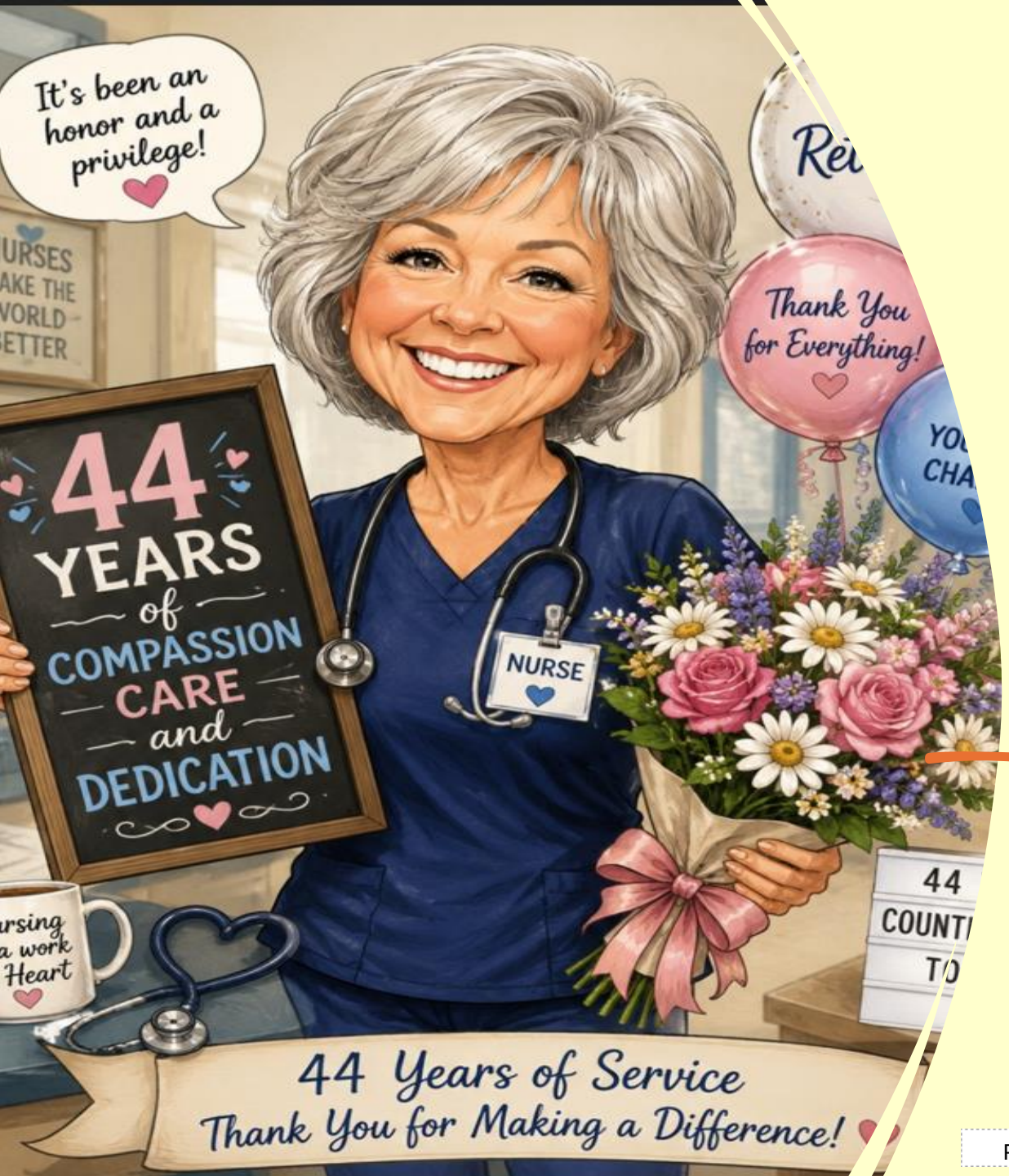
Our health care system takes a value-based approach to improve outcomes that matter most to people in a way that is as sustainable as possible and avoids waste. We make the most effective use of resources to achieve best value in an efficient way. We only do what is needed and undertake treatments targeted at those likely to gain the most benefit, ensuring any interventions represent the best value that will improve outcomes for people.



Our health care system provides everyone with an equal opportunity to attain their full potential for a healthy life which does not vary in quality because of personal characteristics such as age, gender, sexual orientation, race, language preference, disability, religion or beliefs, socio-economic status or political affiliation; the organisation that provides care; or location where care is delivered. We embed equality and human rights in our health care system and promote and protect the welfare and safety of children and adults who become vulnerable or at risk at any time.



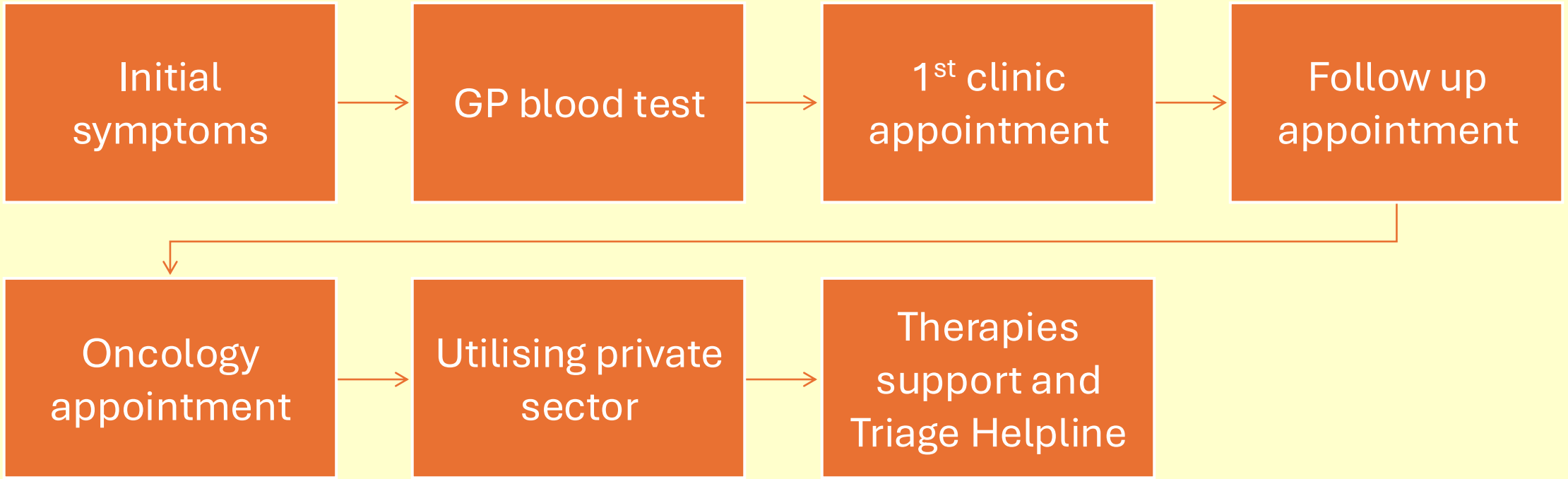
Our health care system meets people's needs and ensures that their preferences, needs and values guide decision-making that is made in partnership between individuals and the workforce. We care about the well-being of individuals, their families, carers and our staff. We ensure that everyone is always treated with kindness, empathy and compassion and we respect their privacy, dignity and human rights. We are committed to working better together to put people and their families at the centre of decisions, seeing them as experts working alongside professionals to get the best outcome and experience.



A Carer's Story

Undertaken June 2026

Summary of pathway



Communication & Compassion at Critical Moments

Areas for improvement

- Poor delivery of serious news (blood test results and metastatic diagnosis) caused lasting emotional harm.
- Lack of empathy, sensitivity, privacy and opportunity for questions in some consultations.

What worked well

- Conversely, compassionate, patient-centred communication (eg therapies, second opinion/private sector) had a powerful positive impact and improving understanding and confidence.

“its probably cancer”…she didn’t know he wasn’t by himself.

As a nurse we are always taught to make sure you have someone with you

Fragmented Care, Poor Coordination & Access Barriers

- Absence of a named key worker led to repeated chasing and system navigation by patient/carer.
- Communication failures between teams, inconsistent messaging and information gaps.
- Difficulty contacting staff, reliance on answerphones and lack of proactive follow-up.



Emotional & Psychological Burden on Patient and Carer

- Persistent anxiety driven by uncertainty, waiting for scans/results and lack of clarity.
- Carer assumed significant coordination and advocacy role, with substantial emotional toll.
- Concern for patients without advocates.

The only thing I want is to make it so he didn't have the cancer but I can't change this so I will advocate and try and keep him as healthy as possible.

What happens to the people who haven't got someone to advocate, or ring around or try and improve their health

Value of Timely Care, Holistic Support & Environment

- Early pathway (rapid referral and same-day treatment) was reassuring.
- Holistic services (cancer therapy support team, triage line) were highly valued but not routinely signposted early.
- Care environment (privacy, dignity, comfort) significantly influenced experience and sense of respect.

“You remember the people who are kind to you and those who give you not the best experience”



Your life is not your own anymore and you carry that constant worry of bad news.

You feel how much more can we take and I wondered how do other people manage

2.2

2.2 - Epilepsy in Learning Disabilities Update

Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Olwen Morgan (Hywel Dda UHB - Assistant Director of Nursing), Dana Scott (Hywel Dda UHB - Director of Midwifery & Professional Governance for Women & Children)

For assurance

2.3

2.3 - Assurance and Risk Report- Executive Leads

Attachments

QSEC CRR WHC MD Report - August 2026 FINAL.pptx

Appendix 1 - QSEC Corporate Risk Register.pdf

Overdue Audit Inspection Recommendations aligned to QSEC.pdf



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

Assurance and Risk Report

Quality, Safety and Experience Committee – 11 August 2026

Situation

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

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

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

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

Risk Management - Overview

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

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

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

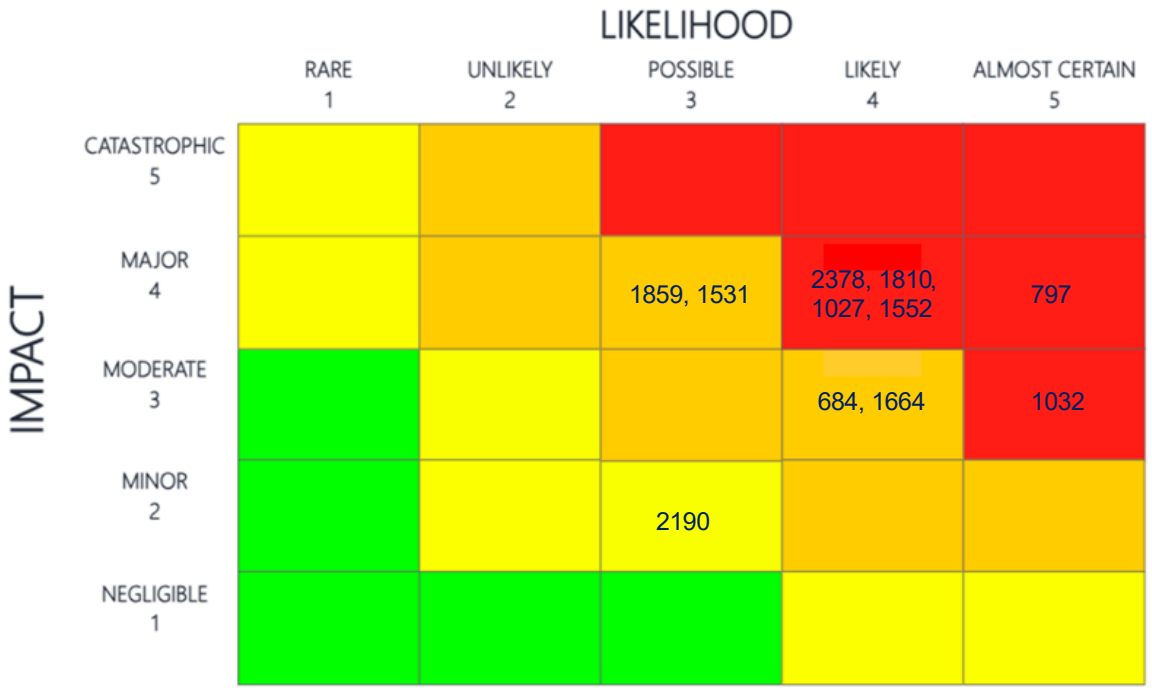
Risks are aligned to an appropriate Clinical Care Group or Executive Function (hereto referred to as "Functions"), and each has a designated risk lead responsible for reviewing in a timely and comprehensive manner.

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

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



Corporate Risks assigned to QSEC



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

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

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

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

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

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

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

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

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

The impact of reportable risks include:

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

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

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



Corporate Risks assigned to QSEC

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

Rationale for Current Risk Score (CRS)

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

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

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

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

Rationale for the Target Risk Score on next slide

Corporate Risks assigned to QSEC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

Rationale for Target Risk Score (TRS)

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

Corporate Risks assigned to QSEC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

Rationale for Current Risk Score (CRS)

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

Rationale for Target Risk Score (TRS)

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

Corporate Risks assigned to QSEC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

Rationale for Current Risk Score (CRS)

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

Rationale for Target Risk Score (TRS)

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

Corporate Risks assigned to QSEC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

Rationale for Current Risk Score (CRS)

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

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

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

Rationale for Target Risk Score (TRS)

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

Corporate Risks assigned to QSEC

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

Rationale for Current Risk Score (CRS)

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

Rationale for the Target Risk Score on next slide

Corporate Risks assigned to QSEC

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

Rationale for Target Risk Score (TRS)

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

Corporate Risks assigned to QSEC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

Rationale for Current Risk Score (CRS)

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

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

Rationale for the Target Risk Score on next slide

Corporate Risks assigned to QSEC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

Rationale for Target Risk Score (TRS)

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

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

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

Corporate Risks assigned to QSEC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

Rationale for Current Risk Score (CRS)

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

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

Rationale for the Target Risk Score on next slide

Corporate Risks assigned to QSEC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

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

Corporate Risks assigned to QSEC

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

Rationale for Current Risk Score (CRS)

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

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

Rationale for the Target Risk Score on next slide

Corporate Risks assigned to QSEC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

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

Corporate Risks assigned to QSEC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

Rationale for Current Risk Score (CRS)

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

Rationale for Target Risk Score (TRS)

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

Corporate Risks assigned to QSEC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

Rationale for Current Risk Score (CRS)

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

Rationale for Target Risk Score (TRS)

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

Corporate Risks assigned to QSEC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

Rationale for Current Risk Score (CRS)

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

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

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

Rationale for Target Risk Score (TRS)

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

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

Risk Themes

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

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

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

Risk Themes

Risk theme	Theme description	Sub-Committee/Group theme reported to	Number of risks
Fragile Services	A fragile service is one where there is a risk or the actual delivery of a diminished service or a service being unable to be delivered due to staffing / or other challenges	Fragile Services Oversight Group	**212**
Infection Control	A risk that may compromise the effectiveness of infection prevention and control measures, leading to staff and/ or patients being exposed to a confirmed or suspected pathogen increasing the likelihood of a transmission event and a healthcare acquired infection (HAI) or outbreak	Infection Prevention Strategic Steering Group	**32**
Medication	A risk that involves the prescribing, dispensing or supply, administration or monitoring of medicines.	Medicines Management Oversight Group	**25**
Medical Devices	A risk relating to a medical device, which is any instrument (other than a medicine) that is used to diagnose, monitor, treat or manage a medical condition. The definition covers a wide range of products including syringes, dressings, surgical tools, scanners, software, apparatus, machines and some medical apps.	Medical Devices Group	**37**
NICE/National Guidance	Risks related to the Health Board's ability to comply with evidence-based guidance for health and care.	Effective Clinical Practice	**119**
Safeguarding	Safeguarding in its wider context is everyone's responsibility and we have duty of care to support children and adults. It is expected that services and professionals "own" their concerns and take responsibility for the work that needs to be done to keep individuals safe. This includes taking action before, during and after a safeguarding referral has been made. Should risks arise whereby children and adults may be put at risk due to gaps in service provision, or training compliance for example, then a safeguarding theme may be assigned to the risk.	Strategic Safeguarding Group	**31**

Risk Themes

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk theme	Theme description	Sub-Committee/Group theme reported to	Number of risks
Consent and Mental Capacity	Risks relating to consent to examination or treatment e.g. missing, illegible, incorrect consent form; failure to obtain consent; mismatch between consent form and list etc. Risks relating to people who may lack mental capacity e.g. failure or concerns relating to: assessment of decision making capacity; acting in the person's best interests; consulting with those close to the person etc.	Mental Capacity Act and Consent Group	**0**
Deprivation Of Liberty Standards (DOLS)	Risks relating to: • a failure to submit DoLS referral when needed • a person being deprived of their liberty when they have capacity to consent to be in hospital • a lack of awareness of what actions can and cannot be taken when a DoLS authorisation is in place (e.g. you can stop someone from absconding • DoLS doesn't give authority for care and treatment decisions • patient with a DoLS authorisation can be discharged).	Mental Capacity Act and Consent Group	**1**

Audits and Inspections - Overview

The Health Board remains in Level 4 status with Welsh Government (WG) as a result of challenges relating to financial sustainability, strategy and planning, service delivery and organisational performance. Whilst the Health Board has been de-escalated for 'Leadership and Governance' from Level 3 to Level 1, the Health Board must meet the revised criteria:

- Evidence that all recommendations from the Royal Colleges / Health Inspectorate Wales (HIW) and other reviews specific to Hywel Dda UHB are discharged and either verified or delivered or scheduled for delivery within the Health Board's longer-term improvement plan;
- Support the implementation and realisation of GIRFT and the national programme reviews opportunities;
- Support the implementation and realisation of the three Ps policy, GIRFT, theatre optimisation, CIN optimisation programmes and related national improvement recommendations; and
- Develop a prompt response to any HIW unannounced inspections, Audit Wales and Royal College recommendation, developing and completing action plans that demonstrate sustainable evidence.

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

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

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

Audits and Inspections - Overview

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

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

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

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

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

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

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

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

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

There are currently 28 reports assigned to QSEC to enable them to undertake the following responsibility set out in their Terms of Reference:

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

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

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

Date of report	Report Issued By	Report Title	Clinical Care Group/ Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommend-ations in original report	Overdue	In progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Barriers to Completion
Oct-19	Delivery Unit	Review of Dermatology Services in Wales Hywel Dda University Health Board	Planned and Specialist Care	Chief Operating Officer	Sep-25	~~Sep-25~~ Apr-28	5	3	0	2	0	0	0	0	Recruitment challenges and lack of available suitable clinical space to provide service.
Feb-23	HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 November (Publication date 16 February 2023)	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	Sep-23	~~Sep-23~~ ~~Aug-25~~ Apr-27	19	1	0	18	0	0	0	0	Recurrent and non-recurrent finance required.
May-23	HIW	Mental Health Discharge Review	Mental Health and Learning Disabilities	Nursing, Quality and Patient Experience	Mar-24	~~Mar-26~~ Dec-26	40	1	0	36	0	3	0	0	No barriers noted.
Sep-23	NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	Planned and Specialist Care	Chief Operating Officer	Dec-24	~~Dec-24~~ ~~Aug-25~~ ~~Jun-26~~ Sep-26	9	2	0	7	0	0	0	0	Financial barriers to provide training and workforce challenges.
Jan-24	HIW IRMER	HIW IRMER Diagnostic Imaging x-ray department Withybush Hospital January 2024	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	Apr-26	~~Apr-26~~ Apr-27	9	1	0	7	0	0	0	1	No barriers noted.

Audits and Inspection reports assigned to QSEC
(Page 2 of 5)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

Audits and Inspection reports assigned to QSEC
(Page 3 of 5)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Date of report	Report Issued By	Report Title	Clinical Care Group/ Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommend-ations in original report	Overdue	In progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Barriers to Completion
May-25	HIW	HIW GGH Maternity Services	Planned and Specialist Care	Chief Operating Officer	Sep-26	Sep-26	13	0	1	12	0	0	0	0	No barriers noted - no overdue recommendations
Jun-25	HIW IRMER	Nuclear Medicine IRMER WGH	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	Apr-27	Apr-27	26	3	0	23	0	0	0	0	Fragility of management.
Jun-25	Internal Audit	Discharge Management (Follow Up) Final Internal Audit Report 2024/25	Community & Integrated Medicine	Chief Operating Officer	Mar-25	N/K	1	1	0	0	0	0	0	0	Included in scope of delayed discharge IA report planned to be reported to Oct26 ARAC
Aug-25	HIW	Mynydd Mawr Ward, Prince Philip Hospital	Community & Integrated Medicine	Chief Operating Officer	Jul-26	Jul-26	24	4	1	16	3	0	0	0	No barriers noted.
Aug-25	Audit Wales	Discharge Planning Progress Update – Hywel Dda University Health Board August 2025	Community & Integrated Medicine	Chief Operating Officer	Mar-26	~~Apr-26~~ Aug-26	1	1	0	0	0	0	0	0	No barriers noted.
Aug-25	Audit Wales	Urgent and Emergency Care: Flow out of Hospital – West Wales Region	Community & Integrated Medicine	Chief Operating Officer	Jun-26	N/K	13	9	0	1	2	1	0	0	No barriers noted
Aug-25	Peer Review	Getting it Right First Time (GIRFT) – Assurance Review of Ambulance Patient Handover Process	Community & Integrated Medicine	Chief Operating Officer	Jun-26	N/K	26	26	0	0	0	0	0	0	Awaiting management responses to be added by service to AMaT
Sep-25	HIW	Derwen Ward, Glangwili General Hospital	Community & Integrated Medicine	Chief Operating Officer	Nov-25	Oct-26	32	5	0	27	0	0	0	0	No barriers noted.

Audits and Inspection reports assigned to QSEC
(Page 4 of 5)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

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

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

Implementation of Welsh Health Circulars

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

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

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

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

WHCs - Overdue



Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

WHCs - Overdue



Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

WHCs - Overdue



Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

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

WHCs – Unable to Complete

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

WHCs – Unable to Complete

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

WHCs – Unable to Complete

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

WHCs - In Progress

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

WHCs - In Progress



Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

WHCs – Reliant on External Factors



Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

WHCs – Complete Pending Formal Approval For Closure

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

WHCs – Complete and Approved

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

Implementation of Ministerial Directions

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

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

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

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

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

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

Recommendations

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

Risk Management

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

Audits, Inspections and Regulatory Reports

- **RECEIVE ASSURANCE** from the lead Executive Director or Supporting Officer on the management of recommendations raised in audit, inspection and regulatory reports within their area of responsibility, particularly in respect of confirming the full implementation of recommendations, any barriers to delivery and subsequent impacts of non/late delivery, and assurance that the risks associated with these are being managed effectively.

Welsh Health Circulars

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

Ministerial Directions

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





DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG

SAFE | SUSTAINABLE | ACCESSIBLE | KIND

GIG CYMRU NHS WALES

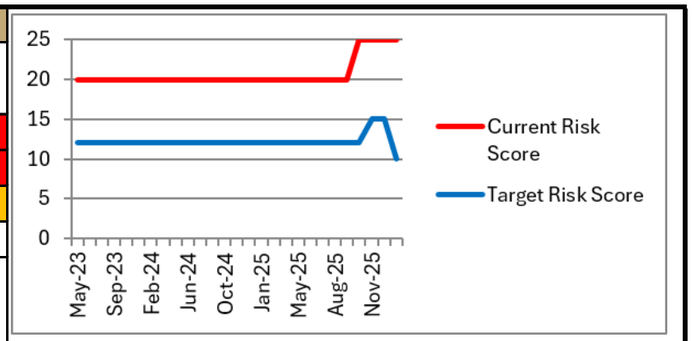
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

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

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

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

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



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

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

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

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

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

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

Report Issued By	Report Title	Recommendation Reference	Priority Level	Recommendation	Management Response	Recommendation Owner	Original Completion Date	Revised Completion Date	Status Category
Delivery Unit	Review of Dermatology Services in Wales Hywel Dda University Health Board	DU_RDS_HDUHB_1019_001	N/A	R1. Health board to invest and support in an additional consultant whole time equivalent, considering increasing the number by a minimum 1 WTE with opportunities of other medical specialities such as plastic surgery to support locally and other dermatology units to support remotely	Awaiting management response	Ceri Wisdom	Sep-25	~~Sep-25~~ ~~Jun-26~~ N/K	Overdue
Delivery Unit	Review of Dermatology Services in Wales Hywel Dda University Health Board	DU_RDS_HDUHB_1019_004	N/A	R4. Re- establish the organisations patch testing service	Awaiting management response	Ceri Wisdom	Sep-25	~~Sep-25~~ Apr-28	Overdue
Delivery Unit	Review of Dermatology Services in Wales Hywel Dda University Health Board	DU_RDS_HDUHB_1019_005	N/A	R5. Allow access to the identified clinic space in outpatients to expand.	Awaiting management response	Ceri Wisdom	Sep-25	~~Sep-25~~ Apr-28	Overdue
HIW IRMER	Diagnostic Imaging Department, Glangwili General Hospital 15/16 November (Publication date 16 February 2023)	HIW_160223_DIDGGH_017b	High	R17b. The employer is required to provide HIW with details of the action taken to improve the ratification process for locally produced documentation so that information does not conflict with the employer's written procedures.	To source a document control system.	Head of Radiology/Superintendent Radiographer	Sep-23	~~Sep-23~~ ~~Aug-25~~ Apr-27	Overdue
HIW	Mental Health Discharge Review	HIW_MHDR_05052023_032	N/A	R32. The health board must consider undertaking a training needs analysis for inpatient and community mental health staff, to identify any training gaps and help ensure all staff have the appropriate knowledge and skills to effectively undertake their role.	Further Action u)Development of a MH/LD essential training framework to reflect training needs across MH/LD services based on a systematic TNA that can be reviewed at regular intervals and monitored for compliance.	Assistant Director of Nursing MH/LD	Nov-23	~~Nov-23~~ ~~Sep-24~~ ~~Oct-25~~ ~~Mar-26~~ Sep-26	Overdue
NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	DU_RPPICYP_004b	N/A	R4. The HB should explore opportunities for improved psychological interventions and patient outcomes by sharing resources and professional expertise, to enhance joint clinical work between SCAMHS and Paediatric Psychology.	Identify and implement opportunities for improved psychological interventions & patient outcomes across Paediatrics and S-CAMHS	Nick Davies	Jul-24	~~Jul-24~~ ~~Mar-26~~ Sep-26	Overdue
NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	DU_RPPICYP_005b	N/A	R5. The HB should ensure equity of training availability and budgets, supervision, and professional leadership between directorates to ensure all staff have equal opportunities for development and support.	Internal review within paediatrics to identify appropriate development of psychological provision within paediatrics, leadership structures and pathways in line with governance arrangements of the wider health board	Nick Davies	Nov-24	~~Nov-24~~ ~~Jun-26~~ N/K	Overdue
NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	DU_RPPICYP_005d	N/A	R5. The HB should ensure equity of training availability and budgets, supervision, and professional leadership between directorates to ensure all staff have equal opportunities for development and support.	Paediatric Service to co-produce an annual training plan to include advice and direction from Professional lead and shared training opportunities with SCHAMS	Nick Davies	May-24	~~May-24~~ Sep-26	Overdue
NHS Wales Executive	Review of Psychology & Psychological Interventions for Children and Young People	DU_RPPICYP_005e	N/A	R5. The HB should ensure equity of training availability and budgets, supervision, and professional leadership between directorates to ensure all staff have equal opportunities for development and support.	Identifying gaps in funding and provision for development in paediatric psychology	Nick Davies	Jul-24	~~Jul-24~~ Sep-26	Overdue
HIW IRMER	HIW IRMER Diagnostic Imaging x-ray department Withybush Hospital January 2024	HIW_IRMER_DIWGH_0124_004a	N/A	R4. The Employer is required to provide HIW with details of action taken to ensure that all written documentation in place include the required level of detail as set out within the employer's procedure for Quality Assurance programme document control.	1. A document control system needs to be sourced	Faith Whitecross	Dec-24	~~Dec-24~~ ~~Aug-25~~ Apr-27	Overdue
Welsh Risk Pool	Welsh Risk Pool Concerns Assessment (December 2024)	WRP_CA_122024_006	N/A	R6. HDUHB to ensure all action plans and evidence of actions undertaken are uploaded to the Datix Cymru System.	Establish a process to ensure all actions associated with moderate or above concerns should be uploaded to the AMAT system and to ensure action plan is linked to the datix record.	Mrs Louise O'Connor	Mar-25	~~Mar-25~~ Mar-27	Overdue
HIW IRMER	IRMER Regulations	HIW_IRMER_1024_002		R2. Identify areas where more than one employer may be involved with an exposure and consider if the co-operation regulation needs actions. e.g. referrer (GP referrals), operator (third party imaging providers) or practitioner (out of hours practitioner service) has a different employer; to other duty holders	Co-operation between employers: consider where relevant	Fiona Osell	Jul-25	~~Jul-25~~ ~~Jan-26~~ ~~Apr-26~~ Sep-26	Overdue

Report Issued By	Report Title	Recommendation Reference	Priority Level	Recommendation	Management Response	Recommendation Owner	Original Completion Date	Revised Completion Date	Status Category
HIW IRMER	IRMER Regulations	HIW_IRMER_1024_009		R9. Schedule 3 is re-organised with changes to core and specific training. Training in the amendment changes is required plus discipline specific review with additions to the "all modalities" elements probably most significant. A plan to cover any additions will be required.	Review training needs of practitioners and operators	Fiona Osell	Jun-25	~~Jun-25~~ ~~Jan-26~~ ~~Apr-26~~ Sep-26	Overdue
Internal Audit	Falls Management Final Internal Audit Report October 2024	HDUHB-2425-10_002	Medium	R2. Previous internal audit recommendation reiterated: A delivery plan for the Falls Strategy should be completed identifying key milestones and timescales for completion. This should form the basis of progress monitoring to QSEC.	Chair of Inpatient Falls Group to clarify strategic direction and responsibility for development of a HDUHB Falls Strategy direction through submission of a SBAR to the executive team for guidance on the direction of a Falls Strategy and agreement on whether we are aiming for a preventative focus sitting with Public Health, or a management focus aligned to 6 Goals workstreams, deconditioning, frailty and dementia.	Executive Lead for Falls / Chair of Inpatient Falls Group	Mar-25	~~Mar-25~~ ~~Apr-25~~ ~~Dec-25~~ ~~May-26~~ Aug-26	Overdue
Internal Audit	Falls Management Final Internal Audit Report October 2024	HDUHB-2425-10_006	Medium	R6. More detailed and frequent (e.g. annual) falls reporting to QSEC, including MFRA compliance, a summary of falls incident themes and trends and action taken to prevent recurrence.	The Inpatient Falls Group will provide an annual report to QSEC (commencing May 2025) which will include oversight of falls improvement work including EQLIP programmes and QI initiatives; compliance with NAIF audits and actions plans, compliance with MFRA reporting, trends and themes of falls incidents including closure timeliness and learning from events / themes identified.	Chair of Inpatient Falls Group	May-25	~~May-25~~ ~~Dec-25~~ Aug-26	Overdue
HIW	Joint Inspection of Child Protection Arrangements (Pembrokeshire)	HIW_ JICPA_0325_003	N/A	R3. The quality of leadership varies significantly by service. In some areas, such as health visiting and school nursing, there is strong professional ownership and proactive approaches to safeguarding. However, the absence of supervision, professional challenge, and reflection is notable. Records frequently show repeated concerns without escalation, suggesting missed opportunities to lead safeguarding practice with vision and purpose.	Clinical Care Groups to identify resource to implement safeguarding specialist roles to support professional ownership and proactive approaches to safeguarding, e.g. Emergency Departments as priority area.	Cathie Steele	Dec-25	~~Dec-25~~ ~~Mar-26~~ Oct-26	Overdue
HIW	Joint Inspection of Child Protection Arrangements (Pembrokeshire)	HIW_ JICPA_0325_005b	N/A	R5. Training compliance is a concern, particularly for Level 3 safeguarding children training. Only 37% of medical and dental staff were compliant in December 2024. The provision of training is regularly available, but attendance levels are often low.	All services to put in place improvement plans to achieve 85% compliance across all professional groups with Level 3 training by 31st March 2026	Paula Goode	Mar-26	~~Mar-26~~ N/K	Overdue
HIW	Joint Inspection of Child Protection Arrangements (Pembrokeshire)	HIW_ JICPA_0325_005c	N/A	R5. Training compliance is a concern, particularly for Level 3 safeguarding children training. Only 37% of medical and dental staff were compliant in December 2024. The provision of training is regularly available, but attendance levels are often low.	All services to put in place improvement plans to achieve 85% compliance across all professional groups with Level 3 training by 31st March 2026	Peter Skitt	Sep-25	~~Sep-25~~ N/K	Overdue
HIW	Joint Inspection of Child Protection Arrangements (Pembrokeshire)	HIW_ JICPA_0325_005e	N/A	R5. Training compliance is a concern, particularly for Level 3 safeguarding children training. Only 37% of medical and dental staff were compliant in December 2024. The provision of training is regularly available, but attendance levels are often low.	All services to put in place improvement plans to achieve 85% compliance across all professional groups with Level 3 training by 31st March 2026- Above plans (JICPA / 09) to be reported to Strategic Safeguarding Steering Group	Peter Skitt	Nov-25	~~Nov-25~~ Oct-26	Overdue
HIW	Joint Inspection of Child Protection Arrangements (Pembrokeshire)	HIW_ JICPA_0325_005h	N/A	R5. Training compliance is a concern, particularly for Level 3 safeguarding children training. Only 37% of medical and dental staff were compliant in December 2024. The provision of training is regularly available, but attendance levels are often low.	All services to put in place improvement plans to achieve 85% compliance across all professional groups with Level 3 training by 31st March 2026- Above plans (JICPA / 09) to be reported to Strategic Safeguarding Steering Group	Paula Goode	Mar-26	~~Mar-26~~ N/K	Overdue
HIW	Joint Inspection of Child Protection Arrangements (Pembrokeshire)	HIW_ JICPA_0325_008	N/A	R8. The Health Board's numerous IT systems do not support the timely collation and sharing of information, when safeguarding concerns arise. Leaders should identify opportunities to strengthen information sharing arrangements.	The Health Board will support the development and implementation of the Safeguarding Linc system in development.	Anthony Tracey	Mar-26	~~Mar-26~~ N/K	Overdue
HIW	Joint Inspection of Child Protection Arrangements (Pembrokeshire)	HIW_ JICPA_0325_017	N/A	R17. The reliance on CP medicals being completed by acute paediatricians in an out-of-county hospital, due to the lack of a service in Pembrokeshire, presents a long-standing and unresolved challenge to all agencies involved. The Health Board should consider how best to resolve theses issues to ensure a more timely and seamless service, both for agencies and for the children and families involved.	CP Medical Pathway: Convene review planning group and scoping meeting. Map current job plans, rota commitments and workload (community vs acute). Draft Options Appraisal (e.g. community-led, acute-led, hybrid model). Final recommendations and implementation plan.	Tracy Owen	Dec-25	~~Dec-25~~ ~~Mar-26~~ N/K	Overdue

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

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

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

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

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

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

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

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

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

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

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

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

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

3

10 Mins

---

3 - Break

4

30 Mins

4 - Clinical Care Group Reports

4.1

4.1 - Allied Health Professions and Health Sciences

Sara Quarrie (Hywel Dda UHB - Service Director for Allied Health Professions and Health Sciences), Angela Bell (Hywel Dda UHB - Assistant Director Quality, Safety + Patient Experience for Allied Health + Health Sciences)

For assurance

Attachments

Clinical Care Group Update Report- Operational Allied health and Health Sci~.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ANSAWDD, DIOGELWCH A PHROFIAD
QUALITY, SAFETY AND EXPERIENCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	11 August 2026
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Clinical Care Group Update Report – Operational Allied Health and Health Science
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Andrew Carruthers, Chief Operating Officer
SWYDDOG ADRODD: **REPORTING OFFICER:**	Sara Quarrie, Service Group Director, Allied Health and Health Science Clinical Care Group Angela Bell, Assistant Director of Quality, Safety and Patient Experience, Allied Health and Health Sciences

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/ For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report provides the Quality, Safety and Experience Committee with assurance from the Allied Health and Health Sciences Clinical Care Group (CCG) Integrated Governance Quality and Safety (IG Q&S) meetings held between April and June 2026 (Quarter 1 (Q1). The CCG remains focused on improving performance within the Quality and Safety domain, with particular emphasis on current Level 2 performance. This report highlights key trends, identifies areas of improvement and summarises actions being taken to support further progress. It also confirms sustained achievement at Level 1 within the Governance domain, which has been maintained since September 2025.

Cefndir / Background

The CCG has maintained a structured monthly Quality and Safety governance cycle covering risk and assurance, regulatory reports, incidents and Duty of Candour, complaints and patient experience, redress and claims, clinical audit, National Institute for Health and Care Excellence (NICE) and national guidance, mortality reviews, population health, and health and safety. During the quarter, operational governance arrangements also transitioned following internal audit findings, including the standing down of the Integrated Quality, Finance and Performance Delivery Group (IQFPDG) and development of revised Chief Operating Officer (COO)-led delivery arrangements. These arrangements form part of a developing Quality Management System, linking quality planning, quality improvement and quality control through routine review and triangulation of risks, incidents, complaints, audit findings, patient experience and regulatory assurance.

The CCG's assurance position improved across several domains during the quarter.

Governance remained at escalation Level 1; risk review compliance remained above 90%; overdue risk actions reduced from 15% in March to 13% in May; risks past target risk score dates reduced from 28 in March to 7 by May; and business continuity plan compliance improved from 63% to 100% by the end of May 2026. However, several material risks remain, particularly within Radiology, Pathology, Physiotherapy, and Nutrition and Dietetics.

Significant challenges include sustained pressure within Radiology, particularly the non-obstetric ultrasound risk, immediate improvement requirements following the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) inspection at Bronglais Hospital (BGH), and senior leadership fragility.

Pathology risks include Laboratory Information Management System 2 (LIMS2) deployment delays, blood transfusion contingency arrangements, clinical haematology fragility, Withybush Hospital (WGH) microbiology estate pressures, mortuary capacity and Blood Sciences staffing gaps.

Physiotherapy reported escalating Clinical Musculoskeletal Assessment and Treatment Service (CMATS) and musculoskeletal (MSK) waits, acute capacity risks and reduced Carmarthenshire Stroke Early Supported Discharge (ESD) capacity. Nutrition and Dietetics reported ongoing adult weight management and paediatric selective eating fragility.

The Q1 review has been framed using Safe, Timely, Effective, Efficient, Equitable and Person-centred (STEEEP) principles to support the Committee's consideration of safety, timeliness, effectiveness, efficiency, equity, patient outcomes and experience. It concludes with an overview of progress since the previous CCG update in December 2025.

Asesiad / Assessment

The CCG has evidence of active governance, improved business continuity, established complaints management progress and strengthened risk oversight. However, several high-scoring risks remain live, incident investigation timeliness has deteriorated in some areas, and a small number of regulatory actions remain dependent on wider organisational decisions, workforce capacity or capital and estate solutions.

1.1.1. Safe Care

1.1.1.1. Incident Management

Monthly governance 1:1 meeting between Service Leads and a Quality and Patient Safety Business Partner commenced in May 2025 and remain a key mechanism for supporting effective incident management and governance oversight. These dedicated sessions provide protected time to review incident performance, address barriers to progressing investigations, resolve outstanding queries and ensure appropriate actions are implemented. This approach was established to improve the timeliness of incident investigation and closure, while strengthening leadership oversight and promoting a positive culture of incident reporting, learning and continuous improvement. Regular review of performance data enables targeted support to services and monitoring of progress against agreed improvement actions.

Monthly performance trends in incident management are illustrated in Figure 2.

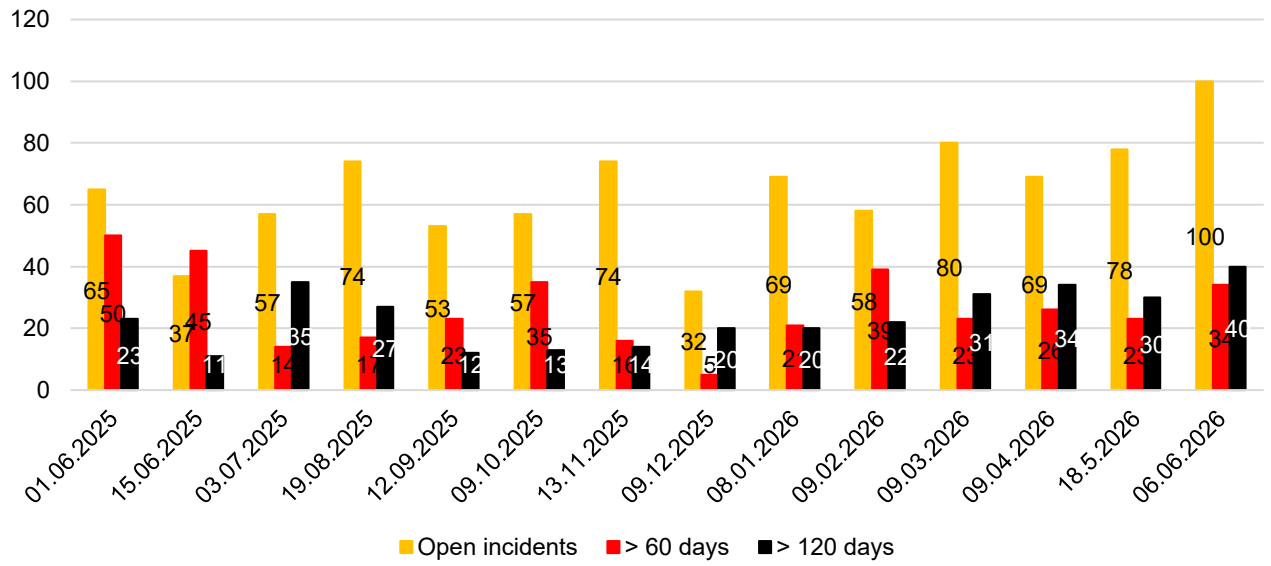


Figure 2 Number of open incidents reported by month- AH & HS CCG - [Data as of 06/06/26]

This structured approach initially delivered a significant reduction in incidents open beyond 60 and 120 days. However, since January 2026, overdue incidents have increased. Two key factors are contributing to this position: leadership capacity within Radiology Services, which affects the ability to complete investigations within required timescales; and a sustained increase in incident reporting.

Monthly incident reporting increased by 16% between November 2025 (n=70) and May 2026 (n=81), reflecting a strengthening safety culture.

Service-level incident data demonstrates alignment between service fragility and timely incident management, with most overdue incidents concentrated in the most operationally challenged services. Radiology holds the largest number of open incidents; however, the reduction in incidents overdue beyond 60 and 120 days indicates improved management of longstanding cases, aligned to focused support from Quality Assurance and Safety Team (QAST) colleagues.

Improvement in Radiology incident management is dependent on stabilising leadership capacity through the current Organisational Change Process. Recruitment to additional leadership roles is expected to commence in autumn, with staffing levels anticipated to improve by March 2027. This is expected to support sustained improvement in incident management during Q 1 and Q2 of 2027/28.

The CCG notes that incident reporting trends remain aligned with the service's established risk profile. Analysis of incident subtypes continues to show that Assessment, Treatment and Diagnosis is the most frequently reported category, with the highest volume of incidents arising within Radiology and Pathology. This reflects the workforce, equipment and infrastructure challenges currently identified within these services. Both services continue to implement mitigating actions within existing resource constraints to manage and reduce associated risks.

Incident reporting levels have risen consistently throughout 2025 and reached their highest level in 2026, as shown in Figure 3 below. Monthly totals peak at approximately 80 incidents. While month-to-month fluctuation is evident, overall reporting activity remains significantly above 2024 levels, before establishment of the CCG model.

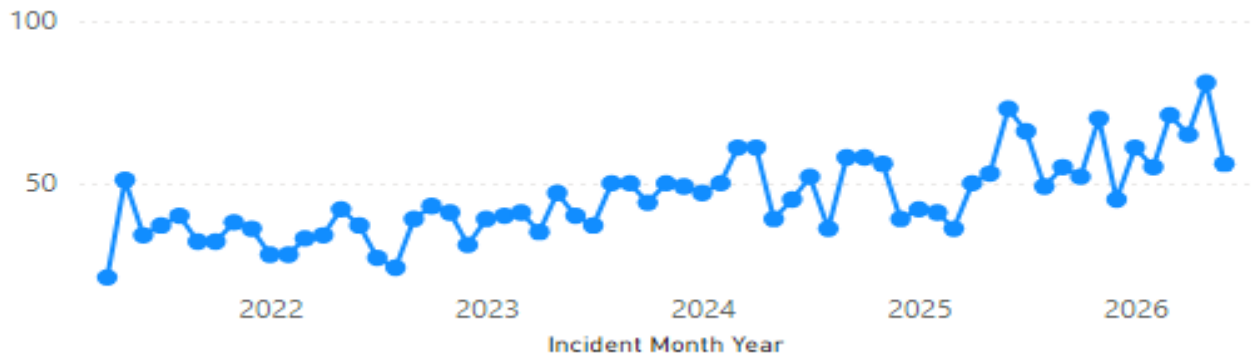


Figure 4 Number of incidents reported by month- AH & HS CCG - Our Performance Dashboard [Data as of 20/07/26]

The increase is likely to reflect a combination of ongoing service pressures, workforce challenges and greater reporting maturity across services. Higher reporting rates indicate improved identification of issues, with sub-categories aligned to known risks and concern themes. Continued monitoring of incident themes, sharing of thematic learning from investigations and timely incident management will provide oversight and support quality improvement.

In summary, incident reporting culture appears active, with no open Nationally Reportable Incidents reported in Q1. However, incident investigation timeliness remains a concern, particularly in Radiology, where sustained improvement is required for longest-open incidents. This is expected to become more achievable following stabilisation of leadership capacity.

1.1.1. Timely

The Clinical Care Group recognises that workforce risks affect timely service provision across several Allied Health and Health Science services. The most significant pressures relate to ultrasound service sustainability, clinical haematology workforce, radiology imaging equipment and infrastructure, and Allied Health Profession service pressures. These pressures result in prolonged waits and delayed access to diagnostics. The resulting patient impacts are summarised below:

Risk	Patient impact	Quality & Safety implication
Sonography workforce risk (ID 797)	Delayed scans	Delayed diagnosis and treatment
Radiology Imaging equipment and infrastructure (ID 684)	Delayed scans	Delayed diagnosis and treatment
Clinical Musculoskeletal Assessment and Treatment Service (CMATS)/musculoskeletal	Delayed assessment	Increased deterioration and complaints

(MSK) waits – physiotherapy (ID 2346/ID 1517)		
Selective eating pathway waits - Nutrition & Dietetics (ID1603)	Delayed intervention	Nutritional and developmental impact
Clinical Haematology Workforce (ID 834)	Delayed assessment	Delays in review, diagnosis, treatment planning

These risks are recorded and monitored through Health Board risk management arrangements, with mitigations in progress. These include separation and refresh of the corporate ultrasound risk, radiology infrastructure replacement schemes, temporary haematology agency workforce alongside workforce planning, annual planning stabilisation funding for radiology capacity and formal consultation on the Radiology Leadership Organisational Change Process.

CCG actions are in progress to maintain and improve timely access where demand continues to exceed available capacity. Services are progressing short-term controls, demand and capacity management, pathway redesign and productivity improvements. Examples include ultrasound pathway diversification, proposed transfer of growth scan activity to a midwifery-led pathway, telephone triage and risk stratification within Physiotherapy, Welsh Patient Administration System (WPAS) diary implementation, and actions to strengthen self-referral information within Podiatry and Surgical Appliances.

While some risk actions remain dependent on external funding, commissioning decisions, capital approval or regional programme delivery, the current position demonstrates active CCG oversight of risks, clear identification of residual gaps and continued escalation through operational governance structures where actions cannot be fully mitigated within existing resources.

1.1.2. Effective

Clinical effectiveness processes are established across the Clinical Care Group, including monthly review of NICE and national guidance, and sharing of clinical audit findings and learning.

1.1.3.1 Clinical Audit

The Clinical Audit Manager has provided an overview of the clinical audit function and programme. This has enabled the CCG to identify the need to strengthen visibility of CCG audit activity and enhance the contribution of Allied Health and Health Sciences to the local clinical audit programme.

Within Adult Speech and Language Therapy (SLT), the ***Acute Stroke SLT Clinical Note Audit*** demonstrated strong compliance with documentation of stroke diagnosis and imaging results, timely referrals, multidisciplinary communication and delivery of evidence-based therapy. Areas for improvement were identified in the use of formal assessments, goal setting, documentation standards, family communication and discharge reporting. The findings provide assurance that key components of the acute stroke SLT pathway are delivered consistently and that governance arrangements are in place to identify and address variation in practice. Actions include service-wide feedback, reinforcement of staff roles and responsibilities, targeted support to the site requiring improvement, ongoing

monitoring through Stroke Lead oversight, and a planned re-audit in August 2026 to assess sustained improvement.

Within Nutrition and Dietetics, an ***Audit of Dose Adjustment for Normal Eating (DAFNE) – Structured Education for People with Type 1 Diabetes*** demonstrated significant clinical benefit, with participants achieving an average reduction of 10.7 mmol/mol in haemoglobin A1c (HbA1c) one year after programme completion. This supports improved diabetes control and reduced risk of complications. The findings also identified the need to increase access to the programme to maximise patient benefit. The results provide assurance that the DAFNE programme delivers sustained improvements in glycaemic control, quality of life and long-term health outcomes for people with Type 1 Diabetes. Actions are focused on continuing initiatives to improve access and maintaining effective audit and data collection processes to support ongoing service improvement and quality assurance.

An Audit of the Process of Care of Patients who Receive Parenteral Nutrition (PN) demonstrated that mandatory clinical monitoring and documentation of PN prescriptions were largely completed, supporting safe and effective care. Consistent biochemical monitoring was also evident, helping to prevent avoidable metabolic complications and optimise clinical outcomes. The findings provide assurance that PN monitoring and prescribing processes are largely embedded and support patient safety, accuracy and continuity of care. Required actions include the development of educational resources and training for all staff involved in PN decision-making and care delivery.

The Podiatry service has continued to progress its clinical audit programme, including the National Diabetes Foot Audit, Patient Record Audit and Clinical Checklist Audit. Completion of the National Diabetes Foot Audit provides assurance of monitoring against national standards. Local audit activity has identified opportunities to strengthen record-keeping standards, with implementation of electronic clinical records addressing legibility issues identified through audit of clinical checklists.

1.1.3.2 Governance

The Clinical Care Group has established service-level governance arrangements to support effective risk management. These arrangements have supported sustained achievement at Level 1 within the Governance domain. Bi-monthly risk review workshops provide a structured process for validating risk assessments, ensuring risk scores are appropriately justified and consistently applied. The workshops also focus on reviewing target risk scores and identifying gaps in existing controls, with mitigating actions put in place to address areas of residual risk.

Sustained effective risk management is illustrated in table 1 below.

Risk overview

Open risks	Risks overdue	% overdue	Open actions	Actions overdue	% overdue
127	10	8%	254	22	9%

Table 1 CCG risk overview [Data as of 20/07/26]

Triangulation of quality metrics from clinical effectiveness processes supports delivery of safe, effective and person-centred services. As a next step, the Clinical Care Group will strengthen links between learning identified through incidents and service risk registers. This will enhance triangulation of intelligence from patient experience, including complaints and incidents, quality assurance, including clinical audit and regulatory inspections, and risk management processes to inform targeted mitigation and improvement actions.

Radiology provides a practical example of effective triangulation of quality intelligence. Findings from a clinical audit of referral quality align with recommendations from Audit Wales *Are Radiology Services Improving?* report (May 2026) and ongoing work with digital partners to develop a digital referral-vetting solution. The system will automate identification of incomplete, inappropriate and duplicate referrals, using the same referral quality standards applied within the clinical audit. This approach links assurance, external review and service improvement activity to support improvements in referral quality patient safety and service efficiency.

In summary, CCG risk management is sustained, and completion of actions arising from audit and inspection improved during Q1, with risk review compliance maintained above 90%. Clinical audit, NICE and mortality oversight are in place, although further development of a proactive CCG clinical audit programme is required.

1.1.3. Equitable

Equity considerations are reflected in several access and capacity risks across the Clinical Care Group, including Physiotherapy (Clinical Musculoskeletal Assessment and Treatment Service (CMATS) and musculoskeletal (MSK)), Adult and Paediatric Speech and Language Therapy, Paediatric Selective Eating, Adult Weight Management, Bone Density Scanning / Dual-energy X-ray Absorptiometry (DXA) and Podiatry services.

The CCG's top equity priorities are Paediatric Selective Eating and Adult Weight Management within Nutrition and Dietetics, and CMATS/MSK waits within Physiotherapy. These areas represent the highest demand and capacity risks and the greatest challenges to delivering equitable access, directly linked to availability of funded workforce.

Paediatric selective eating remains a significant demand and capacity risk, with associated nutritional, developmental and equity impacts. Temporary agency capacity is providing short-term mitigation, while access criteria, triage and referral processes are reviewed. A recurrent workforce solution has been progressed through annual planning.

Adult Weight Management remains a significant risk. Mitigating actions include waiting-list validation, revised referral criteria, patient communications and pathway redesign supported by successful funding through the Obesity Pathway Innovation Programme. These actions are intended to support development of a sustainable service model.

The Physiotherapy Service has maintained active oversight of CMATS and MSK access risks through escalation within Health Board planning processes, development of recovery proposals with Radiology, implementation of alternative triage models and ongoing service redesign aligned to the National MSK Specification. These actions demonstrate a proactive approach to managing risk and mitigating patient impact. However, demand continues to exceed available capacity, and sustainable improvements in access remain dependent on

resolution of underlying workforce and funding challenges. Risks to timely and equitable access therefore remain under close review through established governance arrangements.

Business Continuity Plan compliance improved to 100% by the end of May 2026, strengthening the CCG's ability to maintain safe and sustainable service delivery where locality-based services are affected by known workforce or service fragilities. This supports a more equitable approach to service provision by helping to mitigate variation in access and ensuring service changes and continuity arrangements are managed in a way that minimises unintended impacts on patient experience and outcomes.

1.1.4. Person Centered

1.1.4.1. Patient Stories

Patient stories feature within CCG governance meetings, supported by a schedule to ensure each service shares learning from patient experience. Key themes are summarised and triangulated with complaints, incidents, risks and audit, demonstrating that patient experience intelligence is not reviewed in isolation but informs governance and service improvement activity.

A phlebotomy service patient story demonstrated the value of this approach. Feedback relating to waiting times, perceived fairness of the queuing process and communication prompted a review of service delivery. This resulted in revisions to the service model that improved patient flow and reduced waiting times. Learning was also shared with staff to strengthen communication practices, illustrating how patient feedback and concerns can directly inform service improvement and enhance patient experience.

An Occupational Therapy end-of-life patient story demonstrated the value of collaborative planning, risk management and ethical decision-making, enabling a patient to return home, celebrate a birthday and marry. Learning centred on dignity, fairness, communication and outcomes that matter to patients.

A Physiotherapy patient story demonstrated the value of coordinated multidisciplinary working in the delivery of end-of-life care. Collaborative input from acute and community physiotherapy, respiratory and palliative care teams ensured care was aligned to an advance care plan. Feedback from the family and multidisciplinary team was highly positive, with key learning focused on strengthening communication, staff training and multidisciplinary documentation processes.

Story	Key theme
Phlebotomy experience	Communication and access
Occupational Therapy story	Coordination and responsiveness
Physiotherapy Story	Integrated multidisciplinary care

Theme	Complaints	Incidents	Risks	Audit
Communication	✓	✓		
Access and timeliness	✓	✓	✓	

Coordination of care	✓		✓	✓

1.1.4.2. Complaints

The CCG has maintained monthly deep dives into its longest-open complaints. This approach resulted in a 73% reduction in overdue complaints, from 22 to 5, between September 2025 and April 2026, as shown in Figure 4 below.

Figure - Complaints performance - AH & HS CCG

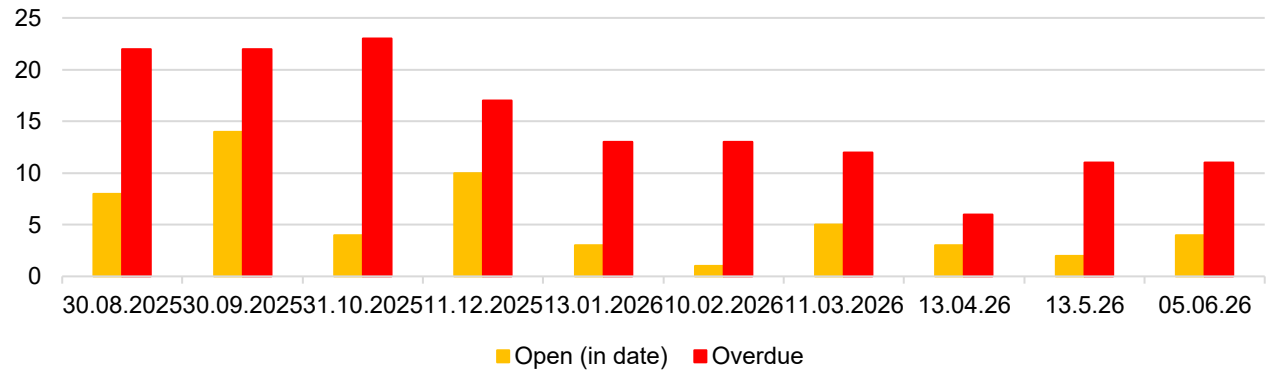


Figure 4 Number of open complaints- AH & HS CCG [Data as of 05/06/26]

Patient experience and complaints oversight continue to support organisational learning and service improvement across the CCG. While several complaints remain overdue, services continue to engage constructively with the process. Monthly deep dives provide oversight of the longest-open complaints and assurance that required actions are progressing. A number of complaints require collaboration across Clinical Care Groups and corporate functions to support comprehensive investigation and shared learning, reflecting the complexity of concerns and the commitment to producing high-quality responses.

The transition to the *Listening to People* approach is expected to reduce the clinical time required to develop complaint responses, enabling greater focus on thematic analysis and triangulation of complaint intelligence with incidents, risks and other quality metrics. Current themes remain aligned to known risks relating to diagnostic capacity and pathway reliability, providing assurance that governance processes are identifying areas of greatest concern and informing improvement activity.

<u>Progress since the previous (QSEC) update</u>

The following summary provides an overview of CCG progress since the previous CCG update in December 2025:

Maintained

- Governance performance sustained at Level 1
- Risk review and risk action compliance maintained

Improved

- Business continuity compliance improved to 100%.

- Overdue complaints reduced by 73%

Requiring continued oversight

- Overdue incidents remain limited by current Radiology capacity, with a plan in place to improve leadership capacity
- Overdue complaints, including complex cross-CCG complaints requiring support from corporate teams
- Risks referenced on page 11 remain under continued oversight, ensuring mitigating actions are aligned to themes identified through lessons learned from incidents.

Argymhelliad / Recommendation

The Committee is asked to:

- Receive assurance from the quality governance arrangements in place within the Allied Health and Health Sciences Clinical Care Group in relation to quality safety and patient experience.
- Note evidence of strengthened governance, improved business continuity compliance, sustained risk oversight and active patient safety governance, while recognising that significant risks remain in relation to the fragility of Radiology, Pathology, Physiotherapy, Nutrition and Dietetics services.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee Terms of Reference (ToR) Reference:	3.1 Provide advice to the Board on the adoption of a set of key indicators of quality of care against which the University Health Board's performance will be regularly assessed and reported on.
Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	Key risks referenced include: Radiology ultrasound corporate risk 797 and non-obstetric ultrasound (NOUS) risk 2336; Pathology Laboratory Information Management System 2 (LIMS2) risks 2079/1526; mortuary capacity risk 1552; Radiology infrastructure risk 684; Physiotherapy Clinical Musculoskeletal Assessment and Treatment Service (CMATS) risk 2024, musculoskeletal (MSK) Referral to Treatment (RTT) risk 1517, acute capacity risk 2145 and Stroke Early Supported Discharge (ESD) risk 2080; Nutrition and Dietetics risks 2169/1661 and 1603; Pathology workforce and estate risks 834, 1309, 838 and 2136; Radiology risks 1706, 1681, 2102, 2131 and 2132.
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	Safe care; Timely care; Effective care; Efficient care; Equitable care; Person-centred care.
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	Leadership; Culture; Learning, improvement and research; Whole-system perspective; Information and insight.

Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Nodau Cynllunio 2026/27 Planning Goals 2026/27	6. Safe, Timely, High Quality Care
Hyperlink to HDdUHB Well-being Objectives 2026	The report supports the Health Board's well-being objectives by focusing on prevention of harm, timely access, resilient services, learning from experience, workforce sustainability and equitable patient outcomes.
Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau) A Social Model for Health and Wellbeing: (*complete for strategic change and/or significant service changes)*	The report identifies access, timeliness and capacity risks
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Quarter 1 (Q1) Allied Health and Health Sciences (AH&HS) Clinical Care Group (CCG) Integrated Governance Quality and Safety (IG Q&S) agendas and minutes for April, May and June 2026; CCG assurance and risk overview reports; safety dashboard data; incident, complaints, redress and claims reports; service exception reports; Healthcare Inspectorate Wales (HIW), Audit Wales and Internal Audit updates; health and safety reports; business continuity compliance data.
Rhestr Termau: Glossary of Terms:	AH&HS: Allied Health and Health Sciences; CCG: Clinical Care Group; QEC/QSE Committee: Quality, Safety and Experience Committee; STEEEP: Safe, Timely, Effective, Efficient, Equitable and Person-centred; LIMS: Laboratory Information Management System; HIW: Healthcare Inspectorate Wales; IR(ME)R: Ionising Radiation (Medical Exposure) Regulations; NRI: Nationally Reportable Incident; BCP: Business Continuity Plan;

	QIA: Quality Impact Assessment; EqIA: Equality Impact Assessment.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	Allied Health and Health Sciences (AH&HS) Clinical Care Group (CCG) Integrated Governance Quality and Safety (IG Q&S) Group; Heads of Service; CCG risk and assurance leads; quality, patient safety, patient experience, redress, complaints, clinical audit, and health and safety representatives. Relevant escalation routes include the Chief Operating Officer (COO) Integrated Operational Delivery Group and CCG Monthly Delivery Group.

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
Ariannol / Gwerth am Arian: **Financial / Service:**	There are financial and value risks associated with LIMS2 deployment extension costs, adult weight management and paediatric selective eating service fragility, Podiatry non-pay pressures, Radiology infrastructure
Ansawdd / Gofal Claf: **Quality / Patient Care:**	Quality and patient care impacts include delayed access, potential diagnostic delay, incident investigation delays, long waits, fragile diagnostic and laboratory services.
Gweithlu: **Workforce:**	Workforce risks are material across Radiology, Pathology, Physiotherapy, Adult Speech and Language Therapy (SLT), Children's Speech and Language Therapy (SLT), Nutrition and Dietetics, Occupational Therapy (OT) and Podiatry. Key themes include consultant and specialist workforce gaps, sickness absence, maternity leave, recruitment delays, reliance on agency or temporary models, training compliance and leadership fragility.
Tegwch Iechyd: **Health Equity:**	Potential health equity impacts have been considered. The main equity risks relate to differential waiting times, geography, pathway access, diagnostic capacity, workforce-dependent service availability and referral management decisions. A full equity-focused health impact assessment has not been undertaken for this assurance report; individual service changes or decisions will require appropriate Quality Impact Assessment (QIA), Equality Impact Assessment (EqIA) or equity assessment as applicable.
Risg: **Risk:**	The report identifies multiple high and extreme risks currently managed through the CCG risk register and escalation routes. Mitigations include risk review, service SBARs, workforce planning, waiting list validation, escalation to delivery groups, regulatory action plans, business continuity completion, training actions and Quality Impact Assessment (QIA) / Equality Impact Assessment (EqIA) processes where service change is proposed.
Cyfreithiol: **Legal:**	There are legal and regulatory considerations relating to Duty of Candour, Welsh Risk Pool requirements, Ionising

	Radiation (Medical Exposure) Regulations (IR(ME)R), Natural Resources Wales (NRW) inspection, Healthcare Inspectorate Wales (HIW) action plans and health and safety legislation.
Enw Da: **Reputational:**	There is reputational risk if regulatory actions, long-open incidents, complaints, redress learning, diagnostic pathway risks, LIMS2 delays, Radiology infrastructure concerns and long waiting times are not demonstrably progressed. Conversely, strengthened governance, transparent escalation and evidence of improvement support organisational assurance.
Gyfrinachedd: **Privacy:**	This report uses aggregated governance information and does not include patient-identifiable information.
Cydraddoldeb: **Equality:**	This is an assurance report and no standalone Equality Impact Assessment (EqIA) has been undertaken. Equality implications arise where service changes are proposed, including pausing referrals, changing service models, workforce redesign or access criteria. Those changes should be supported by relevant Quality Impact Assessment (QIA) / Equality Impact Assessment (EqIA) processes.

4.2

4.2 - Facilities

Elin Brock (Hywel Dda UHB - Head of Research, Innovation & Improvement), Jo Bradburn (Hywel Dda UHB - Deputy Director of Allied Health Professions)

For assurance

Attachments

Facilities Service Group report.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	11 August 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Facilities Service Group Quality Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	James Severs, Executive Director of Allied Health Professions and Health Science
SWYDDOG ADRODD: REPORTING OFFICER:	Elin Brock, Head of Research, Innovation and Improvement

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report provides the Quality, Safety and Experience Committee with assurance regarding the effectiveness of quality governance arrangements within the Facilities Service. The report highlights key sources of assurance, current areas of risk and planned improvement activity relating to environmental cleanliness, food safety, patient experience and implementation of national standards.

Cefndir / Background

The Facilities Service Group provides a range of support services across Hywel Dda University Health Board that are integral to enabling good clinical delivery. This includes cleaning services, portering services, catering services and the provision of linen. These services form part of the facilities service's governance arrangements and are scrutinised on a monthly basis at site level Integrated Governance Groups (IGG) that report into the Facilities Service Group.

The aim of the Facilities Service Group in summary is to:

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

Meeting the Duty of Quality is the highest priority for the Facilities Service Group and its governance structures and oversight has developed significantly. This report is set out under each of these domains.



The Facilities Service Group has strengthened its quality governance arrangements over the last 12 months through the development of a structured governance framework, strengthened reporting arrangements and enhanced multidisciplinary oversight of cleaning and catering through the Environmental Hygiene Group and Catering Assurance Group.

Asesiad / Assessment

Quality Assurance

The Facilities Service Group operates a formal quality governance structure, reporting through Facilities Integrated Governance Group (FIGG) to the Executive Director of Allied Health Professions and Health Science Directorate Integrated Governance Group (DIGG).

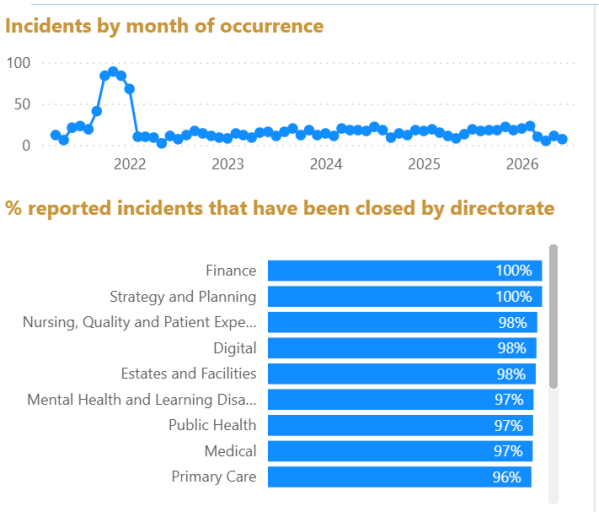
The monthly Facilities Service Group provides oversight of risks, incidents, audits and improvement activity; supported by monthly Environmental Hygiene Group (EHG) and Catering Assurance Group (CAG) meetings. The EHG provides operational oversight of Health Board cleaning services, ensuring compliance with audit schedules and scrutiny of cleaning standards compliance. The CAG provides operational oversight of Health Board catering services, supporting the development of procedural documents and performance metrics to enable greater oversight of the service.

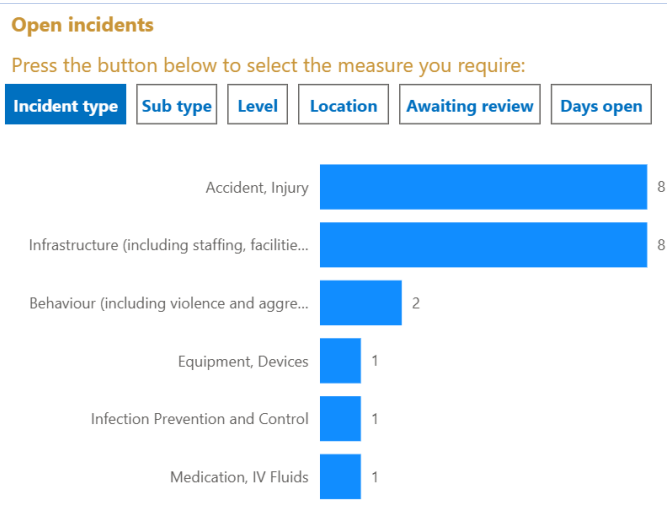
Further work is required to establish performance assurance arrangements across all service areas and sites and to increase multidisciplinary collaboration across facilities, nursing, estates and Infection Prevention and Control which is scheduled to conclude no later than 30 October 2026.

Safe Care

Incident Reporting

During the reporting period, incident reporting within the Facilities Service Group remained relatively low, with no themes identified that indicate widespread or systemic quality concerns. The largest proportion of incidents reported related to accidents and injuries and infrastructure/facilities issues**,** reflecting the operational nature of the services provided.



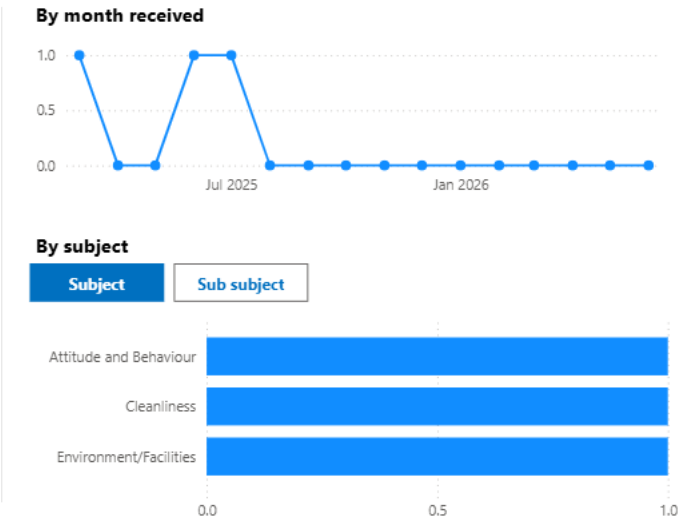


All incidents are reviewed at the Facilities Integrated Governance Group (FIGG), where trends, contributory factors and required actions are scrutinised.

There have been no significant themes emerging from incident reporting that would indicate a deterioration in the quality or safety of Facilities services. The overall reporting profile suggests an engaged workforce that continues to identify and report safety concerns, enabling timely investigation and organisational learning.

Complaints

The number of complaints relating to Facilities services remains low when considered in the context of the volume of services delivered across the Health Board. Complaints received during the reporting period primarily related to environmental cleanliness, catering provision and patient experience issues associated with non-clinical services.



Whilst complaint numbers are low, the Facilities Service Group recognises the importance of understanding the experiences of patients, visitors and staff. Work is therefore underway through the Catering Assurance Group and wider quality governance arrangements to develop more robust patient experience measures, ensuring that future service improvements are informed not only by complaints but also by routine feedback from service users.

Working in Partnership for Continuous Improvement

It is important to highlight the range of different services provided across the footprint of the Health Board, and that incidents and complaints relating to facilities may be raised by patients, visitors or staff via other departments or services across the Health Board. The facilities senior leadership team is working with clinical care groups and quality and assurance teams to triangulate incidents which include facilities staff to ensure learning is identified and lessons for learning are shared and implemented. The process will be developed throughout quarter 3 2026-27, trialled in quarter 4 2026-27 and evaluated for effectiveness scheduled in late quarter 4 2026-27.

Timely

Risk 1825 – Risk of non-compliance with cleaning standards due to lack of funding

Risk 1825 is a moderate risk due to workforce instability and the increasing cleaning requirements outlined in the new NHS Wales National Standards of Cleanliness (2025). Some assurance can be provided by the facilities service that effective controls and oversight are in place, including:

Governance and oversight
- Cleaning standards are monitored monthly through the EHG;

Monitoring
- Local cleaning audits are undertaken in line with national guidance; internal audits are undertaken on an annual basis;
- Areas of good practice shared, and non-compliance are scrutinised at EHG;

Workforce stabilisation
- Reducing reliance on variable pay by recruiting to substantive long-term vacancies.
- Over 30 new domestic assistants (WTE) are currently being recruited across each site.
- A ‘request rostering’ trial is currently underway at Prince Philip Hospital (PPH) and Glangwili Hospital (GGH).

Prioritisation of resources
- Further work is to be actioned to allocate available cleaning resources according to risk, with critical risk areas being prioritised;
-Reconfiguration of Pembrokeshire community cleaning resources being assessed
-Purchase of two cleaning robots to trial use of technology to improve cleanliness across hospital, complementing our domestic cleaning teams at GGH. This is scheduled to commence at GGH by 1 September 2026 with the view of evaluating impact before considering opportunities to upscale of technology within cleaning services.

Effective

Quality assurance framework for the provision of cleaning services

A quality assurance framework to support the standards of cleanliness is currently being developed. The aim is to set clear standards, defining how performance should be measured and drive continuous improvement in a meaningful way. The aim is to compliment the current auditing schedules that are currently in place but add greater value and assurance to how areas of non-compliance are prioritised and progressed, ensure corrective actions are identified

and progressed and enable greater monitoring and control. It is also imperative that the new approach supports a more collaborative approach to quality assurance, ensuring multi-disciplinary ways of working across facilities, estates, nursing and IP&C colleagues across each site and aligns with NHS Wales National Quality Outcome Framework. The use of automated processes is also being explored to ensure that staff can work in a more efficient way. The draft quality assurance framework is scheduled for presentation at the Executive Director of Allied Health Professions and Health Science Directorate Integrated Governance Group on 28 July 2026, with onwards consideration by Infection Prevention Strategic Steering Group (IPSSG) before the end of quarter 3 2026/27.

Evidence based

NHS Wales Standards of Cleanliness 2025

The NHS Wales National Standards of Cleanliness (2025) have been published and shared with Health Boards across Wales. The standards bring an updated position following the 2009 National Standards of Cleanliness, providing a consistent, risk-based, and outcomes-focused framework to support all NHS hospitals in Wales in delivering and assuring excellence in cleanliness.

In March and May 2026, Health Boards in Wales were requested to undertake a self-assessment against these standards, including a financial impact assessment and a quality impact assessment that supports a risk-based approach to implementing the standards within each respective Health Board. The Health Board undertook a functional risk-based approach, particularly in relation to the cleaning frequency guidelines. There has been no suggestion that there will be additional funding to support the implementation of these new cleaning standards.

Quality Impact Assessment

1. The output of the revised Quality Impact Assessment supports the reduction of cleaning frequencies and the ability to divert cleaning staff from low-risk areas to very high-risk areas.

2. The risk-based approach involves reducing the frequency of cleaning for the following elements:
   - Floor (polished)
   - Floor (non-slip)
   - Soft floor
   - Electrical items
   - Low surfaces
   - High surfaces
   - Waste receptacles
   - Showers
   - Toilets and bidets
   - Replenishments

3. By reducing the frequencies of cleans and checks in low and significant risk areas, it offers the Health Board the opportunity to move cleaning staff resource from the 2 lower risk areas (Low / Moderate) to the higher risk areas (High / Critical) to deal with the extra demand in required clinical areas.

Financial Impact Assessment

The initial financial assessment indicated a significant financial expense to adopt the All-Wales Cleaning Standards 2025. Health Boards were requested to consider a revised risk-based financial assessment, despite this reducing the financial expense, there was still a significant increase in the financial resource required to achieve this standard which only accounted for the facilities service. Additional work is required to fully inform the financial impact which needs to include estates and nursing aspect of these cleaning standards. A comprehensive assessment will be developed and presented to the Executive Team in early October 2026.

<u>All Wales Nutrition and Catering Principles and Standards for Food and Fluid Provision for Hospital Inpatients – 2026</u>

New standards for nutrition and catering principles have recently been developed by Welsh Government and shared with key stakeholders as part of the document consultation.
The standards will have an impact on the catering service which will considered more formally once the standards have been published. Early review indicates the need to:

- Ensure training compliance for staff involved in food service;
- Monitor and aim to reduce any negative impacts of the food production system on the environment i.e. reducing & recycling packaging, monitoring and reducing food waste during production.
- Monitor plate waste and any opportunities to reduce where possible.
- Enhance the accessibility to plant-based options on menu's whilst still maintaining choice and control of food waste.
- Consider reducing the volume of meat in meat-based recipes and enhance plant-based alternatives within these dishes to avoid adversely affecting protein content.
- Reduce the use of highly processed foods on menus where possible.
- Develop hospital protocols for the provision of therapeutic, specialist, religious, cultural and lifestyle dietary needs, ensuring they meet any clinical treatment requirements and nutritional standards.
- Consider the use of food service technology to promote safe and efficient meal ordering.
- Explore digital technology capabilities to safely record and monitor patient intake and food waste.

The standards also introduce an All-Wales self-assessment tool, enabling NHS organisations to review current arrangements for nutrition and hydration, identify strengths, and target areas for quality improvement. The self-assessment tool will provide a consistent basis for monitoring and demonstrating improvement in the quality of nutrition and hydration provision over time. It will also link directly to organisational quality reporting and quality improvement plans, supporting assurance against the seven national principles set out within these standards.

The Nutrition and Hydration Group will play a critical role in interpreting and implementing the standards. The standards will be discussed at the August 2026 meeting and an implementation plan developed to embed any changes required. The Catering Assurance Group will support in progressing any operational changes needed across the catering service.

Equitable

Food Safety and Allergen Awareness Training

Risk 2200 relates to the potential impact on patient safety arising from low compliance with food safety and allergen awareness training requirements, and the service continues to control and mitigate this risk.

The Facilities Service Group receives monthly reports on training compliance and progress is monitored through established governance arrangements, including reporting to the Health, Safety and Compliance Group (HSCG). In July 2026, HSCG reviewed the current position and agreed an improvement plan to address areas of non-compliance across all sites.

Training requirements have been clearly defined following advice provided by Pembrokeshire Local Authority when acting as Primary Authority. These requirements specify the appropriate level of food hygiene and allergen awareness training for staff groups involved in food handling, service provision and meal preparation.

Current compliance data demonstrates generally strong compliance within Catering Services, with most sites achieving between 87% and 100% compliance for Level 2 and Level 3 food hygiene training. Areas of lower compliance are predominantly within Domestic Services Level 2 training, where staffing turnover, recruitment activity and seasonal fluctuations have affected compliance rates. Compliance is monitored monthly and workforce data is used to identify individuals requiring training.

To mitigate the risk, a structured improvement programme has been implemented, including:

- Additional Level 2 training sessions across all sites.
- Targeted training for evening and hard-to-reach staff groups.
- A "Train the Trainer" programme to increase local training capacity.
- Regular monitoring through the HSCG.
- Follow-up arrangements to ensure newly appointed staff complete mandatory training promptly.

Additional training sessions are scheduled throughout July and August 2026 are expected to significantly improve compliance levels, with over 50 staff already identified for training. Progress against the improvement plan will continue to be monitored monthly at the HSCG.

Person Centred

Cleaning audits

Environmental cleanliness remains a key quality and patient safety priority for the Facilities Service Group. Monthly cleaning audits continue to identify variation in compliance against the required standards across a number of sites and clinical areas. Whilst audit performance remains below the Health Board's expected compliance threshold, the results have enabled a more systematic understanding of the underlying causes and have informed targeted improvement actions. Whilst planned audit compliance at Bronglais Hospital (BGH), GGH and PPH are compliant, there is a need for improvement at WGH due to supervisory staffing challenges. This has affected the overall Health Board compliance score, as shown below.

Hywel dda	Target	Apr '26	May '26	Jun '26	Jul '26	Aug '26	Sep '26	Oct '26	Nov '26	Dec '26	Jan '27	Feb '27	Mar '27
Planned audits completed	95%	92%	92%	93%									

Hywel dda	Target	Apr '26	May '26	Jun '26	Jul '26	Aug '26	Sep '26	Oct '26	Nov '26	Dec '26	Jan '27	Feb '27	Mar '27
Met the required standards	93%	54%	49.4%	43.5%									

Key contributory factors include workforce vacancies, inconsistent staffing resilience across some areas, increasing service demands and variation in local implementation of cleaning schedules.

Risk 1825 outlines the risk more fully with key controls and mitigating actions. The service continues to monitor this risk through the Environmental Hygiene Group, Service Integrated Governance and Directorate Integrated Governance Groups. Audit findings are routinely reviewed with site teams, nursing, Infection Prevention and Control colleagues and operational managers to ensure areas of concern are identified and addressed promptly.

A significant recruitment programme is currently underway across all sites, with approximately 30 additional Domestic Services staff expected to commence over the coming months. This investment is intended to improve service resilience, reduce vacancy levels, increase compliance with planned cleaning schedules and strengthen the overall quality of the patient environment.

Alongside workforce expansion, work continues to modernise rostering arrangements within Domestic Services. A request-rostering trial is currently being undertaken at GGH and PPH. The trial forms part of a broader workforce transformation programme aimed at improving staff experience, supporting recruitment and retention, reducing reliance on overtime and bank cover, and ensuring workforce resources are aligned more effectively to patient and service needs. This trial will run during quarter 3 2026/27 with evaluation and learning being collated at the end of quarter 3 2026/27.

The Facilities Service Group is also developing a formal Quality Assurance Framework for cleanliness standards, which will provide enhanced oversight of audit performance, corrective actions and improvement trajectories. This framework will strengthen multidisciplinary collaboration between Facilities, Nursing, Estates and Infection Prevention and Control teams and support implementation of the NHS Wales National Standards of Healthcare Cleanliness (2025).

Whilst current audit performance does not yet provide full assurance that all cleanliness standards are consistently being achieved, the combination of workforce investment, strengthened governance arrangements and enhanced quality assurance processes is expected to deliver sustained improvement before the end of quarter 4 2026/27.

Patient Experience Information

The Facilities Service Group recognises that cleanliness, food quality, meal choice, timeliness of food service and the overall environment have a significant impact on patient experience, dignity and wellbeing. Whilst formal complaints relating to Facilities services remain low, current arrangements do not provide sufficiently comprehensive insight into the routine experiences of patients, visitors and carers, particularly in relation to cleaning and catering services.

The Facilities Service Group has identified strengthening patient experience measurement as a priority during quarter 3 and quarter 4 2026/27. A structured Patient Experience Framework will support the routine collection, analysis and reporting of feedback relating to both cleaning and catering services. This will enable the service to better understand what matters most to patients and use this intelligence to inform service planning, quality improvement activity and performance monitoring.

Areas that could be explored include:

- Point-of-service meal satisfaction feedback.

- Real-time feedback on environmental cleanliness and ward environments.
- Inclusion of Facilities-related questions within existing patient surveys and discharge feedback processes.
- Patient and staff walkarounds undertaken jointly with clinical teams.
- Use of patient stories and qualitative feedback to complement performance and audit data.

The introduction of the proposed Quality Assurance Framework for cleaning services and ongoing work to strengthen catering assurance arrangements provide a significant opportunity to better align quality indicators with patient experience measures. This will ensure that performance is assessed not only through compliance and audit outcomes and also through the experiences and perceptions of those who use our services.

Argymhelliad / Recommendation

The Quality, Safety and Experience Committee is asked to receive assurance on the quality governance arrangements in place within the Facilities Service Group in relation to quality, safety and patient experience.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.6 Provide assurance that all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality and safety of care provided, and in particular that sources of internal assurance are reliable, there is the capacity and capability to deliver, and lessons are learned from patient safety incidents, complaints and claims.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	1825 & 2200
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	1. Safe 2. Timely 3. Effective 5. Equitable
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	1. Leadership 2. Culture and valuing people 3. Data to knowledge 6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Nodau Cynllunio 2026/27 Planning Goals 2026/27	All Planning Goals Apply

Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	1. Plan and deliver services to increase our contribution to low carbon 2. Develop a skilled and flexible workforce to meet the changing needs of the modern NHS 7. Plan and deliver services to enable people to particpate in social and green solutions for health 8. Transform our communities through collaboration with people, communities and partners

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Included within the body of the report
Rhestr Termau: Glossary of Terms:	Included within the body of the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	Health, Safety and Compliance Group Facilities Integrated Governance Group

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	N/A
Ansawdd / Gofal Claf: Quality / Patient Care:	The implementation of a number of actions included within the body of the report will have a positive impact on patient care.
Gweithlu: Workforce:	Included within the body of the report
Risg: Risk:	Included within the body of the report
Cyfreithiol: Legal:	N/A
Enw Da: Reputational:	Improving the quality aspects of service delivery will have a positive impact on the reputation of Hywel Dda University Health Board
Gyfrinachedd: Privacy:	N/A

Cydraddoldeb: Equality:	N/A

4.3

4.3 - Estates

Simon Chiffi (Hywel Dda UHB - Head of Operations), Jo Bradburn (Hywel Dda UHB - Deputy Director of Allied Health Professions)

Attachments

Estates Care Group.pdf

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	11 August 2026
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Estates Service Group Quality Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	James Severs, Executive Director of Allied Health Professions and Health Science
SWYDDOG ADRODD: **REPORTING OFFICER:**	Simon Chiffi, Head of Operational Estates

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

Sefyllfa / Situation

This report provides the Quality, Safety and Experience Committee with assurance regarding the effectiveness of quality governance arrangements within the Estates Service Group.

The report highlights progress in incident management, complaints closure, Audit Management and Tracking (AMAt) system action tracking and risk review compliance, while recognising partial assurance in relation to climate resilience, ageing estate infrastructure and the need for sustained capital investment. Key mitigations are in place, monitored through monthly governance arrangements and escalated where required.

Cefndir / Background

The Estates Service Group provides a range of support services across Hywel Dda University Health Board that are integral to enabling good clinical delivery. This includes estates maintenance and engineering and estates compliance and risk. These services form part of the estates service's governance arrangements and are scrutinised on a monthly basis at site level Integrated Governance Group (IGG) that report into the Estates Service Group.

The aim of the Estates Service Group in summary is to:

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

Meeting the Duty of Quality is the highest priority for the Service Group, and its governance structures and oversight has developed significantly. This report is set out under each of these domains.



Asesiad / Assessment

The Estates and Facilities Integrated Governance Group was established in April 2025, chaired by the Executive Director of Allied Health Professions and Health Science and supported by the Head of Estates Operations. Following an agreed change in approach with the “New Ways of Working”, the overseeing Allied Health and Health Science Directorate Integrated Governance Group has feeder groups, of which the Estates Integrated Governance Group is one. This approach began in July 2026.

The initial six months focused on establishing governance structures and collaboration across the Health Board functions. The initial priority was to gain access to the root data to allow analysis and immediate actions in relation to the position shown within the Health Board Performance and Safety dashboards.

The following six months allowed the Service Group) to begin embedding ways of working to track progress against the improvement metrics identified by the Health Board Escalation Framework. Updates in relation to these areas are contained under the Safe, Timely, Effective, Equitable, Efficient and Person Centred (STEEEP) domains of this report.

Recent focus from April 2026 to July 2026 has centred on embedding CCG Quality, Safety and Experience management system processes within each area. Moving forward, the focus will shift to identifying profession-specific quality metrics and triangulating learning themes to drive improvement.

Quality Assurance

The Integrated Governance Group (IGG) meetings are scheduled monthly and are well represented by professional leaders from all services in Estates Risk, Fire, Maintenance and Engineering, all of whom take an active part in meetings and shape the overall agenda. The IGG would like to note that it values continued support from business partners in Risk, Finance, Performance and Legal, and views escalation, assurance and oversight at IGG meetings as essential to governance. Each service provides a monthly assurance report from its Quality and Safety meetings.

A key focus of the Integrated Governance Group leadership has been to deep dive into domains of escalation to understand the root data and progress rapid improvement. This report will concentrate on the following areas:

Quality and Safety

- Improvement in incidents open greater than 120 days.
- Review of complaints open greater than 180 days.

Governance

- Achievement of >90% risk and risk action reviews.
- Improvement in target risk score achievement.
- Closure of AMaT and Internal Audit actions.

Each Service Group within the Estates IGG (Maintenance & Engineering and Estates Risk) holds monthly Quality and Safety meetings, and further work is underway to strengthen this structure and reporting to the Directorate IGG meeting.

Safe Care

AMaT Position

The IGG has sustained a long-term focus on the management of the Executive Director of Allied Health Professions and Health Science/ Estates AMaT system by remaining in Level 1 Escalation for Governance. Audit workshops have continued within each service monthly, together with operational teams monthly. The initial focus has been to ensure that all service reports and actions are captured and have consistent information with tracked dates for closure.

Current update: as of 16 July 2026, there are 60 open reports on AMaT, of which 11 are overdue. There are also 59 Letters of Fire Safety Matters, of which 10 are currently overdue; seven of these do not have revised completion dates, and 30 reports are pending approval to close. One Internal Audit report remains overdue: the Energy Management Final Internal Audit Report 2024/25.

Open reports and recommendations	Overdue reports and recommendations	Total Number of Recs Reliant on External Factors	Total Number of Recs Overdue 6-12 months	Recommendations Without Revised Completion Dates
Reports: 60 Recs: 429	Reports: 14 (22%) Recs: 35 (8%)	Recs: 17	Recs: 9	Recs: 32 (7%)

The Head of Fire Safety is working with the Assurance and Risk Team to close the reports that are pending closure. At present, uploading evidence is the only remaining barrier, alongside recent sickness within the team, which has now been resolved. The remaining reports are all being worked through, and resolution and closure are currently projected to be on time.

Incident Management

From June 2025, each Service Lead has had an allocated monthly Governance 1-1 meeting with support from a Quality Assurance Service Team (QAST) business partner. This ring-fenced time is used to resolve outstanding queries for open incidents and reduce the exchange of emails regarding queries and actions. The aim is to build a positive incident reporting and management culture through dedicated time. This approach has supported timely incident management, with a view to achieving a trajectory of zero incidents open for more than 120 days. Progress to date can be seen in Figure 2.

Data shows that Estates figures are low and that incidents are being managed in a timely way. It also shows that any impacts on quality and safety are reviewed quickly, with changes to controls and mitigations acted upon. We are working to improve cross-CCG communication with other incident managers to ensure that any incidents requiring Estates input are acted

upon swiftly. This will support wider learning from all incidents, irrespective of the incident manager or CCG “owner”.

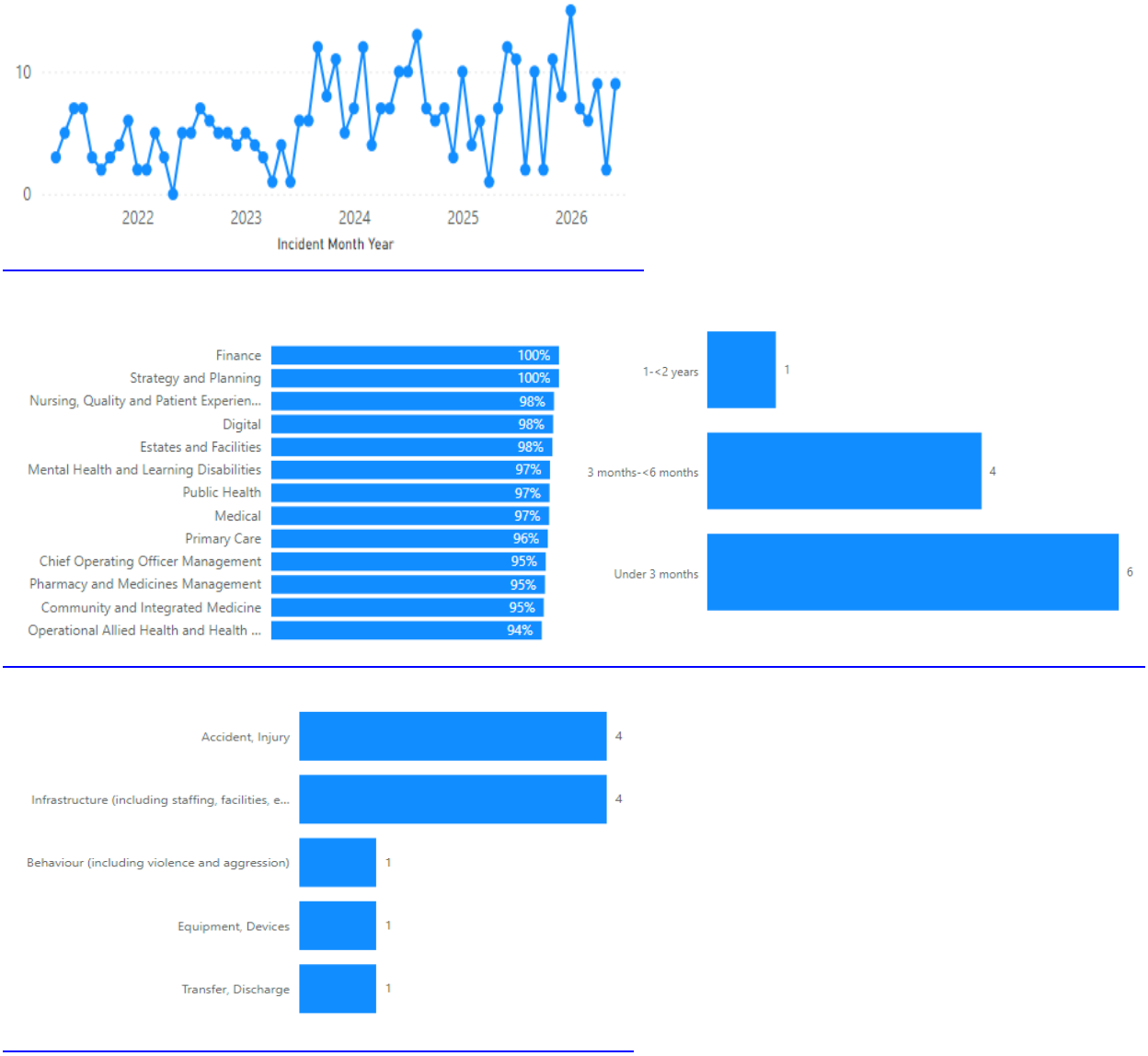


Figure 2; Number of open incidents and highlights of themes.https://app.powerbi.com/MobileRedirect.html?action=OpenReport&reportObjectId=ce9c3944-0798-4963-b08c-f07ac4ec7193&ctid=bb5628b8-e328-4082-a856-433c9edc8fae&reportPage=ReportSectioncc82ed950e416c93c4a2&pbi_source=copyvisualimage
Our Performance Dashboard Data as of 14/07/26.

To date, this structured approach has resulted in an overall reduction in overdue open incidents to four cases open for more than 120 days. Compared with previous years’ reporting, there are single figure increases in the number of reported incidents, which aligns with the age of our estate, infrastructure and risk profile.

Once timely incident management has been achieved, the next step will be to focus on the analysis of incident themes to drive improvement. Data shows that most incident types within the IGG are reported as infrastructure and accidental injury incidents. Due to the limited number of incidents, there are currently no hotspot locations or service areas, however this will be reviewed in the next quarter to identify any specific areas. As part of our approach, we work with our risk partner and all Estates teams to prioritise extreme and high-level risks monthly, supported by accompanying action plans.

Whilst incident management performance remains strong, the IGG recognises the ongoing challenge of cultivating a proactive reporting culture for low and no harm events. Increasing reporting rates will improve organisational learning and enable earlier identification of emerging risks.

Working in Partnership for Continuous Improvement

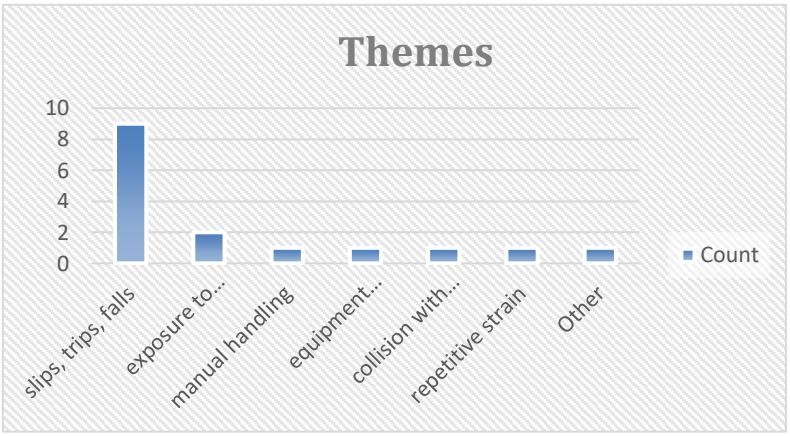
It is important to highlight the range of different services provided across the footprint of the Health Board, and that incidents and complaints relating to estates may be raised by patients, visitors or staff from other departments or services across the Health Board. The Estates Senior Leadership Team is working with CCGs and quality and assurance teams to triangulate incidents which include estates staff to ensure learning is identified and lessons for learning are shared and implemented. The process will be developed throughout quarter 3 2026-27, trialled in quarter 4 2026-27 and evaluated for effectiveness scheduled in late quarter 4 2026-27.

Timely

Personal Injury Claims

All claims are supported through the Estates IGG, with close liaison with the Health Board's Legal Redress Manager. The legal redress partner routinely attends the monthly IGG meeting to report on the latest position. This established partnership and embedded systems ensure that claims are reviewed within target timeframes and that learning-from-events exercises are conducted for all claims. This has resulted in the IGG improving its response rate, with no outstanding issues.

Personal injury claims include incidents and accidents within the Health Board estate caused by environmental hazards, equipment malfunctions and workplace slips, trips and falls. Most claims are confirmed as accidents or injuries, with some liability accepted or denied. Claims involve a range of injuries, from minor to serious, including falls, equipment malfunctions and exposure to hazards such as asbestos. Financial estimates vary, with total damages reaching over £180,000, and defence and claimant costs reflecting the severity and liability status. A review of the themes has identified the following:



Claims ongoing by theme

These patterns reflect the prevalence of slip, trip and fall incidents and highlight opportunities to improve external surface maintenance, inspect ramps and stair nosings, and provide clearer hazard signage. To address these safety issues, senior Estates managers complete monthly

site walkabouts to identify critical concerns, which are then logged on the helpdesk system and resolved according to priority.
The data shows that slips, trips and falls make up over half (56%) of all cases. Targeting uneven surfaces, loose or raised slabs, potholes and ramp or stair edges is now a clear focus for the IGG.

Site	Total
Glangwili General Hospital (GGH)	5
Prince Philip Hospital (PPH)	4
Withybush General Hospital (WGH)	4
Bronglais General Hospital (BGH)	3

Table 2 – Claims ongoing by site

Heatwave Issues & Concerns

Wales experienced a period of exceptional heat and humidity during May and June 2026, with amber and red weather warnings in place and a corresponding increase in service demand, patient acuity, and operational pressures. The sustained high temperatures created significant challenges across health and care services, including:

- Increased patient demand and clinical acuity
- Risks to patient safety, comfort and wellbeing
- Workforce pressures, including staff wellbeing, availability and increased operational demands
- Infrastructure challenges associated with maintaining safe care environments

Key engineering and estates findings include:

- In all acute hospitals, most wards have limited or no mechanical ventilation, cooling and humidity control capability.
- High humidity reduced comfort levels and increased heat stress for patients and staff.
- Due to design constraints, the plant of the Prince Philip Hospital (PPH) Day Surgery Unit (DSU) was unable to cope with the high temperatures and high humidity.
- Opening windows frequently introduced additional warm, humid air, reducing the effectiveness of natural ventilation.
- Some plant operated at maximum practical capacity.
- Overheating risk is greatest in older ward blocks, upper floors, high occupancy areas and locations with significant solar gain.

Estates resilience and investment priorities include:

- Short term: strengthen heatwave response procedures, increase environmental monitoring and review affected clinical areas.
- Medium term: targeted reviews of ventilation capacity, optimisation of Building Management System (BMS) controls and pursuit of Air Handling Unit (AHU/chiller) replacement opportunities.
- Continue delivery of Targeted Estates Fund (TEF)-funded resilience schemes and wider refurbishment work, including chiller replacements and AHU upgrades.
- Long term: develop a Health Board Heat Resilience Strategy aligned to climate change projections.

The Deputy Director of Nursing, Quality and Patient Experience has led a task and finish group consisting of key stakeholders to consider learning from these recent heatwave events, including representation from the Estates Service Group.
The Estates Service Group has reported its findings and has a specific report covering the key findings and risks. Overall, the debrief suggests that while concerns regarding heat, ventilation and the physical environment were a recurring theme, these issues were frequently balanced by strong appreciation for the commitment, resilience and professionalism of staff. Patients consistently recognised that colleagues continued to provide compassionate, person-centred care despite the challenges presented by the exceptional weather conditions.

Extreme weather events continue to expose vulnerabilities associated with an ageing estate and limited environmental control infrastructure. Long-term resilience requires sustained capital investment aligned to Corporate Risk 1745.

Effective

Risk Management

The Estates Service Group has sustained a ten-month focus on the effective management of the Executive Director of Allied Health Professions and Health Science/Estates risk register by remaining in Level 1 Escalation for Governance. Risk workshops have continued monthly within each service and with operational teams. The initial focus has been to ensure that all service risks are captured and have mitigating actions. July's data shows that 99% of risks were reviewed within period and 96% of risk actions were completed within period against the Health Board's target of 90%. This comes from a total number of 136 risks as broken down:

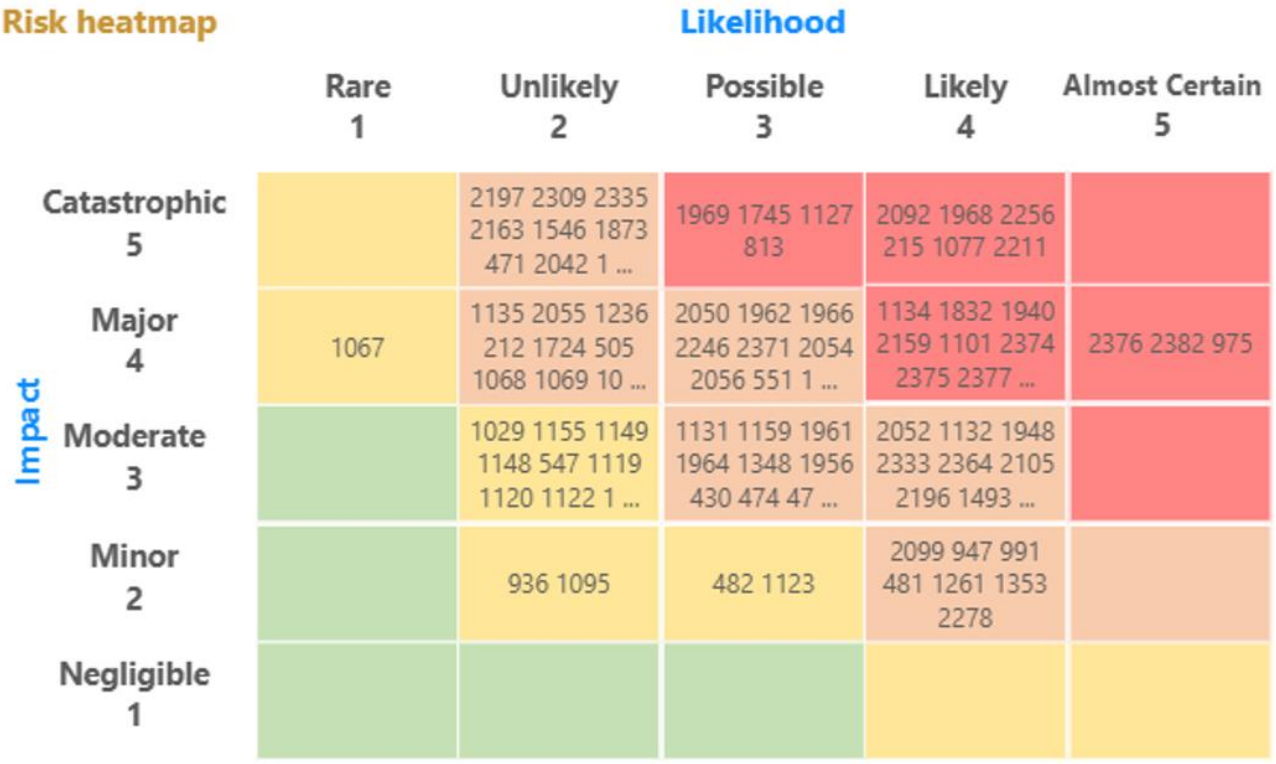
	Corporate Level	Operational Level
Total Number of Risks: 136 →	2	134
Extreme (Red) Risks (based on 'Current Risk Score')	2	23
High (Amber) Risks (based on 'Current Risk Score')	0	91
Moderate (Yellow) Risks (based on 'Current Risk Score')	0	20
Low (Green) Risks (based on 'Current Risk Score')	0	0

Estates Risk overview (Data provided by Risk Partner and Power Bi Dashboard for July 2026)

Risk overview

Open risks	Risks overdue	% overdue	Open actions	Actions overdue	% overdue
136	2	1%	171	6	4%

Risk heatmap



Estates Risk overview (Data provided by Risk Partner and Power Bi Dashboard for July 2026)

Risk Ref	Title	Date Risk Identified	Current Risk Score	Risk Level (Current)	Target Risk Score	RR - Target Risk Score Expected Date	Directorate	Service/Department	RR - Clinical Sub-Group	Domain	Lead Committee	Date of Review	Review date	Approval status
1745	Risk of not being able to safely deliver services due to ageing estate and infrastructure across the Health Board	02/08/2023	15	Extreme	10	31/08/2032	Estates & Facilities	Estates & Facilities	E&F: Directorate Team	Safety - Patient, Staff or Public	Health and Safety Committee	23/06/2026	23/07/2026	Corporate Risk
813	Risk of non-compliance with the Regulatory Reform (Fire Safety) Order 2005 due to ageing infrastructure	01/10/2019	15	Extreme	5	31/08/2029	Estates & Facilities	Estates & Facilities	E&F: Fire	Statutory duty/inspections	Health and Safety Committee	23/06/2026	23/07/2026	Corporate Risk

Estates overview of corporate risks (Data provided by Risk Partner for July 2026)

The two corporate-level risks continue to expose vulnerabilities associated with an ageing estate. For assurance, the Fire Safety Risk is tracked monthly through the Fire Safety Group. Significant capital investments in fire safety include completed Phase 1 works at Glangwili Hospital (GGH) and Withybush Hospital (WGH), with Phase 2 ongoing at both sites and completion expected in 2028. Major capital investment projects are also progressing at Bronglais Hospital (BGH) and PPH through the Major Capital Team. These schemes, together with a renewed focus on fire safety training, are expected to support reduction of the target score within timescales agreed with the Fire Service and Welsh Government. Long-term resilience across the ageing estate requires sustained capital investment aligned to Corporate Risk 1745. Nine major projects are planned over the next three financial years through the Major Capital Team, including air handling, electrical resilience, replacement water tanks and secondary generators, to extend the life of key infrastructure.

Management controls remain in place for all extreme risks, and progress continues against agreed mitigation plans. No new risks require further escalation. Other risks categorised as extreme and high-level risks are being managed in line with risk management strategy, however many remain dependent on capital resources to fully mitigate and reduce to target score; therefore, continued strategic oversight is required and continues monthly. All actions and controls are in place, and the approach taken is approved and supported by Estate Management, Risk Partners and external partners, such as NHS Wales Shared Services Partnership (NWSSP).

Carmarthenshire East is now carrying the highest overall risk burden, with 46% of the total risk, replacing Pembrokeshire. Carmarthenshire East accounts for 46%, Pembrokeshire 42%, Ceredigion 4%, Carmarthenshire West 4%, and the Directorate Team 4%. The themes of ageing estate, failing infrastructure, compliance risks and business continuity vulnerabilities are consistent across all areas. The target risk dates range from 2026 to 2032, reflecting a reliance on capital programmes and multi-year infrastructure upgrades, with prolonged exposure to risk until works can be completed.

Extreme level risks newly added to register since last report include:

Risk Ref	Title	Date Risk Identified	Current Risk Score	Risk Level (Current)	Target Risk Score	RR - Target Risk Score Expected Date	Directorate	Service/Department	RR - Clinical Sub-Group	Domain	Lead Committee
1127	Risk of avoidable service disruption due to high voltage electrical infrastructure affecting WGH	12/06/2017	15	Extreme	2	30/04/2030	Estates & Facilities	Estates & Facilities	E&F: Pembrokeshire	Service/Business interruption/disruption	Quality, Safety and Experience Committee
1331	Risk of loss of mains water due to Storage Tank failure, PPH.	13/07/2016	16	Extreme	4	31/03/2027	Estates & Facilities	Estates & Facilities	E&F: Carmarthenshire East	Service/Business interruption/disruption	Quality, Safety and Experience Committee
1832	Risk of service disruption at Fishguard Health Centre due to failing condition of roof	01/01/2024	16	Extreme	3	30/04/2030	Estates & Facilities	Estates & Facilities	E&F: Pembrokeshire	Service/Business interruption/disruption	Quality, Safety and Experience Committee
2374	Risk of potential loss of income due to inaccurate data being recorded by estates staff	03/04/2023	16	Extreme	4	31/12/2026	Estates & Facilities	Estates & Facilities	E&F: Ceredigion	Quality/Complaints/Audit	Strategy and Planning Committee
2375	Risk of potential loss of income due to inaccurate data being recorded by estates staff	03/04/2023	16	Extreme	4	31/12/2026	Estates & Facilities	Estates & Facilities	E&F: Carmarthenshire West	Quality/Complaints/Audit	Strategy and Planning Committee
2377	Risk of potential loss of income due to inaccurate data being recorded by estates staff	03/04/2023	16	Extreme	4	31/12/2026	Estates & Facilities	Estates & Facilities	E&F: Pembrokeshire	Quality/Complaints/Audit	Strategy and Planning Committee
2376	Risk of potential loss of income due to inaccurate data being recorded by estates staff	03/04/2023	20	Extreme	4	31/12/2026	Estates & Facilities	Estates & Facilities	E&F: Carmarthenshire East	Quality/Complaints/Audit	Strategy and Planning Committee

Estates newly added extreme level risks (Data provided by Risk Partner for July 2026)

All risks have controls and planned actions to mitigate and manage each risk.

The IGG has established service management systems to ensure that risks are reviewed within target periods and risk actions are completed. This has resulted in the IGG improving to Level 1 within the Governance domain and routinely reporting improvement in target risk score dates.

The IGG aims to maintain level 1 by setting the expectation that services embed risk register review within their governance structures and maintaining oversight of performance management within the IGG Governance meeting.

Next steps will be to further enhance and utilise risk review workshops to ensure validation of the risk scoring matrix, provide clear justification of risk scores, and focus on target risk scores to understand how these are set and identify any themes in relation to barriers to achievement.

Evidence based

Compliance with national standards, guidance and protocols remains consistent within the Estates IGG. The Risk and Compliance Group maintains a register of all NWSSP shared notices, and we are governed by Welsh Health Technical Memoranda (WHTMs), which form

the bedrock of our compliance systems. This is supported by independent audits by Shared Services, who routinely attend and provide reports on Electrical Safety, Medical Gases and Water, to name a few. All reports and actions contained therein flow into the AMaT system for tracking purposes and are reflected in the AMaT section. There has been considerable progress in these areas in recent years, with increased scrutiny and reporting through the Health and Safety Committee (HSC) and the Health and Safety Compliance Group (HSCG). Metrics have been developed to help demonstrate compliance, supported by evidence and audit.

Equitable

There are natural variations in Estates compliance and quality across all sites due to the age, nature and deterioration of our estate. It is recognised and acknowledged that the condition of our estate can affect patient safety and quality; therefore, every risk is reviewed with that in mind, together with a comprehensive capital request matrix to ensure that our highest priorities are targeted. Significant focus is being applied to those variations, with resource provided to address our highest-scoring and extreme risks.

There are no Health Inspectorate Wales (HIW) reports containing Estates-related actions currently outstanding. All have been completed. The estate also affects vulnerable patient groups and can affect dignity concerns. To ensure this remains in sight, we are communicating with other CCG leaders to target the highest concerns and ensure that critical focus is maintained on patient safety.

Person Centred

Broadly, feedback to the Estates IGG highlights examples of compassionate care and positive staff engagement. However, patient stories, feedback and reviews of our approach require greater focus, including a detailed review of the systems needed to evidence this in future.

Our clear intention is as follows:

- CIVICA feedback analysis.
- Ward/environment feedback themes.
- Patient stories relating to estates facilities.
- Accessibility and wayfinding feedback.

This will be considered at the next Estates IGG and reported on here in future reports with actions and timelines.

<u>Complaints</u>

The IGG has reviewed its complaints and, as shown within the tables below, can confirm that all complaints have now been closed since July 2025, with no outstanding complaints within Estates. All complaints, numbering 45 prior to this date, have been resolved through cross-directorate responses. This represents noteworthy progress in the way we handle complaints.

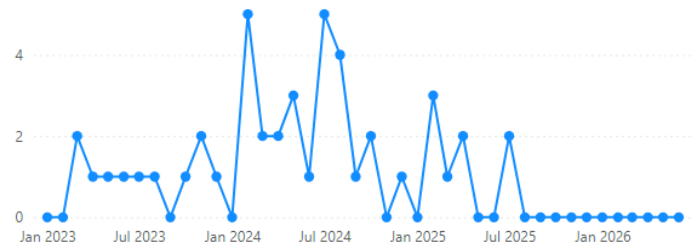


Table 1 Our Performance Dashboard – Closed complaints
Data as of 14/07/26, 15:39

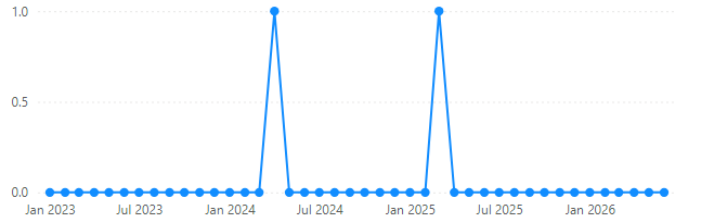


Table 2 Our Performance Dashboard – Overdue complaints
Data as of 14/07/26, 15:39

Argymhelliad / Recommendation

The Quality, Safety and Experience Committee is asked to receive assurance on the quality governance arrangements in place within the Estates Service Group in relation to quality, safety and patient experience.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	2.1 Scrutinise, assess, and seek assurance in relation to the patient impact, quality and health outcomes of the services provided by the Board.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	As contained within report
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply

Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Power Bi Information as of July 2026 Risk Partner HDdUHB Legal Partner HDdUHB Performance Partner HDdUHB Estates Integrated Governance Group, formerly Estates & Facilities Integrated Governance Group
Rhestr Termau: Glossary of Terms:	As contained within report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	Power Bi Information as of July 2026 Risk Partner HDdUHB Legal Partner HDdUHB Performance Partner HDdUHB Estates Integrated Governance Group, formerly Estates & Facilities Integrated Governance Group

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not applicable
Ansawdd / Gofal Claf: Quality / Patient Care:	As contained within report
Gweithlu: Workforce:	Not applicable
Risg: Risk:	As contained within report
Cyfreithiol: Legal:	As contained within report
Enw Da: Reputational:	As contained within report
Gyfrinachedd: Privacy:	Not applicable
Cydraddoldeb: Equality:	Not applicable

5

60 Mins

5 - Assurance

5.1

5.1 - Quality Assurance Report

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

For assurance

Attachments

3.1 QS Assurance Report Aug 2026 v0.1 CB additions.pptx

Appendix Assurance Report Action plans extracted July 2026 (002).pdf



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

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

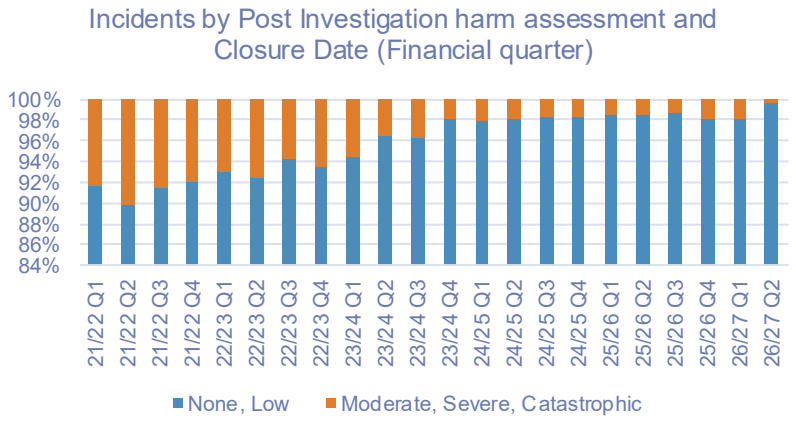
Common QMS logic

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

Patient Safety Incidents

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

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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.

7 Minute Patient Safety Briefing

Patient Safety Incidents closed during Q1 2026

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?

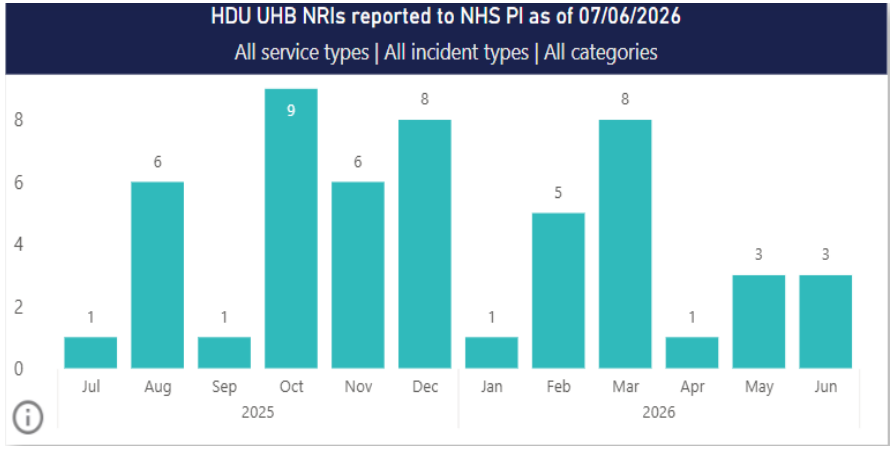
7 Reflect and share learning

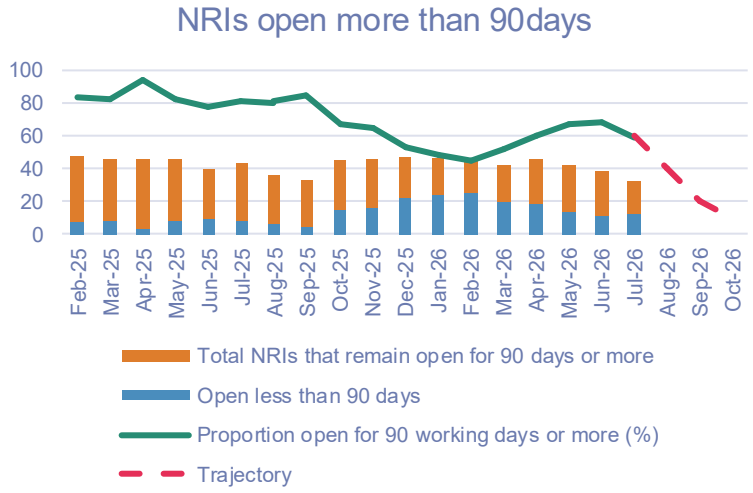
Consider: What adverse event have I witnessed? Did I report it via Datix Cymru to ensure that the learning is considered and captured? What could I do differently next time, and have I shared that learning with my team?

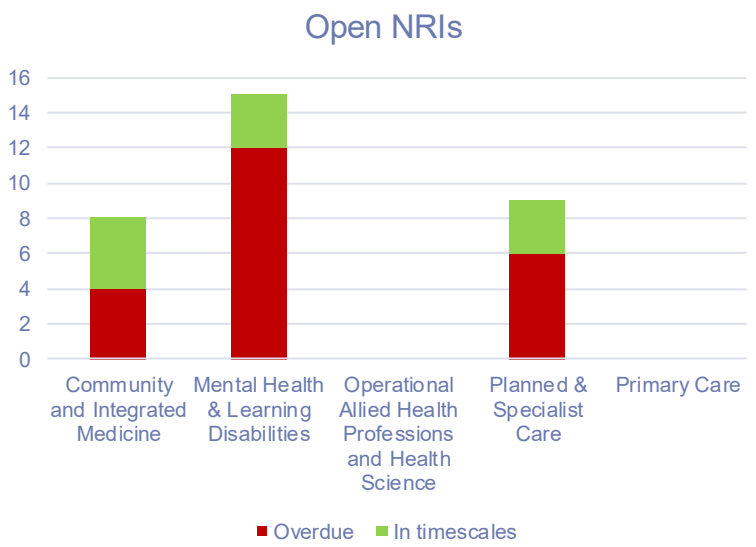
Learning from near misses and incidents is important.
Please report any adverse event via Datix Cymru

Nationally Reportable Incidents (NRIs)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

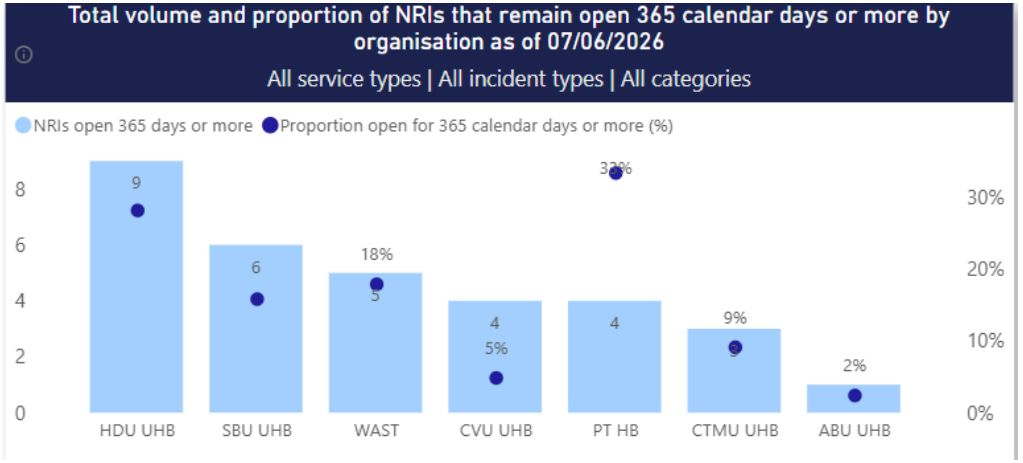






Source: Beacon Dashboard
12/07/2026

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

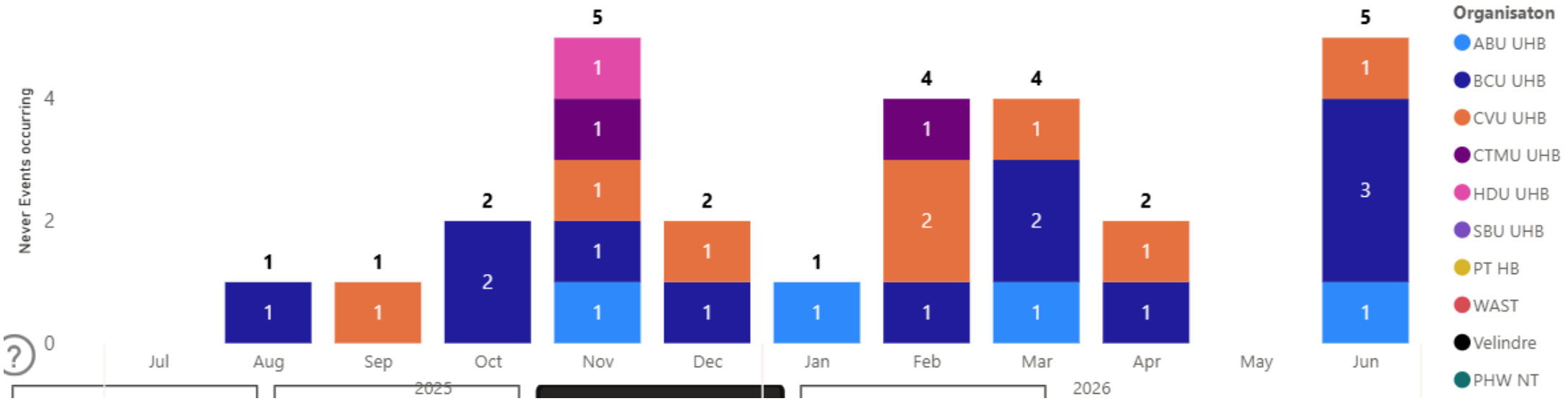
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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 ts can map to more than one theme.

Inquests and Regulation 28

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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**

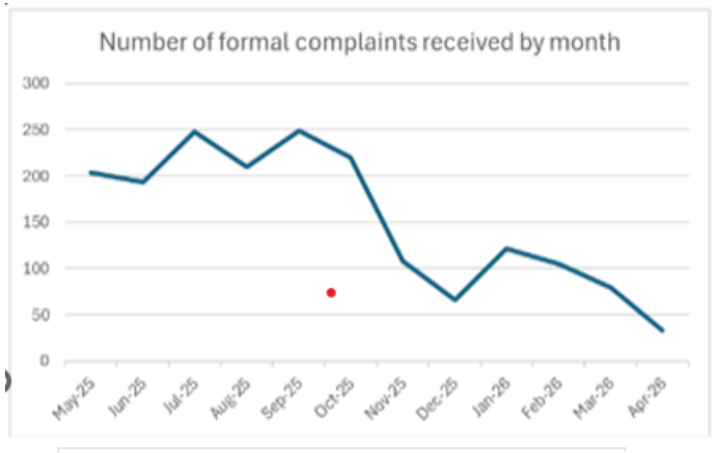
Report Key

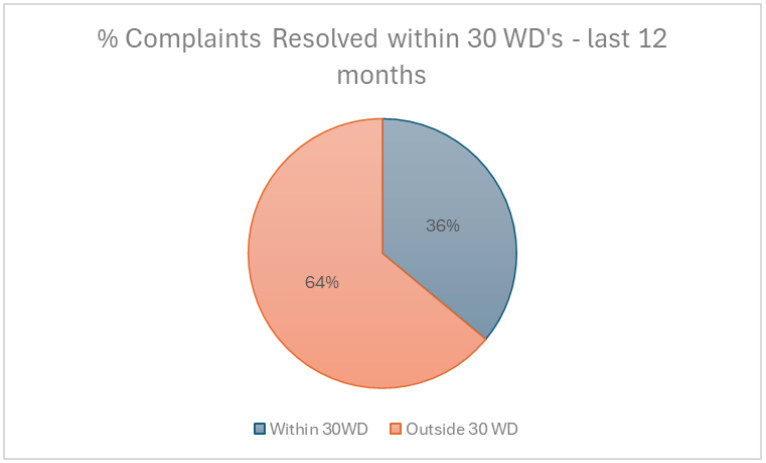
Report sent to single health board/trust:

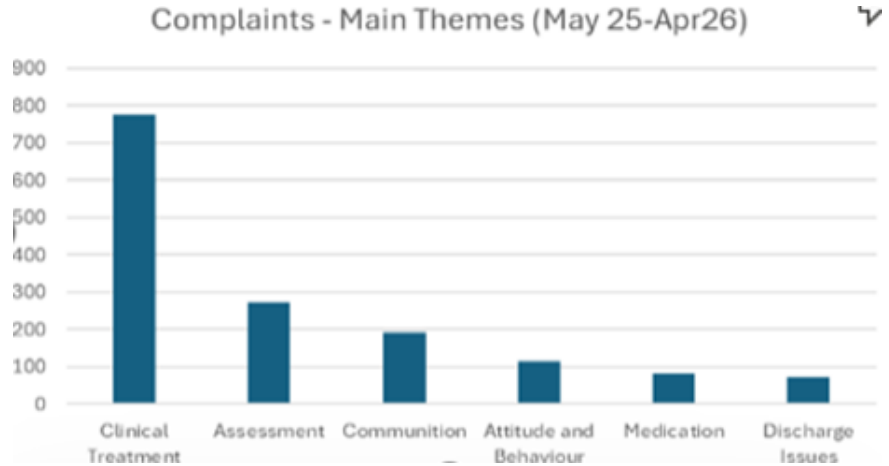
Report sent to multiple health boards/trusts:

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

Health Board Overview: Complaints Management







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

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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.

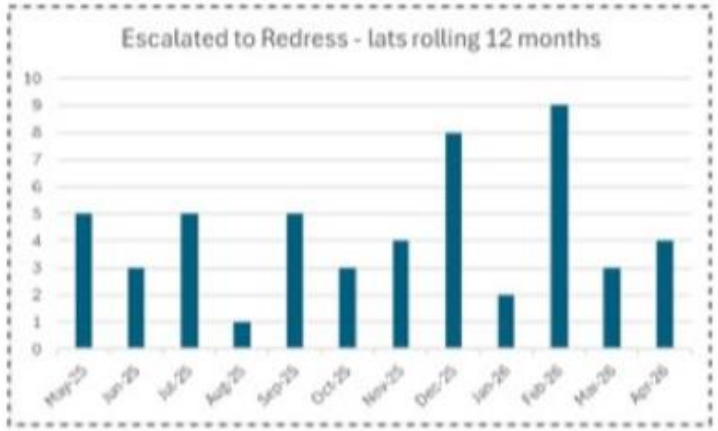
Reducing backlog of Putting Things Right (PTR) complaints

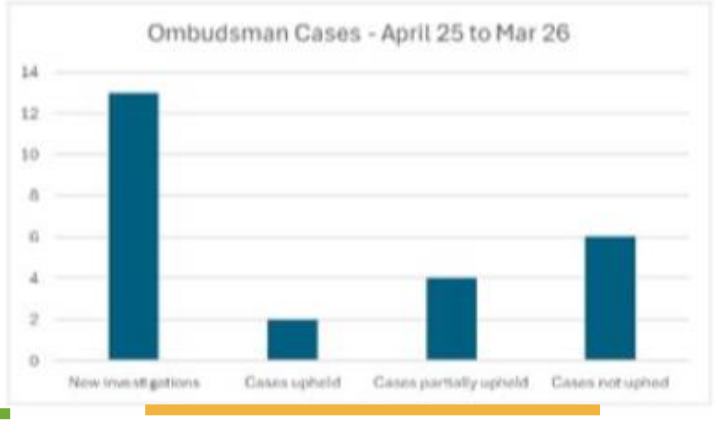
The closure of the remaining low-level PTR complaints has been successful and close to trajectory with only 8 complaints left to close. For more complex complaints, we are currently running a few weeks behind schedule, although it is likely that by the time we reach the end of June target marker (144 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.

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.





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

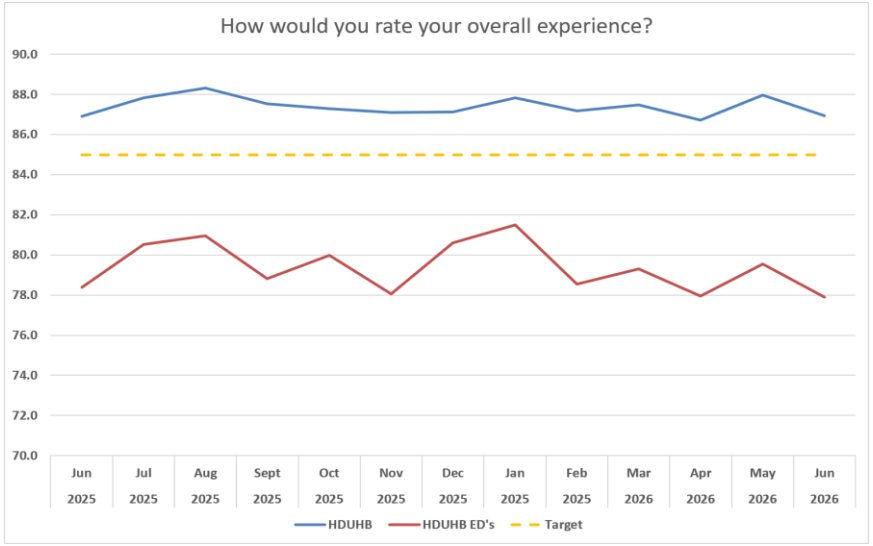
Early resolution improving; clinical, waiting-time and communication themes still drive concerns.

4 Action

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

People's Experience Feedback

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board



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

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

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

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

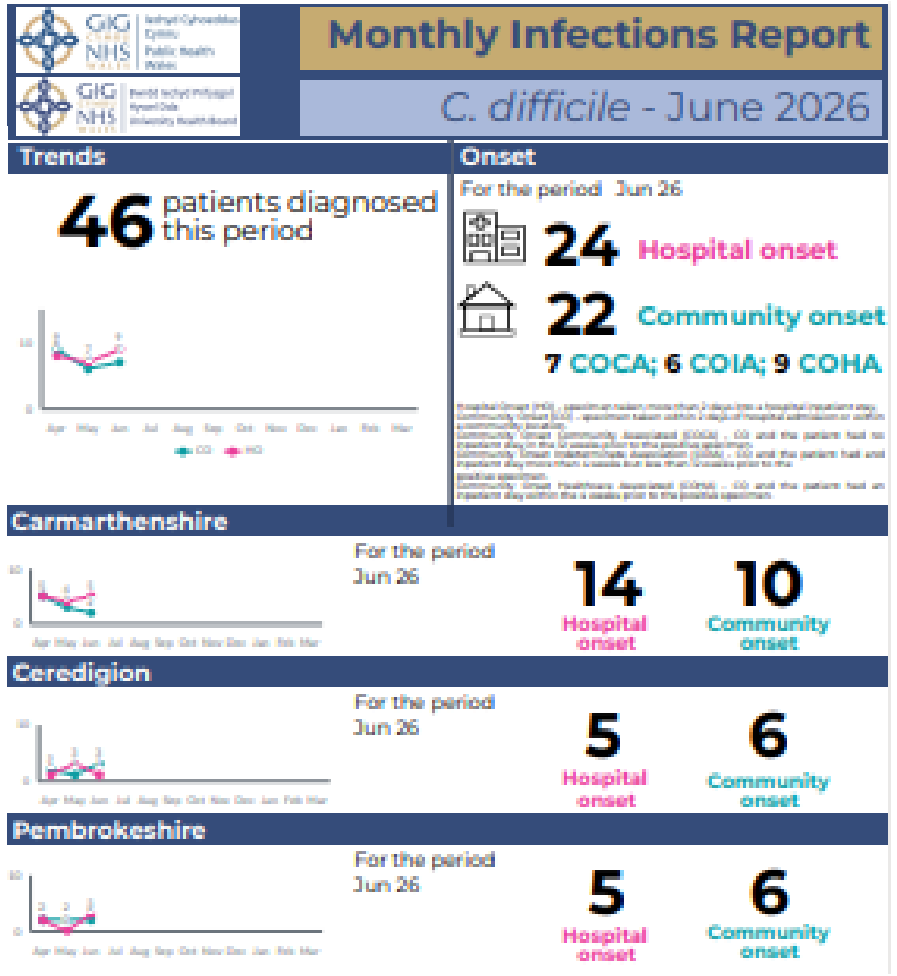
Improvement Goal: To reduce the overall burden of C. diff infection by at least 25% against the 2024-25 counts

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

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.



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

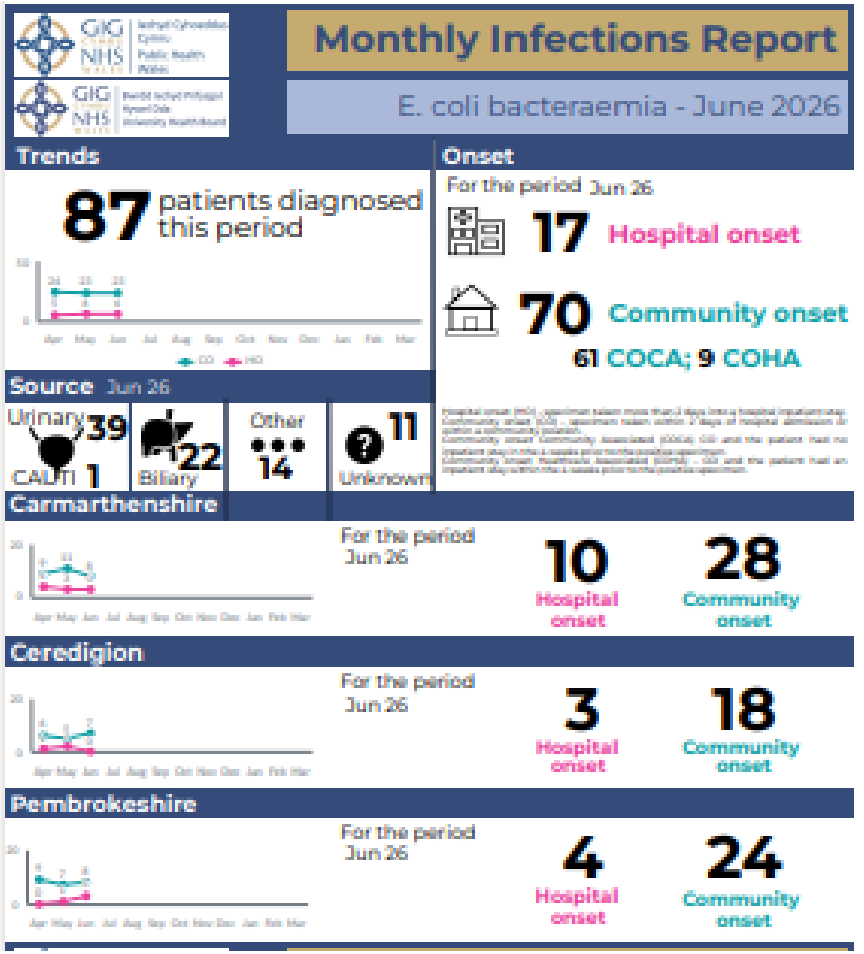
Infections primarily community-onset, linked to urinary tract and some catheter-related infections.

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

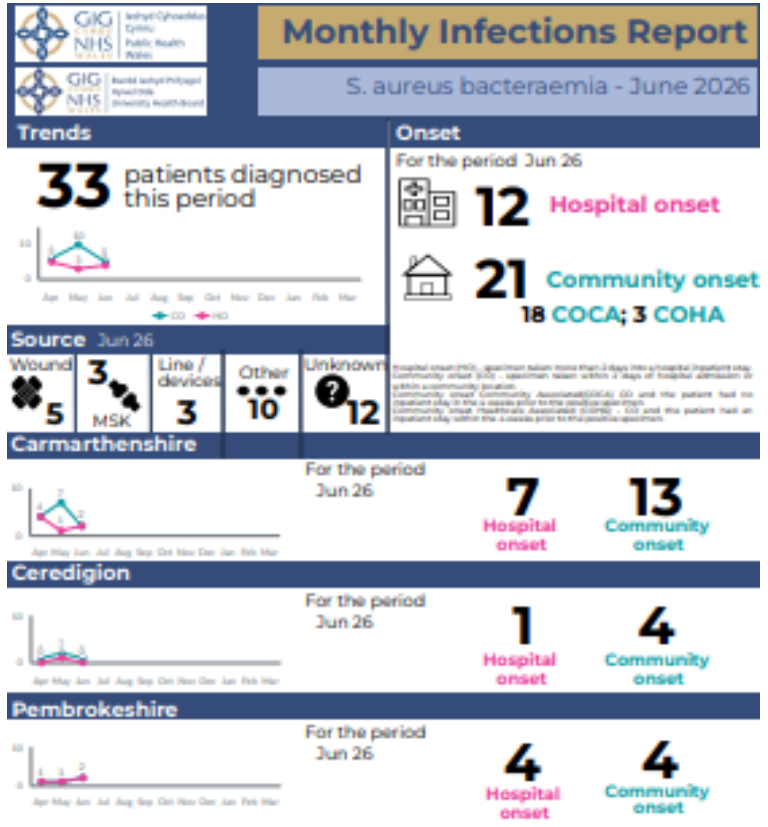
	Total count	CO* count	HO** count	% HO***	Total rate per 1,000 hospital admissions	Total rate per 100,000 population
2026/27	31	19	12	39%	2.20	31.95
April 2026	11	6	5	45%	2.15	34.39
May 2026	11	8	3	27%	2.15	33.28
June 2026	9	5	4	44%	2.35	28.14

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.

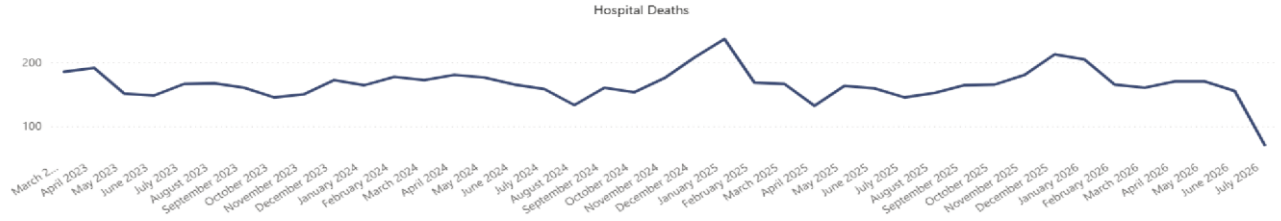
Illustrative QMS structure for the IP&C section

Mortality Overview:

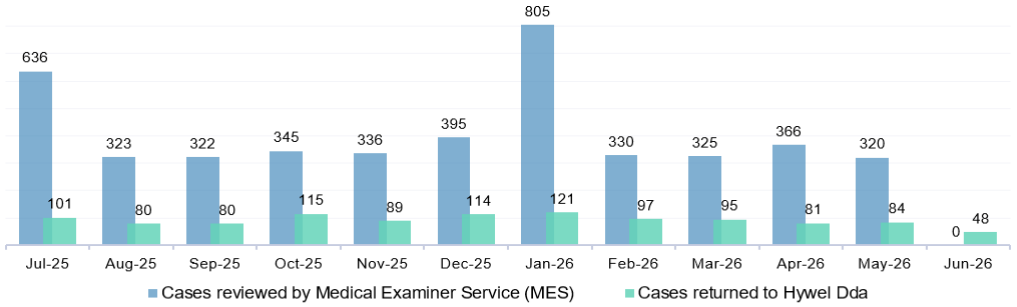
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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.

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 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.

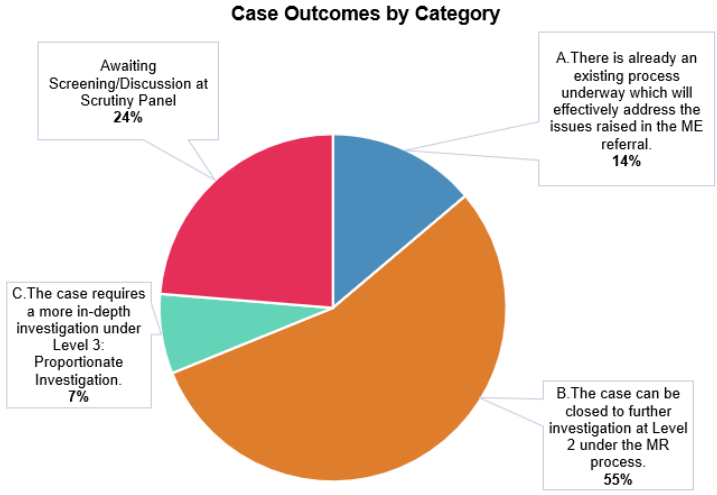


Note: *June cases are still being received, and the Medical Examiner review report has not yet been received. June review figures are therefore provisional and subject to change.*

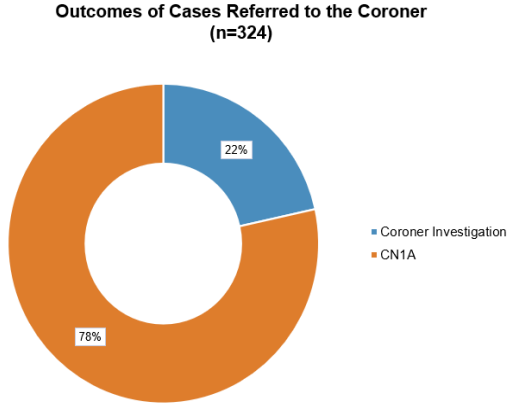
Those cases referred to the Health Board for further review are categorised into categories:

- ***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*

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:

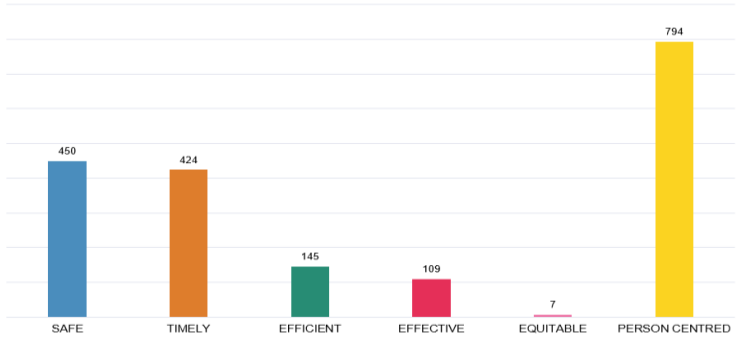


Note: *Outcome data are taken directly from the Medical Examiner Service (MES) letter and reflect the information available at the time of case upload.*

Mortality themes and performance:

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

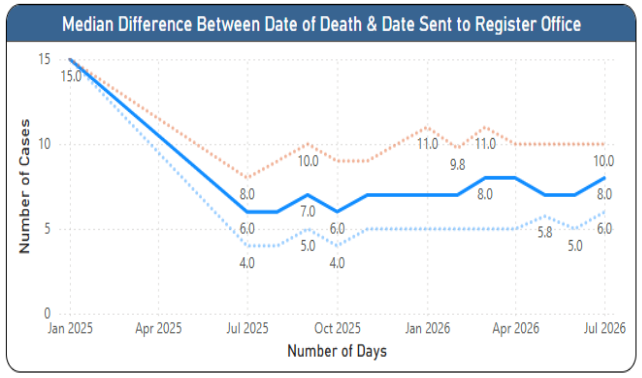
STEEEP themes identified through the Medical Examiner Review are demonstrated in the graph below:

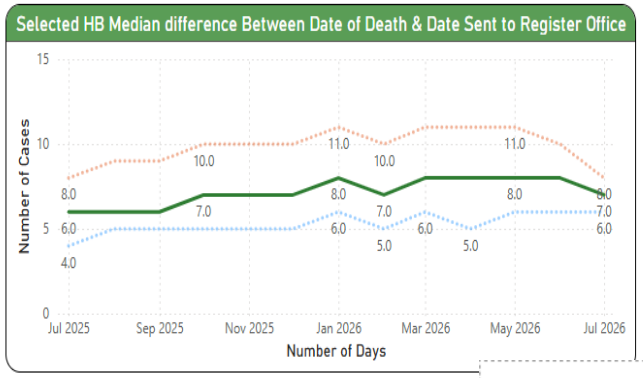


***Note:** Themes are selected by the MES and multiple themes may be assigned to a single case. As theme selection is based on professional judgement, the findings should be considered subjective.*

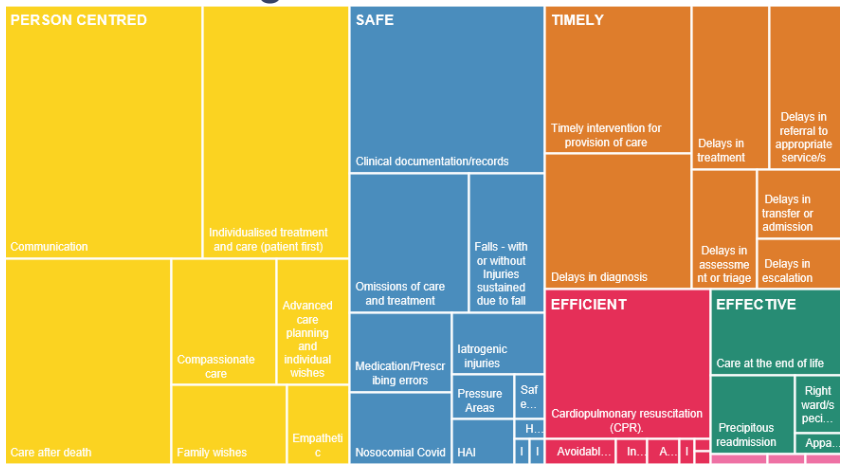
We are in the process of analysing the STEEEP themes that are being identified through the proportionate investigations being undertaken, this will be used to compare themes against the Medical Examiner STEEEP data.

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.



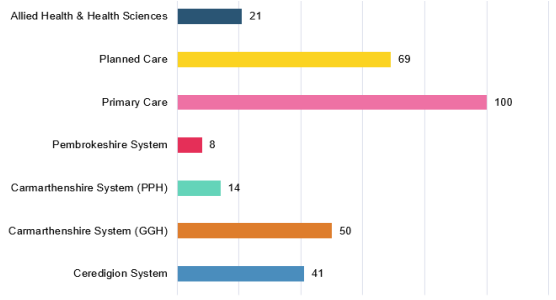


Distribution of learning themes across STEEEP themes:



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:



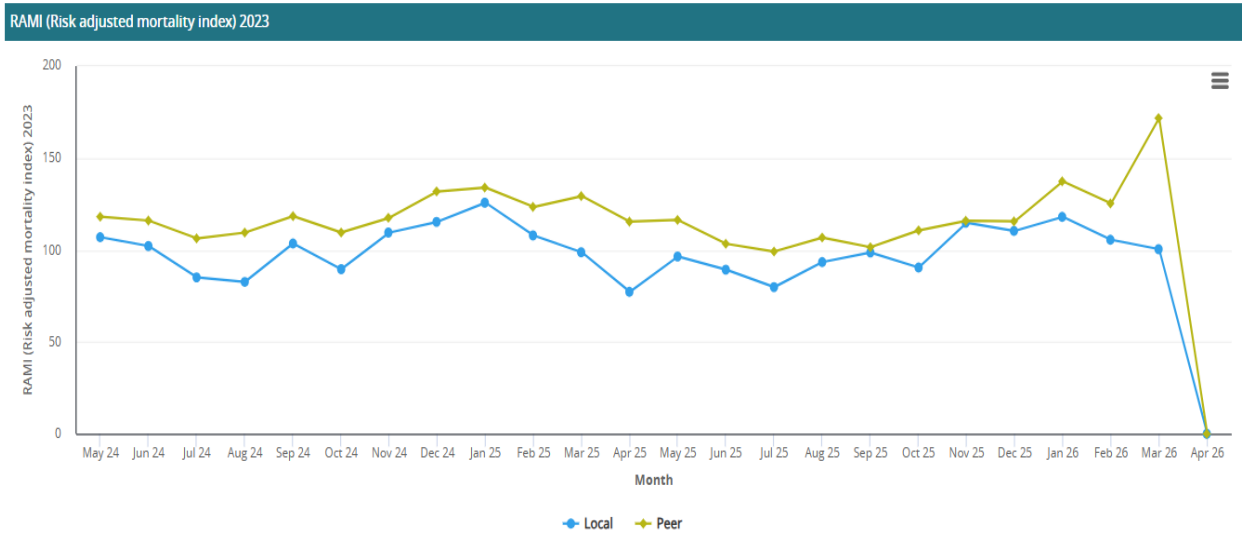
***Note:** The figures shown relate to open proportionate investigations associated with cases received between July 2025 and June 2026. Investigations that have since been completed and returned are not represented within these numbers.*

Mortality: Deep dive into RAMI data

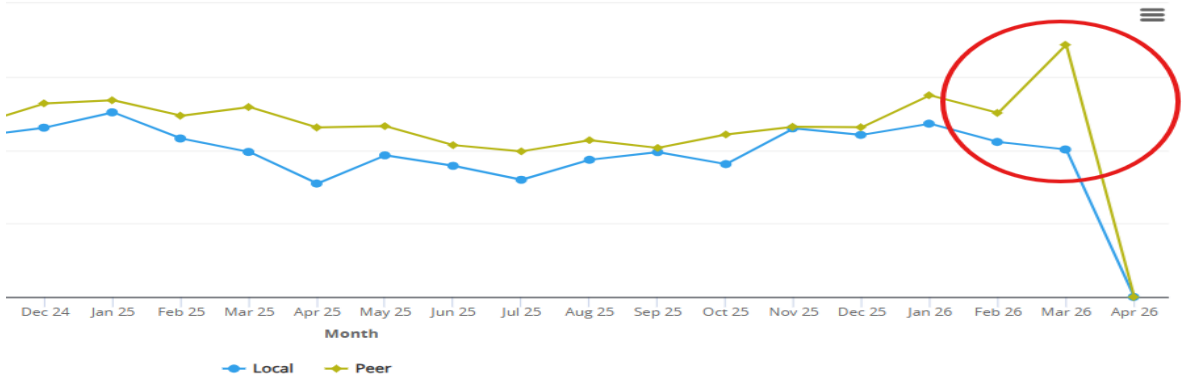
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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.

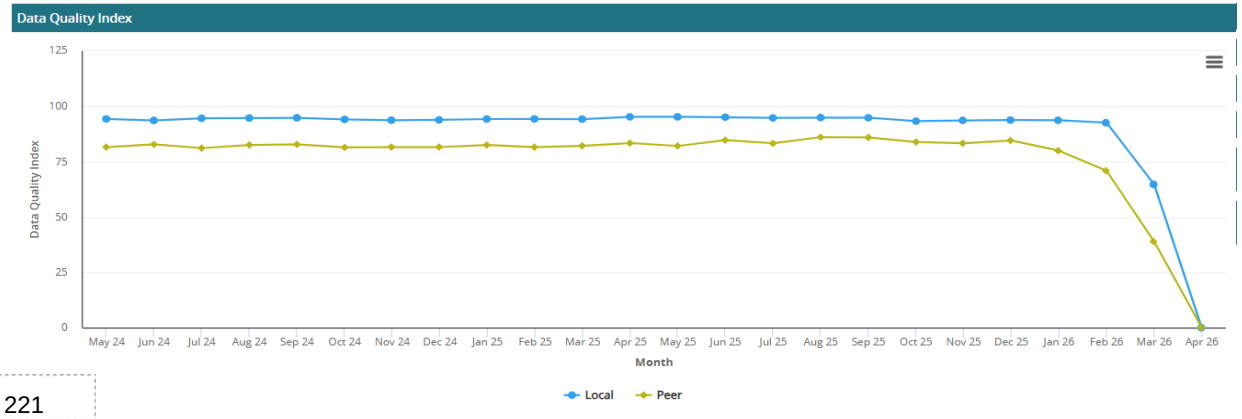
A deep dive was conducted on Risk Adjusted Mortality Index (RAMI) data 2025 – 2026 to understand the accuracy of an apparent rise in RAMI reported in February 2026 (132). The rise in February has now been corrected with the update of submitted coding data to CHKS . The latest CHKS adjacent graph demonstrates 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

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

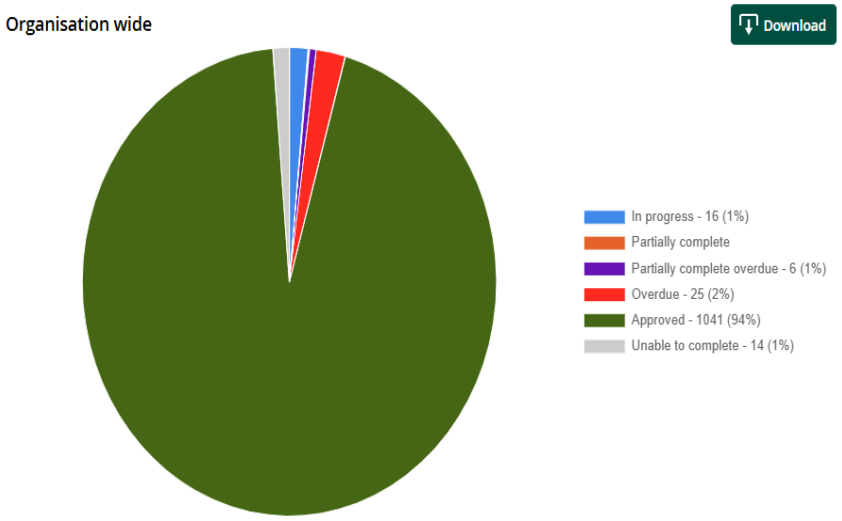
Date of letter	HIW ref	Matter
14/04/2026	16659	• O2 provision / care community • Monitoring of O2 provision • Unsafe O2 management
25/02/2026	16228	• GGH Palliative • Added a bed to a 2 bedroom • Felt lack of care & self discharge
27/01/2026	15863	PPH ward 4 • Personal care for a patient during a 6 day 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.

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

4 Action

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

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.

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



GIG CYMRU NHS WALES
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

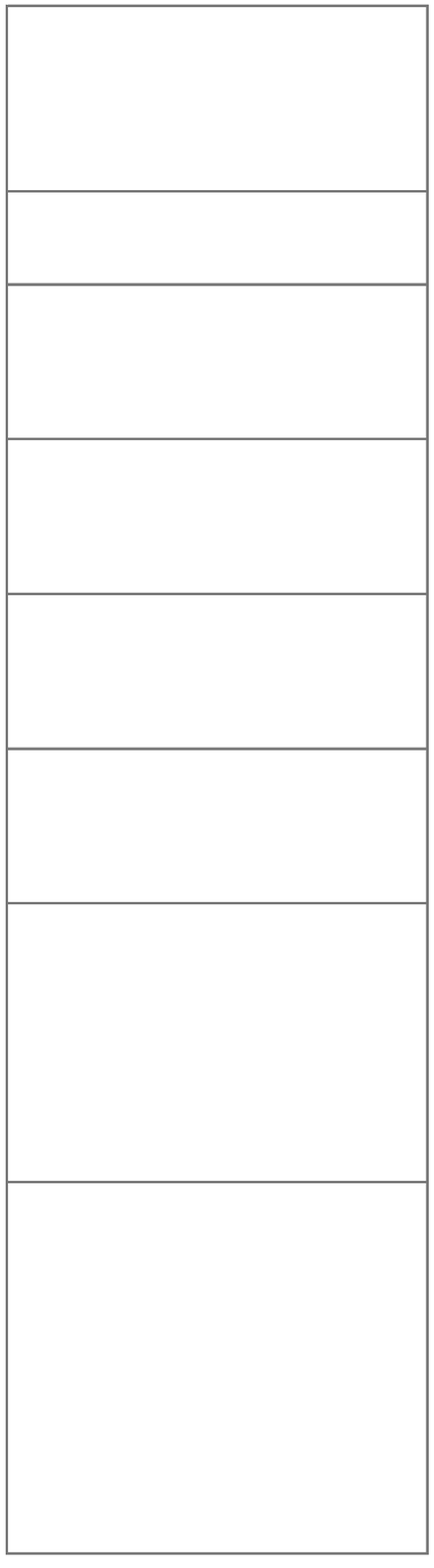
Nuclear Medicine IRMER WGH 03909	The employer must ensure that the replacement of the gamma camera is completed, and contingency plans are put in place as a matter of priority to reduce the risk of this identified current single point of failure.	Exploration of an SLA arrangement with a neighbouring 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)

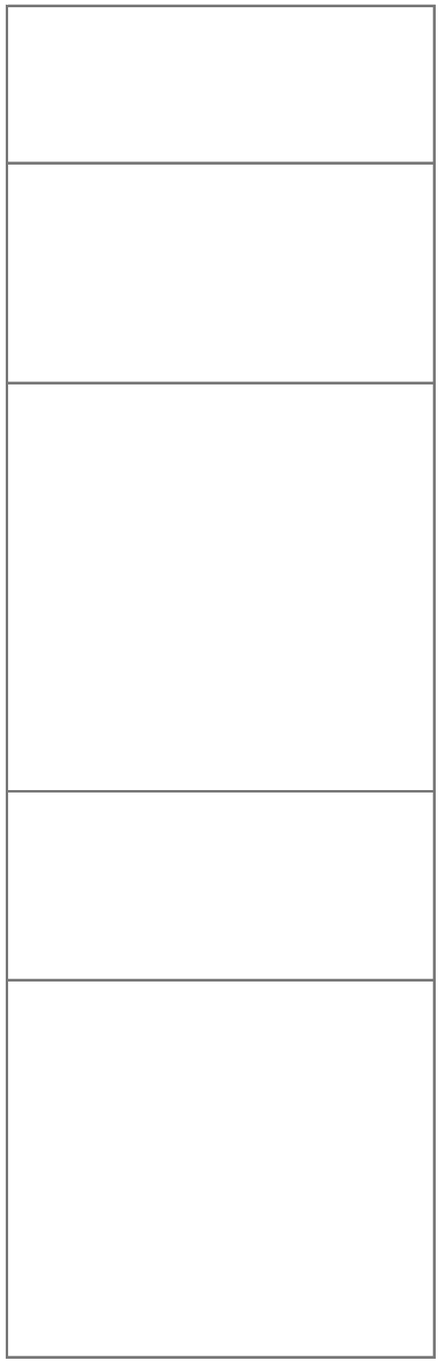
Nuclear Medicine IRMER WGH 03909	The employer must ensure that: •A document list of relevant IR(ME)R theoretical training is introduced and completed by staff •The relevant employer's procedure states the process for the review of training records and how the review of training records is recorded.	Preceptorship 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)

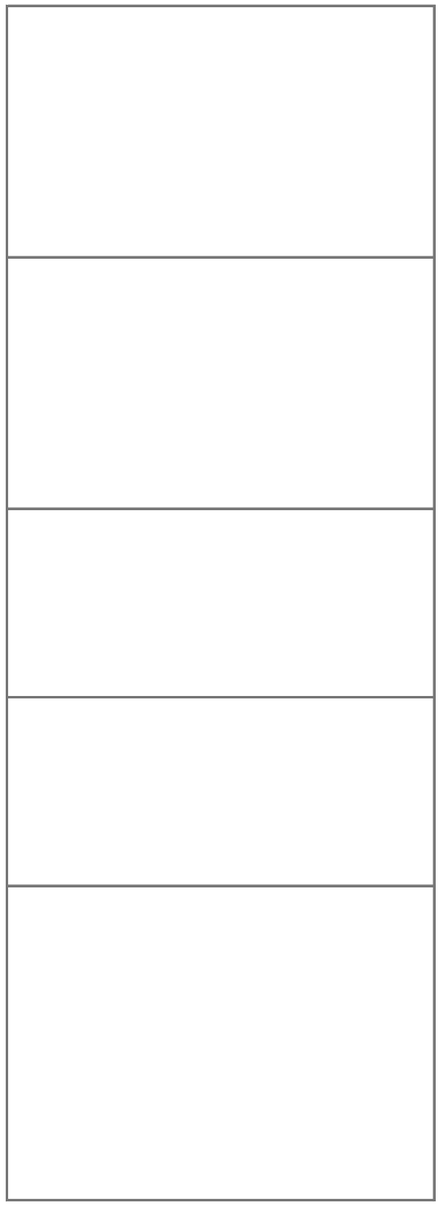
Comments/Updates
Service update 27/5/26- A Task and Finish Group met on 22 April 2026 to identify a set of standardised document tags to support both (1) the efficient identification of multiple documents for audit purposes and (2) improved search functionality for clinicians when locating specific records. 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





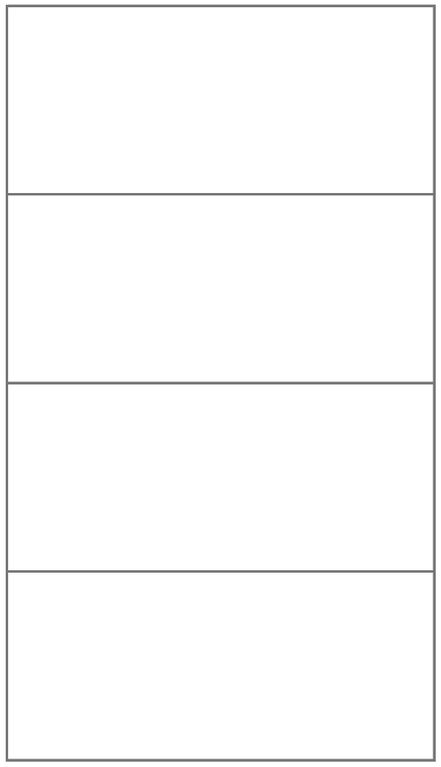


Multi disciplinary Discharge Review Task and Finish Group established. Training provided to the group by the Clinical Effectiveness Team on the process of benchmarking and use of the AMaT system to record, track and monitor benchmarking work. Initial scoping undertaken of NG 53. Due to the large scale 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.

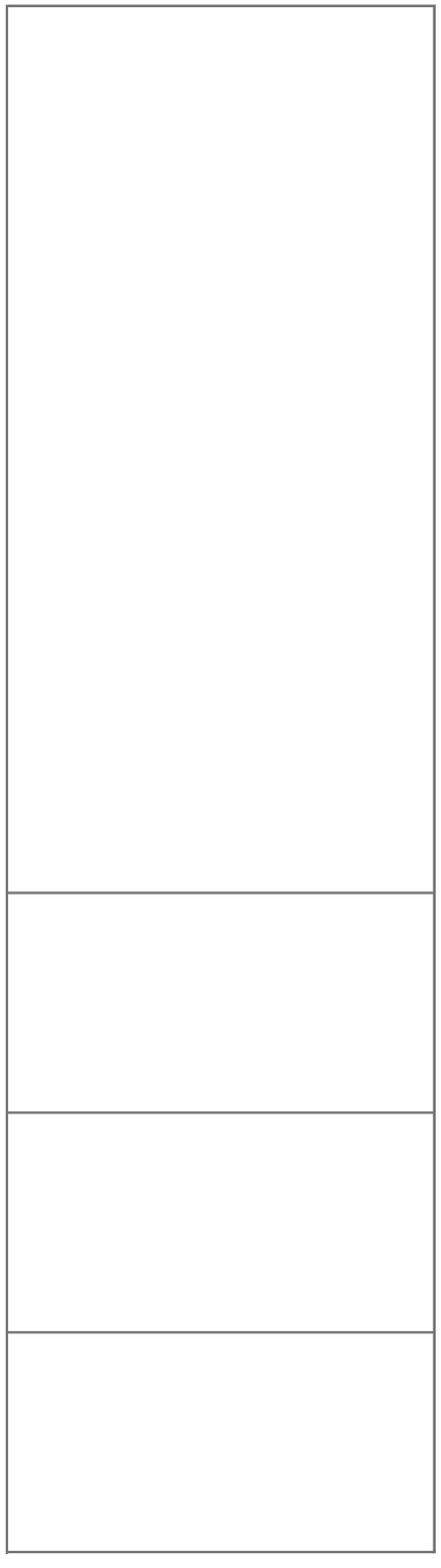
Update 23/05/24 Local Project Management Capacity remains impacted by long term absence. All Wales Patient

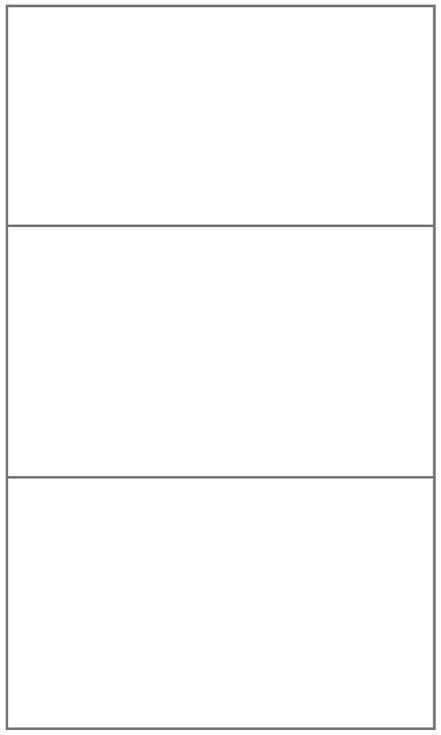
Update 10/10/23 Review of Health Board Policy #370 Discharge and Transfer of Care underway however detailed input from mental health services incumbent on local standards interpreted from NICE guidelines as per action MD7/1 therefore delayed. Revised timescale for completion 28/02/24. Update 09/05/24 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.

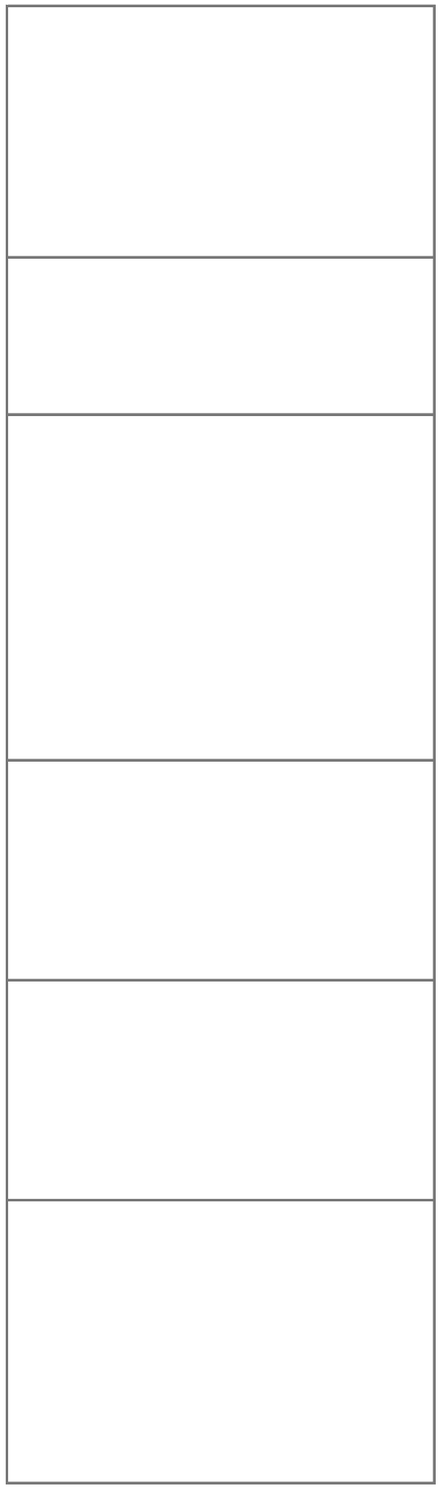


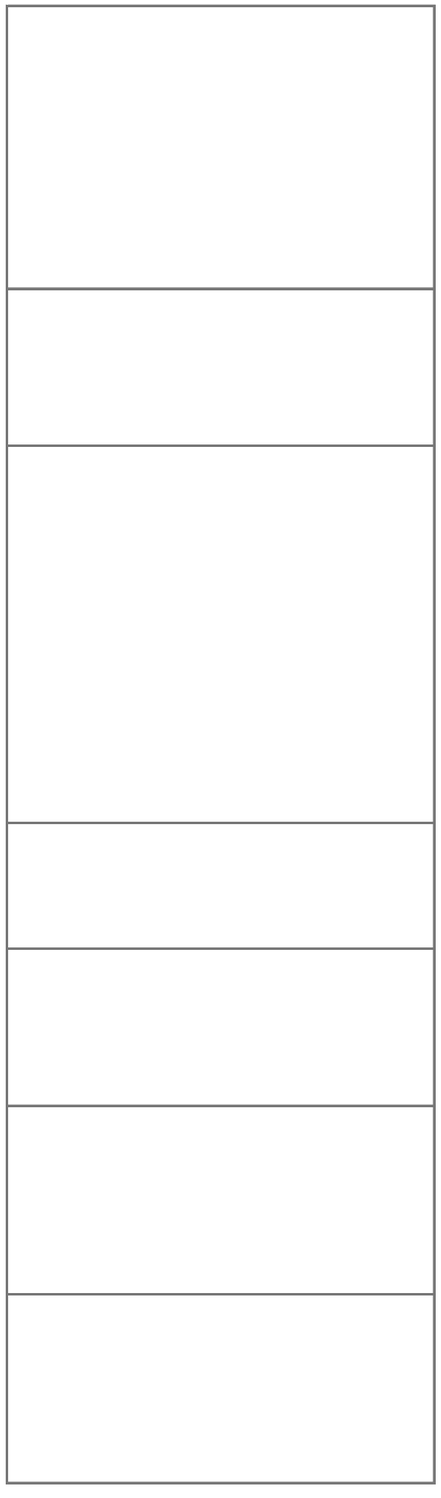
Update 22/11/23 Training Needs Analysis tool developed by Learning and Development Team to be piloted across MHLD services. Update 24/05/24 Update. Progress with action delayed due to directorate capacity to facilitate pilot of TNA tool. Directorate to re engage with Learning and Development to agree 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	

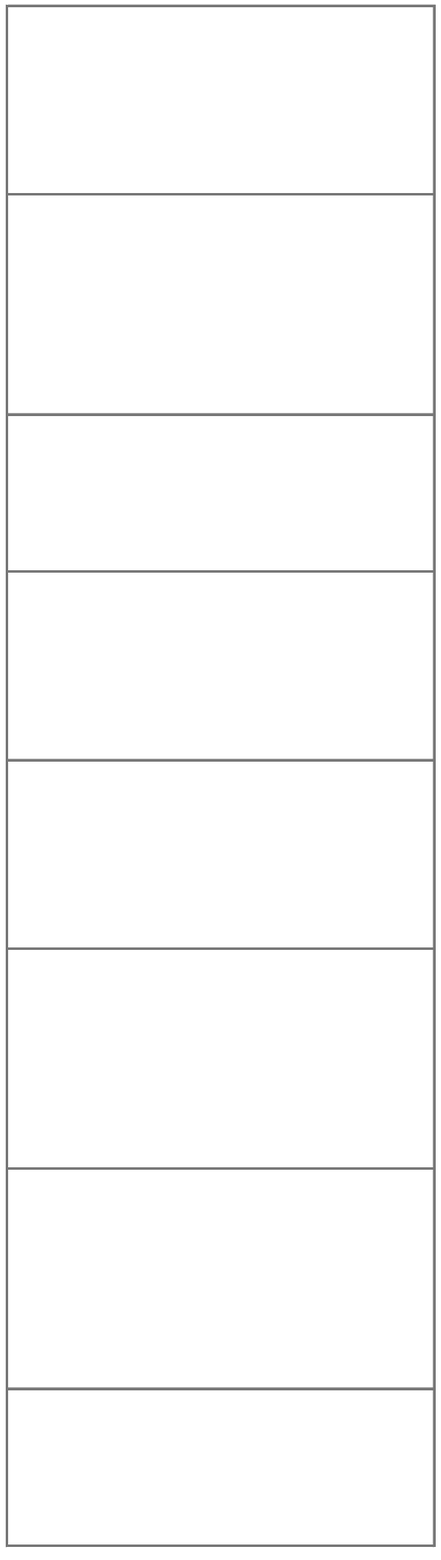


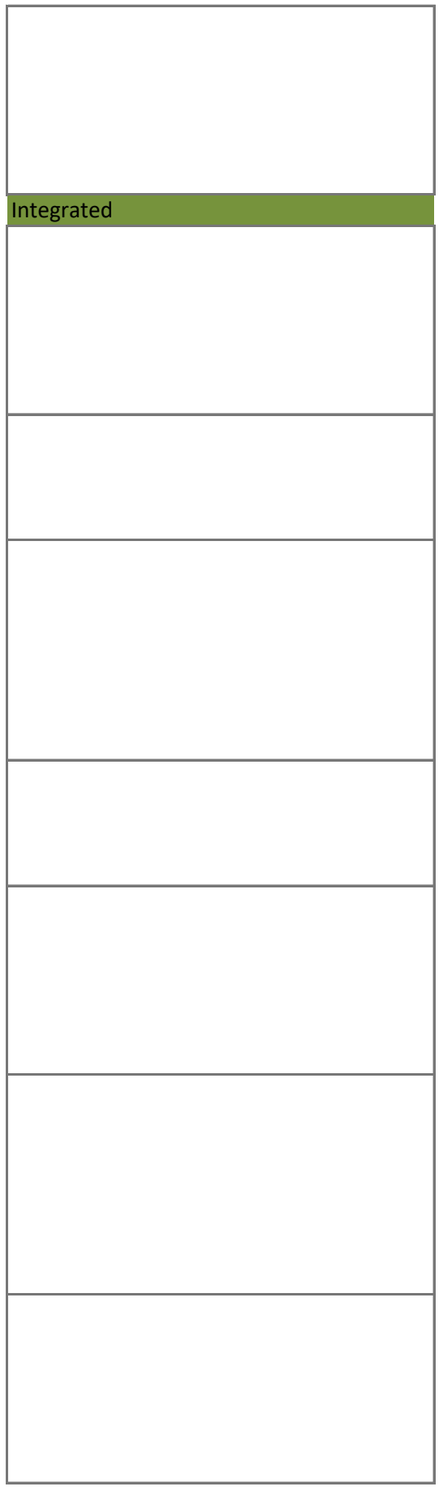


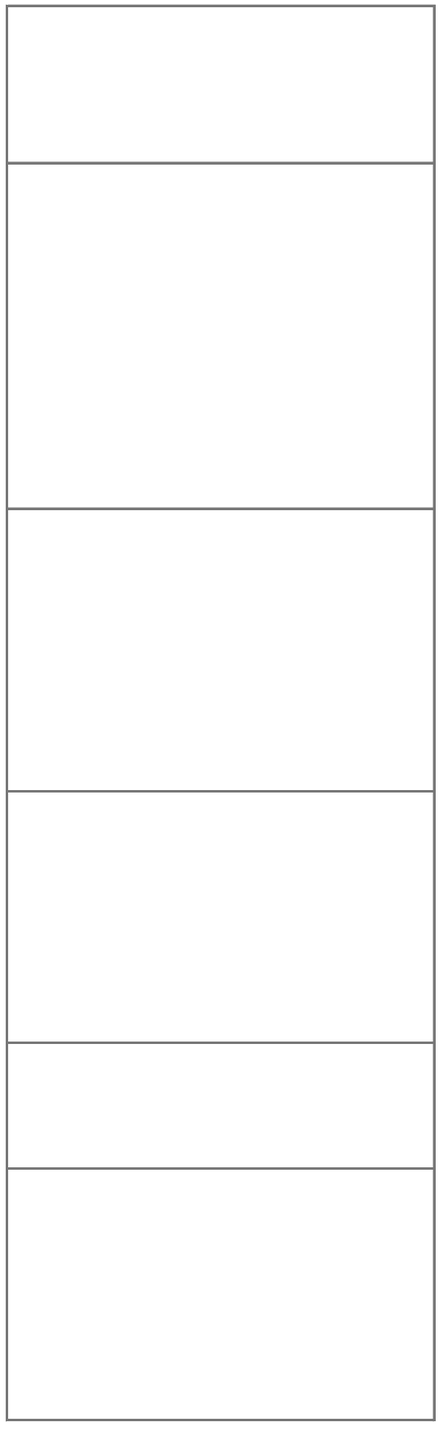
Update 10/10/23 Options to enable direct access to Datix for social workers who provide a service on behalf of the health board has been explored and the ability to provide access through the Patient Safety Team has been confirmed. Details of existing Social Workers are being gathered in order to establish 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

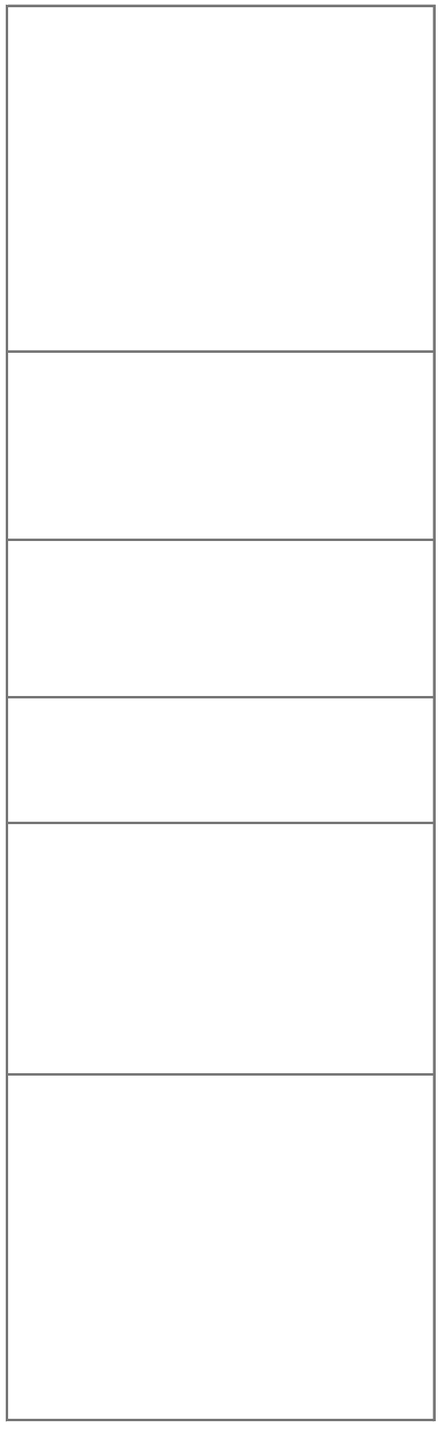


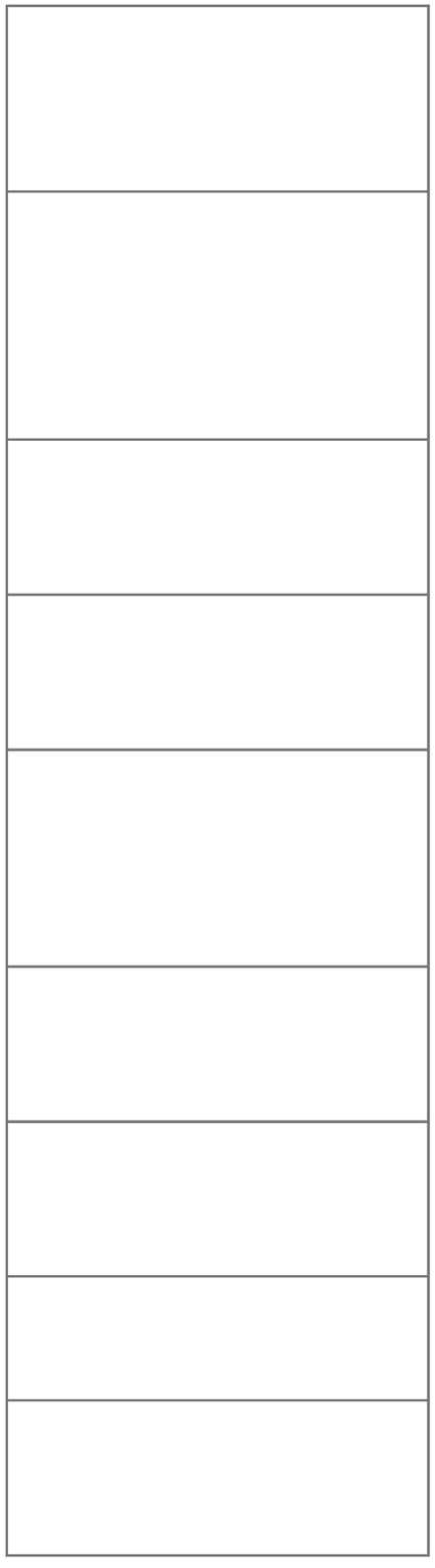


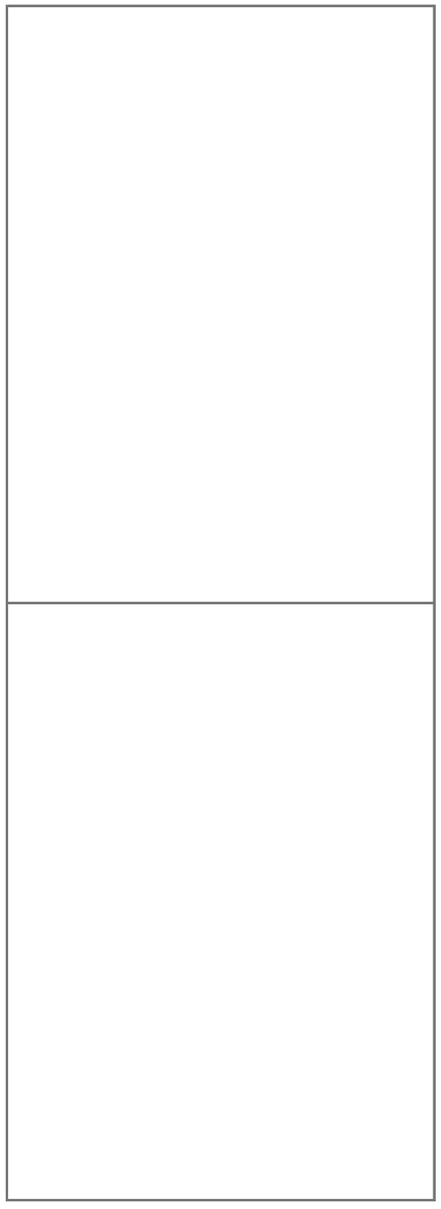


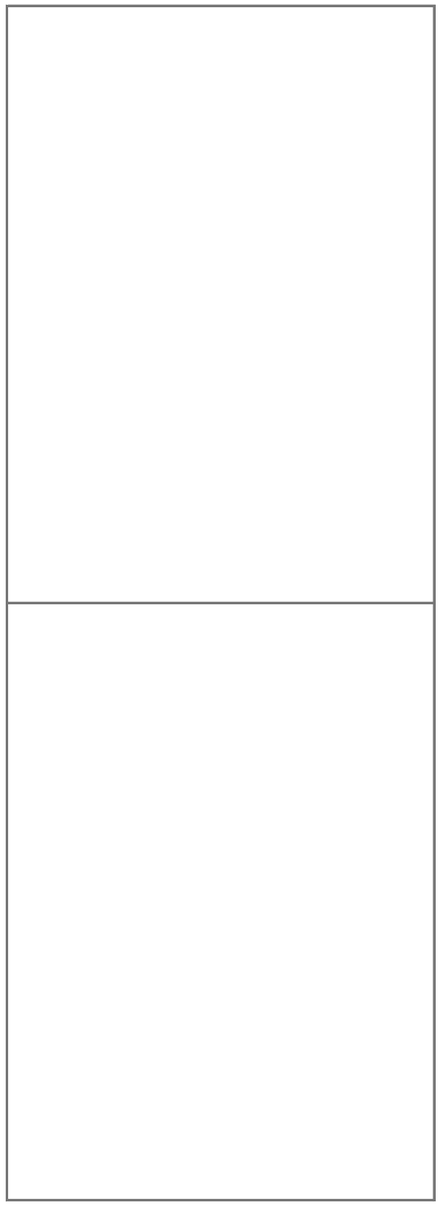

Integrated

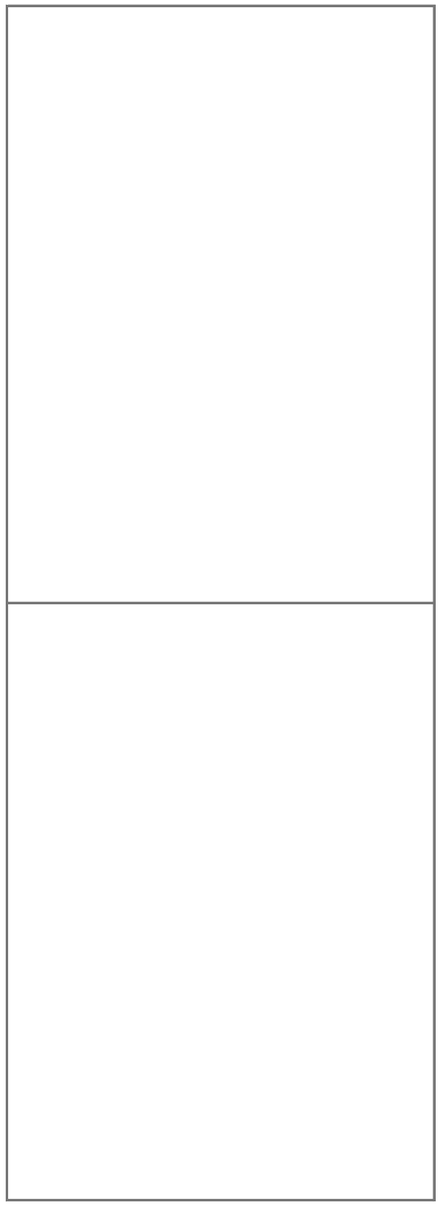


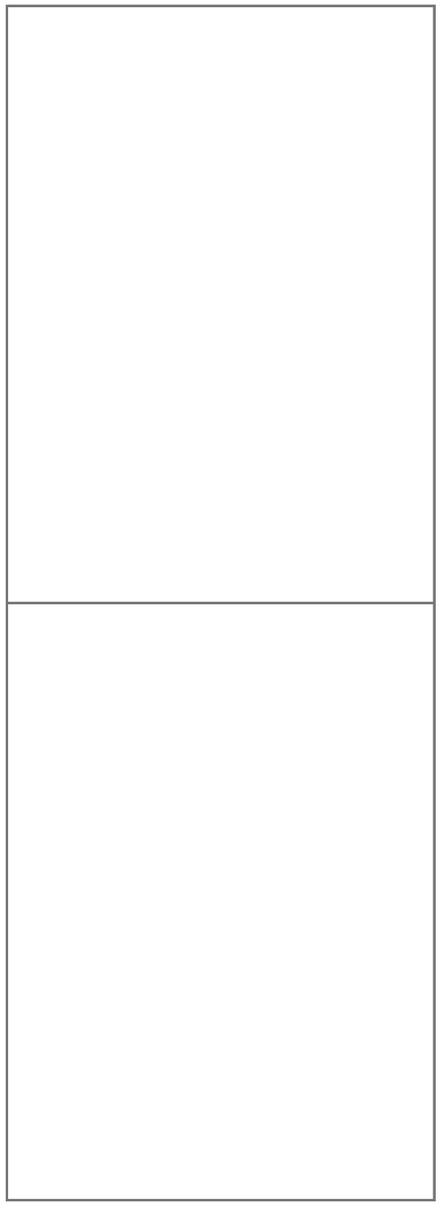


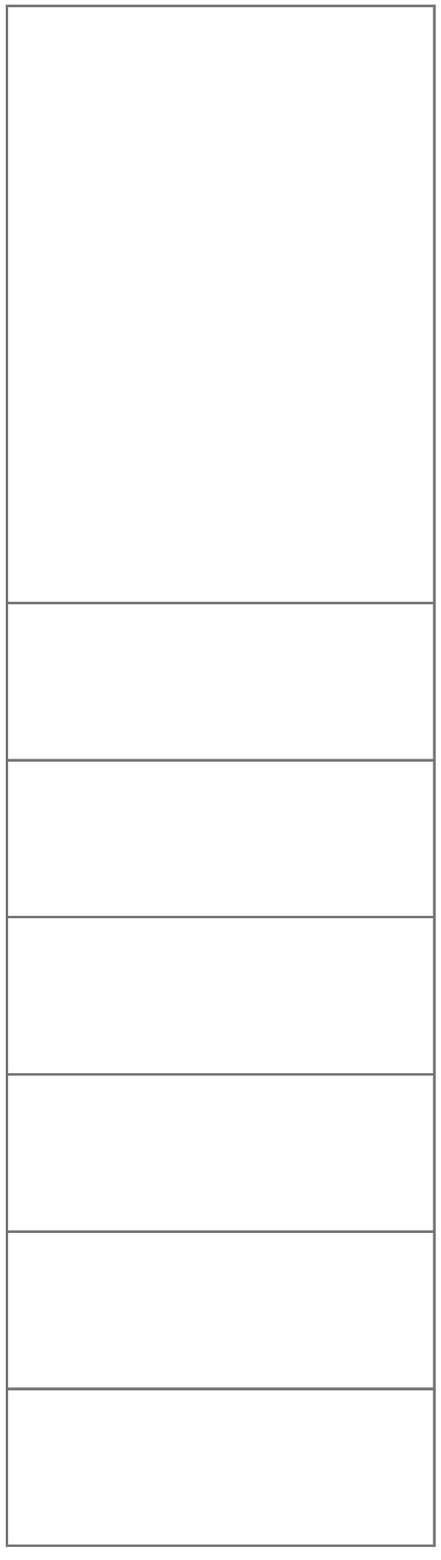


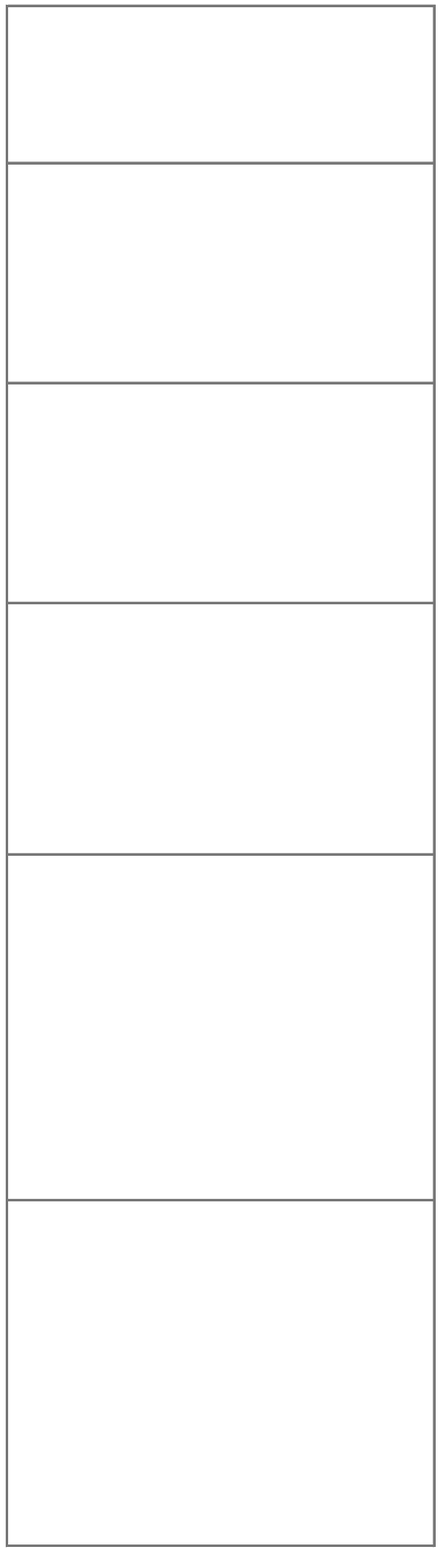


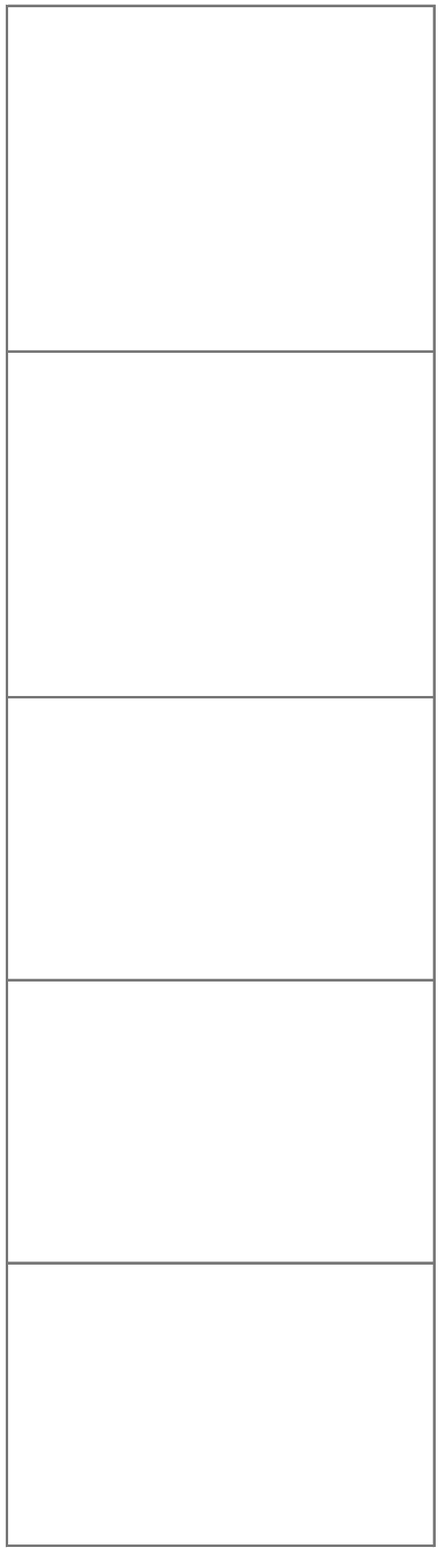


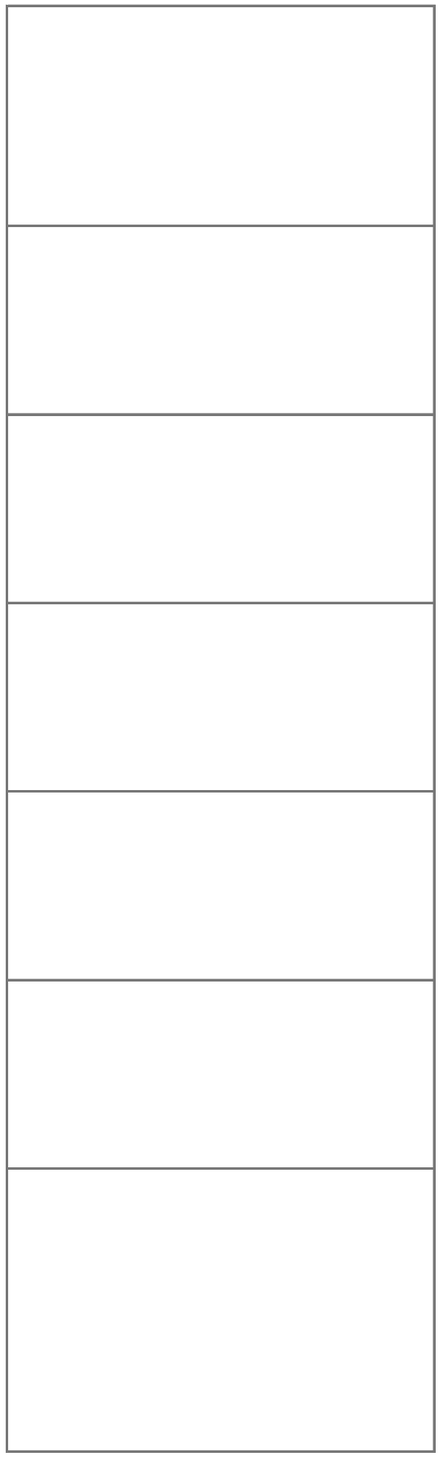




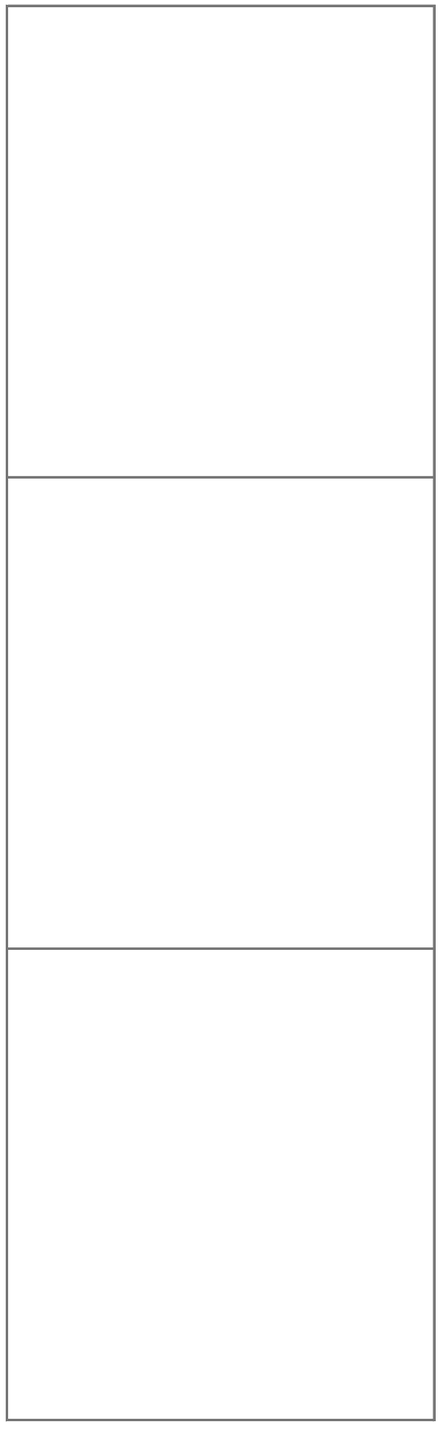


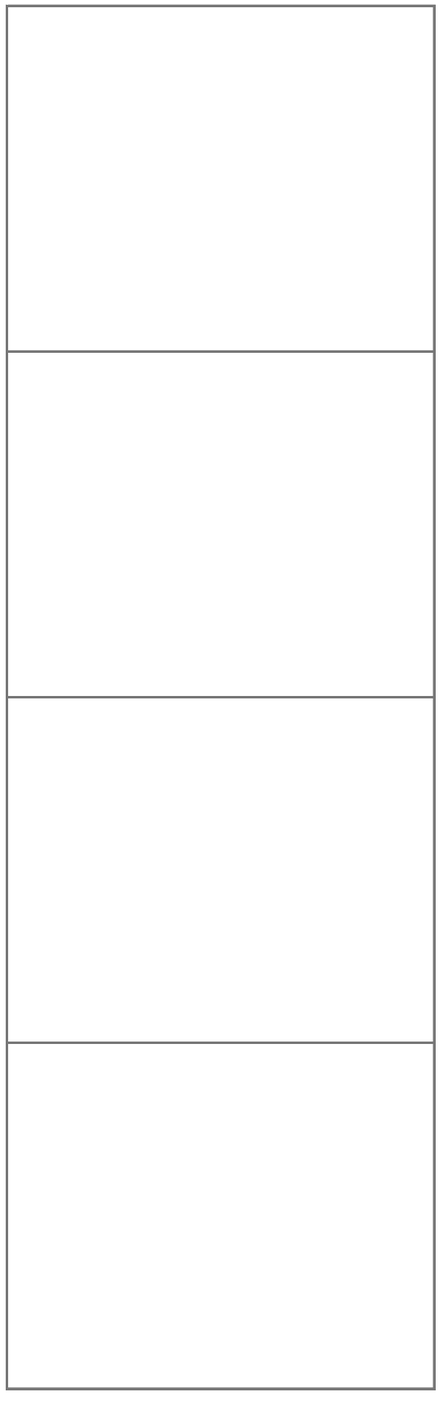


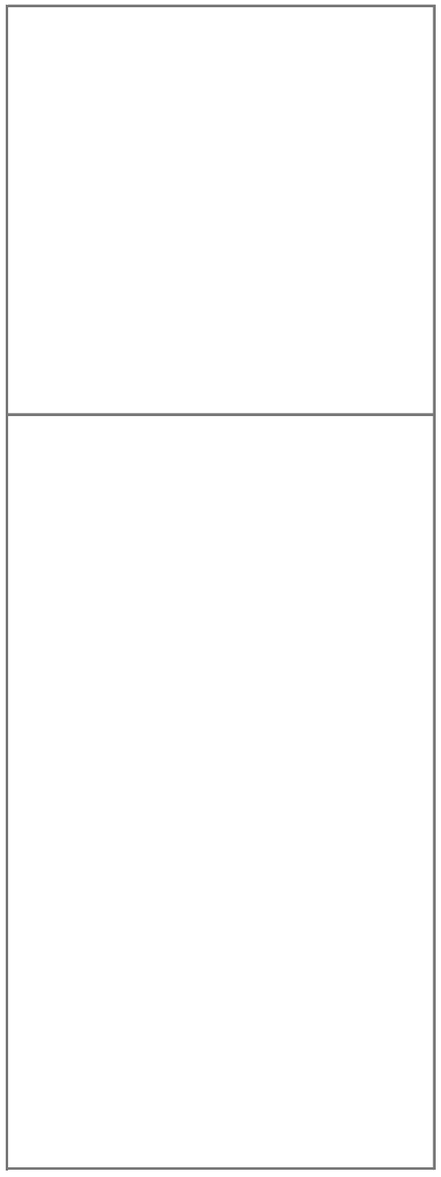


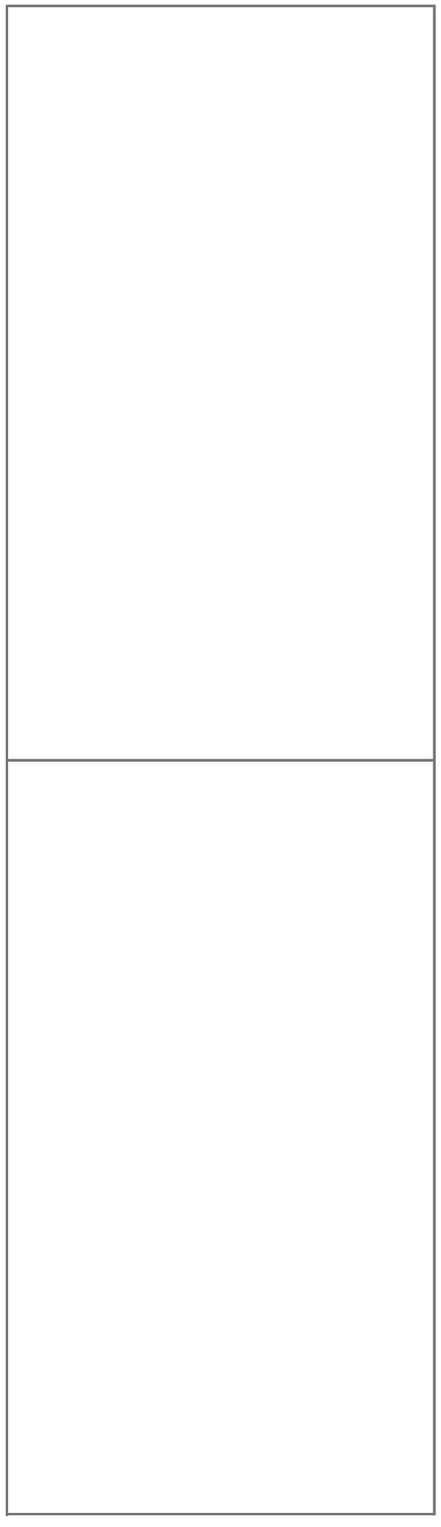


23/07/2026 - evidence uploaded of staff booked onto training sessions
23/07/2026 - email uploaded as evidence requesting Sensory Loss Training for the ward

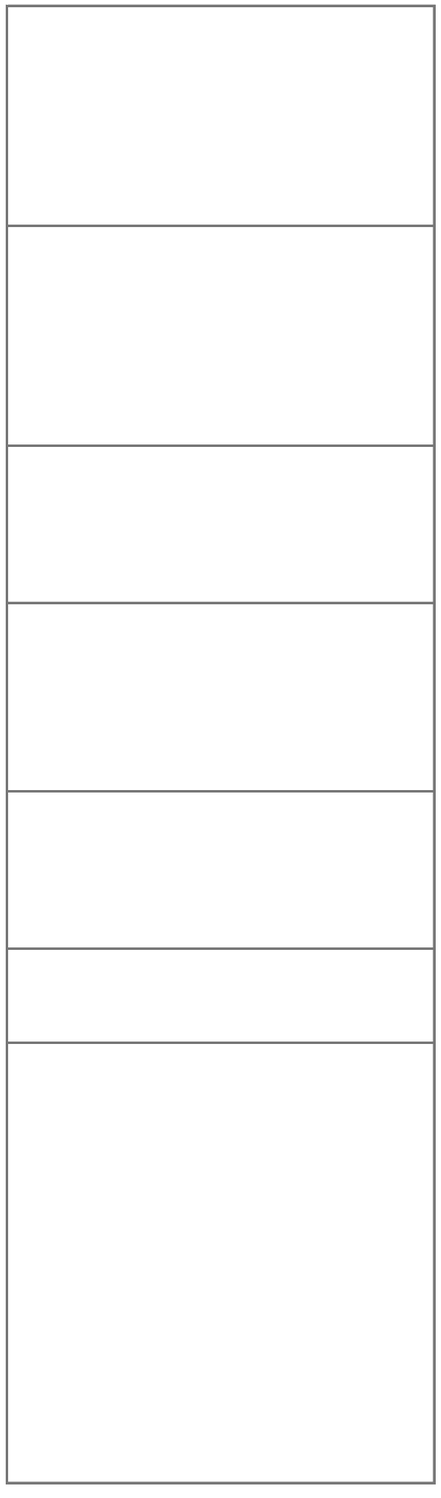


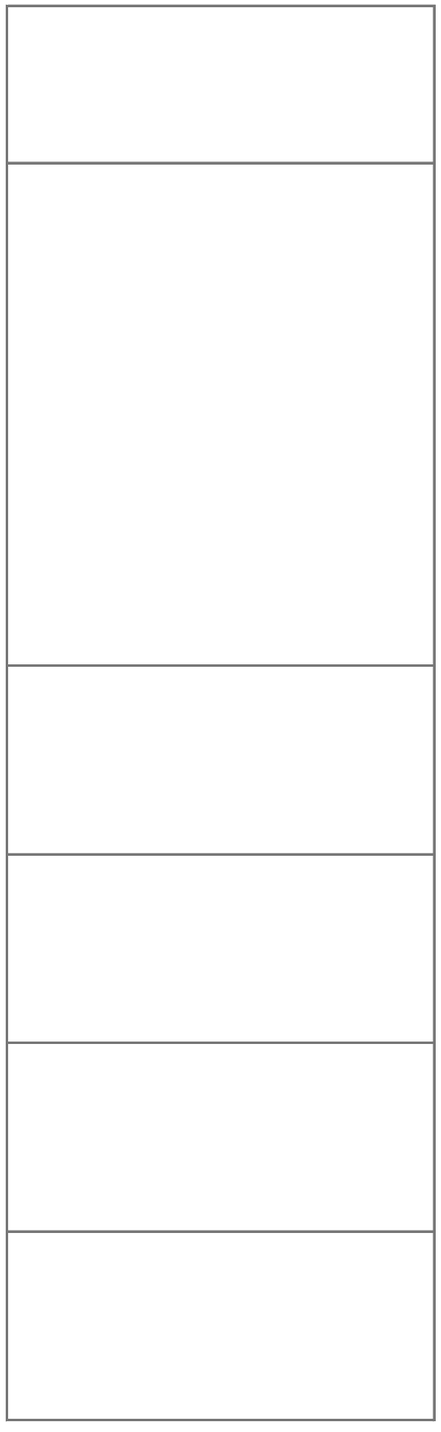






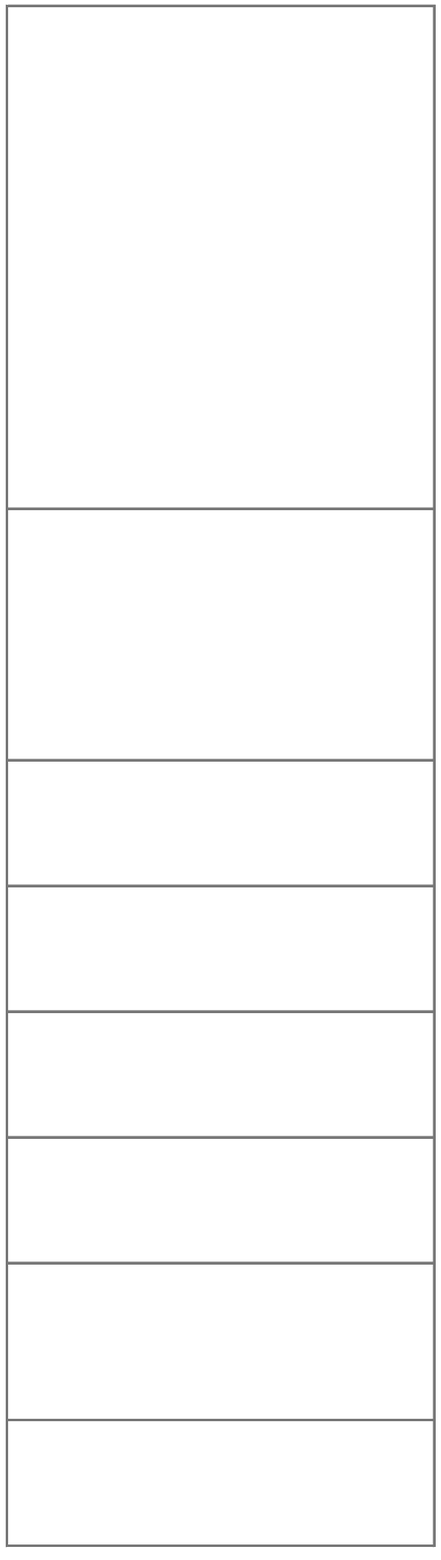
Update 18/5- we submitted a SBAR to the Executive Director of WFOD in March seeking approval to go to consultation with staff. Lisa wasn't happy to approve at the time and asked us to review the rotas that had been developed and consider more family-friendly rota patterns. We have completed this piece 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.





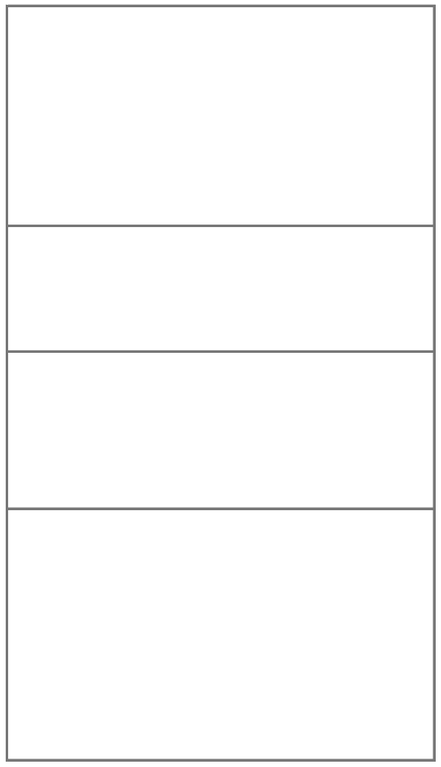
26/3/26- update: It's challenging to prove an intended go live date for eObs, so I have included a screen shot of the key milestones from the project plan (I cannot share the wider document due to confidentiality) and have highlighted Key Milestone M8 eObs integrated solution indicating a go live of 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.

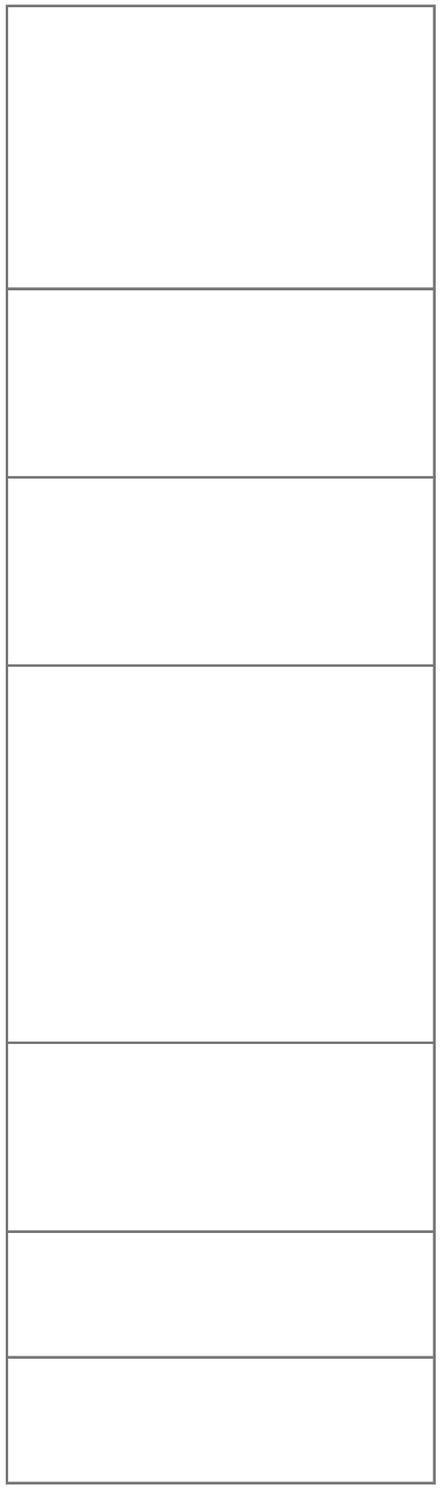


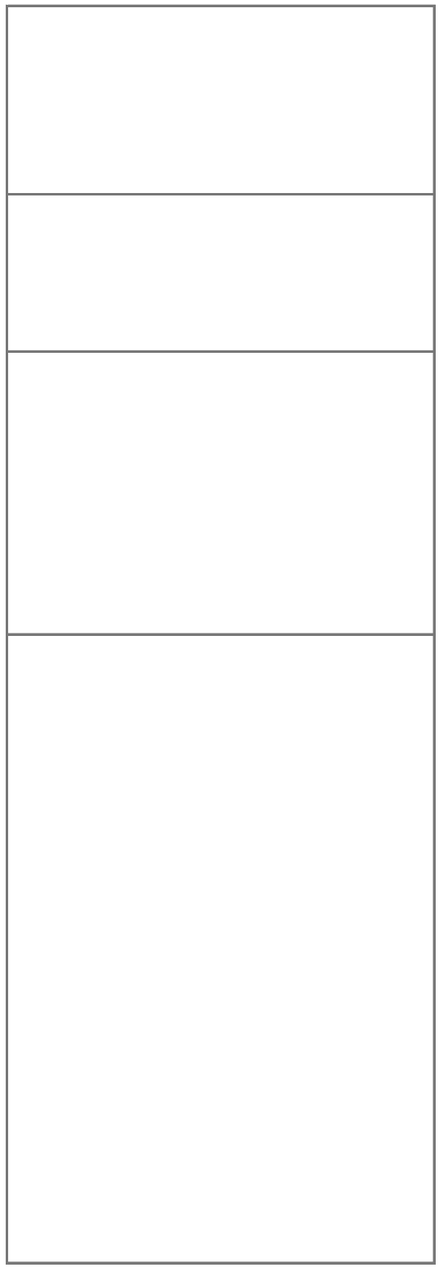
Temperature Controlled Medicines Task and finish group September 2025 Update 9/3/26 : The Temperature Control Medication Task and Finished Group has met a number of times. A draft 'manging temperature excursion in ambient storage area storing medicines' procedure is out for comment from the group. This 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

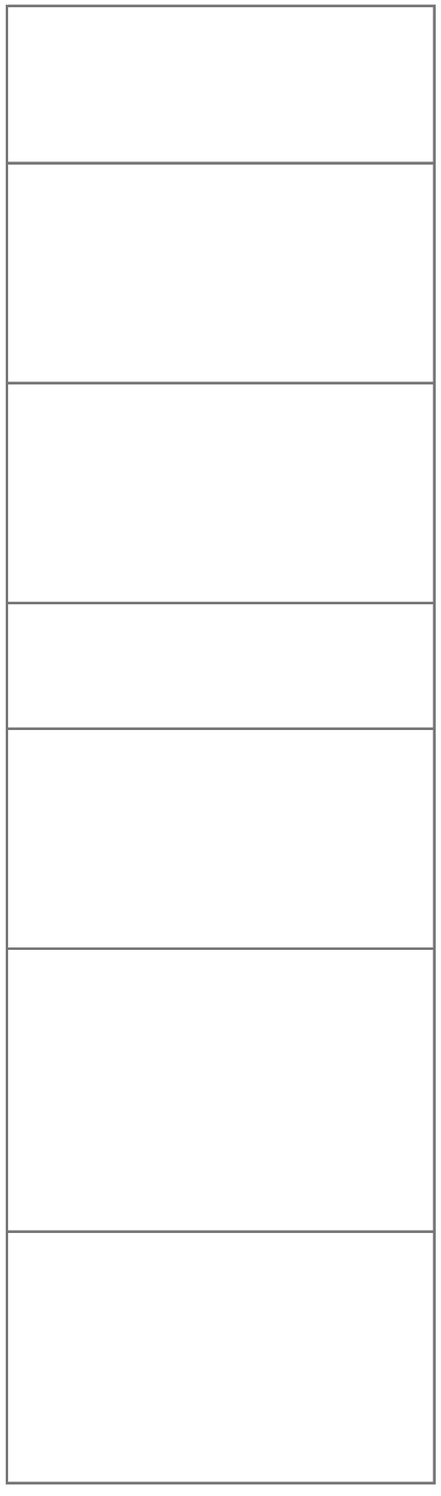
All Wales Group are updating this work underway, working with HIW for editing to ensure capability with ESR This is an All Wales piece of work that is underway. No clear time scale on completion. Group to meet in the next month. Updated 7/10/25 No new update to give .Work remains to be done on this. 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

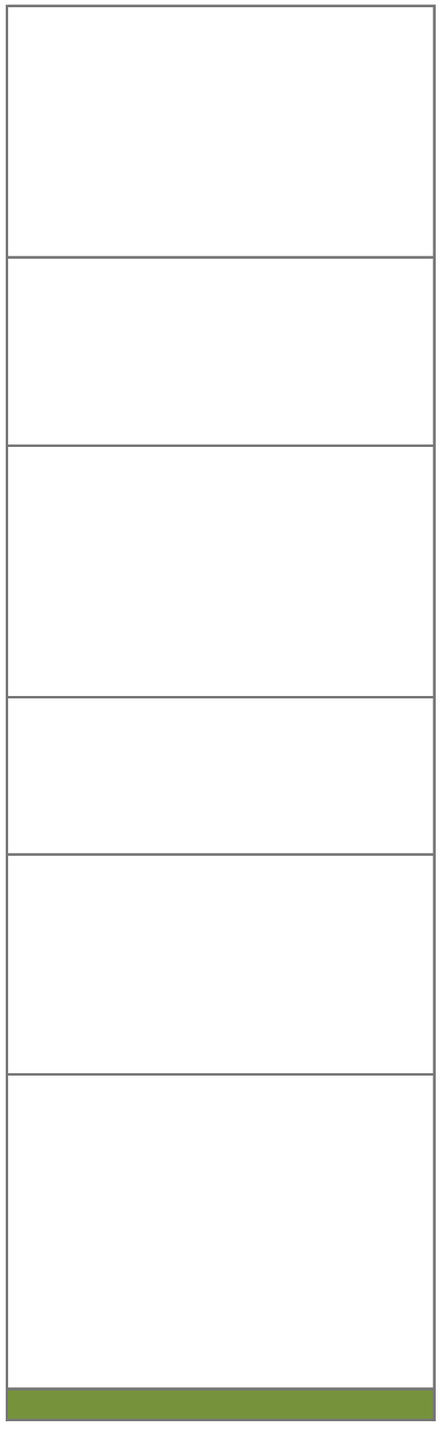
03/03/2026 Planned work for garden to start July 2026. https://hywelddahealthcharities.nhs.wales/news/charity-news/work-begins-on-new-therapeutic-gardens-at-prince-philip-hospital/

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









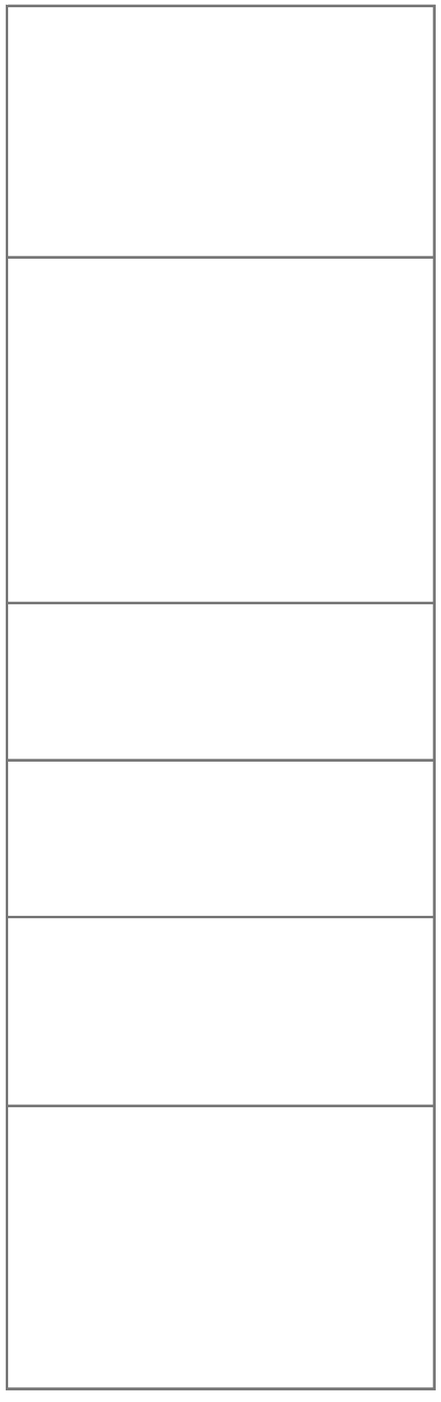
This improvement plan is agreed with Clinical Care Groups, but an update on progress is to be reported to the November 2025 Strategic Safeguarding Steering Group. 28/01/2026: Just recruited into Head of Safeguarding with role commenced on 1st of January 2026 (Charlotte Westacott). Updated responsible 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|26726218 0.77% NHS|CSTF|Safeguarding Children - Level 2 - 3 Years|26726218 0.77% NHS|CSTF|Safeguarding Children - Level 3 - 3 Years|26726166 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

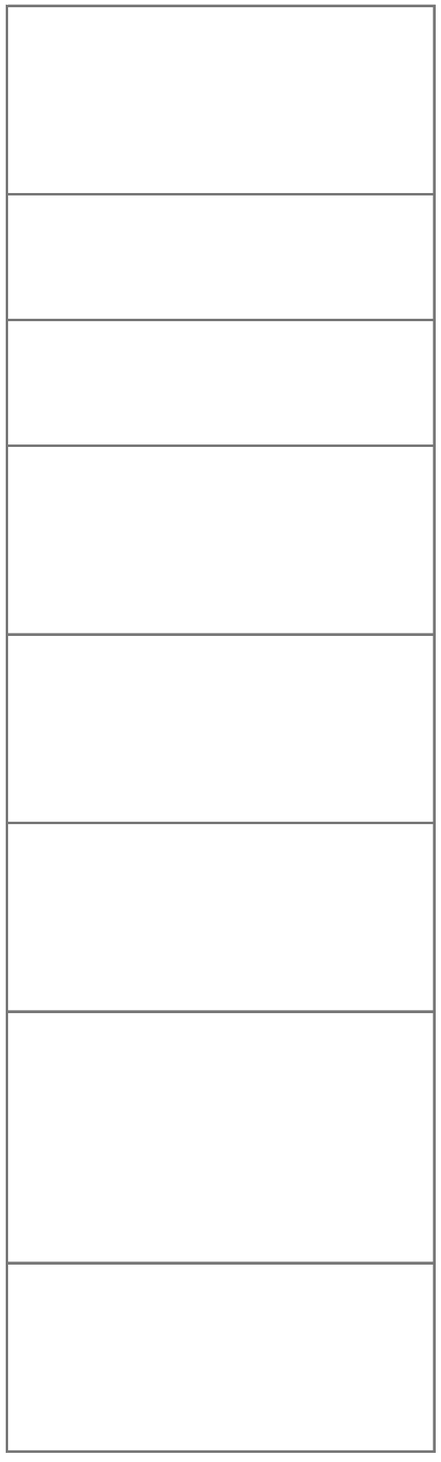
As this 'sits in Nursing, Medical, Quality & patient Experience the Assistant Director of Nursing, Quality, Safety & patient Experience should be the overall action lead, assisted by the Care Group Associate Medical Director, IA. 30/03/2026 update from PE updated from medical perspective new clinical 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.

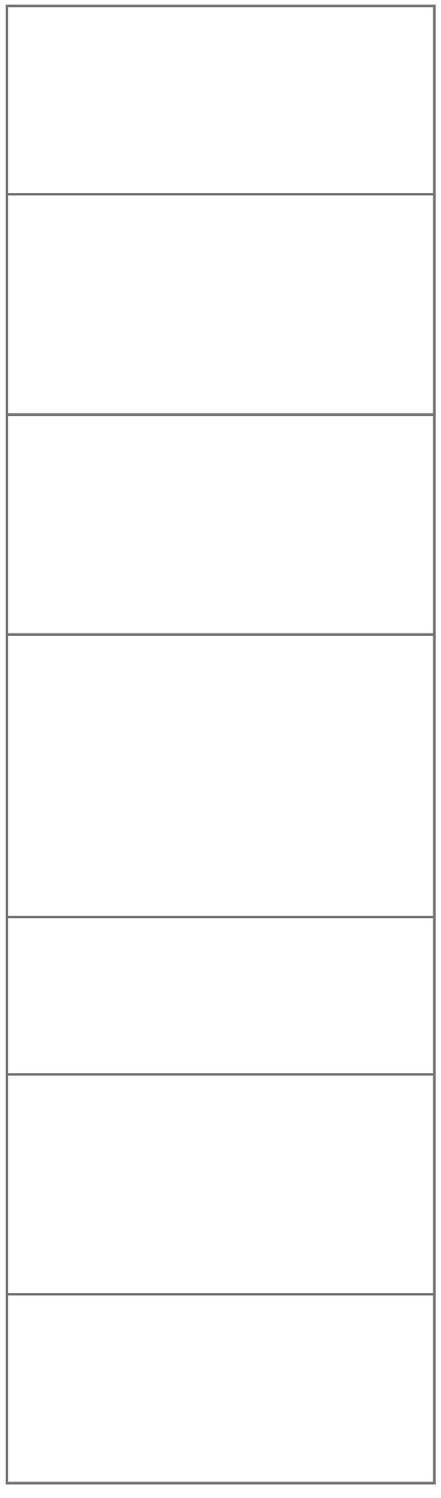
HDdUHB are engaging well with this pilot and are represented at the Strategic and Practitioner groups.

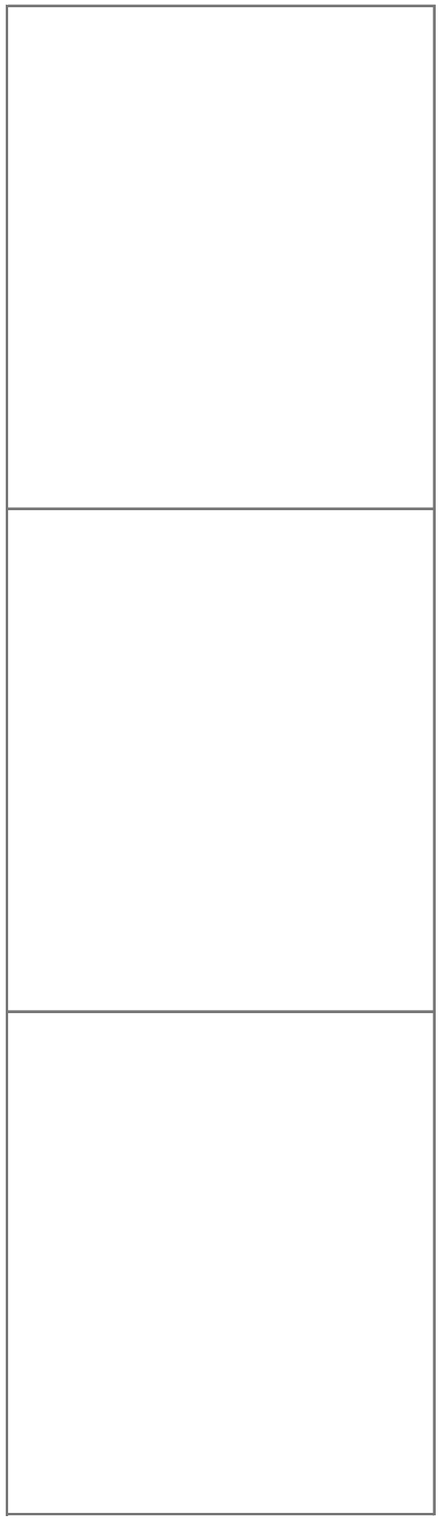


A review planning group has been established. 12/01/2026 - safe guarding lead and clinical lead appointments out to advert. The plan is to implement a new pathway in March 2026. 13/04/26 - Named Doctor for Safeguarding and Clinical Lead for Acute paediatrics both appointed and roles commenced in March 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

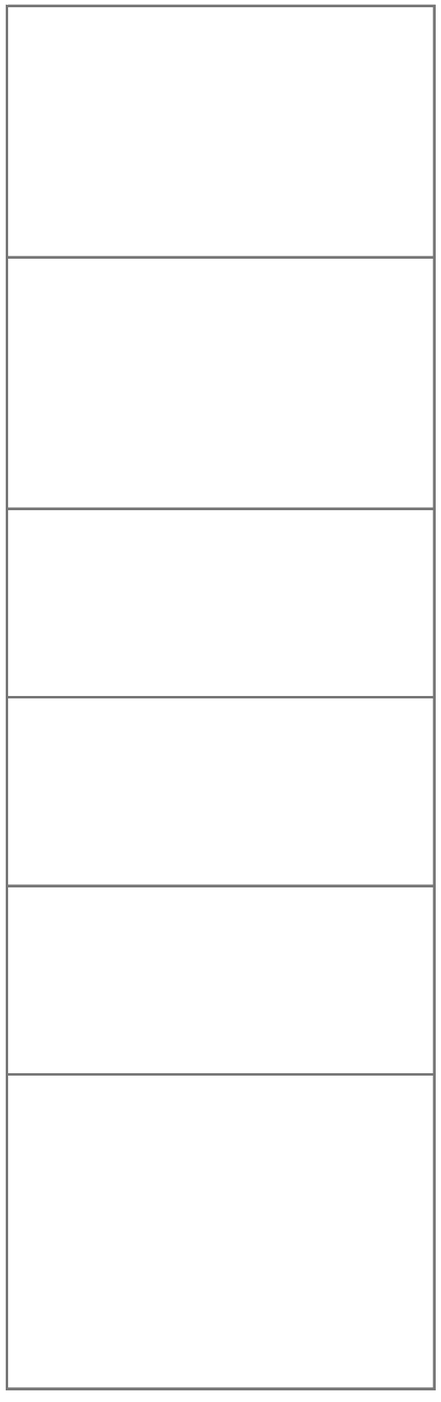


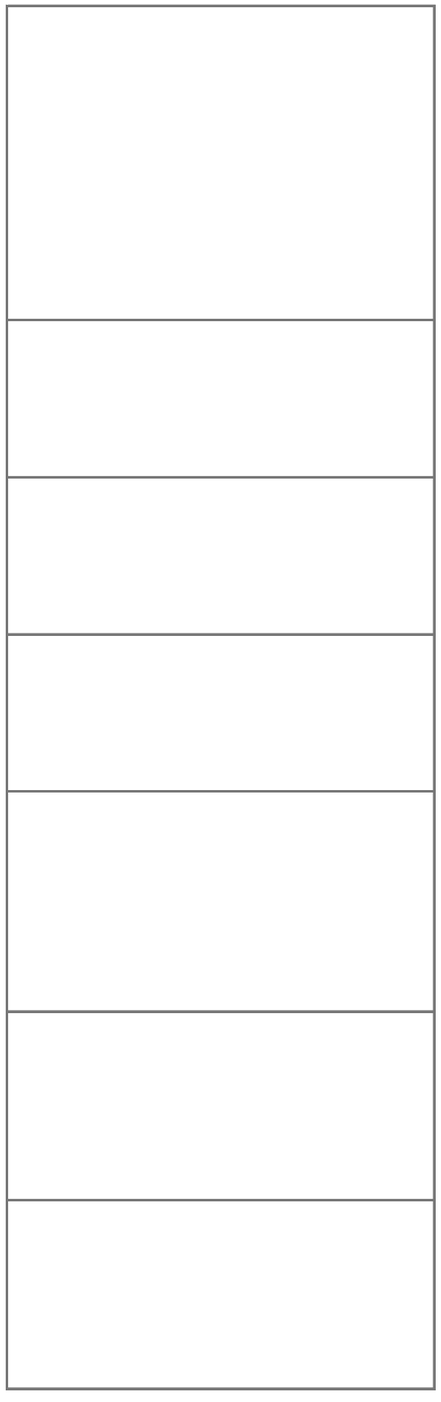


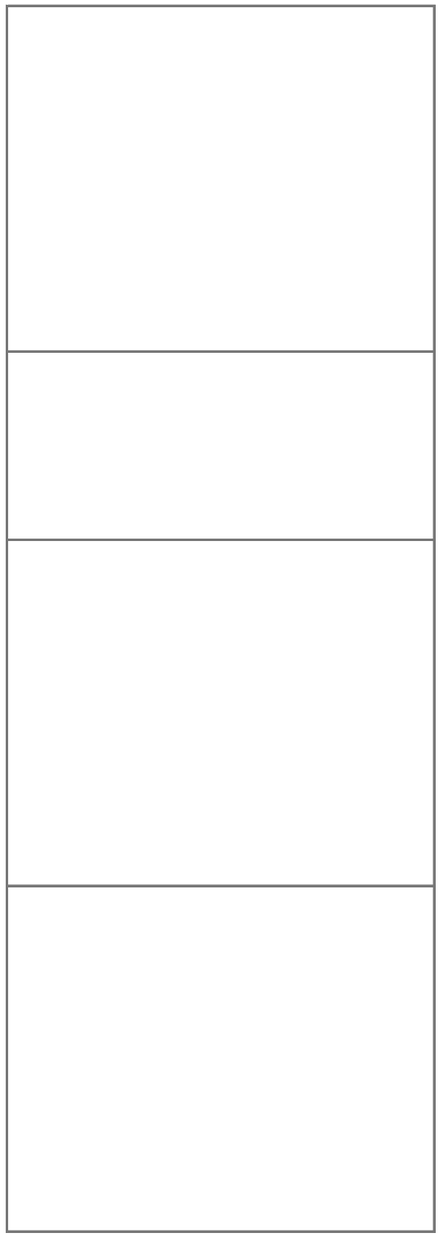




Update 23/11/23 added to risk register Requirement escalated in exception report to OQSEC 09/01/2024 6/9/24- Update: This action cannot be completed at this time as it requires additional investment. I will be escalating this in my next QSEG report. 13/12/24- Update- presented to QSEG- on annual plan 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.

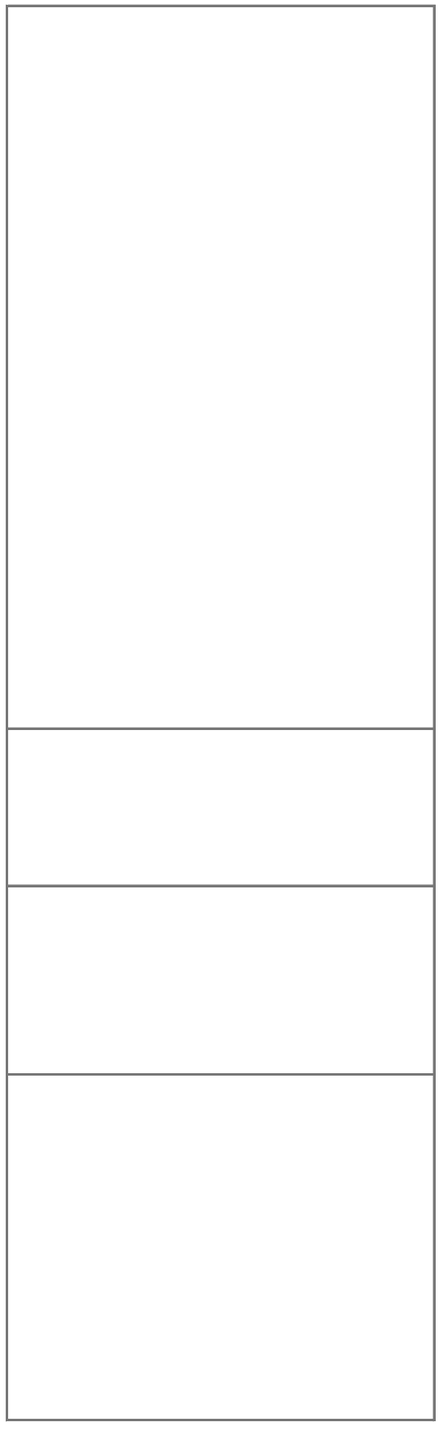






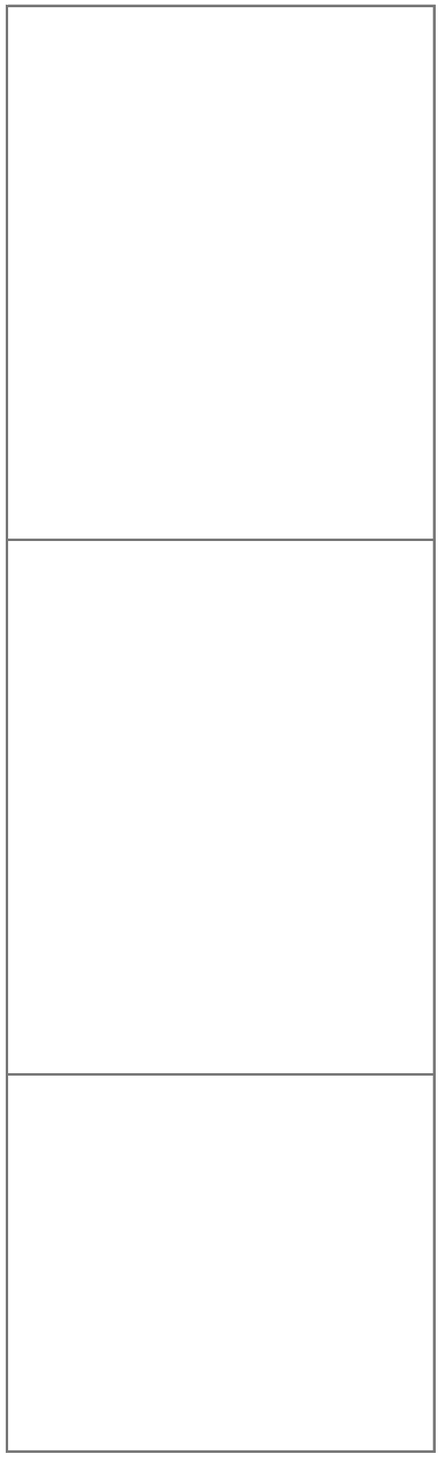
13/12/24- presented to QSEG- ongoing review and remains on risk register. Feb 2025- Update need for document control system and quality lead Radiographer included in Radiology annual plan March 2025 update- HB annual plan approved by the Board on 28/03/2025 which has included the Quality Lead Radiographer 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.

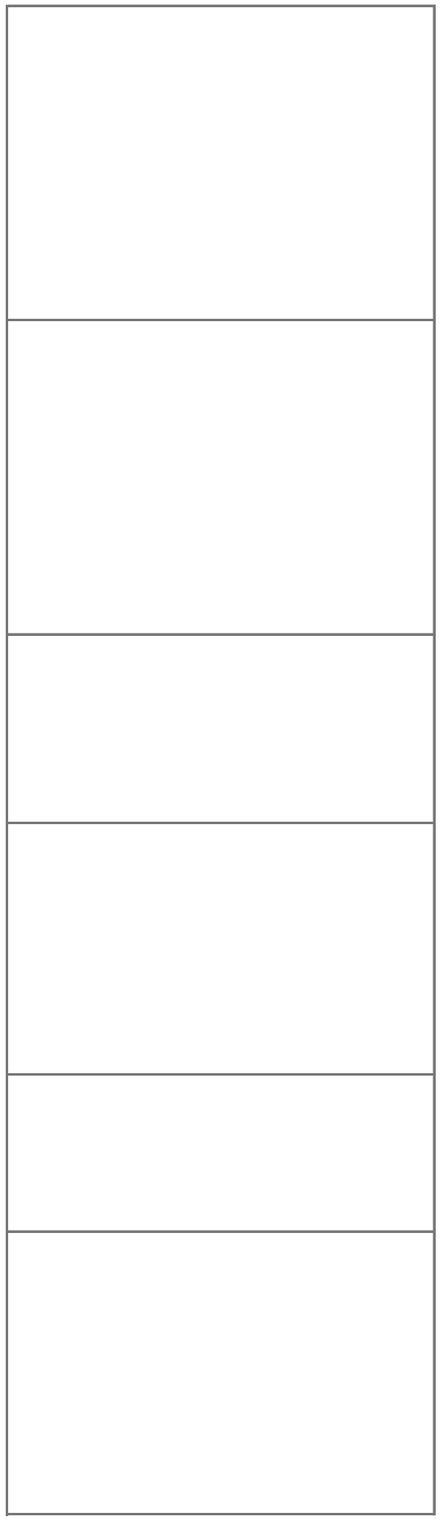


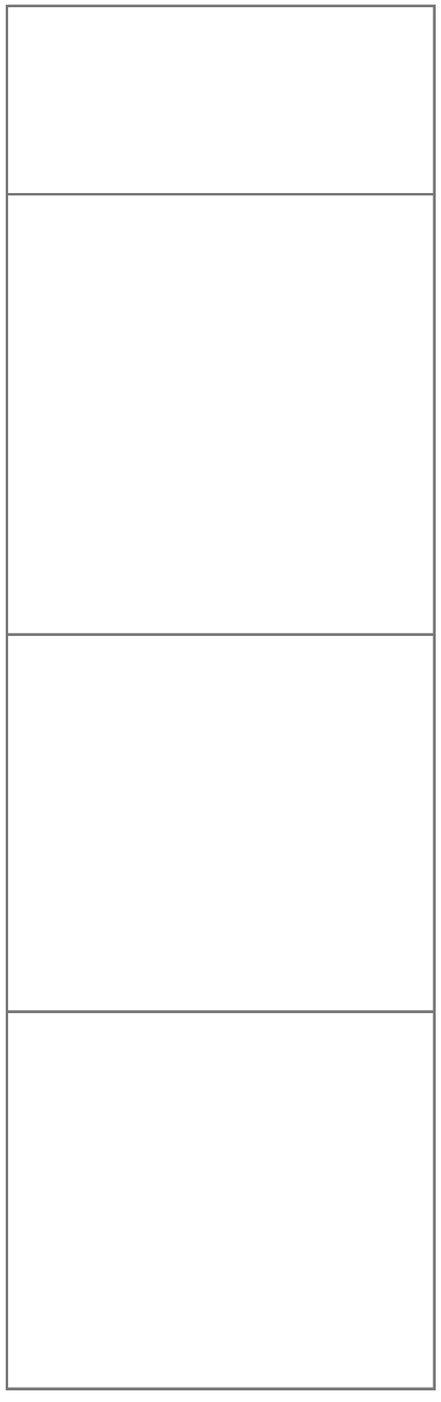
Update 3.9.25- All Wales approach – FO taking to AWIQF for update and progress. no progress All wales - will consider HB approach until All Wales policy sorted. Meeting will be arranged with MPE - Simon Evans. meeting delayed due to inspection revised target date 31.9.26

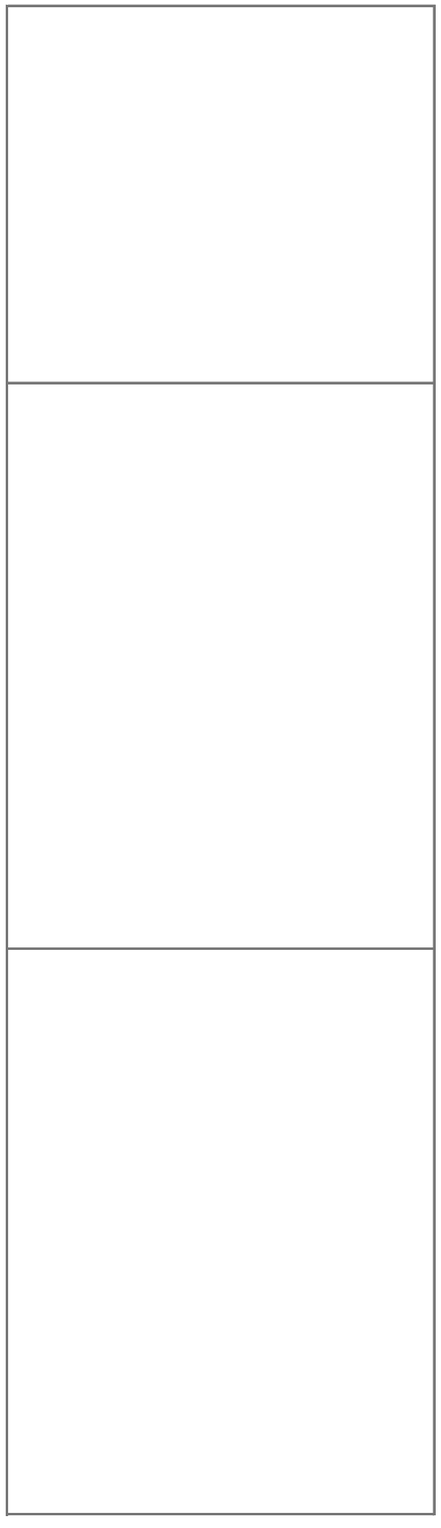
update 3.9.25- Query sent to SE on 21/7 re All Wales progress made to date revised target date 31.1.26, update 12.11.25 need action from JA/MH to ensure E-IRMER is added as mandatory. - email sent to JA /MH to see what progress has been made. revised target date 31.4.26 - still awaiting process to ensure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

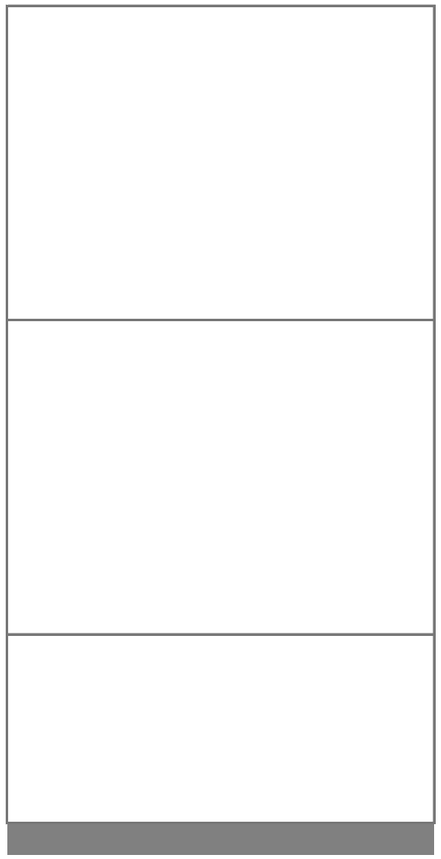






Previous contingency plan has been sourced. Draft contingency plan written and awaiting review by Deputy Head of Radiology 23/06/26

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



5.2

5.2 - Listening and Learning Sub Committee Update Report and Annual Report 2026/27

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

For approval

Attachments

LLSC August 2026.pdf

LLSC Annual Review 2526 2.pdf

SUB COMMITTEE UPDATE REPORT/ ADRODDIAD DIWEDDARU'R LISTENING AND LEARNING SUB-COMMITTEE

Date of last meeting/ Dyddiad y cyfarfod diwethaf: 11 June 2026

Quoracy/ Cworwm: Met

Report by/ Adroddiad gan: Eiry Edmunds, Sub-Committee Vice Chair

---

KEY DISCUSSION POINTS AND MATTERS TO BE ESCALATED FROM THE DISCUSSION AT THE MEETING/ PWYNTIAU TRAFOD ALLWEDDOL A MATERION I'W HUWCHGYFEIRIO O'R DRAFODAETH YN Y CYFARFOD:

Alert[1] (may require discussion)/ **Rhybuddio** (efallai y bydd angen trafodaeth)

The Listening and Learning Sub Committee wishes to **alert** the Committee that :

- Recurring themes of poor compassion, communication, dignity and respect in end-of-life and bereavement experiences are potentially causing distress to families and undermine trust in the organisation.
- Similar themes are being identified across complaints, bereavement feedback and Medical Examiner discussions and case reviews, indicating a wider organisational improvement requirement rather than isolated service issues.
- Variation and inequity in bereavement support, including bereavement counselling currently being available only to individuals living in Carmarthenshire, requires an integrated service response to address postcode variation.
- Delays in **Medical Certificate of Cause of Death (MCCD)** completion particularly those extending beyond 10 days, alongside mortuary staffing and estates pressures, are contributing to family distress and present operational, governance and Human Tissue Authority licensing risks.
- A delayed death verification incident identified process weaknesses in process, ownership, documentation and mortuary access, reinforcing the need for immediate learning and strengthened controls and clear accountability.

Advise[2] (to monitor)/ **Cynghori** (i fonitro)

The Listening and Learning Sub Committee wishes to **advise** members of the Committee that:

- The Sub-Committee recognised the need for continued monitoring of how learning from concerns, patient safety investigations, Medical Examiner reviews, mortality learning and care after death intelligence is triangulated, so that recurrent themes can be identified and improvement actions tracked.
- Members supported the development of a more structured early post-bereavement engagement process, enabling clinicians or relevant teams to

[1] *There is a lack of confidence that any action in place is sufficient to address the issue satisfactorily and/or within the scope of the operational team or executive to resolve. Engagement, action or intervention required.*
[2] *There are areas of concern where assurance has been taken on actions in place but requires close monitoring. An early warning of an emerging and potentially serious concern*.

respond to immediate questions before distress becomes entrenched through lengthy formal processes.
- The Sub-Committee noted the importance of providing bereaved families with early, clear and consistent information, including a named or consistent point of contact where several processes are underway, such as a complaint, serious incident review, Duty of Candour, Medical Examiner review or inquest.
- The Sub-Committee emphasised that compassionate communication, dignity, privacy and practical support should be treated as core elements of care after death and bereavement support, and should be reflected in training, policy and service improvement work.

Assure[3] (to note)/ Sicrhau (i nodi)

The Listening and Learning Sub Committee wishes to **assure** members of the Committee that:

- The Sub-Committee considered a detailed programme of patient, family and staff experience evidence focused on **care after death and bereavement,** including end-of-life care, complaints, Medical Examiner arrangements, learning from concerns and the developing Listening to People integrated patient safety, concerns and resolution policy.
- The Sub-Committee welcomed the direction of travel in the draft integrated patient safety, concerns management and resolution policy and supported early consultation comments to strengthen the draft. The final version will be presented for approval to the QSEC in October 2026.
- Members welcomed progress through dedicated Care After Death leadership, Medical Examiner engagement, renewed steering group arrangements and work to develop a cohesive Care After Death and Bereavement service model, including improved equity across hospital sites and communities.
- The Care After Death service is updating policy, standardising documentation and piloting improved processes in three emergency departments, supported by professional standards and assurance input.
- Medical Examiner engagement and training sessions have taken place across sites, with further work planned to support doctors completing MCCDs and reinforce that mortuary processes form part of patient care.
- Learning is being managed through investigation reports, stakeholder sign-off, action plans, AMAT tracking and seven-minute briefings, although members recognised the need to strengthen links with complaints learning.
- The Sub-Committee considered its Annual Report 2025/26, which summarised the business conducted during the year and ahead of the Committee's review and endorsement.
- No immediate compliance concerns were identified in current Hywel Dda cases, and recommendations in two current Public Services Ombudsman for Wales cases were reported as completed, with compliance and closure confirmed by the Ombudsman.

[3] *There is confidence that actions are robust and will be sufficient to address the issue or generally operating effectively. Routine monitoring.*

Review Of Risks/ Adolygiad O Risgiau

The Sub-Committee recognises the significant and compassionate work underway to strengthen care after death, bereavement support, Medical Examiner processes and learning from concerns. However, the consistency of themes across patient stories, staff reflection, case studies, complaints, Medical Examiner updates and Ombudsman learning indicates a heightened organisational risk requiring continued senior oversight. Key risks relate to inequity in bereavement support, MCCD delays, mortuary capacity and resilience, fragmented learning systems, and the potential for families to experience secondary harm through delayed, complex ineffective organisational processes.

Recommendation/ Argymhelliad

The Quality, Safety and Experience Committee is asked to:

- **Approve** the LLSC Sub-Committee Annual Report 2025-26.
- **Respond** to the items the Sub-Committee is alerting them to
- **Note** the items the Sub-Committee is advising them of
- **Take assurance** from the items that the Sub-Committee is providing assurance on.

Date of next meeting/ Dyddiad y cyfarfod nesaf: 10 September 2026: Theme Gynaecology

LISTENING AND LEARNING SUB COMMITTEE

ANNUAL REVIEW REPORT

2025/2026

DRAFT

1. Introduction

In accordance with Standing Orders, the Listening and Learning Sub-Committee is required to submit an Annual Report to the Quality, Safety and Experience Committee, through the Chair, within six weeks of the end of the reporting year. This report summarises the activity undertaken during 2025/26 and describes how the Sub-Committee has discharged its responsibilities in line with its Terms of Reference.

The reporting year has been one of significant transition and development. The Sub-Committee has provided an important forum for scrutiny, oversight and assurance in respect of organisational preparedness for the implementation of the revised Listening to People Regulations. Its work has supported the Health Board's ambition to strengthen person-centred approaches to listening, responding, learning and improving services.

Throughout the year, the Sub-Committee has continued to triangulate intelligence from patient experience, complaints, incidents, claims, redress, inquests, Ombudsman reports and external reviews. This has enabled members to identify recurrent themes, consider opportunities for improvement and seek assurance that learning is translated into meaningful and measurable change.

2. Terms of Reference and Annual Workplan

The Terms of Reference were reviewed during the year to ensure they remained aligned with the Sub-Committee's evolving responsibilities, particularly in relation to implementation of the Listening to People Regulations. The review strengthened the Sub-Committee's focus on evidencing improvement, demonstrating impact and providing assurance that learning contributes to safer care and improved experience.

The workplan continued to be structured around themed reviews of services and cross-cutting issues, supported by intelligence from a range of sources including patient and staff experience, complaints, redress, claims, Ombudsman reports, incidents, inquests and external reviews. The programme remained responsive to emerging risks, organisational priorities and areas where further assurance was required.

3. Reporting Arrangements

The Listening and Learning Sub-Committee does not have any formal reporting groups.

4. Attendance and Quoracy

The Sub-Committee remained quorate throughout the reporting year. Meetings reviewed as part of this annual report were confirmed as quorate, reflecting sustained member engagement and the importance placed on learning from patient feedback, concerns and patient safety events across the organisation.

5. Sub-Committee Activity: Alert, Advise and Assure

Following each meeting, the Sub-Committee reports to the Quality, Safety and Experience Committee through the established Alert, Advise and Assure framework.

5.1 Alert: Matters Requiring Escalation or Additional Oversight

The following matters were identified during the year as requiring additional organisational attention, oversight or intervention.

5.1.1 Ophthalmology Services

A significant area of concern during 2025/26 related to Ophthalmology services. Through triangulation of patient experience, complaints, redress activity and external scrutiny, the Sub-Committee highlighted the level of risk associated with the Ophthalmology waiting list and the

potential impact on patients at risk of permanent sight loss. Particular concern was noted in relation to the volume of patients requiring urgent review, alongside continuing workforce and capacity constraints. Although extensive mitigation arrangements were in place, the Sub-Committee recognised that residual risks remained and required ongoing escalation, monitoring and executive oversight.

The Sub-Committee also considered a Public Services Ombudsman for Wales Public Interest Report relating to Ophthalmology services. Members noted the importance of strengthening clinical documentation, communication, referral pathways and governance arrangements in response to the findings, and of ensuring that learning from the report was embedded within wider service improvement activity.

5.2 Advise: Matters Requiring Continued Monitoring

The following matters were identified where assurance was available, but continued monitoring and scrutiny were considered necessary.

5.2.1 Implementation of the Listening to People Regulations

A significant proportion of the Sub-Committee's work during 2025/26 focused on supporting organisational readiness for the implementation of the Listening to People Regulations and the wider National Patient Safety Plan. The regulations represent the most substantial change to concerns, incidents, complaints and redress arrangements since the introduction of the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011, establishing a different approach to listening, responding and learning from people's experiences.

Throughout the year, the Sub-Committee received regular updates on implementation planning and provided scrutiny, challenge and support in relation to the new arrangements. Members considered the implications of introducing a mandatory listening discussion, strengthening early resolution, revising redress arrangements and adopting a more proportionate approach to investigations focused on learning and improvement. The Sub-Committee recognised that these changes require both cultural and operational transformation across the organisation.

DRAFT

The Sub-Committee provided oversight of the development of an integrated patient safety operating model, bringing together complaints, concerns, incidents, redress and learning arrangements through a coordinated approach to triage, risk assessment and oversight. A key feature of this model is the proposed establishment of a central Patient Safety Hub to support proportionality, consistency and quality assurance, ensuring that organisational resources are directed to areas of greatest risk, harm and opportunity for improvement.

Members also recognised the importance of moving from a predominantly procedural model towards one that prioritises meaningful engagement with patients, families and staff. This includes ensuring concerns are understood and addressed as early as possible, and that learning is embedded at every level of the organisation. The Sub-Committee welcomed the Welsh Government ambition to increase the proportion of concerns resolved through early resolution and supported local initiatives designed to improve responsiveness, reduce escalation and strengthen relationships with patients and families.

The Sub-Committee further recognised that successful implementation depends on robust arrangements for demonstrating learning and evidencing improvement. Attention was therefore given to strengthening organisational approaches to Learning from Events and Redress, improving governance arrangements, enhancing quality assurance processes and ensuring that learning is translated into measurable changes in practice. Members noted the increasing expectations of Welsh Risk Pool regarding evidence of organisational learning and viewed this as an important opportunity to strengthen assurance across the Health Board.

The Sub-Committee considers the Listening to People programme to be a key enabler in achieving its overarching aim that listening leads to learning, and learning leads to safer care, improved experiences and better outcomes for the population served by Hywel Dda University Health Board. The Sub-Committee will continue to maintain oversight of implementation during 2026/27 to seek assurance that the intended benefits are realised and that the voices of patients, families and staff remain central to improvement activity.

DRAFT

5.2.2 Neurodevelopmental Services

The Sub-Committee reviewed feedback relating to ADHD and autism assessment pathways and noted the continuing impact of prolonged waits on patients and families. Concerns included deterioration in wellbeing while awaiting assessment, increasing reliance on private assessments and pressure on existing support arrangements. The Sub-Committee recommended further consideration of integrated models that bring together neurodevelopmental and mental health support services to improve coordination, accessibility and responsiveness.

5.2.3 Ophthalmology Risk Stratification

The Sub-Committee maintained oversight of Ophthalmology risk stratification processes during the year and recognised the importance of continued monitoring, particularly given reliance on a small number of specialist clinicians and sustained service pressures.

5.3 Assure: Evidence of Action and Improvement

The following matters provided assurance to the Sub-Committee that actions were being taken to improve patient experience, strengthen patient safety and support organisational learning.

5.3.1 Accessible Communication and Information Standards

The Sub-Committee received detailed assurance regarding implementation of the revised Accessible Communication and Information Standards.

Reviews considered communication needs, access to services, interpreter provision, patient information, staff awareness and environmental accessibility. A powerful patient story highlighted the impact that communication barriers can have on informed consent, autonomy and overall patient experience, reinforcing the importance of identifying and responding to communication needs at the earliest opportunity.

5.3.2 Mental Health and Learning Disability Services

The Sub-Committee undertook a detailed thematic review of mental health and learning disability services. Patient and family stories were central to this discussion, including testimony from the family of a young man who died by suicide and a positive recovery story from a service user supported through Early Intervention Psychosis and neurodevelopmental services.

These discussions highlighted both the challenges experienced by patients and families and the positive impact that person-centred care can have when services are coordinated, responsive and compassionate.

Assurance was received regarding:

- Suicide prevention surveillance and trend analysis.
- Person-centred safety planning across inpatient services.
- The Post Event Team Reflection Approach (PETA) supporting staff following traumatic events.
- Improvements arising from Public Services Ombudsman recommendations relating to learning disability epilepsy services.
- Progress against recommendations arising from national discharge reviews.

5.3.3 Learning from Events and Welsh Risk Pool Requirements

The Sub-Committee maintained oversight of organisational learning arrangements and reviewed developments associated with Learning from Events and Redress. Emphasis was placed on ensuring that learning is identified, evidenced, monitored and embedded within services, alongside strengthening governance arrangements and improving consistency across organisational learning processes.

5.3.4 Service Improvement Through Patient Experience

Throughout the year, the Sub-Committee received evidence of service improvements arising directly from complaints, patient feedback, incidents and external scrutiny. Key themes reviewed included communication, equality and inclusion, waiting times, access to care, documentation quality, discharge planning, patient safety and workforce capacity. The Sub-Committee welcomed examples of services acting on patient feedback and embedding learning within local improvement plans, while recognising that communication remained a significant and recurring source of concern and poor experience across the Health Board.

5.3.5 Patient, Family and Staff Stories

Patient, family and staff stories remained central to the Sub-Committee's work throughout 2025/26. These narratives provided important insight into the human impact of healthcare experiences and supported discussion, reflection and improvement activity.

Stories included:

- Families affected by suicide and mental health services.
- Individuals experiencing communication barriers because of disability and hearing impairment.
- Patients affected by delays in Ophthalmology services.
- Positive examples of person-centred mental health and neurodevelopmental support.
- Learning from unexpected deaths, incidents and concerns.

5.3.6 Written Control Documents

During 2025/26, the Sub-Committee reviewed and approved the following written control documents and supporting arrangements:

- Revised Terms of Reference for the Listening and Learning Sub-Committee.
- Protocols supporting implementation of the Listening to People Regulations.
- Guidance supporting concerns management, communication standards and organisational learning arrangements.
- Quality assurance approaches supporting learning from events and redress processes.

6. Conclusion

The Listening and Learning Sub-Committee provides assurance to the Quality, Safety and Experience Committee that it has operated effectively throughout 2025/26 and in accordance with its Terms of Reference. Matters requiring additional oversight, intervention or assurance have been escalated appropriately, while examples of improvement and good practice have been shared to support learning across the organisation.

DRAFT

The year has been characterised by preparation for, and early implementation of, the Listening to People Regulations. Alongside its continuing role in scrutinising feedback, concerns, incidents and learning, the Sub-Committee has supported the development of a more integrated, proportionate and person-centred approach to listening, learning and improvement.

Looking ahead to 2026/27, the Sub-Committee will focus on seeking assurance that the new arrangements are implemented effectively, that a culture of curiosity and continuous improvement is embedded, and that evidence of learning and impact is strengthened. This will support the organisation in demonstrating that listening to people leads to safer care, better experiences and improved outcomes for those who use its services.

DRAFT

5.3

5.3 - Safeguarding Assurance Report

Charlotte Westacott (Hywel Dda UHB - Head of Safeguarding)

For assurance

Attachments

Safeguarding report to QSEC Aug 26.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ANSAWDD, DIOGELWCH A PHROFIAD QUALITY, SAFETY AND EXPERIENCE COMMITTEE	
DYDDIAD Y CYFARFOD: DATE OF MEETING:	**11 AUGUST 2026**
TEITL YR ADRODDIAD: TITLE OF REPORT:	Safeguarding Assurance Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Sharon Daniel, Executive Director of Nursing, Quality and Patient Experience
SWYDDOG ADRODD: REPORTING OFFICER:	Charlotte Westacott, Head of Safeguarding

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/ For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report provides an update to the Quality, Safety and Experience Committee on the Health Board's safeguarding arrangements, outlining current activity, key developments, and actions underway to strengthen compliance with statutory safeguarding requirements.

Cefndir / Background

Safeguarding duties for health boards in Wales are principally set out in the Social Services and Well-being (Wales) Act 2014, supported by associated statutory guidance. While local authorities hold the primary statutory responsibility for safeguarding the welfare of children, the Health Board—alongside police, NHS Trusts, probation services, and youth offending teams—has a legal duty under Section 28 of the Children Act 2004 to ensure its functions are discharged with due regard to safeguarding and promoting the welfare of children.

Under Part 7 of the Social Services and Well-being (Wales) Act 2014, local authorities must establish Safeguarding Children Boards, with representation from statutory partners including the Health Board. In this context, Local Health Boards and NHS Trusts are recognised as statutory relevant safeguarding partners.

The Wales Safeguarding Procedures set out all-Wales framework for safeguarding children and adults at risk of abuse or neglect. They apply to all practitioners—across statutory, private, and voluntary sectors—ensuring consistency in safeguarding practice regardless of organisational structure or professional background.

The Health Board is an active member of the Mid and West Wales Statutory Safeguarding Board, established under the Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015. To support internal governance, the Health Board has established a Strategic Safeguarding Steering Group (SSSG), which provides assurance to the Quality & Safety Intelligence Group on the organisation's statutory responsibilities relating to safeguarding children, adults, and broader public protection.

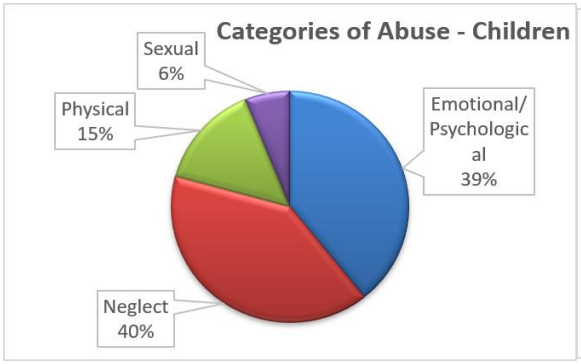
The Health Board's Safeguarding Team supports compliance with the Social Services and Well-being (Wales) Act, the national guidance Working Together to Safeguard People and the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015.

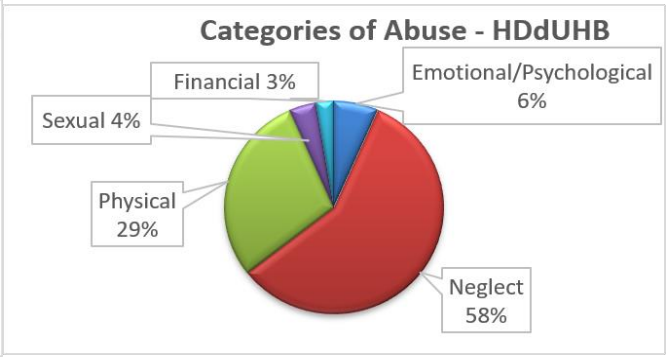
Asesiad / Assessment

Quality Assurance

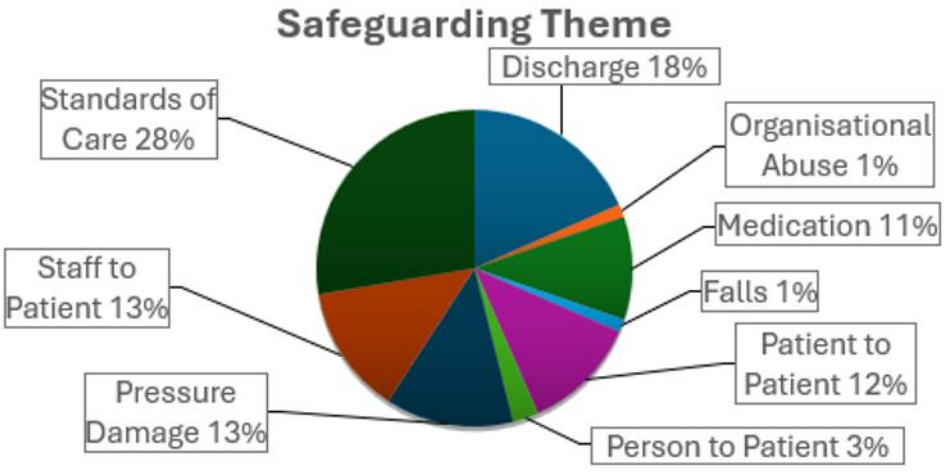
The Safeguarding Team continues to provide comprehensive oversight through established governance arrangements including performance monitoring, supervision frameworks, audit activity, risk review processes and scrutiny through Clinical Care Group (CCG) bi-monthly Safeguarding Delivery Groups and the Safeguarding Strategic Steering Group (SSG).

- Continued oversight of safeguarding activity, with **699** safeguarding reports received during April and May 2026, enabling organisational monitoring of safeguarding trends and themes for both children and adults at risk. **476** reports relate to child or unborn baby, 130 of which relate to abuse or neglect.





Neglect is by far the most prevalent alleged abuse type, accounting for over half of all allegations. In addition to capturing the categories, a theme and sub theme is assigned to each report allowing services to analyse and identify patterns and learning opportunities specific to their own area of practice.



Standards of Care remains the most prominent theme, comprising just over a quarter of all themes, continuing to align with the neglect-related concerns. Overall, the thematic profile for April and May 2026 continues to show that care quality, workforce practices, and discharge

processes are key drivers of safeguarding activity, with neglect and physical abuse categories underpinning most concerns.

- Ongoing monitoring of the Joint Inspection Child Protection Arrangements (JICPA) improvement plan continues, with 27 of 34 actions completed and a further 3 in progress with 4 being overdue which continue to be monitored via SSSG.
- Expansion of safeguarding supervision into additional services including Community Nursing and Occupational Therapy, strengthening practitioner support and safeguarding accountability.
- Positive evidence of effective multi-agency safeguarding practice demonstrated through complex Children Looked After (CLA) case management involving legal, medical and nursing teams.
- The number of Children Looked After (CLA) within the Health Board area increased to 968 during April to May 2026, representing a 2.1% increase from the previous reporting period and continuing the upward trend in demand. At the time of reporting, CLA numbers have risen further to 982, this is closely monitored and reported on by the CLA Lead Nurse.
- There are currently 167 children placed out of county (125 in Wales; 42 in England), reflecting increased reliance on external placements reflecting in the associated Health Board expenditure.
- A recent Healthcare Inspectorate Wales (HIW) focused review of the Health Board's arrangements for managing Section 5 Persons in a Position of Trust (PIPOT) has been completed. Stages 1 and 2 of the review found the Health Board's arrangements to be effective, with appropriate processes and governance in place. As a result, the review did not progress to Stage 3, providing positive assurance regarding the Health Board's compliance and oversight in this area.

There is evidence that safeguarding systems are functioning effectively and that governance arrangements provide visibility of risk, performance and compliance.

Quality Planning;

Strategic considerations required to influence safeguarding delivery.
Key planning considerations include:

- Increasingly complex safeguarding presentations among vulnerable children and young people with significant trauma histories are placing growing demands on safeguarding services. Referrals relating to abuse or neglect have increased significantly over the last three years, rising from 679 to 927 in 2025/26, a 36.5% increase. This upward trend reflects growing demand on the safeguarding service, with an increasing number of complex cases requiring specialist assessment, intervention, and multi-agency coordination in turn resulting in sustained pressure on service capacity and staff resources.
- The number of Children Looked After continues to rise, currently at 984, with increasing out-of-area placements creating additional pressures on care coordination, safeguarding oversight, multi-agency working, and Health Board resources.
- There is an anticipated increase in demand for Prevent and Channel activity as vulnerable individuals are increasingly exposed to extremist content online. This emerging pressure continues to be highlighted through internal safeguarding training and remains a standing item within regional safeguarding discussions. Mitigation requires ongoing awareness raising, workforce training across all partner agencies, and continued government-led support and public awareness initiatives to reduce wider Prevent-related risks and strengthen early identification and intervention.

- Uncertainty regarding replacement digital systems supporting Health Visiting and wider community services following discontinuation of existing platforms and a procurement exercise is currently taking place to support this.

The Committee should recognise that future safeguarding risks are increasingly influenced by wider system factors including workforce availability, service demand, digital infrastructure and inter-agency dependency. These factors require continued strategic planning and executive oversight.

Quality Control;

The principal safeguards currently in place include:

- Significant concerns remain regarding capacity, resilience and sustainability of Child Protection Medical Services. This remains the most significant safeguarding risk identified during the reporting period and has been formally escalated through governance arrangements.
- Safeguarding training compliance across the Health Board continues to improve, with strong engagement at Levels 1 and 2. Compliance at Level 3 (Adults and Children) and Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) remains below the 85% organisational target, largely due to a significant increase in the number of staff appropriately role-mapped as requiring these levels of training.
- Additional quality assurance processes have been introduced to review Multi-Agency Risk Assessment Conference (MARAC) referrals and improve consistency in safeguarding decision-making and reporting across services.
- Monthly multi-agency S5 Person in a Position of Trust (PIPOT) review meetings continue to provide robust oversight of complex investigations, enabling the identification and monitoring of delays, risks, and emerging themes. Work is progressing to further strengthen internal governance arrangements, enhancing CCG and Professional Standards oversight, improving accountability and supporting the timely progression and resolution of cases.

Appropriate controls are in place; however, some risks, training compliance and Child Protection Medical Service resilience, remain only partially mitigated and continue to require executive oversight.

Quality Improvement;

Several improvement initiatives have progressed during the reporting period:

- Delivery of the JICPA improvement programme and continued oversight of outstanding actions continues to be monitored by SSSG.
- Development of improvement action plans following Midwifery audit findings relating to safeguarding in pregnancy communication and handover processes.
- Expansion of safeguarding supervision across additional professional groups. An audit of the quality of safeguarding supervision is due to take place.
- Organisational learning from Single Unified Safeguarding Review (SUSR)'s and National learning is being disseminated through governance structures.
- Identification of discharge communication failures as a recurrent organisational learning theme requiring system-wide improvement.
- Development of revised Terms of Reference for SSSG aligned to the Quality Management System governance framework.
- Children's Safeguarding Team practitioners are now attending MARAC, strengthening information-sharing processes and improving the identification of additional risks from

health information, promoting more in-depth discussions and professional challenge around safeguarding actions and management of risk.
- Additional safeguarding specialist posts are being considered with funding support from Specialist care to strengthen safeguarding expertise, support the delivery of high-quality safeguarding practice with specialist oversight.

There is evidence of a positive improvement culture, with audits, reviews, incidents and external scrutiny being translated into improvement actions. The key challenge remains achieving sustainable improvement in areas where risks are driven by workforce and system capacity constraints.

Additional assurance is required regarding:

- The sustainability of the Child Protection Medical Service remains a statutory risk and is currently under review. An assessment is underway, with an associated action plan to be developed and monitored through SSSG to ensure service resilience and statutory compliance.
- Safeguarding training compliance remains a key focus. Ongoing work to align ESR role profiles has recalibrated compliance percentages and reflects improved alignment with National Safeguarding Training Standards and Intercollegiate guidance. Sufficient training provision is available, CCGs remain accountable for improving and sustaining compliance, with performance monitored through Safeguarding Delivery Groups and SSSG.
- Organisational responses to discharge-related safeguarding concerns remain a strategic priority. Work is ongoing through the Community Integrated Medicine Clinical Governance Group to review current arrangements and identify opportunities for improvement. This includes strengthening collaborative engagement with Local Authorities to enhance safeguarding processes, support effective multi-agency decision-making, and improve the safety and quality of discharge pathways for vulnerable individuals.
- The increasing demand and complexity within Children Looked After (CLA) services, including the impact of children placed out of county, continue to present significant operational and financial challenges for the Health Board. Discussions are ongoing with Local Authority partners through Corporate Parenting arrangements to strengthen strategic oversight and joint planning. In addition, an internal review of the CLA financial position has been undertaken to better understand current pressures, inform future service planning, and support the sustainable delivery of health services for this vulnerable population.

Argymhelliad / Recommendation

The Committee is asked to receive assurance that robust safeguarding governance arrangements are in place and functioning effectively; however, assurance is moderated by ongoing workforce, service capacity and compliance risks which require continued executive and Board oversight.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	3.20 Provide assurance in relation to the organisation's arrangements for safeguarding vulnerable people, children and young people.

Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	Child protection medical risk. Risk No 2391.
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	2. Culture and valuing people
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Nodau Cynllunio 2026/27 Planning Goals 2026/27	6. Safe, Timely, High Quality Care
Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	7. Improve health and well-being by focusing on prevention and early intervention, while working in partnership to ensure everyone has equal access to care and opportunities for good health
Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau) A Social Model for Health and Wellbeing: (*complete for strategic change and/or significant service changes)*	5. A more preventative approach, including earlier identification and intervention, will be taken to support people to maintain and improve their health and wellbeing.
Gwybodaeth Ychwanegol: Further Information:	

Ar sail tystiolaeth: Evidence Base:	Social Services and Well-being (Wales) Act 2014, Children Act 2004 Wales Safeguarding Procedures Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015. Working Together to Safeguard People Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015
Rhestr Termau: Glossary of Terms:	Included within the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	Clinical Care Group (CCG) Safeguarding Delivery Groups Safeguarding Strategic Steering Group (SSG).

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not applicable
Ansawdd / Gofal Claf: Quality / Patient Care:	Contained within the report
Gweithlu: Workforce:	Contained with the report
Tegwch Iechyd: Health Equity:	Not applicable
Risg: Risk:	Contained with the report
Cyfreithiol: Legal:	Contained with the report
Enw Da: Reputational:	Not applicable
Gyfrinachedd: Privacy:	Not applicable
Cydraddoldeb: Equality:	Not applicable

5.4

5.4 - Inpatient Falls Assurance Report

Anna Chiffi (Hywel Dda UHB - Assistant Director of Nursing, Patient Safety, Quality)

For assurance

Attachments

Inpatient Falls Assurance report.pdf

Bronglais Decaffeinated Drinks Patient Story.pptx

Pwyllgor Ansawdd, Diogelwch a Phrofiad/ Quality, Safety and Experience Committee

DYDDIAD Y CYFARFOD: DATE OF MEETING:	11 AUGUST 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Inpatient Falls Assurance Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Sharon Daniel - Executive Director of Nursing, Quality and Patient Experience
SWYDDOG ADRODD: REPORTING OFFICER:	Anna Chiffi - Assistant Director of Nursing, Quality and Patient Safety

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/ For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report provides the Quality, Safety and Experience Committee (QSEC) with an annual update on the work of the Inpatient Falls Group, now transitioning towards a system-wide Safer Mobilisation Group, to strengthen strategic leadership, oversight and assurance across the whole care pathway. The report is presented to enable QSEC to take assurance on current performance, improvement activity and governance, and to support the next phase of system-wide transformation.

Whilst improvement activity is well established and examples of positive practice are evident, ongoing variation in compliance, workforce pressures and patient complexity continue to present risks that require focused action during 2026/27.

Cefndir / Background

The Inpatient Falls Group has operated throughout 2025/26 as the principal forum for oversight of falls prevention, management and learning. Chairing the Group transitioned to Assistant Director of Nursing – Patient Safety & Quality in April 2025, providing senior clinical leadership and clear accountability for delivery and assurance.

Over the course of the year, the Group has evolved from a predominantly inpatient-focused model towards a whole-system safer mobilisation approach, reflecting national direction and local learning.

The revised Terms of Reference establish the Group as providing strategic leadership, system-wide oversight and robust assurance, with a clear emphasis on prevention, early intervention, and reduction of deconditioning-related harm.

The Group's scope now extends across the full patient pathway, including community, acute, rehabilitation, long-term care and chronic disease management, ensuring a consistent and integrated approach to falls prevention and mobilisation.

Minutes across the reporting period demonstrate a progressive shift in focus, including:

- Recognition of duplication and the need to align with deconditioning programmes
- Agreement to broaden to a system safer mobilisation model
- Increased emphasis on multi-professional and system-wide engagement

This transition reflects both internal audit requirements and a growing understanding that inpatient falls are intrinsically linked to system-wide factors including frailty, dementia, hydration, infection and functional decline.

Asesiad / Assessment

The Health Board continues to report incidents of inpatient falls as a recurrent patient safety concern, with consistent themes identified across all sites throughout the year. Review of local intelligence and meeting discussions demonstrates increasing maturity in the organisation's ability to identify, understand and respond to contributory factors; however, variation in practice persists.

The Group has identified four recurring risks requiring continued oversight:

- Variation in completion and quality of Multifactorial Falls Risk Assessments (MFRA), across clinical areas.
- Increasing patient acuity, frailty and cognitive impairment resulting in higher falls risk.
- Workforce pressures affecting enhanced observation and supervision of vulnerable patients.
- Environmental and equipment factors, particularly during periods of escalation, boarding and flow pressure.

Whilst the Health Board continues to experience inpatient falls, there is increasing evidence of a more mature and systematic approach to prevention, scrutiny and learning. Key improvements over the reporting period include the establishment of falls learning panels, enhanced thematic review processes, increased scrutiny of contributory factors and stronger alignment with deconditioning, frailty and hydration programmes. These developments have enabled a more proactive identification of risk and targeted intervention at site level.

However, whilst governance arrangements have strengthened, available intelligence demonstrates that the principal challenge remains the consistent implementation of preventative measures at ward level. The most significant opportunities for improvement continue to relate to compliance with MFRA's post-fall reviews, documentation standards,

supervision of high-risk patients and responsive interventions for patients with cognitive impairment and delirium.

Consequently, assurance can be taken from the strengthening of systems and oversight arrangements; however, further work is required to demonstrate sustained reduction in falls incidence and variation across services.

Encouragingly, the Group has demonstrated increasing system-wide learning and improvement capability. The establishment of falls learning panels, structured audit processes, and quality improvement (QI) initiatives has enabled more consistent identification of themes and targeted interventions. There is also evidence of innovation and local improvement, including deconditioning initiatives, hydration programmes, and environmental adaptations.

A specific example of local innovation is the decaffeinated drinks project at Bronglais Hospital (BGH), which has been implemented as part of a wider focus on hydration, nutrition and deconditioning. The initiative has explored reducing caffeine intake and increasing access to alternative and fortified fluids, with early indications suggesting improved hydration, reduced agitation in cognitively impaired patients, and a positive impact on overall patient stability. While attribution to falls reduction alone remains complex due to concurrent interventions, the project demonstrates the value of a multifactorial, person-centred approach to falls prevention, and highlights the potential for system-wide learning and scaling subject to further evaluation.

Importantly, the Group is increasingly drawing together system-wide intelligence, including incident data, audit findings and patient experience, to inform improvement priorities and reduce variation.

Total Number of falls across the care group with no harm to catastrophic harm



The graph above presents the total number of reported falls across the Care Group. Numbers have remained relatively stable over the reporting period, with the majority resulting in no or low harm. While incidents resulting in moderate, severe or catastrophic harm remain infrequent, all such events are reviewed to identify contributory factors, ensure appropriate mitigating actions are implemented, and inform ongoing improvements in safer mobilisation and falls prevention practices. The overall trend highlights the importance of maintaining a strong focus on preventative interventions, risk assessment, and learning from incidents to minimise patient harm. The transition to a safer mobilisation model represents a significant strengthening of approach. This reframes falls not as isolated events within

inpatient care, instead as a system outcome requiring coordinated prevention, early intervention, rehabilitation and recovery.

From a Safe, Timely, Effective, Efficient, Equitable and Person Centred (STEEEP) perspective:

Domain	Rating	Narrative
Safe	Amber	Robust governance and learning structures established; falls-related harm remains a significant patient safety risk.
Timely	Amber	Variation persists in early identification of risk and timely preventative interventions.
Effective	Amber	Improvement initiatives are established but not yet consistently embedded across all sites.
Efficient	Green	Duplication has reduced through alignment with deconditioning and wider improvement programmes.
Equitable	Red	Variation in practice and outcomes remains evident across sites and services.
Person-centred	Amber	Increasing focus on mobilisation, frailty and dementia care; further embedding required.

The Group is also increasingly focused on high-risk populations, including frail adults and people living with dementia, ensuring their needs are explicitly recognised within pathway design and care delivery. Priorities for 2026/2027 include:

1. Full implementation of the transition to a System-Wide Safer Mobilisation Group.
2. Improvement in compliance with MFRA and post-fall review standards.
3. Reduction in variation across sites through standardised audit and assurance processes.
4. Strengthened integration with frailty, dementia, delirium, hydration and deconditioning programmes.
5. Development of outcome measures to monitor falls incidence, harm severity and patient experience more effectively.
6. Increased patient and family involvement in falls prevention improvement work.

Overall, the Health Board should take moderate assurance that governance, leadership and system-wide oversight arrangements are strengthening and that significant progress has been made in transitioning from a traditional inpatient falls model to a broader safer mobilisation approach. However, recurrent themes relating to workforce capacity, patient frailty, cognitive impairment and variation in clinical practice continue to limit the pace of improvement. The priorities identified for 2026/27 are intended to strengthen implementation, improve consistency and support a measurable reduction in falls-related harm across the Health Board.

Argymhelliad / Recommendation

The Committee is asked to:

- Receive assurance from the strengthening of governance, system-wide oversight and improvement activity, including implementation of the Safer Mobilisation Group and the transition to a fully integrated, prevention-focused approach to reducing falls-related harm.
- Note the ongoing risks relating to variation in clinical practice, workforce capacity and compliance with key assessment and documentation requirements.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	3.8 Provide assurance to the Board that current and emerging clinical risks are identified and robust management plans are in place and any learning from concerns is applied to these risks as part of this management.
Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	5. Whole systems persepctive
Amcanion Strategol y BIP: UHB Strategic Objectives:	3. Great care
Nodau Cynllunio 2026/27 Planning Goals 2026/27	6. Safe, Timely, High Quality Care
Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	10. Not Applicable

Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau) A Social Model for Health and Wellbeing: (*complete for strategic change and/or significant service changes)*	5. A more preventative approach, including earlier identification and intervention, will be taken to support people to maintain and improve their health and wellbeing.
Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	Contained within the body of the report
Rhestr Termau: Glossary of Terms:	Contained within the body of the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	Inpatient Falls Group

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
Ariannol / Gwerth am Arian: **Financial / Service:**	Not applicable
Ansawdd / Gofal Claf: **Quality / Patient Care:**	Contained within the report
Gweithlu: **Workforce:**	Not applicable
Tegwch Iechyd: **Health Equity:**	Not applicable
Risg: **Risk:**	Not applicable
Cyfreithiol: **Legal:**	Not applicable
Enw Da: **Reputational:**	Not applicable
Gyfrinachedd: **Privacy:**	Not applicable

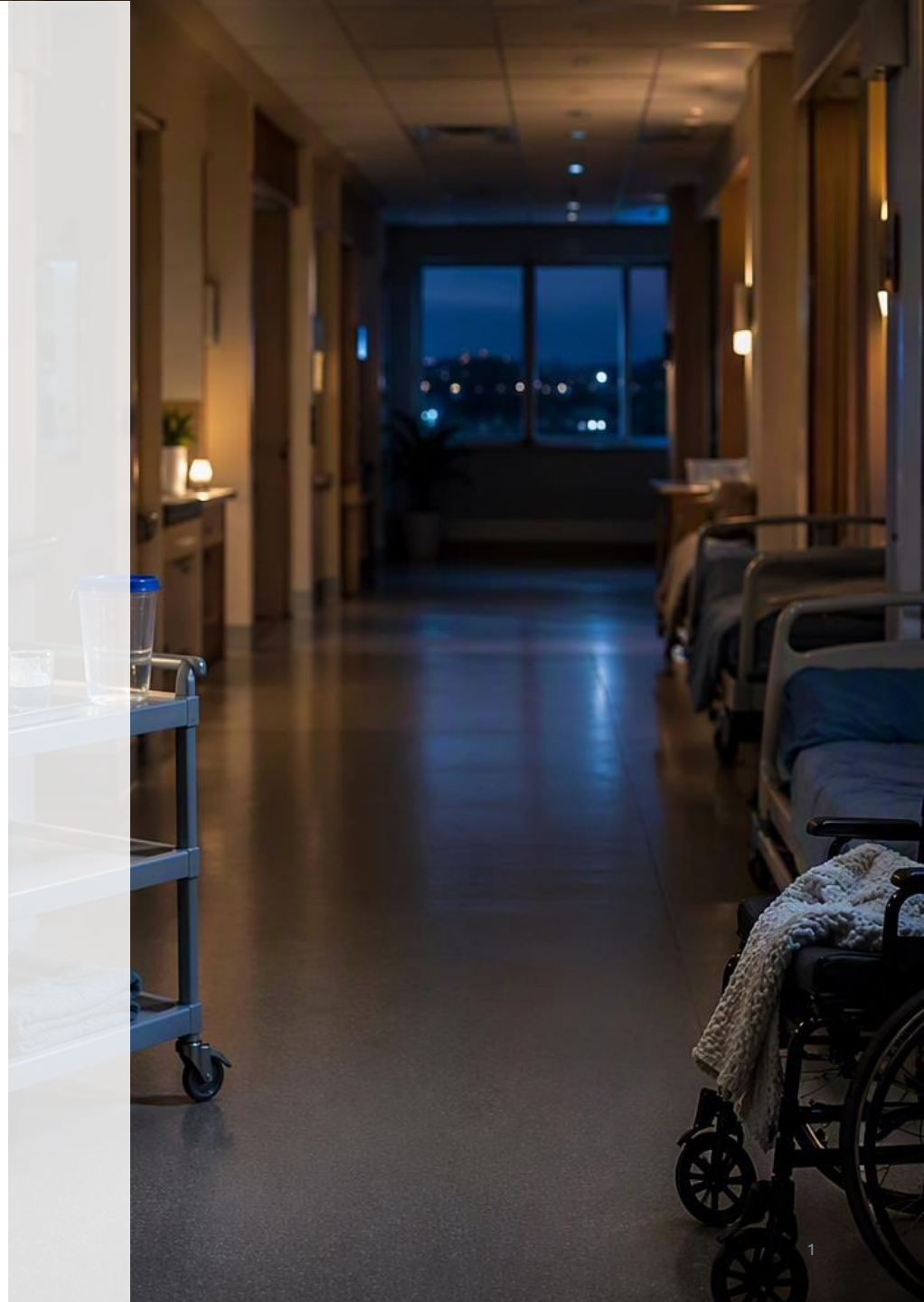
Cydraddoldeb: Equality:	Not applicable

Patient story

Decaffeinated drinks project

Bronglais General Hospital

A composite patient story showing how a clinically initiated change, informed by an emerging evidence base, offers decaffeinated drinks as the default option while preserving patient choice.



Draft narrative for governance, quality improvement and patient experience discussion | clinically initiated project

Meet “Mrs E”

A composite, anonymised patient story reflecting a clinically initiated project, informed by emerging ev

Mrs E is admitted to Bronglais following a fall at home. On admission, she is offered decaffeinated tea and coffee as the default option, with caffeinated drinks still available if preferred or clinically appropriate.

This project was clinically initiated by staff in response to emerging evidence around caffeine, nocturia, sleep, agitation and falls risk.

> *“Being offered decaf as the default made it easier, and I still had a choice.*

Purpose: person-centred care

Lens: comfort, safety, dignity



What mattered to the patient

The story starts with clinical curiosity, emerging evidence and a consistent default offer



Why staff initiated the project

- Clinical staff identified emerging evidence linking caffeine reduction with reduced bladder irritation/nocturia, improved sleep and potential falls prevention benefits.
- The project was therefore framed as proactive quality improvement, rather than a response to a single patient request.
- Decaffeinated drinks were offered as the default, with patient choice and personalised clinical judgement maintained.
- Staff used the admission and falls-risk conversation to consider caffeine intake as one modifiable factor within wider safer mobilisation work.

Key point: the project is clinically led and evidence-informed, with decaf as the default and choice preserved.

The clinically initiated change

Decaffeinated drinks offered as the default, informed by emerging evidence and clinical judgement

Project approach

• Clinical staff initiate the default decaf offer as part of a proactive safety and quality improvement project.
• Use seven drinks rounds per day as the routine delivery point, with caffeinated drinks available if requested or clinically indicated.
• Promote hydration and fortified options where clinically appropriate.
• Discuss caffeine intake when completing the falls risk assessment on admission.

Clinically initiated

Default decaf, choice maintained



What changed for Mrs E

Patient experience benefits aligned to safer mobilisation and hydration



Comfort

The default offer was clinically led rather than dependent on Mrs E knowing to ask.

Dignity

Staff explained the rationale and preserved Mrs E's individual choice.

Confidence

She felt reassured that the team were thinking proactively about night-time comfort and safety.

Safety

The conversation linked hydration, continence, sleep and safer mobilisation as part of wider falls prevention.

Assurance and learning

How to evidence, govern and scale a clinically led improvement

Next Steps

- Confirm consistent availability of decaffeinated drinks as the default option across clinical areas.
- Capture staff and patient feedback on acceptability, choice, comfort and implementation barriers.
- Monitor relevant safety signals alongside other falls and safer mobilisation interventions, recognising attribution will be multifactorial.
- Clarify supply, cost and operational constraints with facilities and catering colleagues.
- Define when caffeinated drinks remain the right personalised or clinically indicated choice.



Closing message

“For Mrs E, the project was not a response to her asking for decaf. It was a clinically initiated change, informed by emerging evidence, which made the safer default easier while still preserving choice.”

Proposed next step: continue the pilot learning through the safer mobilisation, nutrition and hydration lens, with clear assurance on clinical rationale, default decaf availability, patient choice, outcomes and scalability.

Comfort | Choice | Dignity | Safety

5.5

5.5 - Management of Outpatients

Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Lisa Humphrey (Hywel Dda UHB - General Manager), Paula Goode (Hywel Dda UHB - Service Director for Planned and Specialist Care)

R7 Audit Wales Report : Develop targeted interventions to minimise the risk to patients with conditions where they could come to irreversible harm if delays occur in follow-up appointments

For assurance

Attachments

QSEC SBAR - R7 Audit Wales Report - Management of Outpatients.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ANSAWDD, DIOGELWCH A PHROFIAD
QUALITY, SAFETY AND EXPERIENCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	**11 AUGUST 2026**
TEITL YR ADRODDIAD: TITLE OF REPORT:	Management of Outpatients
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Andrew Carruthers, Chief Operating Officer
SWYDDOG ADRODD: REPORTING OFFICER:	Paula Goode, Planned and Specialist Clinical Care Group Director Lisa Humphrey General Manager Planned Care and Cancer, Alex Walsby Head of Nursing

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/ For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Quality, Safety and Experience Committee is requested to consider the report which has been reviewed using the Safe, Timely, Efficient, Equitable, Effective and Person Centred (STEEEP) principles, and to be assured that the actions are adequate and timely regarding the reduction of risk of irreversible harm to follow up patients due to delay in treatment.

The current Hywel Dda University Health Board (HDUHB) Outpatient follow up (F/up) position is in total 72,629 patients.

Count of CRN	No Delay	0 - 25% Delay	26 - 50% Delay	51 - 100% Delay	> 100% Delay	Grand Total
Breast	2014	129	63	48	122	2376
Cardiology	1906	318	277	255	178	2934
Clinical Haematology	2753	53	20	22	34	2882
Colorectal	150	15	38	32	114	349
Dermatology	2226	209	143	198	568	3344
Diabetic Medicine	1807	296	232	237	188	2760
Endocrinology	1408	216	151	156	269	2200
ENT	2284	294	223	272	1060	4133
Gastroenterology	2776	147	58	51	55	3087
General Medicine	676	71	36	61	206	1050
General Surgery	110	13	7	19	27	176
Geriatric Medicine	971	128	84	99	291	1573
Gynaecology	2738	249	162	189	389	3727
Medical Oncology	1018	42	24	27	12	1123
Nephrology	1351	96	41	17	30	1535
Neurology	1016	160	161	218	793	2348
Ophthalmology	5644	867	697	1037	6290	14535
Paediatric Neurology	41	24	40	27	34	166
Paediatrics	2033	344	301	317	682	3677
Pain Management	86	5	4	13	86	194
Respiratory Medicine	2162	279	217	223	217	3098
Rheumatology	2166	324	384	520	1296	4690
Stroke Medicine	89	4	5	8	60	166
Trauma & Orthopaedics	3388	268	159	155	203	4173
Urology	3747	415	309	395	1305	6171
Vascular	100	20	22	10	10	162
Grand Total	**44660**	**4986**	**3858**	**4606**	**14519**	**72629**

Cefndir / Background

The Care Group is actively engaged with the Welsh Government Strategic Group for Outpatients, which sits within the Planned Care National Programme and is chaired by Will Oliver, NHS Wales Assistant Director of Performance and Improvement for Planned Care. National clinical leads are providing support across several outpatient workstreams, including initiatives to reduce follow-up delays.

Work is also progressing with the Clinical Director to assess the suitability of conditions for inclusion in See on Symptoms (SOS) and Patient-Initiated Follow-Up (PIFU) pathways. Current efforts are focused on reducing follow-up delays, particularly within the cohort experiencing delays of more than 100%, with support from Richard Egan, Clinical Lead for the National Planned Care Programme, and Ken Harries, Welsh Government Deputy Clinical Lead for Planned Care.

The Health Board's pre-Covid f/up position was high, with a snapshot at 05/04/2020 showing a total of 74,604 patients, which dropped to a low of 61813 at 04/04/2021. The post-Covid f/up position has steadily grown to its current position of 72,629. Steps taken to address this included admin validation and subsequent targeted clinical validation. However, the care group acknowledges this remains an issue due to the continued volume of f/up referrals being made in outpatient clinics.

Concerns have been raised by clinicians over the use of SOS and PIFU, however the risk remains higher to patients that remain unseen, waiting with delays that far exceed their original f/up appointment date. Corporate risk 2327, score 12 high risk.

Asesiad / Assessment

The proposed approach is centred on reducing the risk of avoidable harm arising from delayed follow-up appointments through systematic clinical risk stratification and pathway redesign. A clinically led review of all follow-up patients waiting more than 100% beyond their intended review date is being undertaken, with priority given to those specialties and patient groups at greatest risk of deterioration, disease progression or loss of treatment opportunity. Patients are stratified according to clinical risk, condition severity, required monitoring intervals and potential consequences of delay. This will ensure patients requiring urgent clinical review are prioritised for appointments, whilst those assessed as clinically stable and suitable for alternative pathways are safely transitioned to Patient Initiated Follow-Up (PIFU) or See on Symptoms (SOS) pathways. This approach supports harm reduction, improves surveillance of high-risk patients and ensures available capacity is directed towards those with the greatest clinical need.

A current assessment of the >100% delays show noted improvements in the specialties of Ophthalmology and Dermatology:

- Ophthalmology has achieved a significant reduction in its Follow-Up Waiting List over the past year, reducing the overall backlog by 1,035 patients and delayed follow-ups by 851 patients. However, performance remains below the 95% Eye Care Measure target, reflecting ongoing workforce, capacity and pathway challenges. The greatest pressure remains within chronic disease management, particularly glaucoma, where many patients require lifelong surveillance. Recovery actions focus on increasing follow-up capacity, expanding virtual and community-based pathways, strengthening workforce, and improving the use of PIFU, SOS and WGOS pathways to reduce avoidable follow-up demand. Whilst improving, follow-up delays remain a key quality and safety risk requiring continued oversight.

- Dermatology have had a focused effort on clinical validation of historic and current f/ups and are embedding clinical validation into practice moving forward. This is an example of best practice.

Concerns remain in the following specialties as their >100% delayed f/up position is worsening:

- Rheumatology and Neurology: These specialties struggle to recruit and are dependent very much on new capacity being offered for first outpatient appointment due to volume of referrals, therefore leaving limited capacity for f/up appointments. Through the reframing of the management of historical and new f/ups, the care group will focus in areas as above to improve the position swiftly.

The proposed method for clinically effective clearance of this backlog is to evaluate the suitability of patients referred for f/up pre-2025. The number of F/up appointments >100% delayed not booked referred from pre-2025 are 3,757 (25.9% of appointments >100% delayed). To mitigate the risk of clinical harm that may come to these patients due to this delay, we propose their conversion to SOS and PIFU pathways where clinically appropriate, in line with the STEEEP framework:

Safe

The primary objective of the programme is to reduce the risk of avoidable harm associated with prolonged follow-up delays. Clinical validation and risk stratification of patients waiting beyond

their intended review date will identify those at highest risk of adverse outcomes, including disease progression, deterioration in functional status, loss of treatment opportunity or irreversible harm. High-risk patients will be prioritised for clinical review, whilst clinically stable patients who meet nationally approved criteria will be transitioned to SOS or PIFU pathways with appropriate safety-netting, escalation routes and patient information. This targeted approach ensures clinical resources are focused on patients with the greatest potential for harm whilst maintaining safe oversight of lower-risk cohorts.

Timely

Risk stratification enables follow-up capacity to be allocated according to clinical urgency rather than chronological waiting time alone. By removing unnecessary routine reviews and prioritising patients based on need, services can respond more rapidly to patients at risk of deterioration, ensuring the right care is delivered at the right time and reducing the likelihood of harm associated with delayed intervention.

Effective

The pathway redesign supports evidence-based follow-up management by aligning appointment utilisation with individual patient risk and clinical need. Patients requiring ongoing surveillance and intervention will continue to receive planned follow-up care, whilst those with stable conditions can access care when symptoms change. This reduces unwarranted follow-up activity and supports more effective management of finite outpatient capacity.

Efficient

The removal of low-value routine follow-up appointments following clinical review and risk assessment will release capacity that can be redirected towards patients experiencing the longest delays and those at highest risk. This supports improved management of waiting lists whilst maximising the use of available clinical resources.

Equitable

A standardised risk stratification methodology and nationally recognised inclusion and exclusion criteria will ensure patients are prioritised consistently based on clinical need and risk rather than specialty, geography or other factors. This will reduce variation in follow-up management and provide a transparent and equitable approach to accessing outpatient care.

Person-Centred

Patients will be partners in managing their ongoing care through PIFU and SOS pathways, supported by clear communication, education, safety-netting advice and direct routes back into specialist services where concerns arise. Patients identified as requiring ongoing surveillance will continue to receive planned follow-up appointments appropriate to their level of clinical risk. This approach provides reassurance that care is tailored to individual need while reducing the burden of unnecessary hospital attendance.

Quality planning: this will be achieved through a clear governance process. Stakeholder engagement will be essential, along with transparent communication with service management teams and clinical leads throughout the process. The efforts will be coordinated to enact this change in a structured interdisciplinary manner.

Quality control: this will be monitored via clinical engagement and adherence to CIN guidance. The clinical conditions most suitable for conversion to SOS and PIFU pathways will be identified. **Quality improvement:** this will be monitored and acted upon in the form of Plan, Do, Study, Act (PDSA) cycles in which the collation of accurate data at start of change process, continued monitoring of data throughout, and continued evaluation following change completion will be monitored. Learning from this process will allow for implementation of new ways of working which can be replicated and standardised across systems and departments.
Argymhelliad / Recommendation The Committee is asked to take assurance that progress is being achieved to mitigate harm to delayed follow up patients, and further work is in development as noted in the SBAR.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	2.1 Provide the Board with assurance that care across the Health Board is safe, timely, efficient, effective, equitable and person-centred.
Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	Corporate risk 2327, score 12 high risk.
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	1. Safe 2. Timely 6. Person-Centred 3. Effective 5. Equitable 7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	5. Whole systems persepctive Choose an item. Choose an item. Choose an item. Choose an item.
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable Choose an item. Choose an item. Choose an item. Choose an item.
Nodau Cynllunio 2026/27 Planning Goals 2026/27	6. Safe, Timely, High Quality Care Choose an item. Choose an item. Choose an item. Choose an item. Choose an item. Choose an item. Choose an item.

Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	1. Deliver plans that increase our contribution to a sustainable, low carbon future 7. Improve health and well-being by focusing on prevention and early intervention, while working in partnership to ensure everyone has equal access to care and opportunities for good health Choose an item. Choose an item. Choose an item. Choose an item. Choose an item. Choose an item.
Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau) A Social Model for Health and Wellbeing: (*complete for strategic change and/or significant service changes)*	Choose an item. Choose an item. Choose an item. Choose an item. Choose an item. Choose an item. Choose an item. Choose an item.
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	This SBAR has been presented to the Clinical Care Group

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No Impact
Ansawdd / Gofal Claf: Quality / Patient Care:	Contained within the report
Gweithlu: Workforce:	No Impact
Tegwch Iechyd: Health Equity:	Contained within the report
Risg: Risk:	Contained within the report
Cyfreithiol: Legal:	No Impact

Enw Da: **Reputational:**	No Impact
Gyfrinachedd: **Privacy:**	No Impact
Cydraddoldeb: **Equality:**	No Impact

6

10 Mins

6 - Escalation Report

Sharon Daniel (Hywel Dda UHB - Executive Director of Nursing, Quality & Patient Experience)

For discussion

Attachments

QSEC Escalation Update - August 2026.pptx

Targeted Intervention Escalation Update: Hospital-Acquired Infections (HCAI)

August 2026

Lead executive: Mrs Sharon Daniel, Executive Director of Nursing, Quality and Patient Experience

Report author: Mr Shaun Ayres, Director of Delivery

Introduction: quality and access

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Purpose. This pack sets out the Committee's quality and safety escalation assurance for August. It covers two connected strands: infection prevention and control, and access.

Infection Prevention and Control. Under the revised escalation framework, the three hospital-acquired infection targets remain as de-escalation criteria. The pack updates the committee on C. difficile, S. aureus and E. coli, now extended to the first quarter of 2026/27, together with the supporting improvement and assurance position.

Access. At our recent Performance and Improvement meeting, Welsh Government set a specific expectation that we focus on quality and access. This pack responds, drawing on the information set out in our Performance dashboard to show what our incident and complaint data tell us about access.

Approach. Both strands are presented by year, by Clinical Care Group (CCG) and by theme, so the Committee can see clearly where to focus. The most recent period is part-year and provisional.

Where we are

The position is unchanged: none of the three organisms have yet achieved the de-escalation standard, which requires monthly cases at or below the threshold for three consecutive months.

C. difficile remains rated Advise. It is the closest to target but has not held the required run.

S. aureus and E. coli remain rated Alert, sitting above threshold in most months.

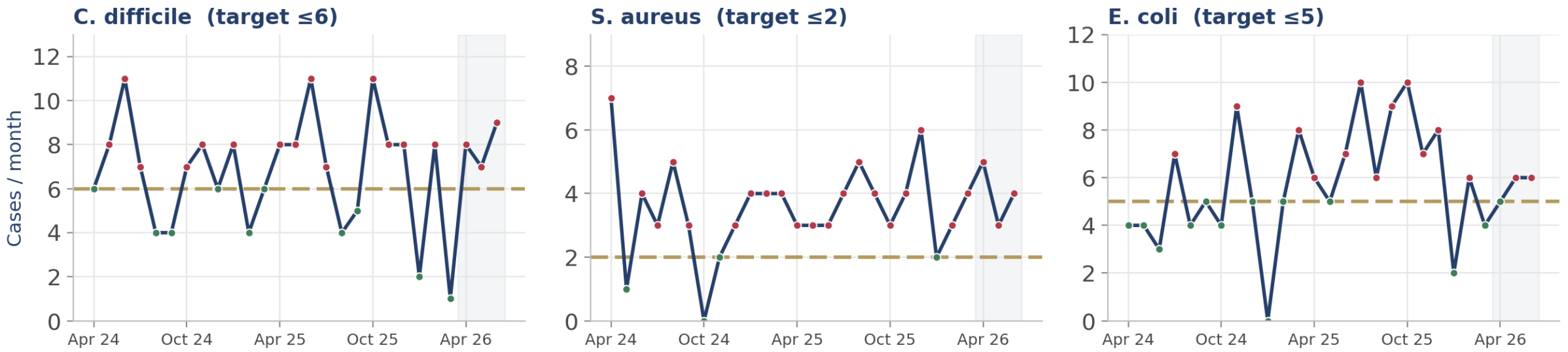
The first quarter of 2026/27 has not improved the picture. For C. difficile it has moved the wrong way.

Organism	Rating	Q1 mean	3-mth met
C. difficile (≤6)	ADVISE	8.0	No
S. aureus (≤2)	ALERT	4.0	No
E. coli (≤5)	ALERT	5.7	No

The infection trend at a glance

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Hospital-onset HCAI: monthly trend, April 2024 to June 2026



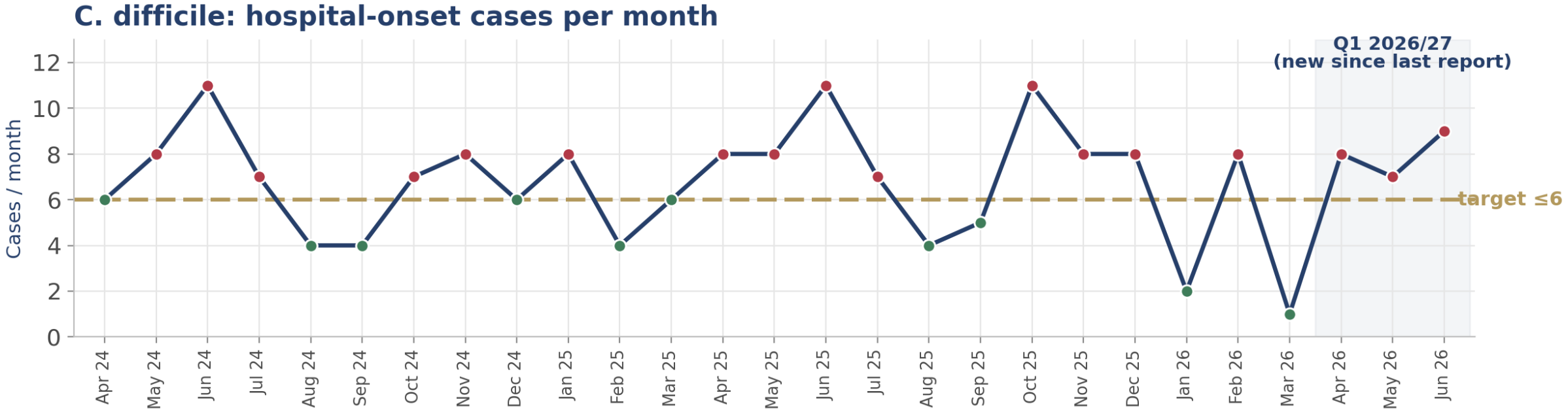
Performance is variable rather than improving. Green points show months at or below target; red points show months above it.

C. difficile: 2025/26 mean 6.8 against a target of 6. The first quarter of 2026/27 has risen to a mean of 8.0, with all three months above threshold.

S. aureus: mean 3.7 in 2025/26 and 4.0 in the first quarter, against a target of 2. Only one month in 2025/26 met the threshold.

E. coli: mean 6.7 in 2025/26 and 5.7 in the first quarter, against a target of 5. April met the target; May and June did not.

C. difficile: Closest, not yet sustained



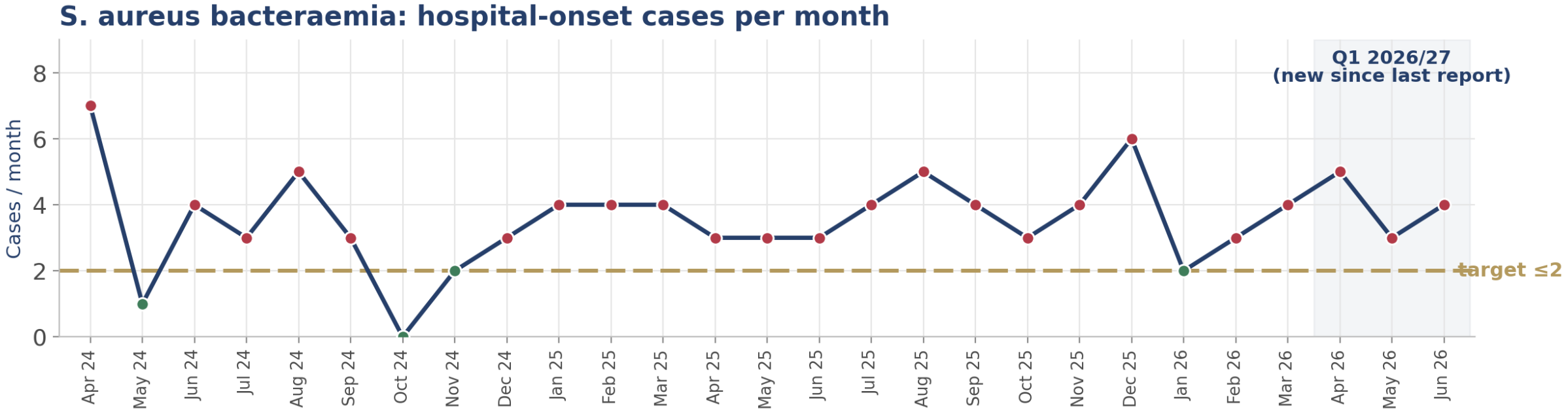
Target. Reduce hospital-onset cases by 25% to no more than 6 per month, sustained for three months. The 2025/26 mean was 6.8; the first quarter of 2026/27 averaged 8.0 (April 8, May 7, June 9).

What the data tells us. The count swings sharply, from 1 in March to 9 in June. Two strong months in early 2026 were not held, and the recent rise coincides with wider antimicrobial pressure.

What the actions are doing. Electronic prescribing and medicines administration is being introduced to strengthen antimicrobial stewardship. The NHS Wales Prevent C. difficile campaign launched here in June 2026. Cases are reviewed monthly at the assurance group for themes and learning.

Assessment. Achievable in individual months but not yet sustained. Continued ownership and environmental decontamination are essential.

S. aureus: persistently above threshold



Target. Reduce hospital-onset cases by 33% to no more than 2 per month, sustained for three months. The 2025/26 mean was 3.7; the first quarter of 2026/27 averaged 4.0 (April 5, May 3, June 4).

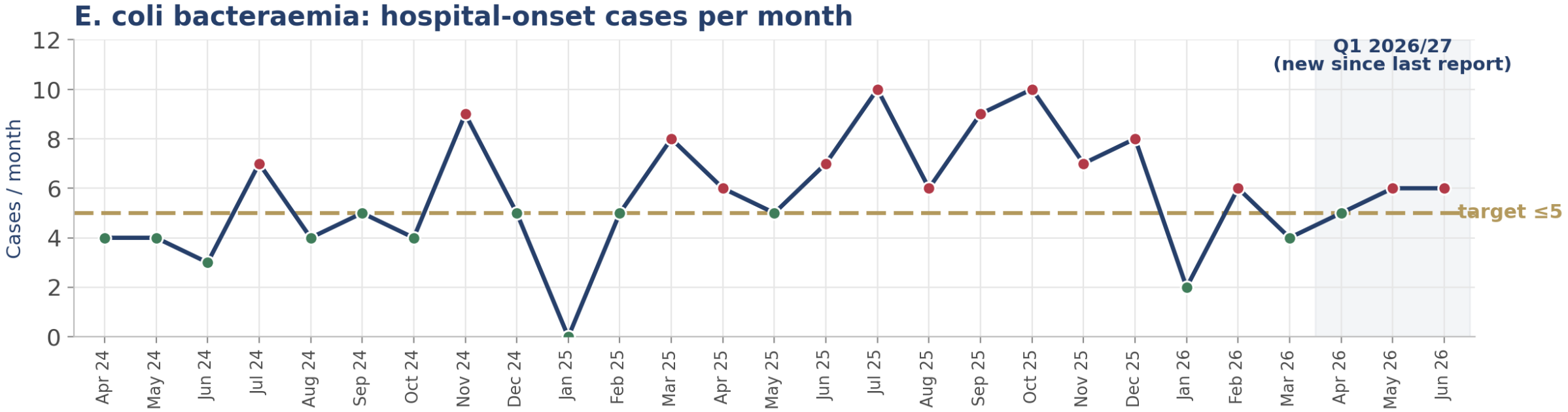
What the data tells us. The threshold is rarely met, reaching it only once in 2025/26 (January). Device-related, wound and musculoskeletal sources predominate, which points to the insertion and maintenance of invasive devices as the main opportunity for prevention.

What the actions are doing. Aseptic non-touch technique, the standard method for handling devices and wounds without introducing infection, is the focus. CCG's monitor compliance, assessor training is offered to clinical areas, and high-rate areas are shared monthly.

Assessment. The trajectory remains above target. Sustained improvement depends on consistent technique and device care.

E. coli: is the most volatile

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board



Target. Reduce hospital-onset cases by 25% to no more than 5 per month, sustained for three months. The 2025/26 mean was 6.7; the first quarter of 2026/27 averaged 5.7 (April 5, May 6, June 6).

What the data tells us. Counts are volatile. Urinary tract infections and catheter-associated sources predominate, and community-onset infection far exceeds hospital-onset, so prevention reaches beyond the hospital.

What the actions are doing. A urinary tract infection quality improvement programme is in development. Health and wellbeing materials have been printed for summer public events. Hand hygiene observational audits and infection prevention validation audits continue.

Assessment. April reached target but the run did not hold. Sustained achievement requires a step change in catheter management and urinary tract infection prevention.

What the infections are telling us

Considered together, the three organisms point to a small number of potentially modifiable drivers rather than isolated events.

Invasive devices. S. aureus is concentrated in device, wound and musculoskeletal sources. This is the clearest line of preventable harm and the strongest argument for reliable aseptic technique.

Urinary tract and catheter care. E. coli is dominated by urinary sources, with most infection arising in the community. Catheter avoidance, prompt removal and hydration are the levers.

Antimicrobial use and environment. C. difficile tracks antibiotic exposure and environmental contamination, which is why clear ownership and decontamination sit at the centre of the response.

The common thread is consistency. The interventions are known and in place. The gap is reliable, everyday delivery at ward level.

The improvement programme

We have an infection prevention and control organisational improvement plan aligned to the Welsh Government Anti Microbial Resistance (AMR) and HCAI improvement goals for 2025 to 2027 and the 2026 quality statement on infection prevention and control.

Ownership. Electronic prescribing and the Prevent C. difficile campaign support more targeted antibiotic use. A clinician-led hospital-acquired pneumonia audit is underway across acute sites, as required nationally.

Technique and training. Aseptic non-touch technique is the priority for device-related infection, with assessor training offered to clinical areas and a request submitted to make competency assessment mandatory on the electronic staff record.

Assurance and learning. Cases are reviewed monthly at the assurance group, with learning and high-rate areas shared with CCG's. An assessment against the new national cleaning standards for Wales is in progress.

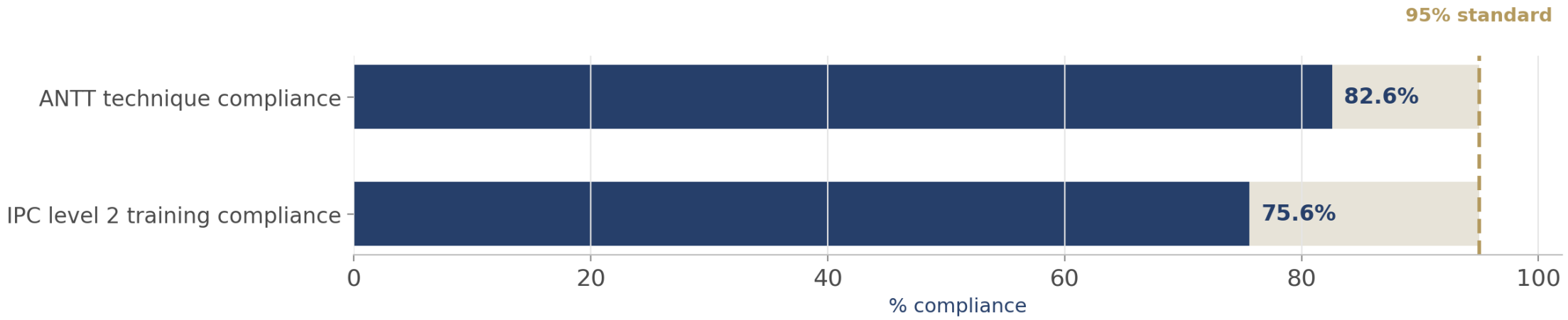
Where assurance is not yet complete

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Spot audits and compliance monitoring show that the right practices are not yet consistently in place. There is a current gap between having the interventions and delivering them reliably.

Technique. Aseptic non-touch technique compliance sits below the 95% standard and varies widely across clinical areas, from below 50% to 100%. Competency assessment is not yet mandatory on the electronic staff record, which limits assurance.

Training and environment. Infection prevention level 2 training is below the required standard, and the assessment against the new national cleaning standards is not yet complete.



The implication to consider closing these compliance gaps is the most direct route to sustained de-escalation. Ward-level detail is available to the Committee on request.

Key risks and next steps

Risks. S. aureus and E. coli remain above threshold with no clear path to the sustained three-month standard, and C. difficile has deteriorated in the first quarter. Compliance gaps in technique and training limit the impact of the programme. Negative pressure isolation capacity is a red-rated infrastructure risk for high consequence infections.

Next steps. Hold aseptic technique compliance to the 95% standard and pursue mandatory competency on the electronic staff record. Complete the cleaning standards assessment. Progress the urinary tract infection quality improvement programme. Sustain monthly case review and shared learning. Continue to develop capital options for isolation facilities for future executive consideration.

Trajectory. The assessment assumes no further deterioration and depends on consistent ward-level delivery. The most recent month is provisional.

Wider infection prevention risks

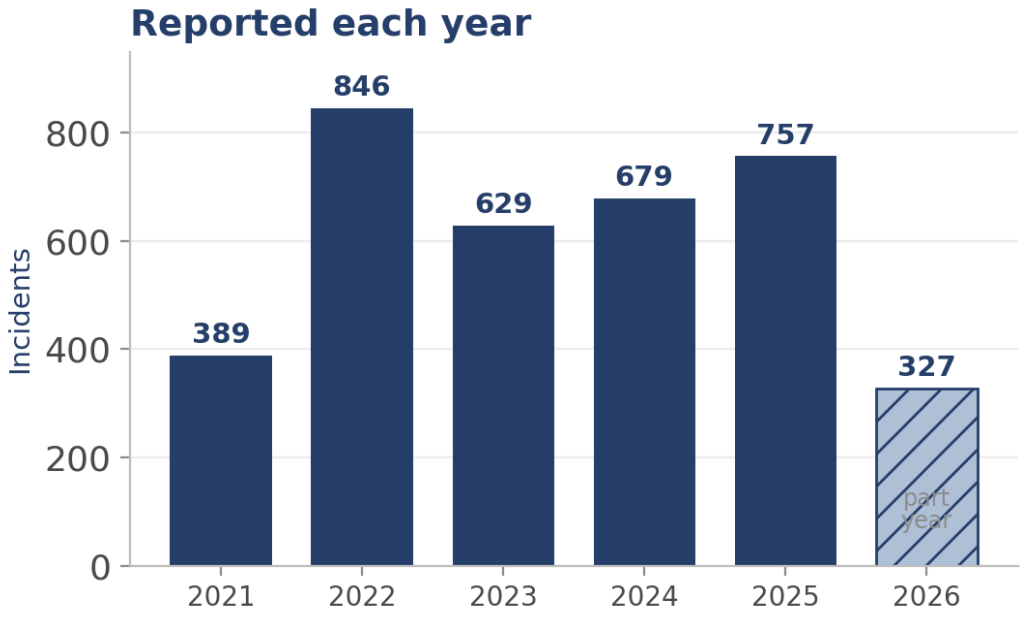
Three wider risks bear on assurance this quarter.

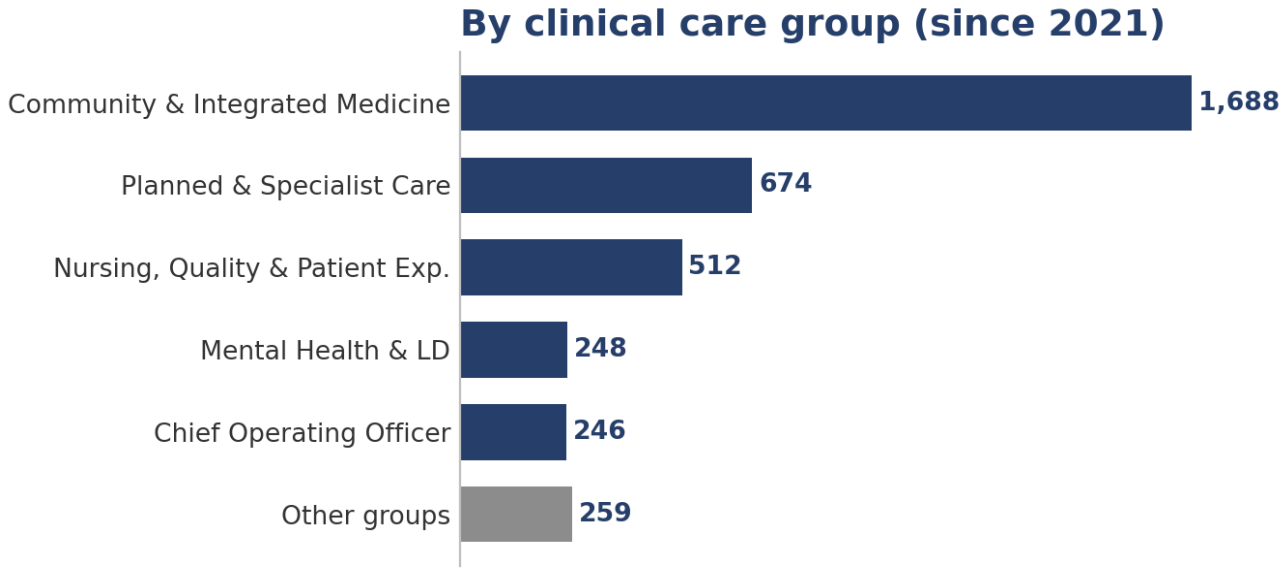
Glangwili Intensive Care. An action plan continues following Stenotrophomonas maltophilia colonisation linked to unit drains. There were no cases in March and April; a new case at the end of May prompted a review with nursing, infection prevention, estates and facilities; and there were no further cases in June.

High consequence infectious diseases. Preparedness for Hantavirus and Ebola continues. Overall acute site readiness is rated Amber, with red-rated risks in negative pressure isolation capacity. A feasibility study for compliant isolation facilities is in progress and will require significant capital investment.

Outbreaks and scabies. No respiratory or norovirus outbreaks were reported in June. Scabies and associated contact tracing remain an operational pressure, reflecting increased prevalence in the community.

Access-linked incidents: scale and spread





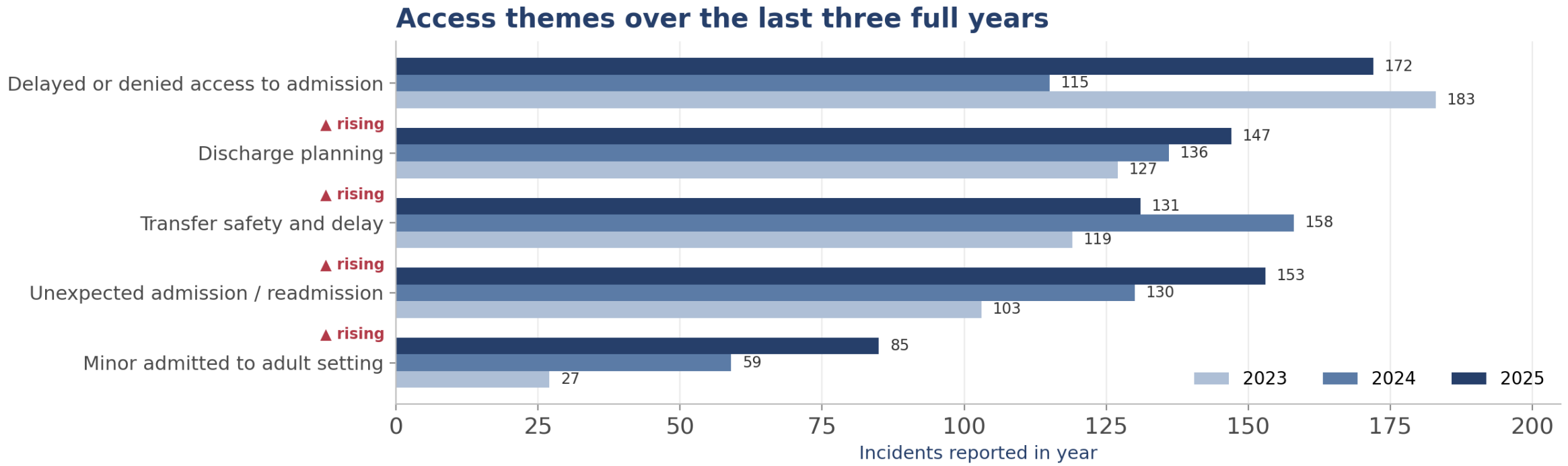
Welsh Government, through Performance and Improvement, has asked us to understand the impact on access. Access is not a formal de-escalation criterion, but our incident data gives an early, ward-level signal of where access pressure is showing.

Scale. We have recorded 3,627 access-linked incidents since 2021, covering delayed access and admission, transfers and discharge. Annual reporting rose from 629 in 2023 to 757 in 2025. The 2026 figure is part-year and provisional (end of June).

Harm. Most cause no or low individual harm (98%), but 91 reached moderate or greater harm, including 6 severe or catastrophic. The value is as a leading indicator of flow and access pressure, not only of harm.

Where it sits. Almost half fall within Community and Integrated Medicine, our Urgent and Unscheduled Care Group, with Planned and Specialist Care next. This is where focus will have most effect.

Access incidents: where to focus



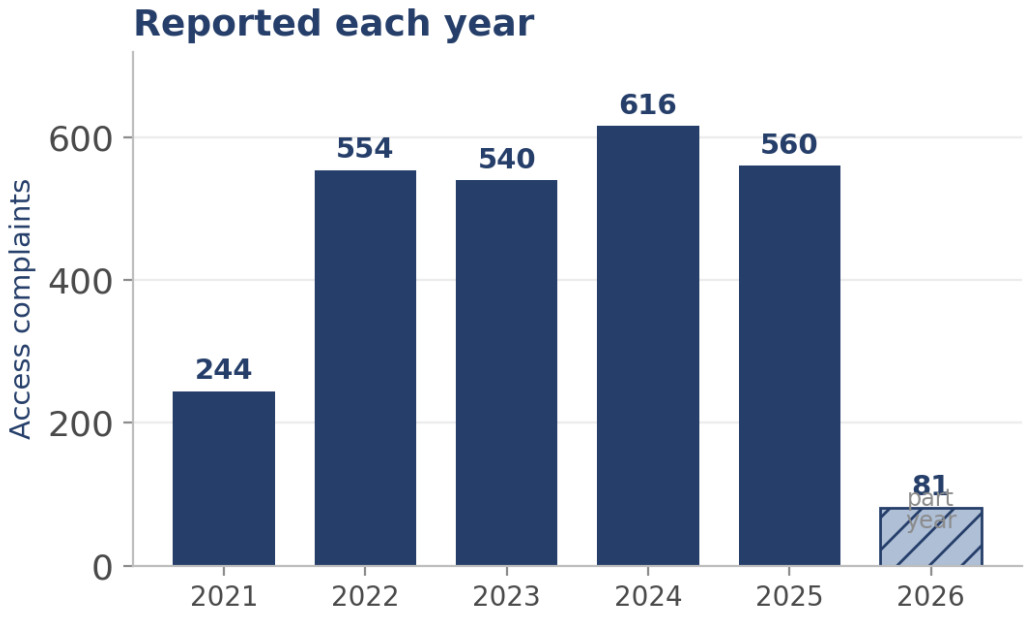
Grouped thematically, five access themes stand out, and four are rising.

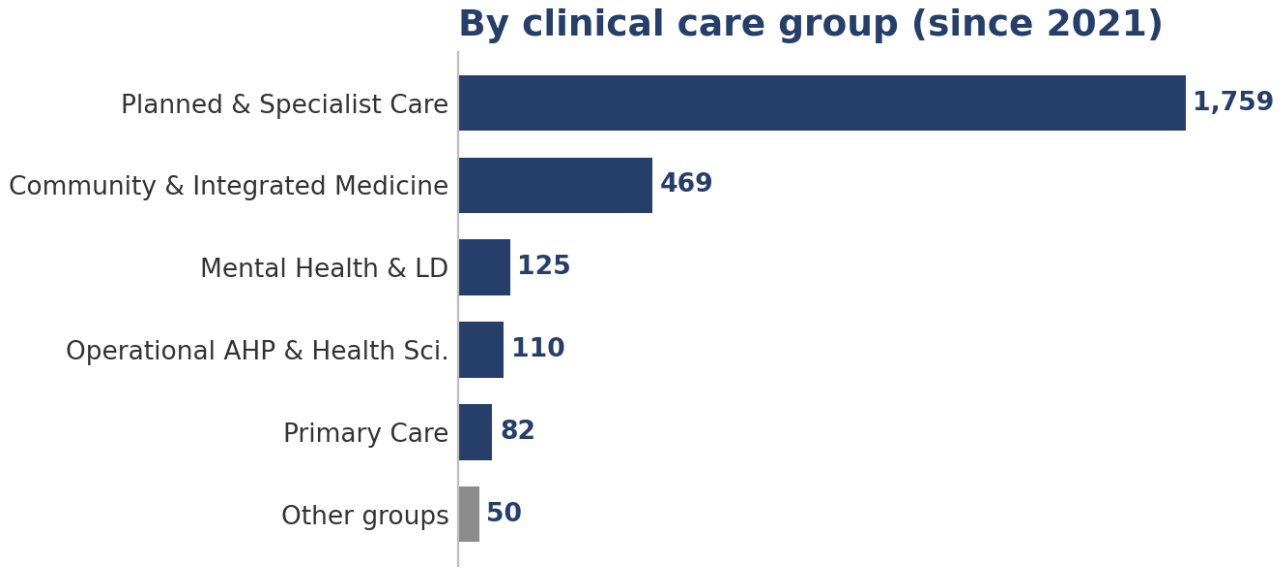
Delayed or denied access to admission remains the largest single theme and reflects front-door and flow pressure.

Four themes are trending upwards and warrant focus: discharge planning, where the most common failure is a service referral not being made; transfer safety, including inappropriate or unsafe transfers; unexpected admissions and readmissions, including escalation to high-dependency care; and admission of a minor to an adult setting, which has more than trebled since 2021 and carries a specific safeguarding concern.

What this suggests. Focus on discharge referral completion, transfer safety, and the readmission and escalation pathway, with a targeted look at the minor-in-adult-setting theme. These are access signals the Committee may wish to seek assurance on and will likely be a focus for Welsh Government and Performance and Improvement in the coming months.

Access complaints: scale and spread





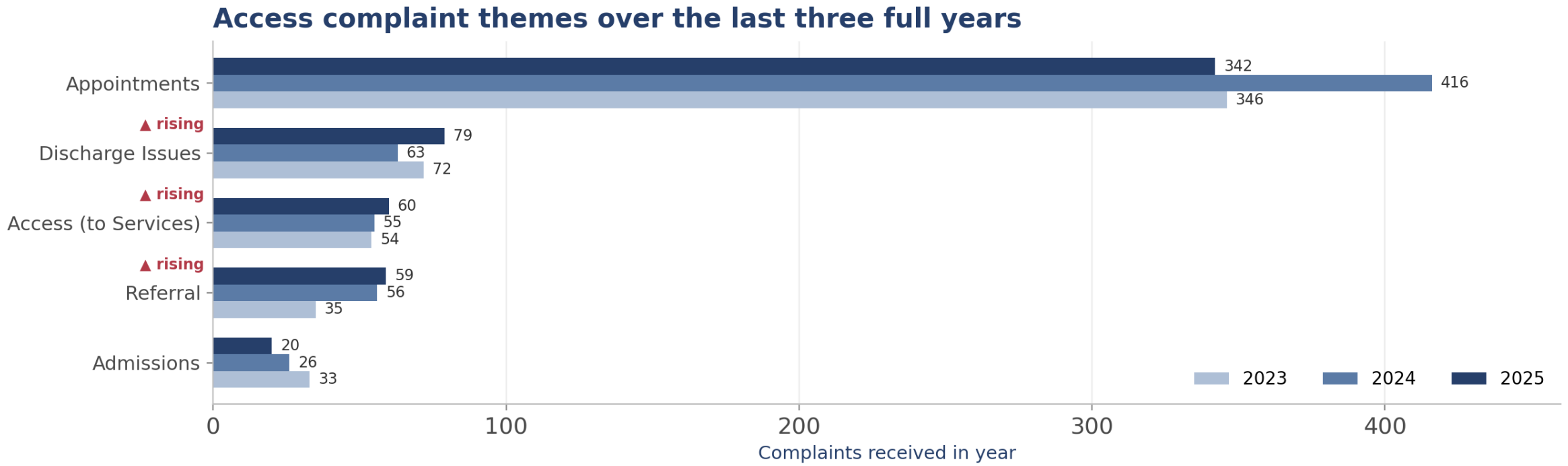
Complaints give a second lens on access, from the patient's side. Here we isolate the access-related complaints, so the Committee sees the same question the incident data raised.

Scale. We have recorded 2,595 access-related complaints since 2021, about one in four of all complaints, covering appointments, access to services, admissions, referral and discharge. Volumes rose from 244 in 2021 to a peak of 616 in 2024, and 560 in 2025. The 2026 figure is part-year and provisional (June 26).

Where it sits. Over two-thirds fall within Planned and Specialist Care, our elective and outpatient services. This is the reverse of access incidents, which concentrate in unscheduled care.

The two lenses together. Complaints point to the planned and outpatient pathway, incidents to unscheduled flow.

Access complaints: which themes stand out



Appointments is by far the largest access complaint theme, at 1,664 since 2021, and reflects waiting and outpatient access pressure.

Three themes are rising and echo the incident picture: access to services, referral, and discharge. Referral complaints have risen from 35 in 2023 to 59 in 2025, and access to services from 54 to 60. Admissions complaints are falling, and appointments, while the largest, has plateaued since its 2024 peak.

What this suggests. Complaints and incidents converge on the same access levers: appointments and access to planned care, referral pathways, and discharge. This is where Committee may wish to focus, and the response to Welsh Government, would have most traction. Clinical treatment remains the largest complaint theme overall but sits outside the access lens.

Recommendation

The Committee is asked to:

- **Scrutinise** that none of the three hospital-acquired infection de-escalation criteria has yet achieved the sustained three-month standard, and that the first quarter of 2026/27 has not improved the position.
- **Consider** the Alert ratings for S. aureus and E. coli and the Advise rating for C. difficile.
- **Receive assurance** from the improvement programme and monthly case review, while recognising that compliance gaps in technique and training remain the principal barrier to sustained de-escalation.
- **Discuss** the continued development of capital options for negative pressure isolation facilities to address the red-rated high consequence infectious disease risk.
- **Request** a future deep dive into current access issues; with a specific focus on Incidents within Community and Integrated Medicine CCG and Complaints within Planned and Specialist CCG

7

7 - Policies/ Procedures for Approval

7.1

7.1 - 309 - Continuing NHS Healthcare Operational Policy to Support Framework for Implementation

Tracy Devantier (Hywel Dda UHB - Performance and Improvement Manager)

For approval

Attachments

CHC Operational policy SBAR June 26.pdf

309 - LTC Operational Policy -v4 for approval.pdf

EqIA Screening form July 2026.pdf

Pwyllgor Ansawdd, Diogelwch a Phrofiad/ Quality, Safety and Experience Committee

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	11 AUGUST 2026
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	LONG TERM CARE OPERATIONAL POLICY
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	ANDREW CARRUTHERS, CHIEF OPERATING OFFICER
SWYDDOG ADRODD: **REPORTING OFFICER:**	JULIA MCCARTHY, HEAD OF LONG-TERM CARE

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/ For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Long-Term Care (LTC) team work within/take guidance from the National Framework for NHS Continuing Healthcare (CHC) and NHS Funded Nursing Care (FNC). It includes Practice Guidance to support staff delivering NHS Continuing Healthcare. The updated LTC Operational policy has been amended to include any new changes in the revised National Framework in July 2022.

Cefndir / Background

The Welsh Assembly Government had produced a 2021(revised in July 2022) Framework for Continuing NHS Healthcare (CHC). It sets out the Welsh Assembly Government's policy for eligibility for CHC and the responsibilities of NHS organisations and local authorities under the framework and related matters. Hywel Dda University Health Board's LTC Operational Policy is based on this National Framework.

The revised National Framework sets out the principles and processes of NHS Continuing Healthcare and NHS-funded Nursing Care and the approach to be taken by practitioners to the assessment and decision-making and indicates the governance arrangements surrounding the application and process.

The updated Operational Policy reflects updated guidance and new processes to be followed.

The effective date for the Framework was 1st April 2022. The Framework has been approved by all Welsh Health Boards.

Hywel Dda University Health Board (HDUHB) has worked with partner organisations to develop this operational policy for Hywel Dda residents. In doing so, the National Framework for Continuing Healthcare issued by Welsh Assembly Government has been very closely followed, to ensure consistency across Wales.

Asesiad / Assessment

The Health Board is responsible for:

- Ensuring consistency in the application of the Continuing NHS Healthcare National Framework; promoting awareness of CHC.

- Implementing and maintaining good practice, ensuring quality standards are met and sustained, delivering joint, consistent training and development opportunities for all relevant health and social care practitioners.

- Identifying and acting on issues arising in the provision of CHC.

- Informing commissioning arrangements, both on a strategic and individual basis.

- Ensuring best practice in assessment and record keeping.

- The provision of strategic leadership and organisational and workforce development and ensuring systems operate effectively and deliver improved performance.

The Health Board is responsible for ensuring access to assessment, decision-making and provision should be fair and consistent. There should be no discrimination on the grounds of race, disability, gender, age, sexual orientation, religion or belief, or type of health need (for example whether the need is physical, mental or psychological). Local Health Boards are responsible for ensuring that discrimination does not occur and should use effective monitoring to monitor this issue.

When an individual has been assessed as having a primary health need, and is therefore eligible for CHC, the Health Board has responsibility for funding the full package of health and social care. Where the individual is living at home, this does not include the cost of accommodation, food or general household support. The Health Board will contract with other organisations and, in particular, the independent sector, and will be responsible for ensuring that the quality and range of services are sufficient to meet the individual's needs.

Regular reviews will take place to ensure those services remain fit for purpose.

Argymhelliad / Recommendation

For the Quality, Safety and Experience Committee to approve the revised 309 Long Term care operational policy

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	3.22 Approve policies and plans within the scope of the Committee, having taken an assurance that the quality and safety of patient care has been considered within these policies and plans.
Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply Choose an item. Choose an item. Choose an item. Choose an item. Choose an item.
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply Choose an item. Choose an item. Choose an item. Choose an item.
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable Choose an item. Choose an item. Choose an item. Choose an item.
Nodau Cynllunio 2026/27 Planning Goals 2026/27	All Planning Goals Apply Choose an item. Choose an item. Choose an item. Choose an item. Choose an item. Choose an item. Choose an item.
Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	9. All HDdUHB Well-being Objectives apply Choose an item. Choose an item. Choose an item. Choose an item. Choose an item. Choose an item. Choose an item.
Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau) A Social Model for Health and Wellbeing: (*complete for strategic*	7. All Apply Choose an item. Choose an item. Choose an item. Choose an item. Choose an item. Choose an item.

change and/or significant service changes)	Choose an item.
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No Impact Identified
Ansawdd / Gofal Claf: Quality / Patient Care:	Working within the CHC framework in Wales should not adversely impact quality or patient care. However, we continue to work collaboratively with our Health Board colleagues, Local Authority partners, and the Regional Partnership Board to ensure that any new initiatives are carefully considered and support the ongoing improvement of quality and patient care.
Gweithlu: Workforce:	The service ensures that its workforce has the necessary skills and competencies to carry out their duties effectively, in line with CHC framework processes.
Tegwch Iechyd: Health Equity:	Equality Impact Assessment completed
Risg: Risk:	Risks within the CHC framework are mitigated through robust governance, clear accountability, comprehensive assessment and care planning, ongoing review, workforce competence, and strong multi-agency collaboration to ensure safe and effective care delivery.
Cyfreithiol: Legal:	Legal risks and potential challenges are mitigated through clear, transparent processes in line with the CHC framework. This includes robust documentation of all decisions, adherence to policy, and the application of formal appeals, complaints, and retrospective review processes to ensure decisions are fair, evidence-based, and able to withstand scrutiny.

Enw Da: **Reputational:**	Reputational risks are mitigated through transparent, consistent, and person-centred delivery of CHC processes, supported by clear communication with families, robust quality assurance, and close partnership working with Health Board colleagues, Local Authorities, and independent sector providers, including private nursing homes.
Gyfrinachedd: **Privacy:**	Privacy risks are mitigated by ensuring all data is handled in line with information governance requirements, including secure storage and sharing, obtaining appropriate consent, and limiting access to those directly involved in care, in accordance with CHC framework and organisational policies.
Cydraddoldeb: **Equality:**	Equality Impact Assessment completed

CONTINUING NHS HEALTHCARE OPERATIONAL POLICY FOR LONG TERM

Policy information

Policy number: 309
Version: 4

Classification: Corporate
Supersedes: 309 previous version
Local Safety Standard for Invasive Procedures (LOCSSIP) reference: NA
National Safety Standards for Invasive Procedures (NatSSIPs) standards: NA
Date of Equality Impact Assessment: 21/12/2023

Approval information

Approved by: QSEC
Date of approval: Click or tap to enter a date.
Date made active: 19/08/2024
Review date: 15/08/2027

Summary of document:
The Welsh Assembly Government has produced a 2021 Framework (referred to throughout this document as the "Framework") for Continuing NHS Healthcare (CHC). It sets out the Welsh Assembly Government's policy for eligibility for CHC and the Responsibilities of NHS organisations and local authorities under the framework and related matters.

Hywel Dda University Health Board's (HDdUHB) Operational Policy is based on this National Framework.

The policy outlines the approach to be taken by practitioners to the assessment and decision making process and indicates the governance arrangements surrounding the application and process.

Scope:
This Policy applies to all HDdUHB staff in Long Term care and Independent stakeholders, contractors, other third parties working in UHB and those who work in partnership with HDdUHB. All Managers working clinical and non-clinical, as well as corporate services in the HDdUHB

To be read in conjunction with:
Welsh Government: Continuing NHS Healthcare Framework 2021
Sustainable Care Planning in Continuing NHS Healthcare Feb 2011

NHS Funded Nursing Care in Care Homes 2004
Responsible Body Guidance Wales
Social Services and Well Being (Wales) Act 2014

Patient information:
Continuing NHS Healthcare Information Booklet for Individuals, Families and Carers (gov.wales)

Owning group: Long Term Care Management Team
Executive Director job title:

Reviews and updates:
Version 1 – November 2012
Version 2 – 3 August 2018 (archived)
Version 3 – August 2024 (Archived 28.8.2025 due to changes required following a recent Ombudsman case)
Version 4

Keywords
CHC / Continuing Health Care/ NHS Funded Care / Decision Support Tool / DST / Care Planning.

Glossary of terms

Term	Definition
All Wales Retrospective CHC Review Document	There are different arrangements concerning the administration of ongoing or contemporary CHC cases and those of backdated, or retrospective ones. The DST is used in contemporaneous assessments and provides a picture of the needs at one point in time. A retrospective review covers a long period of time, and it is necessary to identify changes in need over that period that may indicate eligibility /no eligibility at different times based on identified need. The All Wales Retrospective CHC Review document (formerly the All Wales Needs Assessment document) is based on the DST but facilitates the identification of needs over an extended period of time which may be divided into a number of periods depending on the length of the whole claim period
Assessment	The process whereby the needs of an individual are identified and their impact on independence, daily functioning and quality of life is evaluated, so that appropriate action can be planned. Assessment involves both professionals and those with the needs thinking through different explanations for how needs have arisen, and how different needs interact with each other. Further information on assessment is contained in the guidance 'Social Services and Well Being (Wales) Act 2014'

DRAFT

Behaviours that challenge	Behaviours that challenge are defined as "culturally abnormal behaviour(s) of such intensity, frequency or duration that the physical safety of the person or others is placed in serious jeopardy, or behaviour which is likely to seriously limit or deny access to the use of ordinary community facilities.
Care Co Ordinator	An identified NHS clinical professional or social care professional that takes the lead in ensuring that an individual's package of care is properly managed and monitored. In addition the care co-ordinator ensures that the individual is kept informed of the process and involved in discussions about their care
Care Home	An establishment registered under the Regulations and Inspections of Social Care Act 2016 to provide accommodation, together with nursing or personal care.
Care Management	A process whereby an individual's needs are identified and evaluated, eligibility for services is determined, Personal Plans of Care are drafted and implemented, and needs are monitored and reassessed. ("Case management" is an alternative term.)
Care Package	A combination of support and services designed to meet individual's assessed needs
Care Plan	A document recording the reason why support and services are being provided, what they are, who provides them and what outcomes they seek
Care Planning and Review	Care Planning and Review is a dynamic process, bringing together the individual, their carers and professionals to agree how their needs can best be met, the actions needed and who will do them.
Care and Support Package	A combination of support and services designed to meet individual's assessed health and social care needs, as detailed in the Care and Support Plan.
Care and Support Plan	A Care Plan must contain: plans and actions to be undertaken to help achieve the desired outcomes; • The roles and responsibilities of the individual, carers and family members and practitioners (including for example GP, Nurse), and the frequency of contact with those; • The resources (including financial resources) required from each party; and • The review and contingency arrangements and how progress will be measured.
Carers	The Social Services and Well-being (Wales) Act 2014 defines a carer as a person who provides or intends to provide care for an adult or disabled child. The definition excludes those who

DRAFT

	provide or intend to provide care under, or by virtue of, a contract or as voluntary work.
Care Worker	Care workers provide paid support to help people manage the day-to-day activities of living. Support may be of a practical, social care nature or to meet a person's healthcare needs.
Cognition	The higher mental processes of the brain and the mind including memory, thinking, judgement, calculation, visual spatial skills etc.
Cognitive impairment	Cognitive impairment applies to disturbances of any of the higher mental processes, many of which can be measured by suitable psychological tests. Cognitive impairment, especially memory impairment, is the hallmark and often the earliest feature of dement
Commissioning	Commissioning involves a set of activities by which local health boards and local authorities ensure that services are planned and organised to best meet the health and social care outcomes of people in Wales. It involves understanding the need of their populations, best practice and local resources and using these to plan, implement and review changes in services. It encompasses both planning and procurement. Commissioning requires a whole systems perspective and applies to services across all sectors. Commissioning services to respond to the needs of people with continuing health care should not be undertaken in isolation to commissioning other closely related services. Local health boards can delegate the function of commissioning to local authorities and local authorities can delegate the function of commissioning to local health boards whilst still retaining their statutory responsibilities. This facilitates the development of a coherent approach to commissioning services such as, for example, residential and nursing home care or re-ablement and intermediate care services with one approach to developing contracts, service specifications, fee settings and quality assurance
Continuing NHS Healthcare (CHC)	A complete package of ongoing care arranged and funded solely by the NHS, where it has been assessed that the individual's primary need is a health need. Continuing NHS healthcare can be provided in any setting. In a person's own home, it means that the NHS funds all the care that is required to meet their assessed health and social care needs to the extent that this is considered appropriate as part of the health service. This does not include the cost of accommodation, food or general

	household support. In care homes, it means that the NHS also makes a contract with the care home and pays the full fees for the person's accommodation as well as their care
Decision Support Tool (DST)	The Decision Support Tool (DST) is designed to support the decision-making process. The tool must only be used following a comprehensive assessment of an individual's care needs. It is not an assessment in itself and it does not replace professional judgement in determining eligibility. It is simply a means of recording the rationale and facilitating logical and consistent decision-making. The DST is designed to ensure that the full range of factors that have a bearing on an individual's eligibility are taken into account in reaching the decision, irrespective of client group or diagnosis. It provides practitioners with a method of bringing together and recording the various needs in 12 'care domains' (see below), or generic areas of need. Each domain is broken down into a number of levels of severity.
Domain	One of 12 key areas of consideration within the integrated assessment and the Decision Support Tool. These are breathing, nutrition, continence skin integrity, mobility, communication, psychological & emotional needs, cognition, behaviour, drug therapies and medication, altered states of consciousness and other significant care needs.
End-of-Life Care	Care that helps all those with advanced, progressive, incurable illness to live as well as possible until they die. It enables the supportive and palliative care needs of both patient and family to be identified and met throughout the last phase of life and into bereavement. It includes the management of pain and other symptoms, and the provision of psychological, social, spiritual and practical support.
General Household Support	Such services as cleaning, laundry, meal preparation, shopping, cooking, collecting benefits, sitting with or accompanying on social outings
IRP	Independent Review Panel
Lead Professional/Care Co-ordinator	This is the person who: • Co-ordinates the assessment process, and draws in additional specialists as required; • Acts as a focus for communication for different professionals and the individual to make sure that information is recorded correctly; and, • Ensures that any problems or difficulties in the co-ordination or completion of an assessment are resolved.

DRAFT

	For people with mental health needs the Mental Health Measure makes specific requirements regarding who the Care Co-ordinator should be.
LA	Local Authority
LHB	Local Health Board
Long-term Care	This is a general term that describes the care which people need over an extended period of time, as the result of disability, accident or illness in order to address both physical and mental health needs. It may require services from the NHS and/or social care, and can be provided in a range of settings, such as a NHS hospital, a care home (providing either residential or nursing care), hospice, and in people's own homes. Long-term care is distinct from intermediate/transitional/interim care which has specific time limited outcomes for rehabilitation, reablement or recuperation.
LTCSpN	Long Term Care Specialist Nurse
Mental Capacity	The ability to make a decision about a particular matter at the time the decision needs to be made. The legal definition of a person who lacks capacity is explained in Section 2 of the Mental Capacity Act 2005: ' a person lacks capacity in relation to a matter if at the material time they are unable to make a decision for themself in relation to the matter because of an impairment of, or disturbance in the functioning of, the mind or brain'.
Mental Disorder	Mental disorder is defined in Section 1(2) of the Mental Health Act 1983 (as amended by the Mental Health Act 2007) as meaning 'any disorder or disability of the mind'.
Multi-disciplinary or Multi-agency	These terms refer to professionals across health and social care and the third sector who work together to address the holistic needs of their patients/clients in order to improve delivery of care and reduce fragmentation.
NHS	National Health Service
NHS Funded Nursing Care (FNC)	The provision of NHS Funded Nursing Care derives from Section 49 of the Health and Social Care Act, 2001 (now replaced, in relation to Wales, by Section 47(4) and (5) of the Social Services and Well-being (Wales) Act 2014), which excludes nursing care by a registered nurse from the services which can be provided by local authorities. NHS Funded Nursing Care applies to all those persons currently assessed as requiring care by a registered nurse in care homes. The decision

DRAFT

	on eligibility for NHS Funded Nursing Care should only be taken when it is considered that the person does not fall within the eligibility criteria for CHC.
Nursing Needs Assessment	An assessment undertaken by a registered nurse to determine the type of care required and appropriate setting to meet the needs
Palliative Care	The active holistic care of patients with advanced, progressive illness. This includes the management of pain and other symptoms and provision of psychological, social, spiritual and practical support. The goal of palliative care is the achievement of the best quality of life for patients and their families.
Power of Attorney	An applicant with an Enduring or Lasting Power of Attorney registered with the Court of Protection may, in general, exercise the patient's rights of access to records on behalf of that patient, but only to the extent that the information is necessary for them to be able to carry out their duties as an attorney or deputy. There is an important distinction between: a) Someone acting as Lasting Power of Attorney (health and welfare) who will generally be able to exercise the patient's rights of access to health and social care records in order to make informed decisions about their health and welfare. This includes being able to consent (or refuse consent) to the NHS CHC process and to sharing information with relevant professionals involved in the process. The Power of Attorney (POA) has to be registered and this type of POA can only be used if the individual has lost the capacity to make the relevant decision about their health and welfare. b) Someone with Enduring Power of Attorney (EPA) or someone acting as Lasting Power of Attorney (property and finance). Again the EPA or LPA has to be registered but can be used with the donor's permission to help them make decisions about property and finance even if they still have capacity to make such decisions themselves. More usually, the POA (property and finance) or EPA is used once the individual has lost capacity. Because CHC can have a significant impact on an individual's finances someone with this type of LPA or an EPA may well have legitimate reason for having access to health and social care records but only in so far as these are necessary for them to make a particular decision at a particular time regarding property and finance. An obvious example would be for them to have sufficient information to decide whether or not they agree with the eligibility decision made and whether or not to seek a review of that decision. Any health or welfare records which are

DRAFT

	not directly relevant should not be shared as they may contain sensitive information which the individual would not have wanted shared with the person to whom they gave the right to manage their financial affairs. Generally speaking the information that they are likely to need should be contained within the Decision Support Tool and the assessments which underlie it.
Primary Health Need	An individual is deemed to be eligible for CHC when their primary need is a health need: ‘’the primary health need approach’. This is determined by consideration of the four key characteristics of need: nature, intensity, complexity and unpredictability
Registered Nurse	A nurse registered with the Nursing and Midwifery Council. Within the UK all nurses, midwives and specialist community public health nurses must be registered with the Nursing and Midwifery Council and renew their registration every three years to be able to practise.
Rehabilitation	A programme of therapy and reablement designed to maximise independence and minimise the effects of disability
Social Care	Social care is care provided to support an individual’s social needs. It refers to the wide range of services designed to support people to maintain their independence, enable them to play a fuller part in society, protect them in vulnerable situations and manage complex relationships. Social care services are provided for people who need help/assistance to live their lives as independently as possible in the community (either at home or in a care setting), people who are vulnerable and people who may need protection. Local authorities, the voluntary sector and the independent sector can provide social care. This definition should be viewed in the context of the policy of the Welsh Government to move to a more integrated approach. The Social Services and Well-being (Wales) Act 2014 emphasises the duty of local authorities and local health boards to work together to develop integrated primary, community and wellbeing services that are focussed on the holistic needs of people.
Social services and Wellbeing (Wales) Act 2014	The Social Services and Well-being (Wales) Act (SSWBA) came into force on 6 April 2016. The SSWBA 2014 provides the legal framework for improving the well-being of people who need care and support, and carers who need support, and for transforming social services in Wales. It transforms the way social services are delivered, promoting people’s independence to give them stronger voice and control. The fundamental principles of the SSWBA 2014 are:

DRAFT

	Voice and control – putting the individual and their needs, at the centre of their care, and giving them a voice in, and control over reaching the outcomes that help them achieve well-being. • Prevention and early intervention – increasing preventative services within the community to minimise the escalation of critical need. • Well-being – supporting people to achieve their own well-being and measuring the success of care and support. Co-production – encouraging individuals to become more involved in the design and delivery of services
Social Work	Social work is a professional activity/service provided by a Registered Social Worker. It is an activity that can enable individuals, families and groups to identify personal, social and environmental difficulties adversely affecting them. It is a range of activities that can provide supportive, rehabilitative protective or corrective action. This can include care management, social care assessment and planning and counselling
Sustainable Care Planning Policy	This is a policy which has been developed and adopted by all local health boards in Wales for use when considering care planning options appropriate to meet the assessed need for people eligible for CHC. It describes the approach to fair and sustainable care planning within CHC and to the management of a fair allocation of resources within the wider context of care planning considerations.
WNCR	Welsh Nursing Care Records

DRAFT

Key points:

For individuals who are eligible to receive it, CHC is an entitlement. It is essential to aim for a decision on eligibility to be right first time. Incorrectly denying someone eligible for CHC access to their entitlement can potentially have a negative impact on the individual's health and incur significant financial costs, leading to distress for them and their families. It may also result in retrospective claims which can be expensive and time consuming.

The sole criterion for determining eligibility for CHC is whether an individual's primary need is a health need. The Framework sets out the process for the NHS, working with LA partners, to assess an individual's health needs and to ensure that the appropriate care is provided to meet those needs.

Individuals may require services from both the NHS and their LA. The NHS is responsible for assessing, funding and providing health services to meet the needs of its population. LAs are responsible for the provision of social services and there may be a charge to the individual for some of these.

There must be a clear and transparent rationale to support the decision-making process. Professional integrity is vital.

Individuals and/or their representatives must be fully involved and informed throughout the assessment process, in the language or format of their choice.

The services provided in response to assessed need must be proportionate to need and effectively co-ordinated, in order to avoid unnecessary disruption to the individual and their family

DRAFT

Contents

Policy information 1
Approval information..... 1
Introduction 13
Policy statement 14
Scope 14
Aim 14
Objectives 15
Main body 15
Section two Policy 17
CHC Assessment 18
Section 3 Before an Assessment 19
Refusing Consent to a CHC Assessment 20
Capacity 21
Best Interest 21
Fast Track 21
NHS Long Term Care Discharge to Assess Pathway 21
Section 4 Assessment of Eligibility for CHC 24
Quality Assurance 25
Section 5 Service Provision and Review 27
Payments 28
Joint Funding Process 29
NHS Funded Nursing Care 31
Contingency planning for individuals receiving care packages within their own home 32
Section 6 Links to other policies 33
Section 117 aftercare 37
Deprivation of liberties, Safeguarding 34
Transition from child and young people to adult services 34
Section 7 Disputes and Appeals 35
Complaints 37
Section 8 Retropectives claims for reimbursement 38
Independent Review Panel..... 40

DRAFT

Appendix 1 Client Consent for Assessment of Primary Health Need……..……42
Appendix 2 Standard Assessment & Eligibility Process Checklist……44
Appendix 3 Continuing NHS Healthcare Checklist……..……46
Appendix 4 Fast Track Assessment……...63
Statement of Consent……...64
Assessment of Needs……...72
Appendix 5 Nursing Needs Assessment……87
Appendix 6 Community Nursing Needs Assessment……117
Appendix 7 Impact Assessment and Contingency Plan……118
Appendix 8 Transition Pathway Referral Form from Children Services to Adult CHC……124
Appendix 9 Long Term Care Discharge to Assess Referral Form……..128
References and Links…..……...129

DRAFT

Introduction

The Welsh Assembly Government has produced a 2021 Framework (referred to throughout this document as the "Framework") for Continuing NHS Healthcare (CHC). It sets out the Welsh Assembly Government's policy for eligibility for CHC and the Responsibilities of NHS organisations and local authorities under the framework and related matters.

Framework - Continuing NHS Health Care (gov.wales) (opens in a new tab)

Hywel Dda University Health Board's Operational Policy is based on this National Framework.

The policy outlines the approach to be taken by practitioners to the assessment and decision making process and indicates the governance arrangements surrounding the application and process.

The effective date for the Framework is 1st April 2022. From that date Hywel Dda University Health Board was required to follow the Framework. The Framework has been approved by all Wales Health Boards.

Hywel Dda University Health Board (HDUHB) has worked with partner organisations to develop this operational policy for Hywel Dda residents. In doing so, the National Framework for Continuing Healthcare issued by Welsh Assembly Government has been very closely followed, to ensure consistency of approach across Wales.

The policy outlines the approach to be taken by practitioners to the assessment and decision making process and indicates the governance arrangements surrounding the application process.

CHC is a complete package of ongoing care arranged and funded solely by the NHS through local health boards (LHBs), where an individual's primary need has been assessed as health based.

CHC is one element of a range of services that local authorities (LAs) and NHS bodies need to have in place to support people with health and social care needs. CHC is one aspect of care which people with complex needs may need as the result of disability, accident or illness to address both physical and mental health needs. Given the nature, intensity, complexity and unpredictability of those needs, these services account for a significant proportion of NHS healthcare overall.

CHC can be provided in any setting outside hospital, such as in a person's own home, in a care home, hospice or in a prison and is part of the continuum of care and support that an individual with complex needs may move in and out of.

CHC is different from 'NHS Funded Nursing Care' (FNC) which is only applicable to individuals requiring nursing care in a care home. The provision of FNC derives from Section 49 of the Health and Social Care Act 2001 (now replaced in relation to Wales, by Section 47(4) and (5) of the Social Services and Well-being (Wales) Act 2014), which excludes nursing care by a registered nurse from the services which can be provided by local authorities. The decision on eligibility for FNC should only be taken when it is considered that the person does not fall within the eligibility criteria for CHC.

Note: At the time of publication, the NHS Funded Nursing Care in Care Homes Guidance 2004 remains in effect. This will, however, be subject to review during the lifetime of this Framework

DRAFT

Policy statement

It is the policy of HDdUHB that all staff involved with decision around assessment and eligibility for Long Term Care are aware of the procedure to follow and are also aware of the legal and professional guidance and requirements of the WG Continuing NHS Healthcare Framework 2021.

Scope

HDdUHB is responsible for establishing and maintaining governance arrangements for consideration of CHC eligibility and purchasing and securing care in response to the assessed needs of an individual.

The HDdUHB is responsible for:

- Ensuring consistency in the application of the Continuing NHS Healthcare National Framework; promoting awareness of CHC
- Implementing and maintaining good practice, ensuring quality standards are met and sustained, delivering joint, consistent training and development opportunities for all relevant health and social care practitioners
- Identifying and acting on issues arising in the provision of CHC.
- Informing commissioning arrangements, both on a strategic and individual basis.
- Ensuring best practice in assessment and record keeping
- The provision of strategic leadership and organisational and workforce development, and ensuring systems operate effectively and deliver improved performance.

HDdUHB is responsible for ensuring access to assessment, decision-making and provision should be fair and consistent. There should be no discrimination on the grounds of race, disability, gender, age, sexual orientation, religion or belief, or type of health need (for example whether the need is physical, mental or psychological). LHBs are responsible for ensuring that discrimination does not occur and should use effective monitoring to monitor this issue.

When an individual has been assessed as having a primary health need, and is therefore eligible for CHC, the HDdUHB has responsibility for funding the full package of health and social care. Where the individual is living at home, this does not include the cost of accommodation, food or general household support. HDdUHB will contract with other organisations and, in particular, the independent sector, and will be responsible for ensuring that the quality and range of services are sufficient to meet the individual's

Regular reviews will be arranged to ensure those services remain fit for purpose.

Aim

It is the policy of HDdUHB that all staff involved with decision around assessment and eligibility for Long Term Care are aware of the procedure to follow and are also aware of the legal and professional guidance and requirements of the WG Continuing NHS Healthcare Framework 2021.

The aim of this document is:

- To improve fairness, public understanding and consistency in the application of the eligibility criteria for Continuing NHS Healthcare.

- To support the HDdUHB to provide high quality and safe Continuing NHS Health Care services for the residents of Carmarthenshire, Ceredigion and Pembrokeshire.
- Achieving value for money.

Objectives

The aim of this document will be achieved by the following objectives:

- To enable a consistent approach across the HDdUHB to the delivery of the Welsh Government published Continuing NHS Healthcare Framework 2021
- To outline the approach to be undertaken by practitioners to the assessment and decision making process around Continuing NHS Health Care.
- To outline the governance arrangements surrounding the application and decision making process.
- To ensure that robust processes are in place to enable Hywel Dda Health Board to be legally compliant with the processes and requirements outlined in the Welsh Government Continuing NHS Healthcare Framework.

SECTION 1 INTRODUCTION

CHC is a complete package of ongoing care arranged and funded solely by the NHS through local health boards (LHBs), where an individual's primary need has been assessed as health based. It is one element of a range of care services for those with complex needs. Given the nature and intensity of those needs these services account for a significant proportion of NHS healthcare overall.

CHC can be provided in any residential or non-residential setting and is part of the continuum of care and support that an individual with complex needs may move in and out of.

CHC is different from 'NHS Funded Nursing Care' (FNC) which is aimed towards people in nursing homes. The provision of FNC derives from Section 49 of the Health and Social Care Act 2001 (now replaced in relation to Wales, by Section 47(4) and (5) of the Social Services and Well-being (Wales) Act 2014), which excludes nursing care by a registered nurse from the services which can be provided by local authorities. The decision on eligibility for FNC should only be taken when it is considered that the person does not fall within the eligibility criteria for CHC.

Legal Framework

The Legal Framework Legislation and Case Law.

Primary legislation governing the health service does not use the terms "continuing care", "Continuing NHS Healthcare" or "primary health need". However, Section 1 of the National Health Service (Wales) Act 2006 requires Welsh Ministers to continue the promotion in Wales of a comprehensive health service, designed to secure improvement in: (i) the physical and mental health of the people of Wales; and (ii) the prevention, diagnosis and treatment of illness.

Deciding on the balance between local authority and health service responsibilities with respect to long-term care has been the subject of key court judgments. This Framework reflects relevant Welsh legislation with particular emphasis on the various provisions contained within the Social Services and Well-Being (Wales) Act 2014 ("The SSWB Act").

Social Services and wellbeing Act 2014	Social Services and Well-being (Wales) Act 2014 (legislation.gov.uk)

Equality and Human Rights Legislation

LHBs and LAs have statutory duties to have due regard to the need to promote equality and human rights and ensure it is integral to the way in which health and social care is prioritised and delivered. This should allow people to enjoy quality of life and to be treated with dignity and respect. Such objectives will be supported by:

- Equality of access to care and support, meaning that LHBs and LAs should not preclude anyone from having an assessment for community health and social care services, if their needs appear to be such that they may be eligible for support.
- Equality of outcomes from care and support, meaning that within the same area, individuals with similar levels of needs should expect to achieve similar quality of outcomes, although the type of support they choose to receive may differ depending on individual circumstances.
- Equality of opportunity, meaning that LHBs and LAs should work together with individuals to identify and overcome any barriers to economic and social participation within society.

Equality Act 2010 can be found on the below link

https://www.legislation.gov.uk/ukpga/2010/15/contents (opens in a new tab)

Welsh Language Requirements

The Welsh Language (Wales) Measure 2011 ("the Measure") made the Welsh language an official language in Wales. This means that the Welsh language must not be treated less favourably than the English language. The Measure also created the role of Welsh Language Commissioner and enabled the Welsh Ministers to set standards of conduct relating to the Welsh Language. From March 2016, the Welsh Language Standards replaced the existing system of Welsh language schemes provided for the Welsh Language Act 1993.

As part of the NHS Delivery Framework for 2018-19, the following measure was included under the domain 'individual care':

Evidence of implementation of the Welsh language guidance as defined in the strategic framework below

More than just words | Care Inspectorate Wales (opens in a new tab)

Performance Framework and Reporting

The 2021 Performance Framework forms part of the Governance and Accountability arrangements for CHC in Wales. It provides the Welsh Government with assurance that organisations responsible for the delivery of CHC, are compliant with the CHC Framework. LHBs must comply with the reporting arrangements set out in the 2021 Performance Framework to support continuous service improvement and satisfy the Welsh Government of the consistency of decision-making on CHC eligibility across Wales.

SECTION 2 POLICY

The policy of Welsh Ministers on eligibility for CHC is based on whether an individual's primary need is a health need (this is known as the "primary health need approach").

The sole criterion for determining eligibility for CHC is whether an individual's primary need is a health need.

Establishing that an individual's primary need is a health need requires a clear, reasoned decision which is based on evidence of needs from a comprehensive assessment.

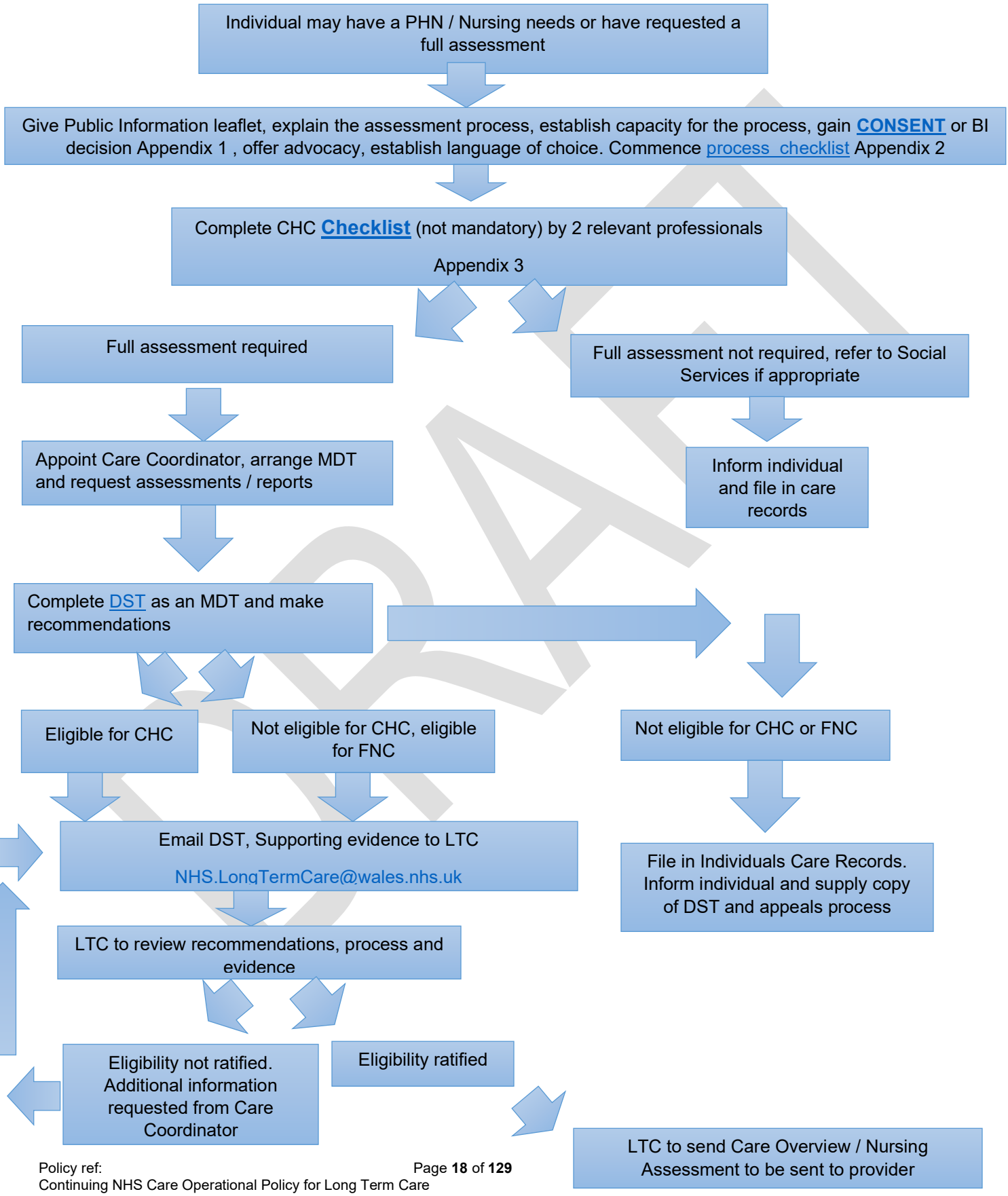
Health and social care practitioners involved are expected to comply with existing Welsh Government practice guidance on assessment and care planning including:

Social Services and Well-being (Wales) Act 2014 Code of Practice relating to Part 3 - Assessing the Needs of Individuals

Social Services and Wellbeing Act Part 3 and 4	https://gov.wales/sites/default/files/publications/2019-05/part-3-code-of-practice-assessing-the-needs-of-individuals.pdf (opens in a new tab https://gov.wales/sites/default/files/publications/2019-05/part-4-code-of-practice-meeting-needs.pdf (opens in a new tab
Code of Practice to Parts 2 and 3 of the Mental Health (Wales) Measure 2010	gen-ld8880-e-English.pdf (Senedd. Wales) (opens in a new tab
Welsh Health circular re Discharge Planning	http://www.wales.nhs.uk/documents/WHC_2005_035.pdf (opens in a new tab
Passing the Baton	https://www.adss.cymru/en/blog/post/passing-the-baton-a-practical-guide-to-effective-discharge-planning (opens in a new tab
Hospital Discharge Service Requirements COVID 19	https://gov.wales/hospital-discharge-service-requirements-covid-19 (opens in a new tab

DRAFT

CHC Assessment Process:



SECTION 3 BEFORE AN ASSESSMENT

Information Booklet

Prior to the assessment individuals should be given A Continuing NHS Healthcare Information Booklet for Individuals, Families and Carers in order to ensure informed consent is obtained prior to the commencement of the process.

CHC Information booklet (English)	Continuing NHS Healthcare (CHC): information booklet for individuals, families and carers | GOV.WALES - (opens in a new tab
CHC Information booklet (Welsh)	Not yet available
Easy Read Information Leaflets	Not yet available
Easy Read guide to eligibility	Not yet available
Easy Read How CHC is organised	Not yet available
Easy Read What if I am not eligible for CHC	Not yet available

Consent

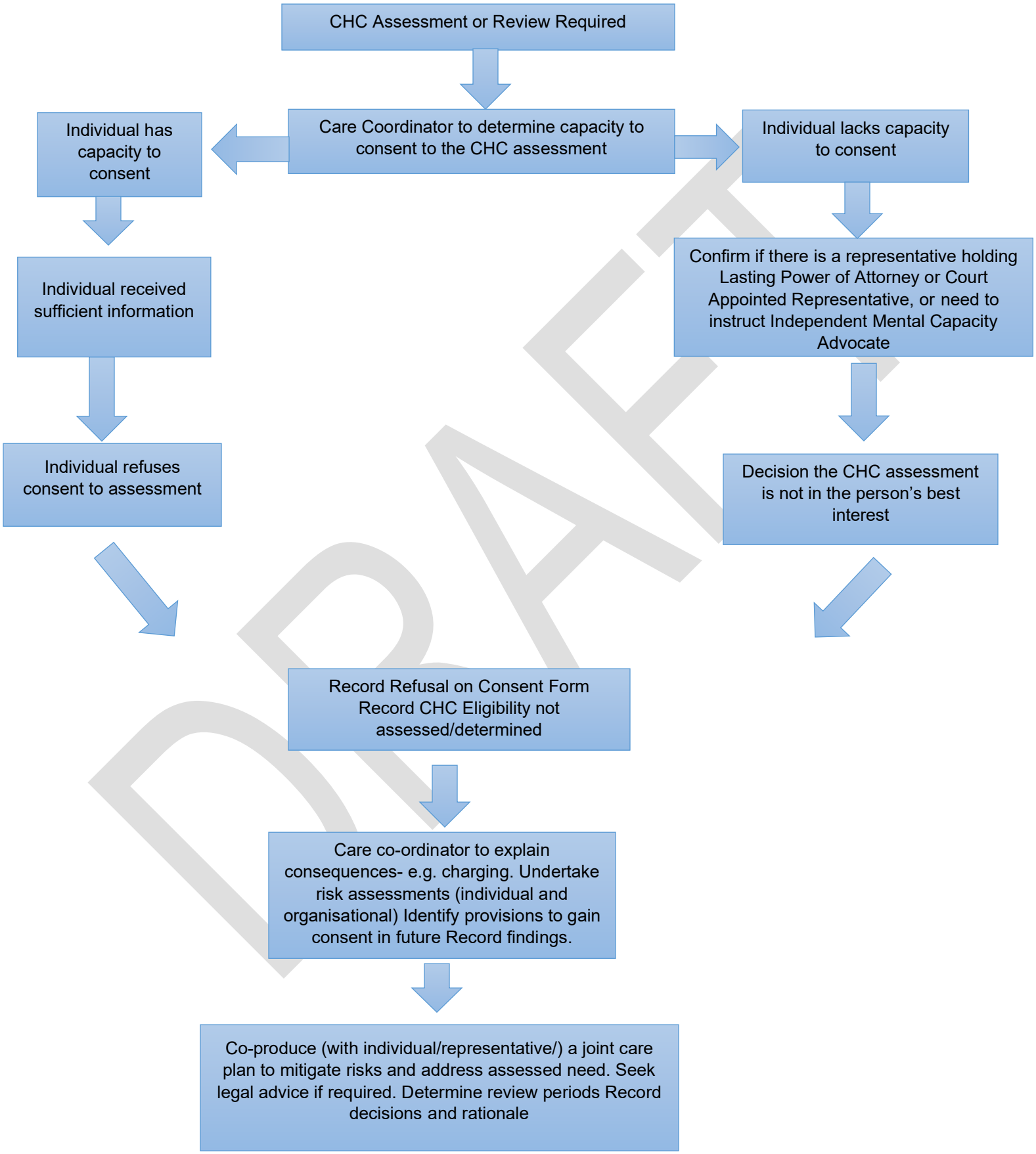
Where the individual concerned has capacity, their informed consent should be obtained before the start of the process to determine eligibility for CHC. This consent will need to encompass permission to undertake the CHC assessment process and also to the 'sharing and processing of data' (i.e. sharing relevant personal information between professionals in order to undertake the eligibility assessment for CHC and, where appropriate, for audit and monitoring of decisions).

The individual must be made aware that they can withdraw their consent at any time, and made aware of the process for doing so, and that this includes withdrawing consent to share information.

It should be explained that, depending on the information in question, the decision to withdraw or withhold consent to share information might affect whether it is possible to complete the CHC eligibility assessment.

DRAFT

Refusing Consent to a CHC Assessment



DRAFT

This process can also be followed where an assessment has been undertaken and the individual then changes their mind or refuses a CHC care package.

Capacity

If there is a concern that the individual may not have capacity to give their consent or to participate effectively in the decision-making process, this should be determined in accordance with the Mental Capacity Act 2005 and the associated Code of Practice. The five key principles of the Mental Capacity Act 2005

Capacity Assessment Template.doc (sharepoint.com) (opens in a new tab

Best Interest

If an individual lacks capacity to consent to the assessment, then a best interest decision needs to be made.

Best Interests Template.doc (sharepoint.com) (opens in a new tab

Fast Track

Occasionally, it will be necessary to safeguard an individual's well-being by 'fast tracking' them for immediate provision of CHC. An example of this may be individuals who are rapidly deteriorating. In such circumstances, people can be supported in their preferred place of care without waiting for the full CHC eligibility process to be completed. LHBs must have a robust fast track process in place to complete the assessment process within two days. However, streamlined processes should still ensure that the individual and/or their representative is fully involved.

Fast Track assessment template Appendix 4

The use of the checklist tool Appendix 3 (opens in a new tab

It's essential to that reasonable steps are taken to ensure that individuals are assessed for CHC in all cases where it appears that there may be a need for such care. Although not mandatory, if an initial screening process is used to identify where there may be a need for such care, then the Checklist is the only screening tool that can be used for this purpose. The Checklist encourages proportionate assessments of eligibility and rationale is provided for all decisions regarding eligibility.

NHS Long Term Care discharge to assess pathway

Assessments should take place in a person's home or in another suitable community setting, not in an acute hospital bed. 'Home first' and the Discharge to Recover Then Assess (D2RA) pathways should be the default position.

It should always be borne in mind that an assessment of eligibility for CHC that takes place in an acute hospital might not accurately reflect an individual's longer-term needs. This could be because, with appropriate support, the individual has the potential to recover further in the near future. It could also be because it is difficult to make an accurate assessment of an individual's needs while they are in an acute services environment.

Where an individual is ready to be safely discharged from acute hospital it is very important that this should happen without delay. Therefore, the assessment process for CHC should not be allowed to delay hospital discharge.

A person who is admitted to a general hospital / MH ward may, at some point during their stay, be identified as ‘complex’ and / or requiring long-term nursing care, and therefore requiring additional support during and after their discharge.

HDdUHB have developed an NHS discharge to assess pathway where it has been identified a person has nursing needs requiring long term care in a 24hour care facility within the Health Boards footprint.

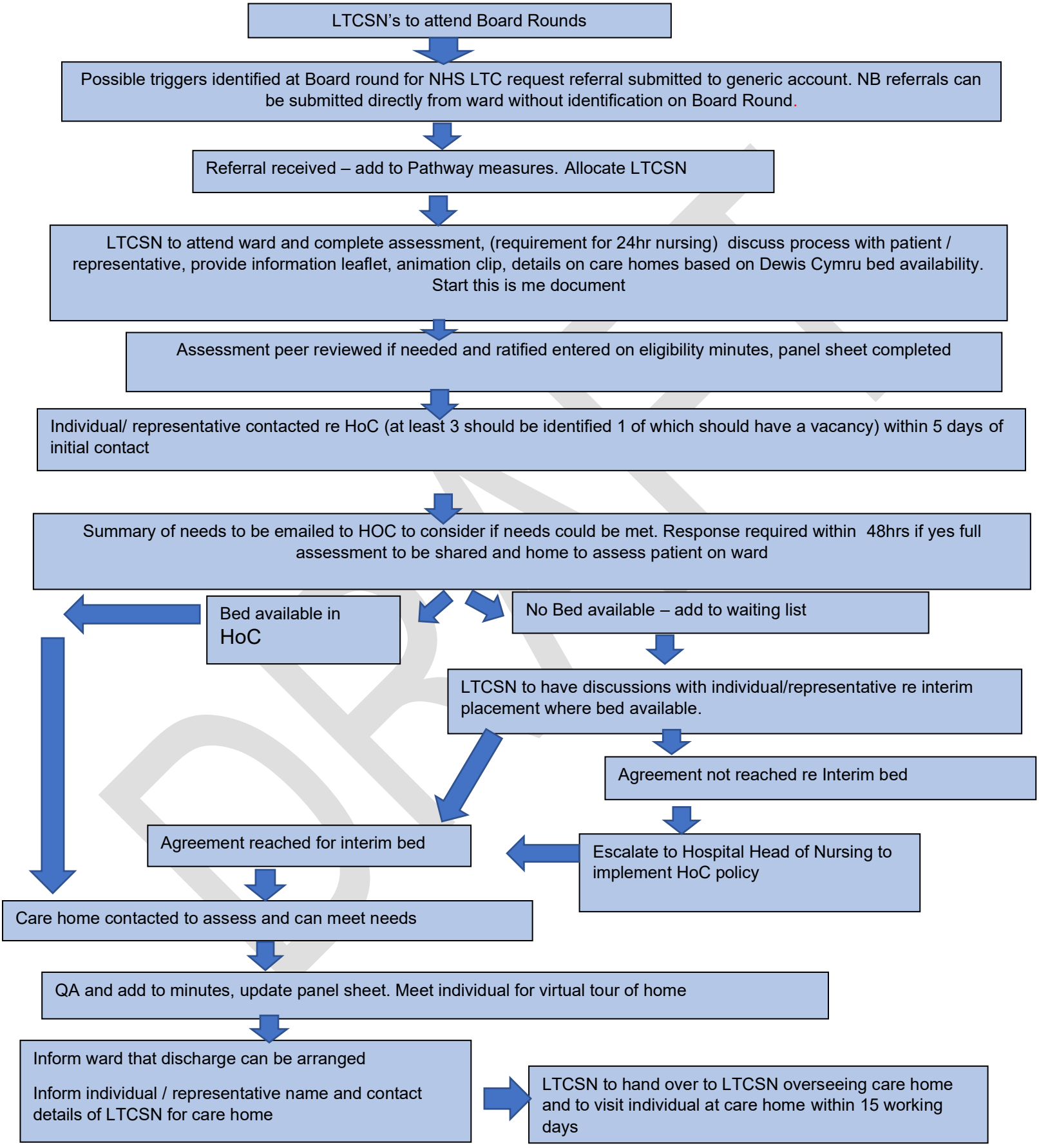
The LTC Team provides one type of support that might be needed, i.e., the assessment of eligibility for CHC and the sourcing of a care home placement / community PoC.

Please see appendix 9 for Referral form

Long Term Care patient information sheet Patient Information Leaflet .pdf

DRAFT

NHS Long Term Care Discharge to Assess Pathway



SECTION 4 ASSESSMENT OF ELIGIBILITY FOR CHC

Establishing whether an individual has a primary health need requires a clear, reasoned decision, based on evidence of needs from a comprehensive range of assessments relating to the individual. A good-quality multi-disciplinary assessment of needs that looks at all of the individual's needs 'in the round' – including the ways in which they interact with one another – is crucial both to addressing these needs and to determining eligibility for CHC. The individual and any representative should be enabled to play a central role in the assessment process

Using the Decision Support Tool

The DST that accompanies this Framework is designed to support the decision making process. The tool must only be used following a comprehensive assessment of an individual's care needs. It is not an assessment in itself and it does not replace professional judgement in determining eligibility. It is simply a means of recording the rationale and facilitating logical and consistent decision-making.

The MDT should use this tool to support consideration of not just the overall needs, but also the interaction between the needs, and evidence from relevant risk assessments. Conversely, the DST should not be completed without a multidisciplinary assessment of needs

The DST is designed to ensure that the full range of factors that have a bearing on an individual's eligibility are taken into account in reaching the decision, irrespective of client group or diagnosis. The tool provides practitioners with a method of bringing together and recording the various needs in 12 'care domains', or generic areas of need. Each domain is broken down into a number of levels. The levels represent a hierarchy from the lowest to the highest possible level of need (and support required) such that, whatever the extent of the need within a given domain, it should be possible to locate this within the descriptors provided.

Decision Support Tool Template	Continuing NHS healthcare: Decision Support Tool (DST) for practitioners | GOV.WALES (opens in a new tab

Pandemic and other emergency situations

The Health Board appreciates that completing a full CHC assessment in hospital during a declared emergency, such as pandemic influenza, would be problematic. As CHC is an assessment of long-term needs, decisions on CHC eligibility should not take priority in these situations. The priority instead should be the safety of the patient, and ensuring they receive the care they need.

In the event of a pandemic or other emergency situation the Health Board will refer to the Welsh Government's webpage for up to date information on CHC.

Making the recommendation on eligibility

The MDT is required to make a recommendation to the LHB as to whether or not the individual has a primary health need, bearing in mind that where the LHB decides that the individual has a primary health need they are eligible for CHC

In coming to this recommendation, the MDT should work collectively using professional judgement. All members of the MDT should be present when an eligibility decision is being made.

The written recommendation needs to be clear and concise whilst providing sufficient detail to enable the LHB and the individual to understand the underlying rationale for the recommendation. In doing so, it should;

- Provide a summary of the individual's needs in the light of the identified domain levels and the information underlying these. This should include the individual's own view of their needs.
- Provide statements about the nature, intensity, complexity and unpredictability of the individual's needs, bearing in mind the explanation of these characteristics
- Give an explanation of how the needs in any one domain may interrelate with another to create additional complexity, intensity or unpredictability.
- In the light of the above, give a recommendation as to whether or not the individual has a primary health need. It should be remembered that, whilst the recommendation should make reference to all four characteristics of nature, intensity, complexity and unpredictability, any one of these could on their own or in combination with others be sufficient to indicate a primary health need.

Where an MDT recommends an individual is not eligible for CHC, a clear rationale is needed that considers their circumstances under the four key characteristics of the primary health need test. Care planning for those individuals with ongoing needs, including any consideration for NHS Funded Nursing Care (FNC), will still be necessary.

Quality Assurance

HDdUHB has robust quality assurance (QA) mechanisms pay way of Eligibility and Quality assurance panel (The panel) in place to ensure consistency of decision-making.

Whilst the majority of cases are agreed outside of the panel process the scope of the panel is that

- The eligibility and quality assurance panel will provide a quality assurance role in scrutinising and ratifying the eligibility and quality assurance of services from across the Board.
- Panel meetings will be held on a weekly basis and minuted
- A submission to the Long Term Care Team will be as a result of and supported by a comprehensive MDT assessment/ review along with identified care package / provider. If a new placement is recommended within a long term care setting a preadmission assessment is required along with confirmation that they can meet the individuals needs
- The panel will not consider cases for individuals under the age of 18 or adults with an overriding Mental Health or Learning Disability

The objectives of panel are to:

- Ensure eligibility criteria are fairly applied consistently.
- Ensure assessment decision making is clear and robust, has an evidence base and will stand up to scrutiny from other professionals, carers and relatives, service providers, statutory authorities and legal challenge
- Audit/review physical and mental health needs to ensure no further input is required.
- Provide a multi-disciplinary review of professional practice.
- Ensure a decision making process is in place that looks objectively at needs.
- Determine whether all appropriate documented evidence has been provided to support the MDT decision / recommendation.

DRAFT

- Ensure assessment decision making is clear and robust, has an evidence base and will stand up to scrutiny from other professionals, carers and relatives, service providers, statutory authorities etc.
- Ensure that the Welsh Government Guidance is adhered to.
- Ensure that the package recommended is appropriate to meet the needs of the individual.

Exceptionality Panel

There are occasions when it will be necessary to arrange an exceptional panel to discuss cases that are in excess of a standard Nursing Home placement. These meeting are help on an as required basis.

The aim of the exceptionality panel is to facilitate comprehensive discussions regarding sustainable care planning for complex cases and / high cost packages of care, to provide assurance to the Health Board's Executive Team that robust consideration has been given, and all options considered. These discussions would be taken in line with the National Framework for CHC (2021), the Sustainable care planning Policy (2011) and the Social Services and Wellbeing Act (2014).

National Framework 2021	Continuing NHS Health Care (gov.wales) (opens in a new tab
Sustainable Care Planning	Sustainable-Care-Planning-Policy---FINAL.pdf
Social Services and wellbeing act 2014	Social Services and Well-being (Wales) Act 2014 (legislation.gov.uk) (opens in a new tab

Communicating the decision on eligibility to the individual

Once the eligibility decision is made by the Long Term Care team, the decision will be communicated via letter from the Long Term Care Department. Details within the letter will include:

- The decision on primary health need, and therefore whether or not they are eligible for CHC
- The reasons for the decision
- A copy of the completed DST
- Details of who to contact if they need further information
- Details on how to request an appeal of the eligibility decision if they are dissatisfied with the decision
- Where an individual is not eligible for CHC, the decision letter may also include, where applicable and appropriate, information regarding FNC or a joint package of care.
- Where an individual is eligible for CHC, an indication of the proposed care package, if known, could be included within this communication, or if not known at that stage, information on what the next steps are.
- Eligibility for CHC is not indefinite, as needs could change. This should be made clear to the individual and/or their representative.

DRAFT

SECTION 5 SERVICE PROVISION AND REVIEW

Service Provision

Where a person is eligible for CHC. The HDdUHB will be responsible for making the necessary arrangements for the individual's care irrespective of their setting.

The HDdUHB will work with other organisations to establish an appropriate package of care, accommodation (where appropriate) and support. Whilst the overall responsibility for the care provision will lie with the HDdUHB there will be ways in which other agencies, such as (but not only) social services may become involved, for example through:

- Ongoing social work services
- Agreed delegated responsibility, under formal partnership arrangements, for purchasing or providing care
- Agreed delegated or shared responsibility for providing ongoing assessment and/or care management
- Locally developed joint service provision
- Their housing, education and leisure services responsibilities, local authorities have a corporate role in enabling people to have fulfilling lifestyles and to participate in and contribute to the wider community
- The provision of equipment via the integrated community equipment services

The CHC package to be provided is that which HDdUHB assesses as appropriate for the individual's health and personal care needs.

It is the responsibility of the HDdUHB to plan, specify outcomes, procure services, and manage demand and provider performance for all services that are required to meet the health and personal care needs of individuals who are eligible for CHC.

Regional partners are expected to develop an integrated approach to the commissioning of care home services, including in relation to negotiating contracts, service specifications, fee negotiations and quality assurance.

HDdUHB and Local Authority partners have set out to develop a regional contract for the placement of Older Adults in residential care or residential care with nursing.

Partners must establish a pooled fund in relation to care home accommodation functions to support these integrated arrangements.

The LTC Team has been working with the Regional Commissioning Group (RCG) since the financial year 2018/19 to establish a 'virtual' pooled fund for the commissioning of older adults' care home (OACH) placements, as required under Part 9 of the Social Services and Well-being (Wales) Act 2014.

Unless the function is formally delegated LHBs continue to have responsibility for the case management/care co-ordination role for those entitled to CHC as well as for the NHS component of a joint care package, including an assessment and review of individual patient needs.

DRAFT

HDdUHB have arrangements in place for brokering and commissioning the services required to deliver the detailed care plan. The MDT recommendations and the individual's preferences will be balanced in accordance with the Sustainable Care Planning Policy

Sustainable Care Planning Policy 2011	Sustainable-Care-Planning-Policy---FINAL.pdf (opens in a new tab

Reviews

HDdUHB will be responsible for monitoring quality, safety, access and patient experiences within the context of provider performance. The ultimate responsibility for arranging and monitoring the services required to meet the needs of those with CHC rests with the LHB.

Where individuals eligible for CHC are cared for in a Care Home, escalating concerns will be managed in accordance with the Welsh Government's 'Escalating Concerns With, and Closures of, Care Homes Providing Services for Adults' Guidance (May 2009). In accordance with this guidance, LHBs and social care agencies should have in place systems and processes which enable registered providers, contract managers, care managers and other professionals to clearly understand what is expected and required from each setting and how such requirements will be delivered and monitored.

Care Home monitoring

Monitoring of all Nursing Homes within the HDdUHB area and within which the Health Board commissions care is undertaken on a quarterly basis. Long Term Care Specialist Nurses have allocated Nursing Homes and it is their responsibility to ensure that these visits are undertaken and a report submitted. Should there be concerns outside of the quarterly arranged visits, further monitoring will be arranged and at times with LA colleagues. Monitoring on a more informal basis takes place whenever a LTCSN attends the Nursing Homes for reviews of individual residents.

Additional personal contributions from an individual who is eligible for CHC

The NHS provides a comprehensive service available to all. Access to NHS services is based on clinical need and not on an individual's ability to pay.

Public funds for healthcare will be devoted solely to the benefit of people that the NHS serves.

As overriding principles, it is essential that: the NHS should never subsidise private care with public money (which would breach core NHS principles) and patients should never be charged for their NHS care, or be allowed to pay towards NHS care (except where specific legislation is in place to allow this) as this would contravene the founding principles and legislation of the NHS.

To avoid these risks, there should be as clear a separation as possible between private and NHS care.

In such cases HDdUHB will ensure that the care plan should set out the services to be funded and/or provided by the NHS. It may also identify services to be provided by other organisations such as local authorities and third sector providers. Where such non-NHS funded support is provided as part of a total package, the individual and their carers should be signposted by the local authority to clear information on charging arrangements and by the voluntary sector to potential alternative funding sources e.g. benefits and charitable organisations.

In addition to such arrangements, there may be circumstances, where individuals and/or their representative may choose to access additional services or premium accommodation by making, and paying for, separate arrangements themselves.

Responsible Body Guidance

The Responsible Body Guidance provides a framework for establishing the body responsible for securing secondary and tertiary health care for an individual within the NHS in Wales.

Responsible Body guidance Wales	Responsible Authority Guidance (gov.wales) (opens in a new tab
Who Pays England	Who-Pays-final-24082020-v2.pdf (england.nhs.uk) (opens in a new tab

Direct Payments Independent User Trusts

It is currently unlawful for Direct Payments to be used to purchase health care which the NHS is responsible for providing, however it is not unlawful for local authorities and health boards to work together to provide individuals with voice and control in respect of their health and social care needs.

Where an individual whose care was arranged utilising Direct Payments becomes eligible for CHC funding, the HDdUHB will work with the individual in a spirit of co-production. Although Direct Payments will no longer be applicable where an individual has a primary health need, this should not mean that the individual loses their voice, choice and control over their daily lives.

There may be circumstances where it is possible for an individual to retain some Direct Payment for the elements of their care for which the local authority is still responsible, e.g. opportunities for social inclusion. HDdUHB and the relevant local authority will work together to explore all the options available to maximise an individual's independence.

An individual in receipt of Direct Payments (or any individual) retains the right to refuse to consent to a CHC assessment and /or care package, as detailed in Section 3. In such cases, partner agencies must work together with the individual and their family/carers to ensure that the risks are fully understood and mitigated as far as possible. If a person is assessed as eligible for CHC but refuses a care package, there may be an impact on the way their care is delivered. It cannot automatically be assumed that LAs will continue to provide those services, as this may mean that they are acting outside of their legal authority. Further guidance on these measures will be published on the Welsh Government website.

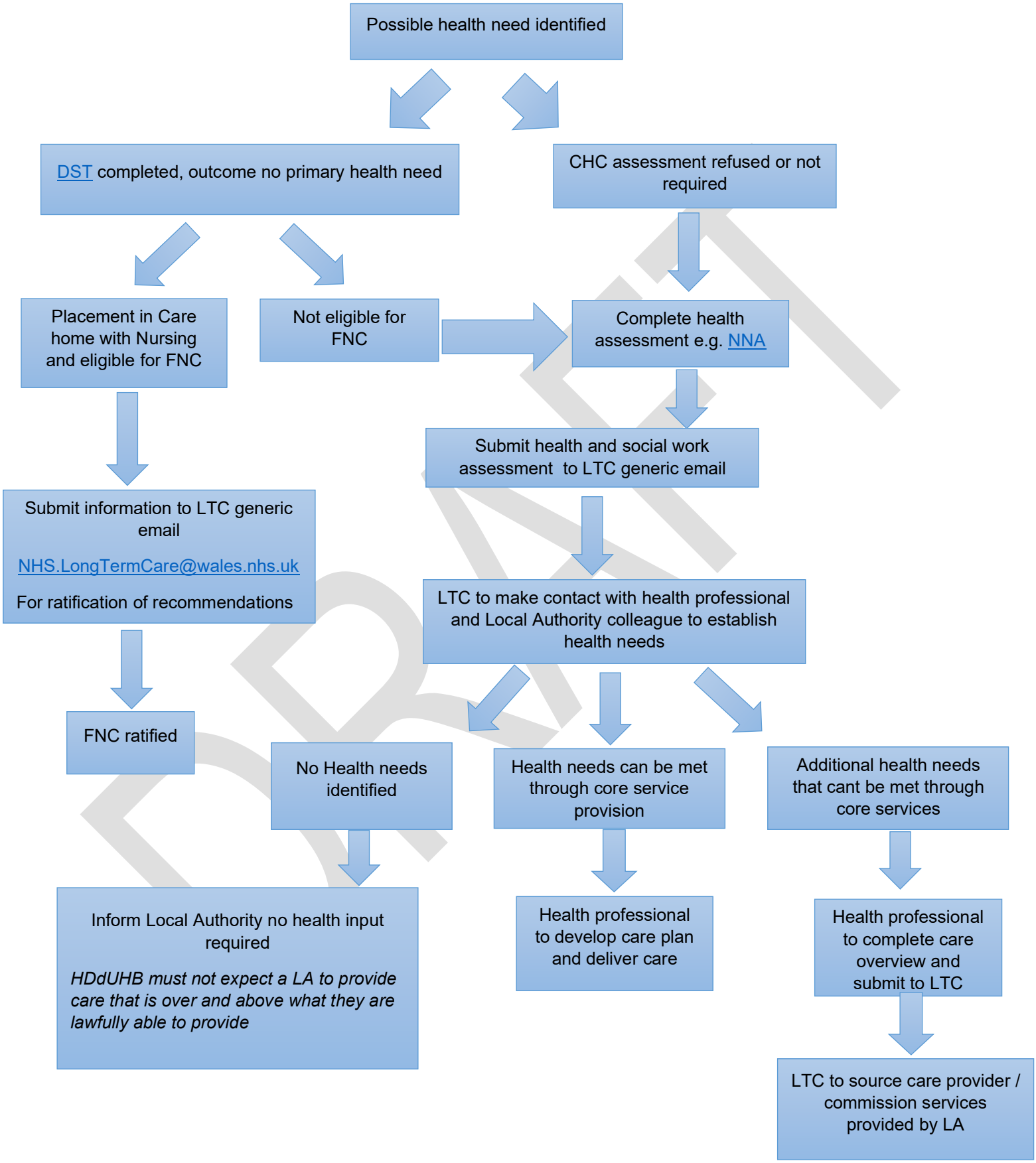
Joint Packages of Health and Social Care

If an individual is not entitled to CHC but has some healthcare and social care needs, they should receive a package of health and social care that is tailored to their individual needs. There will be some individuals who, although they are not entitled to CHC, have needs identified through the DST that are not of a nature that a local authority can solely meet or are beyond the powers of a local authority to solely meet. LHBs should therefore work in partnership with the LA to agree their respective responsibilities in joint care packages and ensure seamless provision of care.

As a matter of principle, if an individual has existing Direct Payment arrangements, these should continue wherever and for as long as possible within a tailored joint package of care.

HDdUHB will work with relevant Local Authorities to identify any Health Needs and meet these needs if appropriate through core service provision or commissioned services.

Joint funding process



DRAFT

NHS Funded Nursing Care

There may be some individuals in Care Home placements who do not have a primary health need indicating eligibility for CHC but are acknowledged to have nursing needs greater than would normally be expected to be covered by the FNC rate and what can be reasonably expected for an LA to commission.

Welsh Government is in the process of developing an interim FNC policy statement.
The intended purpose of the Interim policy is to provide an update on legislative changes and court judgements subsequent to the 2004 FNC Guidance, in advance of a longer-term review of FNC policy.

NHS Funded Nursing Care 2004	Microsoft Word - WHC_2004_024.doc (wales.nhs.uk) (opens in a new tab

Reviews

Any care package, regardless of the funding source, should be regularly reviewed in partnership with the individual and/or their representatives to ensure that it continues to meet their needs.

As a minimum there should be an initial review of the care plan within 3 months of services first being provided unless this is triggered earlier by the individual or their representative or the provider. Thereafter, reviews should be at least annually.

Where an individual's condition is anticipated to deteriorate, more regular review may be necessary. The frequency of such reviews will be determined by professional judgement based on the individual's assessed needs or if there is a change in circumstances. They should be proportionate to the situation in question in order to ensure that time and resources are used effectively. Where there is an obvious deterioration in circumstances, reviews should also be held within 2 weeks and acted upon appropriately.

The individual and/or their representative and the service provider must be provided with the contact details of a named care co-ordinator, so that any changes in the individual's condition or circumstances can be promptly addressed.

Review timescales should be identified and communicated to the individual and their relatives verbally and in writing.

The responsibility of the Health Board to provide or commission care (including CHC) is not indefinite as needs might change. This should be made clear to the individual and their family or carer at the time of the initial assessment and at each subsequent review and confirmed in writing. The individual and the carer or representative should be provided with the Continuing NHS Healthcare Information Booklet at the commencement of their CHC care package

The review will determine whether:

- The individual's needs are being met appropriately,
- Whether eligibility should be reconsidered through a MDT reassessment for CHC.
- Whether the individual's needs have changed, which then determines whether the package of care needs to be revised or the funding responsibilities altered.

The outcome of a review does not necessarily indicate the same outcome should have been reached with a previous assessment, provided that the previous assessment was properly carried out and the decision taken was based on sound reasoning.

The review information should be used to inform the individual's care plan. A copy of the review and care plan should be drafted, agreed and given to the service user. Subject to the constraints of confidentiality, the findings of the review and changes to the care plan should also be shared with those involved in the individual's care.

If the individual and/or their representative relative or their carer is not satisfied with the care plan which has been developed, they will need to raise this with the person responsible for it in the first instance. They may request a re-assessment of their needs and review of the care plan. If they continue to be dissatisfied, they will need to consider making use of the complaints process.

The CHC Independent Review Panel (see Section 7) is not designated to review the content of care plans, only the decision-making process relating to the application of the primary health need approach

Services cannot be discontinued without a full re-assessment being carried out at a formal MDT meeting.

Providers must be made aware, within the contract documentation, of their responsibilities to notify the funding body of any marked deterioration or significant improvement and any other issues affecting the delivery of care.

Neither the HDdUHB nor the LA will unilaterally withdraw from an existing funding arrangement without a joint reassessment of the individual and without first consulting one another and the individual about the proposed change of arrangement. Therefore, in order to ensure continuity of care, if there is a change in eligibility, it is essential that alternative funding arrangements are agreed and put into effect before any withdrawal of existing funding. Any proposed change should be put in writing to the individual by the organisation that is proposing to make such a change. If joint agreement cannot be reached upon the proposed change, the local disputes procedures should be invoked and current funding arrangements should remain in place until the dispute has been resolved.

Appendix 5 LTCSN Assessment Template form

Appendix 6 Community assessment template

Contingency Planning for individuals receiving Care Packages within their own home

Where an individual is eligible for Continuing NHS Health Care, HDdUHB will be responsible for sourcing and commissioning the care package based on the individuals assessed need. Whilst we endeavour to achieve this there may be times where an individual is left without care due to staffing capacity with the care provider To reassure HDdUHB and the individual and / or their family it is essential that a contingency plan is completed to establish action plans in the event of carer disruption.

Appendix 7 Contingency Plan Template (opens in a new tab).

DRAFT

SECTION 6 LINKS TO OTHER POLICIES

Section 117 aftercare

Under Section 117 of the Mental Health Act 1983 (the 1983 Act), health and social services authorities have a duty to provide or arrange after care services for individuals who have been detained under certain provisions of the 1983 Act, until they are satisfied that the person is no longer in need of such services. It should be borne in mind, however, that some people may be eligible for care and support under both CHC and Section 117.

Section 117 is a free-standing joint duty. Local health boards (LHBs) and local authorities (LAs) should develop protocols to help determine their respective responsibilities for the delivery of Section 117 aftercare (see for example Mental Health Act 1983 Code of Practice for Wales, chapter 31). This Framework does not therefore attempt to provide additional guidance on this issue, but focusses on the interface between Section 117 and eligibility for Continuing NHS Healthcare.

Responsibility for the provision of Section 117 is shared between LAs and LHBs, although this does not necessarily mean there should be a 50/50 split in all cases. Where a patient is eligible for services under Section 117 these should be provided under Section 117 and not under CHC.

All those subject to Section 117 are considered to be in receipt of secondary mental health services, as defined under the Mental Health (Wales) Measure 2010 (the Measure) and will therefore have a Care Co-ordinator and an outcome-focussed prescribed Care and Treatment Plan (CTP) that is reviewed at least annually. Detailed guidance regarding care and treatment planning is given in the Code of Practice to Parts 2 and 3 of the Measure.

There are no powers to charge for services provided under Section 117 of the 1983 Act, regardless of whether those services are provided by LHBs or LAs. Accordingly, the question of whether services should be ‘free’ NHS services rather than potentially charged-for services does not arise. It is not appropriate to assess eligibility for CHC if all the services in question are to be provided as after-care under Section 117.

However, an individual in receipt of after-care services under Section 117 may also have additional needs which are not related to their mental disorder. For example, an individual may be receiving services under Section 117 and develop separate physical needs, for example following a stroke, which may then mean they are eligible for CHC or FNC.

In such cases, the general approach set out in this Framework of considering the totality of need in assessing eligibility for CHC still applies. The individual may as a result, have the services required to meet their total care needs funded by the NHS, but this does not necessarily remove the shared duty under Section 117. The Section 117 shared duty remains unless a joint assessment and agreement by both the LA and the LHB determines that those arrangements are no longer needed.

Where an individual in receipt of Section 117 services develops physical care needs resulting in a rapidly deteriorating condition which may be entering a terminal phase (or a catastrophic health event which clearly requires CHC), consideration should be given to the Fast Track process.

Where an individual is to be discharged from Section 117, eligibility for CHC or FNC will need to be considered where the transition assessment and plan indicates that new or other services may be required. 6.10 Information should be provided to the individual or their representative on the effect that discharge from Section 117 may have on their financial circumstances.

Deprivation of Liberty Safeguards (DoLS)

The Mental Capacity Act 2005 contains provisions that apply to a person who lacks capacity and where care arrangements amount to a deprivation of their liberty. The fact that a legal authorisation is being sought or is in place in relation to a deprivation of liberty of capacity does not affect the consideration of whether that person is eligible for CHC. The Liberty Protection Safeguards were introduced in the Mental Capacity (Amendment) Act 2019 and replaces the Deprivation of Liberty Safeguards (DoLS). LHBs must ensure they are compliant with this new legislation when it is implemented.

Where an individual is in receipt of CHC, and they lack mental capacity to consent to their accommodation, or care and support arrangements, the LHB must ensure that the arrangements they commission are lawful and compliant with provisions under the Mental Capacity Act.

For more information on DoLS click the link/s below

DoLS Policy and Code of Practice	Deprivation of Liberty Safeguarding Policy and Code of Practice (sharepoint.com) (opens in a new tab
DoLS Standards	Deprivation of Liberty Safeguards (DoLS) (sharepoint.com) (opens in a new tab

Transition from Child and Young Persons to adult services

Initial planning for transition to adult CHC services must commence when the young person is aged 14, where the need is already identified or as soon as possible, if problems emerge that will require ongoing care, after this age. A lead professional must be identified and supported by all the agencies involved. This person will act as the Transition Co-ordinator and key point of communication for the individual and their family.

Once the young person reaches 16 years of age there should be a formal referral for screening to the appropriate adult CHC team. At the age of 17, eligibility for adult CHC should be determined in principle by the relevant HB, bearing in mind that, in complex cases, needs can change in the course of a year. Local multi-disciplinary teams will need to use their professional judgement regarding the timing of assessment and review to ensure that effective packages of care can be planned and commissioned in time for the individual's 18th birthday. If needs are likely to change, it may be appropriate to make a provisional decision and then to recheck it be repeating the process as adulthood approaches.

Even if a young person is not entitled to adult CHC, provision of services for health needs is the responsibility of the NHS. In such circumstances, LHBs should continue to play a full role in transition planning for the young person and should ensure that services to meet these needs are provided. The focus should always be mutually agreed and take into account the individual preferences.

Financial implications for the young person and their family, including any changes to benefits or other funding sources such as Direct Payments, must be clearly explained at the earliest possible opportunity. Accommodation and independent living choices should be fully explored, and a clear explanation provided of entitlements and options. Support for carers must be included in the care plan, in accordance with the Social Services and Well-Being Act

HDdUHB is currently revising the transition process

Appendix 8 Transition Referral Form

SECTION 7 DISPUTES AND APPEALS

Disputes

The dispute process should be invoked when the HDdUHB and Local Authority are unable to agree on recommendations in relation to a Primary Health Need

A dispute resolution process is currently being developed between HDdUHB and partner Local Authorities (Carmarthenshire County Council, Ceredigion County Council & Pembrokeshire County Council)

Appeals against eligibility decisions from individuals

The formal responsibility for informing individuals of the decision about eligibility for CHC and of their right to request an appeal against that decision lies with the LHB. Whether or not it is considered that an individual has a primary health need, the LHB must give clear reasons for its decisions, setting out the basis on which the decision was made, and explain the arrangements and timescales for dealing with a review of the eligibility decision in the event that the individual or someone acting on their behalf disagrees with it.

If an individual or their representative disagrees with the eligibility decision for either CHC or NHS Funded Nursing Care, and intend to appeal that decision, they must inform the relevant LHB of their intention to appeal within 28 days of receipt of the decision letter.

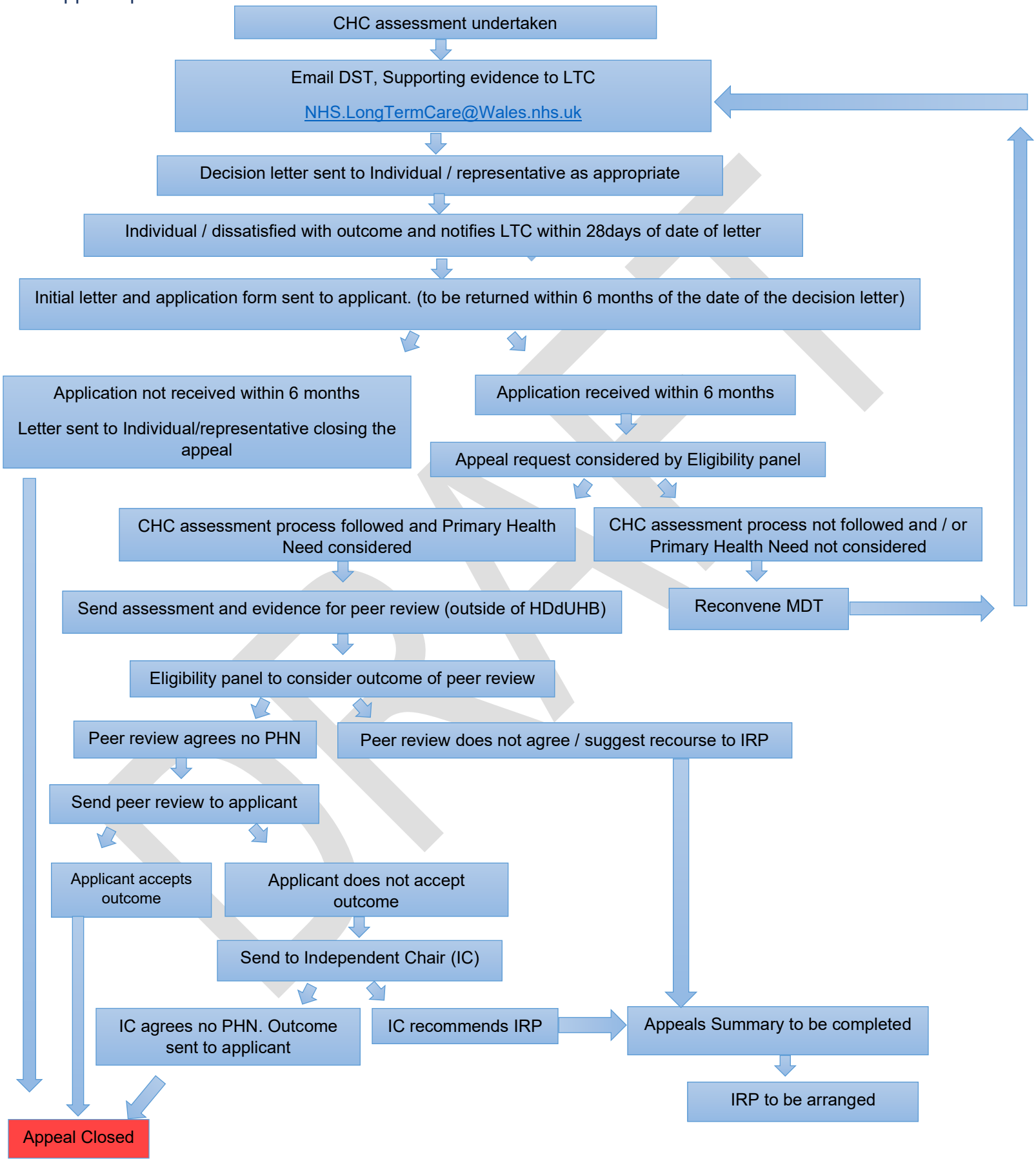
Written notification of intention to appeal a decision outside of the 28 days period will only be accepted in exceptional circumstances.

The individual must submit their written appeal to the relevant LHB within 6 months of the individual /or their representative being informed of that decision. Requests made after this time period will only be considered in exceptional circumstances.

- An individual or their representative may appeal to the relevant LHB if they are dissatisfied with: the procedure followed by the LHB in reaching its decision on the individual's eligibility for CHC or FNC, or
- How the primary health need was considered.

DRAFT

Appeals process



Complaints

If an individual wishes to make a complaint about NHS funded services, they should initially speak to the service provider, if possible, or to the LHB. Under the Regulation and Inspection of Social Care (Wales) Act 2016, individual complaints about the provision of care will be considered by regulated establishments via their own procedures; local authorities will consider complaints relating to the commissioning process (such as the appropriateness of a type of placement); and the Care Inspectorate Wales (CIW) has discretionary powers to investigate complaints where that complaint may inform its role as a regulator of care homes. Any agency receiving a complaint needs to consider whether a referral should be made in line with procedures for protecting adults at risk.

Complaint's procedure	NHS Wales complaints and concerns: Putting Things Right | GOV.WALES (opens in a new tab
Adults at risk Multi Agency Referral Form	Refer to the HB Datix system to access the documentation for referral

DRAFT

SECTION 8 RETROSPECTIVE CLAIMS FOR REIMBURSMENT

An individual and/or their representative may request a retrospective review where they contributed to the cost of their care but have reason to believe that they may have met the eligibility for CHC due to the nature, intensity, complexity and/or unpredictability of their healthcare needs.

If eligibility is demonstrated for either the full or part period of the claim, the principles of good public administration demand that timely restitution be made.

As with the process of determining CHC eligibility, the retrospective claim process is not a legal process. Consideration of an individual's eligibility for a retrospective claim involves the use of distinct processes such as the All Wales Retrospective CHC Review to analyse the chronology of need over the entire period of the claim, as opposed to the Decision Support Tool, which provides indications of need over a snapshot in time. It is delivered by the LHB and therefore no charge will be made to the individual.

The claim may be submitted by either:

- The individual who is the subject of the claim.
- A person authorised by the individual to receive reimbursement on his/her behalf.
- A person holding a registered Enduring or Lasting Power of Attorney or who is a Court-appointed deputy for an individual who lacks mental capacity
- In the case of a deceased individual, an executor named in the Grant of Probate in respect of the deceased's estate or an administrator named in the Grant of Letters of Administration of the estate.

Reimbursement, should eligibility be found, will only be paid to the above.

The process for considering the claim period for a retrospective review is as follows:

- The end of the claim period to be considered will be no longer than 12 months before the date of application.
- If the claim period is after an MDT/Independent Review Panel (IRP) decision of no eligibility, the period to be reviewed may go back to the date of the decision as long as it is no longer than 12 months.
- If the claim period is prior to an MDT/IRP decision, no longer than a 12 month period will be reviewed.
- Within 5 months of registering the claim, claimants will be required to provide evidence of: o proof of fees paid to care home or domiciliary agency
- Where the claimant is not the patient, their right to make the claim on the individual's behalf (i.e., Enduring/Lasting Power of Attorney or Grant of Probate).

Within 5 months of registering the claim, claimants will be required to provide evidence of:

- Proof of fees paid to care home or domiciliary agency
- Where the claimant is not the patient, their right to make the claim on the individual's behalf (i.e., Enduring/Lasting Power of Attorney or Grant of Probate).

DRAFT

HDdUHB will need to balance their requirement to provide timely restitution with that of demonstrating probity with the public purse.

Making an application does not mean that reimbursement is guaranteed; LHBs must satisfy themselves that the application is genuine and that the person was indeed eligible for CHC during the disputed period.

Applications outside of the stated claim period may be considered in exceptional circumstances where there is justification. Such circumstances can include for example, the claimant suffering critical illness, serving with the armed forces or living abroad. This is not an exhaustive list and other circumstances may apply.

The process for considering retrospective claims is as follows:

- Evidence of legal authority to make the application and proof of payment of care fees will be provided by the claimant. ii. A claim form (including a request for the claimant's views), a consent form and an Information Booklet are sent to the claimant.
- On receipt of the consent form, proof of payment and legal authority to make the claim, requests are made to the appropriate care providers for records. In accordance with the all-Wales protocol for obtaining records, all agencies are allowed a maximum of 3 months to provide the records or to inform LHBs that they have been destroyed, lost or are unavailable for any other reason.
- A comprehensive chronology of need is produced from a range of available records including a claimant statement, care home records (inc. care plans, risk assessments and daily diaries etc, GP, district nurse and any other available and relevant clinical records. If any of these records are unavailable then the records that are available will be used. The guidance in this Framework must be applied to the claim.
- Stage 1 Review – The All Wales Retrospective CHC Review (AWRCR) document is used to produce the Stage 1 chronology of need. The Checklist is then applied to the information in the Stage 1 AWRCR. If there are no triggers for consideration of eligibility, the case is closed at this point. An IRP Chair must ratify if the recommendation is "no eligibility" or "partial eligibility." If Chair disagrees with the recommendation of partial or no eligibility, then the case should proceed to Stage 2 on the basis of the highest level of eligibility suggested e.g., full rather than partial; partial rather than no eligibility.
- If the claimant/their representative is already eligible for FNC or CHC, the case should proceed directly to Stage 2, without the need for a Stage 1 Review.
- In order to comply with the ethos of this Framework, the use of the Checklist must not replace professional judgement. Claimants should be sent a written explanation of the outcome of the application of the Checklist to their claim.
- Stage 2 Review - If triggers are found for all or part of the period, the Stage 1 chronology of need is transferred to a Stage 2 AWRCR, all other records are added and this is the document used by the clinical reviewer to analyse the evidence and make a recommendation on eligibility. This is done by analysing the information in the chronology using the 4 key indicators of Nature, Intensity, Complexity and Unpredictability, applying the primary health need approach for the claim period.
- On completion of the analysis, the document will be peer reviewed by HDdUHB's eligibility and Quality Assurance panel to ensure the recommendation is robust, based on the evidence available and that the criteria have been consistently applied.

DRAFT

The recommendation on eligibility will be made on the evidence available. It can be 1 of 4 possibilities:

- Matching- the period of eligibility found matches the claim period in totality from the trigger date partial- eligibility is found for part of the claim period from the trigger date
- No eligibility found for any part of the claim period from the trigger date
- Panel - the reviewer has been unable to make a decision as the information available is complex or the clinicians are unable to agree on the period of eligibility.

Dependant on the recommendation made, the case will go along 1 of 3 pathways:

- Matched cases will go directly for ratification
- Partial and no eligibility cases will be forwarded to claimants with the opportunity to discuss the findings
- Panel cases- an Independent Review Panel will be convened.

Independent Review Panel

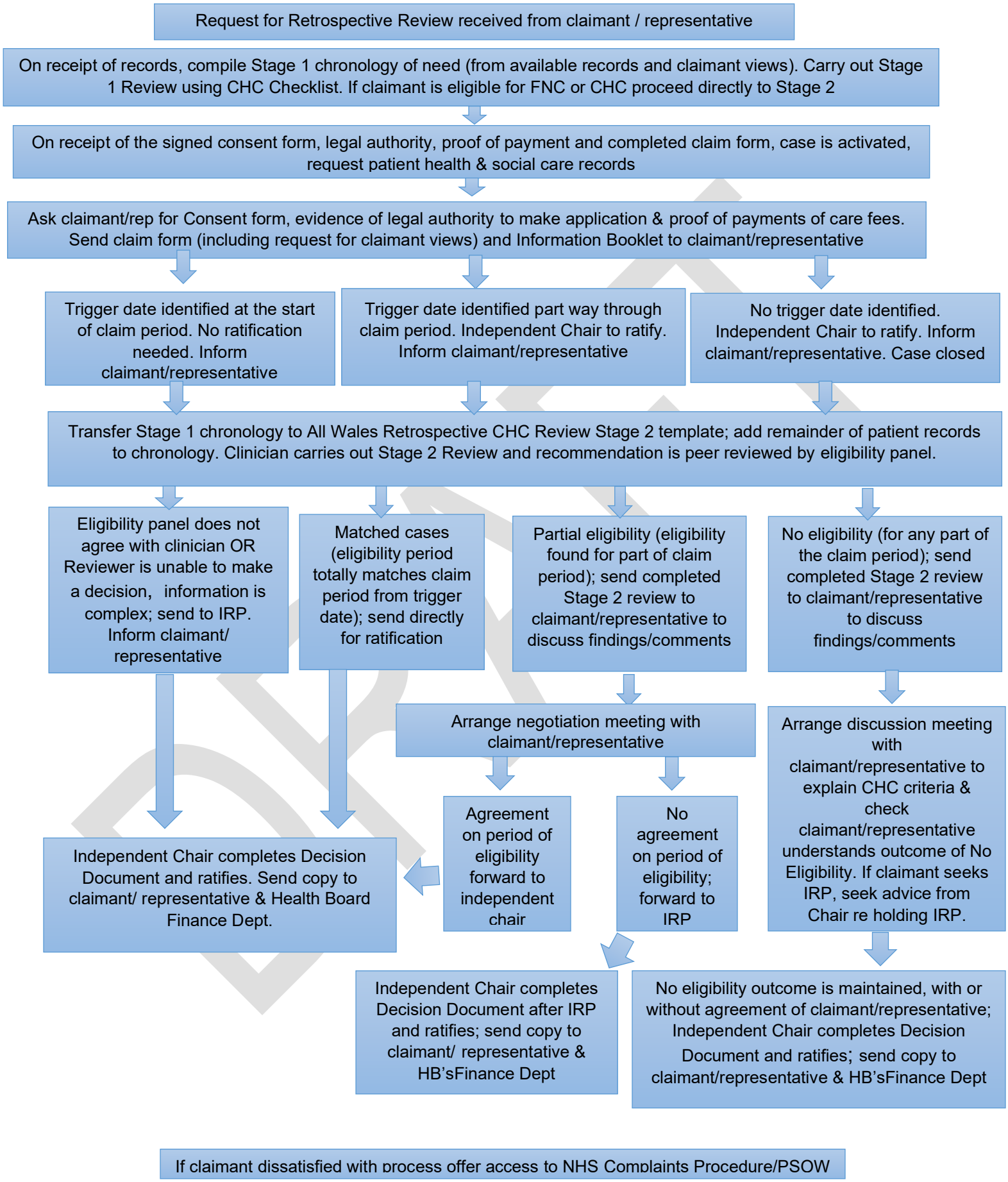
If the peer review indicates that there is an element of doubt then recourse to the IRP process should be granted.

There should be recourse to the IRP process if the individual or their representative has significant additional information to present or exceptional circumstances apply.

Before taking a decision, the LHB will seek the advice of the Chair of the review panel. The Chair provides the lay perspective in the review process. In all cases, where a decision not to convene a panel is made, a full written explanation of the basis of its decision should be provided to the individual and/or their representative, together with a reminder of their rights under the NHS Complaints Procedure and access to the Public Services Ombudsman for Wales.

- The following principles and processes should be followed for all IRP cases:
- All decisions of the IRP should be unanimous. (The Panel attempts to reach a unanimous decision but if not possible a majority decision is accepted.)
- An All-Wales Decision Document will be completed by the person scrutinising and ratifying the recommendation made/Chair of the IRP.
- A copy of the completed Decision Document is provided to the claimant/representative and the LHB Finance Department.
- In cases of no eligibility, if a claimant does not wish to attend a meeting in person, the recommendation should be discussed over the telephone or in writing as far as possible.
- In cases of partial eligibility, a claimant not wishing to attend the negotiation should be able to discuss the recommendation over the phone. An IRP should then be convened

DRAFT


Request for Retrospective Review received from claimant / representative
On receipt of records, compile Stage 1 chronology of need (from available records and claimant views). Carry out Stage 1 Review using CHC Checklist. If claimant is eligible for FNC or CHC proceed directly to Stage 2
On receipt of the signed consent form, legal authority, proof of payment and completed claim form, case is activated, request patient health & social care records
Ask claimant/rep for Consent form, evidence of legal authority to make application & proof of payments of care fees. Send claim form (including request for claimant views) and Information Booklet to claimant/representative
Trigger date identified at the start of claim period. No ratification needed. Inform claimant/representative
Trigger date identified part way through claim period. Independent Chair to ratify. Inform claimant/representative
No trigger date identified. Independent Chair to ratify. Inform claimant/representative. Case closed
Transfer Stage 1 chronology to All Wales Retrospective CHC Review Stage 2 template; add remainder of patient records to chronology. Clinician carries out Stage 2 Review and recommendation is peer reviewed by eligibility panel.
Eligibility panel does not agree with clinician OR Reviewer is unable to make a decision, information is complex; send to IRP. Inform claimant/ representative
Matched cases (eligibility period totally matches claim period from trigger date); send directly for ratification
Partial eligibility (eligibility found for part of claim period); send completed Stage 2 review to claimant/representative to discuss findings/comments
No eligibility (for any part of the claim period); send completed Stage 2 review to claimant/representative to discuss findings/comments
Arrange negotiation meeting with claimant/representative
Arrange discussion meeting with claimant/representative to explain CHC criteria & check claimant/representative understands outcome of No Eligibility. If claimant seeks IRP, seek advice from Chair re holding IRP.
Agreement on period of eligibility forward to independent chair
No agreement on period of eligibility; forward to IRP
Independent Chair completes Decision Document and ratifies. Send copy to claimant/ representative & Health Board Finance Dept.
Independent Chair completes Decision Document after IRP and ratifies; send copy to claimant/ representative & HB'sFinance Dept
No eligibility outcome is maintained, with or without agreement of claimant/representative; Independent Chair completes Decision Document and ratifies; send copy to claimant/representative & HB'sFinance Dept
If claimant dissatisfied with process offer access to NHS Complaints Procedure/PSOW

APPENDIX 1 - Client CONSENT for assessment of a primary health need (continuing NHS Health care eligibility)

1. **Statement of Health Professional / Care Co-ordinator :**

I confirm that I have discussed and explained the reason for the assessment, all the options and consequences along with the submission process with the Client named above, provided the Continuing NHS Health care for Adults in Wales Public information leaflet and have explained the sharing and processing of information to relevant organisations involved for the purpose of the assessment and where appropriate audit and monitoring of decisions

Signature: _____ **Print Name:** _____

Job Title: _____ **Date:** _____

2. **Statement of Client:**

I confirm that the reason for assessment, all options and consequences and the submission process have been explained to me, I have received the Continuing NHS Health care for Adults in Wales Public information leaflet. and the sharing and processing of information to relevant organisations involved for the purpose of the assessment and where appropriate audit and monitoring of decisions has been explained

- I am in agreement that I should be assessed for a Primary Health Need and that this involves sharing relevant information. (Delete as appropriate)

- I am NOT in agreement and Do NOT want to be assessed for a Primary Health Need (Delete as appropriate)

Signature of Client: _____**Date:** _____

3. **To be completed by the lead health professional where the Client does not have the capacity to consent:**

I can confirm that the multi professional team involved in the care, assessment and submission of the identified Client are satisfied that the application is in the Client's best interest. This decision has been made in consultation with the Client's Next of Kin / Advocate / Enduring Power of Attorney (delete as appropriate)

Please attach capacity assessment and Best Interest minutes

Signature: _____**Print Name:** _____

Job Title: _____ **Date:** _____

DRAFT

1. **<u>Statement of Next of Kin / Enduring Power of Attorney</u>:**

I confirm that the reason for the assessment and submission has been explained to me, I have received the Continuing NHS Health care for Adults in Wales Public information leaflet and the sharing and processing of information to relevant organisations involved for the purpose of the assessment and where appropriate audit and monitoring of decisions has been explained

I am in agreement that the submission should be made for consideration.

Signature: _____ **Date:** _____

Relationship: _____

Contact Details: _____

DRAFT

APPENDIX 2 - STANDARD ASSESSMENT & ELIGIBILITY PROCESS CHECKLIST

Name:
DOB:



Date		Tick if complete	Comments
	Care Co-ordinator/Lead professional identified Name: Contact Details: Individual/family informed		
	Rehabilitation/reablement/ recovery programme recommended/commenced Date:		
	Most appropriate place for assessment agreed Rationale/justification required if assessment takes place in acute hospital environment		
	CHC Checklist Tool if required, CHC Information Leaflet & Consent Form		
	Assessment process explained to individual and their family/carer(s) Consent Form completed Yes/ No **(delete as applicable) –** if no explain why in comment box		

DRAFT

	Preferred language for assessment identified Mechanisms in place to accommodate language preference e.g., Welsh speakers in MDT		
	Advocacy offered		
	Appropriate and proportionate MDT input determined: (tick as appropriate) • The individual • Nominated family member as key contact or other unpaid carer • Advocate • Specialist and/or community based practitioner who has regular contact • Existing service provider(s) e.g., care home, domiciliary care agency, voluntary sector service • Social Worker • Occupational Therapist • Physiotherapist • Dietician • Speech & Language Therapist • Benefits advice • Other		
	Assessments completed and collated		
	Formal CHC eligibility meeting arranged Date: Venue:		
	CHC eligibility determined by MDT		
	Outcome and rationale clearly recorded and communicated to individual and/or carer or advocate		

DRAFT

APPENDIX 3 - CONTINUING NHS HEALTHCARE (CHC) CHECKLIST

Introduction

This Checklist, although not mandatory, is a tool to help practitioners identify people who need a full assessment for Continuing NHS Healthcare (CHC), either for current or retrospective cases. Please note that referral for assessment for CHC is not an indication of the outcome of the eligibility decision. This fact should also be communicated to the individual and, where appropriate, their representative.

The Checklist is based on the Decision Support Tool for Continuing NHS Healthcare (DST). The notes to the DST and *Continuing NHS Healthcare – The* National Framework for Implementation in Wales 2021 (the 2021 Framework) will aid understanding of this tool. Practitioners who use this tool should have received suitable training.

The Checklist should be completed in line with guidance set out in the 2021 Framework. It must be completed by at least 2 practitioners, including a representative of the LA. It can be completed by a variety of health and social care practitioners, who have been trained in its use. This could include, for example: registered nurses employed by the NHS, GPs, other clinicians or LA staff such as social workers, care managers or social care assistants.

Care homes should contact the relevant CHC team to arrange for a Checklist to be completed for their residents. The intention is for the Checklist to be completed as part of the wider process of assessing or reviewing an individual's needs. Therefore, it is expected that all staff in roles where they are likely to be involved in assessing or reviewing needs should have completion of Checklists identified as part of their role and receive appropriate training.

The Practitioners completing the Checklist must establish the individual, or their representatives, language of choice prior to any assessment taking place. All written and verbal communication must be in the individual or their representatives' choice of language as set out in **Principle 7: Communicate.**

Individuals may request an assessment for CHC. In these circumstances, the organisation receiving the request should make the appropriate arrangements for a Checklist to be completed. All staff who apply the Checklist will need to be familiar with the principles of the 2021 Framework and with the DST.

How to use the Checklist

Before applying the Checklist, it is necessary to ensure that the individual and (where appropriate) their representative understand that completing the Checklist is not an indication of the likelihood that the individual will necessarily be determined as being eligible for CHC.

The individual should be informed that the Checklist is to be completed and should have the process for completion explained to them. The individual and (where appropriate) their representative should be supported to play a full role in the process and should be given an opportunity to contribute their views

about their needs. As set out in **Principle 3: No decisions about me without me.** Decisions and rationales should be transparent from the outset.

As with any examination or treatment, the individual's informed consent should be obtained before the process of completing the Checklist commences

If there is a concern that the individual may not have capacity to give their consent, this should be determined in accordance with the Mental Capacity Act 2005 and the associated code of practice. Anyone who completes a Checklist should be particularly aware of the five principles of the Act:

- **A presumption of capacity:** A person must be assumed to have capacity unless it is established that they lack capacity.
- **Individuals being supported to make their own decisions:** A person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success.
- **Unwise decisions:** A person is not to be treated as unable to make a decision merely because they makes an unwise decision.
- **Best interests:** An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in their best interests.
- **Least restrictive option:** Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

It must also be borne in mind that consideration of capacity is specific to both the decision to be made and the time when it is made – i.e., the fact that a person may be considered to lack capacity to make a particular decision should not be used as a reason to consider that they cannot make any decisions. Equally, the fact that a person was considered to lack capacity to make a specific decision on a given date should not be a reason for assuming that they lack capacity to make a similar decision on another date.

If the person lacks the mental capacity to either give or refuse consent to the use of the Checklist, a 'best interests' decision, taking the individual's previously expressed views into account, should be taken (and recorded) as to whether or not to proceed. Those making the decision should bear in mind the expectation that everyone who might meet the Checklist threshold should have this opportunity. A third party cannot give or refuse consent for an assessment of eligibility for CHC on behalf of a person who lacks capacity, unless they have a valid and applicable Lasting Power of Attorney (Welfare) or they have been appointed a Welfare Deputy by the Court of Protection. Before making a best interest decision as to whether or not to proceed with the completion of the Checklist the assessor should be mindful of their duty to consult with appropriate third parties. This is particularly important if the decision is not to complete a Checklist.

Further information on consent and mental capacity can be found in, **Section 3** of the 2021 Framework.

Completion of the Checklist

In an acute hospital setting, the Checklist should not be completed until the individual's needs on discharge are clear.

Please compare the descriptions of need to the needs of the individual and select level A, B or C, as appropriate, for each domain. Consider all the descriptions and select the one that most closely matches the individual. If the needs of the individual are the same or greater than anything in the A column, then 'A' should be selected. For each domain, please also give a brief reference, stating where the evidence that supports the decision can be accessed, if necessary.

Where it can reasonably be anticipated that the individual's needs are likely to increase in the next three months (e.g. because of an expected deterioration in their condition), this should be reflected in the columns selected. Where the extent of a need may appear to be less because good care and treatment is reducing the effect of a condition, the need should be recorded in the Checklist as if that care and treatment was not being provided.

A full assessment for CHC is required if there are:

- two or more domains selected in column A;
- five or more domains selected in column B, or one selected in A and four in B; or
- one domain selected in column A in one of the boxes marked with an asterisk (i.e. those domains that carry a priority level in the DST), with any number of selections in the other two columns.

There may also be circumstances where a full assessment for CHC is considered necessary, even though the individual does not apparently meet the indicated threshold.

Whatever the outcome, assessors should record written reasons for the decision and should sign and date the Checklist. Assessors should inform the individual and/or their representative of the decision, providing a clear explanation of the basis for the decision. The individual should be given a copy of the completed Checklist. The rationale contained within the completed Checklist should give enough detail for the individual and their representative to be able to understand why the decision was made.

Individuals and their representatives should be advised that, if they disagree with the decision not to proceed to a full assessment for CHC, they may ask the Local Health Board (LHB) to reconsider it. This should include a review of the original Checklist and any new information available, and might include the completion of a second Checklist. If they remain dissatisfied they can pursue the matter through the normal complaints process.

Each LHB should have clear local processes that identify where a completed Checklist should be sent, in order for the appropriate next steps to be taken. Completed Checklists should be forwarded in accordance with these local processes.

The Equality Monitoring Form should be completed by the individual who is the subject of the Checklist. Where the individual needs support to complete the form, this should be offered by the practitioner completing the Checklist. The practitioner should forward the completed data form to the appropriate location, in accordance with the relevant LHB's processes for processing equality data.

DRAFT

Checklist Record Form

Date of completion of the Checklist	
Name	
Date of birth	
NHS number	
GP and practice	

Permanent address	current location (e.g. telephone number, hospital ward etc.)

Please ensure that the Equality Monitoring Form at the end of the Checklist is completed.

Was the individual involved in the completion of the Checklist? **Yes/No** (please delete as appropriate)

Was the individual offered the opportunity to have a representative such as a family member or other advocate present when the Checklist was completed? **Yes/No**

If yes, did the representative attend the completion of the Checklist? **Yes/No**

Please give the contact details of the representative (name, address and telephone number).

Did you explain to the individual how their personal information will be shared with the different organisations involved in their care, and did they consent to this information sharing? **Yes/No**

DRAFT

Please highlight the outcome indicated by the Checklist:

- Referral for full assessment for Continuing NHS Healthcare is necessary ***or***

- No referral for full assessment for Continuing NHS Healthcare is necessary.

(*There may be circumstances where you consider that a full assessment for Continuing NHS Healthcare is necessary, even though the individual does not apparently meet the indicated threshold. If so, a full explanation should be given*.)

Rationale for decision

DRAFT

Name of patient	Date of completion			
Please circle statement A, B or C in each domain. AN ASTERISK placed against each category indicates a PRIORITY domain				
LEVEL→ CATEGORY↓	**C**	**B**	**A**	**Recorded evidence to support level**
1 Breathing *	Normal breathing, no issues with shortness of breath. **OR** Shortness of breath, which may require the use of inhalers or a nebuliser and has no impact on daily living activities. **OR** Episodes of breathlessness that readily respond to management and have no impact on daily living activities.	Shortness of breath, which may require the use of inhalers or a nebuliser and limit some daily living activities. **OR** Episodes of breathlessness that do not respond to management and limit some daily activities. **OR** Requires any of the following: • low level oxygen therapy (24%); • room air ventilators via a facial or nasal mask; • other therapeutic appliances to maintain airflow where individual can still spontaneously breathe e.g. CPAP (Continuous Positive Airways Pressure) to manage obstructive apnoea during sleep.	Is able to breathe independently through a tracheotomy that they can manage themselves, or with the support of carers or care workers. **OR** Breathlessness due to a condition which is not responding to therapeutic treatment and limits all daily living activities. **OR** A condition that requires management by a non-invasive device to both stimulate and maintain breathing (non-invasive positive airway pressure, or non-invasive ventilation)	
LEVEL→ CATEGORY↓	**C**	**B**	**A**	**Recorded evidence to support level**

DRAFT

2 Nutrition					Name(s) and
	Able to take adequate food and drink by mouth to meet all nutritional requirements. **OR** Needs supervision, prompting with meals, or may need feeding and/or a special diet. **OR** Able to take food and drink by mouth but requires additional/supplementary feeding.	Needs feeding to ensure adequate intake of food and takes a long time (half an hour or more), including liquidised feed. **OR** Unable to take any food and drink by mouth, but all nutritional requirements are being adequately maintained by artificial means, for example via a nonproblematic PEG.	Dysphagia requiring skilled intervention to ensure adequate nutrition/hydration and minimise the risk of choking and aspiration to maintain airway. **OR** Subcutaneous fluids that are managed by the individual or specifically trained carers or care workers. **OR** Nutritional status 'at risk' and may be associated with unintended, significant weight loss. **OR** Significant weight loss or gain due to an identified eating disorder. **OR** Problems relating to a feeding device (e.g. PEG) that require skilled assessment and review.		

signature(s) of assessor(s) **Date**

Contact details of assessors (name, role, organisation, telephone number, email address)

DRAFT

LEVEL→ CATEGORY↓	**C**	**B**	**A**	**Recorded evidence to support level**
3 Continence	Continent of urine and faeces. **OR** Continence care is routine on a day-today basis. **OR** Incontinence of urine managed through, for example, medication, regular toileting, use of penile sheaths, etc. **AND** Is able to maintain full control over bowel movements or has a stable stoma, or may have occasional faecal incontinence/constipation.	Continence care is routine but requires monitoring to minimise risks, for example those associated with urinary catheters, double incontinence, chronic urinary tract mes and/or the management of constipation.	Continence care is problematic and requires timely and skilled intervention, beyond routine care. (for example frequent bladder wash outs, manual evacuations, frequent recatheterisation).	
LEVEL→ CATEGORY↓	**C**	**B**	**A**	**Recorded evidence to support level**

DRAFT

4 Skin Integrity	No risk of pressure damage or skin condition. **OR** Risk of skin breakdown which requires preventative intervention once a day or less than daily, without which skin integrity would break down. **OR** Evidence of pressure damage and/or pressure ulcer(s) either with 'discolouration of intact skin' or a minor wound. **OR** A skin condition that requires monitoring or reassessment less than daily and that is responding to treatment or does not currently require treatment.	Risk of skin breakdown which requires preventative intervention several times each day, without which skin integrity would break down. **OR** Pressure damage or open wound(s), pressure ulcer(s) with 'partial thickness skin loss involving epidermis and/or dermis', which is responding to treatment. **OR** A skin condition that requires a minimum of daily treatment, or daily monitoring/reassessment to ensure that it is responding to treatment.	Pressure damage or open wound(s), pressure ulcer(s) with 'partial thickness skin loss involving epidermis and/or dermis', which is not responding to treatment. **OR** Pressure damage or open wound(s), pressure ulcer(s) with 'full thickness skin loss involving damage or necrosis to subcutaneous tissue, but not extending to underlying bone, tendon or joint capsule', which is responding to treatment. **OR** Specialist dressing regime in place which is responding to treatment.	

LEVEL→ CATEGORY↓	**C**	**B**	**A**	**Recorded evidence to support level**

DRAFT

5 Mobility	Independently mobile. **OR** Able to bear weight but needs some assistance and/or requires mobility equipment for daily living.	Not able to consistently bear weight. **OR** Completely unable to bear weight but is able to assist or cooperate with transfers and/or repositioning. **OR** In one position (bed or chair) for majority of the time but is able to cooperate and assist carers or care workers. OR At moderate risk of falls (as evidenced in a falls history or risk assessment)	Completely unable to bear weight and is unable to assist or cooperate with transfers and/or repositioning. **OR** Due to risk of physical harm or loss of muscle tone or pain on movement needs careful positioning and is unable to cooperate. **OR** At a high risk of falls (as evidenced in a falls history and risk assessment). **OR** Involuntary spasms or contractures placing the individual or others at risk.	

LEVEL→ CATEGORY ↓	**C**	**B**	**A**	**Recorded evidence to support level**

DRAFT

6 Communication	Able to communicate clearly, verbally or non-verbally. Has a good understanding of their primary language. May require translation if English is not their first language. **OR** Needs assistance to communicate their needs. Special effort may be needed to ensure accurate interpretation of needs or additional support may be needed either visually, through touch or with hearing.	Communication about needs is difficult to understand or interpret or the individual is sometimes unable to reliably communicate, even when assisted. Carers or care workers may be able to anticipate needs through nonverbal signs due to familiarity with the individual.	Unable to reliably communicate their needs at any time and in any way, even when all practicable steps to assist them have been taken. The person has to have most of their needs anticipated because of their inability to communicate them.	

LEVEL→ *CATEGORY↓*	**C**	**B**	**A**	**Recorded evidence to support level**

DRAFT

7 Psychological and Emotional Needs	Psychological and emotional needs are not having an impact on their health and well-being. **OR** Mood disturbance or anxiety or periods of distress, which are having an impact on their health and/or well-being but respond to prompts and reassurance. **OR** Requires prompts to motivate self towards activity and to engage in care planning, support and/or daily activities.	Mood disturbance or anxiety symptoms or periods of distress which do not readily respond to prompts and reassurance and have an increasing impact on the individual's health and/or wellbeing. **OR** Due to their psychological or emotional state the individual has withdrawn from most attempts to engage them in support, care planning and/or daily activities.	Mood disturbance or anxiety symptoms or periods of distress that have a severe impact on the individual's health and/or well-being. **OR** Due to their psychological or emotional state the individual has withdrawn from any attempts to engage them in care planning, support and daily activities.	

LEVEL→ CATEGORY↓	**C**	**B**	**A**	Recorded evidence to support level

DRAFT

8 Cognition	No evidence of impairment, confusion or disorientation. **OR** Cognitive impairment which requires some supervision, prompting or assistance with more complex activities of daily living, such as finance and medication, but awareness of basic risks that affect their safety is evident. **OR** Occasional difficulty with memory and decisions/choices requiring support, prompting or assistance. However, the individual has insight into their impairment.	Cognitive impairment (which may include some memory issues) that requires some supervision, prompting and/or assistance with basic care needs and daily living activities. Some awareness of needs and basic risks is evident. The individual is usually able to make choices appropriate to needs with assistance. However, the individual has limited ability even with supervision, prompting or assistance to make decisions about some aspects of their lives, which consequently puts them at some risk of harm, neglect or health deterioration.	Cognitive impairment that could include frequent short-term memory issues and maybe disorientation to time and place. The individual has awareness of only a limited range of needs and basic risks. Although they may be able to make some choices appropriate to need on a limited range of issues, they are unable to do so on most issues, even with supervision, prompting or assistance. The individual finds it difficult, even with supervision, prompting or assistance, to make decisions about key aspects of their lives, which consequently puts them at high risk of harm, neglect or health deterioration.	

LEVEL→ *CATEGORY↓*	**C**	**B**	**A**	**Recorded evidence to support level**
9 Behaviour *	No evidence of 'challenging' behaviour. **OR** Some incidents of 'challenging' behaviour. A risk assessment indicates that the behaviour does not pose a risk to self, others or property or a barrier to intervention. The person is compliant with all aspects of their care.	'Challenging' behaviour that follows a predictable pattern. The risk assessment indicates a pattern of behaviour that can be managed by skilled carers or care workers who are able to maintain a level of behaviour that does not pose a risk to self, others or property. The person is nearly always compliant with care.	'Challenging' behaviour that poses a predictable risk to self, others or property. The risk assessment indicates that planned interventions are effective in minimising but not always eliminating risks. Compliance is variable but usually responsive to planned interventions.	

DRAFT

LEVEL→ CATEGORY↓	**C**	**B**	**A**	**Recorded evidence to support level**
10 Drug therapies and medication *	Symptoms are managed effectively and without any problems, and medication is not resulting in any unmanageable side-effects. **OR** Requires supervision/administration of and/or prompting with medication but shows compliance with medication regime. **OR** Mild pain that is predictable and/or is associated with certain activities of daily living; pain and other symptoms do not have an impact on the provision of care.	Requires the administration of medication (by a registered nurse, carer or care worker) due to: • non-concordance or noncompliance, or • type of medication (for example insulin); or • route of medication (for example PEG). **OR** Moderate pain which follows a predictable pattern; or other symptoms which are having a moderate effect on other domains or on the provision of care.	Requires administration and monitoring of medication regime by a registered nurse, carer or care worker specifically trained for this task because there are risks associated with the potential fluctuation of the medical condition or mental state, or risks regarding the effectiveness of the medication or the potential nature or severity of sideeffects. However, with such monitoring the condition is usually non-problematic to manage. **OR** Moderate pain or other symptoms which is/are having a significant effect on other domains or on the provision of care.	

LEVEL→ CATEGORY↓	**C**	**B**	**A**	**Recorded evidence to support level**

DRAFT

11 Altered states of consciousness	No evidence of altered states of consciousness (ASC). **OR** History of ASC but effectively managed and there is a low risk of harm.	Occasional (monthly or less frequently) episodes of ASC that require the supervision of a carer or care worker to minimise the risk of harm.	Frequent episodes of ASC that require the supervision of a carer or care worker to minimise the risk of harm. **OR** Occasional ASCs that require skilled intervention to reduce the risk of harm.	

Name of patient		**Date of completion**		
TOTAL FROM ALL PAGES	**C**	**B**	**A**	
ADDITIONAL COMMENTS				

DRAFT

SIGNED AND POSITION OF SIGNATORY

EQUALITY MONITORING FORM

Please provide us with some information about yourself. This will help us to understand whether everyone is receiving fair and equal access to CHC. All the information you provide will be kept completely confidential by the NHS. No identifiable information about you will be passed on to any other bodies, members of the public or press.

Please circle or highlight only one box in each category.

1. SEX	
Male	
Female	
Transgender	

2. SEXUAL ORIENTATION					
Only answer this question if you are aged **16 years** or over. Which applies to you? (*If 'Other', please highlight and write in box provided)					
Heterosexual / Straight	Lesbian / Gay Woman	Gay Man	Bisexual	Prefer not to say	*Other

* Any other, write here

3. AGE GROUP –								
Which applies to you?								
0-15	16-24	25-34	35-44	45-54	55-64	65-74	75-84	85+

DRAFT

4. DISABILITY

Do you have a disability, as defined by the *Equality Act 2010?*	The Equality Act defines a person with a disability as someone who 'A physical or mental impairment which has a substantial and long term adverse effect on your ability to carry out normal day to day activities. https://www.gov.uk/definition-of-disability-under-equality-act2010

Yes	No

5. ETHNIC GROUP –

Which applies to you? (*If 'Other', please highlight and write in box provided)

White		Mixed		Asian *or* Asian British		Black *or* Black British		Chinese or other group	
British		White and Black Caribbean		Indian		Caribbean		Chinese	
Irish		White and Black African		Pakistani		African		Other*	
Other*		White and Asian		Banglades hi		Other*			
		Other*		Other*					

*	Any other, write here

6. RELIGION

Which applies to you? (*If 'Other', please highlight and write in box provided)

Christian includes Church of Wales, Catholic, Protestant and all other Christian denominations

Christian	Buddhist	Hindu	Jewish	Muslim	Sikh	

Any other, write here

DRAFT

Appendix 4 Fast Track assessment for the terminal phase of palliative care September 2023

Please identify the level of assessment below to enable the NHS Long Term Care Team to prioritise urgent cases.	**Please indicate**
1. End of Life Care Pathway (48-72 hours) Please submit a copy of the completed **Care Decisions for the last days of life document** together with a complex care plan request **or** submit a **Fast Track Assessment** (completing all sections of pages 1-9 only) if an individual has a primary health need and a rapidly deteriorating condition which is entering a terminal phase and has a **life expectancy of between 48–72 hours.**	
2. Less that 7 days Life Expectancy Please complete all sections of pages **1-9 only** of this **Fast Track assessment** if an individual has a primary health need and a rapidly deteriorating condition which is entering a terminal phase and has a life expectancy of **seven days or less**.	
3. All Other Individuals Entering a Terminal Phase Please complete all sections of the **Fast Track assessment** if an individual has a primary health need and a rapidly deteriorating condition which is entering a terminal phase.	

Please forward completed assessment to:

NHS Long Term Care Team	Email to NHS.LongTermCare@wales.nhs.uk

Statement of Consent

DRAFT

In accordance with Section 3 of The Continuing NHS Healthcare National Framework for Implementation in Wales, informed consent should be obtained before the start of the assessment process to determine eligibility for Continuing NHS Healthcare funding (CHC). Consent should encompass:

- Permission to undertake the CHC assessment and subsequent reviews as stated in framework guidelines.
- Sharing and processing of relevant personal information (both in the assessment process and for audit and monitoring purposes. This information may also be shared with other professionals as part of the multi-disciplinary process)

<u>The Mental Capacity Act 2005 states a person has capacity unless proved otherwise</u>

Name: _____ NHS number:_____

DOB: _____

Address:_____

Please complete questions below

1. Has the individual been provided with a copy of the Continuing NHS Healthcare Information Booklet for Individuals, Families and Carers? Yes/No

2. Are there any doubts regarding the individual's ability to consent to the Continuing NHS Health Care Process? Yes/ No

3. Have practicable steps been taken to support the individual to make a decision and if yes what were these? Yes/No

4. Is the individual's ability to make a decision likely to return or considered a temporary loss? Yes/ No

5. Following an assessment of capacity is the person able to consent to the process? Yes/No

Any concerns/comments:_____

If able to consent please ask individual to sign Statement 1.

If deemed to lack capacity and individual has representation, please proceed to statement 2.

If deemed to lack capacity and individual does not have representation proceed to statement 3.

DRAFT

2) Please confirm if the individual has an appointed Lasting Power of Attorney (LPA) for Health and Welfare / Finance and property or Court Appointed Representative, or Independent Mental Capacity Advocate?

Please specify: _____

Care Coordinator confirms that they have had sight of a certified copy of the original Deputyship Order or registered LPA and confirmed person has relevant authority stated Y/N

Statement of representative:

I confirm that the reason for the assessment and submission has been explained to me, I have received the Continuing NHS Health care for Adults in Wales Public information leaflet and the sharing and processing of information to relevant organisations involved for the purpose of the assessment and where appropriate audit and monitoring of decisions has been explained.

I am / am not in agreement that the submission should be made for consideration.

Name of Representative: _____

Signature of Representative: _____

Date:_____

Name of Lead Health Professional: _____

Signature of Lead Health Professional: _____

Date:_____

3) If there is no nominated individual a Best Interests discussion will need to take place which should include the views of relevant third-party members including family, friends and advocates where reasonable and practicable. Overall responsibility for the decision is with the decision maker and those consulted do not have authority to consent or refuse consent.

I can confirm that the multi professional team involved in the care, assessment and submission of the identified individual are satisfied that the application is in the individual's best interest. This decision has been made in consultation with the individuals NOK/Family:

Name of Lead Health Professional: _____

Signature of Lead Health Processional: _____

Date:_____

Does person want relatives informed of assessment/condition/treatment? Yes / No

If yes, person authorised to receive information:

Name: Relationship:

Name: Relationship:

Signature of person Date

Name of Person

Name and Address Mr / Mrs / Miss / Ms / Other:

Wishes to be called:

DOB: Age:

Tel No.:

Mobile No.:

Sex: Male / Female

NHS Number

Marital Status: Single/Married/Partner/Civil Partner/Divorced/Separated/Widow/ Widower

GP Surgery: GP Practice Name:

Tel No:

Is patient currently in hospital? Yes / No

If No, where is the patient currently? Please give the address where care will be delivered. State if this is at address above, home, nursing home or other location:

DRAFT

Assessment Co-ordinator:

Name: Designation:

Address:

Tel No: Bleep:

Email:

Alternative contact:

Date of Assessment:

Contacts:

Name: Relationship:

NOK / Emergency Contact / Main Carer

Address:

Tel No: Mobile No:

Patient's/Individual's Perspective: Include wishes, preferences, beliefs, values and spirituality.

Has prognosis been discussed with the patient? Yes / No

Has individual an Advance Decision/Advanced Statement/Living Will? Yes / No

If Yes, evidence will be required.

Is there a Lasting Power of Attorney for personal welfare/Deputy/IMCA? Yes / No

If Yes, appropriate paperwork or registration details will be required.

DRAFT

Family/Carer's Perspective:

Has prognosis been discussed with the relative / NOK / main carer? Yes / No

Has a carer's assessment been offered & completed &/or declined?

What assistance has the family stated they will provide?

What support is required to support them in their role as carer?

DRAFT

Medical Opinion: This section must be completed by the relevant Doctor

Primary Health Need Approach

- Nature: This describes the particular characteristics of an individual needs (which can include physical, mental health, or psychological needs), and the type of those needs. This also describes the overall effect of those needs on the individual, including the type ('quality') of interventions required to manage them.

- Intensity: This relates to both the extent ('quantity') and severity (degree) of the needs and the support required to meet them, including the need for sustained/ongoing care ('continuity').

- Complexity: This is concerned with how the needs present and interact to increase the skill needed to monitor the symptoms, treat the condition(s) and/or manage the care. This can arise with a single condition or can also include the presence of multiple conditions or the interactions between two or more conditions. It may also include situations where an individual's response to their own condition has an impact on their overall needs, such as when a physical health need results in the individual developing a mental health need.

- Unpredictability: This describes the degree to which needs fluctuate, creating challenges in managing them. It also relates to the level of risk to the individual's health if adequate and timely care is not provided. Someone with an unpredictable healthcare need is likely to have either a fluctuating, or unstable or rapidly deteriorating condition. Each of these characteristics may, in combination or alone, demonstrate a primary health need, because of the quality and/or quantity of care required to meet the individual's needs. The totality of the overall needs and the effects of the interaction of needs should be carefully considered when completing the DST

Diagnosis**:**

DRAFT

Prognosis:
Treatment:
Is there a Do Not Attempt Resuscitation (DNAR) Order? Yes / No **If yes, for our records please attach a copy to this assessment.**
Summary of Medical Opinion: **Please tick appropriate box**

The individual has a primary health need and a rapidly deteriorating condition which is entering a terminal phase and is on the End of Life Priorities (48 – 72 hours)	
The individual has a primary health need and a rapidly deteriorating condition which is entering a terminal phase and has a life expectancy of less the 7 days.	
The individual has a primary health need and a rapidly deteriorating condition which is entering a terminal phase	

Has the patient's GP been informed of prognosis and discharge? Yes / No

Name:

Signature:

Designation: **Date:**

DRAFT

List Medication & Route: e.g. morphine through syringe driver, I.M. oral medication etc.

Risks: please list whether there are safeguarding issues, or any health and safety risks to individual and others.

Equipment Required: please list whether there is a need to commission a hoist, hospital bed, airflow mattress etc.

Can this be obtained from Equipment Store? Yes / No

Has this been ordered? Yes / No

When is delivery expected?

Total Care Package Required:

Care Co-ordinator in the Community Details:

Name: Designation:

Tel. No: Email:

Base:

Base Tel. No:

Involved in MDT / Discharge Planning? Yes / No

DRAFT

Assessment of Needs

1. Breathing:

Description	Level of need
Normal breathing, no issues with shortness of breath.	No needs
Shortness of breath which may require the use of inhalers or a nebuliser and has no impact on daily living activities. **OR** Episodes of breathlessness that readily respond to management and have no impact on daily living activities.	Low
Shortness of breath which may require the use of inhalers or a nebuliser and limit some daily living activities. **OR** Episodes of breathlessness that do not respond to management and limit some daily living activities. **OR** Requires any of the following: • low level oxygen therapy (24%). • room air ventilators via a facial or nasal mask. • other therapeutic appliances to maintain airflow where individual can still spontaneously breathe e.g. CPAP (Continuous Positive Airways Pressure) to manage obstructive apnoea during sleep.	Moderate
Is able to breathe independently through a tracheotomy that they can manage themselves, or with the support of carers or care workers. **OR** Breathlessness due to a condition which is not responding to treatment and limits all daily living activities.	High
Difficulty in breathing, even through a tracheotomy, which requires suction to maintain airway. **OR** Demonstrates severe breathing difficulties at rest, in spite of maximum medical therapy **OR** A condition that requires management by a non-invasive device to both stimulate and maintain breathing (bi-level positive airway pressure, or non-invasive ventilation)	Severe
Unable to breathe independently, requires invasive mechanical ventilation.	Priority
Please provide brief details	

DRAFT

2. Nutrition

Description	Level of need
Able to take adequate food and drink by mouth to meet all nutritional requirements.	No needs
Needs supervision, prompting with meals, or may need feeding and/or a special diet. **OR** Able to take food and drink by mouth but additional risk assessment indicates additional/supplementary feeding is required.	Low
Needs feeding to ensure adequate intake of food and takes a long time (half an hour or more), including liquidised feed. **OR** Unable to take any food and drink by mouth, but all nutritional requirements are being adequately maintained by artificial means, for example via a non-problematic PEG.	Moderate
Requires skilled intervention to ensure adequate nutrition/hydration and minimise the risk of choking and aspiration to maintain airway. **OR** Subcutaneous fluids that are managed by the individual or specifically trained carers or care workers. **OR** Nutritional status "at risk" and may be associated with unintended, significant weight loss. **OR** Problems relating to a feeding device (for example PEG) that require skilled assessment and review.	High
Unable to take food and drink by mouth. All nutritional requirements taken by artificial means requiring ongoing skilled competent intervention and clinical decision making over a 24 hour period to ensure nutrition/hydration, for example I.V. fluids. **OR** Unable to take food and drink by mouth, intervention inappropriate or impossible.	Severe

Please provide brief details

DRAFT

3. Continence

Description	**Level of need**
Continent of urine and faeces.	No needs
Continence care is routine on a day-to-day basis; Incontinence of urine managed through, for example, medication, regular toileting, use of penile sheaths, etc. **AND** is able to maintain full control over bowel movements or has a stable stoma, or may have occasional faecal incontinence/constipation.	Low
Continence care is routine but requires monitoring to minimise risks, for example those associated with urinary catheters, double incontinence, chronic urinary tract infections and/or the management of constipation.	Moderate
Continence care is problematic and requires timely and skilled intervention, beyond routine care (for example frequent bladder wash outs, manual evacuations, frequent re-catheterisation).	High

Please provide brief details

DRAFT

4. Skin Integrity

Description	Level of need
No risk of pressure damage or skin condition.	No needs
Risk of skin breakdown which requires preventative intervention once a day or less than daily without which skin integrity would break down. **OR** Evidence of pressure damage and/or pressure ulcer(s) either with 'discolouration of intact skin' or a minor wound(s). **OR** A skin condition that requires monitoring or reassessment less than daily and that is responding to treatment or does not currently require treatment.	Low
Risk of skin breakdown which requires preventative intervention several times each day, without which skin integrity would break down. **OR** Pressure damage or open wound(s), pressure ulcer(s) with 'partial thickness skin loss involving epidermis and/or dermis', which is responding to treatment. **OR** An identified skin condition that requires a minimum of daily treatment, or daily monitoring/reassessment to ensure that it is responding to treatment.	Moderate
Pressure damage or open wound(s), pressure ulcer(s) with 'partial thickness skin loss involving epidermis and/or dermis', which is not responding to treatment **OR** Pressure damage or open wound(s), pressure ulcer(s) with 'full thickness skin loss involving damage or necrosis to subcutaneous tissue, but not extending to underlying bone, tendon or joint capsule', which is/are responding to treatment. **OR** Specialist dressing regime in place; responding to treatment	High
Open wound(s), pressure ulcer(s) with 'full thickness skin loss involving damage or necrosis to subcutaneous tissue, but not extending to underlying bone, tendon or joint capsule' which are not responding to treatment and require regular monitoring/reassessment. **OR** Open wound(s), pressure ulcer(s) with 'full thickness skin loss with extensive destruction and tissue necrosis extending to underlying bone, tendon or joint capsule.	Severe

DRAFT

OR Multiple wounds which are not responding to treatment.	

Please provide brief details

DRAFT

5. Mobility

Description	Level of need
Independently mobile	No needs
Able to weight bear but needs some assistance and/or requires mobility equipment for daily living.	Low
Not able to consistently weight bear. **OR** Completely unable to weight bear but is able to assist or cooperate with transfers and/or repositioning. **OR** In one position (bed or chair) for the majority of time but is able to cooperate and assist carers or care workers. **OR** At moderate risk of falls (as evidenced in a falls history or risk assessment)	Moderate
Completely unable to bear weight and is unable to assist or cooperate with transfers and/or repositioning. **OR** Due to risk of physical harm or loss of muscle tone or pain on movement needs careful positioning and is unable to cooperate. **OR** At a high risk of falls (as evidenced in a recent falls history and risk assessment). **OR** Involuntary spasms or contractures placing the individual or others at risk.	High
Has a clinical condition such that, on movement or transfer there is a high risk of serious physical harm and where the positioning is critical.	Severe

Please provide brief details

DRAFT

6. Communication

Description	Level of need
Able to communicate clearly, verbally or non-verbally. Has a good understanding of their primary language. May require translation if English is not their first language.	No needs
Needs assistance to communicate their needs. Special effort may be needed to ensure accurate interpretation of needs or additional support may be needed either visually, through touch or with hearing.	Low
Communication about needs is difficult to understand or interpret or the individual is sometimes unable to reliably communicate, even when assisted. Carers or care workers may be able to anticipate needs through non-verbal signs due to familiarity with the individual.	Moderate
Unable to reliably communicate their needs at any time and in any way, even when all practicable steps to assist them have been taken. The individual has to have most of their needs anticipated because of their inability to communicate them.	High

Please provide brief details

DRAFT

7. Psychological and Emotional Needs

Description	Level of need
Psychological and emotional needs are not having an impact on their health and well-being.	No needs
Mood disturbance, hallucinations or anxiety symptoms, or periods of distress, which are having an impact on their health and/or well-being but respond to prompts, distraction and/or reassurance. **OR** Requires prompts to motivate self towards activity and to engage them in care planning, support, and/or daily activities.	Low
Mood disturbance, hallucinations or anxiety symptoms, or periods of distress, which do not readily respond to prompts and reassurance and have an increasing impact on the individual's health and/or well-being. **OR** Due to their psychological or emotional state the individual has withdrawn from most attempts to engage them in care planning, support and/or daily activities.	Moderate
Mood disturbance, hallucinations or anxiety symptoms, or periods of distress, that have a severe impact on the individual's health and/or well-being. **OR** Due to their psychological or emotional state the individual has withdrawn from any attempts to engage them in care planning, support and/or daily activities.	High

Please provide brief details

DRAFT

8. Cognition

Description	Level of need
No evidence of impairment, confusion or disorientation.	No needs
Cognitive impairment which requires some supervision, prompting or assistance with more complex activities of daily living, such as finance and medication, but awareness of basic risks that affect their safety is evident. **OR** Occasional difficulty with memory and decisions/choices requiring support, prompting or assistance. However, the individual has insight into their impairment.	Low
Cognitive impairment (which may include some memory issues) that requires some supervision, prompting and/or assistance with basic care needs and daily living activities. Some awareness of needs and basic risks is evident. The individual is usually able to make choices appropriate to needs with assistance. However, the individual has limited ability even with supervision, prompting or assistance to make decisions about some aspects of their lives, which consequently puts them at some risk of harm, neglect or health deterioration.	Moderate
Cognitive impairment that could include frequent short-term memory issues and maybe disorientation to time and place. The individual has awareness of only a limited range of needs and basic risks. Although they may be able to make some choices appropriate to need on a limited range of issues they are unable to consistently do so on most issues, even with supervision, prompting or assistance. The individual finds it difficult even with supervision, prompting or assistance to make decisions about key aspects of their lives, which consequently puts them at high risk of harm, neglect or health deterioration.	High
Cognitive impairment that may, for example, include, marked short-term memory issues, problems with long-term memory or severe disorientation to time, place or individual. The individual is unable to assess basic risks even with supervision, prompting or assistance, and is dependent on others to anticipate their basic needs and to protect them from harm, neglect or health deterioration.	Severe

Please provide brief details

DRAFT

9. Behaviour

Description	Level of need
No evidence of 'challenging' behaviour.	No needs
Some incidents of 'challenging' behaviour. A risk assessment indicates that the behaviour does not pose a risk to self, others or property or a barrier to intervention. The individual is compliant with all aspects of their care.	Low
'Challenging' behaviour that follows a predictable pattern. The risk assessment indicates a pattern of behaviour that can be managed by skilled carers or care workers who are able to maintain a level of behaviour that does not pose a risk to self, others or property. The individual is nearly always compliant with care.	Moderate
'Challenging' behaviour that poses a predictable risk to self, others or property. The risk assessment indicates that planned interventions are effective in minimising but not always eliminating risks. Compliance is variable but usually responsive to planned interventions.	High
'Challenging' behaviour of severity and/or frequency that poses a significant risk to self, others or property. The risk assessment identifies that the behaviour(s) require(s) a prompt and skilled response that might be outside the range of planned interventions.	Severe
'Challenging' behaviour of a severity and/or frequency and/or unpredictability that presents an immediate and serious risk to self, others or property. The risks are so serious that they require access to an immediate and skilled response at all times for safe care.	Priority

Please provide brief details

DRAFT

10. Drug Therapies and Medication

Description	Level of need
Symptoms are managed effectively and without any problems, and medication is not resulting in any unmanageable side-effects.	No needs
Requires supervision/administration of and/or prompting with medication but shows compliance with medication regime. **OR** Mild pain that is predictable and/or is associated with certain activities of daily living. Pain and other symptoms do not have an impact on the provision of care.	Low
Requires the administration of medication (by a registered nurse, carer or care worker) due to: Non-concordance or non-compliance of medication, or type of medication (for example insulin), or route of medication (for example PEG). **OR** Moderate pain which follows a predictable pattern; or other symptoms which are having a moderate effect on other domains or on the provision of care.	Moderate
Requires administration and monitoring of medication regime by a registered nurse, carer or care worker specifically trained for the task because there are risks associated with the potential fluctuation of the medical condition or mental state, or risks regarding the effectiveness of the medication or the potential nature or severity of side-effects. However, with such monitoring the condition is usually nonproblematic to manage. **OR** Moderate pain or other symptoms which is/are having a significant effect on other domains or on the provision of care.	High
Requires administration and monitoring of medication regime by a registered nurse, carer or care worker specifically trained for this task because there are risks associated with the potential fluctuation of the medical condition or mental state, or risks regarding the effectiveness of the medication or the potential nature or severity of side-effects. Even with such monitoring the condition is usually problematic to manage. **OR** Severe recurrent or constant pain which is not responding to treatment. **OR** Risk of non-concordance with medication, placing them at risk of relapse	Severe
Has a drug regime that requires daily monitoring by a registered nurse to ensure effective symptom and pain management associated with a rapidly changing and/or deteriorating condition **OR** Unremitting and overwhelming pain despite all efforts to control pain effectively.	Priority

Please provide brief details

DRAFT

11. Altered States of Consciousness (ASC)

Description	Level of need
No evidence of altered states of consciousness (ASC).	No needs
History of ASC but it is effectively managed and there is a low risk of harm.	Low
Occasional (monthly or less frequently) episodes of ASC that require the supervision of a carer or care worker to minimise the risk of harm.	Moderate
Frequent episodes of ASC that require the supervision of a carer or care worker to minimise the risk of harm. **OR** Occasional ASCs that require skilled intervention to reduce the risk of harm.	High
Coma. **OR** ASC that occur on most days, do not respond to preventative treatment, and result in a severe risk of harm.	Priority

Please provide brief details

DRAFT

Other significant care needs

Description	Level of need
	Low
	Moderate
	High
	Severe

DRAFT

MDT Recommendation in regard to a Primary Health Need (Please consider the four key indicators)

DRAFT

Date of MDT if applicable:

List who was present / involved in the MDT:

DRAFT

Appendix 5 HYWEL DDA UNIVERSITY HEALTH BOARD LTC NURSING NEEDS ASSESSMENT



HYWEL DDA UNIVERSITY HEALTH BOARD LTC NURSING NEEDS ASSESSMENT

BASIC PERSONAL INFORMATION for NURSING NEEDS ASSESSMENT	
NAME OF RESIDENT:	**KNOWN AS:**
DATE OF BIRTH	
PREVIOUS ADDRESS: (include postcode)	**NAME OF CARE HOME:** **DATE OF ADMISSION:**
MAIN CONTACT / NEXT OF KIN: Name: Address: (including postcode) Telephone No: Relationship:	**EMERGENCY CONTACT / OTHER CONTACTS / POA** (If Required) Name: Address: Telephone No:

DRAFT

	Relationship to individual:
CONTACT DETAILS WHERE INDIVIDUAL WOULD LIKE CORRESPONDANCE SENT TO (Including telephone contact)	Name: Address: (including postcode) Telephone No: Relationship:

DRAFT

ADMISSION HISTORY:

SERVICE USERS' PERSPECTIVE:

CARERS PERSPECTIVE:

SOCIAL HISTORY:

NAME OF CARE HOME REGISTERED NURSE INVOLVED IN THE ASSESSMENT:

INFORMATION SOURCES:	Able to Consent: Yes / No

DRAFT

Nursing notes: Yes/No	NOK/Representative: Yes/No
GP notes: Yes/No	Prescription Chart: Yes/No
Nursing Staff/ Care Staff: Yes/No	Hospital Notes: Yes/No

NAME AND ADDRESS OF GP

PROFESSIONALS INVOLVED IN CARE

- Social Worker:
- CPN:
- Speech & Language Therapist:
- Dietician:
- Specialist Nurse:
- Physiotherapist / Occupational Therapist:
- Other:

MEDICAL/NURSING HISTORY:

LATEST HOSPITAL ADMISSIONS:

DRAFT

GP/OTHER DISCIPLINE VISITS:

DRAFT

BREATHING

Is there a care plan in place - yes / no

Is the care plan appropriate - yes / no

NUTRITION – FOOD AND DRINK

Height –

Weight –

BMI -

Home Nutritional Risk Score -

Is there a care plan in place - yes/ no

Is the care plan appropriate - yes/ no

ORAL CARE

Is there a care plan in place - yes/ no

Is the care plan appropriate - yes/ no

CONTINENCE

Is there a care plan in place - yes/ no

Is the care plan appropriate - yes/ no

DRAFT

SKIN (INCLUDING TISSUE VIABILITY)

Home risk assessment score –

Is there a care plan in place - yes/ no

Is the care plan appropriate - yes/ no

MOBILITY:

Falls risk score -at risk

Is there a care plan in place – yes/no

Is the care plan appropriate - yes/ no

Has the individual suffered a fall since the admission? (if yes please give details below)

Date and time of fall	**Description**	**Were Physical Observations Completed**	**Accident book completed** **(delete as appropriate)**
		Yes / No	Yes / No
		Yes / No	Yes / No
		Yes / No	Yes / No
		Yes / No	Yes / No

DRAFT

COMMUNICATION:

Is there a care plan in place – yes/ no

Is the care plan appropriate - yes/ no

MENTAL HEALTH (PSYCHOLOGICAL AND EMOTIONALNEEDS)

Is the individual subject to the 1983 mental health act –

Is a referral to the CMHT indicated? - yes / no

Is there a care plan in place - yes/ no

Is the care plan appropriate – yes/ no

COGNITION

Is there a care plan in place - yes/ no

Is the care plan appropriate - yes/ no

DRAFT

DoLS

DoLS Authorisation in Place from hospital or previous setting – yes/no	DoLS Renewal Date -	DoLS Referral Made – yes/no
DoLS Referral Date -	Reason to believe person lacks capacity – yes/no (*see Cognition above*)	Care Home/Provider informed of potential need for DoLS Referral – yes/no
Comments		

Is there a care plan in place - yes / no

Is the care plan appropriate - yes / no

BEHAVIOUR

Is a referral to the CMHT indicated? yes / no

Is there a care plan in place - yes / no

Is the care plan appropriate - yes / no

DRUG THERAPIES AND MEDICATION (Including pain / symptom control)

Able to self medicate: yes / no

Compliant with medication: yes / no (if not give details)

Allergies:

DRAFT

Medication	Dose	Frequency	Comments

Is a pain tool being used? (Please provide details)

Is there a care plan in place - yes / no

Is the care plan appropriate - yes / no

PERSONAL CARE

DRAFT

Is there a care plan in place - yes / no Is the care plan appropriate - yes / no
ALTERED STATE OF CONSCIOUSNESS (ASC) Is there a care plan in place - yes / no Is the care plan appropriate - yes / no
OTHER SIGNIFICANT CARE NEEDS (e.g. Parkinson's disease, epilepsy, rapid deterioration) Is there a care plan in place - yes / no Is the care plan appropriate - yes / no
FREESPACE

Unpaid carers information	
Are you an unpaid carer?	Would you like further information? Yes/No

DRAFT

Dates of previous assessments in last 12 months	

DRAFT

COMPLETE THE 4 KEY INDICATORS OF THE INDIVIDUALS CARE NEEDS

NATURE

INTENSITY

COMPLEXITY

UNPREDICTABILITY

NAME OF LONG TERM CARE SPECIALIST NURSE:

DATE OF COMPLETION:

DRAFT

SIGNATURE:

Assessment Reviewed by: Long Term Care Specialist Nurse Team Leader

(Division)

ISSUES IDENTIFIED:

Details:

Please provide full details of the issue raised, including dates where necessary and name of service user(s) affected, if applicable

Name and Position of Individual (s) issues discussed with:

Date of Discussion:

Summary of Discussion:

Plan

Issues identified at assessment

Discussed with home manager	Yes / No	Date
Issues emailed to home	Yes / No	Date
Issues emailed to CIW	Yes / No	Date
Issues copied into care home folder	Yes / No	Date

DRAFT

Safeguarding

Safeguarding issues identified at assessment	Yes / No	
Referral made	Yes / No	Date

Pressure Damage

Pressure damage noted at assessment	Yes / No	
Datix completed	Yes / No	Date

DRAFT

OUTCOME OF ASSESSMENT

Eligible for NHS Funded Nursing Care	
No Nursing needs identified which are unable to be managed by Community services – no longer eligible for NHS Funded Nursing Care	
Multidisciplinary Team meeting to be arranged to consider Continuing NHS Healthcare eligibility	
Continues to meet eligibility for Continuing NHS Healthcare	
Remains subject to Section 117	
Remains eligible for a joint Health and Social Care package	

Date of next Assessment /Review	

Copies to (delete as appropriate)

Social Services Yes

File Yes

If you have any questions or comments regarding the outcome of this assessment, please do not hesitate to contact at:

DRAFT

BASIC PERSONAL INFORMATION for NURSING NEEDS ASSESSMENT	
NAME OF INDIVIDUAL:	**KNOWN AS:**
DATE OF BIRTH	
ADDRESS: (include postcode)	**MAIN CONTACT / NEXT OF KIN**: Name: Address: (including postcode) Telephone No: Relationship:
Name of Care Coordinator	
Contact Details of Care Coordinator	

DRAFT

Appendix 6 - HYWEL DDA UNIVERSITY HEALTH BOARD COMMUNITY NURSING NEEDS ASSESSMENT

BASIC PERSONAL INFORMATION for NURSING NEEDS ASSESSMENT	
NAME OF INDIVIDUAL:	**KNOWN AS:**
ADDRESS: (include postcode)	**MAIN CONTACT / NEXT OF KIN**: Name: Address: (including postcode) Telephone No: Relationship:
Name of Care Coordinator	
Contact Details of Care Coordinator	
Unpaid carers information	
Are you an unpaid carer? Yes/No	Would you like further information? Yes/No

Dates of previous assessments in last 12 months	

DRAFT

SOCIAL HISTORY:

INFORMATION SOURCES:	Individual: Yes / No
District Nursing notes: Yes/No	NOK/Representative: Yes/No
GP notes: Yes/No	Prescription Chart: Yes/No
Care Staff: Yes/No	Hospital Notes: Yes/No

NAME AND CONTACT DETAILS OF GP

NAME OF PROFESSIONALS INVOLVED IN CARE

- Social Worker:
- CPN:
- Speech & Language Therapist:
- Dietician:
- Specialist Nurse:
- Physiotherapist / Occupational Therapist:
- Other:

MEDICAL/NURSING HISTORY:

DRAFT

LATEST HOSPITAL ADMISSIONS:
GP/OTHER DISCIPLINE VISITS:

DRAFT

BREATHING

NUTRITION – FOOD AND DRINK

Height -

Weight -

BMI -

ORAL CARE

CONTINENCE

DRAFT

SKIN (INCLUDING TISSUE VIABILITY)

MOBILITY:

COMMUNICATION:

DRAFT

MENTAL HEALTH (PSYCHOLOGICAL AND EMOTIONALNEEDS)

Is the individual experiencing any signs or symptoms of low mood? If yes, has the individual been informed to contact their GP or consented to referral to GP?

Is the individual subject to the 1983 Mental Health Act - (if YES please specify which section)

Is a referral to the CMHT indicated? - yes / no (if Yes liaise with GP)

COGNITION

DRAFT

BEHAVIOUR

Is a referral to the CMHT indicated? yes / no (if yes liaise with GP)

DRUG THERAPIES AND MEDICATION (Including pain / symptom control)

Able to self medicate: yes / no

Compliant with medication: yes / no (if not give details)

Allergies:

Medication	Dose	Frequency	Comments

DRAFT

PERSONAL CARE

ALTERED STATE OF CONSCIOUSNESS (ASC)

OTHER SIGNIFICANT CARE NEEDS (e.g. Parkinson's disease, epilepsy, rapid deterioration)

DRAFT

LIST OF EQUIPMENT IN PLACE

Equipment	Requires Electricity?	Battery Back Up?
	Yes/No	Yes/No
	Yes/No	Yes/No
	Yes/No	Yes/No
	Yes/No	Yes/No
	Yes/No	Yes/No
	Yes/No	Yes/No
	Yes/No	Yes/No

Registered on Energy Suppliers Priority Services Register?	Yes/No
Registered on Network Operators Priority Services Register?	Yes/No

CONTIGENCY PLAN IN THE EVENT OF CARER BREAK DOWN/INCLEMENT WEATHER/DETERIORATION IN CONDITION

DRAFT

PREFERRED PLACE OF CARE TO INCLUDE END OF LIFE CARE
WHAT IS CURRENT CARE PACKAGE (name of agency / time and length of calls)
INFORMAL CARE SUPPORT (Family /Friends/Neighbours etc)
IS CURRENT CARE PACKAGE APPROPRIATE TO MEET NEEDS (If not recommend appropriate care package)

DRAFT

COMPLETE THE 4 KEY INDICATORS OF THE INDIVIDUALS CARE NEEDS

NATURE

INTENSITY

COMPLEXITY

DRAFT

UNPREDICTABILITY

NAME OF PROFESSIONAL COMPLETING REVIEW:

DESIGNATION

DATE OF COMPLETION:

SIGNATURE:

PLEASE IDENTIFY OUTCOME OF ASSESSMENT

Multidisciplinary Team meeting to be arranged to consider Continuing NHS Healthcare eligibility	
Continues to meet eligibility for Continuing NHS Healthcare	
Remains eligible for a joint Health and Social Care package	

For Long Term Care use Only:

DRAFT

Assessment Reviewed by: Name: Designation: Signature: Date:

DRAFT

Appendix 7 Impact Assessment and Contingency Plan

Impact Assessment and Contingency Plan

NAME OF INDIVIDUAL:	**KNOWN AS:**
ADDRESS: (include postcode)	**MAIN CONTACT / NEXT OF KIN**: Name: Address: (including postcode) Telephone No: Relationship:
Name of Care Coordinator	
Contact Details of Care Coordinator	

DRAFT

Current Care Provider and Package	

Assessment of Critical Functions

Minimum level of service?	*The minimum level of service is the basic function which needs to be delivered.*
Is there any specific training requirement? **How long would training / competencies of new staff / carers take?**	*I.e. suctioning, PEG etc.*
What is the maximum amount of time that formal care could remain undelivered?	*Please specify number of hours, days, weeks etc.*
Is care provision critical at specific times?	*Please specify time/day etc.*

DRAFT

Contingency Plan

1. If formal care package was unable to provide care, could the individual remain in the community	*Please specify what informal support the individual would have (if no please refer to Q2)*
2. What contingency plan has been discussed with the individual?	*Please note the option of remaining in the community may not be an option in the event of care / carer breakdown* *Please consider Short term placement in a Nursing home and possible options (if this is not a sustainable option please refer to Q3)*
3. Is Hospital admission required?	*Please specify why the above options would not be appropriate*

DRAFT

Risk Scoring – Likelihood x Impact = Risk Rating

Likelihood Score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Frequency - How often might it/does it happen? (*how many times will the adverse consequence being* *assessed actually be realised?)*	This will probably never happen/recur (except in very exceptional circumstances).	Do not expect it to happen/recur but it is possible that it may do so.	It might happen or recur occasionally.	It might happen or recur occasionally.	It will undoubtedly happen/recur, possibly frequently.
	Not expected to occur for years.*	Expected to occur at least annually.*	Expected to occur at least monthly.*	Expected to occur at least monthly.*	Expected to occur at least daily.*
* time-framed descriptors of frequency					
Probability - Will it happen or not? *(what is the chance the adverse consequence will occur in a given reference period?)*	(0-5%*)	(5-25%*)	(25-75%*)	(75-95%*)	(>95%*)
*used to assign a probability score for risks related to time-limited or one off projects or business objectives.					

DRAFT

Risk Impact (Domains)

Domains	Negligible - 1	Minor - 2	Moderate - 3	Major - 4	Catastrophic - 5
Safety of Patients, Staff or Public	Minimal injury requiring no/minimal intervention or treatment. No time off work.	Minor injury or illness, requiring minor intervention. Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days.	Moderate injury requiring professional intervention. Requiring time off work for 4-14 days. Increase in length of hospital stay by 4-15 days. Agency reportable incident. An event which impacts on a small number of patients.	Major injury leading to long-term incapacity/disability. Requiring time off work for >14 days. Increase in length of hospital stay by >15 days. Mismanagement of patient care with long-term effects.	Incident leading to death. Multiple permanent injuries or irreversible health effects. An event which impacts on a large number of patients.
Quality, Complaints or Audit	Peripheral element of treatment or service suboptimal. Informal complaint/inquiry.	Overall treatment or service suboptimal. Formal complaint. Local resolution. Single failure to meet internal standards. Minor implications for patient safety if unresolved. Reduced performance if unresolved.	Treatment or service has significantly reduced effectiveness. Formal complaint - Escalation. Repeated failure to meet internal standards. Major patient safety implications if findings are not acted on.	Non-compliance with national standards with significant risk to patients if unresolved. Multiple complaints/ independent review. Low achievement of performance/delivery requirements. Critical report.	Totally unacceptable level or quality of treatment/service. Gross failure of patient safety if findings not acted on. Inquest/ombudsman inquiry. Gross failure to meet national standards / performance requirements.

DRAFT

RISK MATRIX					
	LIKELIHOOD →				
IMPACT ↓	RARE 1	UNLIKELY 2	POSSIBLE 3	LIKELY 4	ALMOST CERTAIN 5
CATASTROPHIC 5	5	10	15	20	25
MAJOR 4	4	8	12	16	20
MODERATE 3	3	6	9	12	15
MINOR 2	2	4	6	8	10
RARE 1	1	2	3	4	5

Risk Scored	Action Timetable - Frequency of review
15-25	Action plan should include immediate action to reduce the risk. Reviewed by Directorate level Group at every meeting.
8-12	Action plan should include urgent action to reduce the risk. Reviewed by Directorate level Group at every meeting.
4-6	Service/Department manager to monitor risk and deliver action plan. Monitored by Directorate at least 6 monthly.

1-3	Service/Department manager to monitor risk and deliver action plan.Reviewed by manager, at least quarterly & local review group level, e.g. service team meeting. Monitored by Directorate at least 6-12 monthly.

DRAFT

Appendix 8 - Transition Pathway Referral Form from Children Services to Adult Continuing NHS Healthcare

DRAFT

Transition Pathway Referral Form from Children Services to Adult Continuing NHS Healthcare

Personal Details:

Name	
D.O.B	
Home Address	
Legal Guardian Name	

Referral Details:

Transition Coordinator	
Service	
Referral Date	
Current Location	
Diagnosis	
Reason for Referral	
PROFESSIONALS INVOLVED IN CARE	
MEDICAL HISTORY:	

Is this person a looked after child	Yes / No
If yes please indicate placing authority	
Date Placed	

Identified Needs

BREATHING
NUTRITION – FOOD AND DRINK
CONTINENCE
SKIN (INCLUDING TISSUE VIABILITY)
MOBILITY:
COMMUNICATION:
PSYCHOLOGICAL AND EMOTIONALNEEDS
COGNITION
BEHAVIOUR

DRAFT

DRUG THERAPIES AND MEDICATION (Including pain / symptom control)

Compliant with medication: yes / no (if not give details)

Allergies:

Medication	Dose	Frequency / Route	Comments

ALTERED STATE OF CONSCIOUSNESS (ASC)

OTHER SIGNIFICANT HEALTH CARE NEEDS

ARE NEEDS LIKELY TO CHANGE IN THE NEXT 12 MONTHS YES / NO

IF YES PLEASE PROVIDE REASON

Name of referrer	
Designation	
Signature	
Contact Details	
Date	

DRAFT

For Shared Patient Pathway to complete (LTC & MH/LD Commissioning)

Date referral received	
Date of SPP	
Outcome of SPP	
Initial Pathway identified	LTC ☐ MH ☐ LD ☐
Transition Nurse informed	

DRAFT

Appendix 9 - NHS Long Term Care Discharge to Assess Pathway Referral Form (D2A) for individuals who have the requirement for 24hr Nursing Care

Date of Referral	
Name of Patient	
DOB	
NHS Number	
Date of Admission	
Hospital / Ward	
Name of Referrer	
Speciality	
Email Address	

	Yes	No
Confirmation Patient / NOK / representative is aware of referral to Long Term Care	☐	☐
Is there reason to doubt Mental Capacity to make decisions regarding care and residency. Copy of MCA to be provided if applicable	☐	☐
Is a best interest meeting required. Copy of BIM to be provided if applicable	☐	☐
Known discharge plan:		
Out of county placement – Y/N	☐	☐
Care Home Placement – Y/N	☐	☐
Package of Care in own Home – Y/N	☐	☐

Reason for Referral with Identification of needs

On receipt of this **COMPLETED** referral form, a return email will be sent from Long Term Care acknowledging the referral form has been accepted .**Failure to provide all required information will result in it being returned which will delay the process.** Please complete and return to: NHS.LongTermCare@wales.nhs.u

DRAFT

References and Links

Continuing NHS Health Care (gov.wales)

Social Services and Well-being (Wales) Act 2014 (legislation.gov.uk)

Written Statement - Developing a Strategic Framework for Welsh Language Services in Health and Social Services (9 March 2011) | GOV.WALES

Continuing NHS Healthcare Information Booklet for Individuals, Families and Carers (gov.wales)

Responsible Authority Guidance (gov.wales)

Who-Pays-final-24082020-v2.pdf (england.nhs.uk)

NHS Wales complaints and concerns: Putting Things Right | GOV.WALES

Safeguarding (sharepoint.com)

DRAFT

Equality Impact Assessment (EqIA) Screening Template

When to complete an EqIA Screening

An EqIA Screening Template must be completed when reviewing, changing and developing procedures/ proposals/ projects/ policies. This is a first step and is used to consider whether there are any negative impacts that may arise.

Purpose of an EqIA Screening Template

The purpose of this short exercise is to ensure that you have shown appropriate due regard when considering the impact for people with protected characteristics in your decision making. The screening process is designed to help you consider the circumstances and to inform evidence-based decisions.

If the proposal is of a significant nature and it is apparent from the outset that a full EqIA will be required, then it is not necessary to complete this Screening Template, you can proceed to complete the full EqIA.

If no negative impacts are identified following completion of the EqIA screening then it is not necessary to undertake a full EqIA however, the decision and justification must be clearly recorded in this document.

On completion of the Screening Template:

- Ensure that all the white boxes within the screening are completed.
- Ensure that the Procedure/ Project/ Proposal/ Policy owner has signed and dated the Screening Template.
- Send a copy of the completed template along with the related policy or project proposal to Inclusion.hdd@wales.nhs.uk for the Diversity & Inclusion Team to review.
- Each Screening Template will be reviewed by the Diversity & Inclusion Team and feedback will be provided to the Procedure/ Project/ Proposal/ Policy owner. This may include recommendations for further action to inform robust decision-making.

Support

For further support please visit the EqIA Sharepoint or contact:
Email: Inclusion.hdd@wales.nhs.uk
Tel: 01554 899055

Director and Directorate	Peter Skitt Community and Integrated Medicine
Service Area	Long Term Care

Title of Procedure, Project, Proposal, Policy being screened:	CHC Operational Policy 309

Description of the Procedure/ Project/ Proposal/ Policy being screened (including key aims and objectives)

The policy sets out the operational framework for the delivery of Continuing NHS Healthcare (CHC) and NHS Funded Nursing Care (FNC) within Hywel Dda University Health Board. The policy is aligned to the Welsh Government Continuing NHS Healthcare Framework (2021) and provides clear guidance for practitioners on the assessment, eligibility determination, commissioning, funding, review, and governance arrangements associated with long-term care. Its key aims are to ensure fair, consistent and legally compliant decision-making, promote person-centred care, support partnership working with local authorities and other agencies, and ensure individuals receive care that is proportionate to their assessed needs. The policy also outlines quality assurance processes, appeals arrangements, discharge pathways, safeguarding considerations, and responsibilities for monitoring care provision to support safe, effective and equitable outcomes for individuals accessing long-term care services.

Evidence considered (including staff and population data, relevant research, expert and community knowledge etc.)

This assessment has been informed by the Welsh Government Continuing NHS Healthcare Framework (2021, revised 2022), relevant legislation, national guidance, operational experience, quality assurance findings, and feedback from health and social care professionals. Consideration has also been given to the diverse needs of the Hywel Dda population, including older people, people with disabilities, individuals who lack capacity, and Welsh language speakers.

Assess which protected characteristics will potentially be affected by the proposal in the table below (please ✓ the relevant box to confirm positive, negative or no impact)**.**

If at any point a negative impact has been identified (actual or potential), you do not need to proceed with the completion of this form, as a full EqIA must be undertaken: Equality Impact Assessments (EqIAs) (sharepoint.com)

Age Is it likely to affect older and younger people in different ways or affect one age group and not another?					
Positive Impact	x	Negative Impact		No Impact	
Justification of impact identified: The Welsh Government published the Continuing NHS Healthcare (CHC) Framework (2021), which sets out the eligibility criteria for CHC and the responsibilities of NHS organisations and local authorities in relation to assessment, decision-making and service provision. Hywel Dda University Health Board's Operational Policy is aligned to this national framework and outlines the processes, governance arrangements and professional responsibilities associated with the assessment and delivery of CHC. The policy applies to adults aged 18 years and over. Children and young people under the age of 18 are subject to separate CHC arrangements. Responsibility for these cases sits within Children's Services rather than the Long Term Care Team. To support effective transition into adult services, Children's Services should identify young people who may have ongoing eligibility for CHC and notify the LTC CHC team at an early stage, ideally from the age of 14. A formal referral to adult CHC services should be made from age 16 to enable appropriate assessment, planning and continuity of care as the young person approaches adulthood					
Disability Is it likely to affect those with a physical disability, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes?					
Positive Impact	x	Negative Impact		No Impact	
Justification of impact identified: As outlined above, the service is already available to people with disabilities and no adverse impact is anticipated. This will continue to be monitored, and any new information or emerging issues will be considered as part of ongoing policy review. Where an individual is not eligible for Continuing NHS Healthcare (CHC), decision letters may include information on alternative support arrangements, such as NHS Funded Nursing Care (FNC) or a joint package of health and social care. Individuals whose needs fall within the scope of Section 117 aftercare of the Mental Health Act will continue to receive support through those statutory arrangements where applicable					
Gender Reassignment Is it likely to affect those who either: • Have undergone, intend to undergo or are currently undergoing gender reassignment. • Do not intend to undergo medical treatment but wish to live in a different gender from their gender at birth					
Positive Impact		Negative Impact		No Impact	x
Justification of impact identified: No impact is foreseen. However, this will be reviewed, and any new or additional information will be considered					

Marriage / Civil Partnership
Under the Equality Act, the characteristic of Marriage and Civil Partnerships is only protected in the workplace/ employment.
Is it likely to affect those who are married or in a Civil Partnership? This means someone who is legally married or in a civil partnership.

Positive Impact		Negative Impact		No Impact	x

Justification of impact identified:
No impact is foreseen. However, this will be reviewed, and any new or additional information will be considered

Pregnancy and Maternity
Is it likely to affect those who are pregnant or have recently had a baby? Maternity covers the period of 26 weeks after having a baby, whether or not they are on Maternity Leave.

Positive Impact		Negative Impact		No Impact	x

Justification of impact identified:
No impact is foreseen. However, this will be reviewed, and any new or additional information will be considered

Race / Ethnicity
Is it likely to affect people of a different race, nationality, colour, culture or ethnic origin including non-English / Welsh speakers, Gypsies/Travellers, asylum seekers and migrant workers?

Positive Impact		Negative Impact		No Impact	x

Justification of impact identified:
No impact is foreseen. However, this will be reviewed, and any new or additional information will be considered

Religion or Belief
Is it likely to affect people who have a religion or belief? The term 'religion' includes a religious or philosophical belief.

Positive Impact		Negative Impact		No Impact	x

Justification of impact identified:
No impact is foreseen. However, this will be reviewed, and any new or additional information will be considered

Sex
Is it likely to affect people who are mostly male or female. Where it applies to both equally does it affect one differently to the other?

Positive Impact		Negative Impact		No Impact	x

Justification of impact identified:
No impact is foreseen. However, this will be reviewed, and any new or additional information will be considered

Sexual Orientation
Whether a person's sexual attraction is towards their own sex, the opposite sex or either.

Positive Impact		Negative Impact		No Impact	x

Justification of impact identified:
No impact is foreseen. However, this will be reviewed, and any new or additional information will be considered

Armed Forces Community
Consider whether this impacts on members of the Armed Forces and their families, whose health needs may be impacted long after they have left the Armed Forces and returned to civilian life. Also consider their unique experiences when accessing and using day-to-day public and private services compared to the general population. It could be through 'unfamiliarity with civilian life, or frequent moves around the country and the subsequent

difficulties in maintaining support networks, for example, members of the Armed Forces can find accessing such goods and services challenging.' For a comprehensive guide to the Armed Forces Covenant Duty and supporting resource please see: **Armed-Forces-Covenant-duty-statutory-guidance**					
Positive Impact		Negative Impact		No Impact	x
Justification of impact identified: No impact is foreseen. However, this will be reviewed, and any new or additional information will be considered					
Socio Economic Duty Consider those on low income, economically inactive, unemployed or unable to work due to ill-health. Also consider people living in areas known to exhibit poor economic and/or health indicators and individuals who are unable to access services and facilities. Food / fuel poverty and personal or household debt should also be considered. For a comprehensive guide to the Socio-Economic Duty in Wales and supporting resources please see: more-equal-wales-socio-economic-duty					
Positive Impact	x	Negative Impact		No Impact	
Justification of impact identified: It is recognised that Hywel Dda serves a diverse population. Eligibility for Continuing NHS Healthcare (CHC) is determined solely through a comprehensive assessment of an individual's assessed health needs and is not means tested. Where an individual is found eligible for CHC, the NHS is responsible for funding the full package of assessed health and social care needs. In a care home setting, this includes the full cost of accommodation, care and support. CHC can also be provided in an individual's own home where this is identified as the most appropriate setting to meet their assessed needs.					
Welsh Language Is it likely to impact on opportunities for people to use the Welsh language? The Welsh language should be treated no less favourably than the English language.					
Positive Impact	x	Negative Impact		No Impact	
Justification of impact identified: The policy supports and promotes the Welsh language by ensuring that individuals, families and representatives are able to receive information, participate in assessments, and communicate throughout the Continuing NHS Healthcare process in their language of choice. The policy requires practitioners to identify language preference at the outset and make appropriate arrangements to accommodate Welsh speakers, helping to ensure that Welsh is treated no less favourably than English and enabling people to engage fully in decisions about their care and support.					

If a negative impact has been identified, you are not required to complete this form as a full EqIA must be undertaken. A full EqIA template and guidance can be found on the following link: Equality Impact Assessments (EqIAs) (sharepoint.com)

Screening Completed by:	Name	Tracy Devantier
	Title	Performance Manager
	Contact details	Tracy.devantier@wales.nhs.uk

	Date	03/06/2026
Screening Authorised by: (Directorate level owner of the procedures/ proposals/ projects/ policy)	Name	
	Title	
	Contact details	
	Date	
Guidance has been provided by Diversity & Inclusion Team:	Name	
	Title	
	Contact details	
	Date	
Diversity and Inclusion Team additional Comments:		

Please note: The D&I team will save a copy of the completed form for reference. If any changes are made after the date of review, it is the directorate's responsibility to update the EqIA and inform the D&I team.

7.2

7.2 - 1097 Corporate Safeguarding Policy

Charlotte Westacott (Hywel Dda UHB - Head of Safeguarding)

For approval

Attachments

Policy 1097 Safeguarding.pdf

1097-CorporateSafeguardingPolicy v2 (002)(003)(004).pdf

1097 EqIA Screening form May 26.pdf

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Y PWYLLGOR ANSAWDD, DIOGELWCH A PHROFIAD
QUALITY SAFETY AND EXPERIENCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	**11 AUGUST 2026**
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	1097 Corporate Safeguarding Policy
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Sharon Daniel, Director of Nursing, Quality and Patient Experience
SWYDDOG ADRODD: **REPORTING OFFICER:**	Charlotte Westacott, Head of Safeguarding

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/ For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

In line with Hywel Dda University Health Board's (HDdUHB's) written control documentation process, the Quality, Safety and Experience Committee is asked to approve the following updated policy:

- 1097 – Corporate Safeguarding Policy (Appendix 1).

The report provides the required assurance that the Written Control Documentation (WCD) Policy (policy number 190) has been adhered to in the development of the above-mentioned written control documents and therefore that the documents are in line with legislation/regulations, available evidence base and can be implemented within the Health Board. An Equality Impact Assessment (EqIA) has been completed to support the policy and ensure compliance with statutory duties.

- 246 – Managing Allegations and Professional Concerns raised against HDdUHB staff, extension request pending receipt of revised WSP S5 guidance.

Cefndir / Background

The 1097 – Corporate Safeguarding Policy establishes the overarching safeguarding framework across Hywel Dda UHB, setting out roles, responsibilities, governance arrangements, and processes for safeguarding children, young people and adults at risk

It aligns with key legislation and guidance including:

Social Services and Well-being (Wales) Act 2014
Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015
Wales Safeguarding Procedures

The policy applies to all staff and individuals working on behalf of the Health Board.
A full review has been undertaken in June 2026 to ensure alignment with updated legislation, national guidance, and organisational governance requirements.

Asesiad / Assessment

The draft policy has been fully consulted on by members of the Strategic Safeguarding Steering Group and Corporate Safeguarding Team and has been through the global consultation process, and a screening Equality Impact Assessment (EqIA) has been undertaken (Appendix 2).

The approved policy will be disseminated to staff via the Strategic Safeguarding Steering Group members and Chairs of Service Safeguarding Delivery Groups as well as via the global email resource.

The policy will be implemented with immediate effect upon approval, by the Head of Safeguarding and Strategic Safeguarding Steering Group members and Chairs of Service Safeguarding Delivery Groups. Confirmation of implementation will be confirmed at the next bimonthly Strategic Safeguarding Steering Group meeting 2026.

Compliance with the policy will be monitored via Service Safeguarding Delivery groups and issues of non-compliance addressed with improvement plans or escalation onto service risk registers.

The updated policy provides a clear and strengthened governance framework for safeguarding across the organisation. Responsibilities are clearly defined from Board level through to all staff.
There is a strong emphasis on:

- Early identification of risk
- Multi-agency working
- Mandatory reporting duties
- Training, supervision and assurance mechanisms

Argymhelliad / Recommendation

The Quality Safety Experience Committee is requested to:

- Approve the Corporate Safeguarding Policy 1097
- Note the completed Equality Impact Assessment and positive equality impacts
- Support continued organisational focus on safeguarding training, compliance and assurance

Request an extension of policy 246 Managing Allegations and Professional Concerns raised against HDdUHB staff.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	3.22 Approve policies and plans within the scope of the Committee, having taken an assurance that the quality and safety of patient care has been considered within these policies and plans.
Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol:	Not Applicable.

Datix Risk Register Reference and Score:	
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	2. Culture and valuing people
Amcanion Strategol y BIP: UHB Strategic Objectives:	3. Great care
Nodau Cynllunio 2026/27 Planning Goals 2026/27	6. Safe, Timely, High Quality Care
Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	7. Improve health and well-being by focusing on prevention and early intervention, while working in partnership to ensure everyone has equal access to care and opportunities for good health
Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau) A Social Model for Health and Wellbeing: (*complete for strategic change and/or significant service changes)*	5. A more preventative approach, including earlier identification and intervention, will be taken to support people to maintain and improve their health and wellbeing.
Gwybodaeth Ychwanegol: **Further Information:**	

Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not Applicable
Ansawdd / Gofal Claf: Quality / Patient Care:	Contained within the report
Gweithlu: Workforce:	Not Applicable
Tegwch Iechyd: Health Equity:	Contained within the report
Risg: Risk:	Not Applicable
Cyfreithiol: Legal:	Contained within the report
Enw Da: Reputational:	Not Applicable
Gyfrinachedd: Privacy:	Not Applicable
Cydraddoldeb: Equality:	Included with report as appendix 2

Corporate Safeguarding Policy
DRAFT

Policy information

Policy number: 1097
Classification: Corporate
Supersedes: N/A
Version number: 3
Date of Equality Impact Assessment: 22/05/2026

Approval information

Approved by: Quality Safety Experience Committee
Date of approval:11/08/2026
Date made active:
Review date:

Summary of document:

This Corporate Safeguarding Policy establishes the overarching framework for safeguarding across Hywel Dda University Health Board (UHB). It sets out the roles, responsibilities and accountabilities of all staff in relation to safeguarding children, young people and adults at risk.

The policy outlines the systems, processes and governance arrangements through which the UHB will prevent, identify and respond to abuse, neglect and harm. It also defines the assurance mechanisms in place to enable the UHB to demonstrate compliance with its statutory duties, national guidance and best practice, and to ensure continuous improvement in safeguarding practice.

Scope:

This policy applies to all individuals working within or on behalf of the Health Board, including permanent and temporary employees, bank and agency staff, students, contractors, volunteers and trainees. It applies irrespective of role, seniority, or whether the individual has direct or indirect contact with children, young people or adults at risk.

All individuals are required to comply with this policy and associated procedures as part of their contractual, professional and organisational responsibilities.

To be read in conjunction with:

508 - Social Services and Well Being Act 2014 (opens in new tab)
868 - All Wales Safeguarding Procedures (opens in new tab)
https://www.safeguarding.wales/ (opens in new tab)
1042- Information Sharing Protocol for the Safeguarding of Children, Young People and Adults within West Wales Procedure (opens in new tab)
592 - "Ask and Act" - Violence against Women, Domestic Abuse and Sexual Violence (VAWDASV) Policy (opens in new tab)
405 - Safeguarding Children and Young People in Emergency Department/Out of Hours Service Procedure (opens in new tab)
887 - Monitoring Vulnerable People who were not Brought or did not Attend Appointments and no Access Visits (opens in new tab)
1041 - Multi-Agency High-Risk Behaviour Policy and Procedure (Including Self-Neglect/Hoarding) (opens in new tab)
944 - Management of Suspected Injuries in Non-Mobile Children Procedure (opens in new tab)
571 - Managing Historical Allegations of Abuse Procedure (opens in new tab)
476 - Safeguarding Supervision Policy (opens in new tab)
714 - Management and Reporting of Female Genital Mutilation (for Health Professionals) Procedure (opens in new tab)
1040 - Decision Making at Child Protection Conferences and Agency Groupings Procedure (opens in new tab)
563 - Procedural Response for Unexpected Deaths in Childhood Procedure (opens in new tab)
441 - Looked After Children (LAC) Policy (opens in new tab)
610 - Provision to Local Authority and Private Residential Children's Homes Guideline (opens in new tab)
246 - Managing Safeguarding Allegations and Professional Concerns Raised Against Hywel Dda University Health Board Staff Policy (opens in new tab)
311 - Domestic Abuse and Sexual Violence Workplace Policy (opens in new tab)
210 - NHS Wales Disciplinary Policy - How-to Procedures WPF November 2025.pdf (opens in new tab)
201 - NHS Wales Disciplinary Policy and Process.pdf (opens in new tab)

Patient information:

Include links to Patient Information Library

Owning group:

Strategic Safeguarding Steering Group (SSSG) 15/06/2026

Executive Director job title: of Nursing, Quality and Patient Experience

Reviews and updates:

1.0 – New Policy 15.12.2022
2.0 – full review 15/6/2026

Keywords

DRAFT

Glossary of terms

UHB - University Health Board
CLA - Children Looked After
HDdUHB - Hywel Dda University Health Board
CT&S Act – Counter Terrorism and Security Act

DRAFT

Contents

..... 1
Policy information 1
Approval information 1
Introduction 5
Policy statement 5
Scope 5
Aim 6
Objectives 6
Legislation and Guidance 7
Approval of National, Regional and Local Policies 7
Statutory Duty to Report a Child or Adult at Risk of Abuse or Neglect 7
Reporting and Escalation Process 8
Multi-Agency Partnership Working 9
Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) and Ask and Act 10
Definition of Domestic Abuse 11
Children Looked After 11
Contest, Prevent, Channel Panel 12
Channel Process 12
UHB Roles and Responsibilities 13
Policy Application 13
Modern Slavery and Trafficking 14
Information Sharing 15
Training and Education 16
Reporting Framework 16
Responsibilities of All Staff 19
References 21
Appendix 1 – Safeguarding and Performance Reporting Framework 22

DRAFT

Introduction

Safeguarding and protecting children, young people and adults at risk is a fundamental priority for Hywel Dda University Health Board (UHB). The UHB is committed to ensuring that robust governance arrangements, systems and processes are in place to meet its statutory responsibilities and to comply with relevant Welsh legislation, including the *Social Services and Well-being (Wales) Act 2014*, the *Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015*, and associated national guidance and safeguarding procedures.

Safeguarding is a shared, multi-agency responsibility that requires effective collaboration with partner agencies to protect individuals from abuse, neglect and other forms of harm. It encompasses both preventative and responsive activity, including the early identification of risk, timely and proportionate intervention, and the promotion of wellbeing to reduce the likelihood of harm occurring.

Hywel Dda University Health Board recognises that all staff, irrespective of role or grade, have a duty to safeguard and promote the welfare of children, young people and adults at risk. This includes individuals who may be experiencing or at risk of gender-based violence, domestic abuse and sexual violence. All staff are expected to remain vigilant, demonstrate professional curiosity, and act in accordance with this policy, associated procedures, and professional codes of conduct.

Whilst Local Authorities hold the statutory lead for safeguarding enquiries under Section 126 of the *Social Services and Well-being (Wales) Act 2014*, the UHB has a clear and defined duty to cooperate under Section 162 of the Act. The UHB will work in partnership with statutory and non-statutory agencies to prevent harm, support early intervention, and ensure an effective and coordinated response to safeguarding concerns, allegations and disclosures.

Policy statement

The UHB recognises that effective safeguarding practice encompasses all activity undertaken to promote the safety and wellbeing of children, young people and adults at risk, and to prevent abuse, neglect and exploitation. This includes creating a culture of vigilance, embedding safe systems of work, and ensuring that safeguarding is integral to all aspects of service delivery.

This Corporate Safeguarding Policy sets out the overarching framework for safeguarding across all services within the UHB. It defines the roles, responsibilities and accountabilities of staff in relation to safeguarding children and adults at risk. It also outlines the governance, assurance and reporting mechanisms through which the UHB will monitor compliance, ensure continuous improvement, and demonstrate that it is meeting its statutory safeguarding duties.

Scope

This policy applies to all individuals working within or on behalf of the Health Board, including permanent and temporary employees, bank and agency staff, students, contractors, volunteers and

trainees. It applies irrespective of role, seniority or whether the individual has direct or indirect contact with children, young people or adults at risk.

All individuals are required to comply with this policy and associated procedures as part of their professional and organisational responsibilities.

Aim

The aim of this document is to:

Ensure that all individuals working within the UHB understand the statutory framework for safeguarding and public protection, and are aware of their roles, responsibilities and duties in accordance with relevant legislation, national guidance and professional standards.

Provide a clear framework for safeguarding practice across the organisation, ensuring a consistent and effective approach to the prevention, identification and response to abuse, neglect and harm.

Establish robust governance and assurance arrangements which enable the UHB to demonstrate compliance with its statutory safeguarding responsibilities and provide assurance that appropriate systems are in place to safeguard children, young people and adults at risk.

Objectives

The aim of this document will be achieved by the following objectives:

- To set out how the Health Board will meet its legal and statutory safeguarding responsibilities in accordance with relevant legislation, national guidance and policy frameworks for children and adults at risk.

- To clearly define the roles, responsibilities and accountabilities of all staff in fulfilling their duties to safeguard and promote the welfare of individuals at risk of abuse, neglect or harm.

- To establish consistent standards of safeguarding practice across the organisation, ensuring timely identification, reporting and response to safeguarding concerns.

- To support effective multi-agency working and information sharing in order to promote coordinated safeguarding interventions and improved outcomes for individuals.

- To provide assurance through robust governance, monitoring and reporting arrangements that safeguarding responsibilities are being met and that continuous improvement is embedded within practice.

Legislation and Guidance

Legislation to safeguard people at risk of abuse or neglect or gender-based violence, domestic abuse or sexual violence are contained within various acts and statutory guidance.

The law, policy and guidance changes from time to time, therefore, not is not possible to provide an exhaustive list of relevant documents, but the most current significant are set out as follows:

- Social Services and Well-being (Wales) Act 2014 and the related Codes of Practice; Part 6 (Looked After Children) & Part 7 (Safeguarding Children and Adults at Risk)
- Children Act 1989, Section 47 (child protection investigations)
- Children Act 2004 Sections 25, 27 and 28 (duty to cooperate to safeguard and promote the welfare of children)
- Violence against Women, Domestic Abuse, Sexual Violence (Wales) Act 2015
- Domestic Abuse Act 2021 (definition of domestic abuse)
- S9(3) Domestic Violence and Crimes Act 2004 (duty to participate in a Domestic Homicide Review)
- S5B of the Female Genital Mutilation Act 2003 (amended by Serious Crime Act) [mandatory reporting of FGM in under 18s to the police]
- Counter Terrorism and Security Act 2015 (to address those drawn into, or at risk of being drawn into terrorist and extremist behaviour)
- Mental Capacity Act 2005
- Modern Slavery Act 2015
- Human Rights Act 1998
- Safe Care Standard 2.7 of Health & Care Standards in Wales
- Wales Safeguarding Procedures 2019

Approval of National, Regional and Local Policies

The Head of Safeguarding is responsible for ensuring that all national, regional and local safeguarding policies and procedures adopted or developed within the UHB are subject to appropriate review, governance and formal approval. This will be undertaken in accordance with the UHB Written Control Documentation Policy.

This includes ensuring that such policies are current, aligned with relevant legislation and national guidance, and appropriately ratified through the UHB's established governance and assurance processes prior to implementation.

Statutory Duty to Report a Child or Adult at Risk of Abuse or Neglect

The Social Services and Well-being (Wales) Act 2014, implemented in April 2016, places a statutory duty on relevant partners, including the Health Board, to report to the Local Authority where there are reasonable grounds to suspect that a child or an adult is at risk of abuse, neglect or other forms of harm.

DRAFT

All individuals working within or on behalf of the Health Board have an individual and professional responsibility to take timely, proportionate and appropriate action where they witness incidents, have concerns, or receive information indicating that a child or adult may be at risk. Concerns must be reported without delay in accordance with this policy and associated procedures. While advice and support may be sought from line managers or the Corporate Safeguarding Team, this must not result in any delay in reporting.

For the purposes of this policy:

A child is defined under the Children Act 1989 as any person under the age of 18 years.

A child at risk is defined under the Social Services and Well-being (Wales) Act 2014 as a child who:

- Is experiencing, or is at risk of, abuse, neglect or other kinds of harm; and
- Has needs for care and support (whether or not the Local Authority is meeting any of those needs).

An adult at risk is defined under the Social Services and Well-being (Wales) Act 2014 as an adult who:

- Is experiencing, or is at risk of, abuse or neglect;
- Has needs for care and support (whether or not the Local Authority is meeting any of those needs); and
- As a result of those needs, is unable to protect themselves against the abuse or neglect or the risk of it.

Safeguarding is the responsibility of all individuals working within the Health Board and applies to all children, young people and adults at risk encountered in the course of their work. This includes patients, service users, carers, visitors, children of patients, and others connected to Health Board services.

Staff must remain vigilant, demonstrate professional curiosity, and act in a manner that prioritises the safety, dignity, rights and wellbeing of individuals. Safeguarding practice must be underpinned by the principles of prevention, early intervention, proportionality, partnership, protection, accountability and empowerment.

Reporting and Escalation Process

In line with the Wales Safeguarding Procedures, all staff must adhere to the following principles when responding to safeguarding concerns:

- Recognise: Be alert to signs, indicators or disclosures of abuse, neglect or harm.
- Respond: Take all concerns seriously. Listen, reassure, and do not promise confidentiality.

- Report: Make an immediate safeguarding report to the Local Authority where there are reasonable grounds for concern. This must be done without delay.
- Record: Ensure that all concerns, actions and decisions are clearly, accurately and contemporaneously documented in line with organisational record-keeping standards.
- Refer/Consult: Seek advice from the Corporate Safeguarding Team or line manager where necessary; however, this must not delay formal reporting.

Where there is an immediate risk of serious harm, staff must take urgent action, including contacting emergency services as appropriate.

The Health Board will ensure that staff are supported to fulfil their responsibilities through access to safeguarding training, supervision, clear procedures and specialist advice from the Corporate Safeguarding Team.

Failure to adhere to safeguarding responsibilities, including failure to report concerns, may result in disciplinary action and could place individuals at continued risk of harm. 201 - NHS Wales Disciplinary Policy and Process.pdf

Multi-Agency Partnership Working

Hywel Dda University Health Board (UHB) recognises that safeguarding is a shared responsibility and that effective protection of children, young people and adults at risk requires strong, collaborative working across organisations and professional boundaries.

The UHB is committed to working in partnership with statutory and non-statutory agencies, including Local Authorities, Police, education providers, third sector organisations and other health partners, to prevent, identify and respond to abuse, neglect and exploitation.

In accordance with the Social Services and Well-being (Wales) Act 2014 and the Wales Safeguarding Procedures, the UHB will:

- Cooperate and collaborate with partner agencies to safeguard individuals and promote their wellbeing
- Share relevant information in a timely, lawful and proportionate manner to support safeguarding decision-making and risk management
- Contribute effectively to multi-agency safeguarding processes, including strategy discussions, case conferences, core groups, adult protection processes and other statutory forums
- Participate in Safeguarding Boards and associated sub-groups, contributing to regional and national safeguarding priorities
- Support and engage in multi-agency reviews, including SUSR's, ensuring that learning is identified, embedded and monitored

All staff are expected to work collaboratively with partner agencies, demonstrating professional respect, clear communication and shared decision-making in the best interests of the individual. Staff must

ensure that their contributions to multi-agency working are timely, accurate and focused on achieving improved safeguarding outcomes.

The UHB will ensure that staff are supported to undertake their multi-agency responsibilities through appropriate training, supervision and access to specialist safeguarding advice.

Failure to effectively engage in multi-agency partnership working may place individuals at risk of harm and will be addressed through the UHB's governance and performance management frameworks.

Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) and Ask and Act

Hywel Dda University Health Board (UHB) is committed to promoting the health, safety and wellbeing of its patients, service users and staff. The UHB recognises that violence against women, domestic abuse and sexual violence (VAWDASV) are significant public health issues and criminal offences that have a profound impact on individuals, families and communities.

The UHB has statutory duties under the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 to prevent, protect and support individuals affected by VAWDASV. This includes a responsibility to ensure that staff are appropriately trained and supported to identify, respond to and refer individuals who may be experiencing, or at risk of, abuse.

In accordance with the Welsh Government Ask and Act framework, the UHB requires relevant staff to:

- Ask – routinely and sensitively enquire about VAWDASV in appropriate settings.
- Act – respond effectively to disclosures, ensuring timely support and referral to specialist services.

All staff must ensure that enquiries are made in a safe and private environment, that individuals are listened to and believed, and that appropriate safeguarding actions are taken in line with this policy and the Wales Safeguarding Procedures.

Further responsibilities and operational guidance for staff are set out in the UHB Ask and Act – VAWDASV Policy and associated procedures.

The UHB also acknowledges its responsibilities as an employer. It recognises that members of the workforce may be affected by domestic abuse, either as victims or, in some cases, as alleged or confirmed perpetrators. The UHB will ensure that appropriate support, management and actions are taken in line with the Domestic Abuse and Sexual Violence Workplace Policy, including providing a confidential, supportive response to affected staff and addressing risks within the workplace.

DRAFT

Definition of Domestic Abuse

For the purposes of this policy, domestic abuse is defined in accordance with the Domestic Abuse Act 2021.

Domestic abuse is any behaviour between individuals aged 16 or over who are personally connected that is abusive in nature. Behaviour is considered abusive if it includes, but is not limited to:

- Physical or sexual abuse
- Violent or threatening behaviour
- Controlling or coercive behaviour
- Economic abuse
- Psychological, emotional or other abuse

This may involve a single incident or a pattern of behaviour.

Individuals are considered personally connected if they are, or have been:

- Married or civil partners
- In an intimate personal relationship
- Parents of the same child or in a parental relationship
- Relatives

The Act also recognises that children are victims of domestic abuse where they see, hear, or experience the effects of abuse between connected individuals.

The UHB requires all staff to:

- Recognise VAWDASV as a safeguarding concern and respond in accordance with statutory duties and organisational procedures
- Undertake relevant training to meet Ask and Act requirements
- Ensure timely report and/or referral to safeguarding and specialist support services
- Maintain accurate and contemporaneous record keeping
- Work in partnership with relevant agencies to support individuals and manage risk

Failure to comply with these responsibilities may result in disciplinary action and place individuals at continued risk of harm. 201 - NHS Wales Disciplinary Policy and Process.pdf

Children Looked After

Children and young people who are looked after are among the most socially excluded groups in society and are known to have significantly greater health needs compared to their peers from similar socio-economic backgrounds.

The term “Children Looked After” (CLA) is defined within the Children Act (1989) and refers to children and young people up to the age of 18 for whom a local authority provides accommodation or care for a

DRAFT

continuous period exceeding 24 hours. These children may be placed in a variety of settings, including with foster carers, in residential homes, or with parents or extended family members under a range of legal arrangements.

Hywel Dda University Health Board (UHB) has implemented the 441 - Looked After Children (LAC) Policy to ensure that it fulfils its statutory responsibilities. This policy supports the effective planning, commissioning, and delivery of services to meet the identified health needs of looked after children and young people.

Contest, Prevent, Channel Panel

Hywel Dda University Health Board (UHB) has a statutory duty under the Counter-Terrorism and Security Act 2015 to have due regard to the need to prevent people from being drawn into terrorism. This duty, known as the Prevent Duty which is supported by updated statutory guidance for England and Wales and brought into force on 31 December 2023, forms part of the Health Board's wider safeguarding responsibilities. CONTEST (2023) is the UK Government's counter-terrorism strategy and is structured around four key pillars:

- Prevent – to stop people becoming terrorists or supporting terrorism
- Pursue – to detect and stop terrorist activity (led by policing and security services)
- Protect – to strengthen protection against terrorist attacks
- Prepare – to mitigate the impact of terrorist incidents

The Prevent strand is of direct relevance to the Health Board and aligns with safeguarding principles. It aims to:

- Address the causes of radicalisation and respond to the ideological challenge of terrorism
- Safeguard and support individuals at risk of radicalisation through early identification and intervention
- Support the disengagement and rehabilitation of individuals involved in terrorism

Prevent is a safeguarding duty and not a criminal justice process. It applies to all forms of terrorism and does not target any single community. The UHB recognises that individuals vulnerable to radicalisation may present within healthcare settings and, as such, this risk must be considered within safeguarding practice. All staff have a responsibility to remain alert to indicators of radicalisation and to report concerns appropriately, in line with safeguarding procedures.

Channel Process

Channel is a key component of the Prevent strategy and is a statutory, multi-agency process established under the Counter-Terrorism and Security Act 2015. It provides a framework for:

Identifying individuals at risk of being drawn into terrorism

Assessing the nature and extent of that risk

DRAFT

Developing and implementing a coordinated, multi-agency support plan

The Channel Duty Guidance (2023, with subsequent updates in 2025) places a legal requirement on local authorities to establish and chair Channel Panels, with specified partners, including Health Boards, required to cooperate and provide appropriate information and support (Schedule 7. CT&S Act 2015).

Individuals are typically referred to Channel via police Prevent teams, and the process is designed to provide early, voluntary support to those at risk of radicalisation.

UHB Roles and Responsibilities

The UHB will ensure that:

Staff are appropriately trained and supported to recognise and respond to concerns relating to radicalisation in line with the Prevent Duty

Concerns are reported promptly through established safeguarding and Prevent reporting pathways

Information sharing is undertaken in accordance with legal, professional and organisational requirements

Healthcare staff should also have regard to the Prevent Duty guidance for healthcare professionals (updated 2024), which outlines roles in identifying and responding to radicalisation risk.

The Public Health Directorate is responsible for representing the UHB at local and regional CONTEST governance structures.

The Corporate Safeguarding Team acts as the central point of contact for Prevent-related safeguarding concerns and for engagement with Local Authority-led Channel Panels. The team is responsible for:

- Coordinating requests for information to support Channel processes
- Contributing to risk assessment and information sharing
- Attending and representing the UHB at Channel Panel meetings
- Providing advice and guidance to staff on Prevent and safeguarding responsibilities

Policy Application

All staff must:

- Recognise radicalisation as a safeguarding concern
- Act promptly on concerns and follow Prevent reporting processes
- Complete required Prevent training in line with organisational requirements
- Work collaboratively with partner agencies to support individuals at risk

DRAFT

Failure to comply with these responsibilities may result in disciplinary action and could place individuals and communities at increased risk of harm.

Modern Slavery and Trafficking

Hywel Dda University Health Board (UHB) recognises that modern slavery and human trafficking are serious criminal offences and significant violations of human rights. The *Modern Slavery Act 2015* encompasses offences of slavery, servitude, forced or compulsory labour, and human trafficking.

Human trafficking involves the recruitment, movement or harbouring of individuals through force, coercion, deception or abuse of vulnerability for the purpose of exploitation. Exploitation may include, but is not limited to, sexual exploitation, forced labour, domestic servitude, criminal exploitation and organ harvesting. Victims may be adults or children and may present across all healthcare settings.

The UHB acknowledges that modern slavery has significant and often complex health consequences at both an individual and population level. These may include physical injury, untreated chronic conditions, sexual health concerns, substance misuse, and significant mental health needs arising from trauma, abuse and exploitation.

In accordance with the *Modern Slavery Act 2015* and the associated *Modern Slavery Statutory Guidance for England and Wales (Section 49)*, the UHB has a responsibility to:

- Identify and respond to potential victims of modern slavery and human trafficking within all healthcare settings
- Ensure that staff are appropriately trained to recognise indicators of exploitation and vulnerability
- Provide immediate and ongoing healthcare, taking a trauma-informed and person-centred approach
- Refer concerns in line with safeguarding procedures and, where appropriate, the National Referral Mechanism (NRM)
- Work collaboratively with partner agencies to ensure effective safeguarding, protection and support

Modern slavery is a safeguarding issue. All staff have a duty to remain vigilant to potential indicators of exploitation and to take prompt and appropriate action where concerns arise. Concerns must be reported without delay in accordance with this policy and the Wales Safeguarding Procedures.

All staff must:

- Recognise modern slavery and human trafficking as forms of abuse and exploitation
- Act promptly on any concerns and follow safeguarding and referral pathways
- Seek advice from the Corporate Safeguarding Team where required, without delaying reporting
- Ensure accurate, clear and contemporaneous record keeping
- Work in partnership with relevant agencies to safeguard and support victims

DRAFT

Information Sharing

Effective information sharing is essential to safeguarding practice and is a key enabler in protecting children, young people and adults at risk of abuse, neglect or harm. Hywel Dda University Health Board (UHB) is committed to ensuring that information is shared appropriately, lawfully and proportionately to support safeguarding activity.

The *Data Protection Act 2018* and the UK General Data Protection Regulation (UK GDPR) do not prevent the sharing of information for safeguarding purposes. These frameworks provide a lawful basis for the processing and sharing of personal information where it is necessary to protect individuals from harm. Information governance requirements must not be used as a barrier to appropriate and timely information sharing.

The UHB adheres to the 1042 - Information Sharing Protocol for the Safeguarding of Children, Young People and Adults within West Wales Procedure which provides a framework to support staff in making informed decisions about when and how to share information. The protocol aims to ensure that staff have the confidence to share relevant information where it is necessary to protect individuals or prevent abuse, neglect or other forms of harm.

Personal information may be shared without consent where there is a legal obligation or where it is justified in the public interest. This includes circumstances where:

- There is a risk of significant harm to a child;
- There is a risk of serious harm to an adult at risk;
- Sharing information is necessary to prevent or detect abuse or neglect;
- Seeking consent would place the individual or others at increased risk.

In such circumstances, the public interest test is likely to be met. Decisions to share information without consent must be based on professional judgement, considering the specific circumstances of each case. The information shared must be:

- **Necessary** for the purpose it is being shared
- **Proportionate** to the level of risk and concern
- **Relevant and accurate**
- **Shared in a timely manner** with appropriate agencies

Where there is uncertainty, staff should seek advice from their line manager, the Corporate Safeguarding Team, or the Information Governance Team. However, seeking advice must not result in any delay in sharing information where there is a risk of harm.

All information sharing decisions, including the rationale for sharing or not sharing information, must be clearly and contemporaneously recorded in accordance with organisational record-keeping standards. Employees should seek advice from the Information Governance Team.

DRAFT

Professionals Accompanying Children and Young People to Healthcare Appointments

Children and young people should, wherever possible, attend healthcare appointments accompanied by a person with parental responsibility or an individual who has delegated authority to make decisions regarding their care and treatment.

Healthcare professionals should remain alert to circumstances where a child is repeatedly presented for assessment, treatment or healthcare appointments by individuals who do not hold parental responsibility and where there is no clear evidence of parental knowledge, consent or involvement. Whilst there may be legitimate reasons for such arrangements, repeated attendance in these circumstances may indicate potential safeguarding concerns, including disguised compliance, parental disengagement, inappropriate delegation of care, private fostering arrangements, or other vulnerabilities.

Where concerns arise, practitioners should, establish the identity and relationship of the accompanying adult to the child and seek clarification regarding parental responsibility and whether parental consent has been obtained where appropriate. Consider the child's age and exercise professional curiosity to consider whether the circumstances indicate potential safeguarding risks.

Staff should ensure that concerns are documented clearly within the clinical record and seek advice from the Corporate Safeguarding Team where necessary, consideration to make a safeguarding report should be given in accordance with the Wales Safeguarding Procedures.

The absence of parental knowledge or involvement does not automatically indicate a safeguarding concern. However, practitioners must be able to demonstrate that appropriate enquiries have been made and that decisions have been based on the child's best interests, welfare and safety

Training and Education

Safeguarding and public protection training is essential to safeguard our patients and the public from harm.

Mandatory training in respect of safeguarding children, adults and violence against women, domestic abuse and sexual violence is accessible on both a single and multi-agency basis.

Mandatory safeguarding training compliance will be monitored by senior service managers and exceptions reported to the Strategic Safeguarding Working Group.

Reporting Framework

The Strategic Safeguarding Steering Group (SSSG) provides strategic oversight and assurance to the Quality, Safety Intelligence Group in relation to the UHB’s legal and statutory responsibilities for safeguarding children, young people and adults at risk. The SSSG is responsible for monitoring organisational performance, reviewing risks, and ensuring that effective systems and processes are in place to support compliance with safeguarding legislation, national guidance and policy requirements.

DRAFT

CCG Safeguarding Delivery Groups are established as operational forums to support the implementation of safeguarding standards across the organisation. These groups are responsible for:

- Promoting consistent, high-quality safeguarding practice across clinical and non-clinical services
- Monitoring compliance with safeguarding policies, procedures and statutory requirements
- Identifying, managing and escalating risks, issues and exceptions relating to safeguarding
- Supporting continuous improvement through audit, training compliance and learning from incidents and reviews
- Facilitating effective multi-agency working and partnership arrangements

Safeguarding Delivery Groups are accountable for reporting performance, risks and assurance to the SSSG in line with the UHB's governance framework.

Where a Service or CCG does not have a dedicated Safeguarding Delivery Group, there remains a requirement to ensure that safeguarding is appropriately embedded within existing governance structures. This includes the routine consideration of safeguarding matters, risks and exceptions within established governance, quality or safety meetings, with clear evidence of oversight and action planning.

The UHB governance and performance reporting framework, including the relationship with regional and national safeguarding structures, is outlined in Appendix 1. Responsibilities

Chief Executive

As the Accountable Officer, the Chief Executive has overall responsibility for ensuring that the Health Board has appropriate Written Control Documents (WCDs) in place. These must comply with relevant legislation, national guidance and mandatory requirements, and support the delivery of services that are safe, effective, evidence-based and sustainable.

The Chief Executive is ultimately accountable for ensuring that the organisation meets its statutory safeguarding responsibilities and that effective governance and assurance arrangements are in place.

Nominated Director – Director of Nursing, Quality and Patient Experience

The Director of Nursing, Quality and Patient Experience holds executive responsibility for safeguarding across the UHB. This includes delegated responsibility for safeguarding children in accordance with Section 28 of the *Children Act 2004*, and for safeguarding adults under the *Social Services and Well-being (Wales) Act 2014*.

The Director provides strategic leadership, ensuring that robust systems, policies and assurance mechanisms are in place to enable the UHB to meet its safeguarding duties and promote a culture of safety and accountability.

Head of Safeguarding

The Head of Safeguarding is responsible for providing professional leadership and strategic oversight of safeguarding across the UHB. This includes ensuring that:

- All national, regional and local safeguarding policies and procedures are developed, reviewed and approved in accordance with the UHB Written Control Documentation Policy
- Effective safeguarding systems, processes and frameworks are in place and aligned with legislative and national requirements
- Mandatory safeguarding training is delivered and monitored to ensure compliance across the organisation
- Specialist advice, guidance and support is available to staff in relation to safeguarding concerns
- Assurance is provided through appropriate governance, reporting and audit mechanisms

Senior Management
Senior Management Teams within each Directorate are responsible for the implementation of this Policy and for providing assurance of compliance with safeguarding legislation, national guidance and organisational requirements.

Senior Managers must ensure that:

- Services are designed and delivered to promote the prevention of abuse, neglect and harm, with a focus on early identification and intervention
- Safeguarding is embedded within local governance arrangements, with clear oversight of performance, risks and compliance
- Staff are supported to participate in statutory safeguarding reviews, investigations and multi-agency processes as required
- Learning from incidents, reviews and audits is disseminated, embedded into practice, and monitored through action plans
- Regular performance reports are submitted to Service Safeguarding Delivery Groups, including information on compliance, training, risks, exceptions and mitigation

Department, Service or Ward Management

Department, Service or Ward Managers are responsible for the operational implementation of safeguarding within their areas of responsibility. They must ensure that:

- All staff complete and maintain required safeguarding training in line with organisational standards
- Staff are competent and supported to recognise and respond appropriately to safeguarding concerns
- Staff understand and fulfil their statutory duty to report concerns, and that any non-compliance is identified and addressed promptly
- Safeguarding is routinely discussed within team meetings, supervision and local governance processes

DRAFT

- Staff are aware that their conduct, both within and outside of the workplace, may give rise to safeguarding concerns and must meet expected professional standards

Managers must also ensure that safeguarding concerns, risks and incidents are appropriately escalated and that accurate records are maintained.

Responsibilities of All Staff

All individuals working within or on behalf of the UHB have a duty to safeguard and promote the welfare of children, young people and adults at risk. This responsibility applies irrespective of role, grade or level of contact with service users.

All staff must take timely, appropriate and decisive action where they witness incidents, have concerns, or receive information indicating potential abuse, neglect or inappropriate care. Concerns must be reported without delay in accordance with this policy and associated procedures. Staff may seek advice and support from their line manager, Safeguarding Lead or the Corporate Safeguarding Team; however, this must not result in any delay in acting.

All staff are required to:

- Comply with relevant legislation, national guidance, organisational policies and safeguarding procedures
- Act in accordance with their applicable **Code of Conduct**, including maintaining appropriate standards of behaviour both within and outside of the workplace where this may impact on their professional role
- Maintain a high level of vigilance and demonstrate professional curiosity in identifying safeguarding concerns
- Ensure that all safeguarding concerns, actions and decisions are accurately and contemporaneously recorded
- Participate in safeguarding supervision where appropriate to their role

All staff must also comply with mandatory and statutory training requirements, including **Safeguarding Children, Safeguarding Adults and Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV)** training, in line with organisational expectations. Staff are responsible for maintaining their own competence and ensuring that training is completed and kept up to date.

Failure to fulfil safeguarding responsibilities or to comply with this policy and associated requirements may result in disciplinary action and could place individuals at risk of harm.

Corporate Safeguarding Team

The Corporate Safeguarding Team provides specialist advice and support to UHB employees and operates as the single point of contact for statutory partners within the safeguarding process. The team is responsible for the delivery of safeguarding training to ensure that staff achieve and maintain the required levels of mandatory competence. In addition, the team provides safeguarding supervision to

support professional practice, works collaboratively with partner agencies, and contributes to multi-agency meetings to facilitate effective information sharing and coordinated safeguarding responses.

DRAFT

References

Children Act 1989 https://www.legislation.gov.uk/ukpga/1989/41/section/47

Children Act 2004 https://www.legislation.gov.uk/en/ukpga/2004/31/contents

Counter Terrorism & Security Act 2015 https://www.legislation.gov.uk/ukpga/2015/6/contents/enacted

Data Protection Act 2018 https://www.legislation.gov.uk/ukpga/2018/12/contents/enacted

Domestic Abuse Act 2021 https://www.legislation.gov.uk/ukpga/2021/17/contents/enacted

Domestic Violence, Crime and Victims Act 2004 https://www.legislation.gov.uk/ukpga/2004/28/section/9

Female Genital Mutilation Act 2003 https://www.legislation.gov.uk/ukpga/2003/31/section/5B

Health and Care Standards 2016 https://gov.wales/health-and-care-standards

Mental Capacity Act 2005 https://www.legislation.gov.uk/ukpga/2005/9/part/1

Modern Slavery Act 2015 https://www.legislation.gov.uk/ukpga/2015/30/contents/enacted

Social Services and wellbeing (Wales) Act 2014
https://nhswales365.sharepoint.com/sites/HDD_Corporate_Governance/SitePages/Policy%20pages/Clinical%20policies/Safeguarding/508--.aspx

Violence Against Women, Domestic Abuse and Sexual Violence Act 2015
https://www.legislation.gov.uk/anaw/2015/3/contents/enacted

Wales Safeguarding Procedures 2019 Safeguarding Wales

DRAFT

Appendix 1 – Safeguarding and Performance Reporting Framework

Allied Health & Health Sciences IGG

DRAFT

Equality Impact Assessment (EqIA) Screening Template

When to complete an EqIA Screening

An EqIA Screening Template must be completed when reviewing, changing and developing procedures/ proposals/ projects/ policies. This is a first step and is used to consider whether there are any negative impacts that may arise.

Purpose of an EqIA Screening Template

The purpose of this short exercise is to ensure that you have shown appropriate due regard when considering the impact for people with protected characteristics in your decision making. The screening process is designed to help you consider the circumstances and to inform evidence-based decisions.

If the proposal is of a significant nature and it is apparent from the outset that a full EqIA will be required, then it is not necessary to complete this Screening Template, you can proceed to complete the full EqIA.

If no negative impacts are identified following completion of the EqIA screening then it is not necessary to undertake a full EqIA however, the decision and justification must be clearly recorded in this document.

On completion of the Screening Template:

- Ensure that all the white boxes within the screening are completed.
- Ensure that the Procedure/ Project/ Proposal/ Policy owner has signed and dated the Screening Template.
- Send a copy of the completed template along with the related policy or project proposal to Inclusion.hdd@wales.nhs.uk for the Diversity & Inclusion Team to review.
- Each Screening Template will be reviewed by the Diversity & Inclusion Team and feedback will be provided to the Procedure/ Project/ Proposal/ Policy owner. This may include recommendations for further action to inform robust decision-making.

Support

For further support please visit the EqIA Sharepoint or contact:
Email: Inclusion.hdd@wales.nhs.uk
Tel: 01554 899055

Director and Directorate	Sharon Daniel EDoN Nursing, Quality and Patient Experience Corporate Directorate
Service Area	Safeguarding

Title of Procedure, Project, Proposal, Policy being screened:	Corporate Safeguarding Policy 1097

Description of the Procedure/ Project/ Proposal/ Policy being screened (including key aims and objectives)

This policy establishes the overarching safeguarding framework across Hywel Dda UHB, setting out responsibilities, governance arrangements and processes for preventing, identifying and responding to abuse, neglect and harm affecting children, young people and adults at risk.

Evidence considered (including staff and population data, relevant research, expert and community knowledge etc.)

Corporate Safeguarding Policy
Relevant legislation (SSWB Act 2014, VAWDASV Act 2015, etc.)
Wales Safeguarding Procedures
Professional expertise from Corporate Safeguarding Team

Assess which protected characteristics will potentially be affected by the proposal in the table below (please ✓ the relevant box to confirm positive, negative or no impact)**.**

If at any point a negative impact has been identified (actual or potential), you do not need to proceed with the completion of this form, as a full EqIA must be undertaken: Equality Impact Assessments (EqIAs) (sharepoint.com)

Age Is it likely to affect older and younger people in different ways or affect one age group and not another?					
Positive Impact	X	Negative Impact		No Impact	
Justification of impact identified: Policy explicitly targets safeguarding of children and older adults at risk and strengthens early identification and response mechanisms.					
Disability Is it likely to affect those with a physical disability, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes?					
Positive Impact	X	Negative Impact		No Impact	
Justification of impact identified: Enhances safeguarding for individuals with physical, learning and mental health vulnerabilities who may be at increased risk of abuse or neglect.					
Gender Reassignment Is it likely to affect those who either: • Have undergone, intend to undergo or are currently undergoing gender reassignment. • Do not intend to undergo medical treatment but wish to live in a different gender from their gender at birth					
Positive Impact		Negative Impact		No Impact	X
Justification of impact identified: Policy applies equally to all individuals and does not disadvantage people undergoing or who have undergone gender reassignment.					
Marriage / Civil Partnership Under the Equality Act, the characteristic of Marriage and Civil Partnerships is only protected in the workplace/ employment. Is it likely to affect those who are married or in a Civil Partnership? This means someone who is legally married or in a civil partnership.					
Positive Impact		Negative Impact		No Impact	
Justification of impact identified: Characteristic only applies to employment; no differential impact identified.					
Pregnancy and Maternity Is it likely to affect those who are pregnant or have recently had a baby? Maternity covers the period of 26 weeks after having a baby, whether or not they are on Maternity Leave.					
Positive Impact	X	Negative Impact		No Impact	X
Justification of impact identified: Supports safeguarding responses for pregnant individuals, particularly within VAWDASV and domestic abuse contexts.					
Race / Ethnicity Is it likely to affect people of a different race, nationality, colour, culture or ethnic origin including non-English / Welsh speakers, Gypsies/Travellers, asylum seekers and migrant workers?					
Positive Impact	X	Negative Impact		No Impact	

Justification of impact identified:
Policy includes safeguarding of individuals exposed to modern slavery, trafficking, and exploitation, supporting diverse populations

Religion or Belief
Is it likely to affect people who have a religion or belief? The term 'religion' includes a religious or philosophical belief.

Positive Impact		Negative Impact		No Impact	X

Justification of impact identified:
Policy is applied equitably regardless of religion or belief, while maintaining dignity and respect.

Sex
Is it likely to affect people who are mostly male or female. Where it applies to both equally does it affect one differently to the other?

Positive Impact		Negative Impact		No Impact	X

Justification of impact identified:
Strengthens organisational response to domestic abuse and gender-based violence, which disproportionately affects women and girls.

Sexual Orientation
Whether a person's sexual attraction is towards their own sex, the opposite sex or either.

Positive Impact	X	Negative Impact		No Impact	X

Justification of impact identified:
Policy applies equally to all individuals regardless of sexual orientation.

Armed Forces Community
Consider whether this impacts on members of the Armed Forces and their families, whose health needs may be impacted long after they have left the Armed Forces and returned to civilian life. Also consider their unique experiences when accessing and using day-to-day public and private services compared to the general population. It could be through 'unfamiliarity with civilian life, or frequent moves around the country and the subsequent difficulties in maintaining support networks, for example, members of the Armed Forces can find accessing such goods and services challenging.'

For a comprehensive guide to the Armed Forces Covenant Duty and supporting resource please see:
Armed-Forces-Covenant-duty-statutory-guidance

Positive Impact		Negative Impact		No Impact	X

Justification of impact identified:
No differential impact identified; policy applies equally to all service users and staff.

Socio Economic Duty
Consider those on low income, economically inactive, unemployed or unable to work due to ill-health. Also consider people living in areas known to exhibit poor economic and/or health indicators and individuals who are unable to access services and facilities. Food / fuel poverty and personal or household debt should also be considered.

For a comprehensive guide to the Socio-Economic Duty in Wales and supporting resources please see:
more-equal-wales-socio-economic-duty

Positive Impact	X	Negative Impact		No Impact	

Justification of impact identified:
Strengthens identification of vulnerability linked to deprivation, neglect, and exploitation.

Welsh Language Is it likely to impact on opportunities for people to use the Welsh language? The Welsh language should be treated no less favourably than the English language.					
Positive Impact	X	Negative Impact		No Impact	
Justification of impact identified: Supports equitable safeguarding access; opportunity to ensure bilingual provision in safeguarding processes.					

If a negative impact has been identified, you are not required to complete this form as a full EqIA must be undertaken. A full EqIA template and guidance can be found on the following link: Equality Impact Assessments (EqIAs) (sharepoint.com)

Screening Completed by:	Name	Charlotte Westacott
	Title	Head of Safeguarding
	Contact details	Charlotte.Westacott@wales.nhs.uk
	Date	22 May 2026
Screening Authorised by: (Directorate level owner of the procedures/ proposals/ projects/ policy)	Name	Charlotte Westacott
	Title	Head of Safeguarding
	Contact details	Charlotte.Westacott@wales.nhs.uk
	Date	22 May 2026
Guidance has been provided by Diversity & Inclusion Team:	Name	
	Title	
	Contact details	
	Date	
Diversity and Inclusion Team additional Comments:		

Please note: The D&I team will save a copy of the completed form for reference. If any changes are made after the date of review, it is the directorate's responsibility to update the EqIA and inform the D&I team.

7.3

7.3 - 982 Incident, Near Miss and Hazard Reporting and Management Procedure

Cathie Steele (Hywel Dda UHB - Interim Assistant Director of Nursing Assurance and Safeguarding), Caroline Burgin (Hywel Dda UHB - Patient Safety and Assurance Manager)

Attachments

QSEC 982 Incident, Near Miss and Hazard Reporting and Management Procedure.pdf

982 - Incident reporting procedure v4 for qsec.pdf

982 - Equality Impact Assessment 20 07 2026.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ANSAWDD, DIOGELWCH A PHROFIAD/ QUALITY SAFETY AND EXPERIENCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	**11 AUGUST 2026**
TEITL YR ADRODDIAD: TITLE OF REPORT:	Incident, Near Miss and Hazard Reporting and Management Procedure– review
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Sharon Daniel, Executive Director of Nursing, Quality and Patient Experience
SWYDDOG ADRODD: REPORTING OFFICER:	Caroline Burgin, Patient Safety and Assurance Manager

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/ For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Incident, Near Miss and Hazard Reporting and Management Procedure has been reviewed as a result of the implementation of Listening to People (from Putting Things Right) on 1st April 2026. This review has been undertaken in advance of the anticipated review date. This is an update to the existing policy within the Health Board (982) and this policy has been amended to bring it up to date and align it to current process and include details relating to Electronic Prescribing and Medicines Administration (EPMA).

Cefndir / Background

The Policy sets out how the Health Board will fully discharge its accountabilities and obligations and notifications to all staff groups in respect of incident, near miss and hazard reporting and management in the Health Board. This policy has been reviewed as an update to the existing policy within the Health Board (982) and this and has been amended to bring it up to date with current guidance and include details relating to EPMA.

Asesiad / Assessment

Those most vulnerable are likely to have at least one and probably multiple protected characteristics and this is likely to have particular relevance for the very young, old and people with disabilities. This protocol will assist in protecting the safety and welfare of patients and so has a positive impact on the Human Rights of Patients.

A trawl of similar written control documents in NHS Wales and Trusts in NHS England did not identify any potential negative impacts against any protected characteristic. No complaints have been received in relation to equality, diversity or human rights in relation to predecessor policies within the Health Board.

The policy has been derived from a number of “best practice” examples and advice received from the Delivery Unit of the Welsh Government. The policy is informed by NHS Wales Complaints and Concerns Listening to People and the NHS Wales incident reporting procedure. This is an existing Health Board policy (982) and amendments have been made to bring it up to date and align it to current process. There is no negative impact identified relating to any of the protected characteristics.
Argymhelliad / Recommendation The Quality, Safety and Experience Committee is asked to approve the Incident, Near Miss and Hazard Reporting and Management Procedure.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	3.22 Approve policies and plans within the scope of the Committee, having taken an assurance that the quality and safety of patient care has been considered within these policies and plans.
Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	1. Safe 2. Timely 3. Effective Choose an item. Choose an item. Choose an item.
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	3. Great care
Nodau Cynllunio 2026/27 Planning Goals 2026/27	Not Applicable

Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	10. Not Applicable
Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau) A Social Model for Health and Wellbeing: (*complete for strategic change and/or significant service changes)*	Not Applicable
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	Contained in the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	Executive Director of Nursing, Quality and Patient Experience

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No impact
Ansawdd / Gofal Claf: Quality / Patient Care:	Not Applicable
Gweithlu: Workforce:	None / EQIA completed
Tegwch Iechyd: Health Equity:	Yes
Risg: Risk:	None
Cyfreithiol: Legal:	None
Enw Da: Reputational:	None

Gyfrinachedd: **Privacy:**	None
Cydraddoldeb: **Equality:**	EQIA assessment completed

Incident, Near Miss and Hazard Reporting and Management Procedure

Procedure information

Policy number: 982
Classification: Corporate
Supersedes: all previous versions
Version number: 3
Date of Equality Impact Assessment: IN DRAFT

Approval information

Approved by: Quality Safety Experience Committee QSEC
Date of approval
Date made active:
Review date: 31/10/2027

Summary of document:
This procedure details the process for reporting incidents, near misses and hazards that arise in the course of Hywel Dda University Health Board (the Health Board) conducting its business. It should be read in conjunction with the '894 –'Integrated Concerns Policy (Incidents, Complaints and Claims) – (opens in a new tab) and, the 010 Health and Safety Policy (opens in a new tab)and 836 - All Wales Information Governance Policy' (opens in a new tab). (This procedure covers all incidents (both clinical and non-clinical) and near misses involving staff, service users, visitors, contractors or any others to whom the Health Board owes a duty of care.

Scope:
The procedure applies to all employed Health Board staff and contractual staff, including primary care contractors, agency or bank staff and Locum staff who have a duty under the Regulations to report and investigate all incidents. Commissioned independent investigations or inspectorate driven investigations do not fall within the scope of this procedure.

These procedures do not take precedence where there is an identified Child or Adult at risk, who is experiencing or is at risk of abuse or neglect. In such instances these cases must be reported to the relevant Local Authority Safeguarding Team or Police in line with: the Social Services and Well-Being (Wales) Act 2014, and the Wales Safeguarding Procedures. The reporting and escalation of safeguarding concerns should run in parallel to this policy, however, incidents must not be investigated via this process unless authorised by Police or the Local Authority Safeguarding Team. Advice in relation to safeguarding incidents can be sought from the Health Board Corporate Safeguarding team. The procedure does not replace the duty and professional accountability of staff to report any adverse incident involving a medical device, hazardous product or unsafe procedure, in line with Health Board policies and other written control documents

To be read in conjunction with:
156 - Risk Management Strategy – opens in a new tab
674 - Risk Management Procedure – opens in a new tab
010 - Health & Safety Policy – opens in a new tab
894 – Concerns Policy Policy (Incidents, Complaints and Claims) – opens in a new tab
467 – Medical Devices Management Policy – opens in a new tab
435 - All Wales NHS staff to Raise Concerns Procedure – opens in a new tab

Owning group: Task and finish group
Executive Director job title: Director of Nursing, Quality and Patient Experience

Reviews and updates:
1 – 2.11.2021 (supersedes policies)
2 – 8.10.2024
3 – updated new regulations coming in on 1st April 2026

Keywords
Alert, notice, safety notice, patient safety solution

Glossary of terms
The Health Board – Hywel Dda University Health Board
PSIs – Patient Safety Incidents
NPSA – National Patient Safety Agency
DI – Designated individual
PD – person designated
SHOT – Serious hazards of transfusion
SABRE - Serious Adverse Blood Reactions and Events
HTA – Human Tissue Agency
MHRA – Medicines and Healthcare Products Regulatory Agency
MDSO - Medical Devices Safety Officer

Contents

Introduction 5
Scope 5
Aim 5
Objectives 5
Purpose of Incident Reporting 5
Benefits of Incident Reporting 6
Just Culture 6
Definitions 7
Patient Safety Incident or Clinical Incident 7
Incident (non-clinical) 7
Serious Incident 8
Adverse Event 8
Near Miss 8
Never Events 8
Surgical Never Events 8
Medication Never Events 8
Mental Health Never Events 8
General Never Events 8
'Trigger Lists' 9
Incident Reporting Actions and Duties & Responsibilities 9
All Staff 9
Person responsible for the immediate management of the incident 10
Managers 10
Directors / General Managers 11
Quality Assurance and Safety Team and Health and Safety Team 11
Incident Reporting 12
Incident Classification 13
Grading of Harm 13
Table showing levels (grades) of incidents on reporting 14
Being Open/Duty of Candour 15

Being Open 15
Duty of Candour 16
When does the duty of candour apply? 16
Incident Investigation 16
Initial Management Review 16
Issues identified during management review requiring further investigation 17
Severe or Catastrophic Incidents, Nationally Reportable incidents including Never Events 17
Focussed Reviews 18
Documenting the findings of the investigation 18
Closure of incident records 18
Feedback to the incident reporter 18
References 19
Appendix 1: Generic 'Trigger' List 20
Appendix 2: External Stakeholders Requiring Notification of Incidents 22

Introduction

This procedure details the process for reporting incidents, near misses and hazards that arise in the course of Hywel Dda University Health Board (the Health Board) conducting its business. It should be read in conjunction with the '894 –'Integrated Concerns Policy (Incidents, Complaints and Claims) – (opens in a new tab) and, the 010 Health and Safety Policy. (opens in a new tab). This procedure covers all incidents (both clinical and non-clinical) and near misses involving staff, service users, visitors, contractors or any others to whom the Health Board owes a duty of care.

It is the responsibility of all employees of the Health Board and, anyone attending Health Board premises for work, to provide a service, to follow this procedure and report any incidents, near misses or hazards, in which they were either directly involved or have witnessed. The Health Board seeks to encourage service users and other stakeholders to report incidents, near misses and hazards to enable the Health Board to obtain a more complete picture of the risks that face the organisation and to improve services.

Scope

The procedure applies to all employed Health Board staff and contractual staff, including primary care contractors, agency / locum or bank staff who have a duty under the Regulations to report and investigate all incidents. Commissioned independent investigations or inspectorate driven investigations do not fall within the scope of this procedure.

These procedures do not take precedence where there is an identified Child or Adult at risk, who is experiencing or is at risk of abuse or neglect. In such instances these cases must be reported to the relevant Local Authority Safeguarding Team or Police in line with: the Social Services and Well-Being (Wales) Act 2014, and the Wales Safeguarding Procedures. The reporting and escalation of safeguarding concerns should run in parallel to this policy, however, incidents must not be investigated via this process unless authorised by Police or the Local Authority Safeguarding Team. Advice in relation to safeguarding incidents can be sought from the Health Board Corporate Safeguarding team.

Aim

Hywel Dda University Health Board's aim is to ensure that all staff are able to identify incidents, take appropriate actions and reduce risks to service users and employees. Integral to this is the development of an organisational culture, which allows incidents to be reported in an open and fair environment.

Objectives

The overall objectives of the procedure are to:

- Ensure that all staff understand and recognise when an incident has occurred, are able to report it in a timely manner and provide advise if requested
- Ensure all staff understand their accountabilities and responsibilities for reporting incidents

Purpose of Incident Reporting

Incident Reporting Systems are considered to be a major tool in the way organisations manage risks.

Their purpose is to:

- Ensure that all incidents/accidents (actual and near miss) are reported, recorded and managed
- Prevent the recurrence of preventable adverse clinical and non-clinical events
- Provide 'early warning' of complaints/claims/adverse publicity
- Ensure that sufficient information is obtained:
    - to meet internal and external (e.g. NHS Performance and Improvement, HSE) reporting requirements
    - to respond to complaints and litigation should these ensue
    - for trend analysis which, in turn, is intended to facilitate the identification and 'learning of lessons' from incidents/mistakes made

Benefits of Incident Reporting

If used effectively, the Incident Reporting System will:

- Enhance the Health Board's ability to continually develop good practice and improve the quality of care
- Enable the Health Board to learn lessons from mistakes made/take prompt action to prevent or minimise recurrence
- Protect individuals: patients, staff, contractors, volunteers and visitors through the provision of a safe environment
- Enhance the Health Board's reputation
- Assist in utilising the Health Board's resources more effectively (i.e. reduces the amount of money being spent on litigation)
- Assist in identifying training, education and resource needs
- Provide 'early warning' of actual and potential claims, complaints and/or adverse publicity and means that the Health Board is 'prepared' for such occurrences
- Strengthen the Health Board's position in the event of litigation (i.e. 'early warning' of incidents likely to lead to litigation enables the Health Board to obtain the necessary information at the time of the incident when memories are fresh, before staff have left the Health Board etc)
- Enable the Health Board to meet the legislative requirements such as Listening to People Regulations 2025 and Health and Safety at Work etc. Act 1974
- Where actual incidents of loss/harm have occurred, enable early notification/explanation to the 'injured' party to occur and, where necessary, swift compensation to the justified claimant

Just Culture

In an organisation as large and complex as the NHS, things will sometimes go wrong. When they do the response should not be one of blame and retribution, but of learning, a drive to reduce risk for future patients and staff. Blame cannot, and should not, be attributed to individual health care professionals. Identifying and addressing dysfunctional systems is, therefore, the key to reducing the risk of harm for many patients and staff.

It is understood that fear of disciplinary action and subsequent sanctions may deter staff from reporting incidents. Therefore, the Health Board's Incident Reporting System continues to be developed within a just culture (opens in a new tab). The Health Board's approach following incidents will focus on 'what went wrong, not who went wrong'. Where errors have occurred and are openly reported, an

investigation into the facts may take place but the disciplinary process will not be instigated in respect of any member of staff, except in well-defined circumstances, as follows:

- an incident in which the Health Board considers that a fundamental breach of professional practice or gross negligence has occurred, and/or an incident which might lead any professional registration body to review the individual's professional status
- further occurrences of actions involving an individual who has previously received supervision, or been subject to disciplinary action related to the type of error that might have led to the incident where it appears that staff may have been guilty of a criminal offence or some act or omission which may result in formal action by a regulatory or professional body
- failure or significant delay in reporting an incident in which a member of staff was directly involved or about which they were aware

It should be noted that when any error is being considered, whether within the Incident Reporting Procedure structure or not, it is universally recognised that when a member of staff is open in admitting to the error and reporting it to the appropriate individual, a considerably more positive and supportive approach may be taken by the Health Board in addressing the matter. Conversely, it is also the case that when a member of staff decides to either delay reporting, or to attempt to conceal the occurrence of an error, the Health Board's response to it is likely to be less favourable and will indeed specifically address this delay or failure to report as a further element of the issue.

Guidance on raising concerns confidentially is also available by referring to the 435 - All Wales NHS staff to Raise Concerns Procedure (opens in a new tab). The Health Board also has Speak Up Safely Champions and Ambassadors and a Working in Confidence Platform. Staff can raise concerns verbally, by letter, email or by completing an incident form. More details about how to raise concerns can be found on the Health Board's SharePoint:

- Working in Confidence (opens in a new tab).
- Speak Up Safely (opens in a new tab).

Definitions

Patient Safety Incident or Clinical Incident

'An event or circumstance arising during clinical care of a patient that could have (i.e. 'near miss') or did lead to unintended or unexpected harm'.

Harm is defined as 'injury (physical or psychological), disease, suffering, disability or death'. In most instances, harm can be considered to be unexpected if it is not related to the natural cause of the patient's illness or underlying condition.

Incidents involving patients are also known as 'Patient Safety Incidents' (PSIs). The former National Patient Safety Agency (NPSA) defines a PSI as 'any unintended or unexpected incident which could have or did lead to harm for one or more patient receiving NHS funded healthcare'.

Incident (non-clinical)

'An event or circumstance that could have (i.e. 'near miss') or did cause unexpected or unwanted harm, loss or damage to any individual(s) involved (including patients but not related to clinical care, staff, visitors etc) or damage to/loss of property/premises for which the Health Board is responsible.'

Serious Incident

'An incident or series of incidents which are likely to produce significant legal, media or other interest or give rise to large scale public concern and which, if not properly managed, may result in significant loss of the Health Board's reputation and/or assets'.

Serious incidents include those where there is harm to the person affected is severe or catastrophic. Never events (see 'never events section') are also classed as serious incidents.

In the event of a serious incident occurring, the requirement is for immediate reporting to the ward manager and senior nurse / consultant (preferably face to face or telephone). Both individuals can be emailed regarding escalation of a serious incident as long as the email is also sent to the Health Board's Quality Assurance and Safety email address: patient.safety@wales.nhs.uk (opens in a new tab). Out of hours the Site Manager should be contacted. The Site Manager, in turn, will contact the on-call Director/Senior Manager.

Adverse Event

Any event that has given or may give rise to actual or possible personal injury, patient dissatisfaction, or to property loss or damage.

Near Miss

Any event or omission that could have potentially caused harm, but due to prompt action by a member of staff, or simply because of good fortune was prevented.

Never Events

"Never events" are very serious, largely preventable patient safety incidents that should not occur if the relevant preventative measures are out in place. These incidents will be reported onto the Datix Cymru system and the NHS Performance and Improvement notified.

The current Never Event list is as follows:

Surgical Never Events

- Wrong site surgery
- Wrong implant/prosthesis
- Retained foreign object post procedure

Medication Never Events

- Mis-selection of a strong potassium solution
- Administration of medication by the wrong route
- Overdose of insulin due to abbreviations or incorrect device
- Overdose of methotrexate for non-cancer treatment
- Mis-selection of high strength midazolam during conscious sedation

Mental Health Never Events

- Failure to install functional collapsible shower or curtain rails

General Never Events

- Falls from poorly restricted windows

- Chest or neck entrapment in bed rails
- Transfusion or transplantation of ABO-incompatible blood components or organs
- Misplaced naso- or oro-gastric tubes
- Scalding of patients
- Unintentional connection of a patient requiring oxygen to an air flowmeter

'Trigger Lists'

In respect of clinically related events, particularly in specialities, where there is perceived higher-risk e.g. where a particular incident or event is a 'known litigation risk', 'trigger lists' of incidents which should always be reported should be developed.

In addition, events will often occur which are unexpected. These events are usually not related to negligence but may be viewed as such by the patient or their relatives. To the doctor or healthcare professional the unexpected event may be a recognised complication of a particular procedure or treatment. Given the potential for dissatisfaction, such events should also be added to specialty specific 'trigger lists'.

It should be emphasised, however, that such lists will not be exhaustive. An element of judgement is, therefore, required as to whether an incident should be reported but where doubt exists the safest option will be to report the incident. For areas wishing to develop their own 'trigger lists' a generic/core list of (clinical) codes is attached for reference at Appendix 1. This can be adapted as appropriate. Advice can also be sought from the Quality Assurance and Safety Team.

Trigger lists are already in place within specific areas and are incorporated into the Health Board's wider list of Incident Codes.

It should also be noted that specialty 'trigger lists' of non-clinical incidents, taking account of the relevant definitions above, could also be developed.

Incident Reporting Actions and Duties & Responsibilities

All Staff

It is a requirement of all Health Board staff that they report any incident, accident or potential (i.e. 'near miss') incident which has caused or has the potential to cause harm, loss or damage to any individual,* or, any property or premises, for which the Health Board is responsible. This includes any incident that has the potential to involve the Health Board in either litigation or adverse publicity.

**This applies whether the 'affected' person is a patient, member of staff, contractor, volunteer or visitor to the Health Board.*

Any member of staff who is involved in, witnesses or discovers an adverse incident/accident or near miss incident/accident can complete an Incident Report Form through Datix. The report should not wait until the affected person has returned to work and can be completed by a third person on the affected persons behalf if required.

As outlined in serious incident section, in the event of a serious incident occurring, the requirement is for immediate reporting to the Service Management Team e.g. consultant or senior nurse (preferably face to face or telephone).

Out of hours, the Site Manager should be contacted. The Site Manager, in turn, will contact the on-call Director/Senior Manager.

For serious patient safety incidents, the Health Board's Quality Assurance and Safety Team must also be notified by either telephoning 01267674010 (during office hours) or by emailing patient.safety@wales.nhs.uk (opens in a new tab).

For serious staff related incidents the Health Board's Health and Safety Team must also be notified.

Person responsible for the immediate management of the incident

The person responsible for the immediate management of the incident (e.g. the nurse in charge of the ward at the time an incident occurs) should:

- Undertake an immediate assessment of the situation;
- Determine any immediate treatment and/or ongoing care needs of the affected person; and/or
- Determine the extent of any loss/damage to property; and any other immediate action required (e.g. removal and isolation of faulty equipment).

The situation/scene should be made safe. Where possible the scene should be protected (e.g. cordoned off) and/or recorded (e.g. photograph). Medical devices and other equipment, if a factor in the incident, should be taken out of use and stored securely.

Managers

Following every incident, whether a near miss or an incident resulting in injury, managers must take and record (on the incident report form) any required immediate and/or preventative actions.

Depending on the circumstances and severity of the incident, the action taken by managers following an incident may include:

- Ensuring patient/relatives have been informed of the incident, the investigation and action taken and apologies are offered, in Welsh Language if required, as necessary/appropriate –also refer to the Health Board's 894 'Integrated Concerns Policy (Incidents, Complaints and Claims) – opens in a new tab.
- Ensuring appropriate follow-up treatment/care of the affected person.
  (Where this is a member of staff ensuring that he/she receives first aid and/or are advised to attend A&E or their GP);
  If an error occurs noted in the Electronic Prescribing Medication Administration (EPMA) system, this should also be reported as an incident utilising the Health Board incident reporting system.
- Ensuring that faulty equipment has been taken out of use and isolated pending investigation by a competent person for example, Estates or Clinical Engineering, and/or the MHRA prior to re-use;

- Ensuring appropriate escalation of the incident (certain incidents are reportable externally and/or have a requirement under *Listening to People regulations* for an appropriate level of investigation. Therefore, there is a Health Board requirement to escalate certain serious incidents to corporate teams e.g. serious patient safety incidents must be escalated to the Patient Safety Team and RIDDOR reportable incidents escalated to the Health and Safety Team. For the full list of external reporting please see appendix 2
- Ensuring an appropriate investigation is undertaken;
  (*N.B. The level of investigation and resulting management action/preventative measures should be related to the severity grading of the incident*). Also refer to the Health Board's Concerns Investigation and Management Guidance (opens in a new tab).
- Ensuring feedback to staff raising the issue and reporting the incident. – opens in a new tab
  This includes staff who may have raised concerns through the Speak Up (opens in a new tab) - process;
- Debriefing/counselling and support of staff, as necessary appropriate;
- Implementing appropriate preventative actions; and
- Monitoring and review of those actions to ensure they remain effective.

Directors / General Managers

Directors / General Managers will be responsible for ensuring:

- That appropriate arrangements are in place within their Directorates / Services / Specialities / Departments for the reporting, investigation and follow-up of incidents in accordance with both this procedure and the Health Board's 'Procedure for Dealing with Serious Incidents' and in accordance with their responsibilities for governance and risk management; and
- The review of data on incidents in order to identify and monitor trends/problems, and for taking appropriate action
- Accountable for completion of incident or concern investigations within the timescale agreed and implementing learning that arises

Quality Assurance and Safety Team and Health and Safety Team

The Patient Safety Team and the Health and Safety Team will be responsible for:

- The overall management and co-ordination of the Health Board's incident reporting arrangements including the central coding of incident data;
- The reporting of incidents, as necessary, to the relevant external agencies (see appendix 2);
- The compilation of analysis reports (e.g. for Quality, Safety and Experience Committee, Health and Safety Committee, Directorate Quality and Governance Groups) and provision of data for safety dashboards; and
- Monitoring, as appropriate, that follow-up of incidents/changes in practice occur as necessary/appropriate. Ultimately, changes in practice and learning lessons are the responsibility of the area in which the incident occurred.

Incident Reporting

- The Health Board currently uses the Datix Cymru system for incident reporting. The Datix Incident Report Form captures the detail of the incident, and the parts of the organisation and the people involved. It acts as a record of the incident and a prompt to support action planning and reporting.

- Any member of staff who is involved in, witnesses or discovers an adverse incident/accident or near miss incident/accident must complete the Datix Cymru Incident Report Form, which is available on the Health Boards intranet. If the incident involves a member of the public or someone who is external to the Health Board i.e. an Independent Contractor then the employee who witnessed the incident, or to whom the incident is reported, should complete the Incident Report Form.

- As indicated in section 'serious incident', Serious Incidents should be reported immediately to the department manager and senior nurse / consultant (in addition to being escalated within the Directorate Management Team). Out of hours the Site Manager should be contacted. The Site Manager, in turn, will contact the on-call Director/Senior Manager.

- It is understood that remedial action is often likely to take priority over the completion of the Incident Report Form. However, the incident should be reported as soon as possible, ideally within 24 hours but no later than 2 days after the incident. It is also just as important to report incidents where the outcome is identified at a later stage.

- The reporting timescales enable timely escalation, and investigation, of such incidents internally. This also mean that the relevant external reporting requirements can also be met. Details of the external stakeholders who require notification of certain incidents/accidents which occur within the Health Board is attached at Appendix 2.

- When completing the Incident Report Form, it is important to include as much information as possible and that a clear, sequential analysis of what failed is documented. However, person identifiable data must be excluded from the detail of the incident. There are appropriate fields, such as the contacts section, where this can be recorded.

- Once the Incident Report Form has been completed, it is submitted into Hywel Dda Health Board's Datix Cymru Concerns Management system. This enables the collation and analysis of information on incidents.

- If the incident is a result of faulty equipment the Manager must ensure that, it is taken out of use as soon as practically possible (see section: Person responsible for the immediate management of the incident).

- Incident Report Forms must be reviewed on Datix Cymru by the relevant nominated manager ideally within 24 hours but no later than 3 working days after the incident and the Management Review Form must be completed.

N.B. The outcome of most incidents is immediately identifiable. However, it is just as important to report incidents where the outcome is identified at a later stage. For example, a back sprain resulting from manual handling may not become apparent for a few days.

Incident Classification

- Once added to DATIX, all incidents are given a classification 'code'. This enables the same types of incidents to be grouped together, which in turn aides the analysis process in order to identify trends/problems. The coding of incidents in this way also enables the easy identification/selection of the incidents, which must be reported externally.
- Within the Health Board, the classification of incidents is undertaken by the reporter.
- The coding is reviewed at a number of investigation stages. It is first reviewed by the nominated manager when they undertake the initial review (within 3 working days).
- On conclusion of the investigation the code is reviewed by the manager responsible for approving closure of the incident record.
- Validation of the coding is undertaken by the Quality Assurance and Safety Team or Health and Safety Team (dependent on the type of incident).

Grading of Harm

- In accordance with national guidance and good risk management practice, all incidents reported within the Health Board will be graded using the principles adopted for the proactive risk assessment. Grading is undertaken according to the:
    - Actual impact on the affected person(s), whether patient, member of staff or visitor to the Health Board;
    - Actual consequences for the organisation.

- The grading of harm will also reflect whether there are any acts or inaction that led to the harm of the person affected by the incident. When reporting an incident, this may not be known and therefore the level of harm may change as the investigation progresses and concludes.
- The Datix Cymru Incident Reporting System allows for the level of harm to be captured at various stages:
- On reporting - harm to the person affected at time of reporting the incident as perceived by the reporter of the incident (see table below showing levels of grading) This will allow the nominated manager to prioritise incidents for review when a significant number have been reported.
- Initial management review - assessment of harm by the nominated manager. This will assist in establishing the level of:
    - Risk associated with a particular incident;
    - Whether duty of candour has been triggered; and
    - Investigation required.
    - Conclusion of the investigation. This grading will consider whether there were any acts or inactions (in healthcare) that lead to the outcome for the person affected.

Table showing levels (grades) of incidents on reporting

Level of Harm	Examples of concerns
Level 1 **No harm**	a) Concerns which normally involve issues that can be easily / speedily addressed; b) Potential to cause harm but impact resulted in no harm having arisen; c) Outpatient appointment delayed, but no consequences in terms of health;, d) Difficulty in car parking; e) Patient fall – no harm or time of work; f) Concerns which have impacted on a positive patient experience.
Level 2 **Minor Harm**	a) Concerns regarding care and treatment which span a number of different aspects/specialties b) Increase in length of stay by 1 – 3 days c) Patient fall – requiring minor treatment d) Requiring time off work – 3 days e) Concern involves a single failure to meet internal standards but with minor implications for patient safety f) Return for minor treatment, e.g. requiring local anaesthetic further treatment/monitoring by GP g) Samples taken from the wrong patient – not acted upon but require repeat venepuncture. h) Pathology labelling error detected post analytically before further intervention
Level 3 **Moderate harm**	a) Clinical / process issues that have resulted in avoidable, semi-permanent injury or impairment of health or damage that requires intervention b) Additional interventions required or treatment / appointments needed to be cancelled c) Readmission or return to surgery, e.g. requiring general anaesthetic d) Necessity for transfer to another centre for treatment / care (e.g. for an incident in a GP Practice, admission to hospital) e) Increase in length of stay by 4 – 15 days f) RIDDOR reportable incident (moderate harm) g) Requiring time off work 4 – 14 days h) Concerns that outline more than one failure to meet internal standards i) Moderate patient safety implication

Level of Harm	Examples of concerns
	j) Concerns that involve more than one organisation (e.g. cross border incidents that may involve English providers or other Health Boards, incidents involving interface with Local Authority, or Ambulance Trusts)
Level 4 Major Harm	a) Clinical process issues that have resulted in avoidable, semi-permanent harm or impairment of health or damage leading to incapacity or disability b) Additional interventions required or treatment needed to be cancelled c) Unexpected readmission or unplanned return to surgery d) Increase in length of stay by >15 days e) Necessity for transfer to another centre for treatment / care f) Requiring time off work >14 days g) A concern outlining non-compliance with national standards with significant risk to patient safety h) RIDDOR reportable incident (significant harm)
Level 5 Catastrophic Harm	a) Concern leading to unexpected death, multiple harm or irreversible health effects b) Concern outlining gross failure to meet national standards c) Normally clinical/process issues that have resulted in avoidable, irrecoverable injury or impairment of health, having a lifelong adverse effect on lifestyle, quality of life, physical and mental well being d) Clinical or process issues that have resulted in avoidable loss of life e) RIDDOR reportable incident (catastrophic harm) f) Significant / consistent reporting errors i.e. malignant as benign.

Further examples are provided in the Duty of Candour (opens in a new tab) guidance.

Being Open/Duty of Candour

Being Open

A culture of openness, transparency and candour is widely associated with good quality care.

When an incident has occurred it is essential that all staff ensure that the patient's/relatives/carers are offered an apology and that they are informed of the next steps e.g. an incident investigation.

Any Being Open discussions must be documented in the patient's health records and in the "openness and transparency" section of the incident report form.

Whilst Being Open primarily applies to patients and service users, it is also good practice for staff related incidents.

Duty of Candour

When undertaking the initial management review of a patient safety incident, the nominated manager must consider whether Duty of Candour (opens in a new tab - has triggered.

The Duty of Candour (opens in a new tab)- requires NHS providers to follow a process when a service user suffers an adverse outcome which has or could result in unexpected or unintended harm that is more than minimal, **and** the provision of health care was or may have been a factor**.** There is no element of fault, enabling a focus on learning and improvement, not blame.

When does the duty of candour apply?

The duty is triggered in relation to an NHS body if it appears to the body that both of the following conditions are met:

1. The first condition is that a person (the "service user") to whom health care is being or has been provided by the body has suffered an adverse outcome.
2. The second condition is that the provision of the health care was or may have been a factor in the service user suffering that outcome.

A service user is to be treated as having suffered an adverse outcome if the user experiences, or if the circumstances are such that the user could experience, any unexpected or unintended harm that is moderate or above.

The duty may be triggered by an action taken by a NHS body during the provision of health care or by a failure to take action.

The duty is not triggered where harm is related to the natural course of the service user's illness or underlying condition.

Further guidance is available on the Health Board's SharePoint (opens in a new tab). or within the 894 'Integrated Concerns Policy (Incidents, Complaints and Claims) (opens in a new tab).

Incident Investigation

Initial Management Review

Within 48-72 hours of an incident being reported, the manager of the area must review the incident report form.

When reviewing the initial report, the manager should consider whether there is an immediate patient safety issue, whether the action taken at the time of the event was sufficient and whether further "make safe" actions are required.

The manager will decide whether further investigation is required (the decision regarding investigation may be taken in conjunction with other managers / teams).

The findings of the manager's initial review must be documented on Datix Cymru in the relevant investigation section.

Issues identified during management review requiring further investigation

When further investigation is required, recognised investigation methodology will be used. Timely investigation is critical.

The principles of a good investigation are:

- Plan and outline the investigation before starting;
- Engage with those affected.
- Do not simply record the steps of the event;
- Take a system-based approach (safety arises from interactions and not from a single component)
- Capture multiple perspectives to reduce bias;
- Capture the view from inside the situation;
- Do not find fault, but find facts that can lead to corrective actions; and
- Be fair and objective.

Further guidance on investigation can be found on the Health Board's SharePoint Concerns investigation and management (opens in a new tab).

Severe or Catastrophic Incidents, Nationally Reportable incidents including Never Events

For incidents where there is severe or catastrophic harm or when an incident is a Never Event or nationally reportable, within 2 working days of the recommendation that an investigation be undertaken, an initial Incident Management Group meeting must occur.

The main purpose of the Incident Management Group meeting is to:

- Review and consider the findings of the initial scrutiny;
- Identify any immediate actions required to mitigate the risk of re-occurrence;
- Consider the 'Just Culture' tool;
- Set the Terms of Reference and scope for the investigation;
- Agreed the lead Investigatory and supporting investigation team;
- Confirm whether Duty of Candour has been triggers and agree the lead for the further Duty of Candour discussions;
- Confirm support arrangements for staff involved in the incident i.e. well-being support;
- Consider external reporting requirements.
- Review concern for learning

Focussed Reviews

To assist investigation managers, a number of focussed reviews templates have been developed on an all Wales basis:

- Extravasation
- In-patient falls
- Manual handling
- Pressure damage
- Sharps

These focussed reviews must be completed by the investigating officer before conclusion of the investigation.

Documenting the findings of the investigation

The investigation report will be documented on Datix Cymru.

Investigation reports should be written in a way that is accessible and understandable to all readers (which will include the patient and/or family in most cases). The report must not contain any patient or staff names and the content should be clear and concise.

Concerns investigation reports, emails and any correspondence are disclosable documents, and may be used in a court of law (including at Coroner's Court) and as evidence during litigation.

The draft report should be shared with stakeholders (those who have been interviewed or who have provided information for the investigation). The purpose of sharing the report with stakeholders is so that they can check the report for factual accuracy. The stakeholders are not being asked to agree or disagree with the investigation conclusion but ensure that there is no information missing or incorrectly reported.

Closure of incident records

All investigation reports require formal sign-off before the incident record can be closed. If the incident is a Nationally Reported Incident (NRI) the NRI should be formally closed by NHS Performance and Improvement prior to closure of the incident record. This formal signoff process ensures the quality of the investigation.

An incident record should not be closed by the investigator of the incident.

Ensuring that there are improvement actions and learning are critical to ensuring that the likelihood of the event recurring is reduced. An improvement action plan should be developed by the service and implemented in a timely manner following completion of the investigation including disseminating and embedding those actions. For some issues identified during the incident investigation, there may be a need to use recognised quality improvement methodology.

The improvement action plan should be monitored to completion at the service or directorate quality and governance meeting (whichever is most appropriate for the event).

Feedback to the incident reporter

Feedback to the incident reporter is a critical for a positive safety culture and for staff to feel psychologically safe.

A positive safety culture is one where the environment is collaboratively crafted, created, and nurtured so that everybody (individual staff, teams, patients, service users, families, and carers) can flourish to ensure brilliant, safe care by:

1. Continuous learning and improvement of safety risks
2. Supportive, psychologically safe teamwork
3. Enabling and empowering speaking up by all

Psychological safety is a dynamic team-level phenomenon which exists when team members believe that it is safe to take interpersonal risks. In healthcare teams, the presence of psychological safety is critical to delivering safe care.

The Datix Cymru system sends an automatic email to the reporter of the incident (where the reporter has used an NHS Wales email address). The nominated manager must ensure that the specific field in the system is completed and that it includes the outcome of the investigation, the learning and the actions taken following the incident.

References

Welsh Government (2025) Listening to People: Listening to People: NHS Wales complaints, incidents and redress process | GOV.WALES

Appendix 1: Generic 'Trigger' List

This list is not exhaustive

Access, admission

- Delay in admitting to hospital
- Referral not made as planned in patient pathway

Accident, Injury

- In-patient fall
- Contact with needles or medical sharps
- Manual handling injury
- Entrapment in bed rails

Assessment, Investigation and Diagnosis

- Delay in clinical diagnosis
- Missed diagnosis
- Specimen mislabelled or lost
- Test results / reports – delay in interpreting or acting upon

Behaviour

- Self harming behaviour of an in-patient
- Patient clinically challenging behaviour
- Violence or aggression

Consent

- Procedure undertaken without consent
- Lack of documentation of the patient's decision
- Lack of capacity assessment in accordance with the requirements of the Mental Capacity Act

Medical Devices

- Failure of a medical device
- Equipment malfunction
- Unauthorised use of a medical device

Infection Prevention and Control

- Healthcare Acquired Infection
- Increased incidence or outbreak

Information Governance, Confidentiality

- Patient records/information sent to wrong recipient.
- Staff/patient records inappropriately accessed

Medication

- Administration errors noted in EPMA system
- Prescription errors noted in EPMA system
- Lost/stolen medication

Monitoring, Observations

- Failure to carry out adequate observations (NEWS)
- Delay in requesting clinical assistance (escalation)
- Delay in assessing and recognising patient deterioration

Nutrition and hydration

- Failure to complete assessments
- Nil by Mouth issues – prolonged NBM, cancelled operations etc

Patient / service user death

- Unexpected death
- Maternal death (within 12 months)
- Death of service user known to learning disabilities
- Death of service user known to mental health services

Pressure damage, Moisture damage (see additional guidance on SharePoint)

- Pressure damage developed or worsened during clinical care;
- Pressure damage on admission from nursing home;
- Pressure damage on admission where there has been a delay in handover from ambulance to hospital
- Severe continence related moisture damage

Records, Information

- Missing, incorrect, incomplete documentation by healthcare professional
- Documents misfiled in healthcare record

Treatment, Procedure

- Delay in treatment/operation
- Incorrect treatment (including operation on wrong patient/body part)
- Foreign body left in situ
- Treatment/intra-operative problems
- Allergic reaction (including diathermy burns/reaction to prep agent)
- Post-operative complications
- Transfusion problems

Appendix 2: External Stakeholders Requiring Notification of Incidents

The Health Board will ensure that, where relevant, the following external stakeholders are informed of and, where appropriate, involved in the investigation of adverse incidents/accidents which occur. Unless, otherwise stated within each relevant section, reporting to the external stakeholders listed below will be undertaken centrally by the risk management department.

Health & Safety Executive (HSE)

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)

Under RIDDOR, the Health Board has a statutory responsibility to report to the HSE certain incidents / accidents which occur during the course of work activity.

Failure to comply with this regulation can lead to the Health Board being prosecuted for a breach of regulations and further enforcement action being taken.

RIDDOR incidents are reported to the HSE by staff within the Health and Safety Team on receipt of the incident form.

Early notification of accidents/incidents means that the Health Board is able to comply regulatory requirements of RIDDOR. Details of the incident need to be reported to the HSE within strict timeframes based on the type of incident:

- **Without delay** - Deaths, major injuries, hospital treatment to non-workers and dangerous occurrences
- **Within10 days of the incident** - injuries, fatalities and dangerous occurrences full RIDDOR report
- **15 Days** – Over 7 day incapacitation

Serious Incidents

There may be other instances where the HSE may need to be notified of incidents which occur. This will depend on the circumstances and severity of the incident. The Health, Safety and Security Team will advise whether it is necessary to inform the HSE and whether the area involved needs to be isolated until a HSE Inspector has visited.

NHS Performance and Improvement

The Health Board is required to report certain incidents to the NHS Wales Performance and Improvement. Further guidance is detailed on the Nationally Reportable Patient Safety Incident SharePoint page (opens in a new tab).

Principle 1 - 'Must Reports'

Incidents related to the following are always nationally reportable

- Never Events* even where no harm has occurred;

- Suspected mental health homicides;
- Suspected suicide or self-inflicted death
  - in any clinical setting; or
  - during authorised/agreed leave, following recent planned discharge, or following unplanned leave/discharge; and
- Maternal, perinatal and infant deaths**.

Principle 2 - outcome/harm

A safety incident should be nationally reported if it is **assessed or suspected an action or inaction** in the course of a patient or service user's treatment or care, in any healthcare setting, **has**, or **could have caused or contributed** to their **severe harm or death**.

It will not always be possible to rapidly determine the extent to which a safety incident caused or contributed to the harm or death of a patient or service user within seven working days. In this case, the incident should be nationally reported, specifying that the position is unclear and/or investigations are ongoing. Incidents can be downgraded at a later date.

Acts and inactions can relate equally to human interactions, technical failures and/or delays in systems and processes.

Principle 3 - number of patients or service users involved

Special consideration must be given to incidents where the numbers of patients or service users affected is significant, even where direct harm has not been, or is difficult to, identify. This includes but is not limited to incidents involving significant:

- Screening services;
- IT failures;
- Data breaches;
- National system failures; and/or
- Service disruptions

Principle 4 - learning opportunities

Incidents should be nationally reported where they present new learning opportunities, particularly where a similar risk may be present in other NHS organisations. This may include:

- Near misses and/or no or low harm incidents where the learning would be beneficial to be shared nationally with other organisations to help raise awareness and mitigate risks for other patients or service users; and/or
- Incidents may present which are unusual, unexpected or surprising, where seriousness of the incident requires it to be nationally reported and the learning would be beneficial for others.

Principle 5 - joint decision making around reporting and investigation

Some patient safety incidents will require joint investigation with another organisation. Early consideration must be given to involving relevant stakeholders in any discussions around incidents potentially requiring joint investigation, to ensure relevant information is obtained from all sources in order to inform the discussion.

In all cases the immediate management of the incident is paramount including the safety of the patient affected and other patients. The service management team e.g. senior nurse, must be informed of the incident and an incident report form submitted via Datix Cymru.

Reporting of nationally reportable incidents to the NHS Performance and Improvement will be undertaken by the Quality Assurance and Safety Team.

Medicines

Doctors, pharmacists or nurses can report suspected adverse drug reactions by completing the suspected adverse drug reactions form. This is a yellow coloured form which can be found in the back of the current edition of the British National Formulary. The form also includes the address to forward the report to the Medicines & Healthcare Products Regulatory Agency (MHRA). More detailed information on reporting and a list of drugs/products currently under intensive surveillance (black triangle list) can be found on the MHRA website: www.mhra.gov.uk/

Defective Medicinal Products

This is defined as:

- Proves to be harmful under normal conditions of use;
- Lacking in therapeutic efficacy;
- The qualitative and quantitative compositions of the product is not as declared;
- The controls on the medicinal products and/or on the ingredients and the controls at the intermediate stage of the manufacturing process have not been carried out, or if some other requirement or obligation relating to the grant of the manufacture authorisations has not been filled.

If a healthcare professional observes:

- A clinical symptom(s); or
- A patient event, which indicates that a defective medicinal product has been used or that a defective product might be the explanation of this observation; or
- Who may recognise that a medicinal product may be defective prior to use should contact a member of the pharmacy department or pharmacist or pharmacist on-call immediately for further advice. The pharmacist should refer to a Guide to Defective Medicinal Products for guidance on how to proceed. Copies of the guidance are located in the pharmacy department.

Serious Hazards of Transfusion (SHOT)

SHOT collects anonymised reports from across the UK on adverse events related to transfusion of blood and blood components (red cells, platelets, fresh frozen plasma, cryoprecipitate, granulocytes), anti-D Immunoglobulin and cell salvage. More recently they have also started gathering evidence of exceptional transfusion practice by a team or department that was above and beyond routine practice and that has wide spread learning opportunities. All reporting to SHOT is recorded on the MHRA Serious Adverse Blood Reactions and Events (SABRE) reporting system.

If staff become aware of any incidents relating to blood transfusion they should contact the Blood Transfusion Department immediately. Incidents involving the transfusion of blood products will be highlighted at the Blood Transfusion Group. Individual investigation of all blood transfusion incidents will be undertaken by the Transfusion Practitioner and/or Blood Bank Manager and recommendations for changes in practice forwarded to the areas concerned.

Reporting of incidents to SHOT will be undertaken by the Transfusion Practitioner and/or Blood Bank Manager

Human Tissue Authority

The Human Tissue Authority (HTA) is the watchdog for tissue and organs. Their aim is to protect the public by licensing and inspecting organisations that store and use human tissue and organs for purposes including research, patient treatment, transplantation, post-mortem examinations, teaching and public exhibitions.

The HTA must be notified of all reportable incidents (HTARIs) that occur at licensed establishments in the post mortem sector. Notification of HTARIs must be submitted to the HTA within 5 working days of the incident occurring or being discovered. Establishments must not wait until any internal review or investigation is complete before notifying the HTA of a HTARI.

Notifications must be made using the HTARI form on the HTA web Portal.

https://portal/hta.gov.uk/ (opens in a new tab).

This form can only be completed by a Designated Individual (DI) or Person designated (PD) named on the license who has a web Portal account. DIs are responsible for ensuring the HTA is notified of HTARIs, and must ensure systems are in place for reporting in their absence.

Refer to the Pathology Department *Standard Operating Procedure for Reporting to the Human Tissue Authority*

The Medicines and Healthcare Products Regulatory Agency (MHRA)

The MHRA is the Executive Agency of the Department of Health responsible for protecting and promoting public health and patient safety by ensuring that medicines, healthcare products and

medical equipment meet appropriate standards of safety, quality, performance and effectiveness, and are used safely.

Medical Devices

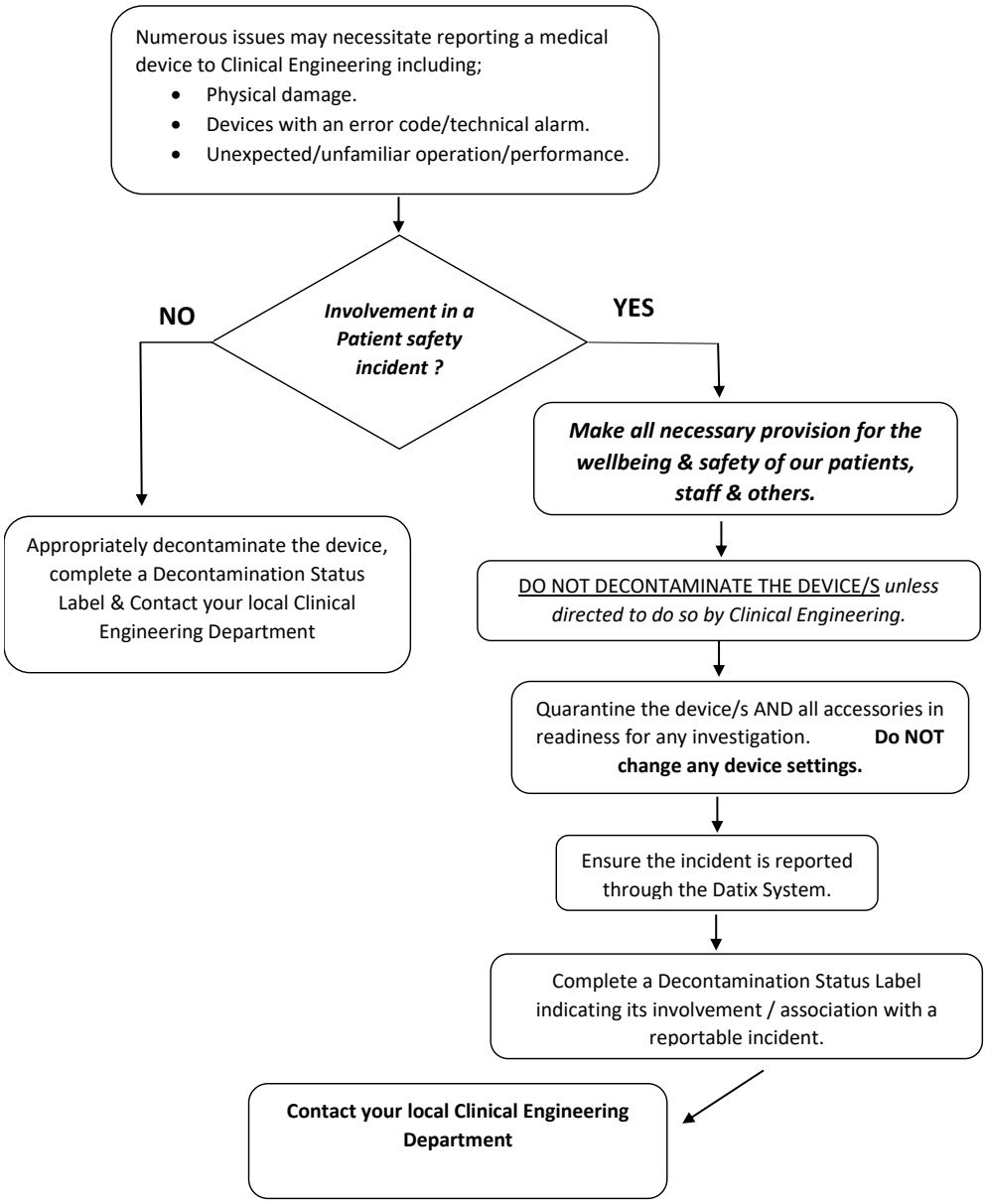
The Health Board is required to report to the MHRA, any adverse incident involving a medical device via the UHB's Medical Devices Safety Officer (MDSO), especially if the incident has led to or, were it to occur again, could lead to death or serious injury, medical or surgical intervention (including implant revision), hospitalisation or unreliable test results.

The Head of Clinical Engineering acts as the Health Board's Medical Devices Safety Officer (MDSO) and all users of medical devices are requested to follow the process detailed below:

The Information Commissioners Office (ICO)

The Information Commissioner's Office (ICO) is the United Kingdom's independent regulator for data protection and freedom of information legislation. The Health Board, via our Information Governance department, must notify the ICO within 72 hours if a breach poses a risk to individuals.

Medical Device Fault / Patient Safety Incident ?



Clinical Engineering will report to MHRA via the 'Yellow Card System' where appropriate.

Any medical device involved in an incident needs to be taken out of use, quarantined and retained for inspection. It should not be repaired, returned to the manufacturer, or discarded until Clinical Engineering and the MHRA have been given the opportunity to carry out their own investigation.

Equality Impact Assessment (EqIA) Screening Template

When to complete an EqIA Screening

An EqIA Screening Template must be completed when reviewing, changing and developing procedures/ proposals/ projects/ policies. This is a first step and is used to consider whether there are any negative impacts that may arise.

Purpose of an EqIA Screening Template

The purpose of this short exercise is to ensure that you have shown appropriate due regard when considering the impact for people with protected characteristics in your decision making. The screening process is designed to help you consider the circumstances and to inform evidence-based decisions.

If the proposal is of a significant nature and it is apparent from the outset that a full EqIA will be required, then it is not necessary to complete this Screening Template, you can proceed to complete the full EqIA.

If no negative impacts are identified following completion of the EqIA screening then it is not necessary to undertake a full EqIA however, the decision and justification must be clearly recorded in this document.

On completion of the Screening Template:

- Ensure that all the white boxes within the screening are completed.
- Ensure that the Procedure/ Project/ Proposal/ Policy owner has signed and dated the Screening Template.
- Send a copy of the completed template along with the related policy or project proposal to Inclusion.hdd@wales.nhs.uk for the Diversity & Inclusion Team to review.
- Each Screening Template will be reviewed by the Diversity & Inclusion Team and feedback will be provided to the Procedure/ Project/ Proposal/ Policy owner. This may include recommendations for further action to inform robust decision-making.

Support

For further support please visit the EqIA Sharepoint or contact:
Email: Inclusion.hdd@wales.nhs.uk
Tel: 01554 899055

Director and Directorate	Nursing Directorate
Service Area	Quality Assurance and Patient Safety

Title of Procedure, Project, Proposal, Policy being screened:	**Incident, Hazard and Near Miss Reporting and Management Procedure**

Description of the Procedure/ Project/ Proposal/ Policy being screened (including key aims and objectives)

The policy has been updated given the change to the Listening to People regulations. The aim of this procedure is to ensure that all staff are able to identify incidents, take appropriate actions and reduce risks to service users and employees. Integral to this is the development of an organisational culture, which allows incidents to be reported in an open and fair environment.

This will be achieved by:

- Ensuring that all staff understand and recognise when an incident has occurred, are able to report it in a timely manner and provide advise if requested.
- Ensuring all staff understand their accountabilities and responsibilities for reporting incidents.

Evidence considered (including staff and population data, relevant research, expert and community knowledge etc.)

Hywel Dda Health Board is committed to ensuring the health and safety of patients, staff and others; reporting of incidents is crucial to this.

This procedure will assist in protecting the safety and welfare of patients and so has a positive impact on the Human Rights of Patients. The procedure will have a positive impact upon all groups as it is intended to make reporting procedures easier and help to prevent incidents in the future.

A trawl of similar written control documents in NHS Wales and Trusts in NHS England did not identify any potential negative impacts against any protected characteristic. No complaints have been received in relation to equality, diversity or human rights in relation to predecessor policies within the HB.

The procedure has been derived from a number of “best practice” examples.
The procedure was circulated for formal consultation, no relevant feedback was received, and no issues of concern raised.

Assess which protected characteristics will potentially be affected by the proposal in the table below (please ✓ the relevant box to confirm positive, negative or no impact)**.**

If at any point a negative impact has been identified (actual or potential), you do not need to proceed with the completion of this form, as a full EqIA must be undertaken: Equality Impact Assessments (EqIAs) (sharepoint.com)

Age

Is it likely to affect older and younger people in different ways or affect one age group and not another?					
Positive Impact	✓	Negative Impact		No Impact	✓

Justification of impact identified:
The procedure will have a positive impact upon all groups as it is intended to make reporting procedures easier and help to prevent incidents in the future

Older people (e.g., 65 plus) are proportionally more affected by patient safety events than others due to the volume of healthcare they receive and the complexity of their needs.

Ensuring robust reporting of incidents will allow for individual incident review, thematic review and ensuring areas for improvement are identified and remedial action taken to protect future patients and our staff e.g. the use of the Yorkshire Contributory Factors Framework during the incident investigation may make it easier to address concerns specific to patients or staff where age is considered a contributory factor to the incident.

Disability
Is it likely to affect those with a physical disability, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes?

Positive Impact	✓	Negative Impact		No Impact	

Justification of impact identified:
The procedure will have a positive impact upon all groups as it is intended to make reporting procedures easier and help to prevent incidents in the future.

There is evidence that people with learning disabilities may be more at risk of patient safety events in NHS settings due to their vulnerable status.

Ensuring robust reporting of incidents will allow for individual incident review, thematic review and ensuring areas for improvement are identified and remedial action taken to protect future patients and our staff e.g. the use of the Yorkshire Contributory Factors Framework during the incident investigation may make it easier to address concerns specific to patients or staff with a disability where it is considered a contributory factor to the incident. It will improve the way that the organisation learns from safety events and so should enhance understanding and improvement of safety thereby positively impacting on those with a disability.

Gender Reassignment
Is it likely to affect those who either:

- Have undergone, intend to undergo or are currently undergoing gender reassignment.
- Do not intend to undergo medical treatment but wish to live in a different gender from their gender at birth

Positive Impact	✓	Negative Impact		No Impact	

Justification of impact identified:
The procedure has been written to improve and clarify reporting mechanisms and therefore it is considered that there will be a positive impact on this protected characteristic should an incident occur which requires reporting.

There is a lack of evidence to suggest that an individual's trans status affects the likelihood of a person to experience a safety event or affects their experience of involvement in the response to an incident occurring.

Ensuring robust reporting of incidents will allow for individual incident review, thematic review and ensuring areas for improvement are identified and remedial action taken to protect future patients and our staff e.g. the use of the Yorkshire Contributory Factors Framework during the incident investigation may make it easier to address concerns specific to patients or staff who have had, or are intending to have, gender reassignment where it is considered a contributory factor to the incident. It will improve the way that the

organisation learns from safety events and so should enhance understanding and improvement of safety thereby positively impacting on those with who have had, or are intending to have, gender reassignment.

Marriage / Civil Partnership
Under the Equality Act, the characteristic of Marriage and Civil Partnerships is only protected in the workplace/ employment.
Is it likely to affect those who are married or in a Civil Partnership? This means someone who is legally married or in a civil partnership.

Positive Impact	✓	Negative Impact		No Impact	

Justification of impact identified:
The procedure has been written to improve and clarify reporting mechanisms and therefore it is considered that there will be a positive impact on this protected characteristic should an incident occur which requires reporting.

There is a lack of evidence to suggest that an individual's marital or civil partnership status affects the likelihood of a person to experience a safety event relating to their employment or about the workplace or affects the staff member's experience of involvement in the response to an incident occurring.

Ensuring robust reporting of incidents will allow for individual incident review, thematic review and ensuring areas for improvement are identified and remedial action taken to protect staff e.g. the use of the Yorkshire Contributory Factors Framework during the incident investigation may make it easier to address concerns specific to staff who are married or in a civil partnership where it is considered a contributory factor to the incident. It will improve the way that the organisation learns from safety events and so should enhance understanding and improvement of safety thereby positively impacting on this protected characteristic.

Pregnancy and Maternity
Is it likely to affect those who are pregnant or have recently had a baby? Maternity covers the period of 26 weeks after having a baby, whether or not they are on Maternity Leave.

Positive Impact	✓	Negative Impact		No Impact	

Justification of impact identified:
The procedure has been written to improve and clarify reporting mechanisms and therefore it is considered that there will be a positive impact on this protected characteristic should an incident occur which requires reporting.

MBRRACE-UK's (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) 2018 report found that approximately 10 women per 100,000 die during pregnancy or up to six weeks after childbirth or the end of pregnancy, and there are certain risk factors which increase the likelihood of death. Women with multiple health problems or other vulnerabilities, Black and Asian women, older women and overweight or obese women all have a higher risk of dying in pregnancy.

Where adverse outcomes in pregnancy and childcare occur, it is important that the care provided is examined to understand if there were any problems with the safety of the care provided.

The Healthcare Safety Investigation Branch (HSIB) is a national body designed to improve safety by independently investigating patient safety concerns in the NHS.

The incident reporting policy states that directorates and services should develop their own trigger list for reporting of incidents. Maternity services have developed a trigger list. The national directive for reporting of patient safety incidents states that there is a requirement to report maternal, perinatal and infant deaths as an NRI will be aligned with

the current reporting definitions as set out by MBRACE-UK - https://www.npeu.ox.ac.uk/mbrrace-uk/data-collection. Where the MBRACE-UK reporting definition is met, the underlying incident should also be reported as an NRI. This includes all maternal and neonatal deaths, still births and neonatal hypoxic ischaemia.

Ensuring robust reporting of incidents will allow for individual incident review, thematic review and ensuring areas for improvement are identified and remedial action taken to protect future patients and our staff e.g. the use of the Yorkshire Contributory Factors Framework during the incident investigation may make it easier to address concerns specific to patients or staff who are pregnant or who have recently had a baby where it is considered a contributory factor to the incident. It will improve the way that the organisation learns from safety events and so should enhance understanding and improvement of safety thereby positively impacting on those with this protected characteristic.

Race / Ethnicity
Is it likely to affect people of a different race, nationality, colour, culture or ethnic origin including non-English / Welsh speakers, Gypsies/Travellers, asylum seekers and migrant workers?

Positive Impact	✓	Negative Impact		No Impact	

Justification of impact identified:
In relation to the treatment of staff following an event, the Health Board is conscious of the risk of bias and discrimination. Guidance states that organisations must ensure that staff involved in making decisions about referrals to other bodies undertake unconscious bias training and that the protected characteristics of staff referred to other bodies are recorded so that analysis of this data can be undertaken, and any patterns can be reviewed and addressed, and that procedures are consistently reviewed, and steps taken to understand and resolve inequality and potential unfair treatment.

The Incident Reporting Policy should have a particularly positive effect on staff groups that have traditionally faced disproportionate disciplinary actions and referrals for fitness to practice tests, such as staff from Black, Asian and other minority ethnic backgrounds and staff who trained overseas.

Ensuring robust reporting of incidents will allow for individual incident review, thematic review and ensuring areas for improvement are identified and remedial action taken to protect future patients and our staff e.g. the use of the Yorkshire Contributory Factors Framework during the incident investigation may make it easier to address concerns specific to patients or staff who have a different race, nationality, colour, culture or ethnic origin where it is considered a contributory factor to the incident. It will improve the way that the organisation learns from safety events and so should enhance understanding and improvement of safety thereby positively impacting on those with this protected characteristic.

Religion or Belief
Is it likely to affect people who have a religion or belief? The term 'religion' includes a religious or philosophical belief.

Positive Impact	✓	Negative Impact		No Impact	

Justification of impact identified:
There is a lack of evidence to suggest that religion or belief affects the likelihood of a person to experience a patient or staff safety event or affects their experience of involvement in the response.

The procedure has been written to improve and clarify reporting mechanisms and therefore it is considered that there will be a positive impact on this protected characteristic should an incident occur which requires reporting.

Ensuring robust reporting of incidents will allow for individual incident review, thematic review and ensuring areas for improvement are identified and remedial action taken to protect future patients and our staff e.g. the use of the Yorkshire Contributory Factors Framework during the incident investigation may make it easier to address concerns specific to patients or staff where it is considered that their religion or belief was a contributory factor to the incident. It will improve the way that the organisation learns from safety events and so should enhance understanding and improvement of safety thereby positively impacting on those with this protected characteristic.

Sex
Is it likely to affect people who are mostly male or female. Where it applies to both equally does it affect one differently to the other?

Positive Impact	✓	Negative Impact		No Impact	

Justification of impact identified:
There is a lack of evidence to suggest that gender affects the likelihood of a person to experience a patient or staff safety event or affects their experience of involvement in the response to the incident.

The procedure has been written to improve and clarify reporting mechanisms and therefore it is considered that there will be a positive impact on this protected characteristic should an incident occur which requires reporting.

Ensuring robust reporting of incidents will allow for individual incident review, thematic review and ensuring areas for improvement are identified and remedial action taken to protect future patients and our staff e.g. the use of the Yorkshire Contributory Factors Framework during the incident investigation may make it easier to address concerns specific to patients or staff where it is considered that their sex was a contributory factor to the incident. It will improve the way that the organisation learns from safety events and so should enhance understanding and improvement of safety thereby positively impacting on those with this protected characteristic.

Sexual Orientation
Whether a person's sexual attraction is towards their own sex, the opposite sex or either.

Positive Impact	✓	Negative Impact		No Impact	

Justification of impact identified:
There is a lack of evidence to suggest that sexual orientation affects the likelihood of a person to experience a patient or staff safety event or affects their experience of involvement in the response.

The procedure has been written to improve and clarify reporting mechanisms and therefore it is considered that there will be a positive impact on this protected characteristic should an incident occur which requires reporting

Ensuring robust reporting of incidents will allow for individual incident review, thematic review and ensuring areas for improvement are identified and remedial action taken to protect future patients and our staff e.g. the use of the Yorkshire Contributory Factors Framework during the incident investigation may make it easier to address concerns specific to patients or staff where it is considered that their sexual orientation was a contributory factor to the incident. It will improve the way that the organisation learns from safety events and so should enhance understanding and improvement of safety thereby positively impacting on those with this protected characteristic.

Armed Forces Community
Consider whether this impacts on members of the Armed Forces and their families, whose health needs may be impacted long after they have left the Armed Forces and returned to civilian life. Also consider their unique experiences when accessing and using day-to-day public and private services compared to the general population. It could be through

'unfamiliarity with civilian life, or frequent moves around the country and the subsequent difficulties in maintaining support networks, for example, members of the Armed Forces can find accessing such goods and services challenging.' For a comprehensive guide to the Armed Forces Covenant Duty and supporting resource please see: **Armed-Forces-Covenant-duty-statutory-guidance**

Positive Impact	✓	Negative Impact		No Impact	

Justification of impact identified:
There is a lack of evidence to suggest that being a member of the armed forces community affects the likelihood of a person to experience a patient or staff safety event or affects their experience of involvement in the response.

The procedure has been written to improve and clarify reporting mechanisms and therefore it is considered that there will be a positive impact on this protected characteristic should an incident occur which requires reporting.

Ensuring robust reporting of incidents will allow for individual incident review, thematic review and ensuring areas for improvement are identified and remedial action taken to protect future patients and our staff e.g. the use of the Yorkshire Contributory Factors Framework during the incident investigation may make it easier to address concerns specific to patients or staff where it is considered that being a member of the armed forces community was a contributory factor to the incident. It will improve the way that the organisation learns from safety events and so should enhance understanding and improvement of safety thereby positively impacting on those from the armed forces community.

Socio Economic Duty
Consider those on low income, economically inactive, unemployed or unable to work due to ill-health. Also consider people living in areas known to exhibit poor economic and/or health indicators and individuals who are unable to access services and facilities. Food / fuel poverty and personal or household debt should also be considered.

For a comprehensive guide to the Socio-Economic Duty in Wales and supporting resources please see:
more-equal-wales-socio-economic-duty

Positive Impact	✓	Negative Impact		No Impact	

Justification of impact identified:
The procedure has been written to improve and clarify reporting mechanisms and therefore it is considered that there will be a positive impact on the socio economic duty should an incident occur which requires reporting

Welsh Language
Is it likely to impact on opportunities for people to use the Welsh language? The Welsh language should be treated no less favourably than the English language.

Positive Impact	✓	Negative Impact		No Impact	

Justification of impact identified:
The procedure has been written to improve and clarify reporting mechanisms and therefore it is considered that there will be a positive impact on the Welsh language duty should an incident occur which requires reporting

If a negative impact has been identified, you are not required to complete this form as a full EqIA must be undertaken. A full EqIA template and guidance can be found on the following link: Equality Impact Assessments (EqIAs) (sharepoint.com)

	Name	Caroline Burgin

Screening Completed by:	Title	Patient Safety and Assurance Manager
	Contact details	Caroline.burgin@wales.nhs.uk
	Date	20/07/2026
Screening Authorised by: (Directorate level owner of the procedures/ proposals/ projects/ policy)	Name	Caroline Burgin
	Title	Patient Safety and Assurance Manager
	Contact details	Caroline.burgin@wales.nhs.uk
	Date	20/07/2026
Guidance has been provided by Diversity & Inclusion Team:	Name	Kylie Daniels
	Title	Senior Diversity and Inclusion Officer
	Contact details	Kylie.daniels@wales.nhs.uk
	Date	
Diversity and Inclusion Team additional Comments:		

Please note: The D&I team will save a copy of the completed form for reference. If any changes are made after the date of review, it is the directorate's responsibility to update the EqIA and inform the D&I team.

8

8 - For Information

8.1

8.1 - QSEC Work Plan 2026/27

For information

Attachments

Draft QSEC Work Programme 2026 27.pdf

QUALITY SAFETY & EXPERIENCE COMMITTEE WORK SCHEDULE APRIL 2026– MARCH 2027

Currently, Quality Safety & Experience Committee (QSEC) meets bi-monthly. Based on this, the following table represents a proposal to incorporate the duties as outlined in the Committee's Terms of Reference into a basic work programme April 2026 – March 2027.

AGENDA ITEM/ ISSUE	LEAD	PURPOSE	RESPONSIBLE OFFICER	9 April 2026	11 June 2026	11 August 2026	9 October 2026	3 December 2026	9 February 2027
Governance									
Welcome and Apologies	**Chair**		**All**	✓	✓	✓	✓	✓	✓
Declarations of Interests	**Chair**		**CSO**	✓	✓	✓	✓	✓	✓
Minutes from Previous Meeting and Matters Arising not on Agenda	**Chair**	**FOR APPROVAL**	**CSO**	✓	✓	✓	✓	✓	✓
Table of Actions (ToA)	**Chair**	**FOR APPROVAL**	**CSO**	✓	✓	✓	✓	✓	✓
Review of Terms of Reference (TORs)	**Chair**	**FOR APPROVAL**	**CSO**						✓
Annual Review of Sub Committees TORs	**Chair**	**FOR APPROVAL**	**CSO**						✓
Assurance and Risk Report • Corporate Risks • Operational Risks • Internal and External Audit Reports • Monitoring of Ministerial Directions • Monitoring of Welsh Health Circulars (WHCs)	**Executive Leads**	**ASSURANCE**	**RW**	✓	✓	✓	✓	✓	✓

AGENDA ITEM/ ISSUE	LEAD	PURPOSE	RESPONSIBLE OFFICER	9 April 2026	11 June 2026	11 August 2026	9 October 2026	3 December 2026	9 February 2027
Self-Assessment - Six month review of actions August 2026	**Chair**	**ASSURANCE**	**JW**			✓ update on actions			✓outcome report
Patient/Staff Story	**SD**	**ASSURANCE**	**LOC/ Service Leads**	✓	✓	✓	✓	✓	✓
Targeted Intervention Progress Report	**SA**	**ASSURANCE**	**Executive Leads**	✓					
Escalation Report	**SA**	**ASSURANCE**	**Executive Leads**		✓	✓	✓	✓	✓
Assurance									
Annual Report on Committee's Activity	**AL/SD**	**FOR APPROVAL**	**All**	✓					
Annual Report from Sub-Committee	**SD**	**FOR APPROVAL**	**LOC**		D	✓			
A report on the impact of revised governance arrangements	**SD/ AC/ JS/ MH**	**ASSURANCE**		✓					
Clinical Audit Programme for Approval	**MH**	**FOR APPROVAL**	**IB**		✓				

AGENDA ITEM/ ISSUE	LEAD	PURPOSE	RESPONSIBLE OFFICER	9 April 2026	11 June 2026	11 August 2026	9 October 2026	3 December 2026	9 February 2027
Duty of Quality Assurance Report incorporating: • External Inspection and peer reviews *(TI34 & 52)* • Nurse Staffing Act Assurance (every 6 months) • Walkrounds (a thematic review on 6 month basis) • Quality Improvement outcomes *(TI 53)* • Quality Impact Assessments *(TI 32, 33)* • Putting things right *(TI 51)* • HCAI *(TI 50)* • Duty of Candour *(TI 54)* • Learning from significant events • Speaking Up reports on quality themes (every 6 months) • WHC's overview *(every other meeting) (TI 52)*	**SD**	**ASSURANCE**	**CS**	✓	✓	✓	✓	✓	✓
Safeguarding Assurance Report	**SD**	**ASSURANCE**	**CW**			✓			✓
Infection Prevention Control Report	**SD**	**ASSURANCE**	**RR**	✓			✓		

AGENDA ITEM/ ISSUE	LEAD	PURPOSE	RESPONSIBLE OFFICER	9 April 2026	11 June 2026	11 August 2026	9 October 2026	3 December 2026	9 February 2027
Duty of Candour Annual Report 2025/26	**SD**	**FOR APPROVAL**	**CS**		✓				
Duty of Quality Annual Report 2025/26	**SD**	**FOR APPROVAL**	**CS**			✓			
Nurse Staffing Levels (Wales) Act: Assurance Reports (as required) –Annual Report and Spring Calculation Cycle	**SD**	**ASSURANCE**	**HH**		✓				
Cleanliness Standards Audit report and Action Plan	**JS**	**ASSURANCE**	**SC/ EB**			✓			
A review of the implementation of the community Mental Health referral pathway	**AC**	**ASSURANCE**	**AD**		✓				
Fuller Inquiry assurance of progress of recommendations	**JS**	**ASSURANCE**	**CB**	✓					
First Contact Physiotherapist Report	**JS**	**ASSURANCE**	**JB**	✓				Learning from investigation to be shared via LLSC report	
Single point of contact (improvements in delivery of care for patients)	**SD**	**FOR ASSURANCE**	**MD/ MP**					TBC	
Epilepsy in Learning Disabilities Update	**AC**	**FOR ASSURANCE**	**OM**			✓			

AGENDA ITEM/ ISSUE	LEAD	PURPOSE	RESPONSIBLE OFFICER	9 April 2026	11 June 2026	11 August 2026	9 October 2026	3 December 2026	9 February 2027
Ceredigion Community Mental Health Referral Pathway (included in the CCG report)	AC	FOR ASSURANCE	LC		✓				
Quality Assurance Report for Commissioned Services	LD	FOR ASSURANCE	AS		✓				
Listening to People Initiative (Inc in the Quality Assurance Report)	SD	FOR ASSURANCE	LOC		✓				
Insourcing 52 week first consultant appointment quality issues	AC	FOR ASSURANCE	LH				✓		
Deep Dives Clinical Services									
Ophthalmology	AC	ASSURANCE	PG/ AJ		✓				
Urology	AC	ASSURANCE	PG/NG			✓			
Orthopaedics	AC	ASSURANCE	PG/ LG				✓		
Radiology	AC	ASSURANCE	PG / SP					✓	
Dermatology	AC	ASSURANCE	PG/CW				✓		
Endoscopy	AC	ASSURANCE	PG/ SJ					✓	
Clinical Care Group Updates									
Mental Health and Learning Disabilities	AC	FOR ASSURANCE	RTP		✓		✓		✓
Community and Integrated Medicine	AC	FOR ASSURANCE	ACh		✓			✓	
Allied Health Services	AC	FOR ASSURANCE	SQ			✓			✓
Planned and Specialist Care	AC	FOR ASSURANCE	PG	✓			✓		
Estates and Facilities	JS	FOR ASSURANCE	EB/ SC			✓			✓

AGENDA ITEM/ ISSUE	LEAD	PURPOSE	RESPONSIBLE OFFICER	9 April 2026	11 June 2026	11 August 2026	9 October 2026	3 December 2026	9 February 2027
Public Health	**AG**	**ASSURANCE**	**BL**		✓			✓	
Listening and Learning Sub Committee Update Report	**MH**	**ASSURANCE**	**LOC**	✓	✓	✓	✓	✓	✓ TOR for review
Policies				**Expiry**					
1133 Service User Access Policy - Psychological Therapies	**AC**	**FOR APPROVAL**	**Andrew Homfray**	5-Mar-26 Extended whilst full review is finalised	✓				
429 Management and Distribution of Safety Alerts and Notices Policy	**SD**	**FOR APPROVAL**	**Cathie Steele**	13-Jun-26					
004 Claims Management Policy	**SD**	**FOR APPROVAL**	**Louise O'Connor**	5-Oct-26					
894 Putting Things Right Management and Resolution of Concerns Policy (Incidents, Complaints and Claims)	**SD**	**FOR APPROVAL**	**Louise O'Connor**	5-Oct-26					
63 Use of Patient and Carers Stories Guideline	**SD**	**FOR APPROVAL**	**Louise O'Connor**	13-Feb-27					
307 Production of Patient and Carer Information Policy	**SD**	**FOR APPROVAL**	**Louise O'Connor**	21-Mar-27					
892 Incidents Near Miss and Hazard Reporting procedure	**SD**	**FOR APPROVAL**	**Cathie Steele**	31-Jul-27					
18 Inquest guidance	**SD**	**FOR APPROVAL**	**Louise O'Connor**	15-Aug-27		D			
309 - Continuing NHS Healthcare Operational Policy to Support Framework for Implementation	**AC**	**FOR APPROVAL**	**Tracy Devantier**	15-Aug-27					
568 Production and Use of Surveys	**SD**	**FOR**	**Louise**	4-Dec-28					

AGENDA ITEM/ ISSUE	LEAD	PURPOSE	RESPONSIBLE OFFICER	9 April 2026	11 June 2026	11 August 2026	9 October 2026	3 December 2026	9 February 2027
Guideline		**APPROVAL**	**O'Connor**						
1097 Corporate Safeguarding Policy	**SD**	**FOR APPROVAL**	**Charlotte Westacott**	11-Aug-26					
For Information									
HIW Annual Report	**N/A**	**FOR INFORMATION**	**N/A**					✓	
JCC Quality Safety Outcomes Sub Committee	**N/A**	**FOR INFORMATION**	**N/A**	✓	✓	✓	✓	✓	✓
Work plan 2026/27	**N/A**	**FOR INFORMATION**	**N/A**	✓	✓	✓	✓	✓	✓
Patient Experience Report	**N/A**	**FOR INFORMATION**	**N/A**	✓	✓	✓	✓	✓	✓
Agenda setting meeting with Chair and Exec Lead to include discussion on deep dives on new risks (at least 6 weeks before the meeting)	**CSO**		**CSO**	✓	✓	✓	✓	✓	✓
Draft agenda to go to Executive Team prior to being issued.	**CSO**		**CSO**	✓	✓	✓	✓	✓	✓
Call for papers (at least 4 weeks before the meeting to receive papers at least 14 days before the meeting)	**CSO**		**CSO**	✓	✓	✓	✓	✓	✓
Disseminate agenda and papers 7 days prior to the meeting	**CSO**		**CSO**	✓	✓	✓	✓	✓	✓
Type up minutes and TOA within 7 days of the meeting	**CSO**		**CSO**	✓	✓	✓	✓	✓	✓
Circulate minutes and TOA to Committee for comments, points of accuracy and matters arising within 10 days of the meeting	**CSO**		**CSO**	✓	✓	✓	✓	✓	✓

AGENDA ITEM/ ISSUE	LEAD	PURPOSE	RESPONSIBLE OFFICER	9 April 2026	11 June 2026	11 August 2026	9 October 2026	3 December 2026	9 February 2027
Check and send final version of minutes to the Committee Chair following comments received.	**CSO**		**CSO**	✓	✓	✓	✓	✓	✓
Chase updates on TOA before the next meeting and RAG rate	**CSO**		**CSO**	✓	✓	✓	✓	✓	✓
Record and track the TOA as part of the decision tracker	**CSO**		**CSO**	✓	✓	✓	✓	✓	✓
Produce written update report for Board	**CSO**		**CSO**	✓	✓	✓	✓	✓	✓
Prepare schedule of meetings	**CSO**		**CSO**					✓	
QSEC Annual Work Programme	**CSO**		**CSO**	✓	✓	✓	✓	✓	✓

Initials

SD- Sharon Daniel	CSO-Katie Lewis	MP- Marilize Preez	LOC- Louise O'Connor	MH- Mark Henwood
AC- Andrew Carruthers	BL- Bethan Lewis	CS- Cathie Steele	AG- Ardiana Gjini	JS- James Severs
HH- Helen Humphreys	SA- Shaun Ayres	MD- Mandy Davies	RW- Rachel Williams	IB- Ian Bebb
RTP- Rebecca Temple Purcell	ACh- Anna Chiffi	SC- Simon Chiffi	AS- Ann Simpson	LD- Lee Davies
EB- Elin Brocke				

9

9 - Date of Next Meeting : 8 October 2026