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

Quality and Safety Assurance Report

Quality, Safety and Experience Committee

June 2026

Situation

The purpose of this report is to provide the Quality, Safety and Experience Committee (QSEC) with an overview of quality and safety across the Health Board.

Within the Health Board's Quality Management System, a number of assurance processes and quality improvement strategies are used to ensure high quality care is delivered to patients.

This report provides information on:

- Patient safety incidents
- Nationally reported patient safety incidents
- Never Events
- Patient Experience
- Complaints management
- Inquests and Regulation 28
- Infection prevention and control
- Inspections and peer reviews including activity of Healthcare Inspectorate Wales (HIW)

Appendices to this report

- HIW Improvement Actions – overdue
- Infection Prevention and Control Organisational Improvement Plan for 2026-27

Patient Safety Incidents

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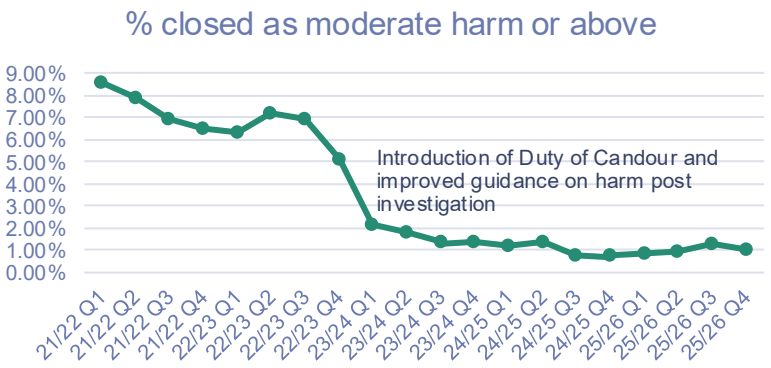
There were 15,312 incidents reported on Datix Cymru in Hywel Dda UHB between 01/05/2026 and 30/04/2026. Of these, 12,152 were Patient Safety Incidents.

Of the 12,152 patient safety incidents reported, 9,676 have been closed. 98 (0.8%) were closed as moderate, severe or catastrophic harm.



The top 3 incident categories (patient safety incidents reported between 01/05/2025 and 30/04/2026 and closed as moderate, severe or catastrophic harm) were:

Slip, trip or fall	23
Treatment or procedure issues	12
Pressure ulcer developed or worsened during care in this clinical care area/caseload	10

A review, using the support of AI, identified the main themes, within the lessons learned of patient safety incidents closed between 01/01/2026 and 31/03/2026 were:

Theme	Main clinical care groups	Recommended action for clinical care groups
Documentation / record keeping / filing	Community & Integrated Medicine (381), Mental Health & Learning Disabilities (65), Planned & Specialist Care (65)	Standardise document upload, filing and ID-check controls across all groups; introduce a mandatory second-check for high-risk records and a monthly documentation audit with feedback.
Assessment / escalation / timely review	Community & Integrated Medicine (289), Planned & Specialist Care (31), Operations (Deactivated 31.03.2025) (29)	Reinforce early assessment and escalation pathways; require safety-critical reviews to be completed within defined timescales and monitor compliance through weekly spot checks.
Falls / pressure ulcer / physical care	Community & Integrated Medicine (262), Operations (Deactivated 31.03.2025) (10), Planned & Specialist Care (7)	Strengthen admission risk assessments, care plans and intentional rounding; ensure falls and pressure-area prevention bundles are completed and reviewed on every shift.

These themes have been shared with:

- Clinical Care Groups for discussion, consideration and improvement action
- The learning library and Viva Engage

Diogel Safe

Nationally Reportable Incidents (NRI)

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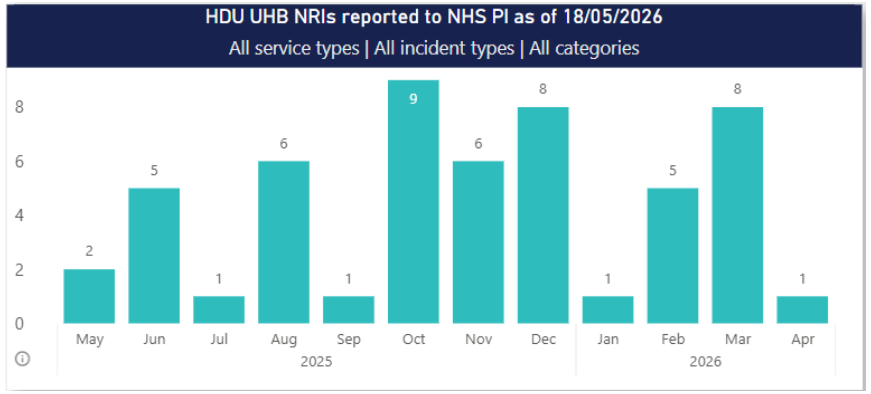
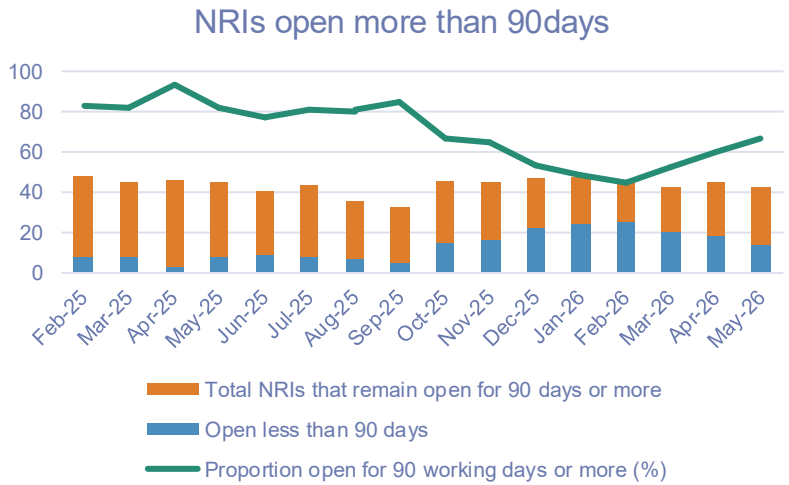
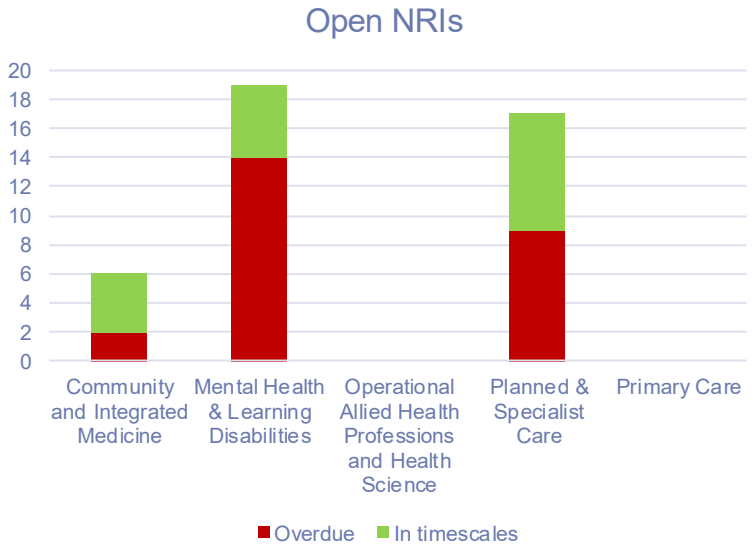
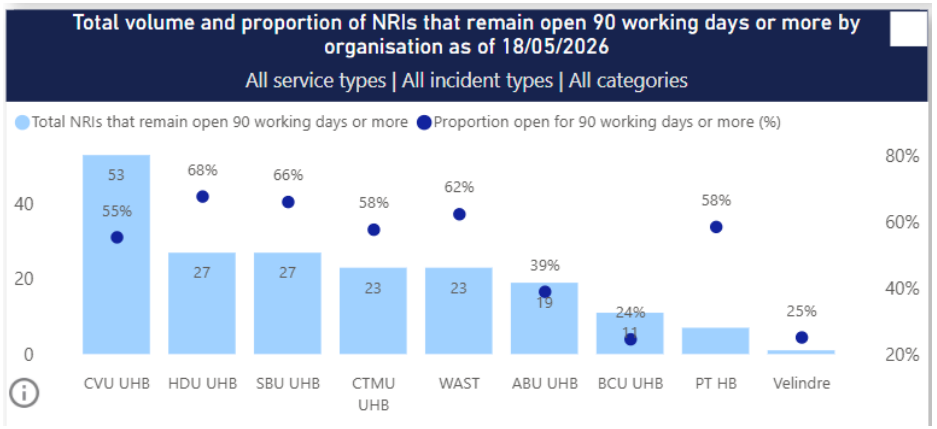


Source: Beacon Dashboard
19/05/2026







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	3	1	0	1	1	6
Mental Health & Learning Disabilities	5	0	1	0	13	19
Operational Allied Health Professions and Health Science						0
Planned & Specialist Care	6	0	3	4	4	17
Primary Care						0
Totals	14	1	4	5	18	42

Never Events

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HDU UHB Never Events occuring (by incident date, May-25 to Apr-26) as of 18/05/2026												
Year	2025								2026			
Never Event	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Retained foreign object post procedure	0	0	0	0	0	0	1	0	0	0	0	0
Total Never Events	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**

Source: Beacon Dashboard 19/05/2026

HDD79894 (NRI-4672)

In April 2026, reported on this incident to QSEC

> "Patient was discharged with a newly inserted nasogastric tube without confirmation of correct placement, contrary to Health Board policy and national safety guidance"

Following further investigation and discussion with the NHS Wales Performance and Improvement, it has been agreed that this event does not meet the criteria for reporting as a Never Event. The incident has been downgraded and closed by the NHS Wales Performance and Improvement

Inquests and Regulation 28

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

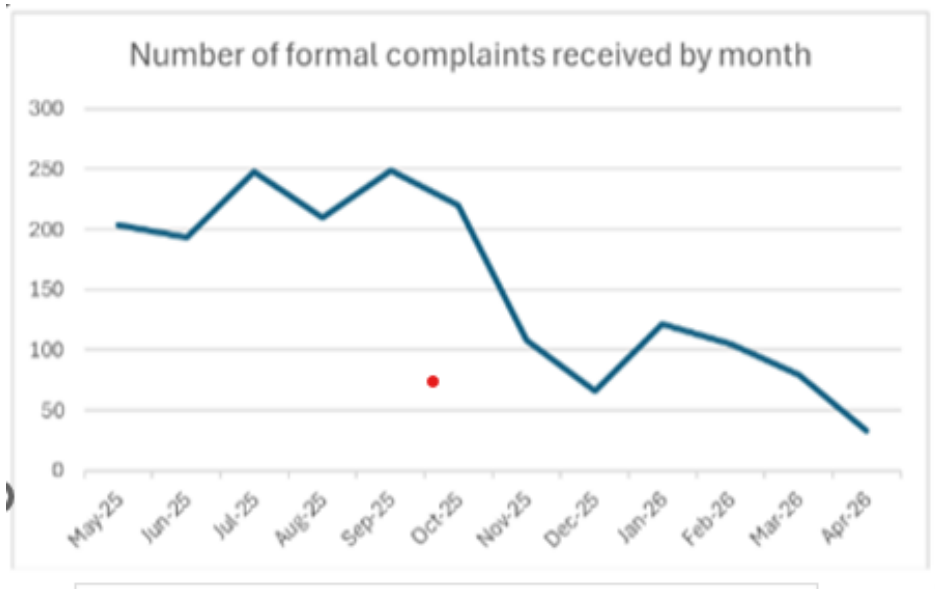
Report Category	Link	Reports
Child Death (from 2015)		**1**
HDUHB		**1**
Report date: 27/02/2026 Ref: (2026-0118)		1
Wales prevention of future deaths reports (2019 onwards)		**1**
HDUHB		**1**
Report date: 27/02/2026 Ref: (2026-0118)		1
Total		**1**

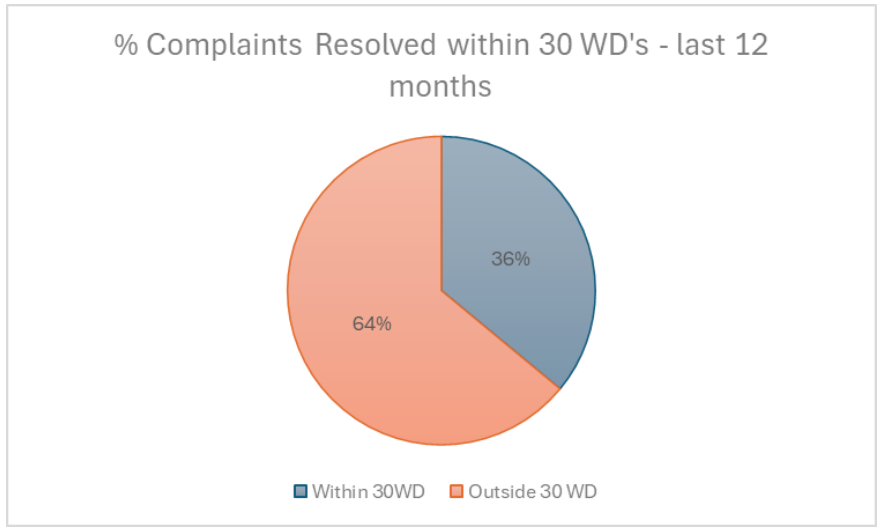
Source: Beacon Dashboard 19/05/2026

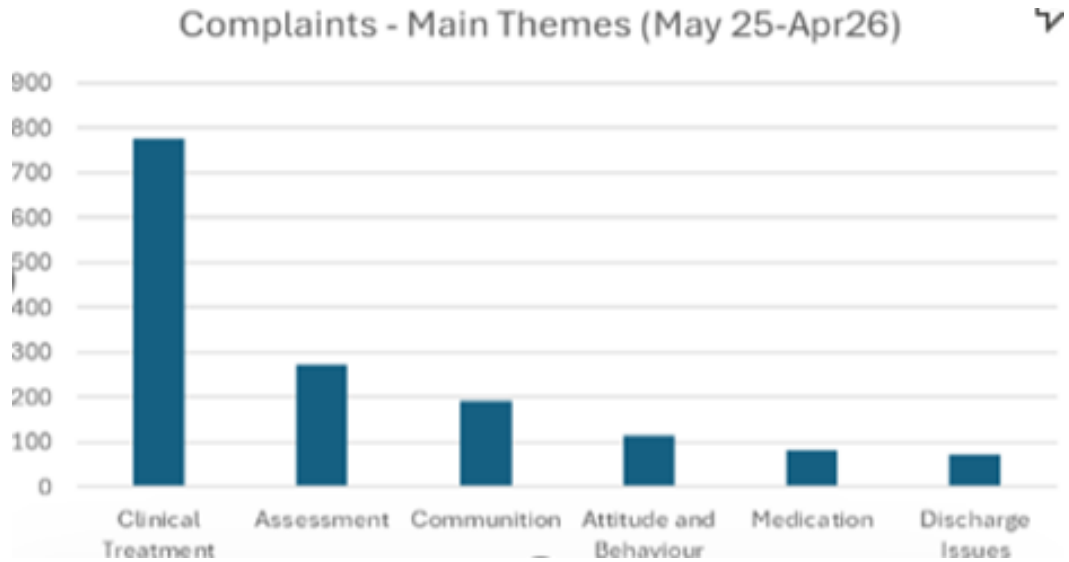
All Wales Regulation 28 - Prevention of Future Death Reports since 2022 - all categories of report (as of 15/05/2026)

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 Reports			**40**	**64**	**27**	**27**	**7**	**13**	**6**	**46**	**14**	**2**		**10**

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.

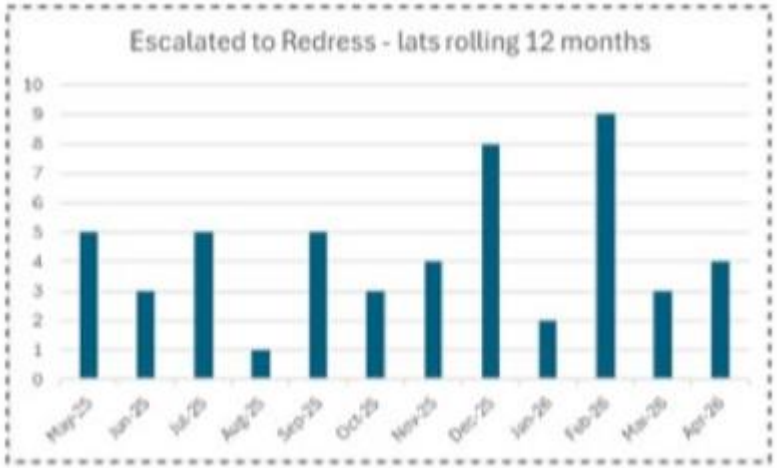
The reduction in the overall number of complaints received reflects the drive towards early resolution, especially since the beginning of 2026 where there was an increased focus on early resolution in anticipation of the new 'Listening to People' complaint regulations. Since coming into effect in April, 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.

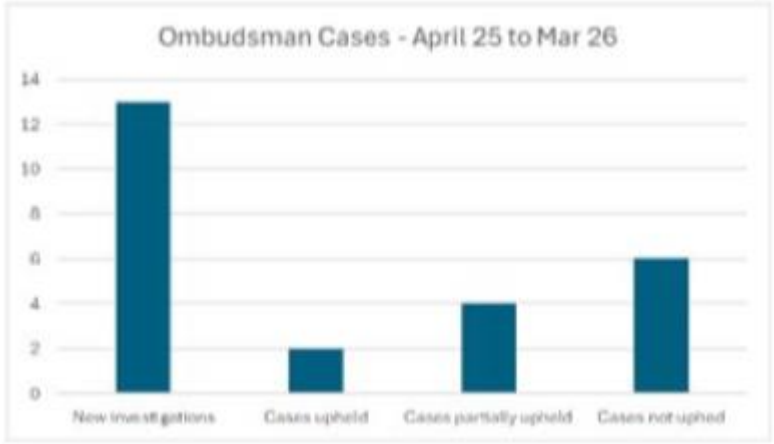
Health Board Overview: Outcomes and Closure Trajectory

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

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

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





Reducing backlog of Putting Things Right (PTR) complaints

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

Update of Listening to People (LTP)

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

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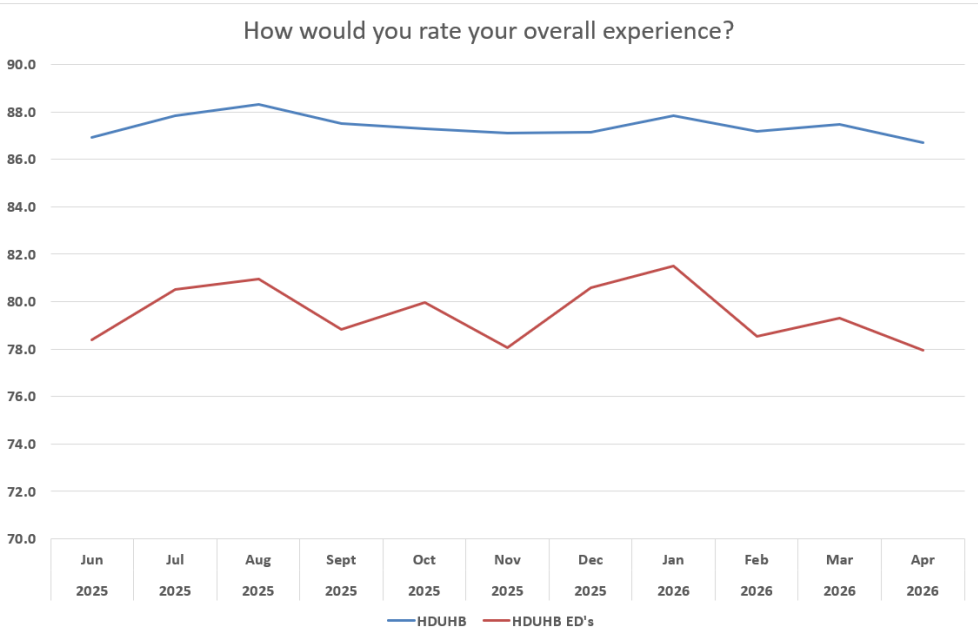
People's Experience Feedback



Measure name	Apr-26 Actual %
I am treated with dignity and respect	89.30%
Things were explained to me in a way I could understand	89.00%
I was able to communicate in my preferred language	95.50%

Overall Experience Trends

What Patients Valued Most:

- Compassion and Empathy
  - Patients highly valued the compassion and empathy shown by healthcare staff during their care.
- Clear Communication
  - Clear explanations and reassurance helped patients feel less anxious and better informed about their care.
- Teamwork in Care
  - Effective teamwork across medical disciplines contributed to smooth and reassuring patient experiences.

Challenges Identified by Patients:

- Waiting Times in Emergency Departments
  - Long waiting times in Accident & Emergency departments were a major patient concern, causing frustration and stress.
- Environmental Discomfort
  - Uncomfortable seating, cleanliness issues, and lack of refreshments negatively impacted patient experience during waits.
- Communication Gaps
  - Lack of clear updates about delays and next steps increased patient anxiety and dissatisfaction.
- Empathy for Staff Pressures
  - Patients recognized the workforce and capacity challenges faced by staff despite their own concerns.

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

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Quality Planning

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

Quality Control

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

Quality Improvement

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

IP&C Strategic Overview continued

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Quality Assurance

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

Performance de-escalation summary

Latest position key

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

	Measure	De-escalation criteria	Baseline	Baseline	Goal	Nov-24	Dec-24	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-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	8	6	6	8	8	11	7	4	5	11	8	8	2	8	1
	Number of laboratory confirmed S.aureus bacteramia cases with hospital onset	33% reduction, maintained for 3 months	3	Baseline (average Q3 23/24)	2	2	3	4	3	3	3	4	5	4	3	4	6	2	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	9	5	8	6	5	7	10	6	9	10	7	8	2	6	4

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 74.34%

Hydrogen Peroxide Vapour (HPV) enhanced cleaning now available at 4 acute sites

IP&C overall trend

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Table 1. Latest month rate per 1,000 hospital admissions of specimens by HB, Apr 26

Additional filters for Table 1.

Select month or FY: Latest month

Select organism group: All organisms

- < than last month
- = last month
- > than last month

	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Aneurin Bevan UHB	1.8	0.3	2.1	3.2	0.8	0.1
Betsi Cadwaladr UHB	3.53	0.13	3.14	6.02	1.7	0.52
Cardiff and Vale UHB	3.14	0.55	1.66	4.8	1.66	0.74
Cwm Taf Morgannwg UHB	3.24	0.2	1.82	5.07	1.22	0.2
Hywel Dda UHB	3.53	0	2.28	6.02	1.45	0
Powys THB	9.17	0	0	0	0	0
Swansea Bay UHB	3.32	0.39	0.78	3.91	2.93	0.39
Velindre NHST	3.6	0	0	0	3.6	0
Wales	2.98	0.26	2.04	4.65	1.54	0.31

Table 1. Latest month count of hospital onset (HO)* specimens by HB, Apr 26

Additional filters for Table 1.

Select month or FY: Latest month

Select organism group: All organisms

- < than last month
- = last month
- > than last month

	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Aneurin Bevan UHB	8	3	7	3	2	0
Betsi Cadwaladr UHB	9	0	7	6	2	1
Cardiff and Vale UHB	9	2	4	5	2	2
Cwm Taf Morgannwg UHB	6	0	2	2	0	0
Hywel Dda UHB	8	0	5	5	1	0
Powys THB	0	0	0	0	0	0
Swansea Bay UHB	9	2	2	4	9	1
Velindre NHST	0	0	0	0	0	0
Wales	49	7	27	25	16	4

IP&C Outbreaks / Incidents

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

April 2026-

Site	Area	Pathogen	Commenced	Impact	Opened
Glangwili Hospital (GGH)	Gwenllian	Norovirus	01/04/2026	<5 patients and <5 staff. Stroke pathway maintained - admit at risk for confirmed stroke only	10/04/26
Bronglais Hospital (BGH)	Ceredig	Influenza A	15/04/2026	12 patients and 9 staff. Ward surged to 31 beds, 7 beds in 6 bedder bay. Delays in reporting multiple staff absences due to respiratory illness.	24/04/26
BGH	Meurig	Influenza A	27/04/2026	<5 patients, unable to split ward. Patient to be admitted at risk if absolutely required to deliver care- patients to be advised of outbreak.	Ongoing at time of report
Prince Philip Hospital (PPH)	Ward 1	Norovirus	20/04/2026	<5 patients and <5 staff. Patients across ward. Ward held until 72 hours clear of symptoms due to lessons learnt of recent outbreaks	24/04/26

IP&C Outbreaks / Incidents

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Site	Area	Pathogen	Commenced	Impact	Opened
PPH	Ward 5	Norovirus	26/04/26	6 patients confirmed. Closed over a weekend.	Ongoing at time of report

Incidents

Water concerns (ongoing)-
Stenotrophomonas Maltophilia colonisation on Intensive Therapy Unit (ITU) GGH
Verona Integron-Encoded Metallo (VIM), Pseudomonas aeruginosa (PA) and Vancomycin-Resistant Enterococci (VRE) on Derwen Ward
Tuberculosis (TB) in healthcare worker. Contact tracing in place. Move to FFP3
Upcoming changes to transmission-based precautions (TBPs) and adoption of National Infection Prevention Control Manual (NIPCM)

Outbreaks Lessons Learnt

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Theme	Lesson Learnt
Early Identification & Isolation	Improve early identification and isolation of symptomatic patients at entry points to prevent bay-level spread.
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.
Staff Sickness & Attendance	Reinforce “do not attend work when unwell” for staff, with clear sickness reporting lines. This was a factor in the Ceredig, BGH outbreak.
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

IP&C C. difficile infection

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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

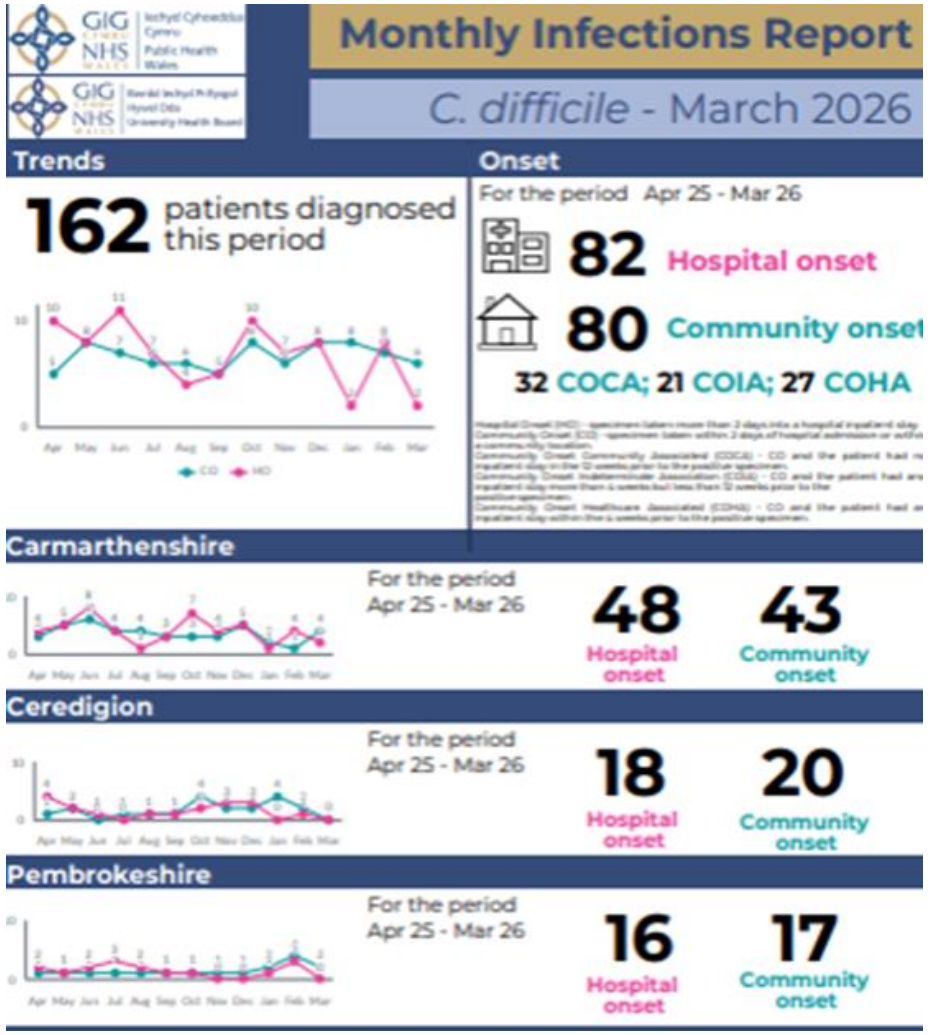
Additional filters for Table 2.

Select FY: 2026/27

	Total count	CO* count	HO** count	% HO***	Total rate per 1,000 hospital admissions	Total rate per 100,000 population
2026/27	17	9	8	47%	3.53	53.29
April 2026	17	9	8	47%	3.53	53.29

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

**Hospital onset (HO) - specimen taken more than 2 days into a hospital inpatient stay



- 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
- The Quality Improvement (QI) project based on intravenous drip (IV) to Oral switch for the Health Board as part of the national C.diff Collaborative requires further action. This needs to be monitored through the Community and Integrated Medicine (CIM) Clinical Care Group (CCG) and through the CDI Improvement Group/ Antimicrobial Group

Genomically and epidemiologically linked clusters identified during reporting period (1 April 2025 – 31 March 2026)

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: 5 clusters (several open)

Glangwili General Hospital: 9 clusters (majority closed; 1 open)

Prince Philip Hospital: 7 clusters (all closed)

Withybush General Hospital: 6 clusters (all closed)

Community Hospitals: 1 cluster (South Pembrokeshire Hospital closed)

Overall Interpretation

Across Hywel Dda University Health Board, episodes of cross-infection during 2025–26 were predominantly small, ward-based clusters rather than large outbreaks. The use of whole genome sequencing has enabled early identification of linked cases, supporting prompt IPC response and closure of investigations in most instances.

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

C. difficile infection: Learning identified and actions

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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
Review of historic Proton Pump Inhibitors: Identify and review	• Share key themes and findings with clinical teams and discuss at HCAI Assurance meetings/ CDI Improvement Group

IP&C E. coli bacteraemia

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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.

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

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

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

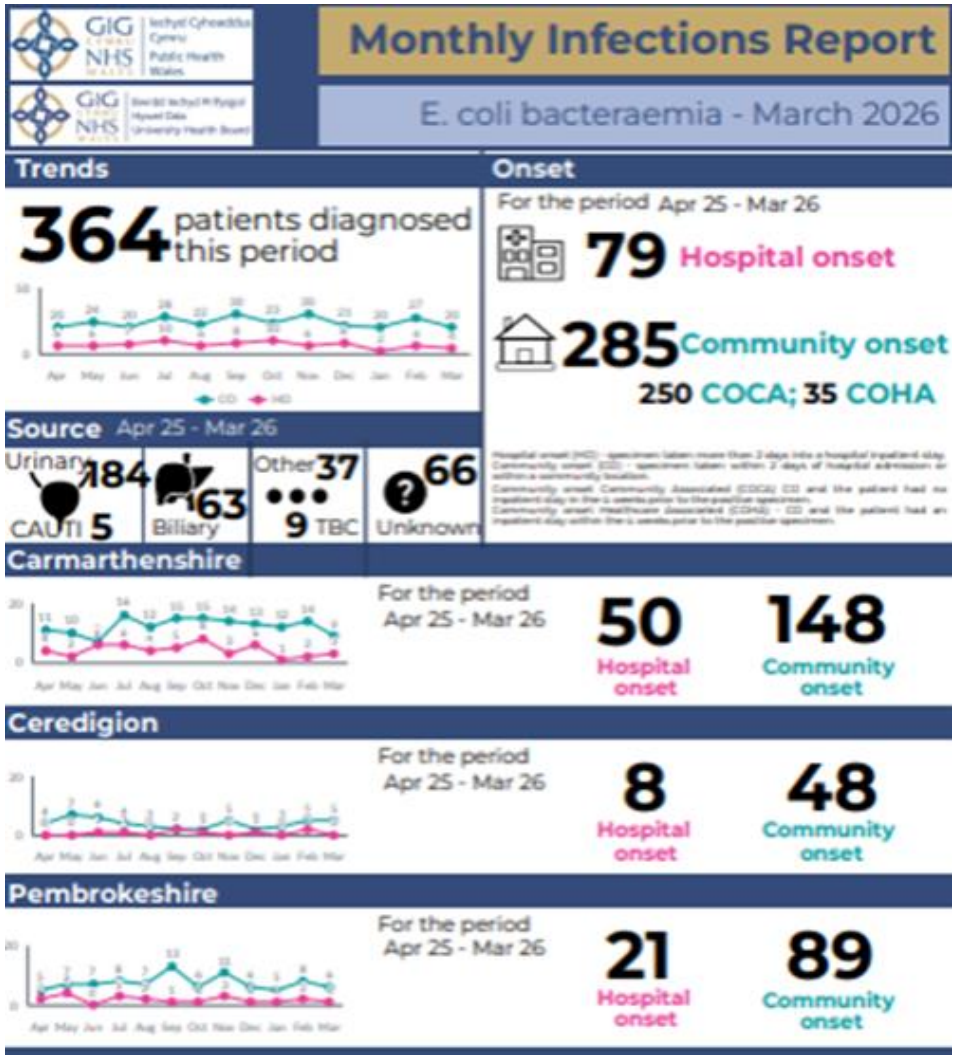
Additional filters for Table 2.
Select FY: 2026/27

	Total count	CO* count	HO** count	% HO***	Total rate per 1,000 hospital admissions	Total rate per 100,000 population
2026/27	29	24	5	17%	6.02	90.90
April 2026	29	24	5	17%	6.02	90.90

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

**Hospital onset (HO) - specimen taken more than 2 days into a hospital inpatient stay

N.B. a hospital inpatient stay



Infections primarily community-onset, linked to urinary tract and some catheter-related infections. The Welsh Health Circulars Antimicrobial resistance and Healthcare Associated infections 2025 to 2027 sets an improvement goal: a reduction of at least 10% in cases of hospital onset E. coli bloodstream infections (BSI) is expected vs the cases in 2024-2025. There were 60 cases of E.coli bloodstream infections in 2024/25 FY, for 206/27 FY the Health Board would need to achieve 54 cases or less to meet the improvement goal.

E. coli bacteraemia: Learning identified and actions

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 Urinary Tract Infections (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

IP&C S.aureus bacteraemia

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.

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	11	6	5	45%	2.28	34.48
April 2026	11	6	5	45%	2.28	34.48

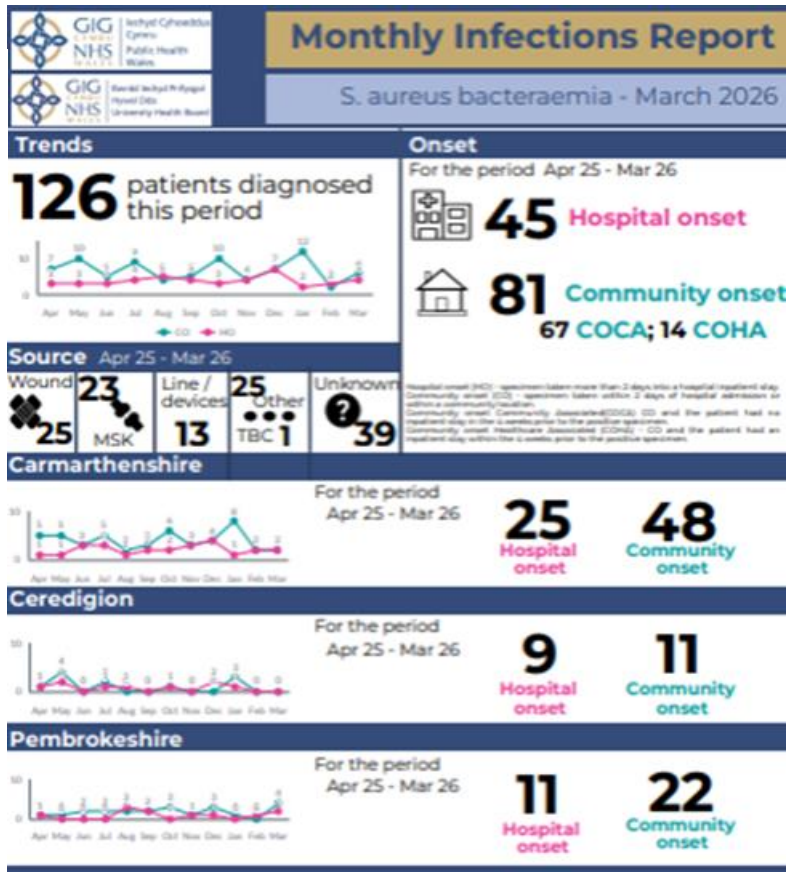
Table 2. Monthly count and rate of MRSA bacteraemia in Hywel Dda UHB, 2026/27

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

**Hospital onset (HO) - specimen

	Total count	CO* count	HO** count	% HO***	Total rate per 1,000 hospital admissions	Total rate per 100,000 population
2026/27	0	0	0	0%	0.00	0.00
April 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

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Learning Identified	Recommendations for the CCGs
Peripheral vascular catheter (PVC) bundle not completed: Gaps PVC bundle compliance increase risk of infection	• Compliance to be monitored through Infection Prevention Quality Indicator Audit (IPIAs) • Ensure use of Peripheral Venous Catheter bundles as best practice and ensure documentation
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.

Health Inspectorate Wales (HIW) / Care Inspectorate Wales (CIW) / Human Tissue Authority (HTA) inspection activity: 22/01/2026 - 05/05/2026

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

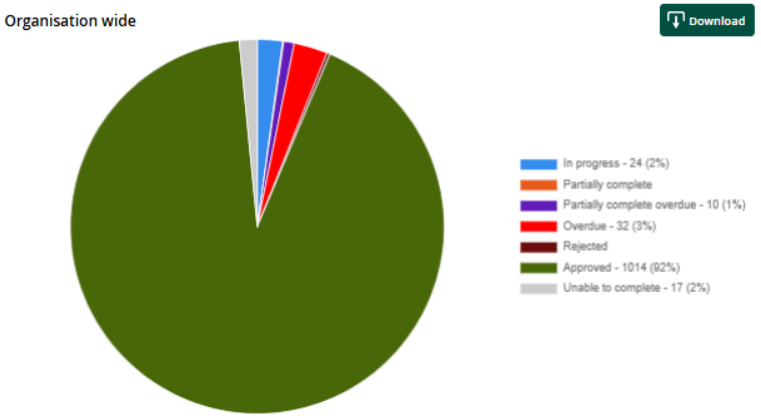
*Those shown in grey type have been previously reported to QSEC

Date of letter	HIW ref	Matter
16/01/2025	12474	Emergency Department staffing, GGH
30/01/2025	12589	Ceredig Ward, BGH – care of patient
14/02/2025	12702	Cwm Seren – care of patient
14/02/2025	12734	Staff behaviour in Radiology, GGH
25/02/2025	12858	Theatre Department staffing, GGH
18/03/2025	12994	PPH Bryngolau – care of patient
20/03/2025	12997	Ward 12 staffing, WGH
11/04/2025	13271	Paediatric Medical Workforce
12/04/2025	13272	Mental health services provision in north Ceredigion
12/04/2025	13274	Member of staff St Nons Ward, Bro Cerwyn
30/04/2025	13391	Critical care provision in Carmarthenshire
02/05/2025	13274	Member of staff St Nons Ward, Bro Cerwyn - additional query
20/05/2025	13271 13272 13274	Paediatric Medical Workforce – request for update regarding recruitment progress Mental health services provision in north Ceredigion – request for further information St Non's Ward – request for update
06/06/2025	13747	Withybush General Hospital – care of patient
11/06/2025	13391	Critical care provision in Carmarthenshire - status and timescales CSP consultation
11/06/2025	13274	St Non's Ward – request for update
18/08/2025	14435	Bro Cerwyn
13/08/2025	13272	MH&LD CTP compliance including update on actions to improve compliance
13/08/2025	14414	Withybush Hospital - procedures in place for informing patients about the re-enablement team, as well the information provided to them
24/07/2025	13747	WGH / Mental Health family concern – outcome date requested. Responded to 29/07/25 to advise plan to share on 8th Aug 25.
18/07/2025	14165	WGH Ward 10 assurance – assurance re provision for food and water and support for patients on ward
08/07/2025	13747	WGH / Mental Health family concern – update requested
08/07/2025	14043	GGH Radiology anonymous staffing concerns

Health Inspectorate Wales (HIW) Quality Checks/Inspections: Reviews and inspections

Improvement Actions relating to HIW reviews

Source: AMaT 05/05/2026



	Overdue	Partially complete (overdue)
Community and Integrated Medicine	11	6
Estates and Facilities	0	0
Mental Health and Learning Disabilities	9	1
Nursing, Quality and Patient Experience	0	0
Operational Allied Health and Health Science	6	1
Planned and Specialist Care	0	0

	Position as at 03/03/2026	Position as at 05/05/2026
Overdue	108	32
Partially complete (overdue)	12	10
Partially complete	0	1
In progress	45	24
Rejected (to be resubmitted)	0	3

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
13	186/263 (71%)	1/1 (100%)	0	0	24	1	10	32	10	0	3	426

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.

Completed 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
31	310/310 (100%)	18/18 (100%)	0	0	0	0	0	0	7	0	0	588

HIW Quality Checks/Inspections: Open reviews and inspections

GIG CYMRU NHS WALES
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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)/2025/716	HIW Cwm Seren LSU & PICU	6/15 (40%)	0	0	0	7	0	0	2	1	0	0	10
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)	18/40 (45%)	0	0	0	0	0	0	3	4	0	0	26
Healthcare Inspectorate Wales (HIW)/2025/750	HIW Improvement plan – Community Learning Disability Team	1/6 (17%)	0	0	0	7	0	0	0	0	0	0	2
Healthcare Inspectorate Wales (HIW)/2025/668	HIW Inspection BGH Emergency Department	20/29 (69%)	0	0	0	1	0	2	3	1	0	3	63
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)/2023/69	HIW St Non, St Caradog, Canolfan Bro Cerwyn WGH	13/18 (72%)	1/1 (100%)	0	0	0	0	1	4	0	0	0	24
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)	15/21 (71%)	0	0	0	0	0	3	6	0	0	0	25
Healthcare Inspectorate Wales (HIW)/2025/595	Mynydd Mawr Ward, Prince Philip HospitaL 03921	20/24 (83%)	0	0	0	1	0	3	1	2	0	0	51
Healthcare Inspectorate Wales (HIW)/2025/596	Nuclear Medicine IRMER WGH 03909	23/26 (88%)	0	0	0	5	0	0	0	1	0	0	36

HIW Quality Checks/Inspections:
Example open action plans for inspections:

In the appendix section of this report some example extracts of action plans from the Audit Management Tracking System (AMAT) are included.

1) To demonstrate the hard work of Derwen ward at GGH, the action plan shows 125 actions arose from this inspection. Of those 7 are overdue, and 2 are partially complete overdue.

2) The Bronglais Emergency Department (ED) action plan is included to show 73 actions arose from this inspection. There remain only 3 actions overdue, 2 partially complete overdue and 3 to be resubmitted.

3) The new Ionising Radiation Medical Exposure Regulations (IRMER) regulations came into force in April 2024. The action plan saw 9 recommendations and 10 actions. Of those, 3 remain overdue.

4) The St Non's and St Caradog inspection took place in 2023. The inspection had 29 actions arising. Of these, 4 remain overdue and 1 partially compete overdue.

5) Finally, The Joint Child Protection Arrangements in Pembrokeshire reported in 2025 with 34 actions. Of those, 6 actions remain overdue and 3 are currently partially complete overdue.

Recommendations

The QSEC is asked to take assurance that processes are in place to review, monitor and improve the quality of our service through:

- Patient safety incidents
- Nationally reported patient safety incidents
- Never Events
- Patient Experience
- Complaints management
- Inquests and Regulation 28
- Infection prevention and control
- Inspections and peer reviews including activity of Healthcare Inspectorate Wales (HIW)

The QSEC is asked to approve the Infection Prevention and Control Organisational Improvement Plan for 2026-27 (included as an appendix to this report)

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 - Cathie Steele, Interim Assistant Director of Nursing, Assurance and Safeguarding
7. Infection Prevention and Control – Rebecca Richards, Head of Infection Prevention and Control
8. Healthcare Inspectorate – Caroline Burgin, Patient Safety and Assurance

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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

Inspection Title	Recommendation	Action	Original Due Date	Progress Status	Comments/Updates
HIW St Non, St Caradog, Canolfan Bro Cerwyn WGH	The health board must ensure that staff have alarms and engage with staff to come up with solutions to make staff feel safer whilst working in a remote area.	CB to ensure all actions closed and evidence uploaded prior to closure of report	05/05/2025	Partially complete (Overdue)	
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	30/04/2024	Overdue	
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	30/04/2024	Overdue	
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.	30/04/2024	Overdue	
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.	30/04/2024	Overdue	
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)	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 . Updated responsible person for this action. 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 action returned to original owner as these are service specific actions and not corporate actions – the ownership needs to be within the CCGs
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)	

Inspection Title	Recommendation	Action	Original Due Date	Progress Status	Comments/Updates
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	CCGs to identify targeted improvement plans and report to Strategic Safeguarding Steering Group November 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	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 Achieving 85% compliance remains challenging. Aim to do so by 28.03.36	30/11/2025	Partially complete (Overdue)	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. 30/03/2026 update 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 has been appointed who will work with the individual clinical leads reviewing training requirements. There is quarterly delivery group meeting where nurse training is reviewed and areas of non compliance is addressed with the senior nurse managers. (Non-Compliance is <85%)
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	Overdue	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.
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	Overdue	To be reported to November 2025 Safeguarding Delivery Group. 28/4/26 - Supervision is monitored closely, HO Safeguarding reports supervision figures monthly to service leads. Services are also accountable for capturing supervision compliance within their SDG assurance report where compliance is monitored.

Inspection Title	Recommendation	Action	Original Due Date	Progress Status	Comments/Updates
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	HDdUHB are engaging well with this pilot and are represented at the Strategic and Practitioner groups.
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	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 support- but is reliant on successful recruitment/ onboarding- and resolution of other issues. Given the complexities and risks involved, this issue has now been escalated to the Deputy Director of Nursing, Quality & Patient Experience 28/4/26 The CCG Clinical Lead agreed that a six-week
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	

Inspection Title	Recommendation	Action	Original Due Date	Progress Status	Comments/Updates
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	

Inspection Title	Recommendation	Action	Original Due Date	Progress Status	Comments/Updates
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 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	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
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	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.

Inspection Title	Recommendation	Action	Original Due Date	Progress Status	Comments/Updates
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 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.	28/02/2026	Partially complete (Overdue)	Short stay triage implemented Trial of SDUC for 3 days / week
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.	29/09/2025	Overdue	
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.	30/09/2025	Overdue	
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.	30/09/2025	Overdue	
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.	30/09/2025	Partially complete (Overdue)	
Healthcare Inspectorate Wales (HIW)/2024/498/MD2/1	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	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. revised target date 31.4.26
Healthcare Inspectorate Wales (HIW)/2024/498/MD9/1	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	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

Inspection Title	Recommendation	Action	Original Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2024/498/MD9/2	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.	CB to ensure all actions complete to allow for closure	30/06/2025	Overdue	unable to complete until earlier actions have been completed

Infection Prevention and Control (IP&C) Organisational Improvement Plan 2026-27

Purpose: Demonstrate readiness for de-escalation by providing assurance to IPSSG, QSEC and Welsh Government demonstrating:

- Reduction in hospital-onset infections
- Reduce community-onset infections through system-wide prevention and early intervention
- Effective governance and escalation
- Evidence of sustained improvement

Executive Lead: Executive Director of Nursing, Quality and Patient Experience
Monitoring Group: Infection Prevention Strategic Steering Group
Action Owners: Assistant Director for Patient Safety, Quality and Experience (ADPS,Q&E) (for each CCG) / Associate Medical Director (AMD) (for each CCG) / Interim Assistant Director of Nursing, Assurance and Safeguarding (ADoN (A&S) / Head of Infection Prevention and Control (IPC) / Head of Nursing Health Protection

Objective	Action	Evidence expected	Date to be achieved	Action lead	Update
Quality Planning					
Establish a single Board-approved IP&C improvement programme	Develop and approve one integrated IP&C improvement plan aligned to escalation requirements, HCAI trajectories and the QMS framework	Plan approved by QSEC Improvement plan monitored through use of AMaT and updates on delivery provided to each IPSSG meeting.	**30 June 2026** **31 Dec 2026**	ADON (A&S) / Head of IPC	RAG: Amber Status: In progress Update: Presented to IPSSG on 02/06/2026. For approval by QSEC on 11/06/2026
Define the IP&C governance and accountability framework	Review and ratify the IP&C governance structure, including IPSSG, subgroups, CCG reporting lines and revised Terms of Reference	IPSSG Terms of Reference reviewed and approved by QSIG Letter to be sent to all IPSSG members reminding members about submission of written	**30 June 2026** **30 June 2026**	ADON (A&S) EDoNQPE	RAG: Amber Status: In progress Update:

RAG key:
Green = on track
Amber = in progress / some risk
Red = off track / significant risk

		reports and attendance at meetings 100% of subgroups reporting to IPSSG bi-monthly CCG reporting arrangements clarified with 100% of CCGs reporting bimonthly (as per workplan)	 **30 Sept 2026** **30 Sept 2026**	 IPSSG Sub-group chairs ADPS,Q&E (for each CCG)	
Translate organisational priorities into ward-level IP&C plans	Ensure all Clinical Care Groups (CCGs) have local IP&C plans aligned to organisational priorities, local infection challenges and incidence, with a focus on high-impact interventions such as care bundles and targeted ward-based controls.	All CCG plans include named leads, escalation routes, HCAI reduction targets, and defined high-impact interventions aligned to local infection risks.	**31 July 2026**	ADPS,Q&E (for each CCG)	RAG: Amber Status: In progress Update:
Strengthen public health partnership working for infection prevention	Establish a formal joint work programme with Public Health, local authority and primary/community services to coordinate surveillance, outbreak prevention, vaccination promotion, antimicrobial stewardship and health protection messaging.	Agreed work programme with named leads Regular joint review meetings in place Shared reporting on risks, outbreaks and prevention priorities Evidence of coordinated system action	**31 Dec 2026**	Head of Nursing Health Protection / Senior Community Infection Prevention Nursing Team	RAG: Amber Status: In progress Update:
Quality Control					
Implement a standardised IP&C audit and surveillance system	Implement an IPSSG-approved IP&C audit programme covering environment, hand hygiene, device care and antimicrobial practice	100% of high-risk areas audited monthly ≥90% completion of planned audits	**30 Sept 2026**	ADON (A&S) / Head of IPC	RAG: Amber Status: In progress Update:

		100% of audits with documented action plans	**31 Dec 2026**	ADPS,Q&E (for each CCG)	
Strengthen real-time HCAI surveillance and escalation	Further develop and embed the existing HCAI dashboard so that it supports routine use for infection surveillance, audit compliance, incidents, outbreaks and escalation.	Dashboard refined and used consistently across all sites. Reviewed at each IPSSG meeting. Reviewed weekly within the CCG and CSG	**31 Dec 2026** **31 Mar 2027**	ADON (A&S) / Head of IPC / Head of Performance / Director of Digital ADPS,Q&E (for each CCG)	RAG: Amber Status: In progress Update:
Improve workforce compliance with key IP&C practices	Achieve ≥85% compliance with IP&C training (Levels 1 and 2), with targeted improvement for Medical and Dental staff Baseline: Medical/Dental Level 2 compliance 41.12%	≥85% compliance across all staff groups Monthly compliance reports from each CCG	**31 Dec 2026**	Medical Director / AMD (for each CCG)	RAG: Amber Status: In progress Update:
Strengthen device and antimicrobial controls	Strengthen high-impact interventions for device and antimicrobial management, including care bundles, EPMA-enabled prescribing oversight, daily review of invasive devices, and operational scrutiny of compliance and exceptions.	≥95% compliance with device care bundle and review documentation. ≥90% compliance with antimicrobial stewardship and EPMA-related audit measures. Evidence of routine operational scrutiny at ward, site or CCG level.	**30 September 2026**	ADPS,Q&E (for each CCG) / AMD (for each CCG)	RAG: Amber Status: In progress Update:
Deliver measurable reductions in hospital-onset HCAIs	Deliver the required improvement trajectories for hospital-onset HCAIs, with monthly reductions in hospital-onset infections: • *E. coli* −2,	Monthly reduction trajectories achieved and reported for each priority organism.	**June 2026–March 2027**	ADPS,Q&E (for each CCG) / AMD (for each CCG)	RAG: Amber Status: In progress Update:

	• *C. diff* −2, • *Klebsiella* −1, and • MSSA/MRSA −0.5.				
Improve antimicrobial stewardship across community settings	Work with Primary Care and Public Health to strengthen community antimicrobial stewardship through prescribing review, guideline compliance, audit and targeted support for high-prescribing areas.	Community prescribing baseline established Audit programme in place Reduction in inappropriate antimicrobial prescribing Improvement in compliance with local antimicrobial guidance	**31 Mar 2027**	Head of Nursing Health Protection / Senior Community Infection Prevention Nursing Team / Deputy Medical Director Primary Care	RAG: Amber Status: In progress Update:
Strengthen community surveillance, learning and escalation	Develop routine reporting arrangements for community-onset infection data, outbreaks in non-acute settings, and recurring themes from case review, so that learning informs prevention activity across the whole system.	Community surveillance reporting incorporated into governance structure Escalation triggers defined for community infection risks Learning from cases/outbreaks shared across services Collation of evidence of actions taken in response to trends (action maybe needed by Local Authority and Primary Care)	**31 Dec 2026**	Head of Nursing Health Protection / Senior Community Infection Prevention Nursing Team	RAG: Amber Status: In progress Update:
Quality Assurance					

Strengthen the IP&C assurance framework and evidence pack	Strengthen the existing IP&C assurance framework and evidence pack, aligned to the organisational improvement plan and the Welsh Government Quality Statement, for Board and Welsh Government scrutiny.	Assurance framework/evidence pack includes HCAI trends, audit compliance, training, risks, improvement actions and alignment to the Quality Statement. Used in 100% of QSEC reports.	**31 July 2026**	ADON (A&S) / Head of IPC	RAG: Amber Status: In progress Update:
Demonstrate readiness for de-escalation	Provide assurance to IPSSG, QSEC and Welsh Government on reduced hospital-onset infections, effective governance and sustained improvement	Quarterly assurance reports evidencing de-escalation readiness	**Quarterly from Q2 2026/27**	ADPS,Q&E (for each CCG) / ADON (A&S) / Head of IPC	RAG: Amber Status: In progress Update:
Quality Improvement					
Target high-risk wards and services	Identify the top three high-risk wards per site and implement intensive improvement plans	Weekly oversight by Heads of Nursing and Senior Nurses in place ≥30% reduction in repeat infections and outbreaks in targeted areas	**31 July 2026**	ADPS,Q&E (for relevant CCGs)	RAG: Amber Status: In progress Update:
Embed a structured QI methodology	Implement PDSA-based improvement cycles for IP&C in all CCGs, with support from QI-trained staff within services across the organisation identified through liaison with Health Board QI Team	≥1 documented QI project per CCG. Evidence of implemented change and measurable outcome. QI support identified and linked to priority projects through Health Board QI Team	**31 March 2027**	ADPS,Q&E (for each CCG) / AMD (for each CCG)	RAG: Amber Status: In progress Update:
Strengthen organisational learning and response	Implement a structured review and learning process for all HCAI cases and outbreaks	100% of HCAI cases reviewed	**31 July 2026**	ADPS,Q&E (for each CCG) / Head	RAG: Amber Status: In progress Update:

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Red = off track / significant risk

		Learning shared monthly across the organisation		of IPC / IP&C Team	
Reduce community-onset infections through earlier prevention and intervention	Work with Primary Care, Local Authority, Community Services, Care Homes and Public Health to identify the main drivers of community-onset infections (for example UTIs, cellulitis, respiratory infections and community-onset bacteraemias) and implement targeted prevention measures.	Agreed list of priority community-onset infections Baseline and trajectory for community-onset cases established Joint prevention plan in place with primary and community partners Reduction trend demonstrated for priority community-onset infections	**31 Dec 2026**	Head of Nursing Health Protection / Senior Community Infection Prevention Nursing Team	RAG: Amber Status: In progress Update:
Improve prevention of infections associated with long-term conditions and frailty in the community	Target high-risk populations, including older people, care home residents and patients with recurrent infections, with focused interventions such as hydration, catheter care, wound care, vaccination uptake and early recognition/escalation pathways.	High-risk cohorts identified Targeted prevention bundles implemented Training/resources provided to community teams and care homes Reduction in avoidable infection-related admissions from targeted groups	**31 Dec 2026**	Head of Nursing Health Protection / Senior Community Infection Prevention Nursing Team	RAG: Amber Status: In progress Update: