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

Assurance and Risk Report

Quality, Safety & Experience Committee – 11 June 2026

Situation

This report provides the Quality, Safety & Experience Committee (QSEC) with the status of the principal risks, operational risks, and audit and inspections recommendations within its remit.

The Committee is asked to seek assurance from the Lead Executive Directors that the principal risks are being refreshed and will be reported to the Board in July, and that there are processes in place to oversee operational risks to ensure these are being managed effectively, and that recommendations from audits and inspections are being implemented by the Health Board.

Corporate risks, Welsh Health Circulars and Ministerial Directions are reported at alternate meetings and will be presented to QSEC at its next meeting in August 2026.

Principal Risks:
4
Under Review

Operational Risks
484

Audit and Inspection Reports
29

Risk Management - Overview

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

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

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

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

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

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

Principal Risks

As a result of the Strategy Refresh, presented to Board in January 2026, the plan is to present a refreshed Board Assurance Framework (BAF) to Board in July 2026. A review of principal risks will be undertaken as part of the BAF refresh, in addition to the supporting planning goals and outcome measures per the timeline below.

Principal risks and outcome measures have been reviewed and discussed at FET in May, with final amendments being made by Executive Risk Owners ahead of presentation at Board seminar in June 2026, and to the Board in July 2026.

Each principal risk will be aligned to a Board committee and will be reported on via the Assurance and Risk Report to ensure that they are being managed appropriately, taking in to account gaps in control, planned actions and agreed tolerances, and to provide assurance to the Board through their update report the management of these risks.

Operational Risks assigned to QSEC

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Of the 484 operational risks aligned to QSEC, 428 have been identified as reportable based on the following criteria:

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

Following identification and assessment of risks, each risk is aligned to a specific Health Board committee or sub-committee. Effective risk management requires a 'monitoring and review' structure, ensuring that risks are effectively identified and assessed, and that appropriate controls and responses are in place.

Operational risks are managed within Clinical Care Groups (CCG) and Executive Functions (collectively referred to as "Functions") under the ownership and leadership of individual Executive Directors. Each CCG must establish local arrangements for the review of their Risk Registers, which includes the validation of the information and risk scores, and the prioritisation and identification of solutions to their risks. Each CCG Integrated Governance Group (CCG IGG) is provided with an Assurance and Risk Report, with any issues escalated through the operational directorate governance structure via the 3As Report following each CCG IGG meeting.

The Health Board has formal monitoring and scrutiny mechanisms in place to provide assurance to the Board regarding the effective management of risks. Monthly assessments are made for each Function on their risk management, informing their overall level within the 'Governance' domain as part of the Health Board's internal escalation framework. A key metric in the Health Board's internal escalation process under the Governance domain is how Functions are managing risks in terms of the scale, significance, timeliness and quality, with measures extended from April 2025 to inform levels to be awarded (detailed on the next slide).

The Assurance and Risk Team provide focussed support for those Functions at levels 3 and 4 to aid their de-escalation / recovery and prevent those awarded level 2 status being further escalated. Detail is provided within each report provided and presented at Function governance meetings explaining the reasons behind their escalation status, and suggested actions required to de-escalate (where appropriate). Whilst the four levels within the escalation framework have been agreed, the Executive Team are currently determining processes to support those Functions who may be assessed as being in Level 4. Functions are currently assessed as being either level 1, 2 or 3 pending formalisation of these processes. As at April 2026 month end Community & Integrated Medicine are at level 3.

Operational Risks assigned to QSEC

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Measures to assess against the Governance Domain (risk management) for 2026/27

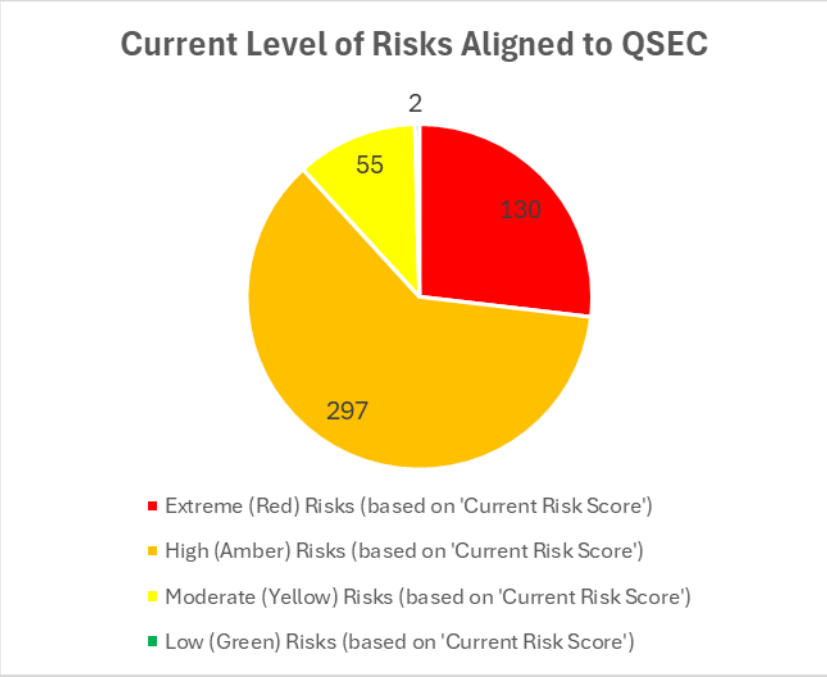
Level	Criteria
Level 4 – no assurance and insufficient actions / engagement	No plan in place and no engagement, (eg no risk action plans, no expected date to achieve Target Risk Score). Evidence where known risks are not articulated on the function's risk register. No evidence that risks are escalated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

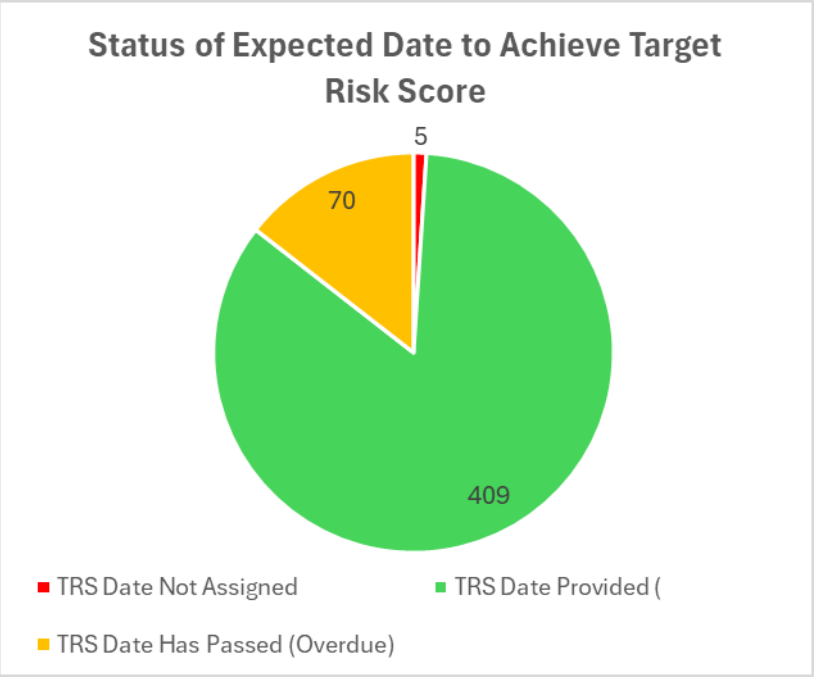
Operational Risks assigned to QSEC

484 operational risks are aligned to QSEC (an increase from the 467 previously reported to the Committee in February 2026). Due to the large number of risks aligned to the Committee, a summary of the 48 operational risks with a current risk score of >20 is provided over the next slides.

Details related to target risk scores (TRS) became mandatory fields on Datix as of 1 July 2025, and therefore for the 5 risks which do not currently have this detail (noted as 'Unable to Assign TRS date'), risk leads will be asked to provide this detail by the next report to QSEC.

Where expected dates to achieve the TRS have lapsed (denoted in red on the following slides), the Assurance and Risk Team continue to remind risk leads to ensure the appropriate actions and updates are taken on Datix (e.g., has this risk now been fully managed and mitigated? If the TRS has not been met what further actions are required? What is the revised TRS date and an updated rationale?).





Operational Risks assigned to QSEC

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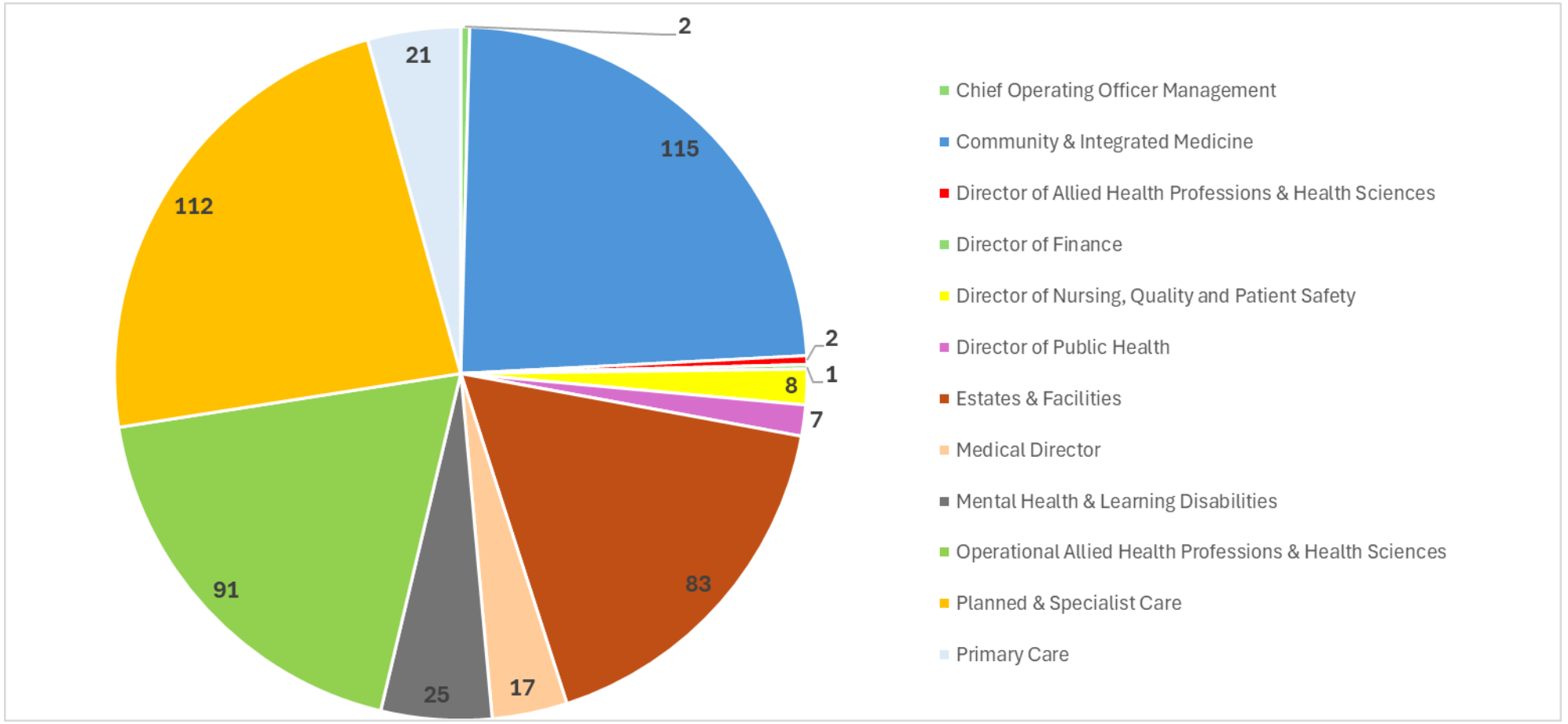
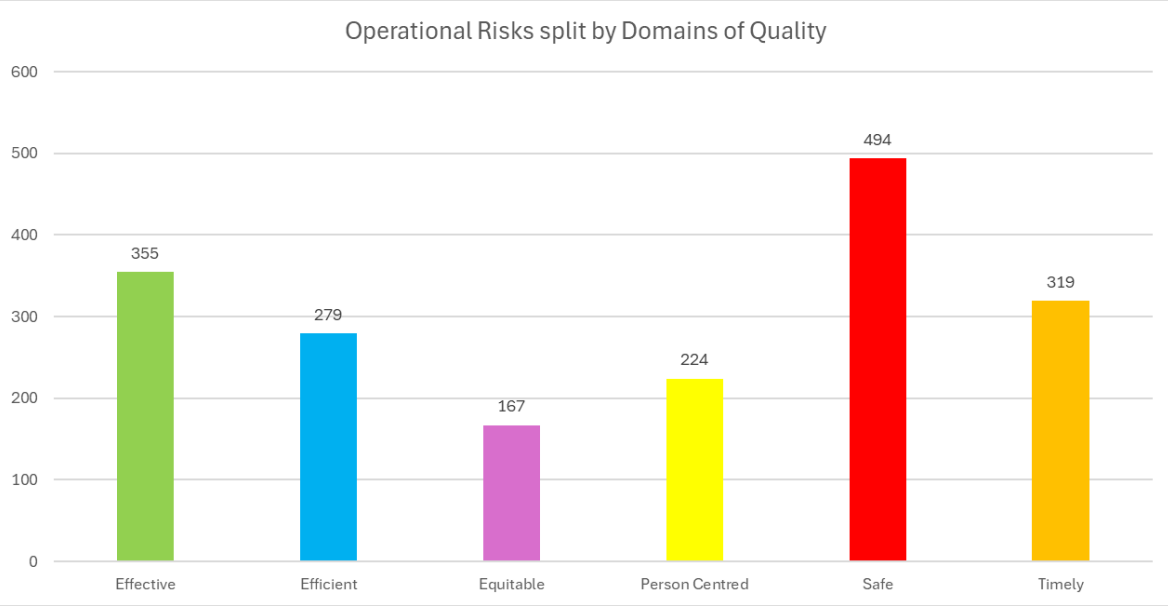
Risks Split Out By Clinical Care Group/Executive Function



Domains of Quality

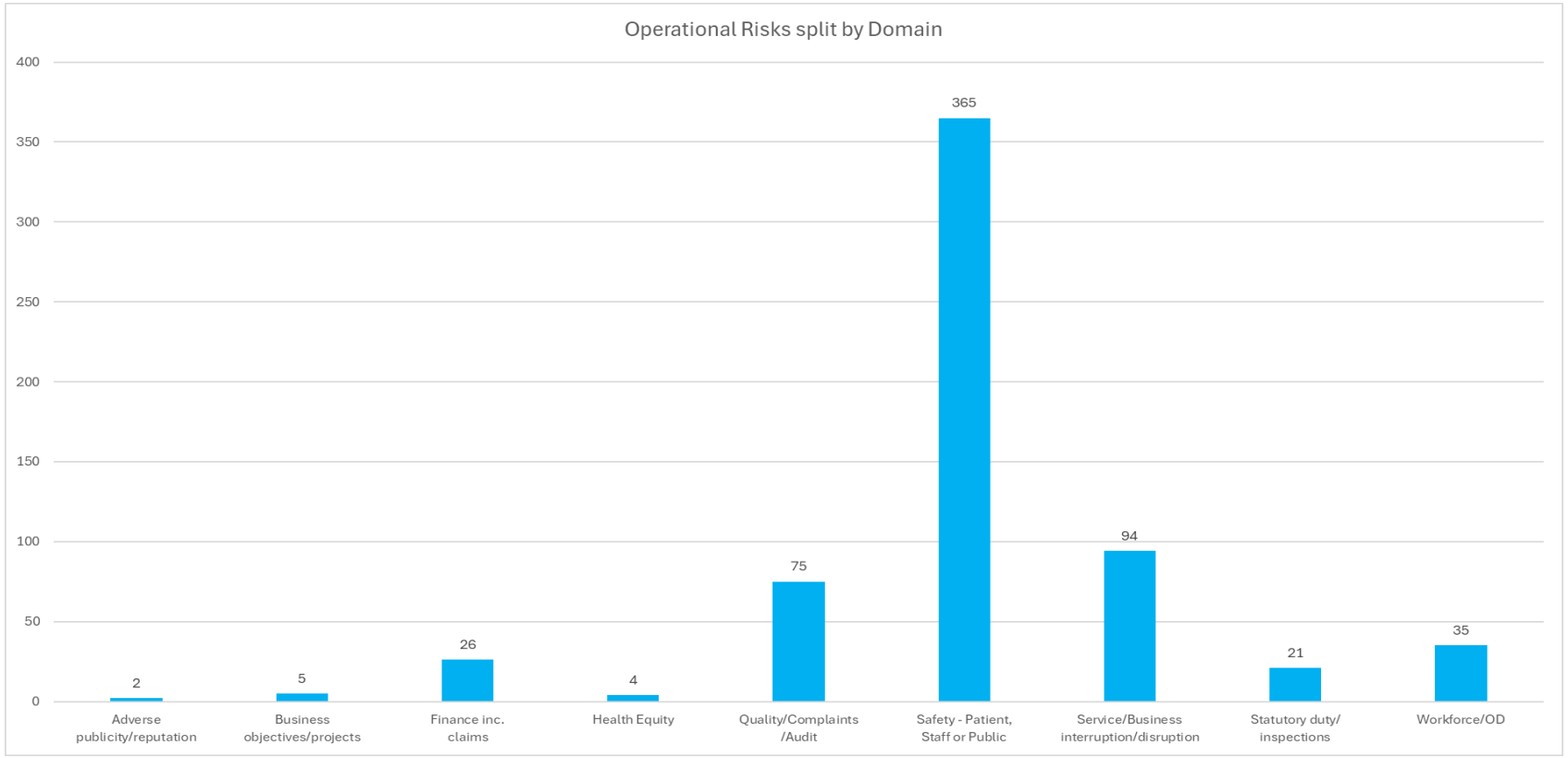
Risk owners can assign one or more of the six Domains of Quality to each risk. The chart shows the distribution of all operational risks across the six Domains of Quality (regardless of the Committee the risk is assigned to), highlighting that the highest number of risks is associated with the Safe domain (494), followed by Effective (355) and Timely (319).



Operational Risks by Domain

Each risk on Datix is assessed by analysing the consequences/impact of the risk (i.e. its impact or magnitude of effect), and the likelihood that those consequences may occur (i.e. its frequency or probability). The consequence and likelihood are rated against established criteria which are on the Risk Scoring Matrix. Risk Owners assess the risk against only one 'domain' based on the consequence/impact identified in the risk description. Where a number of impacts have been identified, the domain selection should be based on the impact with the severest consequence/impact.

Out of 627 operational risks, 365 as assessed against the domain of 'Safety- Patient, Staff or Public' and 75 against 'Quality/Complaints/Audits'.



Risk Impact Domains:

- Safety of Patients, Staff or Public
- Quality, Complaints or Audit
- Workforce & OD
- Statutory Duty or Inspections
- Adverse Publicity or Reputation
- Business Objectives or Projects
- Finance including Claims
- Service or Business interruption or disruption
- Health Equity

Extreme Level Operational Risks
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Risk Reference	Risk Title	Overseeing Clinical Care Group / Executive Function	Lead Director	Current Risk Score	Target Risk Score	Expected Date to Achieve Target Risk Score	Date of last risk review
834	Risk to meeting demands in Clinical Haematology due to workforce shortfall	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	25	4	29/12/2028	05/05/2026
1256	Risk to safety and management of hip fracture patients due to lack of Orthogeriatric service at GGH	Planned & Specialist Care	Chief Operating Officer	25	4	30/06/2026	30/04/2026
2228	Risk of patient safety affected due to discontinuation of the electronic prescribing system Vision for OPD clinics and services	Medical	Medical Director	25	4	30/06/2026	05/05/2026
2336	Risk of adverse patient and workforce outcomes due to unsustainable health board wide ultrasound services	Allied Health Professions & Health Sciences	Director of Allied Health Professions and Health Sciences	25	10	31/03/2030	05/05/2026
1349	Risk of being unable to deliver ultrasound services at WGH due to a lack of appropriately trained obstetric staff	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	25	10	31/03/2030	27/04/2026
215	Risk of disruption to business continuity at Day Surgical Unit, WGH due to ageing and non-compliant Air Handling Units	Estates & Facilities	Director of Allied Health Professions and Health Sciences	20	2	31/03/2027	06/05/2026
1706	Risk of loss of Nuclear Medicine Service due to decline in condition of equipment and failure to comply with NRW compliance.	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	2	30/07/2027	27/04/2026
2133	Risk of unsustainable Cellular Pathology Service Delivery and Service Collapse due to extremely poor estate condition and size	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	2	29/12/2028	29/04/2026
2219	Risk of delays in patient pathways due to the on-going backlog in triaging GP electronic referrals	Planned & Specialist Care	Chief Operating Officer	20	2	31/03/2027	28/04/2026

Extreme Level Operational Risks
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Risk Reference	Risk Title	Overseeing Clinical Care Group / Executive Function	Lead Director	Current Risk Score	Target Risk Score	Expected Date to Achieve Target Risk Score	Date of last risk review
2256	Risk of disruption to business continuity due to ageing and non-compliant Air Handling Unit in Theatre 3, WGH	Estates & Facilities	Director of Allied Health Professions and Health Sciences	20	2	31/03/2027	06/05/2026
2265	Risk of patient harm due to the ceiling-mounted ophthalmic operating microscope reaching end-of-life and potentially failing	Planned & Specialist Care	Chief Operating Officer	20	2	31/07/2026	12/05/2026
1077	Risk of service disruption and non-compliance due to insufficient quantity of Standby Generators, PPH & Amman Valley	Estates & Facilities	Director of Allied Health Professions and Health Sciences	20	3	31/03/2027	14/04/2026
1992	Risk to patient safety due to insufficient Medical staffing to volume of medical patients severe & inpatient acuity.	Community & Integrated Medicine	Chief Operating Officer	20	4	31/10/2026	12/05/2026
2092	Risk of closure/loss of service to the Day Surgical Unit, PPH due to unsupported Building Management System	Estates & Facilities	Director of Allied Health Professions and Health Sciences	20	4	31/03/2028	14/04/2026
2258	Risk of timely access to the ENT procedure room on Merlin due to boarding policy when GGH is in surge escalation	Planned & Specialist Care	Chief Operating Officer	20	4	31/03/2027	30/04/2026
2156	Risk of patient harm within the bone health service due to lack of clinical capacity across the Hywel dda University HB	Community & Integrated Medicine	Chief Operating Officer	20	4	31/05/2026	24/04/2026
2264	Risk to patient safety, quality & experience due to inconsistent delivery of urgent and emergency care due to system fragility.	Community & Integrated Medicine	Chief Operating Officer	20	5	31/03/2027	10/04/2026
2293	Risk of suboptimal care for patients requiring nasogastric and gastrostomy feeding routes due to under resourcing	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	5	04/01/2027	24/04/2026

Extreme Level Operational Risks
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Risk Reference	Risk Title	Overseeing Clinical Care Group / Executive Function	Lead Director	Current Risk Score	Target Risk Score	Expected Date to Achieve Target Risk Score	Date of last risk review
1968	Risk of closure of wards and departments due to failure of roof structure of PPH	Estates & Facilities	Director of Allied Health Professions and Health Sciences	20	5	31/03/2030	14/04/2026
2136	Risk of being unable to provide a haematology and blood transfusion service due to insufficient staffing	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	5	31/08/2026	16/04/2026
2141	Risk of harm to patients, staff and public due to insufficient physical security measures in place at BGH	Community & Integrated Medicine	Chief Operating Officer	20	5	09/08/2028	10/04/2026
2114	Risk of patient harm from a delay in surgical management due to inadequate capacity for Mastoid surgery	Planned & Specialist Care	Chief Operating Officer	20	5	31/12/2026	30/04/2026
2090	Risk to patient care in the Ceredigion area due to workforce capacity	Mental Health and Learning Disabilities	Chief Operating Officer	20	6	03/08/2026	07/05/2026
1930	Risk of harm to mortuary staff and porters when manual handling due to failure of hoist (Whisper 200)	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	6	31/08/2026	29/04/2026
118	Risk of avoidable harm to patients awaiting in-patient pacemaker implantation due to prolonged waiting times	Community & Integrated Medicine	Chief Operating Officer	20	6	31/03/2050	09/04/2026
1661	Risk to delivery of quality, effective weight management service due to demand outstripping capacity	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	6	14/04/2027	07/05/2026
1308	Risk of Urgent Treatment Delays for Stone Patients in Urology due to backlog outweighing capacity	Planned & Specialist Care	Chief Operating Officer	20	6	31/03/2027	28/04/2026

Extreme Level Operational Risks
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Risk Reference	Risk Title	Overseeing Clinical Care Group / Executive Function	Lead Director	Current Risk Score	Target Risk Score	Expected Date to Achieve Target Risk Score	Date of last risk review
1717	Risk of harm to children and young people living with obesity due to no weight management service provision	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	6	31/03/2027	01/05/2026
1454	Risk of being unable to meet service demand due to staffing levels in Blood Sciences	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	6	31/03/2027	15/04/2026
2318	Risk of potential patient safety issues due to inadequate staffing levels in GGH pharmacy	Medical Director	Medical Director	20	6	31/03/2027	28/04/2026
2289	Risk of service unsustainability due to staff wellbeing, limited prescribing capacity, and demand exceeding capacity	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	6	01/10/2027	08/05/2026
2241	Risk of delayed fundamentals of care and deconditioning of patients due to large shortfall of Health Care Support Workers	Community & Integrated Medicine	Chief Operating Officer	20	8	30/06/2026	08/05/2026
1488	Risk of major endoscopy service disruption if decontamination equipment fails at BGH due to age	Planned & Specialist Care	Chief Operating Officer	20	8	31/03/2027	16/04/2026
1547	Risk to timely and safe radiology provision due to demand exceeding capacity	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	8	30/03/2029	27/04/2026
1820	Risk of patient harm due to the withdrawal of funding for the Diabetes Remission service.	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	8	31/08/2026	08/05/2026
1894	Risk of stroke patients not receiving the therapy rehabilitation they need due to lack of staffing	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	8	30/06/2026	28/04/2026
1996	Risk of reduced workforce recruitments and developments due to lack of funding	Planned & Specialist Care	Chief Operating Officer	20	8	31/08/2026	30/04/2026
2151	Risk of poorer outcomes due to delayed prescribing for those with complex co-morbid Obesity	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	9	31/08/2026	07/05/2026

Extreme Level Operational Risks
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Risk Reference	Risk Title	Overseeing Clinical Care Group / Executive Function	Lead Director	Current Risk Score	Target Risk Score	Expected Date to Achieve Target Risk Score	Date of last risk review
2102	Risk of unsafe staffing levels and non-delivery of radiology service due to leadership fragility	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	10	01/12/2026	27/04/2026
1603	Risk of delayed response and breach of waiting time targets due to increased referrals for children with selective eating	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	10	30/04/2027	07/05/2026
1309	Risk to meeting demands for diagnostic reporting due to shortfall in Consultant Cellular Pathologist workforce	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	10	31/08/2028	29/04/2026
1287	Risk of clients not being provided with timely interventions due to waiting lists for assessment & diagnosis of ASD.	Mental Health and Learning Disabilities	Chief Operating Officer	20	12	31/03/2032	17/04/2026
1115	Risk of increased time in A&E due to lack of inpatient beds, GGH.	Community & Integrated Medicine	Chief Operating Officer	20	12	31/03/2027	12/05/2026
750	Risk of delays at Emergency Department due to lack of substantive middle grade doctors	Community & Integrated Medicine	Chief Operating Officer	20	12	03/08/2026	01/05/2026
1517	Risk of poor patient outcomes and poor experience due to breaches of routine Physiotherapy waiting times	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	12	31/12/2026	08/05/2026
2113	Risk of patient harm in Emergency department Withybush hospital due to demand exceeding capacity,	Community & Integrated Medicine	Chief Operating Officer	20	12	01/06/2026	01/05/2026
2145	Risk of harm to patients due to insufficient capacity to meet physiotherapy intervention demand in acute hospitals	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	12	31/03/2027	08/05/2026
1290	Risk of increased Adult ADHD waiting list due to referrals exceeding service capacity.	Mental Health and Learning Disabilities	Chief Operating Officer	20	16	26/04/2030	17/04/2026

Risk Themes (1 of 3)

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Risk owners can allocate themes to their risks, which allows the Health Board to share risk information on specific areas with relevant experts as part of the second line of defence. Risks are allocated to a committee based on their main impact on reporting. Risk themes are assigned based on any additional impacts or contributory factors, with each theme aligned to the appropriate committee for oversight. Risk themes provide assurance that a holistic approach to risk management is undertaken and enables the Health Board to better identify the risk appetite, risk capacity and total risk exposure in relation to each risk, group of similar risks, or generic type of risk.

Theme owners are provided with a thematic risk register on a bi-monthly basis to identify trends, or risk clusters, and to consider whether there are gaps in controls in the Health Board's control framework, and to determine whether further action is required to prevent risks from materialising.

The risk themes have been reviewed with the Assistant Director of Nursing, Assurance and Safeguarding to re-align with them to the revised quality and safety operational governance structure which underpins the newly established Quality and Safety Intelligence Group (QSIG). It will be the responsibility going forward of the relevant QSIG sub-group to review those operational risks thematically aligned to them to oversee and monitor (second line of defence) to help ensure that operational leads (first line of defence) are effectively managing risks. This process, along with a number of new risk themes as included in the table on the next slide will be in place from Q2 2026/27. **The following new risk themes have been identified and will be aligned to QSEC:**

New theme	Definition	QSIG Group
HTA Compliance	A risk that involves complying with the regulations and legislation under the Human Tissue Act.	Human Tissue Authority Assurance Group
Nutrition & Hydration	A risk in relation to patient care and treatment relating to nutrition and hydration	Nutrition and Hydration Group
Resuscitation	A risk in relation to patient care and treatment relating to resuscitation and DNACPR	RADAR Group
Medical Exposure/ IRMER	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

Risk Themes (2 of 3)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

The following themes are currently aligned to QSEC as of May 2026:

Theme	Definition	Number of risks	Date Themed Risk Register last shared	QSIG Group
Business continuity /service disruption	A risk that threatens to disrupt the functioning of the organisation, typically caused by an untoward incident or disaster that has a negative impact on operations.	118	15/04/2026	N/A
Consent and Mental Capacity	Risks relating to consent to examination or treatment e.g. missing, illegible, incorrect consent form; failure to obtain consent; mismatch between consent form and list etc. Risks relating to people who may lack mental capacity e.g. failure or concerns relating to assessment of decision-making capacity; acting in the person's best interests; consulting with those close to the person etc.	0	N/A	Mental Capacity Act and Consent Group
Deprivation of Liberty Safeguards (DoLS)	Risks relating to a failure to submit DoLS referral when needed, a person being deprived of their liberty when they have capacity to consent to be in hospital, a lack of awareness of what actions can and cannot be taken when a DoLS authorisation is in place (e.g. you can stop someone from absconding), DoLS doesn't give authority for care and treatment decisions, a patient with a DoLS authorisation can be discharged).	1	08/05/2026	Mental Capacity Act and Consent Group
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	175	N/A	Fragile Services Oversight Group

Risk Themes (3 of 3)

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Theme	Definition	Number of risks	Date Themed Risk Register last shared	QSIG Group
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.	22	08/05/2026	Infection Prevention Strategic Steering Group
Medical Devices	A risk related to a medical device or devices, including any instrument (other than a medicine) that is used to diagnose, monitor, treat or manage a medical condition. The definition covers a wide range of products including syringes, dressings, surgical tools, scanners, software, apparatus, machines and some medical apps.	25	15/04/2026	Medical Devices Group
Medication	A risk that involves the prescribing, dispensing or supply, administration or monitoring of medicines.	21	08/05/2026	Medicines Management Oversight Group
NICE / National Guidance	Risks related to the Health Board's ability to comply with national evidence-based guidance for health and care.	43	30/04/2026	Effective Clinical Practice
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.	24	08/05/2026	Strategic Safeguarding Group

Audits and Inspections - Overview

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

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

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

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

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

Audits and Inspection reports assigned to QSEC
(Page 1 of 6)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

There are currently 29 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 1.**

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.
Oct-24	Internal Audit	Falls Management Final Internal Audit Report October 2024	Director of Nursing, Quality and Patient Experience	Nursing, Quality and Patient Experience	May-25	~~May-25~~ ~~Dec-25~~ Jun-26	6	2	0	4	0	0	0	0	No barriers noted.
Jan-25	Internal Audit	Mortuary Services Final Internal Audit Report 2024/25 Swansea Bay University Health Board Hywel Dda University Health Board	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	Mar-25	N/K	9	1	0	4	4	0	0	0	Awaiting signed transitional Memorandum of Understanding from Swansea Bay University Health Board
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	Meeting being arranged with Internal Audit to agree outstanding evidence required.

Audits and Inspection reports assigned to QSEC
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Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Date of report	Report Issued By	Report Title	Clinical Care Group/ Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommend-ations in original report	Overdue	In progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Barriers to Completion
Feb-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~~ Dec-26	19	1	0	18	0	0	0	0	Recurrent and non-recurrent finance required.
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~~ Dec-26	9	1	0	7	0	0	0	1	No barriers noted.
May-23	HIW	Mental Health Discharge Review	Mental Health and Learning Disabilities	Nursing, Quality and Patient Experience	Mar-24	~~Mar-26~~ Dec-26	40	2	0	35	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	9	2	0	7	0	0	0	0	Financial barriers to provide training and workforce challenges.
Oct-23	HIW	St Non, St Caradog, Canolfan Bro Cerwyn WGH	Mental Health and Learning Disabilities	Nursing, Quality and Patient Experience	Oct-24	~~Oct-24~~ ~~Oct-25~~ ~~Jan-26~~ N/K	19	4*	0	15	0	0	0	0	No barriers noted.

*4 recommendations added to the existing report on 7 April 2026 by QAST (noted as overdue as report dated October 2023).

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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)	Director of Nursing, Quality and Patient Experience	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	IRMER Regulations	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	Jul-25	~~Jul-25~~ ~~Jan-26~~ ~~Apr-26~~ N/K	9	2	0	7	0	0	0	0	No barriers noted.
May-25	Internal Audit	Standards of Cleanliness Final Internal Audit Report 2024/25	Estates & Facilities	Allied Health Professions and Health Sciences	Oct-25	N/A	6	0	0	5	1	0	0	0	*None- report awaiting formal approval to close.*
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.
Jul-25	Internal Audit	Nursing Management Final Internal Audit Report 2025/26	Director of Nursing, Quality and Patient Experience	Chief Operating Officer	Sep-25	~~Sep-25~~ ~~Dec-25~~ N/A	3	0	0	2	1	0	0	0	No barriers noted.

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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
Mar-25	HIW	Joint Inspection of Child Protection Arrangements (Pembrokeshire)	Nursing, Quality and Patient Experience	Chief Operating Officer	Mar-26	N/K	21	6	0	14	1	0	0	0	Access to Level 3 training. Paediatric Consultant workforce. The policy will need to include multi-agency partners.
Jun-25	HIW IRMER	Nuclear Medicine IRMER WGH	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	Apr-27	Apr-27	26	1	2	23	0	0	0	0	Fragility of management.
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.
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.
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~~ N/K	1	1	0	0	0	0	0	0	No barriers noted.
Oct-25	Royal College of Physicians	Joint Advisory Group on GI Endoscopy	Planned and Specialist Care	Chief Operating Officer	Mar-26	N/A	2	0	0	0	2	0	0	0	*None - report awaiting formal approval to close.*

Audits and Inspection reports assigned to QSEC
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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	HIW	HIW Inspection BGH Emergency Department October 2025	Community & Integrated Medicine	Chief Operating Officer	Mar-27	Mar-27	29	8	1	18	2	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	3	0	3	0	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	5	5	0	0	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	4	6	4	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	N/K	8	5	0	2	1	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	6	4	2	0	0	0	0	0	No barriers noted.

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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	0	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	0	5	1	0	0	0	0	No barriers noted.
Mar-26	Internal Audit	HTA (Follow Up) Final Internal Audit Report 2025/26	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	Dec-25	Dec-26	1	1	0	0	0	0	0	0	No barriers noted.

Recommendations

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

Risk Management

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

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.

DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG

SAFE | SUSTAINABLE | ACCESSIBLE | KIND

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Inspection Title	Recommendation	Action	Clinical Care Group/Executive Function	Lead Director	Original Due Date	Current Due Date
Audit Wales - Discharge Planning Progress Update – Hywel Dda University Health Board August 2025	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.	On the week commencing 8 September 2025, we are undertaking a 'reset week' with a focus on patient flow, processes and discharge. An element of this exercise is to concentrate on increasing the number of patients being discharged before midday, supported using our discharge lounges. The targeted approach will enable us to capture and develop criteria for patients suitable for transfer to the discharge lounge alongside some of the perceived constraints in relation to this.	Community & Integrated Medicine	Chief Operating Officer	31/10/2025	31/10/2025
Audit Wales - Discharge Planning Progress Update – Hywel Dda University Health Board August 2025	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.	Community & Integrated Medicine	Chief Operating Officer	31/03/2026	31/03/2026
Audit Wales - Discharge Planning Progress Update – Hywel Dda University Health Board August 2025	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.	Community & Integrated Medicine	Chief Operating Officer	31/12/2025	31/12/2025
Audit Wales - Discharge Planning Progress Update – Hywel Dda University Health Board August 2025	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.	Our SharePoint page now holds a toolkit specifically appropriate to hospital discharge. This includes an individual page holding a suite of information concerning discharge lounges. Relevant documentation is accessible from this area and includes forms such as an SBAR transfer document that aims to facilitate and expedite the transfer in a safe and efficient manner. A Welsh PAS transfer to discharge guide also simplifies the process for updating the patient location in a timely approach. Using this data will be conducive to our ongoing monitoring of discharge lounges and the amount of time that patients remain there. This is already embedded as a requirement for the transferring ward however closer monitoring and review will ensure compliance.	Community & Integrated Medicine	Chief Operating Officer	31/10/2025	31/10/2025

Inspection Title	Recommendation	Action	Clinical Care Group/Executive Function	Lead Director	Original Due Date	Current Due Date
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.	Mental Health & Learning Disabilities	Chief Operating Officer	31/03/2026	31/03/2026
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.	Community & Integrated Medicine	Chief Operating Officer	31/12/2025	31/12/2025
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.	Community & Integrated Medicine	Chief Operating Officer	31/01/2026	31/01/2026
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.	Community & Integrated Medicine	Chief Operating Officer	20/02/2026	20/02/2026

Inspection Title	Recommendation	Action	Clinical Care Group/Executive Function	Lead Director	Original Due Date	Current Due Date
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	Community & Integrated Medicine	Chief Operating Officer	01/04/2026	01/04/2026
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.	Community & Integrated Medicine	Chief Operating Officer	28/02/2026	28/02/2026
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.	Community & Integrated Medicine	Chief Operating Officer	30/11/2025	30/11/2025
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.	Community & Integrated Medicine	Chief Operating Officer	03/09/2025	03/09/2025
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.	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	30/09/2023	30/09/2023
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.	Mental Health & Learning Disabilities	Chief Operating Officer	30/11/2023	30/11/2023
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.	Mental Health & Learning Disabilities	Chief Operating Officer	30/11/2023	30/11/2023

Inspection Title	Recommendation	Action	Clinical Care Group/Executive Function	Lead Director	Original Due Date	Current Due Date
HIW Inspection BGH Emergency Department	HIW requires details on how the health board will ensure that the 'difficult airway' trolley is checked regularly and an accurate record of checks maintained.	Weekly spot checks to be undertaken by senior nurse management team to ensure ongoing compliance and submit assurance to System General Manager. This will be monitored through the update report to the Clinical Care Group Governance meeting until action plan is fully implemented.	Community & Integrated Medicine	Chief Operating Officer	30/09/2025	30/09/2025
HIW Inspection BGH Emergency Department	The health board must continue with efforts to reduce the number of patients receiving care in corridor areas.	To progress the accelerated Urgent and Emergency Care work focusses on access, flow and environments. The cumulative result of this will support in the reduction and ultimate elimination of corridor care.	Community & Integrated Medicine	Chief Operating Officer	28/02/2026	28/02/2026
HIW Inspection BGH Emergency Department	The health board must ensure that immunocompromised cancer patients presenting at ED are appropriately accommodated, to reduce the risk of harm.	To establish an oncology assessment pathway, enabling patients who contact the triage line to be signposted directly to a designated assessment space on Meurig Ward. This pathway will enhance timely access to specialist care.	Community & Integrated Medicine	Chief Operating Officer	30/09/2025	30/09/2025
HIW Inspection BGH Emergency Department	The health board must ensure that pressure area risk assessments are undertaken routinely for patients whose presenting condition warrant such a risk assessment.	To ensure that any concerns are escalated to the Care Group's Quality, Health and Safety Meeting providing sustained oversight and improvement.	Community & Integrated Medicine	Chief Operating Officer	30/09/2025	30/09/2025
HIW Inspection BGH Emergency Department	The health board must ensure that falls risk assessments are undertaken routinely and in a timely way for patients whose presenting condition warrant such a risk assessment.	To ensure that any concerns are escalated to the Care Group's Quality, Health and Safety Meeting to ensure sustained oversight and improvement.	Community & Integrated Medicine	Chief Operating Officer	29/09/2025	29/09/2025
HIW Inspection BGH Emergency Department	The health board must ensure that patient assessments are fully completed and documented.	To ensure that any concerns are escalated to the Care Group's Quality, Health and Safety Meeting to ensure sustained oversight and improvement.	Community & Integrated Medicine	Chief Operating Officer	30/09/2025	30/09/2025
HIW Inspection BGH Emergency Department	The health board must ensure that fluid intake and output balance charts are being completed consistently.	To ensure that any concerns are escalated to the Care Group's Quality, Health and Safety Meeting to ensure sustained oversight and improvement.	Community & Integrated Medicine	Chief Operating Officer	30/09/2025	30/09/2025
HIW Inspection BGH Emergency Department	The health board must ensure that staff documentation in patient records provide sufficient clinical/ care details, and records are completed consistently and are legible.	To ensure that any concerns are escalated to the Care Group's Quality, Health and Safety Meeting to ensure sustained oversight and improvement.	Community & Integrated Medicine	Chief Operating Officer	30/09/2025	30/09/2025
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	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	31/12/2024	31/12/2024
HIW St Non, St Caradog, Canolfan Bro Cerwyn WGH	The health board must make sure that temperature checks are consistently recorded on St Nons ward	The health board must make sure that temperature checks are consistently recorded on St Nons ward	Mental Health and Learning Disabilities	Director of Nursing, Quality and Patient Experience	30/04/2024	30/04/2024
HIW St Non, St Caradog, Canolfan Bro Cerwyn WGH	The health board must ensure that out of date medication is disposed of and that clinical waste bins are available in clinical rooms	The health board must ensure that out of date medication is disposed of and that clinical waste bins are available in clinical rooms	Mental Health and Learning Disabilities	Director of Nursing, Quality and Patient Experience	30/04/2024	30/04/2024
HIW St Non, St Caradog, Canolfan Bro Cerwyn WGH	The health board must ensure that menu options include gluten free options of more variety of choices for patients.	The health board must ensure that menu options include gluten free options of more variety of choices for patients.	Mental Health and Learning Disabilities	Director of Nursing, Quality and Patient Experience	30/04/2024	30/04/2024
HIW St Non, St Caradog, Canolfan Bro Cerwyn WGH	The health board must ensure that checks are undertaken on the patients fridge and that no out of date products are stored in the fridges.	The health board must ensure that checks are undertaken on the patients fridge and that no out of date products are stored in the fridges.	Mental Health and Learning Disabilities	Director of Nursing, Quality and Patient Experience	30/04/2024	30/04/2024

Inspection Title	Recommendation	Action	Clinical Care Group/Executive Function	Lead Director	Original Due Date	Current Due Date
Internal Audit - Falls Management Final Internal Audit Report October 2024 (Reasonable)	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.	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	31/03/2025	31/03/2025
Internal Audit - Falls Management Final Internal Audit Report October 2024 (Reasonable)	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.	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	31/05/2025	31/05/2025
Internal Audit - HTA (Follow Up) Final Internal Audit Report 2025/26	R1. Standardisation of SOPs and Forms A legacy of site-specific SOPs and documentation has resulted in multiple versions and inconsistencies. Now that all postmortems are undertaken on one site a review to consolidate and standardise SOPs, forms and documents needs to be completed to simplify naming and referencing and remove duplication and also standardise processes where practicable as part of the regional mortuary with SBUHB.This will be a significant undertaking and there is no plan in place setting out how and when this will be achieved.	An action plan with timescales for achievement and an initial review of documents has been done to identify those that can be merged or are obsolete, however amendments to the documents are not due for completion until 31/12/26.	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	31/12/2025	31/12/2025
Internal Audit - Managed Practices Final Internal Audit Report 2025/26 (Reasonable)	R1. Inconsistent Risk Management Practices Risk management practices are inconsistent, with practice level 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.	Primary Care	Chief Operating Officer	31/03/2026	31/03/2026
Internal Audit - Managed Practices Final Internal Audit Report 2025/26 (Reasonable)	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.	Primary Care	Chief Operating Officer	31/03/2026	31/03/2026

Inspection Title	Recommendation	Action	Clinical Care Group/Executive Function	Lead Director	Original Due Date	Current Due Date
Internal Audit - Managed Practices Final Internal Audit Report 2025/26 (Reasonable)	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	Primary Care	Chief Operating Officer	31/03/2026	31/03/2026
Internal Audit - Managed Practices Final Internal Audit Report 2025/26 (Reasonable)	R5. Open Incidents A datix report of all incidents recorded for managed practices for the period October 2023 – September 2025 identified five incidents (two severe, three moderate) reported prior to March 2025 that remain open.	Open incidents will be reviewed by the individual Practice Manager to ensure that they have been concluded, and subsequently closed on Datix.	Primary Care	Chief Operating Officer	31/03/2026	31/03/2026
Internal Audit - Mortuary Services Final Internal Audit Report 2024/25 Swansea Bay University Health Board Hywel Dda University Health Board (Limited)	R1. Memorandum of Understanding Roles and responsibilities have been clearly documented within the Transitional MoU and Mortuary Service MoU. While the Transitional MoU has been approved by both health boards in May 2024, no signed version of the document could be located during our review. The Mortuary Service MoU was originally instigated in 2022 to address staffing issues in HDUHB. The document has been reviewed and approved by the Chief Executives of both health boards in March 2024. However, the contact point for SBUHB is not recorded within the document; and we have been unable to confirm the reporting of the MoU within the health boards and its communication to mortuary staff.	We will ensure the Transitional MoU is signed and the document is easily accessible. The Mortuary MoU will be reviewed and updated to ensure key contact information is included, and we will ensure the final version is circulated appropriately within both health boards and communicated to mortuary staff.	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	31/03/2025	31/03/2025
Internal Audit - Patient Experience Final Internal Audit Report 2025/26 (Reasonable Assurance)	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.	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	31/01/2026	31/01/2026

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Internal Audit - Patient Experience Final Internal Audit Report 2025/26 (Reasonable Assurance)	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.	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	31/01/2026	30/04/2026
Internal Audit - Patient Experience Final Internal Audit Report 2025/26 (Reasonable Assurance)	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.	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	30/04/2026	30/04/2026
Internal Audit - Patient Experience Final Internal Audit Report 2025/26 (Reasonable Assurance)	R4. Governance Whilst patient story is a standing agenda item for IGG QHS meetings, patient experience data including themes and trends is not. Only two of the service areas reviewed demonstrated reporting of patient experience data at their respective IGGs, this included identification of themes and trends and triangulation with concerns/incidents data.	Patient experience will be incorporated into the Concerns element of the QHS agenda to ensure triangulation with concerns data and identification of key themes and trends.	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	30/04/2026	30/04/2026
Internal Audit - Patient Experience Final Internal Audit Report 2025/26 (Reasonable Assurance)	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.	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	31/03/2026	31/03/2026

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Internal Audit- Discharge Management (Follow Up) Final Internal Audit Report 2024/25 (Assurance Rating: N/A)	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 Withybush General Hospital patients	Community & Integrated Medicine	Chief Operating Officer	31/03/2025	31/03/2025
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	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	31/07/2025	31/07/2025
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	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	30/06/2025	30/06/2025
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.	Director of Nursing, Quality and Patient Experience	Chief Operating Officer	31/12/2025	31/12/2025
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	Director of Nursing, Quality and Patient Experience	Chief Operating Officer	30/09/2025	28/03/2026
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	Director of Nursing, Quality and Patient Experience	Chief Operating Officer	30/09/2025	30/09/2025
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	Director of Nursing, Quality and Patient Experience	Chief Operating Officer	30/11/2025	30/11/2025

Inspection Title	Recommendation	Action	Clinical Care Group/Executive Function	Lead Director	Original Due Date	Current Due Date
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	Director of Nursing, Quality and Patient Experience	Chief Operating Officer	30/11/2025	28/03/2026
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.	Director of Nursing, Quality and Patient Experience	Chief Operating Officer	31/03/2026	31/03/2026
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	Director of Nursing, Quality and Patient Experience	Chief Operating Officer	31/03/2026	31/03/2026
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.	Director of Nursing, Quality and Patient Experience	Chief Operating Officer	31/03/2026	31/03/2026
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.	Director of Nursing, Quality and Patient Experience	Chief Operating Officer	31/12/2025	31/12/2025
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.	Community & Integrated Medicine	Chief Operating Officer	31/10/2025	31/10/2025
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.	Community & Integrated Medicine	Chief Operating Officer	30/09/2025	30/09/2025
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.	Community & Integrated Medicine	Chief Operating Officer	10/10/2025	10/10/2025
NHS Delivery Unit - Review of Dermatology Services in Wales Hywel Dda University Health Board	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	Planned and Specialist Care	Chief Operating Officer	30/09/2025	30/09/2025
NHS Delivery Unit - Review of Dermatology Services in Wales Hywel Dda University Health Board	R4. Re- establish the organisations patch testing service	Awaiting management response	Planned and Specialist Care	Chief Operating Officer	30/09/2025	30/09/2025

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NHS Delivery Unit - Review of Dermatology Services in Wales Hywel Dda University Health Board	R5. Allow access to the identified clinic space in outpatients to expand.	Awaiting management response	Planned and Specialist Care	Chief Operating Officer	30/09/2025	30/09/2025
NHS Wales Executive Review of Psychology and Psychological Interventions for Children and Young People	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	Planned and Specialist Care	Chief Operating Officer	31/07/2024	31/07/2024
NHS Wales Executive Review of Psychology and Psychological Interventions for Children and Young People	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	Planned and Specialist Care	Chief Operating Officer	30/11/2024	30/11/2024
NHS Wales Executive Review of Psychology and Psychological Interventions for Children and Young People	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	Planned and Specialist Care	Chief Operating Officer	31/05/2024	31/05/2024
NHS Wales Executive Review of Psychology and Psychological Interventions for Children and Young People	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	Planned and Specialist Care	Chief Operating Officer	31/07/2024	31/07/2024
NHS Wales Performance and Improvement Report on Urgent and Emergency Care Opportunities: WGH site	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.	Establish and embed regular and robust ED board rounds for medical patients	Community & Integrated Medicine	Chief Operating Officer	31/01/2026	31/01/2026
NHS Wales Performance and Improvement Report on Urgent and Emergency Care Opportunities: WGH site	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.	Community & Integrated Medicine	Chief Operating Officer	28/02/2026	28/02/2026
NHS Wales Performance and Improvement Report on Urgent and Emergency Care Opportunities: WGH site	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	Community & Integrated Medicine	Chief Operating Officer	31/03/2026	31/03/2026
NHS Wales Performance and Improvement Report on Urgent and Emergency Care Opportunities: WGH site	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	Community & Integrated Medicine	Chief Operating Officer	31/03/2026	31/03/2026
NHS Wales Performance and Improvement Report on Urgent and Emergency Care Opportunities: WGH site	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.	review portfolios and agree	Community & Integrated Medicine	Chief Operating Officer	31/03/2026	31/03/2026

Inspection Title	Recommendation	Action	Clinical Care Group/Executive Function	Lead Director	Original Due Date	Current Due Date
Welsh Risk Pool Concerns Assessment (December 2024)	R06 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.	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	31/03/2025	31/03/2025